| | |
|---|---|
| Description of document: | Seventeen (17) Department of Veterans Affairs (VA) Inspector General (OIG) audit and investigation reports, 2004-2010 |
| Requested date: | 25-May-2016 |
| Released date: | 11-August-2016 |
| Posted date: | 13-March-2017 |
| Source of document: | FOIA Request<br>Department of Veterans Affairs<br>Office of Inspector General<br>Release of Information Office (50CI)<br>810 Vermont Avenue, NW<br>Washington, DC 20420<br>Email: vaoigfoia-pa@va.gov<br>Fax: (202) 495-5859 |

**Department of Veterans Affairs**
**Office of Inspector General**
**Washington, DC 20420**

August 11, 2016

This is in response to your Freedom of Information Act (FOIA) request dated May 25, 2016 in which you asked for a copy of 17 VA OIG reports. Your request was received in this office on May 25, 2016.

We have assigned FOIA Tracking Number 16-00299-FOIA to your request. Please refer to it whenever communicating with VA about your request.

We have enclosed a copy of the requested records. However, all inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency have been withheld under FOIA Exemption 5, 5 U.S.C. § 552 (b)(5). A total of 5 pages have been withheld in their entirety under FOIA Exemption 5 as cited above.

We are also withholding all information which, if disclosed, would constitute a clearly unwarranted invasion of an individual's personal privacy under FOIA Exemption 6, 5 U.S.C. § 552 (b)(6), and Exemption 7C, 5 U.S.C. § 552 (b)(7)(C). Specifically, names, job titles and other information which could reveal the identity of individuals mentioned in the records have been withheld. We do not find any public interest that outweighs the privacy interests of the individuals.

You may appeal this decision within 60 calendar days of the date of this determination by submitting a signed, written statement by mail, fax, or email. You may submit your appeal by using either of the following addresses or fax number:

U.S. Department of Veterans Affairs
Office of Inspector General
Office of the Counselor (50C)
810 Vermont Avenue, N.W.
Washington, DC 20420

VAOIGFOIA-Appeals@va.gov

(Fax) 202.495.5859

The appeal should include:

1. The name of the FOIA Officer
2. The date of the determination, if any
3. The precise subject matter of the appeal

If you choose to appeal only a portion of the determination, you must specify which part of the determination you are appealing.

The appeal should include a copy of the request and VA's response, if any. The appeal should be marked "Freedom of Information Act Appeal".

Sincerely,

DARRYL JOE
Chief, Release of Information Office

Enclosures

VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

# Department of Veterans Affairs

*Independent Review of VA's Fiscal Year 2009 Performance Summary Report to the Office of National Drug Control Policy*

March 9, 2010
10-01105-96

**To Report Suspected Wrongdoing in VA Programs and Operations:**
**Telephone: 1-800-488-8244**
**E-Mail: Hvaoighotline@va.gov**
**(Hotline Information: Hhttp://www.va.gov/oig/contacts/hotline.aspII)**

**Department of Veteran Affairs**

# Memorandum

Date: March 4, 2010

From: Assistant Inspector General for Audits and Evaluations (52)

Subj: Final Report – Independent Review of VA's Fiscal Year 2009 Performance Summary Report to the Office of National Drug Control Policy

To: Deputy Chief Patient Care Services, Veterans Health Administration (116)
Chief Research and Development Officer, Veterans Health Administration (12)

1. The Office of Inspector General is required to review the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2009 Performance Summary Report to the Director, Office of National Drug Control Policy (ONDCP), pursuant to ONDCP Circular: *Drug Control Accounting* (Circular), dated May 1, 2007, and as authorized by 21 U.S.C. §1703(d)(7). The Performance Summary Report is the responsibility of VA's management and is included in this report as Attachment A (Patient Care) and Attachment B (Research and Development). The Circular is included as Attachment C.

2. We have reviewed, according to the Circular's criteria and requirements, whether VA has a system to capture performance information accurately and whether that system was properly applied to generate the performance data reported in the Performance Summary Report. We have also reviewed whether VA offered a reasonable explanation for failing to meet a performance target and for any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets; whether the methodology described in the Performance Summary Report and used to establish performance targets for the current year is reasonable given past performance and available resources; and whether VA has established at least one acceptable performance measure for each Drug Control Decision Unit, as defined by the Circular, for which a significant amount of obligations were incurred.

3. Our review was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination,

4. Based upon our review and the criteria of the Circular:

- Nothing came to our attention that caused us to believe that VA does not have a system to capture performance information accurately and the system was not properly applied to generate the performance data reported in the Performance Summary Report in all material respects;

- Nothing came to our attention that caused us to believe that VA did not meet its FY 2009 target for the "Continuity of Care" performance measure (Patient Care) and the substance abuse disorder on-going studies performance measure (Research and Development), in all material respects. As a result, VA is not required to offer an explanation for failing to meet a performance target, for recommendations concerning plans and schedules for meeting future targets, or for revising or eliminating performance targets;

- Nothing came to our attention that caused us to believe that the methodology described in the Performance Summary Reports establishing performance targets for the current year is not reasonable given past performance and available resources, in all material respects; and

- Nothing came to our attention that caused us to believe that VA did not establish at least one acceptable performance measure for each Drug Control Decision Unit, as defined by the Circular, for which a significant amount of obligations were incurred in the previous fiscal year, in all material respects.

5. We provided you our draft report for review. You concurred with our report without further comments.

6. This report is intended solely for the information and use of the U.S. Congress, the ONDCP, and VA management. This report is not intended to be and should not be used by anyone other than these specified parties.

*(original signed by:)*
Belinda J. Finn

Attachments

# Department of Veterans Affairs
# Veterans Health Administration
# FY 2009 Performance Summary Report

## I. PERFORMANCE INFORMATION

**Decision Unit 1: Veterans Health Administration**

**Measure 1: Continuity of Care**

Table 1

| FY 2005 Actual | FY 2006 Actual | FY 2007 Actual | FY 2008 Actual | FY 2009 Target | FY 2009 Actual | FY 2010 Target |
|---|---|---|---|---|---|---|
| 35% | 37% | 44% | 48% | 47% | 52% | 47% |

(a) This measure was established to promote better substance use disorder (SUD) treatment outcomes. It applies to patients entering specialty treatment for SUD in inpatient, residential, domiciliary or outpatient programs, but not opioid substitution, to determine if they are staying in treatment for at least 90 days. Research has shown that good addiction treatment outcomes are contingent on adequate lengths of treatment. Many patients drop out during the initial 90 days of treatment with limited clinical benefit and high rates of relapse. While two contacts per month for at least three months would rarely be sufficient, most patients with chronic conditions require ongoing treatment for at least this duration to establish early remission. Note: SUD includes patients with an alcohol or drug use disorder diagnosis or both.

**Indicator**: Percent of patients beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days after qualifying date
**Numerator**: Veterans beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 days with visits every 30 days for a total of 90 days in any of the outpatient specialty SUD clinics.
**Denominator:** Veterans beginning a new episode of specialty treatment for SUD

(b) In FY 2009, 52% of VA patients in a specialized SUD program successfully met the measure, exceeding the target of 47%.

(c) Performance results are updated monthly on a VA intranet site and discussed on semi-monthly national conference calls. In addition to establishing standards and providing feedback, pay incentives of leaders at the network, facility, service, and program level are directly linked to these quality metrics. Expansion funding over the past several years has been used to improve the continuum of care in order to promote retention. This includes efforts to arrange accessible transitional housing to facilitate program attendance and establishing telemental health services capability at additional locations. Consultation is offered through national resources including the Substance Use Disorder Quality Enhancement Research Initiative and the Centers of Excellence in Substance Abuse

Treatment and Education. Informatics tools are shared within and across VISNs to promote active patient tracking and outreach.

(d) Performance Measures are maintained by the VHA Office of Quality and Performance. In the case of the SUD measure, workload data generated at the facility is transmitted to the VHA Austin Information Technology Center. The extraction methodology uses the appropriate DSS identifier codes (stop codes) to select the patients who meet the criteria for inclusion in the measure. The patient data is then extracted from the Austin PTF files and is maintained by the Office of Quality and Performance. A copy of the FY 2009 Office of Quality and Performance, Substance Use Disorder, Continuity of Care Technical Manual Chapter is attached.

