



Office of Inspector General Department of Veterans Affairs



Semiannual Report to Congress
October 1, 2004 - March 31, 2005



FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2005. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended. OIG is dedicated to helping ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country.

A total of 125 reports on VA programs and operations resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. Audits, investigations, and other reviews identified nearly \$1.71 billion in monetary benefits, for an OIG return of \$50 for every dollar expended.

Our criminal investigators closed 502 investigations involving a wide variety of criminal activity directed at VA personnel, patients, programs, or operations. During the semiannual period, special agents conducted investigations that led to 645 arrests, indictments, convictions, and pretrial diversions. They also produced nearly [\\$146.5 million](#) in monetary benefits to VA (recoveries and savings). Additionally, the efforts of our agents and support staff led to the [apprehension of 252 fugitive felons nationwide](#).

One of our more significant cases involved a former Veterans Health Administration (VHA) medical research coordinator who, after an exhaustive investigation, pled guilty to criminally negligent homicide, mail fraud, and false statements. The indictment charged that the researcher intentionally submitted false and forged medical records to pharmaceutical companies, allowing otherwise ineligible patients to be included in oncology studies being conducted at a VA medical center (VAMC). At least one patient died as a result.

An OIG team conducted a proactive benefits review at the [VA Regional Office \(VARO\) in San Juan, Puerto Rico](#). The review recommended termination from VA benefit rolls of almost 1,400 payees who were not entitled to benefits. Overpayments for these beneficiaries totaled approximately \$29 million and represent a projected 5-year cost avoidance of over \$45 million. Over 1,700 referrals were made to the San Juan VARO regarding possible increases in benefits, aid and attendance, changes of address, corrected dates of birth, and various other changes. Additionally, 82 applications were sent to the National Personnel Records Center and the Bureau of Naval Personnel on behalf of veterans who had never received their service medals.

Audit oversight focused on improving VA services to veterans and their families. Our evaluation of the Workers' Compensation Program (WCP) found that movement of claimants to a retirement benefit plan at age 65 could reduce VA's future annual WCP costs by an estimated \$44.5 million, and potential avoidable lifetime WCP claimant costs could total \$487.8 million. Also, preaward

and postaward contract reviews identified monetary benefits of over \$1.03 billion resulting from actual or potential contractor overcharges to VA. Contract review recoveries have resulted in significant returns to VA's revolving supply fund.

Our health care inspectors focused on quality of care issues in VA. Inspectors visited a number of facilities to respond to congressional and other special requests concerning health care related matters. Our inspectors completed 18 Hotline cases and reviewed 54 patient care and services issues brought to our attention. Inspectors found instances where clinicians had not met the standards of care, patients were not treated satisfactorily, safety procedures designed to protect patients were not followed, and resident physicians were not properly supervised. Our inspectors also oversaw VHA medical facility directors' efforts to address allegations of poor care and services and provided clinical consultative support to investigators on criminal cases. In addition, inspectors provided oversight of the work conducted by VHA's Office of the Medical Inspector and of VHA's quality improvement efforts.

OIG's ongoing Combined Assessment Program (CAP) reviews the quality, efficiency, and effectiveness of VA facilities. Through this program auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VAMCs and VAROs on a cyclical basis. The 35 CAP reviews and 2 CAP summary reports completed during this reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. These reviews also documented monetary benefits of \$17.6 million.

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

A handwritten signature in black ink, reading "Richard J. Griffin". The signature is written in a cursive, flowing style.

RICHARD J. GRIFFIN
Inspector General

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2005. The following statistical data highlights OIG activities and accomplishments during the entire fiscal year (FY).

DOLLAR IMPACT (Dollars in Millions)

Better Use of Funds	\$1,560.2
Fines, Penalties, Restitutions, and Civil Judgments	\$7.2
Fugitive Felon Program	\$51.8
Dollar Recoveries	\$32.2
Savings and Cost Avoidance	\$54.8
Questioned Costs	\$2.4

RETURN ON INVESTMENT

Dollar Impact (\$1,709) / Cost of OIG Operations (\$34)	50:1
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OTHER IMPACT

Arrests	266
Indictments	181
Convictions	178
Pretrial Diversions.....	20
Fugitive Felon Apprehensions	252
Administrative Sanctions.....	1,574

ACTIVITIES

Reports Issued

Combined Assessment Program (CAP) Reviews	35
CAP Summary Reviews	2
Joint Review.....	1
Audits	29
Contract Reviews	38
Healthcare Inspections	15
Administrative Investigations.....	5

Investigative Cases

Opened	526
Closed	502

Healthcare Inspections Activities

Clinical Consultations	6
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Hotline Activities

Contacts.....	6,781
Cases Opened	452
Cases Closed.....	507

OFFICE OF INVESTIGATIONS

During this semiannual period, [the Criminal Investigations Division](#) closed 502 investigations resulting in 379 judicial actions (indictments, convictions, and pretrial diversions) and nearly \$94.7 million was recovered or saved. Investigative activities resulted in the arrest of 266 individuals who had committed crimes on VA property or directed at VA programs and operations. Information developed by our Fugitive Felon Program and provided to other law enforcement agencies resulted in 252 additional arrests of fugitive felons. Criminal investigators also referred 1,540 cases to facility directors for action. [The Administrative Investigations Division](#) closed 16 cases, issuing 5 reports and 3 advisory memoranda. These investigations resulted in management agreeing to take 14 administrative sanctions — including personnel actions against 8 officials — and corrective actions in 6 situations that will improve VA operations.

Veterans Health Administration (VHA)

A former VHA medical research coordinator pled guilty to criminally negligent homicide, mail fraud, and false statements after an extensive investigation revealed that he falsified medical data that “qualified” veterans to participate in an experimental drug study at a VAMC. As a result of the criminal scheme, at least one veteran died, and the health of countless others was put at substantial risk.

Two men pled guilty to demanding a bribe from a company in connection with a Government contract administered by a VA consolidated mail outpatient pharmacy (CMOP). The indictment charged that the CMOP director approached the owners of a company and demanded approximately one-third of the company’s ownership and cash receipts derived from a CMOP contract for over \$50 million, and threatened to cancel the contract if his demands were refused. The second man charged in this scheme worked at the CMOP on an independent contract basis and, in a series of telephone conversations with company owners, requested paperwork that would enable him to obtain a share in the company.

The Tennessean, Nashville, TN

October 21, 2004

Former pharmacy director indicted on bribery charges

Associated Press

The former director of a Dallas-area regional pharmacy operated by the U.S. Department of Veterans Affairs was indicted yesterday by a Nashville federal grand jury on charges of bribery and conspiracy.

conspiracy charges.

Both men are free on personal recognizance.

According to court records, authorities obtained audio recordings and videotapes of Cooper in what essentially was a shakedown scheme.

name of Clark, who had done work at the pharmacy center as an independent contractor, according to the indictment.

“The acts alleged in this indictment constitute a gross abuse of public trust by a federal official and contractor privileged”

Veterans Benefits Administration (VBA)

OIG conducted a proactive benefits review at the VARO in San Juan. An interdisciplinary team of OIG employees conducted the review that resulted in the proposed termination from VA benefits rolls of almost 1,400 payees. To date, the cost savings to VA is over \$29 million in overpayments with a projected 5-year cost savings of over \$45 million by terminating VA payments of those individuals who are not entitled to the benefits.

The wife of a quadriplegic veteran was sentenced to 30 years' imprisonment for murdering him and attempting to conceal the crime by setting their house on fire. A review of VA insurance files revealed that she also forged two life insurance forms naming her and her son beneficiaries, removing the names of the beneficiaries designated by the veteran. The wife has also been indicted for tampering with Government records regarding the arson and forgeries of the two documents. OIG worked this case jointly with the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) and a county sheriff's office.

Fugitive Felon Program

Since 2002, OIG has received approximately 6.5 million felony warrant files from participating law enforcement agencies. Matching these warrant files to more than 11 million VA benefit system records identified over 42,000 matched records and resulted in over 16,000 referrals of information from VA files about fugitive felons to various law enforcement agencies throughout the country. This information has led directly to the apprehension of 757 fugitive felons. OIG agents took part in 368 of these arrests. Over 12,000 fugitive felons identified in these matches have been referred to VA for benefit suspension, resulting in the identification of \$72.4 million in overpayments and a cost avoidance of over \$155 million.

During this semiannual period, there were 252 fugitives apprehended as a result of OIG agents directly assisting law enforcement or by sharing VA information with law enforcement. OIG also referred 2,945 administrative actions to the Department for benefit suspension, identifying overpayments estimated at \$15.3 million and a cost avoidance of \$36.5 million.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for \$1.5 Billion

Audits and evaluations focused on operations and performance results to improve service to veterans. Contract preaward and postaward reviews were conducted to assist contracting officers in price negotiations and to ensure reasonableness of contract prices. During this reporting period, 103 audits, evaluations, CAP reviews, and contract preaward and postaward reviews were conducted.

The evaluation of the Department's WCP found that movement of claimants to a retirement benefit plan at age 65 could reduce VA's future annual WCP costs by an estimated \$44.5 million. Potential avoidable lifetime WCP claimant costs could total \$487.8 million.

OIG's review of VA's efforts to implement an E-Travel service nationwide determined that the Department could save approximately \$7.4 million over the next 10 years by migrating to a General Services Administration (GSA) service, since the average prices available on GSA contracts are less expensive.

Preaward and postaward contract reviews identified monetary benefits of about \$1.03 billion resulting from actual or potential contractor overcharges to VA. In addition, CAP reviews identified monetary benefits of \$17.6 million.

Veterans Health Administration

OIG's summary evaluation of [VHA sole-source contracts with medical schools](#) and other affiliated institutions contains our collective recommendations for improvement in the procurement of health care resources in order to ensure quality health care is provided to veteran patients and to protect the interests of the Government. Our results and recommendations are presented in three sections: general contracting issues, contract pricing, and conflict of interest and other legal issues. With respect to general contracting issues, OIG concluded acquisition planning and justification for contracting out for services was inadequate, and some contracts were awarded to meet the needs of the affiliate, rather than VA.

Office of Management

The audit of [VA's Consolidated Financial Statements for FYs 2004 and 2003](#) resulted in an unqualified ("clean") opinion. The report on internal control discussed two material weaknesses involving inadequate information technology security controls and a lack of an integrated financial management system. The report also discusses two reportable conditions — operational oversight, and judgment fund payment for medical malpractice claims — that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information.

OIG also issued [10 management letters](#) addressing financial reporting and control issues as part of the annual consolidated financial statements audit. The management letters provided VA additional automated data processing security observations and advice that will enable the Department to improve accounting operations and internal controls. None of the conditions noted had a material effect on the FY 2004 consolidated financial statements, but correction of the conditions was considered necessary for ensuring effective operations.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on [24 CAP reviews](#) and reported on specific clinical issues warranting the attention of VA managers. OHI inspectors reviewed health care issues and made 147 recommendations to improve operations, activities, and the care and services provided to patients.

In responding to congressional and other special requests and reviewing patient allegations pertaining to quality of care issues received by the OIG Hotline, OHI completed 18 Hotline cases, reviewed 54 issues, and made 18 recommendations. These recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care and access to care, and making environmental and safety improvements. OHI assisted the Office of Investigations on six criminal cases that required review of medical records and quality assurance documents and monitored the work of VHA's Office of the Medical Inspector.

A review found that a medical center did not have a current decontamination program, and its initial request for decontamination equipment was not filled by VA Central Office (VACO). A delay had been needed to complete certification. OIG recommended submitting a revised equipment request and conducting decontamination training and exercises after the equipment is received.

An inspection to determine the validity of allegations regarding a delay in diagnosis and treatment of a veteran's lung cancer substantiated a delay in treatment, communication problems between providers and the patient's family, and inappropriate management of the patient's acute episode of pain by caregivers. OIG did not conclude earlier treatment would have led to the patient's survival.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

Our Hotline provides an opportunity for employees, veterans, and other concerned citizens to report criminal activity, waste, abuse, and mismanagement. During the reporting period, the Hotline received 6,781 contacts and opened 452 cases. Analysts closed [507 cases](#), of which 182 (36 percent) contained substantiated allegations. The monetary impact resulting from these cases totaled almost [\\$571,000](#). The Hotline staff wrote [50 responses to inquiries](#) received from members of the Senate and House of Representatives. The closed cases led to 20 administrative sanctions against employees and 125 corrective actions taken by management to improve VA operations and activities. Issues addressed by the Hotline included: quality of care, benefits, ethical improprieties, employee misconduct, and abuse of authority.

Follow-Up on OIG Reports

The Operational Support Division continually tracks VA staff actions to implement recommendations made in OIG audits, inspections, and reviews. As of March 31, 2005, there were 141 open OIG reports containing [627](#) unimplemented recommendations with over \$1.9 billion of actual or potential monetary benefits. During this reporting period, we closed 74 reports and 699 recommendations, with a monetary benefit of [\\$3.3 billion](#), after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 1 Year

The *Federal Acquisition Streamlining Act of 1994* provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, the OIG will identify the matter in their semiannual report to Congress. There are nine OIG reports issued over 1 year ago (March 31, 2004, and earlier) with unimplemented recommendations. Eight of these are VHA reports, and one is a VBA report. The OIG is particularly concerned with one report on VBA operations (issued in July 2000) and three reports on VHA operations (issued in March, October, and December 2002) with recommendations that still remain open. Details about these reports can be found in Appendix B.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs

Background

In one form or another, American governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrate our Nation's long commitment to veterans. The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers. The Department of Veterans Affairs was established on March 15, 1989, by Public Law 100-527, which elevated the Veterans Administration, an independent agency, to Cabinet-level status.

Mission

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

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



VA Central Office
810 Vermont Avenue, NW
Washington, DC

Organization

Three Under Secretaries head these administrations that serve veterans:

- Veterans Health Administration (VHA) provides health care.
- Veterans Benefits Administration (VBA) provides income and readjustment benefits.
- National Cemetery Administration (NCA) provides interment and memorial services.

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

- Management (Budget, Finance, and Acquisition and Materiel Management).
- Office of Information and Technology.
- Policy, Planning, and Preparedness (Policy, Planning, and Security and Law Enforcement).

VA and OIG Mission, Organization, and Resources

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

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

Resources

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2005, VA has approximately 222,000 employees and a \$69 billion budget. There are an estimated 24.8 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 203,000 of VA's employees work in VHA. Health care is funded at over \$30.8 billion in FY 2005, approximately 45 percent of VA's budget. VHA provides care to an average of 60,000 inpatients daily. During FY 2005, there will be over 58 million episodes of care for outpatients. There are 157 health care systems, 134 nursing home units, 206 veterans centers, 42 VA domiciliary residential rehabilitation treatment programs, and 916 outpatient clinics (including hospital clinics). In addition, VHA is

funded at over \$698 million for capital projects and the state extended care grant program.

Veterans benefits are funded at \$38.3 billion in FY 2005, about 55 percent of VA's budget. Approximately 12,700 VBA employees at 57 VAROs provide benefits to veterans and their families. Almost 3 million veterans and their beneficiaries receive compensation benefits valued at \$29 billion. Also, \$3.4 billion in pension benefits are provided to approximately 546,000 veterans and survivors. VA life insurance programs insure 7.3 million lives, with policies totaling \$756 billion. Approximately 300,000 home loans will be guaranteed in FY 2005, with a value of approximately \$43.8 billion.

The NCA operates and maintains 120 national cemeteries and 33 related installations and employs over 1,500 staff in FY 2005. NCA operations and capital funding and all of VA's burial benefits account for approximately \$429 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 95,900 for FY 2005. Approximately 358,000 headstones and markers will be provided for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General

Background

VA's OIG was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act* (Public Law 95-452) was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

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

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

Organization

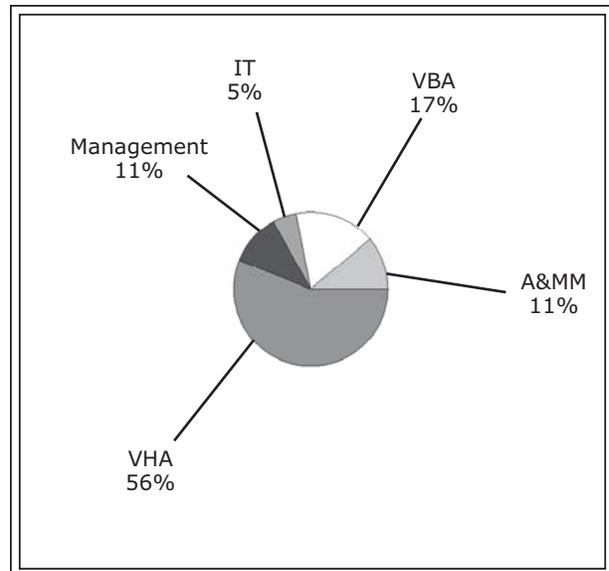
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2005 staffing plan are as follows.

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	155
Audit	197
Management and Administration	64
Healthcare Inspections	61
TOTAL	485

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

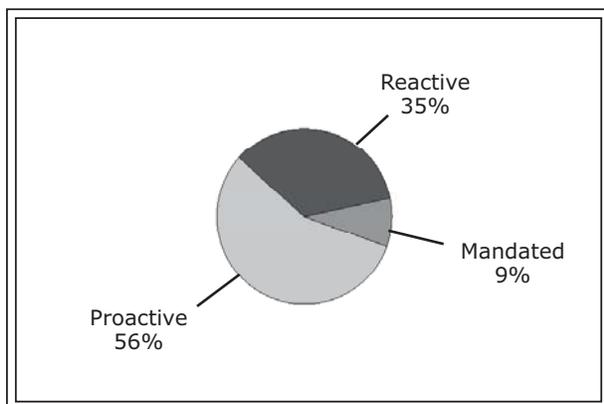
The FY 2005 funding of OIG operations is \$74.0 million, with \$69.1 million from appropriations, \$1.7 million from FY 2004 carryover, and \$3.2 million through reimbursable agreement. Approximately, 73 percent of the total funding is for salaries and benefits, 4 percent for official travel, and the remaining 23 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

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



VA and OIG Mission, Organization, and Resources

OIG resource allocation applied to mandated, reactive, and proactive work is:



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

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

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

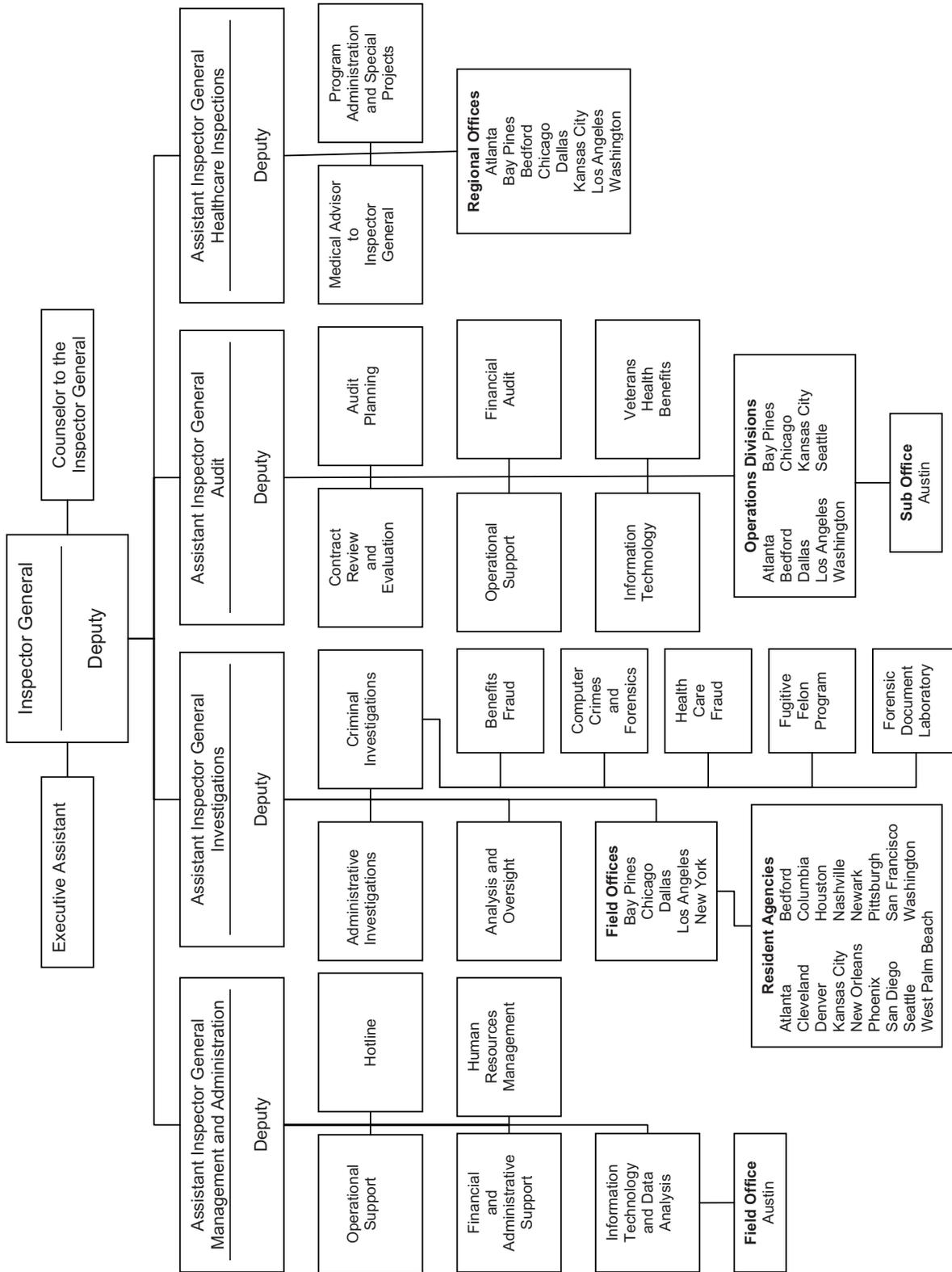
OIG Mission Statement

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

issues that are important to them and the veterans served.

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

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



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COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period October 1, 2004, through March 31, 2005, OIG issued 35 CAP reports with monetary savings of \$17.6 million. Of the 35 CAP reports, OIG reported on 24 VA health care systems (HCS) and VAMCs, and 11 VAROs. We also issued two CAP summary reviews.

