Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
April 1, 2005 - September 30, 2005

FOREWORD

This Semiannual Report to Congress focuses on the Department of Veterans Affairs (VA) Office of Inspector General (OIG) accomplishments for the period of April 1, 2005, through September 30, 2005, and provides a summary of the entire fiscal year. We issue this report in accordance with the *Inspector General Act of 1978*, as amended.

During this reporting period, a total of 99 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 over $20 billion in monetary benefits, for an OIG return of $557 for every dollar expended. One significant national review involved the consistency of VA disability compensation payments made to veterans in different states. The report found insufficient verification of claimed service-related stressor events in the rapidly-growing post-traumatic stress disorder (PTSD) category and made recommendations to improve benefits processing. To demonstrate the potential consequence of the lack of adequate evidence to support a PTSD claim, the error rate we found equates to questionable compensation payments over the lifetimes of the veterans estimated at $19.8 billion.

Our criminal investigators closed 574 investigations involving a wide variety of criminal activity directed at VA personnel, patients, programs or operations. During this period, special agents conducted investigations that led to 675 arrests, indictments, criminal complaints, convictions, and pretrial diversions. They also produced $261.5 million in dollar impact to VA. In one significant case, an attorney who withheld real estate proceeds from over 50 victims was sentenced to over 6 years' incarceration and ordered to pay over $2 million in restitution. Additionally, the efforts of our agents and support staff led to the apprehension of 273 fugitive felons nationwide.

Our health care inspectors focused on quality of care issues in VA. Visiting a number of facilities to respond to congressional and other requests concerning health care-related matters, inspectors made recommendations to improve the standard of care, ensure prompt and effective treatment, reduce waiting times, improve supervision of resident physicians, and protect patients' safety.

OIG's ongoing Combined Assessment Program (CAP) reviews the quality, efficiency, and effectiveness of VA facilities. Auditors, investigators, and health care inspectors collaborate to assess key operations at VA medical and benefit facilities on a cyclical basis. The 30 CAP reviews we completed this period highlighted numerous opportunities for improvement of quality of care, management controls, and fraud prevention.

We will continue to partner with the VA Secretary and Congress to prevent fraud, waste, and abuse in VA programs and operations, maximizing VA's effectiveness in providing benefits to our Nation's veterans.

JON A. WOODITCH
Acting 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 ending September 30, 2005. The following statistical data highlights OIG activities and accomplishments during the entire fiscal year (FY).

	Reporting Period	FY 2005
DOLLAR IMPACT (Dollars in Millions)		
Better Use of Funds	$19,891.3	$21,451.5
Fines, Penalties, Restitutions, and Civil Judgments	$6.6	$13.8
Fugitive Felon Program	$227.6	$279.4
Dollar Recoveries	$3.8	$36.0
Savings and Cost Avoidance	$23.5	$78.3
Questioned Costs	$1.2	$3.6
RETURN ON INVESTMENT		
Dollar Impact ($20,154) / Cost of OIG Operations ($36.2)	557:1	
Dollar Impact ($21,863) / Cost of OIG Operations ($70.2)		311:1
OTHER IMPACT		
Arrests	327	593
Indictments	155	336
Criminal Complaints (new measure this period)	25	25
Convictions	149	327
Pretrial Diversions	19	39
Fugitive Felon Apprehensions	273	525
Administrative Sanctions	229	1,803
ACTIVITIES		
Reports Issued		
Combined Assessment Program (CAP) Reviews	30	65
CAP Summary Reviews	0	2
Joint Review	0	1
Audits	8	37
Contract Reviews	47	85
Healthcare Inspections	8	23
Administrative Investigations	6	11
Investigative Cases		
Opened	590	1,116
Closed	574	1,076
Healthcare Inspections Activities		
Clinical Consultations	6	12
Hotline Activities		
Contacts	7,902	14,683
Cases Opened	568	1,020
Cases Closed	462	969

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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 benefits.

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).

- 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 (HCS), 134 nursing home units, 207 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 $37.3 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 $28.8 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 $1.1 trillion. Approximately 160,000 home loans will be guaranteed in FY 2005, with a value of approximately $23.2 billion.

NCA operates and maintains 121 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 increase each year, with 93,000 for FY 2005 and approximately 363,000 headstones and markers will be furnished 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

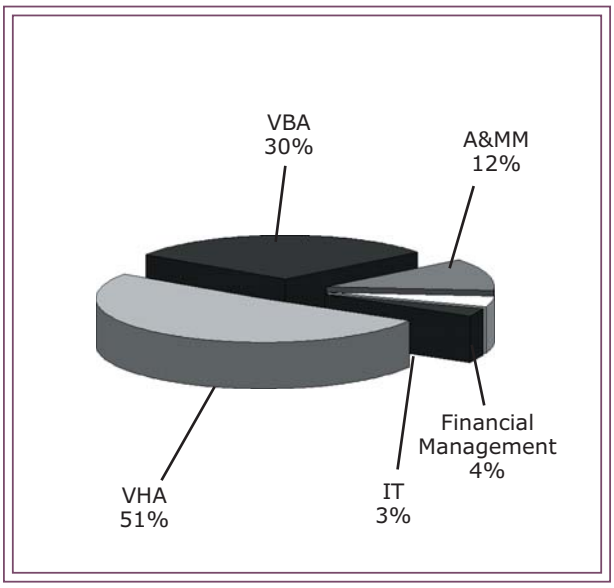
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2005 staffing plan are as follows.

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

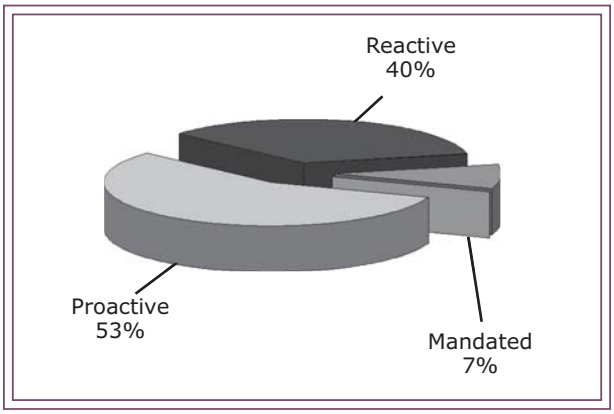
In addition, 25 FTE are reimbursed for a Department contract review function.

The FY 2005 funding of OIG operations was $73.6 million, with $69.1 million from appropriations, $1.7 million from FY 2004 carryover, and $2.7 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.



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 (QM) 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.

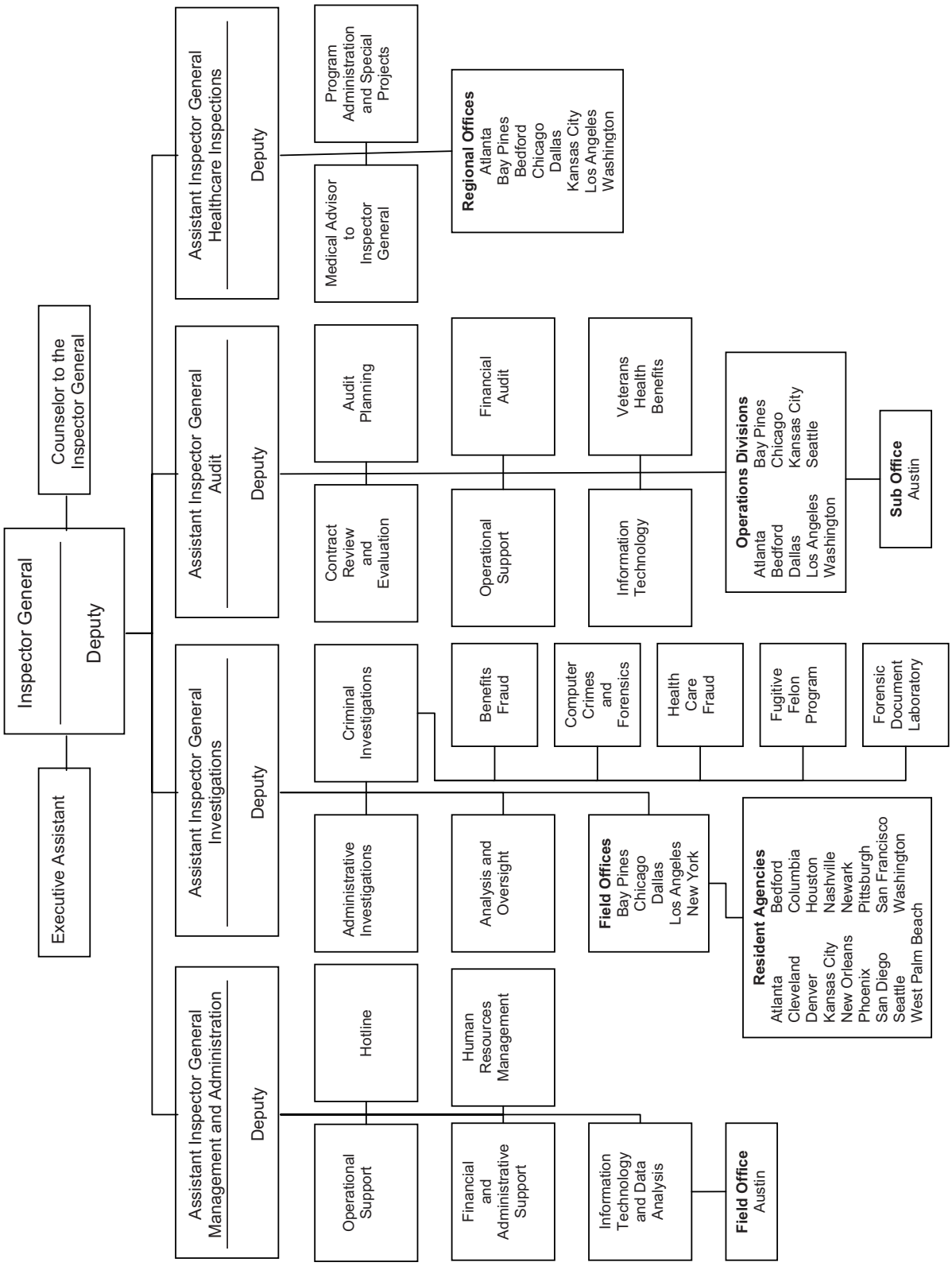
Proactive work is self-initiated, focusing on areas where OIG staff determines there are significant issues.

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.


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

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COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period April 1, 2005, through September 30, 2005, OIG issued 30 CAP reports with associated monetary benefits totaling $14.1 million. Of the 30 CAP reports, OIG reported on 24 VA health care systems (HCS) and VAMCs, and 6 VAROs.

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 are available to the public on our website: http://www.va.gov/oig.

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

OIG identified opportunities for improvement in 9 of the 23 facilities' QM programs we

reviewed. Some needed improvement in more than one aspect. OIG found that:

1. Improvement was needed in data collection, analysis, trend identification, and implementation and evaluation of corrective actions.
2. Patients who experienced adverse outcomes were not adequately notified about the situation, including their rights to file tort or benefits claims.
3. Insufficient evidence of resident supervision.
4. In one facility licensed independent practitioners did not all have documented evidence of current cardio-pulmonary resuscitation certification.
5. Improvement was needed in mortality review analysis.
6. Medical center managers did not adequately analyze whether sufficient numbers of caregivers were available to provide safe, quality care to patients.

VA Medical Center St. Louis
St. Louis, MO

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 11 of 21 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 23 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 all 21 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. Also, management of equipment inventories was deficient at 5 of 7 facilities where we tested records. 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 security deficiencies at 16 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. Facilities did not effectively monitor access to VHA's Veterans Health Information Systems and Technology Architecture and the Internet.
    4. Facilities did not conduct background investigations for designated key hospital staff or contract personnel with access to sensitive areas.
    5. Facilities did not conduct annual security awareness training.
    6. 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 11 of 22 facilities tested. Facilities did not receive and post controlled substances into inventory records witnessed by accountable officers designated by Acquisition and Materiel Management Service as required by VHA policy. Facility management did not conduct or did not document required 72-hour inventories, or conduct unannounced inspections and inventories, or 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 comply with VHA policy to report missing controlled substances to the OIG Office of Investigations.

Colorectal Cancer

- OIG identified opportunities in Colorectal Cancer (CRC) screening, diagnosis, and management at five of the nine facilities where we reviewed these issues. In all five facilities, clinicians needed to improve the timeliness of CRC diagnosis by reducing delays in obtaining diagnostic gastrointestinal procedures. All five facilities provided timely Surgery and Hematology/Oncology consultative services upon making the diagnosis of CRC and developed coordinated interdisciplinary treatment plans. Three facilities met the VHA

performance measure for colorectal cancer screening and promptly informed patients of diagnoses and treatment options. Facility managers needed to ensure that diagnostic GI procedures are performed within reasonable timeframes.

Pressure Ulcers

- OIG identified opportunities for improvement in pressure ulcer prevention and management at 9 of the 14 facilities where we reviewed these issues. Findings at all nine facilities indicated that clinicians needed to more consistently document patient skin integrity assessments, identify patients at risk for pressure ulcers, and consistently document treatments. Also, nurses needed to be properly trained on all aspects of pressure ulcer prevention and management. In two facilities, we found that pressure ulcer education was not consistently provided to patients and/or their caregivers or documented in the medical records. Another facility needed to develop and implement a comprehensive pressure ulcer policy and document treatment efficacy and cost impact information.

Medical Care Collections Fund

- VA health care facilities continue to increase Medical Care Collections Fund (MCCF) collections. However, OIG found deficiencies at 20 of 22 facilities tested. Deficiencies included:

1. Insurance information was not obtained 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 untimely.

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.

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 three of eight facilities tested. The pharmacy walls and dispensing window were not constructed of materials meeting minimum security requirements as required by VA policy.

VA Medical Center Cincinnati
Cincinnati, OH

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 5 of 14 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 accounts receivable function needed improvement at six of nine facilities tested. OIG identified instances where debts were improperly canceled and inaccurate. For example, staff did not properly reconcile debts in the Financial Management System with Integrated Funds Distribution Control Point Activity, Accounting, and Procurement. Also, accounts receivable were untimely processed.

- OIG found that improvement was needed over control of unliquidated obligations at two of four sites. There were instances where undelivered orders and accrued services payable, which were no longer needed and over 90 days past due, were not canceled.

Survey Results

Inpatient Surveys

OIG completed 346 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, 96 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.

- Ninety-three percent of the inpatients told us that staff members explained their care plans to them, and 91 percent felt that they were included in clinicians' decisions about their treatment. Ninety-two percent said that they received education from clinicians on prescribed medications and procedures.

- Nineteen percent of the inpatients told us that they did not have one primary care provider who was responsible for their overall treatment. Ten percent had concerns about the adequacy of discharge planning for continuity of care following discharge from the hospital.

Outpatient Surveys

OIG surveyed 434 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, 96 percent of the outpatients rated the quality of care as good, very good, or excellent. Ninety-seven percent of the outpatients would recommend medical care to eligible family members or friends, 94 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-four 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 explained the reasons for referrals to specialists and why diagnostic tests were ordered.

- Eighty percent were given appointments and were assessed by the specialist within 30 days of the referrals and 76 percent received counseling by a pharmacist when they received new prescriptions. Eighty-four percent said that they received their refills in the mail before they ran out of their medications.

- Only 70 percent of the outpatients said that they were generally able to schedule appointments with their primary care providers within 7 days of their request.