## II. MANAGEMENT'S ASSERTIONS

(1) **Performance reporting systems appropriate and applied.**
Performance Measures are maintained by the VHA Office of Quality and Performance. In the case of the SUD measure, workload data generated at the facility is transmitted to the VHA Austin Data Center. The extraction methodology uses the appropriate DSS identifier codes (stop codes) to select the patients who meet the criteria for inclusion in the measure. The patient data is then extracted from the Austin PTF files and is maintained by the Office of Quality and Performance. The system was properly applied to generate the performance data.

(2) **Explanations for not meeting performance targets are reasonable.**
In FY 2009 the target of 47% was exceeded with an actual rate of 52%.

(3) **Methodology to establish performance targets is reasonable and applied.** The target measures are set by the VHA Office of Quality Performance in conjunction with the Office of Patient Care Services and for FY10 the target will remain at 47%.

(4) **Adequate performance measures exist for all significant drug control activities**
VHA is measuring the identification and treatment of those having a SUD issue.

Attachment

# FY 2009, Q4v1
# TECHNICAL MANUAL
for the

# VHA
# Performance Measurement System

Office of Quality and Performance (10Q)

July 15, 2009

# Performance Measure 19: Mental Health Measure

***19a Substance Use Disorder – Continuity of Care***

VHA Performance Measure (mnemonic sa5)

**Rationale:**
This measure applies to patients entering specialty treatment for substance use disorders (inpatient, residential, domiciliary or outpatient, but not opioid substitution), to determine if they are staying in treatment for at least 90 days. It involves 100% review of administrative databases using clinic stop codes to determine specialty care of substance use disorders (SUD). The performance period applies to patients completing their 90-day retention period from October 08 through August 09. Research has shown that good addiction treatment outcomes are contingent on adequate lengths of treatment. There is no predetermined length of addiction treatment that assures success, but duration of treatment is the factor most consistently associated with successful addiction treatment outcome[1,2,3,4]. Many patients drop out during the initial 90 days of treatment with limited clinical benefit and high rates of relapse. While two contacts per month for three months would rarely be sufficient, most patients require ongoing treatment for **at least** this duration to establish early remission.

Various patient, provider and program level interventions have been associated with improved treatment retention[5,6,7]. The initial intensity of treatment should be considered primarily as a means to promote treatment retention, e.g., severely dependent patients typically may require multiple treatment contacts per week in order to stabilize early remission. However, for many patients following initial stabilization, it may be appropriate to provide a lower intensity of addiction-focused treatment extending over a longer duration with superior remission rates for those who remain engaged in treatment for 6-12 months[8,9]. Available evidence supports the effectiveness of telephone follow-up for patients after they have stabilized during the initial weeks of outpatient treatment[10,11]. Many individuals continue to benefit from treatment (e.g., methadone maintenance) over a period of years.

Consistent with the VHA/DoD Guideline for Treatment of Substance Use Disorder[12], this performance measure is intended to emphasize the importance of early treatment retention as an essential condition of quality care for addiction. Treatment duration beyond 3 months presents important opportunities to individualize treatment plans consistent with treatment response over time by adjusting the intensity of psychosocial interventions (e.g., frequency of group sessions), pharmacotherapy (e.g., dose amount and monitoring frequency), community recovery support (e.g., promoting Twelve-Step program involvement), and management of co-morbid conditions.

**References & Resources:**
[1]Crits-Cristoph, P., & Siqueland, L. (1996). Psychosocial treatment for drug abuse: selected review and recommendations for national health care. *Archives of General Psychiatry*, 53, 749-756.
[2]McKay, J.R., Lynch, K.G., Shepard, D.S., Pettinati, H. (2005). The Effectiveness of Telephone-Based Continuing Care for Alcohol and Cocaine Dependence: 24 Month Outcomes. *Archives of General Psychiatry*, 62,199-207.

[3]Simpson, D.D., Joe, G.W., & Brown, B.S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11, 294-307.

[4]Zhang, Z., Friedmann, P.D., Gerstein, D.R. (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction*, 98, 673-684.
[5]Lash, S.J., Stephens, R.S., Burden, J.L., et al. (2007). Contracting, prompting, and reinforcing substance use disorder continuing care: A randomized clinical trial. *Psychology of Addictive Behaviors*. 21, 387-97.
[6]Schaefer, J.A., Ingudomnukul, E., Harris, A.H.S., & Cronkite, R.C. (2005). Continuity of care practices and substance use disorder patients' engagement in continuing care. *Medical Care*, 43, 1234-1241.
[7]Shepard, D.S., Calabro, J.A.B., Love, C.T., McKay, J.R., Tetreault, J., & Yeom, H.S. (2006). Counselor incentives to improve client retention in an outpatient substance abuse aftercare program. *Administration and Policy in Mental Health*, 33, 629-635.
[8]Finney, J. W., & Moos, R. H. (2002). Psychosocial treatments for alcohol use disorders. In P. E. Nathan & J. M. Gorman (Eds.), A Guide to Treatments That Work (2nd ed.; pp. 157-168.). New York: Oxford University Press.
[9]Ritsher, J.B., Moos, R.H., Finney, J.W. (2002). Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatric Services*, 53, 595-601.
[10]McKay, J.R., Lynch, K.G., Shepard, D.S., Ratichek, S., Morrison, R., Koppenhaver, J., & Pettinati, H. (2004) The effectiveness of telephone-based continuing care in the clinical management of alcohol and cocaine use disorders: 12 month outcomes. *Journal of Consulting and Clinical Psychology*, 72, 967-79.
[11]McKay, J.R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100, 1594-1610
[12]The VHA/DoD SUD Guideline (especially Module R Annotation H)
http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm
Moos, R. H., Finney, J. W., Ouimette, P. C., & Suchinsky, R. T. (1999). A comparative evaluation of substance abuse treatment: Treatment orientation, amount of care, and 1-year outcomes. *Alcoholism: Clinical and Experimental Research*, 23, 529-536
- Principles of Drug Addiction Treatment A Research-Based Guide
http://www.nida.nih.gov/PODAT/PODAT5.html#FAQ5

**Indicator Statement**: Percent of patients beginning a new episode of treatment for SUD who maintain continuous treatment involvement for at least 90 days after qualifying date

**Numerator**: Veterans beginning treatment for SUD who maintain continuous treatment involvement for at least 90 days as demonstrated by at least 2 days with visits every 30 days for a total of 90 days in any of the outpatient specialty SUD clinics.

**Denominator:** Veterans beginning specialty treatment for SUD

**Exclusions:**
- Non veterans are excluded from this measure. They are identified by either a means test response of "n", "no" (zero) which represents a "non-vet", or by eligibility status indicating non veteran.
- Patients without an initial enrollment date
- Patients discharged dead or deceased during the 90-day retention period. To be captured for this measure, data must be in AITC or Beneficiary Identification Record Locator System (BIRLS).
- Smoking cessation visits are excluded. When stop code 707 is paired with any SUD code, the SUD visit is not used in this measure

**Note:** Clinic visits to outpatient SUD clinic stops 513 SA-IND or 514 SA-Home or 519 SA/PTSD or 547 inter-SA TRT, or 560 SA GRP are included in this measure. For discussion on the use of telephone stop code 545, see Table C below. Therefore all other clinic visits,

including non SUD clinic visits and Opioid Substitution visits (Clinic code 523) are not considered in this measure.

**Cohort:** Universe includes all veterans with an SUD outpatient encounter or inpatient discharge from SUD specialty bed section in VHA.

**Definitions:**

- There are 3 events in time analyzed in this measure:
  - Negative SUD Treatment History also called Dormancy
  - New SUD treatment episode through outpatient or inpatient qualification
  - Continuous treatment involvement during the retention period of three 30 day intervals

**TABLE A - Events in Time**

| Event | Negative SUD Treatment History (Dormancy) | Qualification as New SUD Episode | | | Continuous Treatment Involvement (Retention Period) 90 Total Days | | |
|---|---|---|---|---|---|---|---|
| **Event Description** | 90 day period of no SUD treatment in the 90 days prior to the 1st outpatient qualifying event date | Inpatient or Outpatient Qualification Date = T | | | 1st 30 days of retention | 2nd 30 days of retention | 3rd 30 days of retention |
| **Outpatient Qualified Events in Time** | (T-90) minus total days from 1st to 3rd outpatient qualifying event | 1st Qualifying Event Date Not earlier than T-29 | 2nd Qualifying Event Date Not earlier than T-28 | 3rd Qualifying Event Date T | 2 SUD visits in period greater than T but not later than T+30 | 2 SUD visits in period greater than T+30 but not later than T+60 | 2 SUD visits in period greater than T+60 but not later than T+90 |
| **Inpatient Qualified Events in Time** | None required for inpatient qualification | 1st and only Qualifying event T = Date of any inpatient discharge or transfer from a SUD bed-section | | | 2 SUD visits in period greater than T but not later than T+30 | 2 SUD visits in period greater than T+30 but not later than T+60 | 2 SUD visits in period greater than T+60 but not later than T+90 |

- Veterans beginning new SUD treatment episode: To qualify as a New SUD Outpatient Episode, two criteria must be met:
  - A 90-day Negative SUD outpatient or inpatient treatment history (no SUD outpatient visit, telephone 545, specialty SUD inpatient admission or discharge or inpatient SUD encounters) before the date of the 1st of three qualifying SUD outpatient visits **and**

Three visits within 30 days to outpatient SUD clinic stops 513 SA-IND or 514 SA-Home or 519 SA/PTSD or 547 inter-SA TRT, or 560 SA GRP. Listed

  - stops are included if paired with other stops as primary or secondary except smoking cessation 707 **OR** opioid substitution 523. SUD Telephone visits (Stop Code 545) *will NOT be used to qualify new SUD treatment episodes.*

The date of the 3rd SUD visit in 30 days is the "qualifying" date for the outpatient track. The retention period begins the next day.