Combined Assessment Program Overview - Medical

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

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

Auditors conduct reviews to ensure management controls are in place and operating effectively. Auditors assess key areas of management concern, which are derived from a concentrated and continuing analysis of VHA, Veterans

Integrated Service Network (VISN), and VAMC databases and management information. Areas generally covered include procurement practices, financial management, accountability for controlled substances, and information security.

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

During this period, OIG issued 24 health care facility CAP reports. Appendix A contains the full titles, report numbers, and dates of the CAP reports issued this period. These reports relate to the following VA medical facilities:

- [VA Central California Healthcare System, Fresno, California](#)
- [VA Long Beach Healthcare System, Long Beach, California](#)
- [VA Palo Alto Health Care System, Palo Alto, California](#)
- [VA Eastern Colorado Health Care System, Denver, Colorado](#)
- [Carl Vinson VA Medical Center, Dublin, Georgia](#)
- [Edward Hines VA Hospital, Hines, Illinois](#)
- [VA Northern Indiana Healthcare System, Fort Wayne and Marion, Indiana](#)
- [Richard L. Roudebush VAMC, Indianapolis, Indiana](#)

Combined Assessment Program

- Eastern Kansas Health Care System, Leavenworth, Kansas
- Minneapolis VAMC, Minnesota
- VA Montana Health Care System, Fort Harrison, Montana
- VA Nebraska Western Iowa Health Care System, Omaha, Nebraska
- Canandaigua VAMC, New York
- VA Medical Center, Fargo, North Dakota
- Louis Stokes VAMC, Cleveland, Ohio
- VAMC, Dayton, Ohio
- Philadelphia VAMC, Pennsylvania
- Ralph H. Johnson VAMC, Charleston, South Carolina
- VA North Texas Health Care System, Dallas, Texas
- West Texas VA Health Care System, Big Spring, Texas
- South Texas Veterans Health Care System, San Antonio, Texas
- Hunter Holmes McGuire VAMC, Richmond, Virginia
- VAMC, White River Junction, Vermont
- VAMC, Martinsburg, West Virginia

Summary of Findings

Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in OIG's *Summary Report of CAP Reviews at VHA Medical Facilities October 2003 through September 2004*, issued March 7, 2005. During this reporting period, OIG identified similar problems at the medical facilities.

Quality Management

- VHA program officials issued clarifications and initiated corrective actions that addressed most of the recommendations OIG made in its FY 2002 and FY 2003 Quality Management (QM) evaluation reports. CAP reviews found that the facilities included in this summary had active QM programs. OIG noted improvement in data management and also in the implementation and evaluation of corrective actions when problems were identified. Mortality analyses also improved.



VA Central California Healthcare System
Fresno, CA

- A repeat finding is that utilization management programs were inconsistent and needed improvement. In response to the FY 2003 report, VHA released a new directive in March 2005 that will provide improved consistency. Also, facility managers did not consistently benchmark their results or identify specific corrective actions when problems were identified. OIG found that some significant QM actions did not succeed because existing tracking systems did not assure full implementation.

Procurement

OIG identified the need to improve VA procurement practices as one of the Department's

most serious management challenges. OIG continued to identify control weaknesses in this area during CAP reviews. Controls need to be strengthened to effectively administer the Government purchase card program, improve contract award and administration controls, and strengthen inventory management.

- Government purchase card controls were deficient at 10 of 24 facilities where OIG tested for these issues. Policies and procedures were not followed governing the administration of the purchase card program, use of purchase cards, purchasing limits, and accounting for purchases.
- Auditors identified contract award and administration deficiencies at 16 of 24 facilities tested. Controls needed to be strengthened to ensure that:
 1. Acquisition and Materiel Management Service staff follow preaward and postaward contract policies and procedures.
 2. Contracting officials properly monitor contract performance and payment for services.
 3. Contract files include all required documentation, and the documentation is accurate.
 4. Contracting Officer's Technical Representatives are provided training, as required.
- Management of supply inventories was deficient at 22 of 24 facilities tested. Supply inventories were either not performed or inaccurate. Automated controls were either not fully implemented or not effectively utilized. Inventory levels exceeded current requirements resulting in funds being tied up unnecessarily in excess inventories. Ordering, receiving, and distributing functions were not properly segregated. Also, management of equipment inventories was deficient at 10 of 12 facilities

tested. Equipment inventories and spot checks were improperly performed, inaccurate, and not timely.

Information Technology

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

- OIG found inadequate management oversight contributed to inefficient practices, inadequate information security, and problems with physical security of assets. CAP findings complement the results of our FY 2003 Federal Information Security Management Act audit, which identified information security vulnerabilities that place VA at risk of disruption and denial of service attacks on mission critical systems, unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data, and fraudulent receipt of health care benefits.
- OIG found information technology (IT) security deficiencies at 19 of 23 facilities tested. OIG found that:
 1. Security and contingency plans were not prepared or not kept current and lacked key elements.
 2. Personnel access privileging to automated information systems was not performed quarterly.
 3. Access to VHA's Veterans Health Information Systems and Technology Architecture and the Internet was not effectively monitored.

Combined Assessment Program

4. Background investigations were not conducted for designated key hospital staff or contract personnel with access to sensitive areas.
5. Annual security awareness training was not conducted.
6. Risk assessments were not always conducted or in accordance with National Institute of Standards and Technology guidelines.
7. IT physical security needed improvement.

Controlled Substances

- VA has established policies, procedures, and guidelines for accountability of controlled substances and other drugs. However, controlled substance inspection procedures were inadequate to ensure compliance with VHA policy and U.S. Drug Enforcement Administration (DEA) regulations at 16 of 24 facilities tested. Facilities did not receive and post controlled substances into inventory witnessed by accountable officers designated by Acquisition and Materiel Management Service as required by VHA policy. They did not conduct or did not document required 72-hour inventories. Controlled substances awaiting return to the prime vendor were not entered into inventory and were not stored in secure locations. Facilities did not conduct unannounced inspections and inventories, or did not account for or dispose of unusable drugs properly. Discrepancies between inventory results and recorded balances were not reconciled in a timely manner. They did not report suspected thefts, diversions, or suspicious losses of controlled substances to the OIG Office of Investigations. Also, they did not properly segregate the placing and receiving of orders functions.

Medical Care Collections Fund

- VA health care facilities continue to increase Medical Care Collection Fund (MCCF)

collections. However, OIG found deficiencies at 19 of 21 facilities tested. Deficiencies included:

1. Not obtaining insurance information from veterans at the time of treatment.
2. Inadequate and untimely documentation of services provided.
3. Billable care not identified, fee-basis care not forwarded to veterans' health insurers for payment.
4. Billing backlogs being processed in alphabetical order instead of by date of treatment resulting in longer waiting times.

Facility management needs to strengthen billing procedures to avoid missed billing opportunities, improve timeliness of billings, improve accuracy of diagnostic and procedure coding, and aggressively pursue accounts receivable.



Canandaigua Medical Center
Canandaigua, NY

Pharmacy Security

- VA health care facilities need to improve physical security in pharmacy areas to meet VA standards. OIG found physical security deficiencies in pharmacy areas at 5 of 11 facilities tested. The pharmacy walls and dispensing window were not constructed of materials meeting minimum security requirements as required by VA policy. Pharmacy doors were mounted with removable external hinges. One pharmacy did not have a motion intrusion detection system, did not limit controlled substances vault access to 10 or fewer within a 24-hour period, and allowed separated pharmacy employees keypad access to the pharmacy.

Part-Time Physician Time and Attendance

- VAMC managers did not have effective controls in place to ensure that part-time physicians time and attendance records were accurate at 3 of 16 facilities tested. Physicians did not complete appropriate time and attendance records, and timecards were not posted based on the timekeepers' actual knowledge of physicians' attendance. Additionally, timekeepers did not receive annual refresher training, and desk audits were not conducted as required by VA policy.

Financial Controls

- Controls over the agent cashier function needed improvement at 2 of 5 facilities tested. OIG identified instances where unannounced audits were not conducted properly or timely and one instance the agent cashier's cash box was not counted because the box was not accessible to the auditor.
- Controls over accounts receivable needed improvement at 7 of 12 facilities tested. Fiscal service needed to:

1. Aggressively pursue accounts receivable for collection, and document

accounts receivable actions timely and accurately.

2. Reconcile accounts receivable with individual accounts monthly.
3. Properly write off uncollectible receivables.

- Facilities needed to improve their financial controls to prevent duplicate payments, which occurred at 2 of 2 facilities tested. Duplicate payments were processed by VA's Austin Automation Center Financial Management System when batch payments for contract nursing homes were processed that should have been canceled. Fiscal service used the wrong code when attempting to cancel the payments.

- VA facilities needed to comply with VA policy regarding unliquidated obligations at 3 of 9 facilities tested. Deficiencies included delinquent or no longer needed services which should have been canceled for undelivered orders or accrued services payable. Facility personnel should analyze unliquidated obligations monthly, follow up with requesting services to ensure continued need, and promptly cancel unneeded obligations when identified.

Survey Results

Inpatient Surveys

OIG completed 347 inpatient interviews in 24 VHA facilities to ascertain their satisfaction with mental health, medical, surgical, long-term, and intensive care. OIG discussed the results with local management officials before leaving the sites.

- Overall, 97 percent of the inpatients rated the quality of care they received in VHA facilities as good to excellent. Ninety-six percent of the respondents would recommend care at a VHA facility to an eligible family member or friend, and 95 percent said their care needs were being addressed to their satisfaction.

Combined Assessment Program

- Ninety-two percent of the inpatients told us that staff members explained their care plans to them, 95 percent felt that they were included in clinicians' decisions about their treatment. Eighty-six percent said that they received education from clinicians on prescribed medications and procedures.
- Twenty-one percent of the inpatients told us that they did not have one primary care provider who was responsible for their overall treatment. Thirteen percent had concerns about the adequacy of discharge planning for continuity of care following discharge from the hospital.

Outpatient Surveys

OIG surveyed 373 VA outpatients at 24 facilities to ascertain their satisfaction with primary care, mental health, or specialty care clinics. OIG also surveyed outpatients who were in waiting areas of the various supportive services such as pharmacy, radiology, and laboratory.

- Overall, 94 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety-three percent of the outpatients would recommend medical care to eligible family members or friends, 92 percent told us that their treatment needs were being addressed to their satisfaction, and 91 percent said they felt involved in decisions about their care.
- Eighty-eight percent of the outpatients reported that a health care provider discussed the results of tests and procedures with them. Ninety-five percent said their primary care provider discussed the reasons for medications with them, and 93 percent were told the reasons for referrals to specialists and why diagnostic tests were ordered.
- Only 76 percent of the outpatients said that they were generally able to schedule appointments with their primary care providers within 7 days of their request. Only 71 percent were given appointments and were assessed by the specialist within 30 days of the referrals.

- Eighty percent of the outpatients told us that they received counseling by a pharmacist when they received new prescriptions and 92 percent said that they received their refills in the mail before they ran out of their medications. Only 62 percent of the outpatients told us they received their prescriptions within 30 minutes.

Employee Surveys

OIG obtained employee feedback from responses to a web-based survey implemented at 24 CAP reviews. All employees of each facility were notified by e-mail about the survey and were provided with the Web address. OIG received 5,218 responses. Since the earliest CAP reviews, OIG has systematically elicited employees' perceptions on a wide range of issues. The resulting data can provide an independent, objective indicator of employee satisfaction for facility management to use in decision-making.

- Employees generally felt patients received quality care. However, additional emphasis is needed to ensure positive employee morale.
- Eighty percent of the employees who responded felt that quality patient care was the first priority at their medical center. Ninety-two percent believed the quality of care provided to patients at their respective facilities was either good or excellent. Over 78 percent felt that their medical center was clean, and 68 percent would recommend their facility to an eligible family member or friend.
- More than 88 percent of the respondents believed they received proper orientation, education, and training to do their jobs. In addition, 62 percent of these employees felt that management provided them opportunities to fulfill their continuing education needs or requirements. Seventy-five percent asserted that adequate supplies were available for them to do their jobs.

• OIG noted the following deficiencies that were common to most facilities:

1. Fifty-one percent of the responding employees believed they had not been offered opportunities for career advancement.
2. More than 34 percent of respondents asserted that work orders for needed repairs were not addressed promptly at their facilities.
3. Only 40 percent of responding employees felt staffing levels were usually sufficient to provide safe patient care.

Physical Plant Environment

OIG conducted environment of care inspections in 24 facilities evaluating primary care and specialty outpatient clinics, inpatient wards, emergency rooms, intensive care/coronary care units, nursing home care units, domiciliary units, psychiatry units, surgery, and rehabilitation areas, as well as in some kitchens, canteens, or supply processing and distribution areas.

• Twelve of the 24 facilities were generally clean and well maintained with minor issues management corrected immediately during our inspections, and 12 facilities received recommendations to correct deficiencies in the environment of care. Two of these 12 facilities had pervasive unacceptable levels of cleanliness, and safety and infection control deficiencies. One of the two facilities had to divert admissions of immune suppressed patients because of aspergillosis exposure risks to patients. Managers needed to improve procedures to ensure unobstructed hallways, secure chemical storage areas and medications, ensure patient privacy and safety, and strengthen cleaning and sanitation procedures. OIG discussed surveys with managers during site visits.

Combined Assessment Program Overview - Benefits

During this period, OIG issued 11 CAP reports on the delivery of benefits, listed in Appendix A with their exact titles, report numbers, and dates. These 11 reports relate to the following benefit facilities:

- VA Regional Office, Little Rock, Arkansas
- VA Regional Office, Hartford, Connecticut
- VA Regional Office, Indianapolis, Indiana
- VA Regional Office, Louisville, Kentucky
- VA Regional Office, Togus, Maine
- VA Regional Office, Fort Harrison, Montana
- VA Regional Office, Reno, Nevada
- VA Regional Office, Fargo, North Dakota
- VA Regional Office, Pittsburgh, Pennsylvania
- VA Regional Office, Providence, Rhode Island
- VA Regional Office, Sioux Falls, South Dakota

Summary of Findings

Deficiencies identified during prior CAP reviews in the management of veterans benefits programs were discussed in OIG's December 2004 summary report of CAP reviews at VAROs conducted October 2003 through September 2004. During this reporting period, OIG identified similar problems at all 11 facilities.

Compensation and Pension Claims Processing

• Compensation and pension (C&P) benefits for veterans hospitalized for extended periods

Combined Assessment Program

of time at Government expense were not reduced as required at any of the 11 facilities. Veterans Service Centers did not always identify hospitalized veterans whose benefits required adjusting. Management should ensure that payments to certain veterans be reduced as appropriate, consult with medical center staff to improve compliance with requirements for notification when veterans are hospitalized for extended periods, and provide refresher claims processing training for Veteran Service Center staff.

Information Technology

- IT security was deficient at 5 of 7 facilities tested. The CAP review coverage of VBA facilities in FY 2005 identified a wide range of vulnerabilities in VBA systems similar to those identified during VHA CAP reviews. These deficiencies could lead to misuse or loss of sensitive automated information and data. The CAP review findings show a need to improve access controls and contingency planning.



VA Regional Office
Togus, ME

Sensitive Records Security

- Physical security controls over sensitive records needed improvement at 7 of 11 facilities tested. Semiannual reviews of hardcopy and

electronic file security were not performed as required, access to file cabinets containing employee-veteran claims folders and other sensitive records were not properly controlled, sensitive files were not secured in locked files, claims folders were not maintained at the designated regional offices of jurisdiction, and sensitive electronic records were not secured through the common security user manager application.

Other VBA Programs

- VBA's processing and timeliness over vocational rehabilitation and employment claims continue to need improvement. Data entry, claims processing, timeliness of services, needs assessments, and case monitoring errors were noted at 7 of 9 facilities tested. Management and control deficiencies included:

1. Inadequate rehabilitation plans.
2. Missing counseling, evaluation, and rehabilitation folders.
3. Inadequate control of cases.
4. Insufficient documentation.
5. Unsigned education awards.

Appropriate actions are needed to promptly place veterans who are not pursuing their approved training programs in the discontinued status. Veterans who have completed the program must be placed in the rehabilitated status.

- OIG found that improvements were needed in fiduciary and field examination controls and procedures at 7 of 9 facilities tested. Fiduciary and field examination accountings were not always submitted accurately or on time. Management needed to improve the oversight of incompetent veterans by ensuring accountings and field examinations were conducted when needed, and that appropriate corrective actions were taken. In some cases, fiduciaries were not sufficiently bonded or considered for bonding.

- Government purchase card program deficiencies existed at 6 of 9 facilities tested. Supporting documentation for purchases was insufficient, reconciliations and certifications were not timely or not properly documented, and single purchase limits were not enforced. Unauthorized individuals used purchase cards, purchases were split, national contracts were not utilized, and cardholders and approving officials needed appropriate training. Adequate separation of duties between the billing officer and purchase card coordinator was not maintained. Management needs to ensure that cardholders are properly trained and warranted, prevent warranted cardholders from exceeding their \$2,500 micro-purchase limit, and require adequately documenting transactions. Management should use VA's national contracts when feasible, and must oversee expensive or unusual Vocational Rehabilitation and Employment (VR&E) procurements made on behalf of individual veterans.
- Benefits delivery network system-generated messages were not processed timely or properly at 2 of 4 facilities tested. This resulted in our identification of both overpayments and underpayments of veterans' benefits.
- There were processing deficiencies in retroactive payments of benefits at 2 of 11 facilities tested. Third reviews by supervisors and directors for verification of retroactive payments of \$25,000 or more were not on time, not performed, not documented, or were signed by an employee without third-signature authority. This resulted in our identification of both overpayments and underpayments of veterans' benefits.
- There were processing deficiencies in incarcerated veterans' payments of benefits at 3 of 9 facilities tested. Because reviews of incarcerated veterans' information were not timely, overpayments were made to incarcerated veterans.
- Regional office management needed to improve the timeliness of fiduciary activities and rating decisions at 3 of 3 facilities tested. The pending inventory of rating decisions was above the timeliness goal for the national "Balanced Scorecard" performance and average timeliness of rating decisions and fiduciary appointments exceeded performance goals. Improvements were needed in rating accuracy, fiduciary accuracy, and days to complete notices of disagreement. Also, the VR&E rehabilitation, fiscal accuracy, education, planning, and services accuracy rates needed improvement.
- Deficiencies procedures for future examinations appeared at 2 of 2 facilities tested. Staff did not establish proper controls and procedures to ensure that required future medical examinations were scheduled and conducted, nor were award reductions processed when found appropriate. Refresher training for rating specialists was needed to ensure disabilities subject to reduction were reduced when appropriate.
- Instances of improper compensation to veterans with dependent school-aged children were noted at 2 of 3 facilities tested. Compensation to veterans with dependent children was not reduced for Chapter 35 (Dependents' Education Assistance) benefits as required. Improvement was needed in communicating and tracking VBA regional processing offices' education division awards of Chapter 35 benefits to veterans' dependent children and the VARO having jurisdiction over the veterans' claim files. Annual staff refresher training, recoupment of excess payments, and benefit award reductions were needed.

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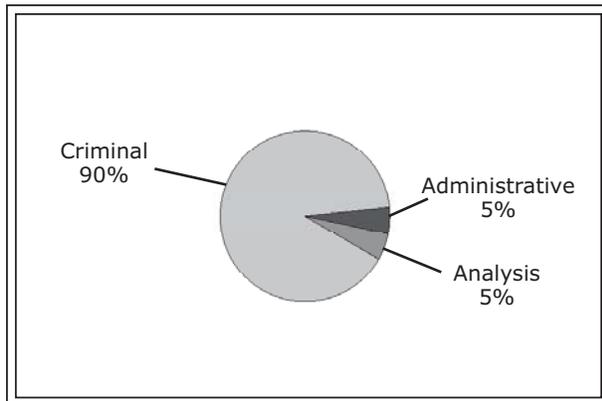
OFFICE OF INVESTIGATIONS

Mission Statement

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

Resources

Overall, the Office of Investigations has 155 FTE allocated to senior management and its three divisions: Criminal Investigations Division, Administrative Investigations Division, and the Analysis and Oversight Division.



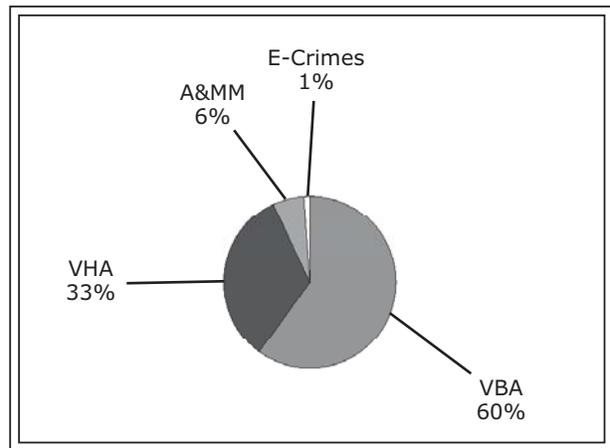
I. CRIMINAL INVESTIGATIONS DIVISION

This Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice or

state or local officials for prosecution. The Division is also responsible for operation of both the Forensic Document Laboratory and the Computer Crimes Forensic Laboratory.

Resources

The Criminal Investigations Division has 139 FTE allocated for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas:



Overall Performance

Output

OIG closed 502 investigations during the reporting period.

Outcomes

Arrests – 266
Indictments – 181
Convictions – 178
Pretrial Diversion – 20
Fugitive Felon Apprehensions – 252*
Administrative Sanctions/Program Referrals – 1,540

Monetary benefits – \$146.5 million (\$7.2 million – fines, penalties, restitutions, and civil judgments; \$515,000 – efficiencies/funds put to better use; \$32.2 million – recoveries; \$51.8 million related to the Fugitive Felon Program; and \$54.8 million in savings and cost avoidance).

*Includes the apprehension of 74 fugitive felons by OIG, and 178 apprehensions made by other law enforcement entities as a result of information provided by the OIG Fugitive Felon Program.

Customer Satisfaction

Customer satisfaction during this reporting period was 4.9 on a scale of 5.0, where 5.0 is high.

Veterans Health Administration

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value, including crimes such as patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, and inferior products. Working closely with VA police services, the Division has placed an increased emphasis on crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VAMCs. During this semiannual period, OIG special agents have participated in, or provided support to, VA police in the arrest of 37 individuals who committed crimes on VHA properties.