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. Twelve facilities received a total of 40 recommendations to correct environment of care deficiencies. Recommendations were distributed among four categories as follows: safety (25), cleanliness (7), infection control (5), and patient privacy (3).

Combined Assessment Program Overview—Benefits

During this period, OIG issued six CAP reports on the delivery of benefits, listed in Appendix A with their exact titles, report numbers, and dates. These reports are available on our website: http://www.va.gov/oig.

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 six facilities.

Compensation and Pension Claims Processing

- Compensation and pension (C&P) benefits for veterans hospitalized for extended periods of time at Government expense were not reduced as required at all six facilities reviewed. Veterans Service Centers (VSC) did not always identify hospitalized veterans whose benefits required adjustment. Management needs to ensure that payments to certain veterans be reduced as appropriate, initiate collection of overpayments, review VA's Automated Medical Information Exchange admission reports and 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 VSC staff.

Information Technology

- IT security was deficient at three of six 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 physical security and contingency planning.

Other VBA Programs

- VBA's processing and timeliness over vocational rehabilitation and employment (VR&E) claims continue to need improvement. Data entry, claims processing, timeliness of services, needs assessments, and case monitoring errors were noted at two of four facilities where we tested these issues. Appropriate actions are needed to promptly place veterans who have completed the program in the rehabilitated status.

- Government purchase card program deficiencies existed at four of six facilities where we tested these issues. Supporting documentation for purchases was insufficient, reconciliations and certifications were not timely or not properly documented, single purchase limits were not enforced, and cardholders and approving officials needed appropriate training. Management needs to ensure that cardholders are properly trained and warranted, warranted cardholders do not exceed their $2,500 micro-purchase limit, and transactions are adequately documented.

- Incarcerated veterans' payments of benefits at two of six facilities, where we tested these issues, had processing deficiencies. VBA overpayed incarcerated veterans because reviews of their information were not timely.

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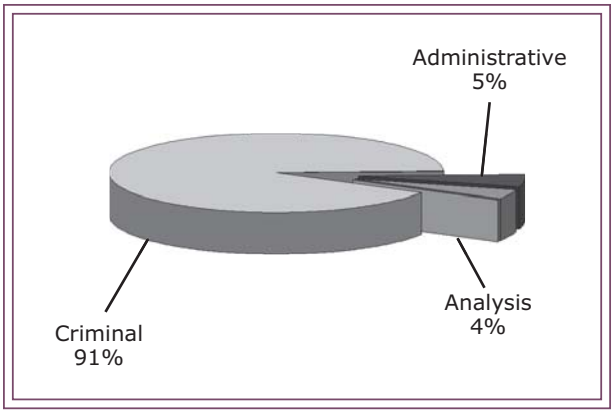
OFFICE OF INVESTIGATIONS

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 Analysis and Oversight Division.

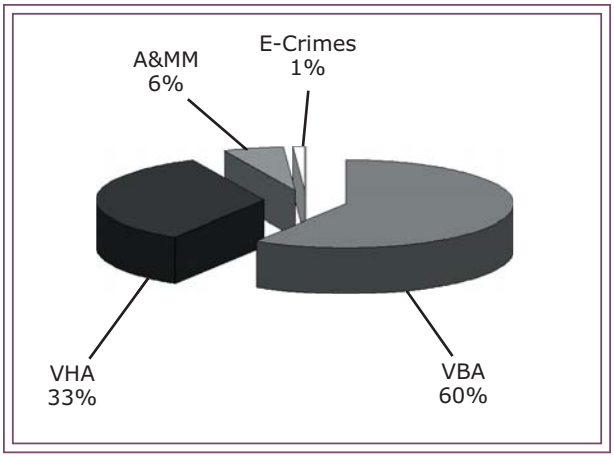


I. CRIMINAL INVESTIGATIONS DIVISION

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



Overall Performance

Output

OIG closed 574 investigations and participated in 30 CAP reviews during the reporting period.

Outcomes

Arrests—327
Indictments—155
Criminal Complaints—25
Convictions—149
Pretrial Diversion—19
Fugitive Felon Apprehensions—273*
Administrative Sanctions—181
Monetary benefits—$261.5 million

This includes: $6,570,375 in fines, penalties, restitutions, and civil judgments; $3,827,520 in recoveries; $15,602,789 in cost avoidance (efficiencies); $7,894,493 in savings; and $227.6 million that includes $145.8 million estimated identified overpayments and $81.8 million estimated cost avoidance specifically relating to the Fugitive Felon Program.

*Includes the apprehension of 106 fugitive felons by OIG, and 167 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 4.8 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 79 individuals who committed crimes on VHA properties.

Theft/Distribution of Controlled Substances

- A former VAMC housekeeping aide pled guilty to possession and distribution of a controlled substance. The aide received deferred sentences of 9- and 12-month prison terms to be served concurrently and was ordered to make restitution for OIG confidential funds used during one of the undercover purchases. The aide was caught selling two grams of cocaine to a confidential informant during a joint OIG and VA police service investigation, and later confessed to distributing cocaine and marijuana to several employees in exchange for cash and a prescription painkiller.

- A joint investigation involving OIG, DEA, and a state auditor's office revealed that a VAMC physician was providing controlled substances to his adopted son and others. The doctor and his son were arrested on state charges for possession of dangerous drugs. A subsequent search of the doctor's residence uncovered numerous prescription narcotics and an illegal firearm.

- A former FedEx employee pled guilty to possession of a Schedule II controlled substance (Oxycodone) by fraud or misrepresentation after being arrested for stealing VA prescription narcotics from three FedEx packages.

- A joint investigation involving OIG and a local police department revealed an individual sold controlled substances to veterans at a VA

outpatient clinic. The subject was sentenced to 3 years' imprisonment.

- A former postal employee was sentenced to 2 years' probation and ordered to pay a fine of $1,000 after pleading guilty to mail theft and possession of a controlled substance with intent to distribute. A joint VA OIG and U.S. Postal Inspection Service (USPIS) investigation determined the postal employee was stealing narcotics intended for veterans.

- Agents from OIG and DEA arrested the daughter of a VA medical center patient for possession of a controlled substance. The joint investigation revealed that, while the daughter was visiting her veteran father, she allegedly took a syringe and withdrew controlled substances from her father's intravenous reservoir. The daughter stated if her father's condition worsened she intended to use the drugs to euthanize him.

Drug Diversion

- A VA pharmacist pled guilty to charges of theft of Government property, illegal possession of a Schedule II controlled substance, and theft or embezzlement in connection with health care. A joint OIG and VA police investigation determined the pharmacist stole 1,000 milligrams of Oxycodone from prescriptions intended for veterans over a 6-month period.

- An OIG investigation revealed that, over a 5-month period, a VA pharmacy technician diverted 2,860 tablets, primarily Oxycodone and morphine, by stealing 1 to 3 tablets per prescription as she prepared them for mailing to veterans. The employee resigned as a result of this investigation, was sentenced to 12 months' probation, and was ordered to pay a $1,000 fine after pleading guilty to unlawful possession of a controlled substance.

- A former VA registered nurse was indicted for obtaining a controlled substance by fraud. Our investigation revealed that he diverted controlled substances, primarily Oxycodone, on 38 occasions over a 3-month period by signing out medications for inpatients and then taking the drugs himself while on duty. The employee resigned as a result of this investigation.

- An OIG investigation revealed a VA registered nurse diverted 634 tablets and syringes of various controlled substances by entering the user identification code and password of a co-worker to access an AcuDose-Rx machine. The nurse was suspended from VA employment and has been indicted for obtaining a controlled substance by fraud.

- A former VA registered nurse was indicted by a Federal grand jury and charged with four counts of obtaining a controlled substance by misrepresentation, fraud, deception, or subterfuge. The indictment followed a joint investigation conducted by the VA police and OIG which revealed that the nurse diverted controlled substances intended for VAMC patients who were discharged or deceased.

The Capital-Journal, Topeka, KS
August 29, 2005

Scranton man faces theft charges

Gregory A. Pelan, 45, of Scranton, was arraigned Monday before U.S. Magistrate Judge K. Gary Sebelius on four counts of stealing controlled substances from the Colmery-O'Neil VA Medical Center in Topeka, where he worked as a nurse.

Pelan entered not guilty pleas on all counts and was released without bond. In a criminal complaint filed Aug. 11, Pelan was charged

• During a joint investigation between OIG and the VA police, a search warrant executed at the pharmacist's residence uncovered approximately $5,000 worth of medical supplies and a variety of drugs and medication which the pharmacist pilfered from a VAMC pharmacy over a 5-year period. The pharmacist pled guilty to theft, possession, and embezzlement.

Unlawful Gratuities

A VA OIG investigation determined that a subcontractor on a $20 million VA construction project paid a $63,000 kickback to a prime contractor in order to secure work on a VAMC project. The defendant increased the price of the proposed subcontract by the amount of the kickback and these inflated costs were passed on to VA through the submission of a fraudulent change order by the prime contractor. The subcontractor was arrested and subsequently pled guilty to charges of providing a kickback.

St. Petersburg Times, St. Petersburg, FL — August 8, 2005

Man pleads guilty in VA kickback scheme

■ The subcontractor, hoping for leniency, has agreed to cooperate with a federal investigation.

By PAUL DE LA GARZA
Times Staff Writer

TAMPA — A subcontractor pleaded guilty in federal court Wednesday to paying a $63,000 kickback to win a contract during a construction project at the VA hospital in Tampa.

Peter Castelli, 62, entered his plea before U.S. Magistrate Judge Mark Pizzo. Castelli has said he did nothing wrong, but that he wanted to avoid the cost of a trial.

Because of a tight schedule, Pizzo accepted Castelli's plea while taking the pleas of three other defendants, all foreign nationals who spoke only Spanish. Two of the men were charged with drug smuggling; the third with entering the country illegally.

At one point, the judge bounced from defendant to defendant so frequently he mistakenly asked Castelli whether he understood the drug charges against him. It was the only time that anybody cracked a smile.

Castelli faces up to 10 years in prison and a $250,000 fine. Hoping for a lenient sentence, he agreed to cooperate with the government "in the investigation and prosecution of other persons."

Federal prosecutor Robert Mosakowski declined comment after the hearing.

But in previous interviews with the *St. Petersburg Times*, Castelli has said the authorities have indicated that others will be indicted, too.

"He entered his plea to take his portion of the responsibility in that transaction," said William Tully, Castelli's attorney. "He will be cooperating with the government as they see fit."

According to Castelli, the scheme unfolded five years ago during construction of the 70-bed, $21.7-million Spinal Cord Injury Center at James A. Haley VA Medical Center.

Peter Castelli was a vice president of a subcontractor on the hospital addition job. He says he did nothing wrong.

The Department of Veterans Affairs picked Dawson Building Contractors Inc. to build the facility.

Dawson selected Liko Inc. to install overhead lifts — or slings — used to move patients in the specialty unit, which has treated scores of soldiers wounded in Afghanistan and Iraq.

Castelli was vice president of overhead lifts for Liko in the United States and Canada. He said that shortly after the project began, Joel Velasco, Dawson's project manager, asked Liko to provide the company with a new pickup truck for the job site.

Castelli said he discussed Velasco's request with Hans Sigvardsson, Liko president, and that Sigvardsson authorized him to buy the vehicle.

Castelli said Velasco then changed his request to two trucks — and finally cash.

On Jan. 25, 2001, Castelli gave Velasco a Bank of America cashier's check for $63,000. (The *Times* has obtained a copy of the check.)

According to the plea agreement, Castelli agreed to pay the kickback to guarantee that Liko landed the Dawson contract. The government said the cost was passed on to the VA.

Velasco repeatedly has denied Castelli's allegations. He said Castelli paid him the money for work he did for Liko during the project at Haley.

Velasco declined comment Wednesday. Sigvardsson did not respond to a message seeking comment.

Identity Theft

• An individual was sentenced to a term of imprisonment not to exceed 23 months after pleading guilty to identity theft. The defendant utilized a veteran's identity to fraudulently obtain $134,014 in unauthorized VA medical care and $24,156 in VA pension benefits.

• An OIG investigation revealed a veteran altered his military records to indicate he had been a prisoner of war (POW) in order to obtain POW status services at a VAMC. The investigation also determined the veteran forged other documents and used the identities of several veterans to receive services at numerous VA facilities. The veteran was sentenced to 3 years' incarceration after pleading guilty to theft of Government benefits.

Theft

• A VA OIG investigation determined a former employee of a veterans' charity engaged in a scheme to steal money from

people by claiming he still worked for the charity and was collecting money on its behalf. The former employee was already under investigation for falsely representing to the public that the charity was collecting money to benefit a VAMC. He deposited the money into his personal bank account. He was indicted on theft charges and arrested. The estimated fraud exceeds $60,000.

Time and Attendance Fraud

- A joint investigation involving OIG, VA police, and state police determined that a VA nursing assistant was "clocked in" simultaneously on 337 occasions over a 3-year period as both a full-time employee on a VA psychiatric ward, as well as a full-time laborer at a local steel plant. The nursing assistant was arrested for fraud. The loss to VA is approximately $18,000.

Bribery

- A joint OIG and FBI investigation determined that a VA prosthetics representative received kickbacks from a vendor who installed ramps in veterans' homes. The vendor submitted both inflated and bogus invoices to the VAMC in order to cover the cost of the bribes. After pleading guilty to making false claims, the former VA employee was sentenced to 5 years' probation and ordered to pay restitution of $11,770. The vendor executed a pretrial diversion agreement wherein he agreed to abide to the conditions of the pretrial diversion program for a period of 12 months.

Workers' Compensation Fraud

- A joint OIG and Department of Labor (DOL) OIG investigation determined a VA nursing assistant, who received workers' compensation benefits from 1980 to 2004, had been working since at least 2000 and failed to report her employment to DOL. The former nursing assistant was sentenced to 36 months' probation, 4 months' home detention, and ordered to pay $57,472 in restitution based on her conviction for making false statements to obtain Federal employee compensation.

- A former VAMC employee was indicted for theft of public money after a joint investigation by VA OIG and DOL OIG determined the former employee made false claims and false statements to DOL's Office of Workers' Compensation Programs. The fraud enabled her to receive workers' compensation benefits of approximately $138,234 while being employed as a nurse's aide with earned income exceeding $200,000.

- A former VHA employee was indicted for making false statements in order to obtain workers' compensation benefits. The former employee made false claims and false statements to DOL, which enabled him to fraudulently receive $225,475 in benefits.

Employee Theft

- A former VA autopsy assistant was sentenced to 32 months' incarceration after pleading guilty to theft of human remains, receiving stolen property, and drug possession. The defendant had stolen 157 pounds of human remains from the VAMC in which he was employed. The remains were found at his residence, along with a variety of VAMC laboratory equipment he had stolen.

- An OIG investigation revealed that for 2 years a VAMC employee overstated her medical transcription line counts. The employee, who also worked while off-duty as a VA contractor providing medical transcription services, pled guilty to a charge of making false claims. She and the senior contracting officer who approved the fraudulent invoices resigned as a result of this investigation. The loss to VA was $46,356.

- A nursing assistant, formerly employed at a VA nursing home pleaded guilty to financial elder abuse and forgery after admitting to

stealing multiple personal checks from a terminally ill veteran, and then forging and cashing the checks. The total loss to the veteran was $4,900.