Patients who accrue outpatient workload while in an inpatient SUD bed section will not "qualify" for the measure via the outpatient track. Since inpatient workload may not be available until after discharge, the patient may be "picked up" as new and tracked for a period of time. However, upon SUD specialty inpatient discharge or transfer, the outpatient track will be dropped and the patient will be qualified in the inpatient track.

To qualify as a New SUD Inpatient Episode, a single criterion must be met:

- a discharge or transfer from SUD inpatient bed section (PTF Discharge Specialty 27 SA Res Rehab or 74 SA HI INT, 86 DOM SA with a length of stay at least 4 calendar days.

The SUD bed section discharge or transfer date is the "qualifying" date for the inpatient track. The retention period begins the next day.

- Continuous Treatment Involvement (Retention period): Continuous treatment involvement for at least 90 days is defined as visits on at least 2 days during every 30 day retention interval for a total of 90 days (three discrete 30 day intervals) in any of the outpatient specialty SUD clinics. The continuous SUD treatment retention period begins the day after the qualifying date and ends the 90th day from the beginning of the continuous treatment involvement retention period.
- Telephone care: Substance use disorder clinical care by telephone which meets the same standard as face-to-face visits (e.g. staff qualifications, time spent with the veteran, etc.) will be accepted for continuity of care for visits during the 2nd and 3rd 30-day retention intervals. Stop code 545 (telephone Substance Abuse) will be used for the measure. Telephone visits will not be used to "qualify" new veterans into the measure.
- Admission during the retention period: If a veteran has already qualified for the measure (from the inpatient or the outpatient tracks) and, during the retention period has an admission to or a discharge from one of the SUD inpatient bed sections listed above, and LOS
    - < 4 calendar days will have no effect on the measure.
    - At least 4 calendar days, the veteran will be dropped from the previous qualifying track. Upon discharge or transfer from the SUD bed section, he will re-qualify for the measure.

**Scoring**: N/D*100 = Percent

Veterans seen in multiple facilities will be attributed to the facility where the last retention visit occurred in order to promote coordinated transitions between facilities.

- If the veteran is not seen in any substance abuse clinic in VHA during the 1st 30 days of the retention period, he fails the measure. The failure will be attributed to the facility where the 'qualifying' event occurred (i.e. where the 3rd visit occurred that qualified the veteran as beginning a new episode of care or where the veteran was discharged from inpatient SUD care).

- If the veteran is seen for a 1st retention visit in a substance abuse clinic during the 1st 30-day retention period but is not seen again, the patient fails the measure. The failure will be attributed to the facility where the first retention visit occurred.
- If the patient passed the first 30-day retention interval requirement but failed to meet the 2nd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.
- If the patient passed the first and second 30-day retention interval requirement but failed to meet the 3rd 30-day retention interval requirement, the patient fails the measure and the failure is attributed to the facility where the latest retention visit occurred.

**Time frame issues:** Reports include patients who have completed the retention period during the report month or quarter selected. The performance period is consistent with EPRP quarters.

**TABLE B: Substance Use Disorder Reporting Timelines and Workload Inclusion Information**

| EPRP Lagged Quarter | Months included in quarter = Patients completing their retention period in: | OQP Executive Briefing Book Reporting Date | Dormancy Check Range (T- days to first qualification visit date - 90) | Index Episode 1st Qualification Visit Date Range for Outpatient Qualification | Index Episode Qualification Date (T) Range | Index Episode Retention Start Date (T+1) Range | Index Episode Retention Completion Date (T+90) Range |
|---|---|---|---|---|---|---|---|
| 1 | Oct , Nov | First Friday February 09 | 03/06/08 - 05/05/08 | 06/04/08 - 08/30/08 | 07/03/08 - 09/01/08 | 07/04/08- 09/02/08 | 10/01/08 - 11/30/08 |
| 2 | Oct, Nov, Dec, Jan, Feb | First Friday May 09 | 03/06/08 - 08/31/08 | 06/04/08 - 11/29/08 | 07/03/08 - 12/01/08 | 07/04/08- 12/02/08 | 10/01/08- 02/29/09 |
| 3 | Oct, Nov, Dec, Jan, Feb, Mar, Apr, May | First Friday August 09 | 03/06/08 - 12/01/08 | 06/04/08- 02/29/09 | 07/03/08 - 03/02/09 | 07/04/08- 03/03/09 | 10/01/08 - 05/31/09 |
| 4 | Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun, Jul, Aug | Mid-October 09 | 03/06/08 - 03/02/09 | 06/04/08 - 05/31/09 | 07/03/08 - 06/02/09 | 07/04/08- 06/03/09 | 10/01/08- 08/31/09 |

**Data**

- Origin: Workload generated in VistA and sent to AITC. Data submitted after the quarterly report has been collected pertaining to veteran care already reported will be updated during the following quarterly run.
- Sample size & Extraction: 100% from AITC database by OQP.
- Repository: Monthly, facility, VISN, VHA and SSN specific data are available for trouble shooting and understanding local patterns retrospectively after the completion of a retention period; however this is not sufficiently close to 'real time' data to provide prospective tracking during the retention period. See VSSC Web http://vssc.med.va.gov/PM/SUD.asp

Will these sources be used to contribute information for specified period/event?

**TABLE C Events / Data Source Use During Dormancy, Qualification, and Retention Determination**

| | Dormant | Qualifying | Retention |
|---|---|---|---|
| SUD Clinic stops | Yes. SUD clinic stops are used to evaluate the dormant period. E.g. If the patient has SUD clinic stops, they will be considered "NOT dormant" and do not newly qualify for the measure for at least 90 more days. | Yes. SUD clinic stops will be used to qualify a veteran. For example, if a veteran has 3 visits in 30 days, he qualifies in the measure. | Yes. SUD clinic stops will be used to determine retention compliance. |

| TABLE C Events / Data Source Use During Dormancy, Qualification, and Retention Determination | | | |
|---|---|---|---|
| | **Dormant** | **Qualifying** | **Retention** |
| Telephone stop 545 | Yes. Telephone clinic stop 545 will be used to evaluate the dormant period. For example, Pt is receiving SUD 'maintenance' telephone care (545) so will 'show-up' in a search for 'dormant time' and 'count' as SUD visits, therefore the patient will not be 'dormant' if 545 visits are present. | No. 545 will NOT be used to evaluate for qualifying events. E.g. Pt has a true dormant period (no SUD workload in 90 days) then 3 telephone visits in 30 days. This workload will NOT be used to determine a 'qualifying' event. The patient will not be considered newly 'qualified' based on 545 workload. | Yes. 545 clinic stops will be used to determine retention compliance in the 2nd & 3rd period only |
| Inpatient SUD Dischg w/ LOS ≥ 4 calendar days | Yes. Discharge data will be evaluated and considered as active SUD workload when evaluating the dormant period. Therefore, if a patient has an admission or discharge during the dormant period, it will not be considered 'dormant'. | Yes. Discharge data from an inpt SUD bed section will be used as a qualifying event. Such a discharge will 'disconnect/drop' a veteran from any previous qualifying track AND will re-qualify a patient with a new qualifying date. | Yes. If a patient was ADMITTED to a SUD Bed Section during the retention period, those data will be used to 'disconnect' him from the previous qualifying track. He will be re-qualified upon discharge or transfer from the SUD Bed sec. |
| Inpatient w/ SUD Encounters[1] | No. SUD encounters provided on inpatients will NOT be used to evaluate for a dormant period. Therefore if a patient has received SUD consult while an inpatient (on any bed section), it will not be considered when evaluating for a dormant period. If the patient had ONLY inpatient encounters for 90 days, he will be considered as having a 'dormant' period. | No. SUD encounters provided on inpatients will NOT be used to evaluate for qualifying events | Yes. SUD encounters provided on inpatients will be used to evaluate retention compliance |
| Census on SUD bed section w/ LOS ≥ 4 calendar days | No. SUD census data will not be used to evaluate a dormant period (when the patient is discharged, the measure will pick-up the discharge information) | No. SUD census data will not be used to evaluate for a qualifying event (when the patient is discharged, the measure will pick-up the discharge information) | Yes (partially). SUD census data will be used to evaluate whether to 'disconnect' a vet from previous qualifying track. But it will not be used to meet retention visit requirements. The patient will be re-qualified upon discharge from the SUD Bed Section. |