Homicide

A former VHA medical research coordinator pled guilty to criminally negligent homicide, mail fraud, and false statements, following an

intensive investigation. He admitted that he intentionally submitted false and forged medical records to pharmaceutical companies, allowing otherwise ineligible patients to be included in oncology studies being conducted at a VAMC. At least one patient died as a result.

New York Times, New York, NY
February 6, 2005

Abuses Endangered Veterans In Cancer Drug Experiments

By DEBORAH SONTAG

ALBANY — Carl M. Steubing, a decorated Battle of the Bulge veteran whose experience of war made him a pacifist but also instilled in him a zest for living life at full tilt, took his diagnosis of gastroesophageal cancer in 2001 as a challenge.

With a thatch of white hair and a rich baritone voice, Mr. Steubing, at 78, was not ready to succumb to illness. A retired music educator and wedding photographer, he remained active as a church choir director, expert cook, painter, golfer and fisherman. He was married to a woman 24 years his junior, and they had seven children and three grandchildren between them.

Mr. Steubing jumped at the chance to participate in an experimental drug study at the Stratton Veterans Affairs Medical Center in Albany, believing it offered him

IN HARM'S WAY

Research, Fraud and the V.A.

medical records, according to prosecutors, and enrolled him in the study. He also posed as a doctor.

In 2001, Mr. Steubing endured about six periodic treatments with an aggressive three-drug chemotherapy combination. Each infusion made him violently ill and forced his hospitalization. He died in March 2002.

Last month, at the federal courthouse in Albany, Mrs. Steubing glared at Mr. Kornak, 53, as he pleaded guilty to fraud, making false statements and criminally negligent homicide in the death of an Air Force veteran, James DiGeorgio. When Mr. Kornak admitted to falsifying the medical data of "subject initials CMS" —

OIG conducted an investigation jointly with VA police and a local police department after a veteran was shot at a VA domiciliary. The veteran subsequently died from complications from the gunshot wound. The suspect was convicted and sentenced to life in prison without parole for first-degree murder and 30 years in prison for armed criminal action. The sentences will be served concurrently.

Sexual Assault

A VAMC employee pled guilty to three counts of sexually abusing minors. The employee admitted to performing unlicensed physical exams and nude bone density scans on a minor

in the guise of conducting cancer research. This is an ongoing investigation involving OIG, the Department of Health and Human Services (HHS) OIG, Secret Service, VA police, and the local police.

Richmond Times-Dispatch, Richmond, VA
January 15, 2005

Man charged with abusing boys

Authorities accuse him of paying boys to be part of bogus study

BY TOM CAMPBELL
TIMES-DISPATCH STAFF WRITER

A Chesterfield County man faces multiple charges of sexual abuse of teenage boys and a possible long prison sentence after a U.S. District Court grand jury indicted him yesterday.

The U.S. attorney's office said Theodore L. Hodson III, 50, is accused of taking the teens to McGuire Veterans Affairs Medical Center, where he was a bone-density technician.

He used the pretense that he was conducting medical research and often paid the boys

to take part in his bogus study, authorities said.

According to the U.S. attorney's office, Hodson is accused of numerous sexual acts with children. He is accused also of performing several inappropriate tests on the children, including nude body scans and rectal examinations.

Hodson told the children that some of the tests were necessary for medical research, officials said. He is accused of inflicting oral sex on a minor.

"This case is particularly troubling both because of the depraved acts perpetrated on young children and because he used a medical health-care provider guise to lure his victims," said U.S. Attorney Paul J. McNulty.

Hodson is charged with nine

counts of sexual abuse and attempted sexual abuse; four counts of sexual abuse and attempted sexual abuse of a minor; one count of assault by striking, beating and wounding; nine counts of simple assault; four counts of simple assault against a child; 14 counts of theft from a health-care benefit program; and six counts of practicing medicine without a license.

Officials said the case is being investigated by several law-enforcement agencies, including the U.S. Department of Veterans Affairs Criminal Investigations Division, the U.S. Secret Service and the Virginia State Police. The case is being prosecuted by Assistant U.S. Attorney Sara E. Flannery.

seizure of five firearms — including an assault rifle — and numerous rounds of ammunition.

A veteran with a long history of violence and employing intimidating tactics was charged with threatening a physician at a VAMC after the veteran, who had been denied a claim for safety goggles, displayed photographs of himself with assault rifles and made fear-provoking statements.

A former VA employee who threatened to shoot his supervisor and co-workers following an altercation at work pled guilty to making criminal threats. He subsequently entered into a 12-month pre-trial diversion program that required completing an anger management course, not possessing a firearm, and staying away from his former VAMC workplace. He was also terminated from employment with the VAMC.

A veteran pled guilty to making threats against a VAMC director and stating that he "was going to shoot up anybody he came in contact with from VA within the next 10 days." He was sentenced to 1 year in prison but was released on probation after serving 38 days. A stipulation of the veteran's probation is that he is to have no contact with the VAMC. If this stipulation is violated, the veteran will be incarcerated for the full 1-year term.

Identity Theft

An OIG investigation determined a veteran who was discharged from military service under less than honorable conditions used the identity of an honorably discharged veteran with the same name in order to fraudulently obtain VA medical benefits. The suspect was sentenced to serve 10 months' incarceration, followed by 3 years' probation, and ordered to pay \$132,494 in restitution.

A joint investigation conducted with the Federal Bureau of Investigation (FBI) resulted in a former Veterans Industries employee at a local VAMC being charged with sexually assaulting a VAMC employee at the facility. The defendant pled guilty to forcible sexual abuse.

Assault

An OIG investigation determined that a man attempting to steal a vehicle at a VAMC tried to run over two VA police officers while fleeing. The defendant pled guilty to a charge of felon in possession of a firearm that included the original charge of assaulting a Federal law enforcement officer. He was sentenced to 64 months' incarceration and 3 years' supervised probation.

Threats

OIG agents and local police arrested a veteran at his residence pursuant to a Federal warrant for threatening to shoot a VA police officer. A search of the subject's residence resulted in the

During a veteran's stay at a VAMC, staff obtained information that led them to discover that he had admitted himself using another veteran's identity. OIG investigators found that the veteran had an outstanding warrant for parole violation, with an underlying charge of robbery, under his true identity. The veteran was arrested by VA police and OIG upon his discharge from the VAMC.

Drug Diversion

A grand jury returned indictments charging three nurses from the same VAMC with unrelated instances of possession of a controlled substance by misrepresentation fraud. An OIG investigation disclosed that one nurse diverted approximately 6,500 milligrams of Oxycodone from the VAMC's transitional care unit for personal use for 30 months. She resigned her position after confessing her guilt. The second, who had worked at the VAMC as a contract nurse, diverted Demerol from the hospital's acute care ward. The third diverted morphine sulfate and methadone pills from the VAMC's transitional care unit for personal use. VA terminated the third nurse's employment as a result of this investigation.

Reno Gazette-Journal, Reno, NV
October 26, 2004

Three former nurses charged in drug theft

By Jaclyn O'Malley
RENO GAZETTE-JOURNAL

Three former nurses at the Veterans Affairs Medical Center in Reno face federal charges alleging they stole patient pain medications for their own use.

Indicted are registered nurses Robert William Stone, 47, Lisa Anne Heilman, 39, and licensed practical nurse Colleen Anne Dito, 41, according to court documents. All are Reno residents. All three are accused of withdrawing pain medication from an automated machine and taking it home. These machines are designed to provide a track-

ing and accountability system for each patient, said Lisa Howard, hospital spokeswoman.

The indictment was issued earlier this month by a federal grand jury in Reno. Stone and Heilman are free on personal recognizance bonds and Dito has an active warrant for her arrest, records show. All three were indicted on multiple counts of possession of a controlled substance by misrepresentation or fraud. Each charged count carries a maximum of four years imprisonment and a \$250,000 fine.

The medications were Demerol, Roxicet and morphine.

Dito and Heilman were accused of 2003 thefts, and Stone was accused of thefts this year. Heilman surrendered her Nevada nursing license voluntarily and admitted to the allegation, records show. Dito and Stone are licensed in different states and the hospital is in the process of reporting them to their respective jurisdictions.

Howard said Dito and Heilman were fired immediately after the alleged thefts, and Stone resigned.

The monetary loss of the alleged thefts was unknown.

Both Heilman and Stone were scheduled for a December jury trial and have

pleaded not guilty. Dito has not been arrested on a warrant stemming from the indictment. Beth Foster, associate chief of pharmacy at the hospital, explained that nurses must swipe their identification badge through the machine and scan a bar code for each medication given to the patient.

"It's quite the state-of-the-art procedure," she said. "Anytime someone has access to controlled substances, we do a perpetual inventory."

"Unfortunately, some good people can get caught up in taking and self-administering controlled substances," Foster said.

VAMC for personal use over a 3-year period. She resigned from her position in lieu of termination. The nurse had been sentenced to 6 months' house arrest and 3 years' probation after pleading guilty to obtaining a controlled substance by fraud/misrepresentation.

A former VAMC pharmacist was sentenced to 2 years' probation and ordered to pay a \$2,000 fine after pleading guilty to possession of a controlled substance. An OIG investigation disclosed that the pharmacist stole Methadone and Oxycodone tablets from the prescriptions of VAMC patients.

Health Care Fraud

An OIG investigation determined that the managing partner of an oxygen and medical equipment company engaged in a scheme to defraud VA through the unauthorized use of a Government credit card obtained while doing business with a VAMC, and submitted \$88,000 in false charges. He pled guilty to wire and bank fraud, and was sentenced to 3 years' incarceration and 6 months' home confinement, to be followed by 3 years' probation.

Embezzlement

An OIG investigation resulted in a former VAMC employee, the local union treasurer, being sentenced to 6 months' house arrest, 3 years' supervised release, and ordered to make restitution of \$46,408 for embezzling union funds.

Operation Clean-Up

The area ringleader of a local drug distribution gang operating in and around a VAMC was sentenced to 50 years' imprisonment following his conviction on charges of conspiracy to distribute cocaine and possessing a firearm during a drug trafficking crime. The ringleader's sentence was the result of a joint investigation

An OIG investigation determined that a licensed VA vocational nurse diverted approximately 5,600 doses of Vicadin and Tylenol 3 from a

Hampton drug dealer receives 50-year sentence

By MONIQUE ANGLE
mangle@dailypress.com | 247-4731

HAMPTON — From 1995 to 2001, Donovan Bradley spent all but nine months in state prisons for dealing cocaine in Hampton and violating his probation. Prison didn't turn his life around.

"Within a month from being released from the penitentiary, he was back in business," said Special Assistant U.S. Attorney Tim Murphy.

The Newport News man set up shop in Phoebus and began selling cocaine and guns on the

street, Murphy said. It took an investigation that involved the Hampton Police Department, the inspector general of the Department of Veteran's Affairs, the Drug Enforcement Administration, and the Bureau of Alcohol, Tobacco, Firearms and Explosives to gather enough information to prosecute Bradley.

On Wednesday, a federal judge in Norfolk sentenced Bradley, 33, to 50 years in prison for one charge of conspiracy to distribute cocaine and two charges of possessing a firearm during a drug trafficking crime.

Bradley pleaded guilty to the charges in December.

On seven separate occasions, prosecutors said, a federal informant wearing a camera met with Bradley in a parking lot of a fast food restaurant and bought cocaine from him. One time, Bradley arranged for the informant to buy cocaine and a shotgun. Another time, he sold a handgun with the drugs.

Murphy said Bradley had his two girlfriends and an associate buy the guns legally from dealers and he would sell them on the street illegally. ■

into allegations of the sale and distribution of illegal drugs by VA employees, veterans, and local citizens that OIG conducted with VA police, DEA, ATF, and a local police department.

Employee Theft

A joint OIG, VA police, and HHS OIG investigation determined that a former VAMC dental resident stole VA dental equipment and sold it on eBay. As part of the plea agreement, the dentist was required to surrender his DEA controlled substance privilege. He was convicted of health care fraud, sentenced to 5 years' probation, and fined \$13,117.

In October 2004, a VAMC nurse supervisor took 20 doses of the VA's flu vaccine from the community-based outpatient clinic (CBOC) where she worked, during a nationwide shortage of those medical supplies. A co-conspirator

administered the stolen vaccine by injection in a McDonald's parking lot to people who were not entitled to receive it. Following a joint investigation between OIG, VA police, and HHS OIG, the nurse was indicted for theft from a health care benefit program.

Employee Misconduct

A former VAMC chief of police, who was the contracting officer's technical representative for a VA contract with a company providing security guards to the VAMC, was charged with receiving funds from this security company to pay for a vehicle that the defendant used for his personal benefit. He was sentenced to 3 years' probation and fined \$10,000 after pleading guilty to supplementing his salary from a source other than the Government.

OIG investigators determined a VAMC nurse provided Fentanyl (synthetic morphine) to a co-worker who subsequently died from a lethal dose of the drug. The nurse was sentenced to 1 year's incarceration and 3 years' probation.

Following an OIG investigation, a former VAMC employee was convicted on charges of access device fraud for using his Citibank-issued Government travel card for personal and non-travel related expenditures. He was sentenced to time served and placed on 24 months' probation.

Procurement Fraud

An OIG investigation disclosed that the corporate president of a construction company, a VA contractor, knowingly used foreign steel in an expansion project at a VAMC in violation of the "Buy American" requirement. The specific charges rose from the false documentation he provided to VA, removing the foreign markings, and knowingly submitting false bills to VA as if in compliance with the contract requirements. Indicted for conspiracy, false statements, and false claims, he entered a guilty plea on behalf of his company.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependents, including compensation and pension payments, home loan guaranty services, and educational opportunities. Each of these benefits programs is subject to fraud by those who wish to take advantage of the system. For example, individuals submit false claims for service-connected disability, third parties steal pension payments issued after the unreported death of the veteran, people provide false information so veterans qualify for VA guaranteed property loans, equity

skimmers dupe veterans out of their homes, and claimants obtain educational benefits under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud VBA operations.

Death Match Project

The Office of Investigations conducts an ongoing proactive project in coordination with OIG's Information Technology and Data Analysis Division. The death match project is conducted to identify individuals who may be defrauding VA by receiving benefits intended for veterans who have died. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. To date, the match has identified in excess of 9,650 possible investigative leads. Over 8,149 leads have been reviewed, resulting in the development of 860 criminal and administrative cases. Investigations have resulted in the actual recovery of \$14.6 million, with an additional \$7.3 million in anticipated recoveries. In addition to these recoveries, the 5-year projected cost avoidance to VA is estimated at \$32.6 million. To date, there have been 131 arrests in these cases with several additional cases awaiting judicial actions.

Compensation Benefits Fraud

An interdisciplinary OIG team conducted a proactive benefits review at the VARO in San Juan, Puerto Rico. The review recommended termination from VA benefit rolls of almost 1,400 payees who were not entitled to benefits. Overpayments for these beneficiaries totaled approximately \$29 million and represent a projected 5-year cost avoidance of over \$45 million. Over 1,700 referrals were made to the San Juan VARO regarding possible increases in benefits, aid and attendance, changes of address, corrected dates of birth, and various other changes. Additionally, 82 applications

were sent to the National Personnel Records Center and the Bureau of Naval Personnel on behalf of veterans who had never received their service medals.

A joint investigation with Social Security Administration (SSA) OIG revealed that a 100 percent service-connected veteran and his wife conspired to increase the veteran's compensation benefits by providing false information to receive payment for aid and attendance allegedly provided by his wife. The wife also provided statements to SSA to increase her disability benefit payments, claiming she could not walk and was in need of aid and attendance for services allegedly provided by the veteran. The veteran and his wife were sentenced to 60 months' incarceration, 36 months' supervised release, and ordered to make restitution of \$145,851 to VA and \$39,264 to SSA.

An OIG investigation disclosed a veteran feigned blindness, beginning in 1973, when he applied for and received disability compensation from VA for a visual disability. The veteran's scheme continued until May 2001, when OIG discovered information leading to VBA terminating benefits. The veteran had received overpayments totaling \$641,283. He was sentenced to a minimum period of incarceration of 30 months, placed on probation for 36 months, and ordered to make restitution of \$237,104.

Dependency and Indemnity Compensation (DIC) Benefits Fraud

An OIG investigation revealed that for more than 17 years the son of a deceased widow stole VA funds that were deposited into his deceased mother's bank account. He was sentenced to 10 months' incarceration, 3 years' probation, and ordered to make restitution of \$112,890.

A veteran's widow was arrested and charged with fraud after an OIG investigation revealed

that after remarrying, she falsely certified that her marital status was a widow. On three separate occasions, she used false statements to obtain more than \$86,000 in DIC benefits from VA.

OIG investigated the remarried widow of a veteran and determined that she did not notify VA of her remarriage in 1980 and received \$201,902 in VA benefits to which she was not entitled. She was indicted for mail and wire fraud.

The daughter of a deceased widow beneficiary was arrested for theft of Government funds after a joint investigation with Office of Personnel Management (OPM). OIG disclosed that the daughter continued to receive her mother's VA DIC benefit checks and OPM annuitant checks after her mother's death. The total loss to the Government was \$345,936, of which VA's loss was \$221,055.

Pension Benefits Fraud

During the course of a financial crimes investigation, OIG and local police determined that a veteran fraudulently applied for and received approximately \$30,000 in VA pension benefits. Investigation also revealed that the veteran had defrauded an elderly woman of more than \$400,000 during the same time period. As a result of a plea agreement in this case, the veteran pled guilty to financial elder abuse.

Education Benefits Fraud

A joint investigation with the Naval Criminal Investigative Service determined that a former active duty Navy personnel clerk had developed a scheme to defraud VA by fraudulently obtaining educational benefits under VA's tuition assistance program for active duty military. The subject conspired with other service personnel to defraud VA by purporting that these members

were furthering their education by attending classes. In addition, he used information he obtained from the personnel files of innocent servicemen to fraudulently apply for additional benefits in their names. After being found guilty of conspiracy to commit theft of Government property, he was sentenced to 30 months' incarceration, 36 months' supervised release, and ordered to pay \$348,653 in restitution.

An OIG investigation determined that 400 veterans received educational benefit payments while falsely claiming they attended college classes. They paid kickbacks to instructors and their assistants to ensure that the required monthly certifications of attendance would be signed and they would receive passing grades. A civil court imposed judgments against 11 veterans for False Claims Act violations. Most of the judgments ordered the veterans to pay double damages. The liability established against the 11 veterans was \$285,000. These recent settlements bring the amount recovered in this case, through civil and criminal actions, to almost \$5.7 million.

Home Loan Fraud

A joint investigation with the Department of Housing and Urban Development (HUD) OIG, the Postal Inspection Service, and the Internal Revenue Service (IRS) found that a man defrauded private financial institutions, VA, and HUD through the operation of corrupt home remodeling businesses. As part of the scheme, the defendant and a co-conspirator directed veterans to make false statements to VA about the satisfactory completion of work so that VA would release payment of VA home improvements and structural alterations funds directly to the defendants. The defendant was sentenced to 27 months' incarceration and 5 years' probation, and ordered to make restitution of \$702,813. His co-conspirator was sentenced to 23 months' incarceration and

5 years' probation, and ordered to make restitution of \$1.3 million.

Mortgage Loan Fraud

A private real estate attorney entered a guilty plea to charges of theft of Government funds and mail fraud. The plea resulted from a joint investigation with a state bureau of investigation that determined the attorney, who was responsible for disbursing the proceeds of real estate closings to sellers such as VA, prior lenders, and lien holders, did not make proper disbursement of closing proceeds. The investigation disclosed the attorney stole funds in excess of \$2 million from his attorney trust account.

Embezzlement

A paralegal employed by a private law firm was sentenced to 1 year and 1 day in prison, 3 years' supervised release, and was ordered to make full restitution for embezzling \$103,534 while acting as a conservator or representative payee for numerous veterans and Social Security beneficiaries. This was a joint investigation with SSA OIG.

Workers' Compensation Fraud

A joint OIG and Department of Labor (DOL) OIG investigation determined that a former VAMC nursing assistant, who received workers' compensation benefits from 1980 to 2004, had been working since at least Fall 2000 and failed to report her employment to DOL. The loss to the Government is \$57,472. She was indicted for fraud to obtain compensation.

Identity Theft

OIG agents arrested a veteran who assumed another veteran's identity to initiate a VA pension claim. The defendant illegally received both VA medical and pension benefits for more than 5 years. Two others who conspired to share

in the proceeds of this fraud were also arrested at the same time because of outstanding felony warrants.

Procurement Fraud

An OIG investigation revealed a funeral director fraudulently charged VA credit cards for indigent veterans' burial services that had been provided by other mortuary companies. The funeral director fraudulently collected funds for the burials of 723 veterans for a total of \$361,500. The funeral director pled guilty to fraudulent transactions with access devices.

Bribery

A former VARO employee pled guilty to conspiracy to commit bribery and defrauding VA, admitting he criminally manipulated over \$4 million in Government contract awards and payments to benefit specific contractors. In exchange, one VA contractor made cash payments of over \$100,000 to the employee. In addition, four VA contractors performed extensive renovations, free of charge, to the residences of the VA employee and a relative.

Fiduciary Fraud

A joint investigation with state police revealed that a fiduciary had misappropriated over \$106,000 in VA benefits from his veteran father's bank account by obtaining a guardianship order and then illegally withdrawing the funds. He pled guilty to misapplication of fiduciary property, was sentenced to serve 2 years' probation and 120 hours of community service, and was ordered to pay \$15,000 in restitution.

Recovery of Funds

The bank account of a widow receiving DIC pension benefits continued to receive direct deposit benefits after her death in January 1987. Working with a bank investigator, an OIG agent recovered \$149,066 of VA funds.

Threats

OIG agents arrested a veteran for using a telephone to make bomb threats to a VARO. An OIG investigation disclosed he made numerous calls to the VARO threatening to blow up the facility and kill the employees if he was not declared competent to handle his VA benefits.

A veteran who had made two prior threats against a VAMC and VARO attempted to crash his van, loaded with full gasoline cans, into the main entrance of the VARO. His attempt to reach the building was thwarted by flowerpot barricades. OIG charged him with destruction of Government property. Domestic terrorism charges are being considered by the U.S. Attorney's Office. This investigation is being worked jointly with the FBI.