Armed Robbery

- An OIG investigation resulted in the Federal conviction of a Texas man for his role in an armed robbery of a VAMC pharmacy. The theft involved a variety of controlled substances with a total street value exceeding $250,000. The defendant faces a 10-year prison sentence and a $750,000 fine.

Purchase Card Fraud

- After an OIG investigation revealed that she charged $19,268 in personal expenses to her Government purchase card, a former VHA employee pled guilty to theft of Government funds. She was sentenced to 3 months' incarceration and 3 months' home detention, and was ordered to make $18,318 in restitution.

Fee Basis Fraud

- A veteran was found guilty of wire fraud after being charged with defrauding the VA Fee Basis Program. A co-defendant and former caregiver of the veteran had previously pled guilty to the same charge. Our investigation uncovered a scheme in which the defendants had created a fictitious company that purportedly provided in-home companion services for the veteran on a 24/7 basis. The loss to VA is approximately $31,000.

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 10,401 possible investigative leads. Over 8,304 leads have been reviewed, resulting in the development of 948 criminal and administrative cases. Investigations have resulted in the actual recovery of $16.4 million, with an additional $7.6 million in anticipated recoveries. In addition to these recoveries, the 5-year projected cost avoidance to VA is estimated at $37.6 million. To date, there have been 145 arrests in these cases with several additional cases awaiting judicial actions.

Deceased Beneficiary Benefits Fraud

- The son of a deceased VA dependency and indemnity compensation (DIC) recipient was sentenced to 70 months' incarceration, 60 months' probation, and ordered to make

restitution of $32,827 to VA and $21,225 to SSA. The defendant had failed to inform VA and SSA of his mother's death and converted the VA and SSA funds to his own use.

- A joint investigation by OIG and the Office of Personnel Management revealed a mother and daughter stole survivor benefits intended for the widow of a VA employee who died in 1979. The loss to the Government is $105,633. The defendants were arrested following an indictment for theft of Government funds.

- A husband and wife pleaded guilty to conspiracy charges stemming from theft of Government funds. The subjects, caretakers for a DIC beneficiary, continued to receive and use the widow's DIC benefits after her death in June 1992. The loss to VA is $146,247.

- An OIG investigation determined the daughter of a deceased VA beneficiary concealed her mother's death for almost 10 years and stole VA funds deposited in her mother's account. The daughter was sentenced to 5 months' incarceration, 36 months' probation, and ordered to make restitution of $106,300.

Dependency and Indemnity Compensation Benefits Fraud

- After pleading guilty to mail fraud, a widow was sentenced to 15 months' incarceration, 36 months' probation and ordered to pay $201,902 restitution. OIG determined that she fraudulently received VA widow's benefits by failing to report her remarriage.

- An OIG investigation determined that a widowed beneficiary failed to notify VA she remarried following the death of her veteran husband. She was sentenced to 6 months' incarceration, 36 months' probation, and ordered to pay $32,879, plus interest, in restitution.

Bribery

- A VA OIG investigation, involving auditors, information technology specialists, and special agents, determined that, over a 5-year period, a VARO property management realty specialist fraudulently awarded $4 million in contracts to VA contractors. As a result of these contracts, he received $100,000 in cash and thousands of dollars in free renovations to 2 family homes. He was sentenced to 63 months' incarceration,

The Union Leader, Manchester, NH — March 31 , 2005

The Union Leader

"There is nothing so powerful as truth" DANIEL WEBSTER

New Hampshire's Newspaper

theunionleader.com

Derry man guilty of bribing federal worker

By PAT GROSSMITH
Union Leader Staff

CONCORD — A Derry man pleaded guilty yesterday to giving $100,000 in cash to a federal employee who then steered $3 million in government contracts to his home repair business.

John Burke, 35, of 4 Cross Road, who owned Burke Renovations, paid the bribes to Robert Mayer, 56, a former Salem Planning Board member and former loan program specialist with the U.S. Department of Veteran's Affairs in Manchester.

Burke pleaded guilty in U.S. District Court to conspiracy to commit fraud on the U.S. Government and bribing a public official.

He faces a maximum sentence of five years on the conspiracy charge and 15 years on the bribery charge, as well as fines of up to $250,000 on each charge and restitution.

He is to be sentenced on June 29.

Mayer faces the same maximum sentences. He pleaded guilty on March 3 to taking bribes and conspiring to defraud the U.S. government by manipulating bidding on $4 million in contracts. His sentencing is May 31.

Assistant U.S. Attorney Robert M. Kinsella explained qualified veterans can obtain home mortgage loans through the VA's Residential Loan Guaranty Program. When a veteran defaults on the loan, the VA buys the property from the lender.

The property is then maintained, repaired and resold.

Mayer was a realty specialist who managed properties in New Hampshire, Massachusetts and Connecticut for the VA. His job was to obtain competitive written and sealed bids for contracts of $1,000 or more.

However, from 1996 to 2001, Kinsella said Mayer awarded more than $3 million in contracts to Burke's business without competitive bids. The contracts, he said, were Burke's sole source of income.

36 months' probation, and ordered to make restitution of $419,400.

- A former VR&E officer pled guilty to theft of Government property, converting the property of another, and obstruction of a Federal audit after a joint OIG Office of Investigations and Office of Audit investigation identified over $16,000 in fraudulent VA credit card purchases. Additionally, he fraudulently allowed a veteran to be involved in a VR&E program in return for work completed at the employee's home and his spouse's new business. Over $36,000 of VA funds were fraudulently used for work, materials, and tools.

- A former VA employee was sentenced to imprisonment of 1 year and 1 day and 2 years' supervised release in connection with his guilty plea to conspiracy to commit bribery. A joint investigation by OIG and the Federal Bureau of Investigation (FBI) determined the employee received payments for providing insider information on Government contracts, allowing the contractor to underbid the competition. In return for his payments, the contractor was awarded contracts totaling $355,462. The employee also submitted fictitious vouchers for payment by VA.

The Baltimore Sun, Baltimore, MD
August 5, 2005

BALTIMORE

Crofton man pleads guilty, gets 1 year in bribery case

A 42-year-old Crofton man was sentenced to one year and a day in federal prison yesterday after pleading guilty in Baltimore's U.S. District Court to conspiracy to commit bribery.

Judge Frederick J. Motz also ordered two years of supervised probation for the defendant, Frank McCreary, after his release.

According to court papers, between 1999 and 2003 McCreary — while working as a realty specialist for the regional Department of Veterans Affairs office — steered contracts for repair work on VA-owned houses to a company owned by Carmelo Vizzi, 48, of Perry Hall, in exchange for bribes of $250 to $600.

In addition, prosecutors said McCreary created false invoices for payments to Vizzi's company and received one-third of the payments in return. Vizzi pleaded guilty earlier to the same charge and received a two-year sentence.

Compensation Benefits Fraud

- Six veterans were indicted for making false statements after a proactive project initiated by the Department of Transportation matched Federal Aviation Administration (FAA) records of active pilots to SSA records of disabled individuals. These six individuals had also received VA benefits for disability ratings ranging from 40 to 100 percent. In order to maintain an active pilot's license, these individuals submitted to periodic medical examinations and continually certified to FAA they did not suffer from significant medical conditions. The disabilities the veterans presented to SSA and VA were inconsistent with certifications made to FAA.

- A veteran and his wife were arrested for conspiracy and theft of public money for making false statements which resulted in an undeserved 100 percent disability rating for a claimed heart condition. In addition, the joint investigation, involving VA OIG, Health and Human Services OIG, and SSA OIG, determined the veteran and his wife forged and negotiated VA benefit checks intended for their daughter's college education expenses. Loss to VA is $115,000. The total Government loss is $235,000.

- A joint investigation by OIG, USPIS, DOL OIG, and the Defense Criminal Investigative Service determined a veteran fraudulently received OWCP benefits and VA disability benefit compensation. The veteran was sentenced to 24 months' incarceration, 2 years' probation, and ordered to pay $559,365 in restitution, fines, and forfeitures.

Pension Benefits Fraud

• A veteran pleaded guilty to making a false statement in connection with his claim for VA pension benefits. Our investigation disclosed he earned over $370,000 of unreported income from 1997 to 2004 while receiving a VA pension, with a loss to VA of $68,303.

El Paso Times, El Paso, TX
July 20, 2005

COURTNEWS

Veteran gets two years in federal fraud case

An El Paso man convicted in U.S. District Court earlier this year of mail fraud and making false statements to obtain federal employee's compensation was sentenced to two years in prison, the office of U.S. Attorney Johnny Sutton announced Tuesday.

John Karl Lee, 50, a veteran of Desert Shield/Desert Storm, faced allegations that in April 1994 he made false claims to the U.S. Labor Department that he was an ex-prisoner of war in order to obtain disability benefits.

U.S. District Judge Frank Montalvo also ordered Lee to pay about $230,000 in restitution to the Office of Worker's Compensation programs of the Department of Labor. Lee was also ordered to pay a fine of $172,000 and to forfeit to the

Education Benefits Fraud

• Criminal charges were filed against a veteran for theft of Government funds related to VA educational benefits. A VA OIG investigation determined the veteran failed to report he had withdrawn from training courses and continued to receive benefits. The loss to VA was $18,534.

Fiduciary Fraud

• An investigation by OIG and a state bureau of investigation determined a private real estate attorney did not make proper disbursement of proceeds of real estate closings on VA-foreclosed and other properties to sellers, prior lenders, and lien holders. The attorney was sentenced to 76 months' incarceration and 36 months' supervised release, and was ordered to pay $2,084,610 in restitution. The prison sentence was enhanced because there were more than 50 victims, the loss was greater than $1 million, and the attorney was in a position of trust.

• An OIG investigation determined the uncle of a VA beneficiary misappropriated VA funds intended for his disabled adult niece over a 7-year period. The uncle was sentenced to 2 months' incarceration, 12 months' probation, and ordered to pay restitution in the amount of $49,224 after pleading guilty to theft of Government funds.

• Two individuals pleaded guilty to bank fraud after an investigation determined they had embezzled money from a non-profit organization that acted as a representative payee for VA and SSA beneficiaries. The loss to the Government is $83,394.

Mortgage Loan Fraud

• A real estate agent was indicted for mail fraud after a joint investigation by VA OIG, the FBI, and HUD OIG determined that she fraudulently obtained VA real estate commission checks. She submitted inflated bids, false income information, and false asset information on behalf of her clients, who were not aware that she had altered documents and forged their signatures. Most of the properties subsequently went into foreclosure. The loss to the Government is in the hundreds of thousands of dollars.

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. The following table identifies the statistics relating to the Fugitive Felon Program.

To date, Memoranda of Understanding/ Agreements have been completed with the U.S. Marshals Service (USMS) and the National Crime Information Center (NCIC), as well as with the States of California, New York, Tennessee, Washington, Pennsylvania, Ohio, Massachusetts, Alabama, Arizona, Delaware, and Michigan. 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

Fugitive Felon Program	This Reporting Period	Total Since Beginning
Felony Warrants Received from Participating Agencies	2.7M	9.2M
Matched Records	7,278	49,913
Referred to Law Enforcement Agency Which Holds the Warrant	4,497	20,778
Arrests Made by Law Enforcement Agency Which Holds the Warrant	167	556
Arrests Made by OIG	106	474
Referrals to VA for Benefits Suspension	6,839	18,985
Estimated Identified Overpayments	$145.8M	$218.2M
Estimated Cost Avoidance	$81.8M	$237.3M

subjects has made VA facilities safer for our veterans, employees, and the general public.

OIG was one of nearly 960 Federal, state and local law enforcement agencies to have participated in Operation FALCON, a nationwide fugitive apprehension operation coordinated by the U.S. Marshals Service (USMS) during the first week of April 2005. The operation resulted in the arrest of a total of 10,340 dangerous fugitives wanted for homicides, sexual assaults, gang-related crimes, kidnappings, major drug offenses, crimes against children and the elderly, and unregistered sex offenders.

Three veterans wanted for a total of five sexual assaults were arrested without incident by OIG agents and other law enforcement officials.

With the assistance of local police and OIG agents, a veteran, wanted on a failure to appear warrant for a robbery charge, was arrested at a VAMC by VA police.

VA OIG agents and deputy U.S. Marshal arrested a veteran at a VAMC relating to a parole violation based on a previous conviction for assaulting a police officer with a dangerous weapon.

A veteran was identified as a fugitive felon wanted for possession of cocaine with the intent to distribute. A USMS Fugitive Task Force assisted by OIG agents arrested him without incident at a VAMC. The fugitive had an extensive violent criminal history, including possession of a sawed off shotgun, aggravated assault, drug dealing, and theft. He had previously been involved in an exchange of gunfire with local police.

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.

The following table identifies the statistics relating to the Computer Crimes and Forensic Laboratory.

Laboratory Cases this Period	
Child/Adult Pornography	4
Financial Crimes	2
E-mail Investigations	1
Other Non-Criminal	3

Ten laboratory cases were completed during this semiannual period. Also, the forensics lab conducted examinations on approximately 2.5 terabytes of data. To put this in perspective, one terabyte is roughly equivalent to 280 million pages of paper.

In addition, the Computer Crimes and Forensics Laboratory has continued to forge professional partnerships with other Government agencies actively engaging in criminal computer forensic investigations. The lab has been professionally represented at the Inspector General Academy, and the Federal

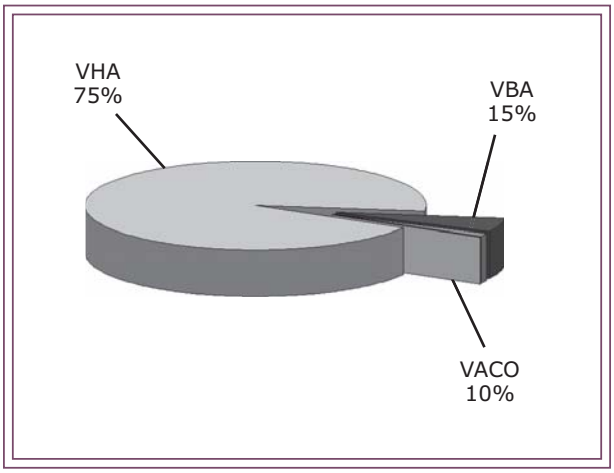
Information Security Conference, and has gained representation with the International Society of Forensic Computer Examiners.

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 17 cases and issued 6 reports and 6 advisory memoranda.

Outcomes

VA managers agreed to take 16 administrative sanctions, including personnel actions against 11 officials, and corrective actions in 5 instances to improve operations and activities. The corrective actions included issuing a bill of collection to a human resources officer for excess salary he received, eliminating a conflict of interest situation involving a VA researcher, and ensuring solicitations for research centers are properly competed

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

Appearance of Preferential Treatment

An administrative investigation substantiated a pattern whereby, in four separate instances, senior managers at a VAMC hired the spouse or fiancée of another senior manager under questionable circumstances, giving the appearance these individuals received preferential treatment. The investigation also substantiated that the facility's associate director improperly requested, and the director improperly approved, a substantial pay increase for the human resources officer by retroactively giving him a superior qualifications appointment. VHA officials agreed with our recommendations to take appropriate administrative action against the senior officials who created the appearance of giving preferential treatment, and agreed to correct the improper superior qualifications

appointment and bill the human resources officer for the excess salary he received.