[1] These are 'encounter forms' generated while a patient is admitted to an inpatient bed section. Prior to 2005, 'outpatient' workload for 'inpatients' was 'blocked' at the facility and not submitted to the Austin Automation Center. In 2005, VHA removed this block and allows encounters for professional workload provided to inpatients to be sent to Austin. See Directive 2006-026 at http://vaww.1.va.gov/vhapublications/publications.cfm?pub=1 Attachment A

# Office of Research and Development, Department of Veterans Affairs Fiscal Year 2009 Performance Summary Report To the Office of National Drug Control Policy

## 1. Performance Information

**Performance Measure:** Each fiscal year the Office of Research and Development (ORD) will have at least 10 ongoing studies directly related to substance abuse disorder: 5 ongoing studies related to alcohol abuse and 5 ongoing studies related to other substance abuse.

**How the measure is used in the program:** Most ORD-funded studies are investigator-initiated. Many clinicians who treat patients also perform research, so their research is targeted at diseases and disorders that they treat. Investigators will be encouraged to undertake research in this important area.

**Performance results for the previous fiscal years:** In fiscal year (FY) 2008, ORD funded 17 studies related to substance abuse disorder, 38 related to alcohol abuse, and 14 that were related to both substance abuse disorder and alcohol abuse.

**Comparison of the most recent fiscal year to its target:** The targets for FY 2009 were exceeded. See Table 1.

**Target for the current fiscal year:** Although the actual values (number of studies) exceeded the target for FY 2009, we have not increased the target for FY 2010. This is because there is wide variation in the amount of funding per project. The more expensive studies are usually multisite clinical trials. Leaving the target at its present level would allow flexibility in the types of studies that are funded.

**Procedures used to ensure that the performance data is accurate, complete, and unbiased.** The data is obtained from the Office of Research and Development's (ORD's) database that lists all of its funded projects. A report is produced that lists all funds sent to the VA medical centers for projects on drug and alcohol dependence for the four ORD services for a given fiscal year. The number of projects in the list is counted.

Table 1

| Measure | FY 2008 Actual | FY 2009 Target | FY 2009 Actual | FY 2010 Target |
|---|---|---|---|---|
| Number of ongoing research studies related to substance abuse disorder | 17 | 5 | 20 | 5 |
| Number of ongoing research studies related to alcohol abuse | 38 | 5 | 45 | 5 |
| Number of ongoing research studies related to both substance abuse disorder and alcohol abuse | 14 | | 10 | |

## 2. Management Assertions

**Performance reporting system is appropriate and applied.**

The VA Office of Research and Development (ORD) consists of four main divisions:

**Biomedical Laboratory:** Supports preclinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans.

**Clinical Science:** Administers investigations, including human subject research, to determine feasibility or effectiveness of new treatments (e.g., drugs, therapy, or devices) in small clinical trials or multi-center cooperative studies, aimed at learning more about the causes of disease and developing more effective clinical care.

The Cooperative Studies Program (CSP) is a major division within Clinical Science R&D that specializes in designing, conducting, and managing national and international multi-site clinical trials and epidemiological research.

**Health Services:** Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality healthcare to Veterans.

**Rehabilitation:** Develops novel approaches to restore Veterans with traumatic amputation, central nervous system injuries, loss of sight and/or hearing, or other physical and cognitive impairments to full and productive lives.

**In order for funds to be allocated to a project, they must be entered into the Research Analysis Forecasting Tool (RAFT) database.**

Starting in FY 2009, all Merit Review proposals (our major funding mechanism) were submitted electronically via the eRA Commons system, and projects that were approved for funding were identified. Funding data for these projects were transferred electronically to RAFT. A few Career Development proposals are included in the list of projects. These proposals are not yet submitted via the eRA Commons system, so they are tracked via spreadsheets and uploaded into RAFT manually (HSR&D and RR&D) or electronically (BLR&D and CSR&D). The capability to submit Career Development proposals electronically via eRA Commons is expected to be in place near the end of FY 2010.

**Preparation of the list of projects:**

The BLR&D/CSR&D administrative officer extracted all funded projects for the fiscal year from RAFT and exported the data into an Excel spreadsheet. The alcohol and drug abuse projects were identified by reviewing the title. Any questionable projects were verified as relevant or not relevant upon review of the abstract. In some cases, the title listed was the type of investigator award. For those, the title was obtained from the abstract. There were multiple rows in the spreadsheet for some projects (for example, if there were multiple researchers on the same project). When that occurred, the rows were combined so that there was just one entry (dollars allocated were summed) per project. Project start and end dates were included in the spreadsheet. If there were multiple researchers or a researcher with multiple funds for the same project (e.g., salary award plus Merit Review award), then the earliest start date and latest end date were used. Although great care is taken to provide an inclusive list of projects, our database management system does not have robust reporting capabilities, so some projects may have been omitted.

For FY 2009, no RR&D projects related to drug or alcohol abuse were identified.

**Explanations for not meeting performance targets are reasonable.**
Not applicable. The targets were met.

**Methodology to establish performance targets is reasonable and applied.**
VA Research and Development focuses on research on the special healthcare needs of Veterans and strives to balance the discovery of new knowledge and the application of these discoveries to Veterans' healthcare. VA Research and Development's mission is to "discover knowledge and create innovations that advance the health and care of Veterans and the Nation." ORD supports preclinical, clinical, health services, and rehabilitation research. This research ranges from studies relevant to our aging Veterans (e.g., cancer, heart disease, Alzheimer's disease) to those relevant to younger Veterans returning from

the current conflicts (e.g., PTSD, spinal cord injury). The targets were set at that level to allow flexibility in the projects funded in terms of both subject (e.g., cancer, addiction, heart disease) and type (e.g., preclinical, clinical trials).

**Adequate performance measures exist for all significant drug control activities.** Since many of the projects do not involve direct interaction with patients, the measure looks at the number of projects rather than specific activities.

# ONDCP Circular: Drug Control Accounting

**May 1, 2007**

**TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS**

**SUBJECT:** Annual Accounting and Authentication of Drug Control Funds and Related Performance

1. **Purpose.** This circular provides the policies and procedures to be used by National Drug Control Program agencies in conducting a detailed accounting and authentication of all funds expended on National Drug Control Program activities and the performance measures, targets, and results associated with those activities.

2. **Rescission.** This circular rescinds and replaces the ONDCP Circular, *Annual Accounting of Drug Control Funds*, dated April 18, 2003.

3. **Authority.**

a. 21 U.S.C. § 1704(d) provides: "The Director [ONDCP] shall –

(A) require the National Drug Control Program agencies to submit to the Director not later than February 1 of each year a detailed accounting of all funds expended by the agencies for National Drug Control Program activities during the previous fiscal year, and require such accounting to be authenticated by the Inspector General of each agency prior to submission to the Director; and

(B) submit to Congress not later than April 1 of each year the information submitted to the Director under subparagraph (A)."

b. 21 U.S.C. § 1703(d)(7) authorizes the Director of National Drug Control Policy to "... monitor implementation of the National Drug Control Program, including – (A) conducting program and performance audits and evaluations; and (B) requesting assistance of the Inspector General of the relevant agency in such audits and evaluations ..."

4. **Definitions.** As used in this circular, key terms related to the National Drug Control Program and budget are defined in Section 4 of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007. These terms include: *National Drug Control Program, National Drug Control Program agency, Bureau, Drug Methodology, Drug Control Functions*, and *Budget Decision Units*. Further, Reprogrammings and Fund Control Notices referenced in Section 6 of this circular are defined in Section 6 and Section 8 of the ONDCP Circular, *Budget Execution*, dated May 1, 2007.