Fugitive Felon Program

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

To date, Memoranda of Understanding/Agreements have been completed with the U.S. Marshals Service (USMS) and the National

Office of Investigations

Crime Information Center (NCIC), as well as with the States of California, New York, Tennessee, Washington, Pennsylvania, Ohio, Massachusetts, Alabama, and Arizona. OIG is negotiating additional agreements with other states. The program has led to additional cooperative efforts between OIG, VBA, and VHA in an attempt to implement this initiative.

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

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

OIG agents and members of a USMS violent crimes fugitive task force arrested a fugitive wanted for aggravated assault, possession of a firearm, possession of a firearm for an unlawful purpose, and questioning regarding a homicide. The fugitive was found with 42 vials of crack cocaine, a handgun, and a fraudulent VAMC identity card. Subsequent investigation revealed that the defendant assumed the identity of the veteran in order to elude law enforcement. Investigation is continuing to determine what VA benefits were illegally received by the defendant.

State parole agents requested OIG assistance to locate a veteran identified as a high risk sex offender and parolee-at-large convicted of child molestation and wanted for failure to register as a sex offender and a drug violation. OIG agents arrested the fugitive after developing information the fugitive was living at a VA-funded residence.

Fugitive Felon Program	This Reporting Period	Total Since Beginning
Felony Warrants Received from Participating Agencies	3.0M	6.5M
Matched Records	3,949	42,635
Referred to Law Enforcement Agency Which Holds the Warrant	3,980	16,281
Arrests Made by Law Enforcement Agency Which Holds the Warrant	178	389
Arrests Made by OIG	74	368
Referrals to VA for Benefits Suspension	2,945	12,146
Estimated Identified Overpayments	\$15.3M	\$72.4M
Estimated Cost Avoidance	\$36.5M	\$155.5M

The Fugitive Felon Program identified a VA employee who was wanted for a parole violation for a 2nd degree murder conviction. He was arrested without incident at a VAMC by OIG agents, local law enforcement, and VA police.

A veteran was arrested pursuant to a warrant for the sexual assault of a juvenile. The veteran had been wanted for 19 years and was located by law enforcement officers as a direct result of the OIG Fugitive Felon Program.

OIG, VA police, and local and state officers arrested a VA employee at a VAMC who had previously been convicted for the rape of a child and failed to register as a sex offender.

OIG and local police apprehended a fugitive veteran on parole for the sexual assault of a child after the veteran had left the country in violation of his parole. As specified in the law, the veteran's benefits were suspended due to his fugitive status, and, with no income, he was forced to return to the U.S.

Local law enforcement officers located and arrested a veteran wanted for 4 years for a sexual assault charge as a direct result of information provided by the OIG Fugitive Felon Program.

Pursuant to a felony probation violation warrant for theft, OIG and the USMS arrested a fugitive veteran at a VAMC. The veteran was one of the area's ten most wanted fugitives.

OIG Forensic Document Laboratory

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

There were 24 completed laboratory cases during this semiannual period.

Laboratory Cases this Period	
Requester	Cases Completed
OIG Office of Investigations	7
VA Top Management	9
VA Regional Offices	8
TOTAL	24

The Board of Veterans' Appeals requested laboratory analysis of medical records submitted to VA by a veteran who used them to obtain VA disability compensation. The Forensic Document Laboratory examined the records submitted by the veteran and compared them with military records, resulting in the identification of alterations the veteran had made to his medical documents.

OIG, ATF, and a local sheriff's department conducted a criminal investigation which resulted in the conviction of the wife of a quadriplegic veteran for his murder. The wife attempted to conceal the crime by setting their house on fire. OIG investigators focused on determining possible fraud by the veteran's wife with regard to his VA life insurance policy. Laboratory examinations determined that the veteran had not signed the last designation of beneficiary for his VA life insurance valued at \$10,000, but rather, that his wife had completed and forged the veteran's signature before signing her own name as a witness on the document.

The wife was found guilty of the homicide and sentenced to 30 years' confinement.

OIG Computer Crimes and Forensic Laboratory

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

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

Computer Crimes and Forensics Laboratory conducted four on-site crime scene support operations. Additionally, it took an active role in the implementation of global positioning satellite tracking capability deployment. It is currently engaged in the deployment of NCIC access terminals at five OIG field offices.

Laboratory Cases this Period	
Child/Adult Pornography	4
Fraud	3
Misuse of Government Systems	1
TOTAL	8

Houston Chronicle, Houston, TX

March 23, 2005

Wife gets 30-year sentence in disabled husband's death

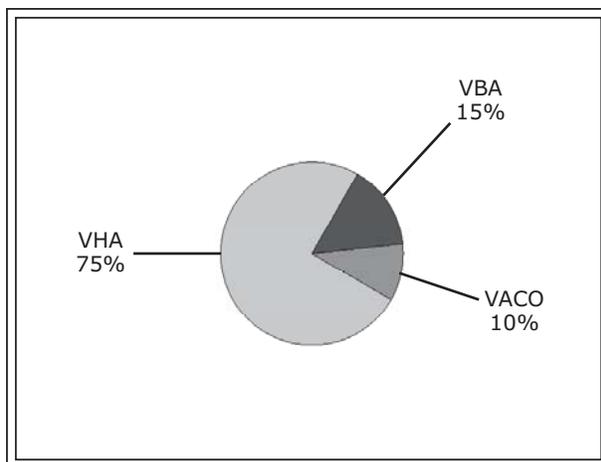


II. ADMINISTRATIVE INVESTIGATIONS DIVISION

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

Resources

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



Overall Performance

Output

The Division closed 16 cases and issued 5 reports and 3 advisory memoranda.

Outcomes

VA managers agreed to take 14 administrative sanctions, including personnel actions against 8 officials, and corrective actions in 6 instances to improve operations and activities. The corrective actions included monitoring a senior

official's absences and reassessing his need to travel outside his geographic area of supervision, charging a full-time physician annual leave (or absence without leave) for unauthorized absences, and modifying employees' improper work agreements and work schedules.

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

Veterans Health Administration

Misuse of Time by Physicians

Two administrative investigations substantiated misuse of official VA time by physicians. In one case, a full-time physician worked for another employer during part of his VA tour of duty on 174 days over a period of nearly 3 years. In the second case, a full-time physician, who has since left VA, performed professional services and generated income for a VA-affiliated medical school during his VA duty hours. In both instances, the physician's supervisor did not ensure the physician followed time and attendance policies. VHA officials agreed to take appropriate administrative action against the physician still employed by VA, and against both supervisors. They also agreed to take corrective action regarding the currently employed physician's unauthorized absences.

National Cemetery Administration

Inappropriate Absences and Purchase Card Use

An administrative investigation substantiated that a NCA senior official was inappropriately absent from his duty station, including sometimes being absent without leave. The official took frequent and unpredictable increments of leave and arrived at work several hours late on a regular basis, which interfered with the efficient management of the office. OIG also questioned whether his frequent official travel for purposes other than that related to the primary purpose of his position was in the NCA's best interest. The investigation further substantiated that he repeatedly allowed a Government purchase card to be misused to purchase personal items. NCA officials agreed to take appropriate administrative action against the official, to approve and closely monitor his leave and travel, and to ensure he makes full restitution for his absences without leave.

III. ANALYSIS AND OVERSIGHT DIVISION

This Division has oversight responsibilities for all operations conducted by the Office of Investigations through a detailed inspection program to ensure the agency is in full compliance with the quality standards for investigations published by the President's Council on Integrity and Efficiency (PCIE). The Division is also responsible for scheduling and facilitating operational and management training for all employees within the Office of Investigations. Additionally, the Division is the primary point of contact for law enforcement communications through the NCIC, the National Law Enforcement Telecommunications System,

the Financial Crimes Criminal Enforcement Network, and other law enforcement professional organizations.

Resources

The Analysis and Oversight Division has seven FTE allocated.

Overall Performance

Output and Outcomes

During the reporting period, the Division accomplished the following:

- Scheduled and/or facilitated 179 instances of training involving 107 different employees for such courses as Criminal Investigator Training Program, IG Transitional Training Program, Continuing Legal Education, Interviewing Techniques, Firearms Instructor Program, Defensive Tactics Training Program, and OPM Management Training.
- Conducted 253 record checks in support of criminal investigations.
- Completed an inspection of a regional field office.
- Issued two revised policy directives.
- Conducted one regional periodic refresher training seminar for all criminal investigators that included firearms qualification, scenario-based exercises, use of force policy discussions, report writing, defensive tactics and related practical drills, legal update, and physical conditioning assessments.

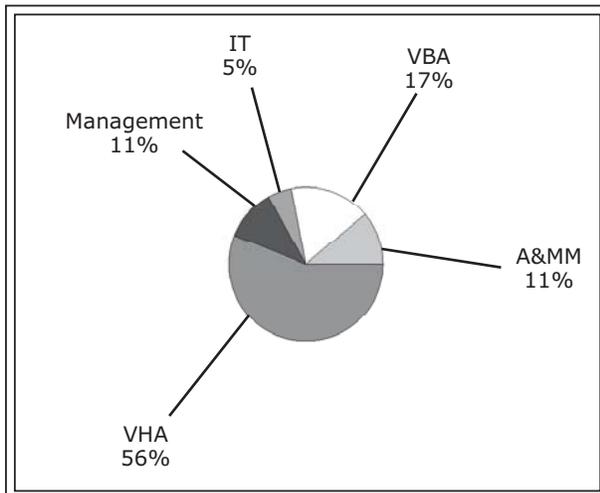
OFFICE OF AUDIT

Mission Statement

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

Resources

The Office of Audit has 17 FTE allocated for headquarters and 180 FTE in 11 operating divisions located throughout the country. The following chart shows the allocation of resources used in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division has 25 FTE authorized for reimbursement under an agreement with the VA Office of Acquisition and Materiel

Management. This division conducts preaward and postaward reviews of certain categories of VA contracts.

Overall Performance

Outputs

- Issued 29 audit reports and 38 contract reviews. In addition, took part in a major joint review.

Outcomes

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately \$536 million. In addition, contract reviews identified monetary benefits of \$1.03 billion associated with the results of preaward and postaward contract reviews.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations average 4.5 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.7 out of a possible 5.0.

Veterans Health Administration

Resource Utilization

Issue: VHA sole-source contracts with medical schools and other affiliated institutions.

Conclusion: VA needed to strengthen controls over sole-source contracts.

Impact: Better use of funds.

OIG has been conducting preaward reviews of proposals for contracts to be awarded on a sole-source basis to VA affiliates. These reviews, combined with postaward reviews, CAP reviews, and interactions with VA personnel, have identified numerous issues that needed to be addressed. This summary report contains our collective recommendations for improvement in the procurement of health care resources in order to ensure quality health care is provided to veteran patients and to protect the interests of the Government.

Our results and recommendations are presented in three sections:

- General contracting issues.
- Contract pricing.
- Conflict of interest and other legal issues.

With respect to general contracting issues, OIG concluded acquisition planning and justification for contracting out for services was inadequate and some contracts were awarded to meet the needs of the affiliate, not VA.

With respect to contract pricing, the sole-source solicitations OIG reviewed were divided into services provided at the affiliate and services provided at VA. When the services were provided at the affiliate, all the proposals were procedure based. OIG concluded VA was overpaying the affiliates for services provided under both of these pricing structures. For services provided at VA, pricing was either full-time equivalent based or procedure based.

The legal issues discussed in this report include:

- Violations of conflict of interest laws.
- Use of personal services contracts.
- Contract requirements that were inherently Governmental functions.

- The Government's liability for acts or omissions of contract employees under the *Federal Tort Claims Act*, even though VA was paying for their medical malpractice insurance under these contracts.

The Acting Under Secretary for Health agreed with the recommendations and provided acceptable implementation plans. (*Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions, 05-01318-85, 2/16/05*)

Issue: Management of VHA major construction contracts.

Conclusion: VHA needed to improve the award and administration process to ensure price reasonableness and prevent fraud, waste, abuse, and mismanagement.

Impact: Better use of \$960,000.

The audit found contract awards, administration, and project management needed to be enhanced to ensure VA does not pay excessive prices for construction work. The audit pointed out a risk for excessive prices involving major construction projects valued at \$133.6 million. It also identified about \$960,000 in unused funds that should be returned to the construction reserve fund if no longer needed. Additionally, the Office of Audit referred potential fraud involving certain contract award actions to OIG's Office of Investigations.

VHA needs to improve the major construction contract process to ensure contracts:

- Result in reasonable prices for work completed.
- Are in the best interests of the Government.

- Are adequately controlled to prevent fraud, waste, abuse, and mismanagement.

The VHA Office of Facilities Management is responsible for managing all major construction projects. At the time of the audit, that office was administering 31 major contracts valued at \$594.6 million where construction had been completed within 24 months of the start of our review or was in process. The audit reviewed each of these contracts and identified contract award and administration problems with 24 contracts.

OIG made a series of recommendations to the Acting Under Secretary for Health to help strengthen the major construction contract award and administration process. The Acting Under Secretary generally agreed with the majority of the audit recommendations. He agreed with qualification on four recommendations and provided alternative wording OIG found acceptable and which met the intent of our original recommendations. In response to the Acting Under Secretary's comments, OIG reduced the monetary benefits estimate to reflect VHA's actions to close out contracts where no additional payments were expected. The Acting Under Secretary's comments provide details on ongoing or planned actions that meet the intent of the recommendations. (*Audit of VHA Major Construction Contract Award and Administration Process, 02-02181-79, 2/8/05*)

Issue: Appropriateness of MCCF first party billings.

Conclusion: VHA can reduce inappropriate billings and collections for medical services provided to certain veterans receiving benefits.

Impact: Improved service to veterans.

The purpose of the evaluation was to determine the appropriateness of MCCF first party billings and collections for certain veterans receiving C&P benefits. OIG found that inappropriate billings and collections had occurred and recommended that the Acting Under Secretary for Health take the following actions:

- Ensure that Health Eligibility Center (HEC) management corrects the database coding problem to recognize the pension status of veterans who are also service-connected less than 50 percent and not bill them for medical care.
- Pending development of VETSNET:
 1. Ensure that medical facility managers direct Information Resource Management staff to distribute HEC MailMan messages to both MCCF eligibility staff and billing staff.
 2. Require medical facilities to access veterans' benefits information through VBA to obtain the effective dates for veterans awarded service-connection rated 50 percent or higher, or awarded VA pensions, and verify that first party debts are appropriate before issuing bills or referring debts to the Debt Management Center for collection.
- Ensure that HEC management timely follows up on rejected award information and uploads the correct information into its database so that veterans' C&P status changes can be updated in medical facilities' VistA systems.

The Acting Under Secretary for Health agreed with the recommendations and provided acceptable implementation plans. (*Evaluation of Selected MCCF First Party Billings and Collections, 03-00940-38, 12/1/04*)

Quality of Care

Issue: Medical sanitation and part-time physicians' time and attendance.

Conclusion: Management did not maintain appropriate levels of cleanliness and fully implement time and attendance controls.

Impact: Strengthened controls over quality of care and time and attendance.

Our purpose was to review alleged deficiencies in the environment of care, quality of patient care, resident supervision, and physician time and attendance as reported during an April 8, 2004, national television broadcast of *Primetime*. This report addresses the results of our review of environment of care and time and attendance issues.

Our review of the quality of patient care, resident supervision, and time and attendance practices specific to the surgeon who was the subject of the *Primetime* broadcast continues, and the findings will be discussed in a separate report. Although there were opportunities to improve general housekeeping at both divisions, OIG did not find the conditions to be as egregious as cited in the *Primetime* broadcast. The hemodialysis unit at the Wade Park Division is scheduled to be moved to a new location early in 2005. However, efforts needed to be made to improve conditions in the existing area. Most patients and employees from both divisions indicated high levels of satisfaction with the quality of care and with the facilities' cleanliness. Medical center managers had not fully implemented time and attendance controls recommended in our February 2004 follow-up report. Although most part-time physicians were on duty as required by their scheduled tours, 4 of the 73 (5 percent) part-time physicians scheduled for duty

were not on duty, approved leave, or authorized absence under circumstances similar to those OIG identified during our follow-up report.

The VISN and Medical Center Directors agreed with the findings and provided acceptable improvement plans. (*Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VAMC, Cleveland, OH, 04-02145-11, 10/29/04*)

Data Validity

Issue: Compliance with Public Law 107-135.

Conclusion: VA data reported on specialized mental health programs for this year, as in prior years, remains error-prone and lacking in adequate support.

Impact: Accurate data.

Our audit showed the data reported in the FY 2003 Capacity Report relating to spinal cord injury/disorders, blindness, prosthetics and sensory aids, and traumatic brain injury were adequately supported. However, the data for specialized mental health programs (including reported staffing, numbers of programs, and expenditures) were not adequately supported. VHA is in the process of implementing a new reporting process in response to the FY 2002 Capacity Report findings and recommendation. This new reporting process is expected to eliminate the data reporting issues associated with specialized mental health programs. As a result, no new recommendation is included in this report. OIG will continue to follow up on VHA's implementation of the prior year report recommendation. (*Audit of VA FY 2003 Special Disabilities Capacity Report, 04-01972-41, 11/29/04*)

Veterans Benefits Administration

Issue: Contracting process and pricing information.

Conclusion: The existing VR&E contracts needed to be replaced, and management and oversight strengthened.

Impact: Better use of \$6.8 million.

OIG conducted the evaluation at the request of the VR&E Task Force, which was concerned about the adequacy of the contracting process and pricing information. Based on the contracting vulnerabilities identified, OIG is concerned about the reasonableness of contract prices. This concern is supported by the fact that prices for similar services included in VR&E contracts provided by some of the same contractors on the prior contracts reviewed varied significantly, and price increases in the base year ranged from 23 to 314 percent. Also, voluntary price reductions have been received from at least 25 contractors nationally, with price reductions expected from additional contractors. Based on the price reductions VA has received, contracting costs could be reduced by as much as 15 percent. This could reduce VA's estimated \$45 million in expenditures expected over the potential 5-year term of the existing VR&E contracts by an estimated \$6.8 million.

OIG made recommendations to the Under Secretary for Benefits to replace the existing VR&E contracts and strengthen regional office contract management and oversight. The Under Secretary provided responsive comments and acceptable implementation plans. (*Evaluation of VBA VR&E Contracts, 04-01271-74, 2/1/05*)

Office of Management

VA's Consolidated Financial Statements (CFS)

Issue: VA's CFS for FYs 2004 and 2003.

Conclusion: Audit resulted in an unqualified opinion, but significant control weaknesses and noncompliance items still remain.

Impact: Improved stewardship of VA assets and resources.

OIG contracted with the independent public accounting firm Deloitte & Touche LLP to perform the audit of VA's FY 2004 CFS. OIG defined the requirements of the audit, approved the audit plans, monitored the audit, and reviewed the draft reports. The independent auditors' report provided an unqualified opinion on VA's FY 2004 and FY 2003 CFS. OIG agrees with the auditors' opinion and with the conclusions in the related report on VA's internal control over financial reporting and compliance with laws and regulation.

The auditor's report on internal control identifies four reportable conditions, of which two are material weaknesses. The two material weaknesses are information technology security controls and the integrated financial management system. The third reportable condition is operational oversight and the fourth is judgment fund payment for medical malpractice claims. During FY 2004, VA management took corrective action to eliminate the medical malpractice and claims data reportable condition reported in the FY 2003 audit report. The report on compliance continues to state that VA is not in substantial compliance with the financial management system requirements of the *Federal Financial*

Management Improvement of 1996 (FFMIA). The internal control issues concerning an integrated financial management system and information technology security controls indicate noncompliance with the requirements of Office of Management and Budget (OMB) Circular A-127, “Financial Management Systems,” which incorporates by reference OMB Circulars A-123, “Management Accountability and Control,” and A-130, “Management of Federal Information Resources.”

The Acting Assistant Secretary for Management reviewed the report and concurs with the reported findings and recommendations. OIG will follow up and evaluate the implementation actions during our audit of the VA’s FY 2005 CFS. ([Report of Audit of VA CFS for FYs 2004 and 2003, 04-00986-14, 11/15/04](#))

Issue: Financial management and information technology security.

Conclusion: Ten management letters issued to improve controls.

Impact: Improved controls over access to financial systems.

The independent public accounting firm Deloitte & Touche LLP, under contract to OIG, performed the audit of VA’s CFS. As part of the audit, OIG issued six management letters addressing application controls over access to specific financial systems and four management letters addressing general controls over access to the data centers, which run financial systems. The management letters for four of the applications controls provided the status of prior year findings and recommendations in the areas of security administration, application systems security, application systems implementation and maintenance, and segregation of duties. The management letter reports for the remaining

two applications provided the initial findings over security administration. The management letters for the general controls provided the status of prior year findings and recommendations and provided additional findings in the areas of an entity-wide security program, access controls, application software development and change control, service continuity, and system software.

The ten management letters related to management of the VA data centers and applications systems are:

- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Financial Statements Financial Management System Application Follow-up Review, 04-00986-25, 11/23/04.*
- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Personnel and Accounting Integrated Data Application Follow-up Review, 04-00986-26, 11/23/04.*
- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Loan Guaranty System Application Follow-up Review, 04-00986-27, 11/23/04.*
- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Integrated Funds Distribution, Control Point Activity, Accounting and Procurement Application Follow-up Review, 04-00986-28, 11/23/04.*
- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Financial Statements Automated Engineering Management System and Medical Equipment Reporting System Application Review, 04-00986-29, 11/23/04.*
- *Management Letter, Audit of VA’s FYs 2004 and 2003 CFS Financial Statements Real Servicing Application Review, 04-00986-30, 11/23/04.*

- *Management Letter, Audit of VA's FYs 2004 and 2003 CFS Financial Statements General Computer Controls Review at the Philadelphia Information Technology Center, 04-00986-31, 11/23/04.*
- *Management Letter, Audit of VA's FYs 2004 and 2003 CFS General Computer Controls Review at the Philadelphia Insurance Center, 04-00986-32, 11/23/04.*
- *Management Letter, Audit of VA's FYs 2004 and 2003 CFS General Computer Controls Review at the Hines Information Technology Center, 04-00986-50, 12/17/04.*
- *Management Letter, Audit of VA's FYs 2004 and 2003 CFS General Computer Controls Review at the Austin Automation Center, 04-00986-51, 12/17/04.*

Issue: Financial management.

Conclusion: VA's Franchise Fund financial statements present their position fairly.