Inappropriate Involvement in Arranging Disposition of VA Real Property

An administrative investigation substantiated that a VAMC director inappropriately involved himself in a university's request to transfer, as a gift, over $102 million in VA real property located on the medical center's campus. The director engaged in discussions with, and provided advice and financial resources to, university officials regarding the transfer without adequately notifying his VA supervisors so they could ensure VA's interests were sufficiently protected. The director's involvement was also a conflict of interest because he resided in one of the buildings requested for transfer, and was a without-compensation faculty member of the university. VHA officials concurred with our recommendation to take appropriate administrative action against the director and to terminate activity related to the proposed transfer that was not in the Government's best interest.

Partiality and Misuse of Position

An administrative investigation substantiated that a senior VHA official failed to act impartially in the performance of her official duties when she made funding decisions relating to a research center proposal because she had previously discussed job and academic opportunities for a family member with participants identified in the proposal. The official's conduct also constituted an improper use of her official position for the private gain of a relative. The senior official resigned after being advised of findings in the draft report.

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 six FTE allocated.

Overall Performance

Output and Outcomes

During the reporting period, the Division accomplished the following:

- Scheduled and/or facilitated 178 instances of training involving 103 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 238 NCIC record checks in support of criminal investigations.

- Completed an inspection of a regional field office.
- Conducted four regional periodic refresher training seminars 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.

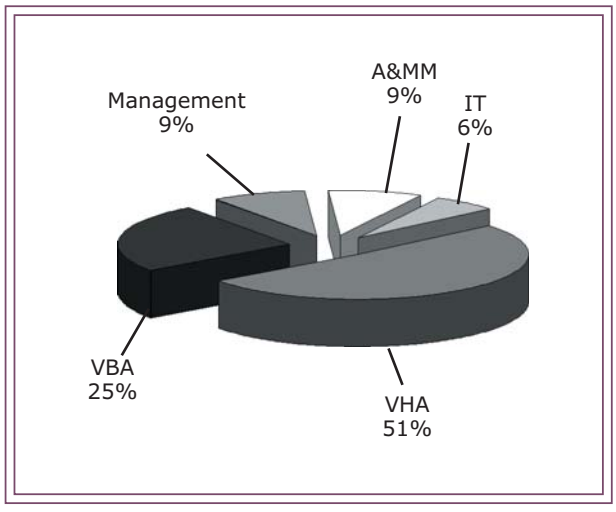
OFFICE OF AUDIT

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 197 FTE allocated for its headquarters and 12 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 8 audit reports and 47 contract reviews. In addition, we took part in a major joint project and 30 CAP reviews.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $19.9 billion. In addition, contract reviews identified monetary benefits of $93.3 million associated with the results of preaward and postaward contract reviews.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations average 4.4 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.5 out of a possible 5.0.

Veterans Health Administration

Resource Utilization

Issue: Outpatient scheduling procedures.

Conclusion: Outpatient scheduling procedures need to be improved to ensure accurate reporting of veterans' waiting times and facility waiting lists.

Impact: Improved service to veterans.

We audited VHA's compliance with outpatient scheduling procedures to determine the accuracy of veterans' waiting times and facility waiting lists. We identified the following deficiencies:

- Schedulers did not follow established procedures for creating appointments.
- Medical facilities did not have effective electronic waiting list procedures.
- VHA did not have an adequate training program for schedulers.
- Outpatient scheduling procedures need improvement nationwide.

We recommended the Under Secretary for Health:

- Ensure managers require schedulers to create appointments following established procedures and monitor the schedulers' use of correct procedures.
- Monitor consult referrals, establish an automated link, and ensure medical facilities prohibit the use of informal waiting lists.
- Develop a standard training package for schedulers.

The Under Secretary for Health agreed with the findings and provided acceptable implementation plans. *(Audit of the Veterans Health Administration's Outpatient Scheduling Procedures, 04-02887-169, 7/8/05)*

Issue: Pharmacy service operations.

Conclusion: Internal controls over pharmacy service needed improvement.

Impact: Strengthened controls over controlled substances.

The Director of the VAMC Miami requested the audit after learning of the arrests of two employees for diversions of controlled substances at the Oakland Park Outpatient Clinic Pharmacy. The purpose of the audit was to determine whether internal controls over pharmacy service operations were adequate to detect or prevent drug diversion. Specifically, the audit objectives were to determine whether the Controlled Substances Inspection Program (CSIP) was operating effectively and in accordance with VA regulations; and inventory management controls over the procurement and distribution of pharmaceuticals and destruction of excess, expired, and unusable drugs were effective and efficient. To correct the identified deficiencies, we recommended the VAMC Director ensure that:

- The VAMC have a comprehensive CSIP that operated in accordance with VHA regulations.
- Pharmacy service fully implements the VA prescribed prime vendor inventory management system to procure and manage pharmaceutical inventories,

including conducting annual wall-to-wall physical inventories.

- Separate the responsibilities for ordering and receiving pharmaceuticals.
- Have the accountable officer witness the receipt and posting of all controlled substances into pharmacy inventory records.

The VAMC Director agreed with the findings and recommendations and provided acceptable implementation plans. (*Audit of Pharmacy Service at VA Medical Center, Miami, FL, 05-00195-195, 9/2/05)*

Veterans Benefits Administration

Issue: State Variances in VA Disability Compensation Payments.

Conclusion: Subjectivity leads to inconsistency in rating decisions.

Impact: Questioned cost of $19.8 billion in funds.

OIG conducted a review to evaluate factors contributing to variances in average annual VA disability compensation payments by state. As of FY 2004, the national average annual compensation payment was $8,378 per veteran, ranging by state from a low of $6,961 to a high of $12,004.

Demographic factors such as representation, military-retired status, period of service, and number of disabilities claimed help to explain such variances, as do claims processing factors such as brokered claims and grant rates. Some disabilities, such as mental disorders, are more susceptible to inconsistent rating decisions because of the subjective nature of evaluating the degree of disability, and because the rating schedule does not reflect modern disability concepts. Our review of 2,100 PTSD claims found 25 percent had insufficient verification of claimed service-related stressor events. We found that VBA's quality review program failed to detect problems identified in our review of PTSD cases. To demonstrate the potential consequence of not obtaining or developing adequate evidence to support a PTSD claim, the 25 percent error rate equates to questionable compensation payments over the lifetimes of these veterans estimated at $19.8 billion.

We recommended the Under Secretary for Benefits take a number of improvement actions. The Under Secretary for Benefits agreed with the review findings and recommendations and provided acceptable improvement plans. (*Review of State Variances in VA Disability Compensation Payments, 05-00765-137, 5/19/05)*

Office of Management

Preaward Contract Reviews

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

Conclusion: Vendors can offer better prices to VA.

Impact: Potential better use of $73 million.

Preaward reviews of 12 FSS and cost-per-test offers made recommendations for potential better use of $73 million. Recommendations to negotiate lower contract prices were made because the vendors were not offering the most favored customer prices to FSS customers when those same prices were extended to

commercial customers purchasing under similar terms and conditions as the FSS. On a continuing basis, we will review contracting officers' final negotiations to determine how much of our recommended better use of funds was achieved in negotiations.

Issue: Health care resource contracts.

Conclusion: VA can negotiate reduced contract costs.

Impact: Potential better use of $19.1 million.

We completed reviews of 23 proposals from VA affiliated medical schools involving the acquisition of scarce medical specialists' services. We concluded the contracting officers should negotiate reductions of $19.1 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 $1.2 million.

We completed 12 reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. The reviews resulted in recoveries of $1.2 million.

OIG efforts to maintain an aggressive postaward contract review program resulted in numerous voluntary disclosures and refund offers from companies relating to overcharges on their contracts with VA. Postaward contract reviews are a major source of recoveries to VA's Revolving Supply Fund.

Multiple Offices Action

Issue: National Vietnam Veterans Longitudinal Study.

Conclusion: VA should effectively plan, procure, and manage the remaining work.

Impact: Improved contract management.

The Office of Inspector General conducted an audit to evaluate the effectiveness of the procurement and project management processes used for the National Vietnam Veterans Longitudinal Study. Public Law 106-419 required that VA contract for this study of the long-term effects of post-traumatic stress disorder among Vietnam Era veterans. After the contractor had worked on the Study for more than 2 years, VA officials declined to extend the contract because of concerns about the escalation in projected study costs and about the contracting methods used. VA did not meet the October 2004 due date for reporting the Study results to Congress.

The audit concluded that the study had not been effectively planned, procured, or managed by Office of Acquisition and Materiel Management's Acquisition Operations Service contracting officials and Veterans Health Administration project officials. Contracting practices did not protect VA's interests or comply with Federal and VA acquisition regulations. Formal acquisition planning was not conducted, and the justification used to award a noncompetitive sole source contract was not accurate or supported by market research. The contract statement of work and cost estimates were inadequately developed

and analyses were not done to determine if prices for the contract and subsequent modifications were reasonable. Payments were authorized for unspecified levels of effort and were not tied to substantive deliverables.

Several inappropriate modifications to extend the contract and increase the price were issued without defining the scope of work or determining price reasonableness. Structured project management was not applied and resulted in poorly defined project requirements, unrealistic cost estimates, and funding requests that were inconsistent with the scope of work and related costs. Project managers allowed the contractor to continue work when no contract was in effect and funding had not been obligated.

Depending on how much of the contractor's original work will be used if the study is resumed, all or a substantial portion of the $4.7 million in costs incurred will have been wasted. We recommended that the Under Secretary for Health and the Chief Management Officer:

- Ensure that, if the study is to be resumed, formal acquisition planning and proper contracting processes are used and that assigned project management and contracting staff have the required knowledge and skills to effectively plan, procure, and manage the project.
- Take appropriate administrative action against officials responsible for the contracting and project management problems.
- Work with the General Counsel to resolve ownership and appropriate disposition of equipment and other assets in the contractor's possession or to recover the value of the equipment.

The Under Secretary for Health and the Chief Management Officer agreed with the recommendations and provided acceptable implementation plans. *(Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study, 04-02330-212, 9/30/05)*

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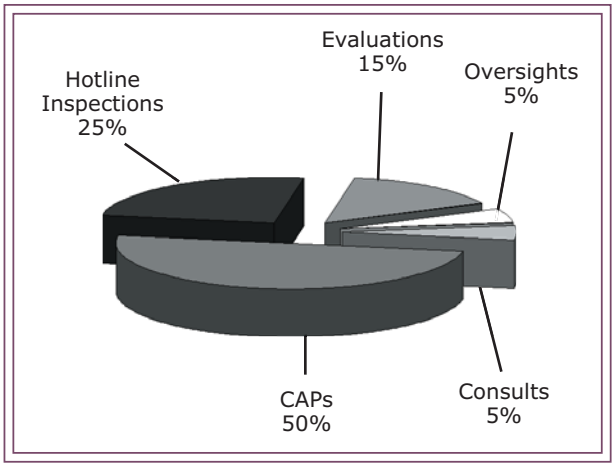
OFFICE OF HEALTHCARE INSPECTIONS

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 8 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 91 recommendations that will improve operations and activities, and the care and services provided to patients.
- Completed 10 Hotline cases, which consisted of reviews of 48 health care related issues. Administratively closed 3 of the 10 cases and issued reports on the remaining 7 cases. Made 14 recommendations that will improve the health care and services provided to patients.
- Completed one national inspection and made nine recommendations to improve patient transportation services and improve patient and employee safety during transport.
- Assisted in a joint review with OIG Offices of Audit and Investigations.
- 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 five technical reviews on recommended legislation, new and revised policies, new program initiatives, and external draft reports.
- Reviewed the responses to 50 Hotline cases consisting of 97 issues that were referred to VHA managers for review.

Outcomes

Overall OHI made or monitored the implementation of 114 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 4.6 on a scale of 5.0.

Veterans Health Administration

Healthcare Inspections

Issue: Management of Patient Transportation Services.

Conclusion: VHA had not established adequate policies and management controls to ensure patient and employee safety during transport.

Impact: Improved patient and employee safety.

The inspection was conducted to determine if Veterans Health Administration (VHA) facilities complied with VA and VHA policies and Federal regulations governing patient transportation, if VHA facilities had effective internal controls to ensure safe patient transportation, and if opportunities existed to improve patient safety by strengthening patient transportation services (PTS) programs. We made nine recommendations to the Under Secretary for Health to ensure deficiencies and vulnerabilities identified are corrected. To improve and strengthen PTS programs at VHA facilities, we recommended the Under Secretary for Health needed to:

- Improve initial and follow-up screenings of motor vehicle operators, incidental operators, and volunteer drivers.
- Ensure annual safe driving training is provided to all employee and volunteer drivers and publish policy regarding mandatory training requirements to include instruction in handling medical emergencies.
- Ensure drivers' compliance with all aspects of VHA's employee safety alert regarding transportation in 15-passenger vans.
- Ensure patient safety is maintained through the consistent practice of securing patient care equipment, other cargo, and vehicles and ensure that security of patients in vehicles is reviewed, policies are established, and observed.
- Publish policy describing required equipment needed in vehicles used to transport patients.
- Provide guidance to VA facilities regarding employee escort for patients with special medical or mental health needs and ensure that incidents occurring during trips are reported to appropriate clinical staff and documented in the patients' medical records.
- Ensure contracts for transportation services require that vendors certify that their drivers have been screened, trained, and are competent to safely transport VA patients, and that medical centers ensure that initial and follow-up certifications are received and retained.
- Ensure VA managers consider the use of volunteer drivers in emergency planning.
- Require that transportation incidents and accidents are reported to VHA Headquarters' managers and program officials.

The Under Secretary for Health concurred with the recommendations and provided an action plan with target dates to implement the recommendations. *(Healthcare Inspection, Inspection of Veterans Health Administration*

Patient Transportation Services, 04-00235-180, 8/4/05)

Issue: Suspicious Death.

Conclusion: Patient care did not meet community standards and VA-Defense data-sharing was not effective.

Impact: Improved quality care and patient safety.

OIG's Office of Healthcare Inspections was requested by the Secretary of Veterans Affairs to review the care of an active duty marine who was seriously wounded in Iraq, treated initially in Department of Defense (DoD) facilities, and transferred for rehabilitative care to the James A. Haley VA Medical Center (JAHVAMC), where he died three weeks later. The purpose of this inspection was to review the care of this marine, focusing particularly on his care at the JAHVAMC. In performing this review, it became apparent that many of the issues it raises have implications for the medical care of other combat-wounded soldiers, sailors, marines, and airmen.

In general, we found the intensity and comprehensiveness of his rehabilitative care to be high. However, we noted significant deficiencies with respect to other specific aspects of care. These involved the evaluation of persistent fever and abnormal white blood cell count, and the management of mental status changes at the end of his life. In addition to these issues, an underlying theme that emerged is that many of the JAHVAMC clinical staff simply did not grasp how inherently fragile this patient was. The lack of appreciation of his medically compromised state may have led to less intensive diagnostic evaluation than were indicated. We also found that the JAHVAMC staff failed to ensure that all medical information was obtained from the referring military treatment facility regarding this patient's medical care and that medical staff required additional training to better manage multiple trauma patients returning from the Gulf for rehabilitation. We made recommendations to improve training for physicians to treat blast injury and other combat-wounded patients, timely and quality clinical consultations, and medical records transfers. Senior VA management concurred with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection, Review of Quality of Care, Department of Veterans Affairs James A. Haley Medical Center, Tampa, Fl, 05-00641-149, 6/1/05)*

VA James A. Haley Medical Center
Tampa, FL

Issue: Delay in definitive treatment.