5. **Coverage.** The provisions of this circular apply to all National Drug Control Program agencies.

6. **Detailed Accounting Submission.** The Chief Financial Officer (CFO) of each agency, or other accountable senior level senior executive, shall prepare a Detailed Accounting Submission to the Director, ONDCP. For agencies with no bureaus, this submission shall be a single report, as defined by this section. For agencies with bureaus, the Detailed Accounting Submission shall consist of reports, as defined by this section, from the agency's bureaus. The CFO of each bureau, or

accountable senior level executive, shall prepare reports. Each report must include (a) a table highlighting prior year drug control obligations data, and (b) a narrative section making assertions regarding the prior year obligations data. Report elements are further detailed below:

a. **Table of Prior Year Drug Control Obligations** – For the most recently completed fiscal year, each report shall include a table of obligations of drug control budgetary resources appropriated and available during the year being reported.[2] Such table shall present obligations by Drug Control Function and Budget Decision Unit, as these categories are displayed for the agency or bureau in the *National Drug Control Strategy Budget Summary*. Further, this table shall be accompanied by the following disclosures:

(1) **Drug Methodology** – The drug methodology shall be specified in a separate exhibit. For obligations calculated pursuant to a drug methodology, this presentation shall include sufficient detail to explain fully the derivation of all obligations data presented in the table.

(a) **Obligations by Drug Control Function** – All bureaus employ a drug methodology to report obligations by Drug Control Function.

(b) **Obligations by Budget Decision Unit** – For certain multi-mission bureaus – Customs and Border Protection (CBP), Coast Guard, Immigration and Customs Enforcement (ICE), Indian Health Service (IHS), Bureau of Indian Affairs (BIA), and the Veterans Health Administration (VHA) – obligations reported by Budget Decision Unit shall be calculated pursuant to an approved drug methodology. For all other bureaus, drug control obligations reported by Budget Decision Unit shall represent 100 percent of the actual obligations of the bureau for those Budget Decision Units, as they are defined for the National Drug Control Budget. (See Attachment B of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007.)

(2) **Methodology Modifications** – Consistent with ONDCP's prior approval, if the drug methodology has been modified from the previous year, then the changes, their purpose, and the quantitative differences in the amount(s) reported using the new method versus the amount(s) that would have been reported under the old method shall be disclosed.[3]

(3) **Material Weaknesses or Other Findings** – Any material weakness or other findings by independent sources, or other known weaknesses, including those identified in the Agency's Annual Statement of Assurance, which may affect the presentation of prior

[2] Consistent with reporting requirements of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007, resources received from the following accounts are excluded from obligation estimates: (1) ONDCP – High Intensity Drug Trafficking Areas (HIDTA) and (2) DOJ – Organized Crime Drug Enforcement Task Force Program. Obligations against these resources shall be excluded from table required by this section but shall be reported on a consolidated basis by these bureaus. Generally, to prevent double-counting agencies should not report obligations against budget resources received as a reimbursement. An agency that is the source of the budget authority for such reimbursements shall be the reporting entity under this circular.

[3] For changes that did not receive prior approval, the agency or bureau shall submit such changes to ONDCP for approval under separate cover.

year drug-related obligations data, shall be highlighted. This may be accomplished by either providing a brief written summary, or by referencing and attaching relevant portions of existing assurance reports. For each material weakness or other finding, corrective actions currently underway or contemplated shall be identified.

(4) **Reprogrammings or Transfers** – All prior year reprogrammings or transfers that affected drug-related budgetary resources shall be identified; for each such reprogramming or transfer, the effect on drug-related obligations reported in the table required by this section also shall be identified.

(5) **Other Disclosures** – Agencies may make such other disclosures as they feel are necessary to clarify any issues regarding the data reported under this circular.

b. **Assertions** – At a minimum, each report shall include a narrative section where the following assertions are made regarding the obligation data presented in the table required by Section 6a:

(1) **Obligations by Budget Decision Unit** – With the exception of the multi-mission bureaus noted in Section 6a(1)(b), reports under this section shall include an assertion that obligations reported by budget decision unit are the actual obligations from the bureau's accounting system of record for these Budget Decision Units.

(2) **Drug Methodology** – An assertion shall be made regarding the reasonableness and accuracy of the drug methodology used to calculate obligations of prior year budgetary resources by function for all bureaus and by budget decision unit for the CBP, Coast Guard, ICE, IHS, BIA, and VHA. The criteria associated with this assertion are as follows:

(a) **Data** – If workload or other statistical information supports the drug methodology, then the source of these data and the current connection to drug control obligations should be well documented. If these data are periodically collected, then the data used in the drug methodology must be clearly identified and will be the most recently available.

(b) **Other Estimation Methods** – If professional judgment or other estimation methods are used as part of the drug methodology, then the association between these assumptions and the drug control obligations being estimated must be thoroughly explained and documented. These assumptions should be subjected to periodic review, in order to confirm their continued validity.

(c) **Financial Systems** - Financial systems supporting the drug methodology should yield data that fairly present, in all material respects, aggregate obligations from which drug-related obligation estimates are derived.

(3) **Application of Drug Methodology** – Each report shall include an assertion that the drug methodology disclosed in this section was the actual methodology used to generate the table required by Section 6a. Calculations must be sufficiently well

documented to independently reproduce these data. Calculations should also provide a means to ensure consistency of data between reporting years.

(4) **Reprogrammings or Transfers** – Further, each report shall include an assertion that the data presented are associated with obligations against a financial plan that, if revised during the fiscal year, properly reflects those changes, including ONDCP's approval of reprogrammings or transfers affecting drug-related resources in excess of $1 million.

(5) **Fund Control Notices** – Each report shall also include an assertion that the data presented are associated with obligations against a financial plan that fully complied with all Fund Control Notices issued by the Director under 21 U.S.C. § 1703(f) and Section 8 of the ONDCP Circular, *Budget Execution*.

7. **Performance Summary Report.** The CFO, or other accountable senior level senior executive, of each agency for which a Detailed Accounting Submission is required, shall provide a Performance Summary Report to the Director of National Drug Control Policy. Each report must include performance-related information for National Drug Control Program activities, and the official is required to make certain assertions regarding that information. The required elements of the report are detailed below.

**a. Performance Reporting-** The agency's Performance Summary Report must include each of the following components:

(1) **Performance Measures** – The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: reflect the purpose of the program; contribute to the National Drug Control Strategy; and are used in the management of the program. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.

(2) **Prior Years Performance Targets and Results** – For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recent fiscal year with the projected (target) levels of performance established in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

(3) **Current Year Performance Targets** – Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.

(4) **Quality of Performance Data** – The agency must state the procedures used to ensure the performance data described in this report are accurate, complete, and unbiased in presentation and substance.

**(b) Assertions** – Each report shall include a letter in which an accountable agency official makes the following assertions are made regarding the information presented in Section 7a:

(1) **Performance reporting system is appropriate and applied** – The agency has a system to capture performance information accurately and that system was properly applied to generate the performance data.

(2) **Explanations for not meeting performance targets are reasonable** – An assertion shall be made regarding the reasonableness of any explanation offered for failing to meet a performance target and for any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets.

(3) **Methodology to establish performance targets is reasonable and applied** – An assertion that the methodology described above to establish performance targets for the current year is reasonable given past performance and available resources.

(4) **Adequate performance measures exist for all significant drug control activities** - Each Report shall include an assertion that the agency has established at least one acceptable performance measure for each Drug Control Decision Unit identified in reports required by section 6a(1)(A) for which a significant amount of obligations ($1,000,000 or 50 percent of the agency drug budget, whichever is less) were incurred in the previous fiscal year. Each performance measure must consider the intended purpose of the National Drug Control Program activity. The criteria associated with these assertions are as follows:

(a) **Data** – If workload, participant, or other quantitative information supports these assertions, the sources of these data should be well documented. If these data are periodically collected, the data used in the report must be clearly identified and will be the most recently available.

(b) **Other Estimation Methods** – If professional judgment or other estimation methods are used to make these assertions, the objectivity and strength of these estimation methods must be thoroughly explained and documented. These estimation methods should be subjected to periodic review to confirm their continued validity.

**(c) Reporting Systems** – Reporting systems supporting the assertions should be current, reliable, and an integral part of the agency's budget and management processes.