Impact: Financial reporting and control.

Our report contains the audit opinion, the report on internal control over financial reporting, and the report on compliance with laws and regulations. The Franchise Fund management contracted with the independent public accounting firm Brown & Company CPAs, PLLC to perform the audit of VA's Franchise Fund FY 2004 and 2003 CFS. The independent auditor's report provided an unqualified opinion on VA's Franchise Fund FY 2004 CFS. The Franchise Fund management defined the requirements of the audit. OIG reviewed the audit plans, monitored the audit, and reviewed the draft reports.

The auditor's report on internal control over financial reporting identifies one material

weakness concerning information technology security controls. This finding and related recommendation were included in the Department's FYs 2004 and 2003 CFS audit reports.

The report on compliance with laws and regulations discloses that VA, as a whole, is not in substantial compliance with the financial management systems requirements of FFMIA. The Franchise Fund uses VA's financial management systems to prepare its financial statements. The auditors' tests of compliance disclosed no instances of noncompliance with other laws and regulations. (*Report of the Audit of VA Franchise Fund CFS for FYs 2004 and 2003, 04-01265-52, 12/20/04*)

Issue: Attestation of VA's accounting for expenditures on National Drug Control Program activities.

Conclusion: Accurate reporting in accordance with requirements.

Impact: Financial reporting and control.

This report contains an attestation on the VA Detailed Accounting Submission for FY 2004 to the Office of National Drug Control Policy (ONDCP). VA's management prepared the Table of Drug Control Obligations and related disclosures in accordance with the requirements of the ONDCP Circular, "Drug Control Accounting," dated April 18, 2003. Based upon our review, nothing came to our attention that caused us to believe that the table and related disclosures are not presented in all material aspects in conformity with the Circular's requirements. (*Attestation of VA Detailed Accounting Submission, 05-01199-92, 2/23/05*)

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.

Conclusion: Vendors can offer better prices to VA.

Impact: Potential better use of \$1.016 billion.

Preaward reviews of 15 FSS and cost-per-test offers made recommendations for potential better use of \$1.016 billion. OIG recommended negotiating lower contract prices because the vendors were not offering the most favored customer prices to FSS customers when those same prices were extended to commercial customers purchasing under similar terms and conditions as the FSS.

Issue: Health care resource contracts.

Conclusion: VA can negotiate reduced contract costs.

Impact: Potential better use of \$10 million.

OIG completed reviews of 16 proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. The review concluded that contracting officers should negotiate reductions of \$10 million to the proposed contract costs because of differences between the proposed costs for the services solicited and the costs the affiliate could justify.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.

Conclusion: Overcharges were identified.

Impact: Recovery of \$2.3 million.

OIG completed four reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts, resulting in recoveries of \$1.7 million. Three OIG drug pricing Public Law 102-585 compliance reviews at pharmaceutical vendors resulted in recoveries of about \$632,000.

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

Issue: Zegato E-Travel service.

Conclusion: VA's implementation of Zegato duplicates GSA's E-Travel service, and lapses in project and contract management led to implementation problems and a high level of user dissatisfaction.

Impact: Better use of \$7.4 million.

This review was conducted to determine whether VA's efforts to implement an E-Travel service nationwide would meet the Department's requirements and user needs, and to review whether acquisition regulations were followed appropriately. OIG determined that the project was not meeting all of VA's requirements and user needs effectively and that VA contracting actions were not adequately protecting the interests

of the Department. VA's E-Travel initiative duplicates the General Services Administration's (GSA) efforts to provide E-Travel services that all Federal Agencies must use. VA proceeded with nationwide implementation efforts without reasonable assurance that the [Zegato E-Travel](#) service could meet all requirements, and without resolving significant problems identified during testing. Project managers were not effectively managing implementation of the Zegato E-Travel service and key project monitoring and reporting controls were never established.

OIG made several recommendations to the prior Acting Assistant Secretary for Management and to VA to initiate timely actions to migrate to one of GSA's approved E-Travel service options. The Department's Chief Management Officer concurred with the report recommendations and VA initiated actions needed to strengthen the current contract, reduce contract costs, and implemented actions to effect a timely migration to one of GSA's services. VA also initiated technical and legal reviews of the existing contracts to better protect its financial, performance, and contractual interests. These actions helped ensure the price reasonableness of current service levels until migration can be completed.

OIG estimated that the Department could save approximately \$7.4 million over the next 10 years by migrating to one of the GSA services, since the average prices available on GSA contracts were less expensive. Actions to effect a timely migration have potential to save the Department the funds identified. OIG considers the report recommendations resolved and will follow up on the planned actions until they are completed. ([Review of VA Implementation of the Zegato E-Travel Service, 04-00904-124, 3/31/05](#))

Issue: Energy management.

Conclusion: VA needs to strengthen compliance with Federal energy management policies and improve the reliability of data used.

Impact: Improved energy efficiency and reduced energy costs, and better use of \$12.9 million.

OIG conducted an evaluation to determine whether VA complied with Federal energy management policies and to assess VA's effectiveness in reducing energy consumption and costs. The evaluation was conducted in accordance with the *Energy Policy Act of 1992*, which encourages OIGs to conduct periodic reviews of their agencies' compliance with the *National Energy Conservation Policy Act of 1978* and other laws relating to energy consumption.

OIG concluded VA did not comply with Federal energy management policies or give sufficient priority to its energy management program. Specifically, VA did not designate energy supervisors at all facilities, ensure facility energy supervisors received energy management training, perform energy audits for 10 percent of VA facilities each year, and purchase energy-efficient products when life-cycle cost-effective.

As a result, VA did not maximize opportunities to improve energy efficiency and reduce energy costs. We estimated VA could better use \$12.9 million annually if it achieved the FY 2000 goal. Evaluation results also showed data used to measure VA's energy efficiency were not reliable. Errors were made in reporting facility size and energy consumption and in preparing annual energy reports. More reliable energy consumption and cost data would

enable managers to accurately assess progress in achieving energy conservation goals. The Assistant Secretary for Management agreed with the findings and provided acceptable improvement plans. This report focused on the results of efforts made prior to the establishment of VA's Department-wide energy conservation program in July 2003. (*Evaluation of VA Compliance with Federal Energy Management Policies, 04-00986-101, 3/9/05*)

Office of Information and Technology

Security Controls

Issue: VA's information security program.

Conclusion: VA's programs and sensitive data continue to be vulnerable to destruction, manipulation, and inappropriate disclosure.

Impact: Improved automated data processing security.

OIG evaluated VA's information security controls and security management. Although OIG concluded VA established an information technology security plan and the required policies, procedures, and guidelines mandated by the Federal Information Security Management Act of 2002 (FISMA), the review determined more needs to be done. As reported in our FY 2001, 2002, and 2003 audits, VA still needs a coordinated and focused security program to address many of its security vulnerabilities. The Chief Information Officer also needs to fully implement a patch management program. OIG's last four audits (FYs 2001, 2002, 2003, and this one) continue to show significant security vulnerabilities.

OIG continues to find VA systems remain vulnerable to unauthorized access and misuse

of sensitive information and data. VA web sites need to be better secured. Managers need to implement *Health Insurance Portability and Accountability Act* requirements. The Department has not been able to effectively address its significant information security vulnerabilities and reverse the impact of its historically decentralized management approach. VA's security remediation efforts continue to be ineffective with inadequate facility compliance with established security policies, procedures, and guidelines. As a result, significant information security vulnerabilities continue to place the Department at risk of:

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

Based on the audit results, VA information security should continue to be identified as a Department material weakness area under the *Federal Managers' Financial Integrity Act*. OIG recommended a number of operational changes that will help improve VA's information security posture, ensure effective control over sensitive information, ensure continuity of operations, and support the Department's missions of providing health care and delivering benefits to the Nation's veterans. The Assistant Secretary for Information and Technology partially agreed with the recommendations and provided acceptable implementation plans. (*Audit of VA Information Security Program, 04-00772-122, dated 3/31/05*)

Multiple Offices Action

Issue: VA procurement of desktop computers.

Conclusion: VA can enhance its computer network security and reduce procurement costs by eliminating the unneeded acquisition of desktop computers with modems.

Impact: Better use of funds.

OIG conducted an audit of VA purchases of desktop computers (workstations) from procurement of computer hardware and software-2 (PCHS-2) contract. The audit was completed as part of a project initiative to determine the effectiveness and efficiency of selected VA information technology (IT) contracts.

The audit found that VA's acquisition of workstations should not include modems unless the need is justified. Workstations procured for use as part of VA's computer network do not generally require modems, unless needed for remote access or used for required maintenance of medical equipment. The unnecessary presence of modems in workstations connected to VA's computer network increases its network IT security vulnerability and procurement costs. OIG found that VA activities are not required to justify the need for modems included in workstations purchased from the PCHS-2 contract. Since VA began purchasing workstations from this contract in April 2002, at least 3,396 included modems. Including modems in these workstations added \$84,900 to VA's procurement costs (\$25 per workstation). Since OIG could not identify complete vendor sales information on modems purchased, OIG is unable to project the extent of future procurement savings to VA by avoiding unneeded acquisition of modems.

During the audit, OIG issued an advisory letter to Department program officials detailing its findings and recommended actions concerning the acquisition and use of modems. In response, the Department is taking various actions to better control the acquisition and use of modems. (*Audit of VA Procurement of Desktop Computers with Modems, 04-03100-66, 1/11/05*)

Human Resources

Issue: VA WCP.

Conclusion: Implementing changes would enhance the detection of fraud and improve effectiveness in VA and other Federal agencies.

Impact: Reduction in program costs by \$487.8 million.

OIG reviewed WCP operating polices to identify opportunities to improve program management and better control costs. Key operating changes were identified to enhance fraud detection and improve the effectiveness and efficiency of program operations but which require legislative changes to the *Federal Employees Compensation Act*.

The following WCP operating changes need to be implemented:

- Authority to compare WCP and SSA records.
- WCP retirement at a pre-determined age.
- A 3-day waiting period before WCP benefits can start.

These WCP operating changes could help identify potential fraud, reduce the incentive for beneficiaries to enter and remain on the disability rolls long after they reach an

appropriate retirement age, and discourage the filing of frivolous claims. Movement of claimants to a retirement benefit plan at age 65 could reduce VA's future annual WCP costs by an estimated \$44.5 million. Potential avoidable lifetime WCP claimant costs could total \$487.8 million. The Assistant Secretary for Human Resources and Administration agreed with the recommendations and the estimated monetary benefits. *WCP Operating Changes, 05-00949-89, 2/24/05*

detailed guidance on monitoring payments to fee appointees and on documenting how fee payment rates were established. The Deputy Assistant Secretary agreed with the findings and provided acceptable improvement plans. *(Evaluation of VAMC Use of On-Station Fee Basis Appointments, 04-02344-97, 3/4/05)*

Issue: On-station fee basis appointments.

Conclusion: VAMCs used fee appointments effectively.

Impact: Strengthen controls over the program.

OIG evaluated VAMC use of on-station fee basis appointments to provide health services when these services are not available by normal methods such as hiring, and when fee appointments are cost-effective.

In recent years, on-station fee basis expenditures have increased substantially, from about \$177 million for 129 VAMCs in FY 2002 to \$213 million for 126 VAMCs in FY 2003. Our review of 200 fee appointments at two representative VAMCs found they properly managed appointments and generally complied with VA policy. The VAMCs used fee appointments effectively to provide services when it was not practical to hire full-time or part-time employees and in situations where there were significant differences between VA and community salaries or critical shortages in medical specialties.

However, to correct two minor program administration deficiencies, OIG recommended the Deputy Assistant Secretary for Human Resources Management and Labor Relations ensure VA policy is amended to include

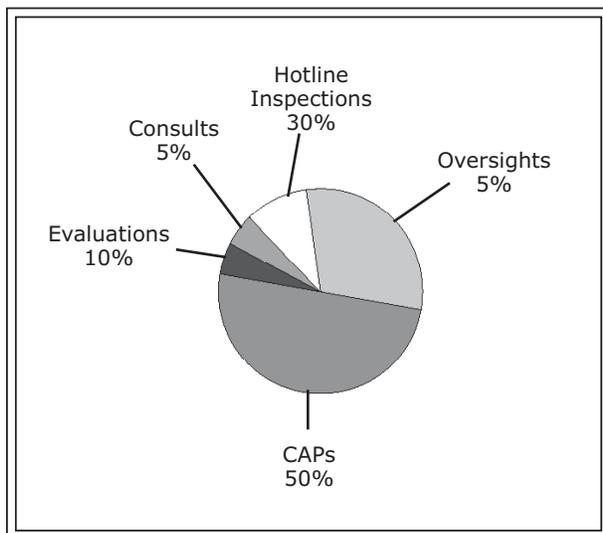
OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

OHI has 61 FTE allocated to staff headquarters and field operations. The following chart shows the allocation of resources utilized to conduct evaluations, inspections, CAP reviews, oversight, technical reviews, and clinical consultations in support of criminal cases.



Overall Performance

Output

During this reporting period, OHI:

- Participated in 24 CAP reviews to evaluate health care issues and made 147 recommendations that will improve operations and activities, and the care and services provided to patients.

- Completed 18 Hotline cases which consisted of reviews of 54 healthcare related issues. Administratively closed 8 of the 18 cases and issued reports on the remaining 10 cases. Made 18 recommendations that will improve the health care and services provided to patients.

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

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

- Completed 23 technical reviews on recommended legislation, new and revised policies, new program initiatives, and external draft reports.

- Reviewed the responses to 92 Hotline cases consisting of 179 issues that were referred to VHA managers for review.

Outcomes

Overall OHI made or monitored the implementation of 165 recommendations to improve the quality of care and services provided to patients and their families. VHA managers agreed with all of our recommendations and provided acceptable implementation plans. VHA implementation actions will improve clinical care delivery, management efficiency, and patient safety, and will hold employees accountable for their actions.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations average 4.75 on a scale of 5.0.

Veterans Health Administration

Healthcare Inspections

Issue: Delay in diagnosis and treatment.

Conclusion: Clinicians did not provide appropriate care for the patient's serious back lesion.

Impact: Corrective actions should reduce the possibility of reoccurrence.

OIG conducted an inspection to determine the validity of allegations regarding the diagnosis and treatment of a back lesion at the VA medical center. The complainant alleged:

- That he went to the VAMC with a complaint of a back lesion and was provided prescribed antibiotics without examining his back.
- That the next day he return to the VAMC complaining the lesion had gotten bigger and was told the antibiotics needed time to work.
- That there were instances of staff inattentiveness and indifference to his needs.

While the inspection did not substantiate the complainant's back was not examined, OIG did conclude that, overall, the complainant did not receive appropriate care for a serious back lesion. In addition, there was inadequate documentation of physician supervision of several physician assistants (PAs) who saw the complainant.

As a result, OIG recommended the VISN and VAMC directors ensure that:

- Systems managers obtain a peer review of this case and discuss the results of the peer review with the PAs and managing physicians involved in this case.
- System managers ensure that all PAs and supervising physicians follow Medical Center Policy Memorandum 11-002, and that PAs are being appropriately supervised.
- System managers address the patient's concerns regarding his treatment and perceived staff indifference with the patient.
- The VISN and VAMC directors agreed with the recommendations and provided acceptable implementation plans. (*Healthcare Inspection, Alleged Delay in Diagnosis and Treatment, Michael E. DeBakey VAMC, Houston, TX Report 04-00036-42, 11/30/04*)



Michael E. DeBakey Medical Center
Houston, TX

Issue: Allegation of poor care.

Conclusion: Patient's death was not attributable to poor care at the nursing home.

Impact: Improved monitoring practices and controls.

OIG conducted an inspection in response to a complainant's allegations of deficient care, inadequate staffing, and administrative issues at a contract nursing home. The complainant alleged that poor care led to her husband's death. OIG did not substantiate the complainant's allegation that her husband received poor care in the facility, which led to his death. The patient developed septicemia and pneumonia while in the nursing home and was transferred to a hospital and received acute care for his condition. Despite concerns that the evaluation and follow up of clinical findings (hypotension) were not acted upon aggressively enough or such actions were not adequately documented, OIG nonetheless concluded that the patient's death almost two months later was not likely attributable to poor care provided at the facility.

OIG determined that although VA clinicians monitored individual patients' care in accordance with established policy, the facility program managers did not establish a performance improvement plan as required by medical center policy or give adequate attention to nursing home performance improvement evaluation. OIG made two recommendations. The VISN and VAMC directors concurred and provided responsive implementation plans. (*Healthcare Inspection, Contract Nursing Home Issues, James H. Quillen VAMC, Houston, TX, 04-01150-47, 12/9/04*)

Issue: Adequacy of emergency decontamination preparedness.

Conclusion: Medical center was selected to have a decontamination program but had not received the equipment.

Impact: Improved preparedness for response to bioterrorism and other public emergencies.

In response to a request from Congressman Lane Evans, Ranking Member of the House Committee on Veterans' Affairs, OIG conducted a review of the medical center's decontamination program. The review found that while the medical center did not have a current decontamination program, its actions complied with those required in the applicable directives and memorandums. The medical center was chosen to have a decontamination program and has sent employees for training. The medical center's initial equipment request was sent to VACO, but not filled. OIG recommended a revised decontamination equipment request be submitted to VACO and decontamination training and exercises be conducted and reported to VACO after decontamination equipment is received. The VISN and HCS directors concurred with the recommendations and submitted an action plan, which included the revised decontamination equipment request list. The action plan adequately responded to the recommendations. (*Healthcare Inspection, Emergency Decontamination Preparedness, VA Salt Lake City HCS, Salt Lake City, UT, 05-00290-78, 2/8/05*)

Issue: Allegations of inappropriate care and poor documentation.

Conclusion: Patient care met community standards.

Impact: Substantiated appropriate treatment and medical record documentation.

OIG reviewed an anonymous complainant's allegations of inappropriate patient care and poor documentation by Surgical Service physicians. Specifically the complainant alleged that surgeons provided poor care to four patients. Despite finding that two patients did suffer complications from surgery as alleged, OIG did not substantiate that the complications were due

to poor care. The review did not substantiate the allegation of delay in treatment of recurring lung cancer, delay in diagnosis of a new lung cancer, or poor documentation. OIG concluded that the patients received appropriate care and that surgeons appropriately documented patient information in the electronic medical record, and therefore made no recommendations. (*Healthcare Inspection, Alleged Poor Care and Mismanagement of Surgical Service, VAMC, Hot Springs, SD, 04-00120-82, 2/11/05*)

Issue: Allegations of negligent medical care.

Conclusion: The patient received timely and appropriate care.

Impact: Substantiated appropriate care.

OIG reviewed numerous allegations received from the wife of a patient currently receiving treatment at VAMC Washington. The complainant wrote a letter to Senator Bob Graham, Ranking Member of the Senate Committee on Veterans' Affairs, requesting an independent review of the allegations of negligent medical care of her spouse. OIG did not substantiate the VAMC nursing home care unit had not adequately planned for the patient's admission following discharge from Walter Reed Army Medical Center, or that the VAMC was not medically equipped to meet the patient's needs. The review concluded the patient received appropriate care while in the VAMC and the unit. Clinicians performed timely and appropriate assessments and obtained consultations when required. The patient was assessed and properly transferred to different levels of care settings as his condition warranted. (*Healthcare Inspection, Quality of Care Issues, DC VAMC, Washington, DC, 04-00367-76, 2/22/05*)



Washington VA Medical Center
Washington, DC

Issue: Anesthesia management and patient care issues.

Conclusion: Appropriate actions were taken to correct deficiencies noted in an earlier OHI inspection.

Impact: Improved anesthesia services and patient safety.

The purpose of this inspection was to ensure that all recommendations made in a previous OIG report had been completed. It also reviewed orthopedic surgery waiting times, as it was alleged that there was a year's wait due to lack of anesthesia provider coverage, and found that managers were in full compliance with 12 of the 13 recommendations in the previous OIG report. During the site visit, the chief of staff provided an action plan that, when implemented, would ensure full compliance with the remaining recommendation. Both the anesthesia service and surgery service had implemented processes and policies to ensure safe patient care. Interviews with staff indicated a major improvement in morale in the operating room. The review concluded that managers had taken appropriate actions to correct the deficiencies noted in our previous inspection. While OIG found that orthopedic waiting

times were excessive, the Chief of Orthopedic Surgery was actively working to reduce surgery waiting times. The VISN and System directors concurred with the results of this inspection and the recommendation to decrease the orthopedic surgery backlog. *(Healthcare Inspection, Anesthesia Management and Patient Care Issues, New Mexico VA HCS, Albuquerque, NM, 05-00720-108, 3/17/05)*

Issue: Patient abuse.

Conclusion: The patient was not properly monitored.

Impact: Improved patient monitoring and documentation of care.

OIG conducted an inspection to determine the validity of a patient abuse allegation. A community nursing home administrator alleged a resident returned from a VAMC admission with initials carved in his left leg. The review concluded the carvings were made while he was admitted at the VAMC, but was unable to positively determine if they were or were not self-inflicted. OIG recommended the facility:

- Develop a skin integrity program for psychiatric patients who are mobility impaired.
- Document activities of daily living for all psychiatric patients.
- Use this case to reinforce the importance of careful monitoring and documentation of care for psychiatric patients.

The review also recommended the nursing home obtain blood samples for baseline testing because of potential risks to the patient. The VISN director concurred with the first two findings and recommendations, partially concurred with the third, and provided acceptable improvement plans. *(Healthcare Inspection, Alleged Patient*

Abuse Issue, Dwight D. Eisenhower VAMC, Leavenworth, KS 04-03348-102, 3/10/05)



Dwight D. Eisenhower Medical Center
Leavenworth, KS

Issue: Alleged patient abuse.

Conclusion: Patients received prescribed medications and nourishments as ordered.

Impact: Did not substantiate patient abuse.

OIG conducted an unannounced inspection to determine the validity of allegations of patient abuse. Specifically, the following was alleged that:

- Evening nurses were combining 6:00 p.m. and 9:00 p.m. medications and administering them to chemically restrain patients.
- Medications from one patient were being administered to another without a physician's order.
- Nursing assistants were stealing patients' nourishments.