Conclusion: Clinicians were not in compliance with VHA treatment standards for myocardial infarction patients.

Impact: Improved quality care and patient safety.

We initiated an inspection in response to a complaint alleging lapses in cardiac catheterization care contributed to a patient's

death. The confidential complainant alleged a patient died under what appeared to be questionable circumstances. We substantiated a delay in definitive treatment of the patient. The patient did not undergo definitive treatment until 3 hours after admission. VHA treatment standards for myocardial infarction call for definitive treatment to begin within 90 minutes after presentation to a hospital. We substantiated the delay in receiving reperfusion therapy was due to the concurrent care of other patients in the cardiac catheterization lab. Under the circumstances, this patient was treated as soon as possible.

We concluded it is doubtful the delay was clinically significant due to the length of time the patient experienced symptoms prior to presenting to the emergency room (ER) and the condition of the patient on presentation. We recommended the VISN Director should ensure the medical center has a written contingency plan for patients arriving in the ER with acute coronary syndrome and coronary intervention not being available. The VISN and Medical Center Directors concurred with the recommendation and have taken actions to develop an action plan to implement the recommendation. *(Allegation of Substandard Cardiac Catheterization Care, Hunter Holmes McGuire VA Medical Center, Richmond, VA, 05-00198-181, 8/4/05)*

Issue: Failure to treat.

Conclusion: Clinicians did not exercise good judgment in declining to speak to a patient.

Impact: Improved patient safety.

The purpose of the review was to determine the validity of allegations made by an anonymous complainant. We substantiated the allegation that psychiatrists refused to treat a suicidal patient because he was not a mental health patient and that mental health clinic staff did not follow established procedures when the patient called threatening to kill other people and then himself. We could not substantiate a deliberate attempt to "cover up" the incident. However, medical center management failed to exercise due diligence in investigating, reporting, and following up on this case.

We also found VA police officers failed to follow policy when they elected not to notify local law enforcement of the patient's situation, the patient's primary care physician failed to refer the patient for a mental health evaluation despite multiple indications for doing so, and the medical center's policies on managing urgent consultations were incongruent. The allegation that the patient might not have committed suicide if he received the treatment that he needed was speculative and therefore could not be substantiated or refuted. However, the relevant literature on this subject indicates a timely and knowledgeable assessment of suicide risk and professional intervention by a mental heath expert would have increased the likelihood of a better outcome. We made several recommendations for improvement in mental health care, suicide prevention, and suicide reporting. The VISN and Medical Center Directors agreed with the recommendations and provided acceptable improvement plans. *(Healthcare Inspection, Alleged Denial of Care, VA Medical Center, Birmingham, AL, 04-03437-175, 7/19/05)*

Issue: Premature discharges and insufficient staffing.

Conclusion: Discharges were appropriate and staffing levels met or exceeded minimum requirements.

Impact: Substantiated appropriate discharges and staffing levels.

OIG conducted an inspection to determine the validity of allegations regarding the care of mental health patients. Specifically, the complainant alleged that suicidal and violent patients were being discharged prematurely, and staffing levels were insufficient, which negatively impacted staff safety when managing patients with violent behavior. The inspection did not substantiate the allegations. However, we found a general lack of understanding of the purpose, policies, and procedures related to a newly established 23-hour observation mental health unit, and we found that performance improvement activities in mental health needed improvement. Medical center managers were responsive to our concerns and provided acceptable documentation to support corrective actions. Therefore, we made no recommendations. *(Healthcare Inspection, Patient Care and Staffing Issues, Gulf Coast Veterans Health Care System, Biloxi, MS, 04-01946-196, 9/2/05)*

Gulf Coast Veterans Health Care System
Biloxi, MS

Issue: Allegations of poor quality of care and services, and unclean environmental conditions.

Conclusion: Patient received quality and timely care, and customer service issues and environmental concerns were adequately addressed.

Impact: Substantiated appropriate care.

The purpose of the review was to determine the validity of allegations concerning quality of care, customer service, and the environment of care at the Buffalo Division of the VA Western New York Healthcare System. We did not find the allegations valid at the time of our inspection. We concluded that: the patient received quality and timely evaluation and care for bladder cancer, the customer service issues were adequately addressed prior to our inspection, and the environment of care concerns were no longer current. Further review of this case was not warranted, and we made no recommendations. *(Healthcare Inspection, Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System, Buffalo, NY, 05-02118-201, 9/19/05).*

Issue: Appropriateness of Surgical Service management and adequacy of DoD sharing agreement.

Conclusion: Physician assistant inappropriately served as chief of surgery and more operating room time should improve access to care.

Impact: Compliance with VHA directives and improved access to care.

The purpose of the review was to determine the validity of two allegations regarding the surgical service at the Anchorage clinic of the Alaska VA Healthcare System and Regional Office. We substantiated the allegations. For the past 4 years, a physician assistant has served as the Chief of Surgical Service, a

position commonly held by surgeons. Prior to that time, a surgeon served in the position. Joint Commission on the Accreditation of Healthcare Organizations standards and VHA directives require all medical staff service chiefs to be board-certified physicians. We recommended a board-certified surgeon be designated as Chief of Surgical Service and the facility director agreed.

Our review found that the facility's sharing agreement with Elmendorf Air Force Base has not adequately served VA patients' surgical needs. While the members of the surgical staff acknowledged problems in the past with obtaining adequate operating room time and supplies needed for the procedures they performed at the joint venture hospital, they stated that the situation was addressed and has improved over the past year. Therefore, we made no recommendations regarding surgery at the joint venture hospital. *(Healthcare Inspections, Surgical Service issues, Alaska VA Healthcare System and Regional office, Anchorage, AK, 05-02527-205, 9/20/05)*

Alaska VA Healthcare System and Regional Office Anchorage, AK

Issue: Communication and documentation.

Conclusion: Medico-legal cases not properly referred, consultations inappropriately canceled, autopsies not requested, and time and attendance documentation needed improvement.

Impact: Improved quality care and compliance with policy.

The purpose of the review was to determine whether multiple allegations made by a former employee had merit. We did not substantiate allegations that medical center employees did not report a sentinel event, provided improper treatment, or falsified autopsy documents. We also did not substantiate allegations that part-time physicians did not work their scheduled tours, medical residents were not properly supervised, or increased physician workload prolonged clinic waiting times. We did substantiate that cases of potential medico-legal significance were not consistently identified and referred to law enforcement authorities, autopsies were not consistently requested per policy, and medical center staff cancelled consultation requests prior to notifying the patients' providers. While not an allegation, we noted that subsidiary time and attendance reports were not always completed.

We recommended that VISN and Medical Center Directors ensure that:

- Cases of potential medico-legal significance are identified and referred to appropriate law enforcement authorities.
- Authorized employees document referrals to law enforcement authorities and their ultimate disposition.

- Providers review the medical records and reschedule cancelled consultations as needed.
- Appropriate staff receive training on the consultation tracking system.
- "Subsidiary Time and Attendance Reports—Part Time Physicians" are completed and signed as required.

Because the medical center had implemented a system to promote autopsy requests, we did not make a recommendation. The VISN and Medical Center Directors agreed with the recommendations and provided acceptable improvement plans. *(Healthcare Inspection, Patient Care, Fraud, and Mismanagement Issues, VA Medical Center, San Juan, PR, 04-02962-158, 6/24/05)*

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OFFICE OF MANAGEMENT AND ADMINISTRATION

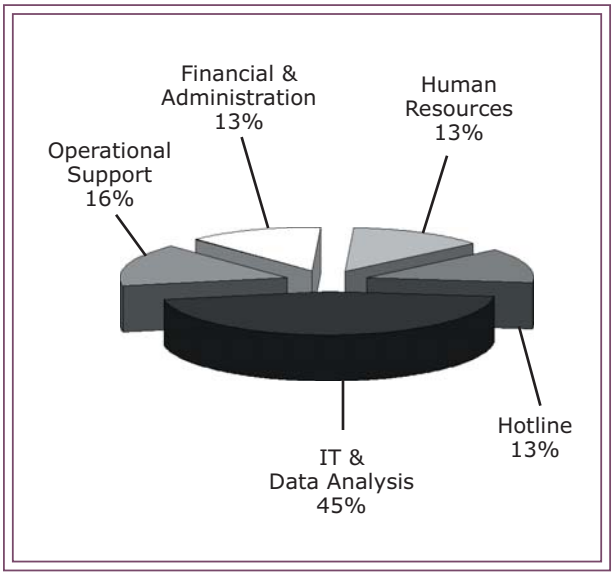
Mission Statement

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.

Resources

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



I. HOTLINE DIVISION

The Hotline Division operates a toll-free telephone service, Monday through Friday, from 8:30 a.m. to 4 p.m. Eastern time. Anyone may report issues of criminal activity, waste, and abuse through calls, letters, faxes, and e-mail messages to its Web site at vaoighotline@va.gov. The Hotline Division carefully considers all complaints and allegations; OIG or other Departmental staff address mission-related issues.

Overall Performance

The following chart contains the Hotline's performance figures for both this reporting period and FY 2005.

OIG Hotline Contacts and Cases		
	3/30/05 through 9/30/05	FY 2005 Total
Contacts	7,902	14,683
Cases opened	568	1,020
Reviewed by OIG	188	326
Referred to VA program office	380	694
Cases closed	462	969
Allegations substantiated	198	380
Administrative sanctions imposed	32	52
Corrective actions taken	130	255
Responses to congressional inquiries	50	100

The monetary impact resulting from these cases totaled almost $400,000 for this reporting period and almost $971,000 for FY 2005. Examples of validated contacts that required corrective action include the following.

Veterans Health Administration

Quality of Patient Care

In 1 of 47 Hotline inquiry allegations regarding deficiencies in the quality of patient care, a VHA review determined several pharmacists had stopped checking dose carts. Management immediately reinstated reviewing all doses daily using a checklist, and counseled the supervisor for failure to detect and address the departure from policy.

In another case, a VHA peer review determined that a physician displayed a significant lack of compassion and kindness, and that the attending nurse did not pursue her concerns about the patient's discharge when the physician disagreed with her. Management counseled both the physician and the nurse and ordered the emergency room staff to participate in a refresher course on proper patient management and documentation of treatment.

Ethical Improprieties/Employee Misconduct

One of the nine allegations of ethical improprieties/employee misconduct resulted in VHA sustaining allegations against a physician for patient abuse, hostile work environment, and conduct unbecoming a supervisor. The physician was removed.

Time and Attendance

A joint VHA and the Office of Security and Law Enforcement investigation uncovered rampant abuse of time and attendance regulations in the police service. A pattern of poor management resulted in low employee morale. The chief of police retired, and management initiated disciplinary action against one supervisor and the timekeeper while reviewing the performance of another supervisor. A former VA police officer was issued a $3,745 bill of collection to recover sick leave advanced and never made up. The current chief of police is in the process of reorganizing the service. This was 1 of 15 allegations of time and attendance abuse.

Cyber Security

In response to one of five allegations of deficient or improper cyber security controls, a VHA review concluded two physicians installed a server on a medical center's computer network without authorization, resulting in numerous security vulnerabilities. IT staff cleaned the server's drives and had it removed. Management proposed a 3-day suspension for both physicians and implemented a surveillance program to monitor the network and detect the presence of unauthorized devices.

Patient Safety

Among the five allegations of patient safety deficiencies at VA facilities was a complaint resulting in a VHA review determining that a treatment provider failed to identify a patient's colon cancer and the patient subsequently experienced a 7-week delay in being scheduled for a specialty clinic appointment. Risk Management met with the veteran to discuss the diagnosis and its implications. The review also found other problems in the delivery of health care involving the lack of communication between specialists and clinicians ordering tests. Management took action to resolve the problem.

Contract Administration

Responding to one of five allegations involving violations of contract administration by employees, a VHA review into improprieties in connection with a prosthetics equipment contract determined that VA employees were confused about the procedures for placing orders once the maximum order limit had been reached under the subject contract. Management issued guidance to clarify those procedures.

Facilities and Services

A VHA review determined an emergency room clerk did not respond appropriately when a patient's daughter requested help for her unconscious father. The clerk's supervisor counseled him, providing guidance on how to respond more appropriately in the future. This was 1 of 15 allegations of deficiencies with VA facilities or services.

We also pursued five allegations regarding Privacy Act/HIPAA issues by VA facilities, including a case in which a VHA review determined a company in India hired through a VA contractor threatened to disclose veterans' medical information over the Internet when the VA contractor failed to pay the subcontractor. VHA paid the subcontractor, which certified the electronic records were deleted and hard copies destroyed. VHA is in the process of determining whether to terminate the contractor's current contract and/or to disallow its further competition for VA contracts.

Abuse of Authority

One of the five allegations regarding abuse of authority resulted in a management review that confirmed the allegation of an employee verbally abusing patients. The employee received counseling on the importance of customer service and was later issued a written reprimand. Based on further investigation, additional discipline is anticipated.

Veterans Benefits Administration

Receipt of VA Benefits

In 1 of the 40 allegations involving improprieties in the receipt of VA benefits, a VBA review determined a veteran and his spouse were receiving a VA pension though their combined gross incomes exceeded the pension threshold. In addition, they owned a home and land valued at over $400,000. The regional office terminated the veteran's pension and assessed an overpayment of $72,013.

Upon receipt of information that a veteran receiving pension benefits was gainfully employed and owned a business, VBA twice requested the veteran provide eligibility verification reports covering 1994 to the present. When the veteran failed to respond, the VARO terminated his benefits and assessed an overpayment of $116,123.

Facilities and Services

In response to 1 of 15 allegations regarding deficiencies with facilities or the services provided, a VBA review determined a computer program limitation resulted in the full amount of a veteran's insurance policy being incorrectly reported to the veteran and in a response to a congressional inquiry. Management divided the single policy into two policies of equal value to facilitate reporting in the future.

II. OPERATIONAL SUPPORT DIVISION

The Operational Support Division is responsible for following up on OIG reports, responding to Freedom of Information Act/Privacy Act (FOIA/PA) requests, conducting policy reviews and development, and conducting strategic, operational, and performance planning. It also provides electronic report distribution, oversees IG reporting requirements, and reviews the impact of proposed legislation and regulations.

Follow-Up on OIG Reports

Operational Support is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $21.78 billion of actual or potential monetary benefits during this reporting period. As of September 30, 2005, VA had 152 open OIG reports with 612 unimplemented recommendations.

Closed Reports and Recommendations		
	4/1/05 through 9/30/05	FY 2005 Total
Reports	83	157
Recommendations	752	1,451
Monetary benefits (in millions)	$532	$1,812

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

Operational Support processes all OIG FOIA/PA requests from Congress, veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, the general public, and subjects of investigations.

Status of FOIA/PA/Disclosure Activities		
	4/1/05 through 9/30/05	FY 2005 Total
Requests processed	139	287
Reports released	119	350
Requests denied	10	15
Partial withholdings	56	133
Requests where no written response was released within 20 days of receipt	0	0
Cases pending over 6 months	0	0

Electronic Report Distribution

In compliance with the President's e-Government initiatives, as described at http://www.whitehouse.gov/omb/egov, OIG distributes reports through a link to the OIG Web page. Recipients receive a short e-mail describing the report, with a link that takes them directly to the report.