8. **Inspector General Authentication.** Each report defined in Sections 6 and 7 shall be provided to the agency's Inspector General (IG) for the purpose of expressing a conclusion about the reliability of each assertion made in the report. ONDCP anticipates that this engagement will be an

attestation review, consistent with the *Statements for Standards of Attestation Engagements*, promulgated by the American Institute of Certified Public Accountants.

9. **Unreasonable Burden.** Unless a detailed report, as specified in Section 6, is specifically requested by ONDCP, an agency or bureau included in the National Drug Control Budget with prior year drug-related obligations of less than $50 million may submit through its CFO, or its accountable senior level executive, an alternative report to ONDCP, consisting of only the table highlighted in Section 6a., omitting all other disclosures. Such a report will be accompanied by statements from the CFO, or accountable senior level executive, and the agency IG attesting that full compliance with this Circular would constitute an unreasonable reporting burden. In those instances, obligations reported under this section will be considered as constituting the statutorily required detailed accounting, unless ONDCP notifies the agency that greater detail is required.

10. **Point of Contact and Due Dates.** Each agency CFO, or accountable senior level executive, shall transmit a Detailed Accounting Submission, consisting of the report(s) defined in Sections 6 and 7, along with the IG's authentication(s) defined in Section 8, to the attention of the Associate Director for Performance and Budget, Office of National Drug Control Policy, Washington, DC 20503. Detailed Accounting Submissions, with the accompanying IG authentication(s), are due to ONDCP by February 1 of each year. Agency management must submit reports to their Office of Inspector General (OIG) in sufficient time to allow for review and IG authentication under Section 8 of this Circular. ONDCP recommends a 31 December due date for agencies to provide their respective OIG with the required reports and information.

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Office of General Counsel
Chief Patient Care Services Officer, Veterans Health Administration
Chief Quality and Performance Officer, Veteran Health Administration
Chief Research and Development Officer, Veterans Health Administration
Chief Financial Officer, Veterans Health Administration
Deputy Chief, Patient Care Services Officer for Mental Health, Veterans Health Administration
Director, Management Review Service, Veterans Health Administration
Director of Performance Management, Veterans Health Administration

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
Office of National Drug Control Policy

VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

# Department of Veterans Affairs

*Independent Review of VA's Fiscal Year 2009 Detailed Accounting Submission to the Office of National Drug Control Policy*

March 8, 2010
10-01106-95

**To Report Suspected Wrongdoing in VA Programs and Operations:**
**Telephone: 1-800-488-8244**
**E-mail: vaoighotline@va.gov**
**(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)**

**Department of Veteran Affairs**

# Memorandum

Date: March 4, 2010

From: Assistant Inspector General for Audits and Evaluations (52)

Subject: Final Report – Independent Review of VA's Fiscal Year 2009 Detailed Accounting Submission to the Office of National Drug Control Policy

To: Chief Financial Officer, Veterans Health Administration (17)

1. The Office of National Drug Control Policy (ONDCP) requires the Department of Veterans Affairs (VA) to submit an annual Detailed Accounting Submission (Submission), as authorized by 21 U.S.C. §1704(d) and ONDCP Circular, *Drug Control Accounting* (Circular), date May 1, 2007, to ONDCP. The Submission, including the assertions made, is the responsibility of VA's management and it is included in this report as Attachment A. The Circular is included as Attachment B.

2. We reviewed VA management's assertions as required by the Circular concerning its drug methodology, reprogrammings and transfers, and fund control notices. The assertions are found in the Submission on page 7.

3. Our review was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination, the objective of which is the expression of an opinion on the assertions in the Submission. Accordingly, we do not express such an opinion.

4. Our report, *Audit of VA's Consolidated Financial Statements for Fiscal Years 2009 and 2008* (Report No. 09-00976-25, November 16, 2009), identified four material weaknesses. Three of the four material weaknesses were repeat conditions from the prior year audit and identified as (i) financial management system functionality,

(ii) information technology security controls and (iii) financial management oversight. The fourth material weakness, compensation, pension, and burial liabilities, was identified during the fiscal year 2009 audit.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected.

5. Based upon our review, except for the effects, if any, of the material weaknesses discussed in the fourth paragraph of this report, nothing came to our attention that caused us to believe that management's assertions included in the accompanying Submission of this report are not fairly stated in all material respects based on the criteria set forth in the Circular.

6. We provided you our draft report for review. You concurred with our report without further comments.

7. This report is intended solely for the information and use of the U.S. Congress, the ONDCP, and VA management. This report is not intended to be and should not be used by anyone other than these specified parties.

*(original signed by:)*
Belinda J. Finn

Attachments

**Attachment A**

**Statement of Disclosures and Assertions for FY 2009 Drug Control Expenditures Submitted to Office of National Drug Control Policy (ONDCP) for FY Ending September 30, 2009**

In accordance with ONDCP's Circular, Drug Control Accounting, dated May 1, 2007, the Veterans Health Administration asserts that the VHA system of accounting, use of actuals, and systems of internal controls provide reasonable assurance that:

Expenditures and Obligations are based upon the actual expenditures as reported by the Decision Support System (DSS).

The methodology used to calculate expenditures of budgetary resources is reasonable and accurate in all material respects and as described herein was the actual methodology used to generate the costs.

Accounting changes are as shown in the disclosures that follow.

**Attachment A**

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
Annual Reporting of FY 2009 Drug Control Funds

DETAILED ACCOUNTING SUBMISSION

**A. Table of FY 2009 Drug Control Obligations**

| (In Millions) | |
|---|---|
| Description | FY 2009 Final |
| **Drug Control Resources by Function:** | |
| Treatment | $377.751 |
| Research & Development | $15.034 |
| Total | $392.785 |
| | |
| Drug Control Resources by Budget Decision Unit: | |
| Medical Care | $377.751 |
| Research & Development | $15.034 |
| Total | $392.785 |

1. Drug Control Methodology

Decision Support System

The 2009 actuals are based on costs using the Decision Support System (DSS) which is the official Managerial Cost Accounting System for VA. DSS maps cost to departments, which are then assigned to one of 56,000 intermediate products using Relative Value Units (RVU). Relative Value Units are defined as the determining factor of how much resources it takes to produce an intermediate product. Each Cost Category, for example Fixed Direct Labor or Variable Labor, has an RVU for each intermediate product. All intermediate products are assigned to an actual patient encounter, either inpatient or outpatient, using the patient care data bases. In DSS, the costs are not averaged; rather they are reported by the total of the encounters and can be drilled down to a specific patient. Also, DSS includes all overhead costs assigned to a facility to include Headquarters, National programs and Network Costs. DSS does not include the costs of capital expenditures; however, it does account for depreciation costs.

VHA has in place a national system of performance monitoring that uses social, professional, and financial incentives to encourage facilities to provide the highest quality health care. This system incorporates performance measures related to substance use disorder treatment.

Efforts to assist programs experiencing difficulty in achieving their performance goals continue through the Centers of Excellence in Substance Abuse Treatment and Education, the Program Evaluation and Research Center and the Office of the Associate Chief Consultant for Addictive Disorders.

**Attachment A**

According to the 2008 *Drug and Alcohol Program Survey* (DAPS) at the end of Fiscal Year 2008, the Department of Veterans Affairs operated a national network of 260 substance use disorder treatment programs located in the Department's medical centers, mental health residential rehabilitation treatment programs and outpatient clinics. Current programs consist of 2 medical inpatient programs, 73 residential rehabilitation programs, 112 intensive outpatient programs, and 73 standard outpatient programs. (It should be noted that identification of these programs involves a "roll up" procedure. Lower intensity programs are not counted separately from a higher intensity level program if the lower level intensity program functions as an integrated component of the higher intensity program.) Based on on-going assessment activities, as of the end of 2009, 12 additional intensive outpatient substance use disorder programs have been added since the 2008 DAPS.

VA provides three types of 24 hour a day care to patients having particularly severe substance use disorders. Two inpatient programs offer acute care, detoxification, and initial stabilization services. Such specialized inpatient treatment for substance use disorders has become rare in VA, just as it has in other parts of the healthcare system, and the remaining substance use disorder inpatient programs in the VA are currently in the process of transitioning into residential rehabilitation programs. These join the large set of 24 hour care settings already classified as residential rehabilitation treatment programs. Finally, 24 hour care is provided for detoxification in numerous inpatient medical and general mental health units throughout the VA system.

Most Veterans with substance use disorders are treated in outpatient programs. Intensive substance use disorder outpatient programs provide more than three hours of service per day to each patient, and patients attend them three or more days per week. Standard outpatient programs typically treat patients for an hour or two per treatment day, and patients attend one or two days a week.