OIG reviewed relevant medical records, quality management documents, policies and procedures, nutrition records, bar code administration records, and official personnel

files. Inspectors inventoried medication carts and the narcotic cart, and also interviewed nurses, pharmacists, quality managers, and administrative employees. The review did not substantiate the allegations. Therefore, OIG made no recommendations. The VISN and VAMC director concurred with our findings. *(Healthcare Inspection, Alleged Patient Abuse, Central Texas Veterans HCS, Temple, TX, 05-01027-116, 3/25/05)*

OFFICE OF MANAGEMENT AND ADMINISTRATION

Mission Statement

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

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

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

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

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

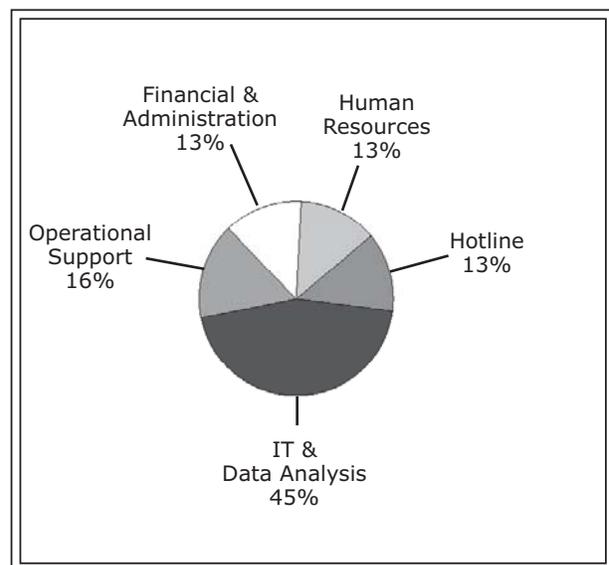
Division maintains the Master Case Index (MCI) system, OIG’s primary information system for case management and decision making. The Data Analysis Section, located in Austin, TX, provides data processing support, such as computer matching and data extraction from VA databases.

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

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

Resources

The Office of Management and Administration has 64 FTE allocated as indicated.



I. HOTLINE DIVISION

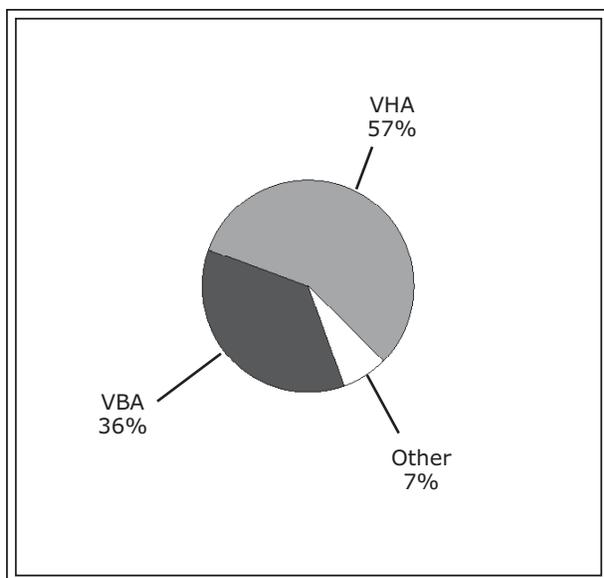
Mission Statement

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

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

Resources

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



Overall Performance

During the reporting period, the Hotline received 6,781 contacts. This resulted in opening 452 cases. OIG reviewed 138 (31 percent) of these and referred the remaining 314 cases to VA program offices for review.

Hotline staff closed 507 cases during the reporting period, of which 182 (36 percent) contained substantiated allegations. OIG wrote 50 letters responding to inquiries received from members of the Senate and House of Representatives.

VA managers imposed 20 administrative sanctions against employees and took 125 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled almost \$571,000.

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 42 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. Examples follow.

- A review by VHA of dental clinics at three medical centers, located in close proximity to each other and linked together into one administrative unit, found staffing inefficiencies and discrepancies, which might have contributed to longer patient wait times at one facility. A dental task force recommended individual dental services be established at each facility with appropriate staffing adjustments, which VISN management approved. The review

further found lapses in security in storing and recording usage of dental supplies. Security enhancements were implemented immediately.

- A VHA review revealed medical staff prescribed a medication to a veteran causing his skin condition to worsen. Additionally, the review found the attending physician did not evaluate the veteran's skin condition or make entries to his medical record. The physician has been admonished.

Ethical Improprieties/Employee Misconduct

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

- A VHA review determined that a VA social worker had a sexual relationship with one of her patients. The social worker was placed in off-duty status and will have no further patient contact. The human resources management service initiated a proposal to remove her.
- A VHA administrative board of investigation determined a care line manager demonstrated poor leadership, creating a hostile work environment, low employee morale, and an unacceptable degree of emotional exhaustion among his employees. Management reassigned the manager.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that 12 allegations of time and attendance abuse at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA review into a report of overtime abuse revealed that employees in one unit of a medical center were not properly supervised

while on overtime. As a result of these findings, management implemented a policy change to require a supervisor or lead employee be present at all times when employees are working overtime.

Fiscal Controls

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

- A VISN review found a former medical center director authorized the Finance Department to bill insurance companies for work performed by residents. Consequently, the Finance Department refunded those carriers more than \$9,944.

Patient Safety

The responses to Hotline inquiries by management officials indicate that 5 allegations of patient safety deficiencies at individual VA facilities were found to have merit and required corrective action. Examples follow.

- A VHA review determined a veteran received inadequate nursing care following a surgical procedure. However, the patient's overall recovery was not adversely affected. Management immediately initiated an extensive education program in the care of post-operative patients and counseled staff involved in this incident.
- A VHA review determined an emergency room physician and nurse failed to warn a patient in discharge instructions to discontinue a medication that may have caused her gastric irritation and bleeding. Management reminded the physician and nurse to alert patients appropriately in such instances. The review noted a telephone triage nurse and the patient's

primary care physician later advised the patient to discontinue the medication.

Contract Administration

The responses to Hotline inquiries by management officials indicate that 5 allegations involving violations of contract administration by employees at individual VA facilities were found to have merit and required corrective action. An example follows.

- A VHA review determined prosthetics employees at a medical center had not been consistently obtaining competitive bids for health care equipment. The Chief of Prosthetics and Sensory Aids Service developed strategies to ensure employees follow all applicable Government regulations in purchasing equipment. The review further determined that a contractor was not returning health care equipment found to be beyond repair to the medical center. As a result, the Chief of Prosthetics implemented procedures to increase accountability for all equipment and to ensure its proper handling.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 13 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples of the issues follow.

- A VHA review determined a veteran's primary care provider had not properly coded the veteran's prescriptions as related to his service-connected condition. The veteran had been improperly billed for those medications. Management ordered the provider to receive needed training and gave the veteran a point of contact for any future problems.
- A national chaplain service review confirmed a VA chaplain was performing pastoral duties at

a community church. However, as the chaplain actually shares those duties on a rotating basis, the review found they do not interfere with his VA responsibilities and commitment. As a result of our inquiry, national chaplain service reviewed VA policy language and made changes to clarify the limits of outside pastoral activity. The new policy is awaiting approval by the Acting Under Secretary for Health.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 40 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples follow.

- A VBA review determined a widow receiving VA benefits failed to report she had remarried. The widow will continue to receive an award on behalf of the veteran's minor child but owes \$15,876, with a cost savings to the Government projected at \$226,656.
- A VBA review determined a veteran receiving a pension failed to report his wife's social security income. The veteran's account has been assessed an overpayment of \$20,340.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 21 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples follow.

- As the result of a Hotline inquiry into an active-duty service member's educational claim, which had not been paid for more than 3 months, a VARO immediately located the

file and processed the payment. A check for \$1,149 was deposited into the service member’s account.

- A VBA review, conducted in conjunction with state officials, determined a state veterans affairs employee, assigned to a VARO, had charged veterans unauthorized fees for processing their claims. State officials terminated his employment.

VA Management

Abuse of Authority

The responses to Hotline inquiries by VA management officials indicated that 12 allegations regarding cyber security were found to have merit. An example follows:

- A review by the Deputy Assistant Secretary for Security and Law Enforcement determined the chief of police of a medical center abused his position of authority by accepting kickbacks and bribes. He was also found to have misused Government resources. As a result of the findings, the chief resigned, two officers received 30-day suspensions, one officer received a 3-day suspension, two officers were reprimanded, and two officers were admonished.

II. OPERATIONAL SUPPORT DIVISION

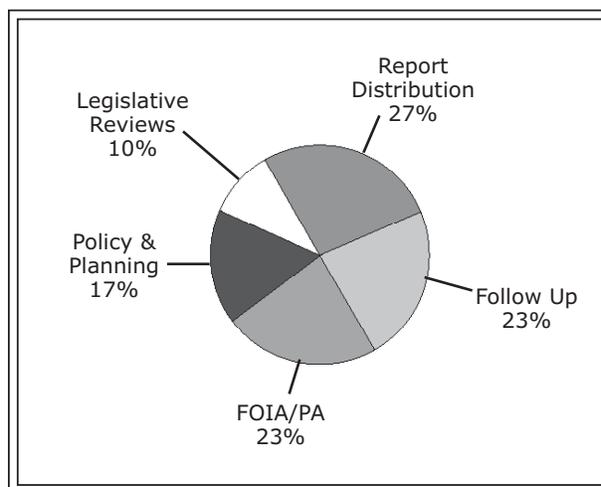
Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely follow-up reporting and tracking on OIG recommendations; responding to Freedom of Information Act / Privacy Act requests; conducting policy review and development; strategic, operational,

and performance planning; providing electronic report distribution; and overseeing Inspector General reporting requirements.

Resources

This Division has 10 FTE assigned with the following allocation.



Overall Performance

Follow-Up on OIG Reports

Operational Support is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over \$1.98 billion of actual or potential monetary benefits as of March 31, 2005.

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

official, resolves any disagreements about recommendations.

After obtaining information that showed management officials had fully implemented corrective actions, Operational Support closed 74 reports and 699 recommendations with a monetary benefit of \$3.3 billion during this period. As of March 31, 2005, VA had 141 open OIG reports with 627 unimplemented recommendations.

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

Operational Support processes all OIG FOIA and PA requests from Congress, veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, the general public, and subjects of investigations. In addition, it processes official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel and the Department of Justice. These requests require the review and possible redacting of OIG hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. Operational Support also processes OIG reports and documents to assist VA management in establishing evidence files used to support administrative or disciplinary actions against VA employees.

During this reporting period, OIG processed 148 requests under the FOIA and PA and released 231 audit, investigative, and other OIG reports. Information was totally denied in 5 requests and partially withheld in 77 requests, because release would constitute an unwarranted invasion of personal privacy, interfere with enforcement proceedings, disclose the identity of confidential sources, disclose internal Departmental matters, or was specifically exempt from disclosure by statute. During this period, all FOIA cases

received a written response within 20 workdays, as required. There are no requests pending over 6 months.

Electronic Report Distribution

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

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

OIG began using this method to distribute our CAP review reports in October 2003 and expanded to include other unrestricted reports in August 2004. During this reporting period a total of 29 CAP reports were released electronically. In addition, 6 non-CAP reports were released electronically or in hard copy.

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 9 legislative, 49 regulatory, and 75 administrative proposals from the Congress, OMB, and VA. OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs

and operations or the prevention and detection of fraud and abuse.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

Mission Statement

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

The Information Technology and Data Analysis Division provides information technology and statistical support services to all components of OIG. It has responsibility for the continued development and operation of the management information system known as the Master Case Index (MCI), as well as OIG's Internet and Intranet resources. The Division interfaces with VA information technology units nationwide to establish and support local and wide area networks, guarantee uninterrupted access to electronic mail, service personal computers, detect and defeat threats to information assurance, and provide support in protecting all electronic communications. OIG's Chief Information Officer and his staff represent OIG on numerous intra- and inter-agency information

technology organizations and are responsible for strategic planning and policy development in support of all OIG information technology requirements. The Data Analysis Section in Austin, TX, provides data gathering and analysis support to employees of OIG, as well as VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of the staff serves as the OIG statistician.

Resources

The Division has 28 FTE allocated in Washington, Bedford, Austin, Dallas, Atlanta, Bay Pines, Los Angeles, and Chicago.

Overall Performance

MASTER CASE INDEX (MCI)

During this reporting period, the first phase of a web-enabled MCI application was completed. A new Oracle database server was installed and configured. The Oracle 8 database was migrated to Oracle's latest database version of 10g. Support was provided to the field offices regarding loading of the new Oracle toolset.

Enhancements to the MCI system included the modification of Hotline and Investigative forms to allow for document uploading and viewing. In support of OIG activities the MCI development team responded to numerous requests for ad hoc reports and modifications to existing reports and forms.

INTERNET AND ELECTRONIC FOIA

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG web sites and posting OIG reports on the Internet. Data files on the OIG web site were accessed almost 1.5 million times by more than 155,000

visitors. OIG reports, vacancy announcements, and other publications accounted for almost 682,000 downloads from our web sites, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed. Reports constituted over 80 percent of the most popular downloads from our web sites.

In conjunction with the OIG electronic reports distribution initiative, we posted all CAP reports issued this semiannual period along with audit, health care inspection, and administrative investigation reports, as well as investigative press releases and other OIG publications on the OIG web sites.

STATISTICAL SUPPORT AND IT TRAINING

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

For the reporting period, the OIG statistician provided statistical consultation and support for all CAP reviews, and data analysis concerning purchase card use at each facility. We also developed and published several online surveys in support of OIG activities.

DATA ANALYSIS SECTION

The Data Analysis Section (DAS) develops proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and refers these leads to OIG auditors and investigators for further review. DAS provides technical assessments and support to all elements

of OIG and other governmental agencies needing information from VA computer files.

Data Mining to Detect Potential Fraud in VA Computer Systems

DAS staff has begun using Audit Control Language (ACL) to assist our data mining efforts. ACL offers analysis tools that will allow a more in-depth analysis of some files for fraud detection.

CAP Reviews

DAS also provided technical support and data to all CAP health care reviews focusing on the quality, efficiency, and effectiveness of medical services provided to veterans. DAS also provided support to all CAP reviews on VA benefits, which focused on the delivery of monetary benefits to veterans and their dependents. A combined total of over 603 data extracts and reports were produced in support of this activity. An additional 135 reports were produced for teams conducting the National Resident Supervision Review of 12 facilities and the Fee Basis Review of 21 facilities.

VA WCP

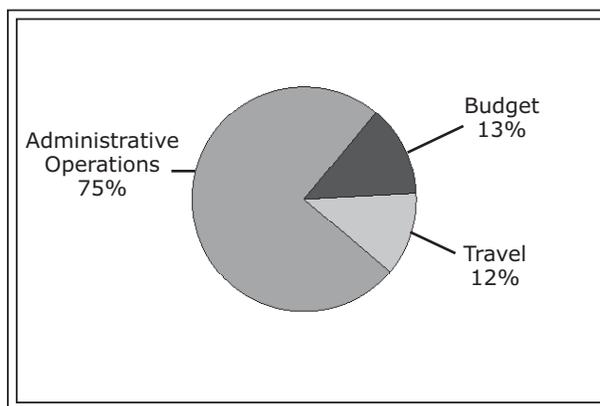
DAS provided assistance on this review by matching WCP participants to past VA payrolls to show the participant's age. OIG wanted to show the benefits of termination of WCP payments for beneficiaries age 65 or older. By allowing OPM retirement or Social Security annuities to take effect at that age, WCP benefits could be terminated at significant savings to the Government.

Assistance to Other Organizations

We provided C&P master file information on three VA facilities to Management Quality Assurance Service (MQAS). DAS also provided a VHA compliance officer with information on VA staff initiating VA payments and who cashed those payment checks.

Other Workload

During the reporting period, DAS completed 150 ad hoc requests for data requested by all other OIG operational elements.



IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

Mission Statement

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

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

Resources

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

Overall Performance

Budget

The staff assisted in the preparation of the FY 2006 budget submission and materials for associated hearings with VA, Office of Management and Budget, and Congressional Committees.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, OIG processed 1,737 travel vouchers. Recruiting efforts led to 11 new permanent change of station authorities.

Administrative Operations

The administrative staff works closely with VA Central Office administrative offices and building management to coordinate various administrative functions, office renovation plans, telephone installations, and the procurement of furniture and equipment. In addition, OIG processed 155 procurement actions (53 acquisition and 102 credit card transactions), and each month reviewed and approved 40 statements on OIG's cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

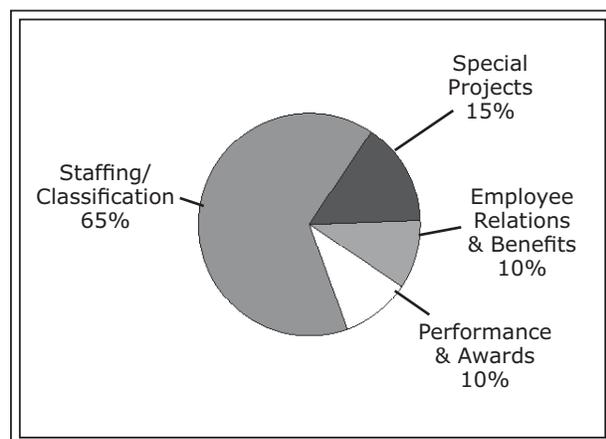
Mission Statement

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

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

Resources

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



Overall Performance

Human Resources Management

During this period, 19 new employees joined the OIG workforce and 23 departed. The current on-board strength is at its highest level in OIG history with 422 employees in authorized positions and 24 employees in positions that are reimbursed by the Department. The staff processed 144 recruitment and placement actions, processed 67 awards, and enrolled 26 employees in advanced leadership and management development classes.

To help employees plan their careers, the Division developed and published a model that identifies the core competencies required for all OIG employees. The model lays out the knowledges, skills, and abilities needed to progress up the career ladder for each of the eight competencies. Employees can now take charge of their careers by seeking training and developmental assignments related to each competency.

The Division held an OIG New Employee Orientation Program in December 2004. Over 30 employees attended the 2-day program and learned about OIG organizational values, history,



VA OIG New Employee Orientation
City Museum
Washington, DC
December 2004

strategic goals, and organizational structure from the senior management staff. A former Vietnam prisoner of war delivered an inspirational speech on the value of public service to the preservation of freedom in America.

OIG adopted a new performance management system that is designed to strengthen the organization's culture of high performance. The new system features five performance rating levels whereas the previous system was limited to a pass or fail rating. The Division trained managers and employees on the new system throughout the months of February and March.

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OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

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

IT Security Committee

- The Director of the Information Technology Audit Division is the subcommittee chair of PCIE's Policy Review Committee, IT Security Committee. The committee met to discuss the impact of recent National Institute of Science and Technology publications on the audit community.

The Policy Review Committee is chartered with reviewing OMB and National Institute of Standards and Technology publications and to coordinate a consolidated response from the IG community to the publishing organization.

OIG Management Presentations

IG Management Institute

- In February 2005, the IG was part of a panel of IGs who spoke to the first two-week class in Applied Management Studies at the Management Institute in Rosslyn, VA.

Office of Acquisition and Materiel Management's Acquisition Forum

- Representatives from OIG's Contract Review and Evaluation Division and the Counselor to the Inspector General made several presentations to VA contracting personnel. The presentations covered various aspects of contracting with affiliates for health care resources.

National Acquisition Center Industry Conference

- The Division Director and an audit manager from the Contract Review and Evaluation Division made a presentation on preaward reviews and voluntary disclosure and refund offers to industry representatives.

- An audit manager from the Contract Review and Evaluation Division participated with a VA Office of General Counsel representative and a Defense Department TRICARE representative on a panel presenting the TRICARE Retail Pharmacy program's access to Federal ceiling prices under Public Law 102-585.

- An audit manager from the Contract Review and Evaluation Division and a VA Office of General Counsel representative presented a class on how to administer various provisions of Public Law 102-585.

OIG Employee Advisory Council

- The OIG Employee Advisory Council met with the IG, along with the Deputy IG and Executive Assistant, during their Washington, DC, meeting.



From left to right, attendees are: Jon Wooditch, Marnette Dhooghe, Celeste Weeks, Leon Roberts, Henry Hoffman, Dana Moore, Greg Bratten, Emjay Wenzler, Christy Bonilla, Ken Myers, Richard Griffin, Vishala Sridhar, Raymond Vasil, and Sean Smith.

Other Significant OIG Activities

Leadership VA 2004 Program

- The Deputy Inspector General made a presentation on the work of OIG to the Leadership VA class of 2004 in Williamsburg, VA. This program is VA's premier leadership development program.

Strategic Planning Retreat

- The Audit Project Manager made a presentation at the Workers' Compensation Strategic Planning Retreat that discussed past work and program findings over the last several years. The presentation highlighted continuing areas of concern to be addressed in developing a strategic action plan for program improvement.

Awards

2004 Presidential Rank Awards

- President Bush awarded the rank of Meritorious Executive to Mr. Michael G. Sullivan, former Deputy Inspector General, and Mr. Jon A. Wooditch, Deputy Inspector General, for their outstanding leadership and public service as career members of the Senior Executive Service (SES). This honor is limited to only five percent of the career SES corps in the Federal Government.

PCIE 2003 Awards Ceremony - October 27, 2004

- The "June Gibbs Brown Career Achievement Award" was presented to Michael G. Sullivan, in recognition of Mr. Sullivan's leadership and executive excellence as Deputy Inspector General.

- An "Award for Excellence - Multiple Disciplines" was presented to 13 staff members in the Office of Investigations and the Information Technology and Data Analysis Division in recognition of their outstanding achievement in developing a highly efficient and effective means of processing data leading to the identification and apprehension of fugitive

felons, who, by law, are prohibited from receiving specified benefits. Team members included Bernard Murray, William Chirinos, John Jones, Brian Sewell, Jenny Pate, Sean Gomez, Sharon Neal, Ray Yench, Francine Kimbrell, Madeline Cantu, Debbie Crawford, Scott Eastman, and Parneet Chauhan.

- An "Award for Excellence - Audit" was presented to eight staff members in the Central Office Audit Operations Division in recognition of outstanding audit work performed on the 2003 audit of the VA information security program, which identified significant information security vulnerabilities. Team members included Stephen Gaskell, Jerry Rainwaters, Barbara Armitage, Fred Livingstone, Rick Purifoy, Kathy Gers, Charles McCarron, and Sheila Murray.