Electronic Report Distribution		
	4/1/05 through 9/30/05	FY 2005 Total
CAP reports released	30	67
Non-CAP reports released	20	46

Review and Impact of Legislation and Regulations

Operational Support coordinated concurrences on 28 legislative, 31 regulatory, and 72 administrative proposals from the Congress,

OMB, and VA. OIG commented and made recommendations concerning the impact of legislation and regulations on economy and efficiency in administration of programs and operations or the prevention and detection of fraud and abuse.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

The Information Technology and Data Analysis Division provides information technology support services to all components of OIG. It has responsibility for the continued development and operation of the Master Case Index (MCI), as well as OIG's Internet and Intranet resources. The Division interfaces with VA information technology units nationwide to provide a broad array of IT support. OIG's Chief Information Officer and 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 (DAS) 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.

Overall Performance

Database Management

MCI is the primary information system supporting OIG's case management and decision making. This system supports nearly 400 users in 25 locations. During this reporting period, four 70-gigabyte hard drives were installed in the Oracle production server to accommodate the increasing growth of the database due to a new document uploading feature and an upgrade of the test environment.

Enhancements to the MCI system included the modification of Hotline contact form to allow for PDF and MS Word document uploading and viewing. An OIG inventory tracking form was created and is in the testing phase. Staff responded to numerous requests for reports and modified 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 2.3 million times by almost 1,027,000 visitors. OIG reports, vacancy announcements, and other publications accounted for over 958,000 downloads from our Web sites, providing both timely access to OIG customers and cost avoidance in the reduced number of reports printed and mailed.

Information Resources Management

Staff completed a nationwide inventory of OIG IT equipment, which replaces an outdated IT inventory system that has problems with missing and incomplete records. The project involved a physical inventory and collection of the technical specifications of the hardware for use in better planning lifecycle replacement of IT equipment.

Field Support Section

The Field Support Section (FSS) coordinates, and manages IT support for all OIG elements outside Washington, DC. During this reporting period the FSS negotiated the creation of a national Organizational Unit (OU) within the

VA network structure for OIG users hosted at VHA facilities. This national OU will allow the consolidation of OIG VHA user accounts under one easily managed unit.

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. Significant efforts include the following.

- Using data mining to detect potential fraud in VA computer systems.
- Developing Fugitive Felon Program matches.
- Providing technical support and data to all CAP health care reviews.
- Providing 348 files and reports for OIG's analysis of benefit payment variations.

During the reporting period, DAS completed 178 ad hoc requests for data requests from OIG operational elements.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

The Financial and Administrative 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.

Overall Performance

Budget

The staff assisted in the preparation of the FY 2007 budget submission and materials for associated hearings with VA, Office of Management and Budget (OMB), and Congress.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 2,074 travel vouchers and 19 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. During 2005, Administrative Operations opened an Office of Healthcare Inspections in Kansas City, MO and expanded the Bay Pines, FL office to include Office of Audit and Office of Healthcare Inspections personnel, making Bay Pines a new Regional Office. In addition, administrative staff processed 195 procurement actions (21 acquisition and 174 credit card transactions), and reviewed and approved monthly the 40 statements received from OIG's cardholders under the Government's purchase card program. The Division also strengthened internal control procedures for the review of credit cards and established internal controls to provide increase oversight over the Transit Benefit Program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

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 that process OIG actions into the VA integrated payroll and personnel system.

Overall Performance

Human Resources Management

During this period, 60 new employees joined the OIG workforce and 17 departed. The current on-board strength is at its highest level in OIG history with 469 employees in authorized positions and 24 employees in positions reimbursed by the Department. The staff processed 122 recruitment and placement actions, processed 401 awards, and enrolled 40 employees in advanced leadership and management development classes.

In July, we joined with 34 other OIGs in "IG E-Learning," a pilot program coordinated by the PCIE to assess the effectiveness of on-line learning. IG E-Learning provides our workforce with access to over 2,000 training courses and a library of over 7,000 reference books with key-word search capability. As a member of the PCIE E-Learning Steering Committee, the Division staff helped design learning programs of recommended courses for the most common occupational disciplines in the inspector general community. These programs will assist employees in choosing the most beneficial courses for continued professional development.

Another education and training initiative undertaken this reporting period is *The Human Resources Newsletter for Supervisors*. This quarterly publication keeps the OIG management staff abreast of new developments in human resources and offers practical advice in solving workplace issues.

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OTHER SIGNIFICANT OIG ACTIVITIES

Inspector General Griffin Leaves VA OIG

- Inspector General Richard J. Griffin left OIG in July after nearly 8 years to accept a presidential appointment as the State Department's Assistant Secretary for the Bureau of Diplomatic Security and Director of the Office for Foreign Missions. Secretary R. James Nicholson presented the departing Inspector General VA's Exceptional Service Award, noting that Mr. Griffin's integrity, leadership, and executive excellence "produced a rich legacy noteworthy for the remarkable impact on VA programs and in the high performing, professional organization that you leave behind."

Secretary Nicholson presents VA's Exceptional Service Award to Inspector General Griffin

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. Also, an audit manager from the Financial Audit Division was the chairperson of the task force, which developed a standard statement of work for financial statement audits to be used by the OIGs. This audit manager is also the chairperson of the task force, which is currently developing standard technical evaluation criteria for evaluating bidders' proposals.

- The Director of the Information Technology Audit Division is the subcommittee chair of the Policy Review Committee, IT Security Committee. The Policy Review Committee is chartered to review OMB and National Institute of Standards and Technology publications and to coordinate a consolidated response from the IG community.

- The Director of the Information Technology Audit Division is the Office of Audit representative to the PCIE IT Roundtable.

- The Director of the Information Technology Audit Division attended the CIO Council presentation on improving the Federal Information Security Management Act grades.

IT Security Committee

- The Director of the Information Technology Audit Division made a presentation on the OIG viewpoint of the state of VA security at the National Information Security Conference in Dallas, TX. Over 1,400 VA staff attended the security conference.

OIG Management Presentations

Federal Audit Executive Council

- In April 2005, the Human Resources Director made a presentation at the Federal Audit Executive Council conference in Williamsburg, VA. The presentation addressed recruitment and retention issues facing the inspector general community. The PCIE Roundtable provides education on information technology audit and investigative activities within the OIG community. The Director of the Planning Division represented the Office of Audit and was appointed to the Council's Human Resource Committee.

NAVREF conference

- The Deputy Assistant Inspector General for the Office of Investigations addressed the annual conference of the National Association of Veterans Research and Education Foundation (NAVREF).

VA Workers' Compensation Steering Committee

- The Audit Project Manager made presentations at VA Workers' Compensation (WC) Steering Committee meetings that discussed past work and program findings. The WC Steering Committee was established to prepare a WC strategic plan and coordinate implementation actions VA-wide in response to OIG related WC findings and recommendations for program improvement.

SmartPay Conference

- The Project Manager, Bedford Audit Operation Division, made a presentation on CAP review coverage of VA's Government Purchase Card Program at VA's annual conference in Boston, MA.

Office of Acquisition and Materiel Management's Acquisition Forum on Health Care Contracting

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

VISN 17 Training on Health Care Contracting

- Representatives from OIG's Contract Review and Evaluation Division and the Counselor to the Inspector General conducted a 2-day training course for contracting officers, contracting officers' technical representatives, administrative officers, service chiefs, heads of contracting, and chief logistics officers. The training covered various aspects of contracting with affiliates for health care resources.

Center for Business Intelligence Medicaid Rebates Conference

- An Audit Manager in the Contract Review and Evaluation Division made a presentation on Public Law 102-585, Section 603 to industry representatives.

IGATI Training

- An Audit Manager in the Contract Review and Evaluation Division was the instructor for the "How to use IDEA" class. IDEA is a software tool used to conduct various types of data analysis such as extractions, summarizations, comparative studies, and statistical sampling.

2004 Federal Human Capital Survey

- In May 2005, the Office of Personnel Management released the results of a survey of over 147,000 Federal employees. The

purpose of the survey was to gather employees' perspectives on factors that characterize high-performing organizations throughout Government. VA OIG was ranked 32 of 218 subcomponents and small agencies surveyed. OIG employees rated managers and management practices as much as 30 percent higher than other Federal workers on such topics as performance culture, leadership, and learning. Other results showed high levels of satisfaction with pay, benefits, alternate work schedules, and access to information technology tools.

Congressional Testimony

- In July 2005, the Director of the Contract Review and Evaluation Division, testified before a Senate Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, and International Security hearing on the General Services Administration (GSA) called "GSA—Is the Taxpayer Getting the Best Deal?" The Director's testimony discussed the benefits of preaward and postaward audits of VA's FSS proposals and contracts in helping ensure that VA is getting the best possible price for the taxpayer. The Director proposed that Congress consider transferring the 11 health care schedules VA currently manages (under delegation) from GSA to VA, providing VA with complete rule-making authority for the schedules.

Briefings

- In May 2005, the Deputy Inspector General briefed representatives from 12 veterans service organizations and answered questions on the OIG national review involving the consistency of VA disability compensation payments made to veterans in different states.

- In June 2005, the Deputy Inspector General and the Assistant Inspector General for Audit testified before the Veterans Disability Benefits Commission on OIG's national review of the consistency of VA disability compensation payments made to veterans in different states.

Awards

Excellence in Government Award

- At the Fourth Annual Awards Gala for Outstanding Leaders in Human Resources, Joanne Moffett, OIG Director of Human Resources, received one of two awards for Excellence in Government for her leadership of OIG's outstanding Human Resources team from HR Leadership Awards of Greater Washington.

Inspector General Richard J. Griffin and Joanne Moffett

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APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
05-00029-127 4/22/05	Combined Assessment Program Review of the VA Medical Center Durham, NC	$259,500	$259,500	
05-00523-128 4/22/05	Combined Assessment Program Review of the VA Puget Sound Health Care System Seattle, WA	$2,057,818	$2,057,818	
04-03403-133 5/5/05	Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, TX	$294,491	$294,491	
04-03069-135 5/5/05	Combined Assessment Program Review of the Sioux Falls VA Medical Center Sioux Falls, SD	$108,849	$108,849	
05-00029-134 5/6/05	Combined Assessment Program Review of the VA Regional Office Los Angeles, CA	$217,968	$217,968	
05-00115-136 5/6/05	Combined Assessment Program Review of the VA Medical Center Hampton, VA	$112,938	$112,938	
04-01893-148 6/2/05	Combined Assessment Program Review of the VA Medical Center St. Louis, MO	$435,286	$435,286	
04-03120-151 6/6/05	Combined Assessment Program Review of the VA Medical Center Cincinnati, OH	$974,797	$974,797	
05-00839-156 6/24/05	Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, IA	$49,851	$49,851	
05-00735-160 6/27/05	Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, CA	$86,133	$86,133	
05-00820-161 6/27/05	Combined Assessment Program Review of the VA Regional Office Baltimore, MD	$371,355	$371,355	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
05-01248-170 7/8/05	Combined Assessment Program Review of the VA Salt Lake Health Care System Salt Lake City, UT	$31,474	$31,474	
05-00502-171 7/8/05	Combined Assessment Program Review of the VA Medical Center Miami, FL			
04-03270-172 7/8/05	Combined Assessment Program Review of the VA Medical Center Louisville, KY	$110,934	$110,934	
04-01138-173 7/13/05	Combined Assessment Program Review of the VA New York Harbor Healthcare System New York, NY	$548,780	$548,780	
05-01241-174 7/19/05	Combined Assessment Program Review of the VA Pittsburgh Health Care System Pittsburgh, PA	$452,613	$452,613	
05-00313-176 7/21/05	Combined Assessment Program Review of the Manchester VA Medical Center Manchester, NH	$115,957	$115,957	
05-01816-184 8/15/05	Combined Assessment Program Review of the VA Regional Office Boise, ID	$75,769	$75,769	
05-01227-185 8/15/05	Combined Assessment Program Review of the VA Regional Office Milwaukee, WI	$405,960	$405,960	
05-01141-186 8/15/05	Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, NM	$443,607	$443,607	
05-01468-190 8/15/05	Combined Assessment Program Review of the VA Regional Office Huntington, WV	$448,495	$448,495	
05-01009-197 9/8/05	Combined Assessment Program Review of the VA Regional Office Washington, DC	$751,621	$751,621	
05-00082-198 9/9/05	Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, MO	$29,698	$29,698	
05-01655-199 9/15/05	Combined Assessment Program Review of the VA Medical Center Wilmington, DE	$675,522	$675,522	
05-02240-206 9/22/05	Combined Assessment Program Review of the Alaska VA Healthcare System Anchorage, AK	$147,002	$147,002	
05-01226-211 9/29/05	Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, MI	$1,068,302	$1,068,302	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
05-01837-214 9/30/05	Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, AR	$201,577	$201,577	
05-01383-215 9/30/05	Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, WI	$978,204	$978,204	
05-00859-216 9/30/05	Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, CT	$1,748,517	$1,748,517	
05-02007-219 9/30/05	Combined Assessment Program Review of the Southern Arizona VA Health Care System Tucson, AZ	$943,373	$943,373	

INTERNAL AUDITS

04-00986-120 4/22/05	Management Letter, Audit of VA's Fiscal Years 2004 and 2003 Consolidated Financial Statements Network Vulnerability Assessment at VA Medical Center Hampton, VA			
04-02887-169 7/8/05	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures			
05-00195-195 9/2/05	Audit of Pharmacy Service at VA Medical Center Miami, FL			
05-00055-204 9/16/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Hines Information Technology Center			
04-02330-212 9/30/05	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	$4,700,000	$4,700,000	

OTHER OFFICE OF AUDIT REVIEWS

05-00765-137 5/19/05	Review of State Variances in VA Disability Compensation Payments	$19,780,000,000	$0	
05-02067-164 7/1/05	Evaluation of Allegation that Disabled Laundry Workers Were Not Properly Compensated at the VA Medical Center St. Louis, MO			
05-01096-218 9/29/05	Department of Veterans Affairs Fiscal Year 2005 Agreed-Upon Procedures for Payroll			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
CONTRACT PREAWARD REVIEWS*				
05-01441-126 4/7/05	Review of Proposal Submitted by University Radiologists of Cleveland, Under Solicitation Number 541-016-05, for Nuclear Medicine Services at Louis Stokes VA Medical Center	$299,870		
05-01148-129 4/21/05	Review of Proposal Submitted by the University of Miami, School of Medicine, Under Solicitation Number 546-12-05 for Neurological Surgery Services at the Department of Veterans Affairs Medical Center, Miami	$961,861		
05-00623-130 4/21/05	Review of Proposal Submitted by University of Wisconsin Medical School, Under Solicitation Number RFP 69D-315-04, for Interventional Radiology Back-Up Services at William S. Middleton Memorial Veterans Hospital, Madison, WI	$48,350		
05-01537-131 4/27/05	Review of Proposal Submitted by CRAssociates, Inc., Under Solicitation Number 674-122-04, for Primary and Preventive Medical Care and Mental Health Services to the Department of Veterans Affairs, Central Texas Veterans Health Care System Marlin, TX			
04-01682-132 4/28/05	Review of Federal Supply Schedule Proposal Submitted by Sandoz, Inc., Under Solicitation Number M5-Q50A-03	$59,422,843		
05-00891-139 5/17/05	Review of Proposal Submitted by Brigham and Women's Hospital, Under Solicitation Number 523-66-05, for Orthopedic Surgeon Services at the Department of Veterans Affairs, Boston Healthcare System	$148,088		
05-00892-140 5/17/05	Review of Proposal Submitted by Brigham and Women's Hospital, Under Solicitation Number 523-61-05, for Hand Surgeon Services at the Department of Veterans Affairs, Boston Healthcare System	$169,265		