In keeping with modern medical practice, the Veterans Health Administration (VHA) continues to improve service delivery and efficiency by integrating services for mental health disorders, including substance use disorder, into primary care settings. Likewise, treatment of substance use disorders has been coordinated more closely with treatment of other mental health conditions. For example, substance use disorders specialist positions have been funded to directly augment care for patients receiving care through post traumatic stress disorder teams or services at each of the VA medical centers.

VA has implemented a major initiative to create primary care-oriented buprenorphine clinics to increase access to care for opiate-dependent veterans and is implementing initiatives to expand access to intensive outpatient services and to include substance use disorder specialists in large community based outpatient clinics, mental health residential rehabilitation programs, and services for homeless Veterans.

The VA investment in health care and specialized treatment of veterans with drug abuse problems, funded by the resources in Medical Care appropriation, helps avoid future health, welfare and crime costs associated with illegal drug use.

In FY 2009, VHA provided specialty substance abuse treatment to 114,457 veterans who had a diagnosed problem with illicit drugs, a substantial increase over FY 2008. The most prevalent drug used was cocaine, followed by heroin, cannabis and amphetamines, respectively. About two-thirds of VA drug abuse patients were in Means Test Category A, reflecting very low income. About one-fourth of these patients had a service-connected disability (the term

"service-connected" refers to injuries sustained in military service, especially those injuries occurring as a result of military action).

The accompanying Department of Veterans Affairs Resource Summary was prepared in accordance with the following Office of National Drug Control Policy (ONDCP) circulars (a) Annual Accounting of Drug Control Funds, dated May 1, 2007, (b) Budget Instructions and Certification Procedures, dated May 1, 2007, and (c) Budget Execution, dated May 1, 2007. In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology only incorporates Specialized Treatment costs.

VA considers substance abuse to include both alcohol abuse and drug abuse. Both conditions are treated in VA substance abuse clinics. ONDCP has requested that VA provide information only on drug abuse patients. To that end, VA has determined the percentage of patients treated in substance abuse settings for residential rehabilitation and treatment substance abuse programs, inpatient treatments in specialized substance abuse programs, and outpatient substance abuse clinics.

VA considers Special Treatment costs to be all costs generated by the treatment of patients with drug use disorders treated in specialized substance abuse treatment programs. For the specialized substance abuse treatment programs and clinics, VA used Decision Support System (DSS) data.

| Specialized Treatment | Obligations (Millions) | Drug Control Related Percent | FTE |
|---|---|---|---|
| Inpatient | $15.537 | 61.9%[1] | 67 |
| Residential Rehabilitation & Treatment | $137.384 | 85.4%[2] | 1,085 |
| Outpatient | $224.830 | 89.2%[3] | 1,612 |
| Total | $377.751 | | 2,764 |

DSS data is used to determine costs in various bed sections and clinical settings. All expenses for specialized inpatient, outpatient care, and extended care are incorporated in the spending mode.

VA does not track obligations and expenditures by ONDCP function. In the absence of such capability, actuals have been furnished, as indicted.

[1] Percent of all Substance Use Disorder Inpatients seen in a Specialized Substance Use Disorder Unit with a drug diagnosis.
[2] Percent of all Substance Use Disorder Extended Care Patients seen in a Specialized Substance Use Disorder Unit with a drug diagnosis.
[3] Percent of all Substance Use Disorder Clinic Stops made by drug patients.

RESEARCH & DEVELOPMENT

The dollars expended in VHA research help to acquire new knowledge to improve the prevention, diagnosis and treatment of disease, and generate new knowledge to improve the effectiveness, efficiency, accessibility and quality of veterans' health care.

| Specialized Function | Obligations (Millions) | Drug Control Related Percent | FTE |
|---|---|---|---|
| Research & Development | $15.034 | N/A | N/A |

2. Methodology Modifications – In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology only incorporates Specialized Treatment costs and no longer takes into consideration Other Related Treatment costs. Drug control methodology detailed in A.1 was the actual methodology used to generate the Resource Summary.

3. Material Weaknesses or Other Findings – Deloitte and Touche LLP provided an unqualified opinion on VA's fiscal year 2009 and 2008 consolidated financial statements. They also identified four material weakneeses. Three of the four material weaknesses are repeat conditions from the prior year audit and identified as (i) financial management system functionality (ii) information technology security controls and (iii) financial management oversight. The fourth material weakness, compensation, pension, and burial liabilities, was identified during the fiscal year 2009 audit. There were no material weaknesses or other findings by independent sources, or other known weaknesses, which may affect the presentation of prior year drug-related obligations data.

4. Reprogrammings or Transfers – There was no reprogramming of funds or transfers that adjusted drug control-related funding because drug control expenditures are reported on the basis of patients served in various VA clinical settings for specialized substance abuse treatment programs.

5. Other Disclosures – This budget accounts for drug control-related costs for VHA Medical Care and Research. It does not include all drug-related costs for the agency. VA incurs costs related to accounting and security of narcotics and other controlled substances and costs of law enforcement related to illegal drug activity; however, these costs are assumed to be relatively small and would not have a material effect on the reported costs.

**B. Assertions**

1. Drug Methodology – VA asserts that the methodology used to estimate FY 2009 drug control obligations by function and budget decision unit is reasonable and accurate based on the criteria set forth in the ONDCP Circular dated May 1, 2007.

2. Application of Methodology – The methodology described in Section A.1 above was used to prepare the estimates contained in this report.

3. Reprogrammings or Transfers – No changes were made to VA's Financial Plan that required ONDCP approval per the ONDCP Circular dated May 1, 2007.

4. Fund Control Notices – The data presented are associated with obligations against a financial plan that was based upon a methodology in accordance with all Fund Control

**Attachment A**

Notices issued by the Director under 21 U.S.C., § 1703 (f) and Section 8 of the ONDCP Circular, Budget Execution

Mark W. Yow
Associate Chief Financial Officer
Resource Management Office (172)

February 4, 2010
Date

Calvin L. Seay, Jr.
Director of Budget Services
Resource Management Office (172)

February 4, 2010
Date

**Attachment A**

Department of Veterans Affairs
Resource Summary
Obligations (In Millions)

| | 2009 Final |
|---|---|
| Medical Care: | |
| Specialized Treatment | |
| Residential Rehabilitation & Treatment | $137.384 |
| Inpatient | $16.537 |
| Outpatient | $224.830 |
| Specialized Treatment | $377.751 |
| Research & Development | $15.034 |
| Drug Control Resources by Function & Decision Unit, Total | $392.785 |
| Drug Control Resources Personnel Summary | |
| Total FTE | 2.764 |
| Total Enacted Appropriations | $99,793.085 |
| Drug Control Percentage | 0.39% |

**Attachment B**

# ONDCP Circular: Drug Control Accounting
**May 1, 2007**

**TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS**

**SUBJECT:** Annual Accounting and Authentication of Drug Control Funds and Related Performance

1. **Purpose.** This circular provides the polices and procedures to be used by National Drug Control Program agencies in conducting a detailed accounting and authentication of all funds expended on National Drug Control Program activities and the performance measures, targets, and results associated with those activities.

2. **Rescission.** This circular rescinds and replaces the ONDCP Circular, *Annual Accounting of Drug Control Funds*, dated April 18, 2003.

3. **Authority.**

a. 21 U.S.C. § 1704(d) provides: "The Director [ONDCP] shall –

(A) require the National Drug Control Program agencies to submit to the Director not later than February 1 of each year a detailed accounting of all funds expended by the agencies for National Drug Control Program activities during the previous fiscal year, and require such accounting to be authenticated by the Inspector General of each agency prior to submission to the Director; and

(B) submit to Congress not later than April 1 of each year the information submitted to the Director under subparagraph (A)."

b. 21 U.S.C. § 1703(d)(7) authorizes the Director of National Drug Control Policy to "... monitor implementation of the National Drug Control Program, including – (A) conducting program and performance audits and evaluations; and (B) requesting assistance of the Inspector General of the relevant agency in such audits and evaluations ..."

4. **Definitions.** As used in this circular, key terms related to the National Drug Control Program and budget are defined in Section 4 of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007. These terms include: *National Drug Control Program, National Drug Control Program agency, Bureau, Drug Methodology, Drug Control Functions*, and *Budget Decision Units*. Further, Reprogrammings and Fund Control Notices referenced in Section 6 of this circular are defined in Section 6 and Section 8 of the ONDCP Circular, *Budget Execution*, dated May 1, 2007.