- An "Award for Excellence - Audit" was presented to 14 staff members in the Seattle and Chicago Audit Operations Divisions in recognition of the team's substantial contribution that will help VA use contract sources more effectively, award more national supply contracts, and reduce medical, prosthetic, and operating supply costs by an estimated \$1.34 billion. Team members included Jay Johnson, Kent Wrathall, Gary Abe, Danny Bauwens, Kevin Day, Angie Fodor, Gary Humble, Claire McDonald, Thomas Phillips, Ron Stucky, Myra Taylor, Melinda Toom, Orlando Velasquez, and Sherry Ware.

- An "Award for Excellence - Audit" was presented to 53 staff members from the Kansas City, Dallas, Chicago, Atlanta, Bedford, and Seattle Audit Operations Divisions, Washington Headquarters, and the Information Technology and Data Analysis Division in recognition of their diligent, collaborative efforts in conducting the follow-up of VHA's part-time physician time and attendance audit, resulting in improved quality medical care for veterans. Team members included William Withrow, Joseph Janasz, Larry Reinkemeyer, Robert Zabel, Kenneth Myers, Carla Reid,

Lynn Scheffner, James Garrison, Tim Halpin, Russ Lewis, Henry J. Mendala, Oscar Williams, Marcia Schumacher, Greg Gibson, Dennis Sullivan, Terra Ansari, Melvin Reid, Carla Vines, Nicolas Torres, Clenes Duhon, Glen Gowans, Curtis Hill, Michael Jacobs, Debra Major, Nicholas Dahl, Jacqueline Stumbris, Maureen Barry, Carl Looby, Steven Rosenthal, Joseph Vivolo, George Boyer, Melissa Colyn, Marcia Drawdy, Earl Key, George Patton, Al Tate, Walter Pack, Don Bunce, Mark Collins, Ken Dennis, Mary Ann Fitzgerald, Cynnde Nelson, Bill Wells, Myra Taylor, Randy Alley, Gary Humble, Tom Phillips, Angie Stow, Ron Stucky, Orlando Velasquez, Mary Lopez, and Gilberto Melendez.

- An “Award for Excellence - Investigations” was presented to two staff members from the Office of Investigations in recognition of their outstanding achievement, thwarting a bribery conspiracy directed at the VA vocational rehabilitation services program by the owners of a technical college. Team members were Jeff Hughes and Gregg McLaughlin.

- An “Award for Excellence - Management” was presented to ten staff members from the Offices of Audit and Healthcare Inspections and the Information Technology and Data Analysis Division in recognition of the outstanding performance of this team whose hard work and diligent efforts significantly contributed to the improvement in VHA’s ability to manage nursing resources. Team members included Julie Watrous, John Tryboski, Terra Ansari, Carol Arthur, Daisy Arugay, Elizabeth Bullock, Marisa Casado, Marnette Dhooghe, Gilberto Melendez, and Victoria Pilate.

Special Thanks

McDermott House for Formerly Homeless Veterans

- For the last several years, OIG employees have given gift bags to 30 formerly homeless veterans who live at McDermott House and are in the VAMC Washington, DC, Compensated Work Therapy program. This year wrapped gifts included warm hats, gloves, socks, mufflers, toiletry items, snacks and sweets, along with a \$100 gift certificate to the VA Canteen for each veteran. OIG received a thank-you card signed by the house manager, staff, and all the veterans at McDermott House reading, "All at IG 2004, thanks from residents of McDermott House."



OIG staff gifts for McDermott House veterans

- OIG employees have participated in the U.S. Marine Corps Reserve Toys for Tots program for the past 6 years. Most years, they collected more than 100 toys. In December 2003, the total was around 250. This year’s donation of more than 350 toys for needy children in the Washington metropolitan area topped them all. Shirley Landes, Chief, Freedom of Information Act Section, and Adrienne Mitchell, a management analyst, coordinated the toy drive, and Secretary Anthony Principi was on hand when employees

Other Significant OIG Activities

presented the gifts to the Marines at the OIG's holiday party.



LCpl Adefunke T. Adeyeye, Cpl Agella R. Mitchell, Inspector General Griffin, Toys for Tots chair Shirley Landes, co-chair Adrienne Mitchell, and Secretary Principi.

Recognition Awards

- Special Agent Brian Celatka was presented a "2004 Award of Excellence in Law Enforcement" by U.S. Attorney James Vines of the Middle District of Tennessee for conducting investigations and assisting in presenting and prosecuting those cases. During the awards ceremony, U.S. Attorney Vines commented on Brian's attention to detail and said the manner in which he conducts investigations and presents criminal cases is worthy of the highest recognition.
- Special Agent Tim Bond was awarded a certificate of appreciation by the U.S. Attorney, Eastern District of Pennsylvania, for his outstanding efforts in the successful prosecution of a VA contractor. In a joint investigation with the Small Business Administration, Tim proved that the contractor and two employees conspired to defraud various lending companies, financial institutions, Federal agencies, and municipalities of over \$10 million in an insurance bond scheme.
- Bruce Sackman, Special Agent in Charge of the Northeast Field Office, received the

"2004 Vision Award" from the International Association of Forensic Nurses at its 12th annual scientific assembly in Chicago, IL. This award recognizes the efforts of a non-nurse in promoting forensic nursing.

Operation Clean-Up Award

- The Hampton, VA, Chief of Police wrote a letter of commendation praising several OIG special agents for their outstanding cooperation and assistance, professionalism, and "fine support" in the arrests and indictments of 47 suspects charged with drug distribution and firearm violations. The commendation was extended to Special Agent in Charge Bruce Sackman and Special Agents Jeff Stachowiak, Pat McCormack, Chris Wagner, Jim O'Neill, Sean Smith, Mark Lazarowitz, Tim Bond, Sean Gomez, Paul Lazzaro, and Kevin Russell. Special thanks were extended to Agent Stachowiak "for his outstanding assistance in planning and organizing this operation."

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended		
		OIG	Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
04-01944-7 10/22/04	Combined Assessment Program Review of the VA Central California Healthcare System, Fresno, CA	\$8,821	\$8,821	
04-02528-10 10/29/04	Combined Assessment Program Review of the VA Regional Office, Fort Harrison, MT	\$16,528	\$16,528	
04-02247-12 11/3/04	Combined Assessment Program Review of the Louis Stokes VA Medical Center, Cleveland, OH	\$707,438	\$707,438	
04-01878-34 11/26/04	Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, TX	\$224,350	\$224,350	
04-01562-35 11/26/04	Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, NY	\$572,969	\$572,969	
03-02837-37 11/26/04	Combined Assessment Program Review of the VA Regional Office, Togus, ME	\$179,300	\$179,300	
04-01463-39 12/1/04	Combined Assessment Program Review of the VA Regional Office, Louisville, KY	\$184,827	\$184,827	
04-01822-45 12/7/04	Combined Assessment Program Review of the VA Medical Center, Dayton, OH	\$676,602	\$676,602	
04-02277-48 12/13/04	Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA	\$919,413	\$919,413	
04-03028-49 12/13/04	Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, GA			
04-01740-53 12/27/04	Combined Assessment Program Review of the VA Northern Indiana Healthcare System, Fort Wayne and Marion, IN	\$48,000	\$48,000	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
04-01805-55 12/27/04	Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, CO	\$586,360	\$586,360	
04-02315-57 12/28/04	Combined Assessment Program Review of the VA Regional Office, Reno, NV	\$92,650	\$92,650	
04-03071-62 1/6/05	Combined Assessment Program Review of the VA Medical Center, Fargo, ND	\$74,245	\$74,245	
04-02499-63 1/6/05	Combined Assessment Program Review of the Edward Hines VA Hospital Hines, IL	\$35,500	\$35,500	\$29,300
04-02842-64 1/7/05	Combined Assessment Program Review of the VA Regional Office, Hartford, CT	\$424,613	\$424,613	
04-00603-65 1/10/05	Combined Assessment Program Review of the VA Regional Office, Indianapolis, IN	\$695,540	\$695,540	
04-02527-67 1/14/05	Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, MT	\$65,148	\$65,148	
04-02398-70 1/18/05	Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System, Omaha, NE	\$6,050	\$6,050	
04-02293-73 1/28/05	Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, TX	\$59,443	\$59,443	
04-03271-77 2/4/05	Combined Assessment Program Review of the VA Regional Office, Fargo, ND	\$19,512	\$19,512	
05-00048-84 2/14/05	Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center, Charleston, SC	\$1,150,200	\$1,150,200	
04-02974-90 2/25/05	Combined Assessment Program Review of the VA Medical Center, Martinsburg, WV	\$297,174	\$297,174	
04-03331-91 2/25/05	Combined Assessment Program Review of the VA Regional Office, Little Rock, AR	\$1,503,199	\$1,503,199	
04-02815-88 3/3/05	Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, CA	\$149,556	\$149,556	
04-03200-96 3/3/05	Combined Assessment Program Review of the VA Regional Office, Sioux Falls, SD	\$32,280	\$32,280	
04-03359-105 3/16/05	Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, CA	\$938,542	\$938,542	

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	for Better Use Management	
04-02592-107 3/16/05	Combined Assessment Program Review of the VA Medical Center, White River Junction, VT	\$291,802	\$291,802	
04-01130-109 3/23/05	Combined Assessment Program Review of the VA Medical Center, Philadelphia, PA	\$501,421	\$501,421	
04-00731-110 3/24/05	Combined Assessment Program Review of the VA Regional Office, Providence, RI	\$2,428,392	\$2,428,392	
05-00194-106 3/25/05	Combined Assessment Program Review of the VA Regional Office, Pittsburgh, PA	\$184,273	\$184,273	
05-00222-111 3/25/05	Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, TX	\$2,230,328	\$2,230,328	
04-02331-112 3/25/05	Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Leavenworth, KS	\$143,420	\$143,420	
04-03408-113 3/25/05	Combined Assessment Program Review of the VA Medical Center, Minneapolis, MN	\$638,656	\$638,656	
04-01852-115 3/28/05	Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN	\$1,465,000	\$1,465,000	

COMBINED ASSESSMENT PROGRAM SUMMARY REPORTS

04-03311-58 12/29/04	Summary Report of Combined Assessment Program Reviews at Veterans Benefits Administration Regional Offices October 2003 Through September 2004
04-03310-94 3/7/05	Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities October 2003 through September 2004

JOINT REVIEW

04-00260-100 3/7/05	Summary of the Benefits Review of the VA Regional Office, in San Juan, Puerto Rico
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INTERNAL AUDITS

04-00986-14 11/15/04	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2004 and 2003
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Report Number/ Issue Date	Report Title	Funds Recommended		
		OIG	for Better Use Management	Questioned Costs
04-00986-25 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Financial Management System Application Follow-Up Review			
04-00986-26 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Personnel and Accounting Integrated Data Application Follow-Up Review			
04-00986-27 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Loan Guaranty System Application Follow-Up Review			
04-00986-28 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Integrated Funds Distribution, Control Point Activity, Accounting and Procurement Application Follow-Up Review			
04-00986-29 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Automated Engineering Management System and Medical Equipment Reporting System Application Review			
04-00986-30 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Real Servicing Application Review			
04-00986-31 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements General Computer Controls Review at the Philadelphia Information Technology Center			
04-00986-32 11/23/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements General Computer Controls Review at the Philadelphia Insurance Center			
04-01972-41 11/29/04	Audit of Department of Veterans Affairs Fiscal Year 2003 Special Disabilities Capacity Report			
04-00986-50 12/17/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements General Computer Controls Review at the Hines Information Technology Center			

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	Management	
04-00986-51 12/17/04	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements General Computer Controls Review at the Austin Automation Center			
04-01265-52 12/20/04	Report of the Audit of the Department of Veterans Affairs' Franchise Fund Consolidated Financial Statements for Fiscal Years 2004 and 2003			
04-00986-59 1/3/05	Management Letter, Audit of the Department of Veterans Affairs Consolidated Financial Statements for the Year Ended September 30, 2004			
04-03100-66 1/11/05	Audit of Department of Veterans Affairs Procurement of Desktop Computers with Modems			
02-02181-79 2/8/05	Audit of Veterans Health Administration Major Construction Contract Award and Administration Process	\$957,164	\$957,164	
04-00772-122 3/31/05	Audit of the Department of Veterans Affairs Information Security Program			

OTHER OFFICE OF AUDIT REVIEWS

04-01971-4 10/15/04	Evaluation of Department of Veterans Affairs Policies and Procedures Addressing the Location of New Offices and Other Facilities in Rural Areas			
04-02145-11 10/29/04	Review of Environment of Care and Part-Time Physician Time and Attendance at the Louis Stokes VA Medical Center, Cleveland, OH			
05-00070-18 11/12/04	Promptness of Department of Veterans Affairs' Payments to the District of Columbia Water and Sewer Authority for Fiscal Year 2004			
03-00940-38 12/1/04	Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections			
04-01271-74 2/1/05	Evaluation of Veterans Benefits Administration Vocational Rehabilitation and Employment (VR&E) Contracts	\$6,750,000	\$6,750,000	

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	for Better Use Management	
05-01318-85 2/16/05	Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions			
05-01199-92 2/23/05	Attestation of the Department of Veterans Affairs Detailed Accounting Submission			
05-00949-89 2/24/05	Workers' Compensation Program (WCP) Operating Changes	\$487,832,913	\$487,832,913	
04-02344-97 3/4/05	Evaluation of VA Medical Center, Use of On-Station Fee Basis Appointments			
02-00986-101 3/9/05	Evaluation of VA Compliance with Federal Energy Management Policies	\$12,880,320	\$12,880,320	
05-00055-103 3/9/05	Management Letter, External Penetration Testing of Veterans Affairs Medical Center, Washington, DC			
04-00904-124 3/31/05	Review of VA Implementation of the Zegato Electronic Travel Service	\$7,379,699	\$7,379,699	

CONTRACT PREAWARD REVIEWS*

04-02699-2 10/8/04	Review of Proposal Submitted by Mayo Clinic of Scottsdale for Ophthalmology Outpatient and Surgical Services for the Carl T. Hayden VA Medical Center, Phoenix, AZ	\$2,323,376		
04-01590-3 10/13/04	Review of Proposal for Contract Extension Submitted by Automed Technologies, Inc., Under Contract V797P-3481k			
04-01862-5 10/13/04	Review of Federal Supply Schedule Proposal Submitted by Steris Corporation Under Solicitation Number 797-FSS-0025-R3	\$3,000,257		
04-02967-8 10/18/04	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-44-04 for Otolaryngology Surgeon Services at Richard L. Roudebush VA Medical Center,	\$505,488		
04-03237-9 10/21/04	Review of Federal Supply Schedule Proposal Submitted by Fujisawa Healthcare, Inc., Under Solicitation Number M5-Q50A-03	\$4,149,810		

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

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	for Better Use Management	
04-01285-13 11/2/04	Review of Tyco Healthcare Group LP D/B/A Kendall Healthcare Products Company's Proposal for Medical Supplies Under Solicitation Number 797-FSS-99-0025-R3	\$27,078,813		
04-02556-16 11/3/04	Review of Federal Supply Schedule Proposal Submitted by Dade Behring Inc., Under Solicitation Number RFP-797-FSS-03-0001			
04-03302-20 11/10/04	Review of Proposal Submitted by University of Illinois - Chicago, Under Solicitation Number RFP 69D-275-04 for Anesthesia Services, at Jesse Brown VA Medical Center,			
04-01302-17 11/12/04	Review of Federal Supply Schedule Proposal Submitted by Draeger Medical, Inc., Under Solicitation Number 797-FSS-99-0025-R3	\$3,610,091		
04-02969-21 11/15/04	Review of Proposal Submitted by Biotronics, Inc., Under Solicitation Number RFP 244-04-00070 for Perfusionist Services, at VA Pittsburgh Healthcare System			
04-01801-23 11/15/04	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-49-03 for Orthopedic Surgeon Services at Richard L. Roudebush VA Medical Center	\$467,457		
05-00088-36 11/22/04	Review of Proposal Submitted by the University Physicians, Inc., Under Solicitation Number 678-021-04 for Cardiothoracic Surgery Services at Southern Arizona VA Health Care System	\$1,020,497		
04-02618-33 11/23/04	Review of Federal Supply Schedule Proposal Submitted by Takeda Pharmaceuticals America, Inc., Under Solicitation Number M5-Q50A-03			
05-00044-40 11/29/04	Review of Proposal Submitted by New York University, School of Medicine, Under Solicitation Number 10N3-242-04, for Emergency Medicine Services at the Department of Veterans Affairs, New York Harbor Healthcare System	\$455,972		
04-02443-43 12/2/04	Review of Federal Supply Schedule Proposal Submitted by Aventis Pasteur, Inc., Under Solicitation Number M5-Q50A-03	\$227,386		

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	Management	
05-00417-46 12/6/04	Review of Proposal Submitted by Vanderbilt University, School of Medicine, Under Solicitation Number 626-05-11, for Radiology Services at the Department of Veterans Affairs Medical Center, Nashville, TN	\$238,393		
04-01589-54 12/22/04	Review of Federal Supply Schedule Proposal Submitted by UCB Pharma, Inc., Under Solicitation Number M5-Q50A-03	\$5,093,352		
04-03209-56 12/22/04	Review of Proposal Submitted by University of Pennsylvania, Under Solicitation Number 642-17-04, for On-Site Radiology Physician Services at the Department of Veterans Affairs Medical Center, Philadelphia, PA	\$954,938		
04-03426-60 12/30/04	Review of Proposal Submitted by New York University, School of Medicine, Under Solicitation Number 10N3-231-04, for Vascular Surgeon Services at the Department of Veterans Affairs, New York Harbor Healthcare System	\$529,356		
05-00650-61 1/3/05	Review of Proposal Submitted by New York University, School of Medicine, Under Solicitation Number 10N3-121-04, for Chief of Anesthesia Services at the Department of Veterans Affairs, New York Harbor Healthcare System	\$80,558		
04-02325-68 1/11/05	Review of Federal Supply Schedule Proposal Submitted by Merck & Co., Inc., Under Solicitation Number M5-Q50A-03	\$959,133,684		
05-00510-69 1/12/05	Review of Proposal Submitted by University Physicians Group for Professional Radiology Services for the South Texas Veterans Health Care System			
04-02968-71 1/14/05	Review of Proposal Submitted by the Medical College of Wisconsin, Under Solicitation Number RFP 69D-324-04 for Perfusionist Services, at the Clement J. Zablocki VA Medical Center	\$794,535		
04-03211-72 1/27/05	Review of Proposal Submitted by Baylor College of Medicine, Under Solicitation Number RFQ 580-27-04, for Angiographer/Neuroradiologist Services at Michael E. Debakey VA Medical Center	\$1,957,185		

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	for Better Use Management	
04-02198-81 2/18/05	Supplemental Review of Federal Supply Schedule Proposal Submitted by E. Fougera & Company, Division of Altana, Inc. Under Solicitation Number M5-Q50A-03			
04-03301-87 2/23/05	Review of Proposal Submitted by Indiana University Under Solicitation Number 583-44-04 for General Surgeon Services at Richard L. Roudebush VA Medical Center	\$687,157		
05-00546-99 3/8/05	Review of Proposal Submitted by the University of Pennsylvania Health System Under Solicitation Number 642-38-04 for Emergency Cardiac Surgery Services for the Department of Veterans Affairs Medical Center, Philadelphia, PA			
04-02716-104 3/23/05	Review of Federal Supply Schedule Proposal Submitted by Astrazeneca LP Under Solicitation Number M5-Q50A-03	\$791,515		
04-02557-117 3/25/05	Review of Cardinal Health 200 Inc.'s 5-Year Extension Request of Federal Supply Schedule Contract V797P-3492k	\$659,093		
04-02700-118 3/28/05	Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Healthcare Systems, Inc. on Behalf of McNeil Consumer & Specialty Pharmaceuticals Under Solicitation Number M5-Q50A-03	\$1,987		

CONTRACT POSTAWARD REVIEWS

01-01156-6 10/14/04	Settlement Agreement Pharmaceutical Manufacturer			\$521,447
05-00312-22 11/4/04	Supplemental Report on the Verification of UCB Pharma, Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5404x			\$26,389
00-02780-24 11/12/04	Bill of Collection on a Voluntary Disclosure			\$22,184
04-00817-44 12/3/04	Review of Claim Submitted by Rotech Healthcare, Inc., Under Contract Number V554P(NASC) 02-00			\$1,374,527
04-02326-75 2/2/05	Verification of Merck & Co. Self-Audit Under Federal Supply Schedule Contract Number V797P-5236x			\$306,102

Report Number/ Issue Date	Report Title	Funds Recommended		Questioned Costs
		OIG	Management	
04-02750-83 2/10/05	Review of Federal Supply Schedule Proposal Submitted by Roche Diagnostics Corporation Under Solicitation Number RFP-797-FSS-03-0001	\$12,007,560		
02-00800-98 3/3/05	Post-Award Review of Department of Veterans Affairs Denver Distribution Center Contract V791P-0260 Awarded to Starkey Laboratories, Inc.			
05-00700-114 3/23/05	Verification of Genzyme Corporation's Self-Audit Under Federal Supply Schedule Contract Number V797P-5702x			\$84,822

HEALTHCARE INSPECTIONS

04-00036-42 11/30/04	Healthcare Inspection, Alleged Delay in Diagnosis and Treatment Michael E. DeBakey VAMC Houston, TX			
04-01150-47 12/9/04	Healthcare Inspection, Contract Nursing Home Issues James H. Quillen VA Medical Center, Mountain Home, TN			
05-00290-78 2/8/05	Healthcare Inspection, Emergency Decontamination Preparedness VA Salt Lake City Health Care System, Salt Lake City, UT			
04-00120-82 2/11/05	Healthcare Inspections, Alleged Poor Care and Mismanagement of Surgical Service, VA Medical Center, Hot Springs, SD			
04-00770-86 2/18/05	Healthcare Inspection, Alleged Quality of Care Issues, Michael E. DeBakey VA Medical Center, Houston, TX			
04-00367-76 2/22/05	Healthcare Inspection, Quality of Care Issues, DC Veterans Affairs Medical Center, Washington, DC			
04-02051-95 3/3/05	Healthcare Inspection, Patient Care and Mismanagement Issues VA Medical Center, West Palm Beach, FL			
04-03348-102 3/10/05	Healthcare Inspection, Alleged Patient Abuse Issue Dwight D. Eisenhower VA Medical Center, Leavenworth, KS			

Report Number/ Issue Date	Report Title	Funds Recommended		
		OIG	for Better Use Management	Questioned Costs
05-00720-108 3/17/05	Healthcare Inspection, Anesthesia Management and Patient Care Issues, New Mexico VA Healthcare System, Albuquerque, NM			
05-01027-116 3/25/05	Healthcare Inspection, Alleged Patient Abuse Central Texas Veterans Health Care System, Temple, TX			

ADMINISTRATIVE INVESTIGATIONS

03-03104-1 10/8/04	Administrative Investigation, Misuse of Time by a Physician, VA Medical Center, Minneapolis, MN			
03-03058-15 11/5/04	Administrative Investigation, Preferential Treatment in Hiring, VA Medical Center, Atlanta, GA			
04-00257-19 11/12/04	Administrative Investigation, Inappropriate Absences and Purchase Card Use, Memorial Service Network 1 Philadelphia, PA			
04-00004-80 2/8/05	Administrative Investigation, Physician Time and Attendance Issue, VA New York Harbor Healthcare System, New York, NY			
04-02656-93 2/28/05	Administrative Investigation, Improper Alternative Work Agreement and Tuition Reimbursements VISN 1 Bedford, MA			
TOTAL	125 Reports	\$1,559,120,108	\$533,351,648	\$2,364,771

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APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

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

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

The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2004, and earlier).