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
04-01763-138 5/18/05	Review of Federal Supply Schedule Proposal Submitted by Eastman Kodak Company Under Solicitation Number M5-Q50A-03	$4,906,449		
05-01536-141 5/18/05	Review of Proposal Submitted by the Loyola University Physician Foundation, Under Solicitation Number 69D-035-05 for Anesthesiology Services at the Edward Hines Department of Veterans Affairs Medical Center	$271,047		
05-00453-142 5/19/05	Review of Federal Supply Schedule Proposal Submitted by A-dec, Incorporated, Under Solicitation Number RFP 797-652C-04-0001			
04-02292-143 5/23/05	Review of Federal Supply Schedule Proposal Submitted by Pfizer, Inc., Under Solicitation Number M5-Q50A-03	$45,099		
05-01650-145 5/23/05	Review of Proposal Submitted by University of New Mexico, Under Solicitation Number 501-27-04 for Radiation Oncology Services to the New Mexico VA Health Care System	$2,606,184		
05-01215-146 5/24/05	Review of Proposal Submitted by New York University, School of Medicine, Under Solicitation Number RFP 10N3-102-05 for Cardiothoracic Surgery Services at Department of Veterans Affairs, New York Harbor Healthcare System	$3,902,952		
05-01118-152 6/3/05	Review of Proposal Submitted by Medical University of South Carolina, Under Solicitation Number RFP 247-0057-05 for Radiation Oncology Services to the Ralph H. Johnson VA Medical Center			
05-00452-150 6/7/05	Review of Federal Supply Schedule Proposal Submitted by BioMerieux Inc., Under Solicitation Number RFP-797-FSS-03-0001	$3,666,173		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
05-01535-153 6/7/05	Review of Proposal Submitted by the University of New Mexico, Health Sciences Center, Under Solicitation Number 501-0014-05 for Brachytherapy Treatment Services for the New Mexico Veterans Affairs Health Care System	$511,985		
05-01197-159 6/23/05	Review of Proposal Submitted by Medical University of South Carolina, Under Solicitation Number RFP 247-0285-04, for Orthopedic Services at Ralph H. Johnson VA Medical Center	$306,574		
05-01711-163 6/29/05	Review of Proposal Submitted by Virginia Commonwealth University Health System, Under Solicitation Number RFP 246-05-01774, for Liver Transplant Services to Hunter Holmes McGuire VA Medical Center	$2,306,863		
04-01763-165 7/1/05	Review of Federal Supply Schedule Proposal Submitted by Monarch Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03	$22,801		
05-01424-166 7/5/05	Review of Proposal Submitted by Roxane Laboratories, Inc. to Modify Contract Number V797P-5771x			
04-01182-168 7/8/05	Review of Federal Supply Schedule Proposal Submitted by Roche Laboratories Inc., Under Solicitation Number M5-Q50A-03	$4,922,615		
05-01649-178 7/20/05	Review of Proposal Submitted by Indiana University, Under Solicitation Number 583-44-05, for Cardiovascular Surgeon Services at Richard L. Roudebush VA Medical Center	$193,250		
05-01766-179 7/28/05	Review of Proposal Submitted by University Physicians, Under Solicitation Number 438-23-04, for Non-Invasive Cardiac Services at the Department of Veterans Affairs Medical Center Sioux Falls, SD	$770,064		
05-01844-182 8/9/05	Review of Proposal Submitted by the University Medical Center Corporation, Under Solicitation Number 678-0131-04, for Radiation Oncology Services for the Southern Arizona Veterans Affairs Health Care System	$1,682,908		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
05-02810-187 8/11/05	Review of Proposal Submitted by University of Pittsburgh Physicians, Under Solicitation Number 244-05-00920, for Anesthesiology Physician Services at VA Pittsburgh Health Care System	$2,387,587		
05-01907-191 8/12/05	Review of Proposal Submitted by Indiana University School of Medicine, Under Solicitation Number RFP 583-16-05, for Hematology/Oncology Services at Richard L. Roudebush VA Medical Center	$161,695		
05-02669-192 8/17/05	Review of Proposal Submitted by the University of Nevada - Reno, Under Solicitation Number 261-0176-05, for Cardiology Physician Services at the VA Sierra Nevada Health Care System			
05-01763-193 8/18/05	Review of Proposal Submitted by University Physicians of Brooklyn, Under Solicitation Number RFQ 10N3-089-05, for Radiology Services for Brooklyn Campus VA Medical Center			
05-01682-194 8/25/05	Review of Federal Supply Schedule Proposal Submitted by Schick Technologies, Inc,. Under Solicitation Number RFP-797-652C-02-0001			
05-00723-200 9/15/05	Review of Federal Supply Schedule Proposal Submitted by Mylan Pharmaceuticals, Inc., Under Solicitation Number M5-Q50A-03			
05-02232-208 9/22/05	Review of Proposal Submitted by the University of California - Irvine, Under Solicitation Number 600-982-05, for Anesthesiology Services at the Long Beach VA Healthcare System	$1,417,412		
05-02563-209 9/22/05	Review of Proposal Submitted by University of Miami, School of Medicine, Under Solicitation Number RFP 546-46-05, for Cardiothoracic Surgery Services at VAMC Miami	$684,454		
05-01754-210 9/26/05	Review of Federal Supply Schedule Proposal Submitted by Organon USA, Inc., Under Solicitation Number M5-Q50A-03			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
05-02310-213 9/27/05	Review of Proposal Submitted by Medical College of Wisconsin, Under Solicitation Number RFQ 69D-156-05, for Radiology Services for Clement J. Zablocki VA Medical Center	$268,884		

CONTRACT POSTAWARD REVIEWS

05-00262-119 4/1/05	Verification of Par Pharmaceutical Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5295x			$62,369
05-00454-123 4/4/05	Final Report Review of Claim Submitted by JCJS Enterprises, Inc. d/b/a Slim 'N Lite Optical Under Contract Number V249P-0456			
05-01581-121 4/6/05	Review of Pharmion Corporation's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5619x			$5,138
05-00424-125 4/6/05	Review of Johnson and Johnson Ortho Clinical Diagnostics' Voluntary Disclosure and Refund Offer on Federal Supply Schedule Contract V797P-5383x			$52,957
05-01315-144 5/20/05	Verification of Elan Pharmaceutical Inc.'s Refund Offer Under Federal Supply Schedule Contract Number V797P-5161x			$366
05-01307-147 5/26/05	Verification of Novo Nordisk Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5224x			$782
05-01424-155 6/16/05	Verification of Roxane Laboratories Inc.'s Refund Offer Under Federal Supply Schedule Contract Number V797P-5348x			$94
05-02133-162 6/28/05	Review of SAB-Pharma, Inc. c/o Sandoz, Inc.'s Voluntary Disclosure Under Federal Supply Schedule Contract Number V797P-5693x			$2,414
05-02436-183 8/11/05	Review of Pharmacia & Upjohn Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5331x			$108,919
05-02364-188 8/11/05	Review of Hospira Worldwide, Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5396x			$19,077

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
04-01258-189 8/16/05	Review of KPMG's Analysis of Monarch Pharmaceuticals' Compliance Review Concerning Federal Supply Schedule Contract V797P-5185x			$953,626
05-02439-202 9/20/05	Review of Amphastar-IMS, Ltd. Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5742x			$4,918
05-02135-217 9/29/05	Review of Upsher-Smith Laboratories, Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5783x			$2,770

HEALTHCARE INSPECTIONS

05-00641-149 6/1/05	Healthcare Inspection, Review of Quality of Care Department of Veterans Affairs James A. Haley Medical Center Tampa, FL
04-02962-158 6/24/05	Healthcare Inspection, Patient Care, Fraud, and Mismanagement Issues VA Medical Center San Juan, PR
04-03437-175 7/19/05	Healthcare Inspection, Alleged Denial of Care VA Medical Center Birmingham, AL
04-00235-180 8/4/05	Healthcare Inspection, Inspection of Veterans Health Administration Patient Transportation Services
05-00198-181 8/4/05	Allegation of Substandard Cardiac Catheterization Care Hunter Holmes McGuire VA Medical Center Richmond, VA
04-01946-196 9/2/05	Healthcare Inspection, Patient Care and Staffing Issues Gulf Coast Veterans Health Care System Biloxi, MS
05-02118-201 9/19/05	Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System Buffalo, NY
05-02527-205 9/20/05	Healthcare Inspection, Surgical Service Issues Alaska VA Healthcare System and Regional Office Anchorage, AK

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
04-01235-154 6/17/05	Administrative Investigation, Supervision of Physician Time and Attendance, Resident Supervision, and Documentation VA Medical Center Memphis, TN			
04-00536-157 6/24/05	Administrative Investigation, Misuse of Resources and Transit Benefits VA Medical Center Chicago, IL			
04-01580-167 7/7/05	Administrative Investigation, Conflict of Interest and Misuse of Time Issues VA Medical Center Miami, FL			
05-00114-177 7/22/05	Administrative Investigation, Inappropriate Involvement in Arranging Disposition of VA Real Property VA Medical Center Mountain Home, TN			
04-00616-203 9/19/05	Administrative Investigation, Appearance of Preferential Treatment VA Medical Center Fayetteville, NC			
05-01157-207 9/23/05	Administrative Investigation, Noncompetitive Selection of Proposal, Partiality, and Misuse of Position, Office of Research and Development, VHA Central Office Washington, DC			
TOTAL	**99 Reports**	**$19,890,931,664**	**$18,846,391**	**$1,213,430**

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 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 (September 30, 2004, and earlier).

Unimplemented OIG Reports and Recommendations

VA Office	Total		Issued 9/30/04 and Earlier	
	Reports	Recommendations	Reports	Recommendations
VHA	54	338	9	33
A&MM	88	196	0	0
VBA	7	24	1	2
OM	3	13	1	3
OI&T	2	24	1	8
OHRA	1	14	1	14
OPPP	1	3	1	3
Totals	**156***	**612**	**14****	**63**

* There are 152 total unimplemented reports, but 2 reports have actions for two or more offices.
** There are 11 total unimplemented reports over 1-year old, but 1 report has action for four offices.
Acquisition and Materiel Management (A&MM)
Office of Information and Technology (OI&T)
Office of Human Resources and Administration (OHRA)
Office of Management (OM)
Office of Policy, Planning, and Preparedness (OPPP)

OIG is particularly concerned with one report on VBA operations (issued in July 2000) and four reports on VHA operations (two issued in 2002 and two in 2003) 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 September 30, 2005, 2 of 26 recommendations remain unimplemented pending VBA actions. Both open recommendations are tied to implementation of the VETSNET Award application. VETSNET is a combination of applications being deployed to replace the current Benefits Delivery Network. VETSNET Award implementation is slated for December 2006. As for recommendation 2, VBA established an interim C&P large-payment review process in 2001.

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Veterans Health Administration

Unimplemented Recommendations and Status

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

Recommendation: 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 September 30, 2005, there are 5 veterans residing in 1 unlicensed community residential care home, as compared to 182 veterans in 28 unlicensed homes on October 1, 2002. If the license is not received by November 2005, the Health Care System will consider relocating the remaining veterans.

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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 September 30, 2005, 3 of 11 recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care. Information technology issues have prevented finalizing the CNH Education and CNH Certification Report Web sites. Also, the VHA Chief Consultant for Geriatrics and Extended Care plans to develop summary CNH status reports that will be provided to senior VHA managers.

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

Recommendation 1: To improve physician timekeeping, we recommend that the Under Secretary for Health:

- 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.
- Recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.
- Provide continuing timekeeping education to supervisors, physicians, and timekeepers.
- Evaluate appropriate technological solutions that will facilitate physician timekeeping.

- Establish appropriate training modules, making best use of technological solutions, for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.

Recommendation 2: To better align physician staffing with patient care workload, we recommend that the Under Secretary for Health:

- 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.
- 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.
- 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.
- 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 September 30, 2005, 9 of 17 recommendations remain unimplemented pending actions by a number of VHA staff offices.

Recommendation 1. VHA has explored ways to create a time and attendance system that meets the needs of VA in providing patient care while at the same time allowing flexibility in scheduling for those part-time physicians who need such accommodations. VHA has submitted revised policies to the Office of Human Resources Management for national release, which is expected to occur in October 2005. Five VA medical centers have been testing the new policies together with supporting software changes to the Enhanced Time & Attendance System. Concurrently, the Employee Education System has developed a training module to assist the field when national implementation of the new policies becomes mandated. A period of 60 to 90 days will be needed after the issuance of the policies to allow installation and debugging of the software at all facilities and completion of necessary training. Once that has been completed, the policies will be mandatory for all VHA facilities.

Recommendation 2. VA has developed a proposed policy to meet this staffing requirement. It relates staffing levels and staff mix to patient outcomes and other performance measures. V A's goal is to develop information management strategies that permit analysis of the relationships between staffing numbers, mix, care delivery models, and patient outcomes for multiple points of care. Projects currently underway will be used to develop a standardized evidence-based approach to staffing plans and use such information to provide high-quality patient care in the most efficient manner possible. Systems for the collection and analysis of this information will be developed in phases over a 4-year period and will be in place by September 30, 2009. OIG

continues to work with VHA to review its proposed policy due to concerns over compliance with the intent of Public Law 107-135, particularly with respect to:

- National standards for nurse staffing.
- The length of time VHA projects to establish a complete set of staffing standards.

Questions remain over the need to develop new data systems versus using existing data resources such as Decision Support System (DSS) in a consistent manner.

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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:

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

Status: As of September 30, 2005, two of four recommendations remain unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care to finalize the Home Health Care Program Administration handbook and implement a Geriatrics and Extended Care referral form. The VHA program office has not provided a planned completion date to issue the handbook that was first drafted in January 2004, and the referral form is on hold at most sites.

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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 Environmental Protection Agency (EPA)-recommended guidelines to ensure all VA medical facilities are considering and applying similar safety measures.

Status: As of September 30, 2005, one of three recommendations remains unimplemented pending actions by the VHA Environmental Engineering Office. VHA anticipates issuing a directive on improving the security of water systems on VHA properties by the end of the first quarter of 2006.

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Report: *Healthcare Inspection, VHA's Community Residential Care (CRC) Program*, 03-00391-138, 5/3/04

Recommendations: The Under Secretary for Health needs to assure that appropriate VAMC CRC program managers, inspection team members, or clinicians:

- Conduct annual fire safety inspections of CRC homes per Chief Network Officer IL 10N-2000-02.
- Give CRC caregivers instructions for managing patient care needs at the time of placement, and after hospitalizations and clinic visits, and document these discussions in the medical records.
- Document that patients and families sign statements of agreement when accepting referrals to CRC services and programs not approved by VA.
- Conduct and document annual discussions with VBA field examination supervisors regarding incompetent CRC patients, and take actions as appropriate.

Status: As of September 30, 2005, 4 of 11 recommendations remain unimplemented pending VHA actions, which included drafting required regulatory changes for Title 38, Code of Federal Regulations. VHA issued handbook 1140.1 in March 2005, but did not address the last recommendation involving discussions with VBA. The next handbook revision will address all recommendations. The planned completion date is FY 2007.