<i>Unimplemented OIG Reports and Recommendations</i>				
VA Office	Total		Issued 3/31/04 and Earlier	
	Reports	Recommendations	Reports	Recommendations
VHA	48	345	8	38
A&MM	80	183	0	0
OM	4	27	0	0
VBA	7	25	1	2
OI&T	2	24	0	0
OHRA	3	20	0	0
OPPP	1	3	0	0
Totals	145	627	9	40

* There are 141 total unimplemented reports. We have listed 145 reports because 2 reports have actions for two or more offices.

Acquisition and Materiel Management (A&MM)

Office of Management (OM)

Office of Information and Technology (OI&T)

Office of Human Resources and Administration (OHRA)

Office of Policy, Planning, and Preparedness (OPPP)

OIG is particularly concerned with one report on VBA operations (issued in July 2000) and three reports on VHA operations (issued in March, October, and December 2002) with recommendations that still remain open. The following information provides a summary of reports over 1 year old with open recommendations.

Veterans Benefits Administration

Unimplemented Recommendations and Status

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

Recommendations: The Under Secretary for Benefits should:

1. Establish a positive control Benefits Delivery Network (BDN) system edit keyed to an employee identification number that ensures employee claims are adjudicated only at the assigned regional office of jurisdiction and prevents employees from adjudicating matters involving fellow employees and veterans service officers at their home office.
2. Establish a BDN system field for third-person authorization and a control to prevent release of payments greater than \$15,000 without the third-person authorization.

Status: As of March 31, 2005, 2 of 26 recommendations remain unimplemented pending VBA actions.

1. The Veterans Services Network (VETSNET) (the BDN replacement system) Award system, as designed, prohibits employees from adjudicating fellow employees' records at their home stations. This is an internal security feature in place for all awards processed in VETSNET. Internal alpha testing has confirmed that employee claims are properly processed by a station other than their home station. Beta testing continues at one VARO. More rigorous testing is planned to confirm proper system restrictions are in place. The planned completion date for this testing is December 2005.
2. VETSNET programming is complete and beta testing has confirmed that an automatic third-person authorization to control the release of large payments (greater than \$25,000) is in place. As an interim control, VBA instituted a C&P large-payment review process in 2001. This process continues to be reviewed by C&P Service site visits and is also validated through the OIG CAP review process. VBA has requested the OIG review and validate that VBA has completed systemic controls for third-person authorizations. The OIG is currently validating whether the controls are in place.

Veterans Health Administration

Unimplemented Recommendations and Status

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

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

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

15. Provide researchers and other appropriate personnel necessary training on security issues, including security of high-risk and sensitive agents, and procedures to forward requests for research articles through their managers and the facility Freedom of Information Act officer.

Status: In March 2002, the VA Deputy Secretary requested the VA staff to issue a joint report by September 30, 2002, certifying that all the OIG recommendations had been completed. However, as of March 31, 2005, 15 of 16 recommendations remain unimplemented. Most of the report's recommendations were made to the Under Secretary for Health; however, several recommendations required joint efforts on the part of VHA and the Office of Security and Law Enforcement. During the prior semiannual period, the Office of Security and Law Enforcement completed their actions by revising two security publications. Also, VHA issued handbooks for control of hazardous agents in VA research laboratories, and for pathology and laboratory medicine biosecurity and biosafety.

In September 2004, the Under Secretary for Health committed to the VA Deputy Secretary that VHA will complete certification of guidance by December 31, 2004. However, this action has been delayed. On March 25, 2005, VHA sent the VISN directors detailed research and clinical checklists so facilities can reassess the criteria and implement the requirements in the issued publications. The VISN consolidated certification reports from the facilities is to be completed by May 1, 2005. The purpose of the certification requirement is to document compliance with the directives and provide assurance that the intent of the OIG recommendations to address all the security and control vulnerabilities presented in the report have been addressed and corrected at each facility.

VHA is also developing a Web-based educational program that outlines security training requirements that will be available through the Intranet. VHA has also drafted procedures requiring requests for research articles be sent for review to the facility Freedom of Information Act officer.

Report: *Healthcare Inspection, Patient Care Issues, VA Hudson Valley Health Care System, Franklin Delano Roosevelt Campus, Montrose, NY, 02-02374-08, 10/18/02*

Recommendations:

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

Status: As of March 31, 2005, there are 31 veterans residing in 4 unlicensed community residential care homes, as compared to 182 veterans in 28 unlicensed homes on October 1, 2002. The VA Hudson Valley Health Care System continues facilitating the licensure process of the homes by working closely with the VA Central Office program office (VHA Chief Consultant for Geriatrics and Extended Care); the New York State Department of Health and Office of Child and Family Services; and the VA sponsored homes. The homes are inspected regularly and provisions are in place for immediately relocating the veterans from a home if a home fails to meet inspection requirements. The veterans will be relocated should a home fail to demonstrate a good faith effort in the licensure process. The Health Care System anticipates that all homes will be licensed by the end of July 2005.

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

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

1. VHA medical facility managers devote the necessary resources to adequately administer the CNH program.
2. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.
3. Coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and VBA fiduciary and field examination employees can most effectively complement each other and share information such as medical record competency notes, on-line survey certification and reporting data, and VBA reports of adverse conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Status: As of March 31, 2005, 3 of 11 recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care. The revised VHA handbook on CNH oversight was published in June 2004. VHA needs to finalize new performance indicators; upgrade the CNH website from the prototype to a finalized site; and finalize the implementation plan/coordinated efforts on how VHA, CNH, and VBA fiduciary and field examination employees can most effectively complement each other and share information. Completion of all the actions is expected by July 2005.

Report: *Audit of VHA's Part-Time Physician Time and Attendance, 02-01339-85, 4/23/03*

Recommendations:

1. To improve physician timekeeping, we recommend that the Under Secretary for Health:
 - a. Determine what reforms are needed to ensure VA physician timekeeping practices are effective in an academic medicine environment and VA physicians are paid only for time and service actually provided.
 - b. Recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.
 - c. Ensure desk audits are conducted of timekeeping functions.
 - d. Provide continuing timekeeping education to supervisors, physicians, and timekeepers.
 - e. Evaluate appropriate technological solutions that will facilitate physician timekeeping.
 - f. Develop comprehensive guidance for VAMCs to use when conducting desk audits.
 - g. Establish appropriate training modules, making best use of technological solutions, for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.
2. To better align physician staffing with patient care workload, we recommend that the Under Secretary for Health:

- a. Publish policy and guidance that incorporates the use of workload analysis to determine the number of physicians needed to provide timely, cost effective, and quality service to veterans seeking care from VA.
- b. Require VAMCs to review their staffing structures (such as part-time, full-time, intermittent, or fee basis) and determine if these appointments are appropriate to the needs of the medical center.
- c. Evaluate alternative methods to acquire physician services and publish national guidance to assist VISN and VAMC directors in determining the best strategies for their regional, academic, and patient care circumstances.
- d. Publish guidance describing how VISN and VAMC managers should determine, monitor, and communicate the allocation of physician time among patient care, administrative duties, academic training, and medical research.

Status: As of March 31, 2005, 11 of 17 recommendations remain unimplemented pending actions by a number of VHA staff offices. Revised electronic time and attendance (ETA) software remains on schedule for release in late April/early May 2005. Final edits to VHA handbook 5011 are being made as a result of the hours bank pilot and alpha and beta testing of the revised ETA system. Once the ETA system is distributed nationally, facilities will have 30 days to implement. VHA intends to have all the related directive and handbooks issued in mid-May 2005. The revisions made clarify terminology and do not change the processes that were reviewed by the OIG previously. There are two web-based courses in development covering software and entry of time and attendance; and policy and requirements. Both will be available with the launch of the revised ETA system.

The Physician Productivity and Staffing Committee have been in active discussions with the OIG staff regarding the physician productivity standards in primary and specialty care. Both the primary care panel size model and the relative value unit-based specialty productivity model use direct patient care FTE as a fundamental measurement of physician workforce. This is consistent with external benchmarks.

Primary Care Update. VHA has issued three directives and created a real-time primary care data reporting system for patient care in primary care that includes support staffing and practice characteristics. VHA also established two national performance monitors regarding implementation of the primary care productivity and staffing model, and is also refining the implementation of the business rules and databases for the primary care staffing model.

Specialty Care Update. Below is a summary of the projects initiated in FY 2005:

- **Inpatient workload capture pilot studies:** This project will evaluate the quality, cost effectiveness and return on investment of coder abstraction versus physician data collection of inpatient professional services. Capturing this professional inpatient workload, for which there is no current standardized process, is essential for productivity analysis for inpatient-based medical specialties. The projected timeframe, following approval, funding, and coder recruitment is 12 months.
- **Specialty physician database:** In February 2005, a detailed listing of all paid physician staff and the associated labor mapping distribution of their time was provided to the field. These data by facility provides for the first time a breakdown of all paid physician staff time spent

in clinical care, research, education and administration as well as listing the current specialty. Validation of this database by all VA facilities is now being done. The final step to complete a national VHA specialty physician database will be to merge this database with the contract and fee physician database, currently under development. The projected completion of this merged database is June 2005.

- Specialty care productivity models and analyses: This project will assess productivity and develop models for 16 specialties during FY 2005. These specialties include: 10 surgical specialties, 5 outpatient-based medical specialties, and radiology. For each of these specialties a collection and inventory of significant productivity modifiers is in development. Surveys in each specialty areas have been submitted to the field for completion. These surveys will gather information on important factors that may impact productivity including information on practice setting, teaching mission, patient complexity, and capital infrastructure. It is anticipated that the models and measurement for these 16 specialties will be completed in July 2005.

Database and Directives. As the above referenced projects are initiated, modifications and/or establishment of databases and directives are required. A group has been specifically charged with ascertaining that required business practices, databases and field guidance are considered and effectively communicated. Specifically, development and modifications are being considered for directives that will improve the quality of physician productivity related data: Ambulatory Care Data Capture, DSS Labor Mapping, Person Class File Taxonomy, and VHA Enhanced Sharing Agreement Physician Database. Also databases have been developed or are in the process of being developed in several key areas of information.

Report: *Healthcare Inspection, Evaluation of VHA Homemaker and Home Health Aide Program, 02-00124-48, 12/18/03*

Recommendations: We recommend that the Under Secretary for Health issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that:

1. Patients receive thorough initial interdisciplinary assessments prior to placement in the program.
2. Patients receiving Homemaker and Home Health Aide services meet clinical eligibility requirements.

Status: As of March 31, 2005, 2 of 4 recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care. The information technology package containing the geriatrics and referral form was released to the field in February 2005. In addition, guidance has been provided to the field via three teleconferences. However, the VHA program office has not provided a planned completion date to issue the Home Health Care Program Administration handbook that was first drafted in January 2004. The program office also stated reporting on the performance measures are expected to commence in the 3rd quarter 2005, however, we are concerned that field guidance on the performance measures has not been issued.

Report: *Administrative Investigation, Contract and Employee Retreat Expenditure Issues, VHA Financial Assistance Office, 03-01120-86, 2/18/2004*

Recommendation: The VHA Chief Financial Officer should ensure a bill of collection for \$823 is issued to the former Director of the Financial Assistance Office to recoup the appropriated funds he allowed to be spent on a “sunset” cruise.

Status: In October 2004, the former Director requested relief from financial liability for the Office of Comptroller General. Based on this request, in December 2004, VA General Counsel received correspondence from the Assistant General Counsel, U.S. Government Accountability Office (GAO). GAO requested a number of documents and asked several questions regarding the individuals responsibility, including his role in obligating, approving, or certifying agency funds. The VA Office of General Counsel has responded to the GAO. VHA is unable to take any further action regarding this recommendation other than await a final decision from GAO. There are no administrative appeal rights after GAO renders a decision.

Report: *Healthcare Inspection, Survey of Efforts to Safeguard VA Potable and Waste Water Systems, 03-01743-114, 3/18/04*

Recommendation: The Under Secretary for Health, in conjunction with VISN directors, needs to standardize water system security assessments and requirements using guidelines recommended by the Environmental Protection Agency (EPA) to ensure all VA medical facilities are considering and applying similar safety measures.

Status: The VHA Environmental Engineering Office will evaluate the drinking water security measures in place at VHA facilities to determine if there are existing security measures that might have applicability VHA-wide. VHA will also continue to interact with EPA for possible application of other water security measures within VHA. If there are existing water security measures that can be implemented, VHA will issue appropriate implementation directions. The planned completion date is December 2005. This effort will be limited to facilities producing their own water from on-site sources such as wells and facilities storing significant quantities of water provided by municipal sources.

Report: *Administrative Investigation, Use of Government Funds, Travel, Personnel, Impartiality, and Management Issues, VHA Office of Research and Development (ORD), 03-03053-115, 3/22/04*

Recommendations: The Under Secretary for Health should ensure that the Deputy Under Secretary for Health:

1. Coordinates with the pharmaceutical companies to properly dispose of the excess funds in accordance with the agreements between VHA and the pharmaceutical companies and in accordance with appropriate Federal regulations.
2. Transfers remaining funds from ongoing studies from the Friends Research Institute, Inc (FRI), the organization that maintained the pharmaceutical companies’ funds and administered them for ORD, to an appropriate VA-affiliated nonprofit research corporation or to the General Post Fund.

3. Issues bills of collection to the former ORD chief, and all other current and former VA employees responsible for approving the use of FRI-administered funds since January 2002 for their own or others' personal benefit.
4. Reviews the travel vouchers of those staff who routinely traveled with the former ORD chief to determine if similar irregularities exist in their claims.

Status: As of March 31, 2005, 4 of 23 recommendations remain unimplemented pending VHA actions.

1. The proper placement of the excess funds is now more than 98 percent complete. A review of the remaining two accounts showed they were old (approximately 15 years) and had little documentation as to the purpose of the account. VHA has identified the two account sponsors and will request the funds be used to support future research activities. The two remaining accounts with \$489,423, represents less than 2 percent of the identified funds.
2. The transfer of remaining funds is now more than 97 percent complete. Only one account remains open with \$747,108 that represents less than 3 percent of the identified FRI funds. The accounts will retain a small balance until June 30, 2005, to cover any committed costs incurred during the closeout and movement of funding. Once the commitments have been met, the remaining balance will be sent to the proper depository.
3. VHA has completed its review and is developing a plan with consultation from the Office of General Counsel. The planned completion date is June 2005.
4. VHA has completed its review and notified the appropriate individuals regarding the irregularities found. Each has been requested to respond within 30 days as to whether they have additional information.

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APPENDIX C

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	54
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	77 (App. B)
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	88 (App. C)
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	65-75 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	i-vi
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	89 (Table 1)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	90 (Table 2)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	78-85 (App. C)
Section 5 (a) (11)	Significant revised management decisions	88 (App. C)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	88 (App. C)
Section 5 (a) (13)	Information described under section 5(b) of the <i>Federal Financial Management Improvement Act of 1996</i> (Public Law 104-208)	88 (App. C)

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS (CONT'D)

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

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

Obtaining Required Information or Assistance

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

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

The IG Act requires the OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the requirements of Public Law 104-208. VA began operational testing of a new integrated financial management and logistics system (CoreFLS) on October 6, 2003, at three VA facilities. VA planned to expand operational testing to several other facilities during the fiscal year. However, due to deployment and information technology security issues, further implementation of the system was halted. VA is currently evaluating how it will proceed with the system development effort. At the time it was halted, the project was under the VA Chief Financial Officer. Subsequently, the project has been transferred to the VA Chief Information Officer.

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

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no OIG reports unresolved for over 6 months.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

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

Table 1: Resolution Status Of Reports With Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/04*	0	\$0
Issued during reporting period	7	\$2.4
Total inventory this period	7	\$2.4
Management decisions during the reporting period.		
Disallowed costs (agreed to by management)	7	\$2.4
Allowed costs (not agreed to by management)	0	\$0
Total Management Decisions This Reporting Period	7	\$2.4
Total Carried Over To Next Period	0	\$0

Questioned Costs

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

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

Disallowed Costs

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

Allowed Costs

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

Table 2: Resolution Status Of Reports With Recommended Funds To Be Put To Better Use By Management

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/04*	50	\$633.8
Issued during reporting period	52	\$1,559.1
Total inventory this period	112	\$2,192.9
Management decisions during the reporting period.		
Agreed to by management	50	\$732.0
Not agreed to by management	8	\$294.3
Total Management Decisions This Reporting Period	58	\$1,026.3
Total Carried Over To Next Period	54	\$1,166.6

* Figures revised from 9/30/04 semiannual report.

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

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

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 D

OIG OPERATIONS PHONE LIST

Investigations

Headquarters Investigations Washington, DC	(202) 565-7702
Northeast Field Office (51NY) New York, NY	(212) 951-6850
Boston Resident Agency (51BN) Bedford, MA	(781) 687-3138
Newark Resident Agency (51NJ) Newark, NJ	(973) 297-3338
Pittsburgh Resident Agency (51PB) Pittsburgh, PA	(412) 784-3788
Washington Resident Agency (51WA) Washington, DC	(202) 530-9191
Southeast Field Office (51SP) Bay Pines, FL	(727) 319-1215
Atlanta Resident Agency (51AT) Atlanta, GA	(404) 929-5950
Columbia Resident Agency (51CS) Columbia, SC	(803) 695-6707
Nashville Resident Agency (51NV) Nashville, TN	(615) 695-6373
West Palm Beach Resident Agency (51WP) West Palm Beach, FL	(561) 422-7720
Central Field Office (51CH) Chicago, IL	(708) 202-2676
Denver Resident Agency (51DV) Denver, CO	(303) 331-7673
Cleveland Resident Agency (51CL) Cleveland, OH	(216) 522-7606
Kansas City Resident Agency (51KC) Kansas City, KS	(913) 551-1439
South Central Field Office (51DA) Dallas, TX	(214) 253-3360
Houston Resident Agency (51HU) Houston, TX	(713) 794-3652
New Orleans Resident Agency (51NO) New Orleans, LA	(504) 619-4342
Western Field Office (51LA) Los Angeles, CA	(310) 268-4269
Phoenix Resident Agency (51PX) Phoenix, AZ	(602) 627-3252
San Diego Resident Agency (51SD) San Diego, CA	(619) 400-5326
San Francisco Resident Agency (51SF) Oakland, CA	(510) 637-6360
Seattle Resident Agency (51SE) Seattle, WA	(206) 220-6654

ext 31

Healthcare Inspections

Central Office Operations Washington, DC	(202) 565-8305
Healthcare Regional Office Washington (54DC) Washington, DC	(202) 565-8452
Healthcare Regional Office Atlanta (54AT) Atlanta, GA	(404) 929-5961
Healthcare Regional Office Bedford (54BN) Bedford, MA	(781) 687-2134
Healthcare Regional Office Chicago (54CH) Chicago, IL	(708) 202-2672
Healthcare Regional Office Dallas (54DA) Dallas, TX	(214) 253-3330
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA.....	(310) 268-3005

Audit

Central Office Operations Washington, DC	(202) 565-4625
Central Office Operations Division (52CO) Washington, DC	(202) 565-4434
Contract Review and Evaluation Division (52C) Washington, DC	(202) 565-4818
Financial Audit Division (52CF) Washington, DC	(202) 565-7913
Information Technology Division (52IT) Washington, DC	(202) 565-5826
Veterans Health and Benefits Division (52VH) Washington, DC	(202) 565-8447
Atlanta Audit Operations Division (52AT) Atlanta, GA	(404) 929-5921
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Austin Residence (52AU) Austin, TX	(512) 326-6216
Kansas City Audit Operations Division (52KC) Kansas City, MO	(816) 426-7100
Los Angeles Audit Operations Division (52LA) Los Angeles, CA	(310) 268-4335
Seattle Audit Operations Division (52SE) Seattle, WA	(206) 220-6654

APPENDIX E

GLOSSARY

ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
C&P	Compensation and Pension
CAP	Combined Assessment Program
CBOC	Community-Based Outpatient Clinic
CFS	Consolidated Financial Statements
CMOP	Consolidated Mail Out Pharmacy
DAS	Data Analysis Section
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DOL	Department of Labor
EPA	Environmental Protection Agency
FBI	Federal Bureau of Investigation
FFMIA	Federal Financial Management Improvement Act
FISMA	Federal Information Security Management Act of 2002
FOIA/PA	<i>Freedom of Information Act/Privacy Act</i>
FSS	Federal Supply Schedule
FTE	Full-time Equivalent
FY	Fiscal Year
GSA	General Services Administration
HCS	Health Care System
HEC	Health Eligibility Center
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
IG	Inspector General
IRS	Internal Revenue Service
IT	Information Technology
MCCF	Medical Care Collection Fund
MCI	Master Case Index
NCA	National Cemetery Administration
NCIC	National Crime Information Center
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONDCP	Office of National Drug Control Policy
OPM	Office of Personnel Management
PCIE	President's Council on Integrity and Efficiency
QM	Quality Management
SSA	Social Security Administration
USMS	U.S. Marshals Service
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VR&E	Vocational Rehabilitation and Employment
WCP	Workers' Compensation Program

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Office of Inspector General
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