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Report: *Healthcare Inspection, Evaluation of Quality Management in VHA Facilities, Fiscal Year 2003*, 03-00312-169, 7/14/04

Recommendation: The Acting Under Secretary for Health, in conjunction with VISN and facility managers ensures all facilities have policies and have fully implemented processes for "communication" to patients who have been injured by adverse events.

Status: The draft policy on "Disclosure of Adverse Events to Patients" has been completed and the concurrence process is done. The document is ready for signature and anticipate signature no later than October 2005.

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Report: *Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities*, 03-00079-183, 8/13/04

Recommendations: The Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to:

- Develop and oversee the implementation of a national nurse staffing policy that applies a single staffing methodology to generate consistent facility staffing standards.
- Identify specific data elements and systems that will be used.

- Ensure appropriate data validation and database maintenance.
- Ensure that data systems, such as DSS and the nursing package, are complimentary, consistent, and used by nurse managers in making decisions regarding staffing levels and staffing mix.
- Design a process to ensure the efficient and appropriate management of nurse staffing resources.
- Involve staff nurses in staffing decisions.
- Design a process to systematically measure the impact of nurse staffing issues on patient care outcomes.
- Develop and implement a process to ensure that direct patient care assignments offer opportunities similar to non-patient care assignment.
- Evaluate the effectiveness of recruitment and retention practices.
- Monitor overtime use in accordance with Public Law 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished.
- Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and monitored.

Status: As of September 30, 2005, 11 of 14 recommendations remain unimplemented pending VHA actions.

Recommendations 1-6. See VHA actions that address the staffing issue in the above OIG Audit of VHA's Part-Time Physician Time and Attendance, 02-01339-85, 4/23/03.

Recommendation 7. In 2002, VHA approved funding for the VA Nursing Outcomes Database project to collect data related to nurse-sensitive indicators of quality and integrated it into a national database. The project continues to evolve and the planned completion date remains the end of 2009. The project includes a pilot project at 12 acute care VA facilities that ended in June 2004. It established reliable data collection methods for obtaining quality indicators that impact patient outcomes. The plan is to expand indicator development to geriatrics and extended care, mental health and ambulatory care over the next 3 to 5 years. The goal is to have a system rollout of the data collection processes and indicators to all acute care sites by the end of FY 2009.

Recommendation 8. The Office of Nursing Services created a task force in FY 2003 that included an assessment and analysis of current trends and structures that define nursing performance. The task force is refining drafts of four proposed career paths and will need to address a potential additional grade legislatively.

Recommendation 9. A VA nurse outcomes report is being prepared that looks at the 5-year outcomes study of nurses who have participated in VHA Employee Incentive Scholarship

Program/National Nurse Education Initiative programs. Scholarships and tuition reimbursement are strong recruitment and retention tools and this report is designed to analyze VHA outcomes. There were delays in the contracting process with a final report not expected until early 2006.

Recommendation 10. VAMCs have been manually collecting overtime data for the third and fourth quarters of FY 2005. A final report will be prepared in early second quarter of FY 2006.

Recommendation 11. The National Center for Organizational Development has analyzed data from the most recent VHA all-employee surveys to that of the all-employee survey results from the 10 facilities that OIG originally surveyed. Preliminary results indicate that there is no statistical significance difference between the 10 facilities and the universe surveyed. Action awaits the review of the overtime data currently being manually collected.

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Office of Human Resources and Administration

Unimplemented Recommendations and Status

Report: *Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program (WCP) Cost*, 02-03-56-182, 8/13/04

Recommendations: The Assistant Secretary for Human Resources and Administration take the following actions to strengthen VA's WCP and reduce unnecessary program costs:

- Establish a centralized Department-wide program management and oversight process to proactively address WCP case management deficiencies and reduce the risk for program abuse, fraud, and unnecessary costs. This should include:
  - Developing performance criteria to measure WCP case management effectiveness.
  - Evaluating adequacy of compliance with WCP performance criteria.
  - Identifying performance deficiencies that require corrective action.
- Ensuring that responsible WCP officials and staff are held accountable for implementing required case management enhancements and meeting performance criteria.
- Ensure that adequate staff resources are available to complete necessary WCP case management actions throughout VA in a timely manner. Staffing guidelines and training requirements should be developed to help identify needed staffing levels and training to provide the skills needed to effectively perform WCP assigned duties
- Ensure that the Department's WCP case management process includes the following key requirements:
  - Establish and maintain a VA case file on all open/active claims.

- Provide timely follow up actions on all open/active claims.
- Make a job offer if a claimant has work capacity.

- Monitor the extent of facility WCP claims involving violent patient incidents and coordinate with VHA on appropriate actions needed to address the safety of employees in their work areas.
- Coordinate with individual Department elements to conduct a one-time review of all open/active WCP cases to prioritize and identify those cases where additional case management efforts could return employees back to work or otherwise remove them from the WCP rolls. Provide the IG with the results for oversight review. (Repeat recommendation from the 1998 IG WCP audit.)
- As part of the one-time review, emphasize the need for WCP case managers to identify and report potential program fraud to the IG. Ensure that the IG handbook on case management and fraud detection and other fraud related information that can be found on our web site at http://www.va.gov/oig/52/wcp/wcp.htm is fully utilized in this review. Work with the IG to establish a Web based fraud referral process, including referral criteria.
- Collect Continuation of Pay (COP) information and use as a management tool to monitor WCP cost trends and employee health and safety issues. (Repeat recommendation from the 1998 IG WCP audit.)
- Collect information on Department actions to controvert COP and/or dispute claims and use as a management tool monitor WCP cost trends, and employee health and safety issues, and to evaluate the effectiveness of Department efforts to identify questionable claims and avoid unnecessary WCP related costs.
- Initiate dialog with Department of Labor to discuss opportunities where both organizations could benefit from improved coordination/support in the delivery of WCP benefits to Department employees.

Status: As of September 30, 2005, all but one recommendation remain unimplemented pending VA actions. A Workers' Compensation Strategic Planning Committee was formed in October 2004, and a strategic plan was approved in February 2005 that consists of five strategic goals:

- Case management.
- Return to work.
- Education.
- Partnerships.
- Identifying and reducing fraud, waste, and abuse.

The Strategic Planning Committee meets monthly to review progress toward meeting the goals, but has not provided a planned completion date. The final two recommendations await implementation of the new VA personnel/payroll system scheduled for implementation in December 2008.

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Multiple Office Action

Unimplemented Recommendations and Status

Report: *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, 04-01371-177, 8/11/04

Recommendation 1: The Under Secretary for Health needs to develop and implement productivity standards for physicians as directed by Public Law 107-135.

Recommendation 2: The Assistant Secretary for Management should:

- Initiate a review of all payments to BearingPoint to determine whether there were any improper or erroneous payments for collections.
- If the discounts offered for Phase IV work and/or the award fee cannot be recovered, take appropriate administrative action against the responsible VA personnel.
- Conduct a complete review of all travel vouchers submitted by BearingPoint since commencing work in January 2000 to determine if the claimed costs are allowable in accordance with the provisions of the Joint Travel Regulations, coordinate findings with the OIG, collect any amounts found to be in excess of those allowable under regulations, clarify return home allowable expenses, and check rebates.

Recommendation 3: The Assistant Secretary for Policy, Planning, and Preparedness should:

- Include in the VA Directive and Handbook 0710 currently being amended, a requirement for the Office of Cyber and Information Security to be the approving authority for sensitivity designations for non-VA employees with access to VA systems.
- Initiate the process of including an approval signature block on VA Form 2280 for the Office of Cyber and Information Security approval of the sensitivity designation recommended by VA organization unit sponsoring the non-VA employees.
- Take interim action to ensure that recommendations 3a and 3b are implemented pending the completion of the revised VA Directive and Handbook 0710.

Recommendation 4: Other implementation actions under this recommendation are suspended pending decisions on future CoreFLS activities. VA management expects to make a decision on how, or whether, to proceed with CoreFLS during the first quarter of FY 2006.

Status: As of September 30, 2005, 15 of 66 recommendations remain unimplemented pending actions by a number of VA staff offices.

Recommendation 1. See VHA actions that address the staffing issue in the above OIG Audit of VHA's Part-Time Physician Time and Attendance, 02-01339-85, 4/23/03.

Recommendation 2. The Office of Management continues to review expenditures made to the CoreFLS vendors and review all travel expenditures submitted by the vendor, and will consider the issue of discounts for Phase IV work and/or award fee within the context of OIG's continuing investigation of this matter

Recommendation 3. Federal Information Processing Standards Publication 201 (FIPS 201), issued in February 2005, mandates that all departments be able to implement identity proofing and issuance process by October 2005, and begin issuing personal identification verification cards by October 2006. Furthermore, OMB has requested completion of a national rollout by September 30, 2008. VA's implementation of FIPS 201 requirements is anticipated to correct concerns about background checks and contract employees as presented in the OIG report, but OMB has not finalized this issue.

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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	52
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-55
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-55
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	71 (App. B)
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	5
Section 5 (a) (5)	Summary of instances where information was refused	84 (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	61-70 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	21-47
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	85 (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	86 (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	71-81 (App. B)
Section 5 (a) (11)	Significant revised management decisions	84 (App. C)
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	84 (App. C)
Section 5 (a) (13)	Information described under section 5(b) of the *Federal Financial Management Improvement Act of 1996* (Public Law 104-208)	84 (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 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 halted development of a new financial management system in 2004. The Department has not established new target dates.

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

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no internal OIG reports unresolved for over 6 months. However, there were 50 OIG contract review reports unresolved because a contracting officer decision has not been made for over 6 months. Thirty-five of these reports have actions by the National Acquisition Center contracting officers and the remaining 15 reports have actions by VAMC/VISN contracting officers. These contract review reports were issued before the start of this semiannual reporting period and will be closed after the OIG receives the contracting officer price negotiation memorandum following contract awards.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

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

Table 1: Resolution Status Of Reports With Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 3/31/05	0	$0
Issued during reporting period	12	$1.2
Total inventory this period	**12**	**$1.2**
Management decisions during the reporting period.		
Disallowed costs (agreed to by management)	12	$1.2
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Reporting Period	**12**	**$1.2**
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 3/31/05	54	$1,166.6
Issued during reporting period	56	$19,890.9
Total inventory this period	**110**	**$21,057.5**
Management decisions during the reporting period		
Agreed to by management	45	$19,819.3
Not agreed to by management	7	$5.1
Total Management Decisions This Reporting Period	**52**	**$19,824.4**
Total Carried Over To Next Period	**58**	**$1,233.1**

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

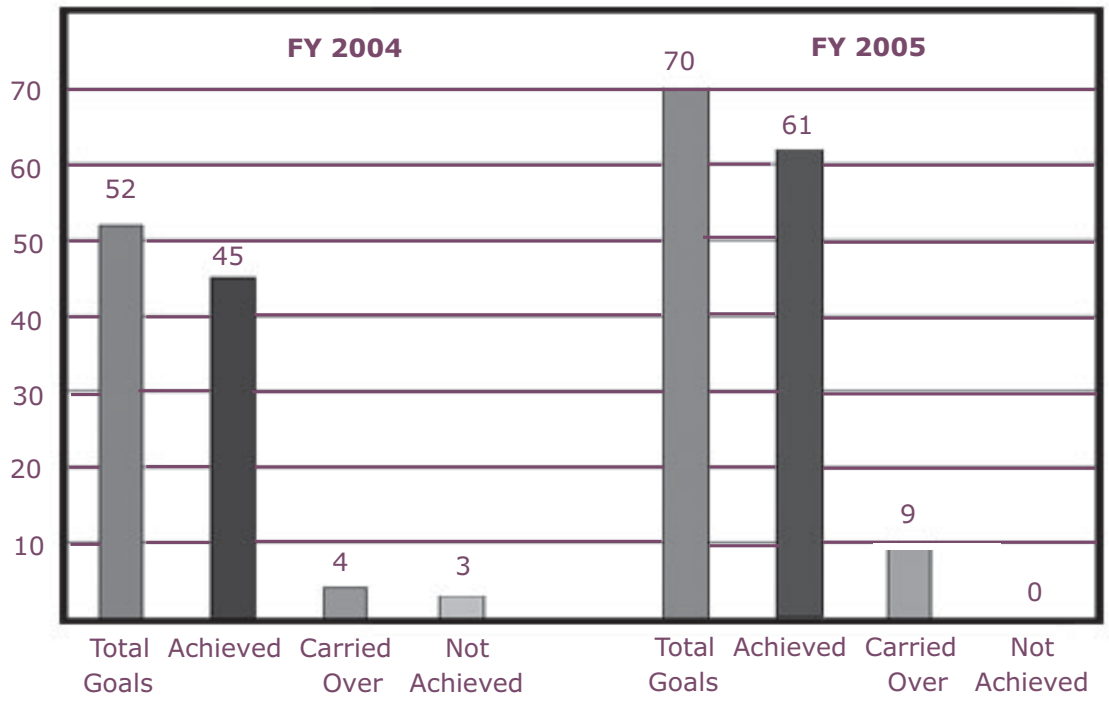
VA OIG PERFORMANCE REPORT FY 2005

Overview of FY 2005 Accomplishments

OIG is resolved to ensure VA programs and operations are efficiently and effectively managed, and free of criminal activity, waste, and abuse. Over the next 5 years, OIG will focus on examining major management challenges and high-risk areas facing VA within five strategic goals: health care delivery, benefits processing, financial management, procurement practices, and information management.

Presented here are the results of our efforts in FY 2005 against the planned goals. Our performance goals and results are transitioning from the *OIG Strategic Plan 2001-2006*. Overall, we planned a total of 70 annual performance goals; we accomplished 61 (87 percent). Nine goals were carried over to FY 2006 due to competing demands on resources. The chart below illustrates our increased performance levels. OIG's new *FY 2005-2010 Strategic Plan* is available on our website: http://www.va.gov/oig.

Annual Goals Accomplished



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APPENDIX E

OIG OPERATIONS PHONE LIST

Investigations

Headquarters Investigations Washington, DC ..... (202) 565-7702

Northeast Field Office (51NJ) Newark, NJ ..... (973) 297-3338

Boston Resident Agency (51BN) Bedford, MA ..... (781) 687-3138

New York Resident Agency (51NY) New York, NY ..... (212) 951-6850

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) 331-7674

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) 627-3251

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

Bay Pines Audit Operations Division (52SP) Bay Pines, FL..... (727) 395-2422

Bedford Audit Operations Division (52BN) Bedford, MA ..... (781) 687-3120

Chicago Audit Operations Division (52CH) Chicago, IL..... (708) 202-2667

Dallas Audit Operations Division (52DA) Dallas, TX..... (214) 253-3300

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 F

GLOSSARY

C&P	Compensation and Pension
CAP	Combined Assessment Program
CFS	Consolidated Financial Statement
DAS	Data Analysis Section
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DOL	Department of Labor
FFMIA	*Federal Financial Management Improvement Act*
FISMA	*Federal Information Security Management Act of 2002*
FOIA/PA	*Freedom of Information Act/Privacy Act*
FSS	Federal Supply Schedule
FTE	Full-time Equivalent
FY	Fiscal Year
GSA	General Services Administration
HCS	Health Care System
HIPAA	*Health Information Portability and Accountability Act of 1996*
HUD	Department of Housing and Urban Development
IG	Inspector General
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
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
USPIS	U.S. Postal Inspection 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
VSC	Veterans Service Center
WCP	Workers' Compensation Program

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Department of Veterans Affairs
Office of Inspector General
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