5. **Coverage.** The provisions of this circular apply to all National Drug Control Program agencies.

6. **Detailed Accounting Submission.** The Chief Financial Officer (CFO) of each agency, or other accountable senior level senior executive, shall prepare a Detailed Accounting Submission to

**Attachment B**

the Director, ONDCP. For agencies with no bureaus, this submission shall be a single report, as defined by this section. For agencies with bureaus, the Detailed Accounting Submission shall consist of reports, as defined by this section, from the agency's bureaus. The CFO of each bureau, or accountable senior level executive, shall prepare reports. Each report must include (a) a table highlighting prior year drug control obligations data, and (b) a narrative section making assertions regarding the prior year obligations data. Report elements are further detailed below:

a. **Table of Prior Year Drug Control Obligations** – For the most recently completed fiscal year, each report shall include a table of obligations of drug control budgetary resources appropriated and available during the year being reported.[1] Such table shall present obligations by Drug Control Function and Budget Decision Unit, as these categories are displayed for the agency or bureau in the *National Drug Control Strategy Budget Summary*. Further, this table shall be accompanied by the following disclosures:

(1) **Drug Methodology** – The drug methodology shall be specified in a separate exhibit. For obligations calculated pursuant to a drug methodology, this presentation shall include sufficient detail to explain fully the derivation of all obligations data presented in the table.

(a) **Obligations by Drug Control Function** – All bureaus employ a drug methodology to report obligations by Drug Control Function.

(b) **Obligations by Budget Decision Unit** – For certain multi-mission bureaus – Customs and Border Protection (CBP), Coast Guard, Immigration and Customs Enforcement (ICE), Indian Health Service (IHS), Bureau of Indian Affairs (BIA), and the Veterans Health Administration (VHA) – obligations reported by Budget Decision Unit shall be calculated pursuant to an approved drug methodology. For all other bureaus, drug control obligations reported by Budget Decision Unit shall represent 100 percent of the actual obligations of the bureau for those Budget Decision Units, as they are defined for the National Drug Control Budget. (See Attachment B of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007.)

(2) **Methodology Modifications** – Consistent with ONDCP's prior approval, if the drug methodology has been modified from the previous year, then the changes, their purpose, and the quantitative differences in the amount(s) reported using the new

[1] Consistent with reporting requirements of the ONDCP Circular, *Budget Formulation*, dated May 1, 2007, resources received from the following accounts are excluded from obligation estimates: (1) ONDCP – High Intensity Drug Trafficking Areas (HIDTA) and (2) DOJ – Organized Crime Drug Enforcement Task Force Program. Obligations against these resources shall be excluded from table required by this section but shall be reported on a consolidated basis by these bureaus. Generally, to prevent double-counting agencies should not report obligations against budget resources received as a reimbursement. An agency that is the source of the budget authority for such reimbursements shall be the reporting entity under this circular.

method versus the amount(s) that would have been reported under the old method shall be disclosed.[2]

(3) **Material Weaknesses or Other Findings** – Any material weakness or other findings by independent sources, or other known weaknesses, including those identified in the Agency's Annual Statement of Assurance, which may affect the presentation of prior year drug-related obligations data, shall be highlighted. This may be accomplished by either providing a brief written summary, or by referencing and attaching relevant portions of existing assurance reports. For each material weakness or other finding, corrective actions currently underway or contemplated shall be identified.

(4) **Reprogrammings or Transfers** – All prior year reprogrammings or transfers that affected drug-related budgetary resources shall be identified; for each such reprogramming or transfer, the effect on drug-related obligations reported in the table required by this section also shall be identified.

(5) **Other Disclosures** – Agencies may make such other disclosures as they feel are necessary to clarify any issues regarding the data reported under this circular.

b. **Assertions** – At a minimum, each report shall include a narrative section where the following assertions are made regarding the obligation data presented in the table required by Section 6a:

(1) **Obligations by Budget Decision Unit** – With the exception of the multi-mission bureaus noted in Section 6a(1)(b), reports under this section shall include an assertion that obligations reported by budget decision unit are the actual obligations from the bureau's accounting system of record for these Budget Decision Units.

(2) **Drug Methodology** – An assertion shall be made regarding the reasonableness and accuracy of the drug methodology used to calculate obligations of prior year budgetary resources by function for all bureaus and by budget decision unit for the CBP, Coast Guard, ICE, IHS, BIA, and VHA. The criteria associated with this assertion are as follows:

(a) **Data** – If workload or other statistical information supports the drug methodology, then the source of these data and the current connection to drug control obligations should be well documented. If these data are periodically collected, then the data used in the drug methodology must be clearly identified and will be the most recently available.

[2] For changes that did not receive prior approval, the agency or bureau shall submit such changes to ONDCP for approval under separate cover.

(b) **Other Estimation Methods** – If professional judgment or other estimation methods are used as part of the drug methodology, then the association between these assumptions and the drug control obligations being estimated must be thoroughly explained and documented. These assumptions should be subjected to periodic review, in order to confirm their continued validity.

(c) **Financial Systems** – Financial systems supporting the drug methodology should yield data that fairly present, in all material respects, aggregate obligations from which drug-related obligation estimates are derived.

(3) **Application of Drug Methodology** – Each report shall include an assertion that the drug methodology disclosed in this section was the actual methodology used to generate the table required by Section 6a. Calculations must be sufficiently well documented to independently reproduce these data. Calculations should also provide a means to ensure consistency of data between reporting years.

(4) **Reprogrammings or Transfers** – Further, each report shall include an assertion that the data presented are associated with obligations against a financial plan that, if revised during the fiscal year, properly reflects those changes, including ONDCP's approval of reprogrammings or transfers affecting drug-related resources in excess of $1 million.

(5) **Fund Control Notices** – Each report shall also include an assertion that the data presented are associated with obligations against a financial plan that fully complied with all Fund Control Notices issued by the Director under 21 U.S.C. § 1703(f) and Section 8 of the ONDCP Circular, *Budget Execution.*

7. **Performance Summary Report.** The CFO, or other accountable senior level senior executive, of each agency for which a Detailed Accounting Submission is required, shall provide a Performance Summary Report to the Director of National Drug Control Policy. Each report must include performance-related information for National Drug Control Program activities, and the official is required to make certain assertions regarding that information. The required elements of the report are detailed below.

**a. Performance Reporting-** The agency's Performance Summary Report must include each of the following components:

(1) **Performance Measures** – The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: reflect the purpose of the program; contribute to the National Drug Control Strategy; and are used in the management of the program. The description must include sufficient detail to permit

non-experts to understand what is being measured and why it is relevant to those activities.

(2) **Prior Years Performance Targets and Results** – For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recent fiscal year with the projected (target) levels of performance established in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

(3) **Current Year Performance Targets** – Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.

(4) **Quality of Performance Data** – The agency must state the procedures used to ensure the performance data described in this report are accurate, complete, and unbiased in presentation and substance.

**(b) Assertions** – Each report shall include a letter in which an accountable agency official makes the following assertions are made regarding the information presented in Section 7a:

(1) **Performance reporting system is appropriate and applied** – The agency has a system to capture performance information accurately and that system was properly applied to generate the performance data.

(2) **Explanations for not meeting performance targets are reasonable** - An assertion shall be made regarding the reasonableness of any explanation offered for failing to meet a performance target and for any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets.

(3) **Methodology to establish performance targets is reasonable and applied** – An assertion that the methodology described above to establish performance targets for the current year is reasonable given past performance and available resources.

(4) **Adequate performance measures exist for all significant drug control activities** - Each Report shall include an assertion that the agency has established at least one acceptable performance measure for each Drug Control Decision Unit identified in reports required by section 6a(1)(A) for which a significant mount of obligations

**Attachment B**

($1,000,000 or 50 percent of the agency drug budget, whichever is less) were incurred in the previous fiscal year. Each performance measure must consider the intended purpose of the National Drug Control Program activity.

The criteria associated with these assertions are as follows:

(a) **Data** – If workload, participant, or other quantitative information supports these assertions, the sources of these data should be well documented. If these data are periodically collected, the data used in the report must be clearly identified and will be the most recently available.

(b) **Other Estimation Methods** – If professional judgment or other estimation methods are used to make these assertions, the objectivity and strength of these estimation methods must be thoroughly explained and documented. These estimation methods should be subjected to periodic review to confirm their continued validity.

(c) **Reporting Systems** – Reporting systems supporting the assertions should be current, reliable, and an integral part of the agency's budget and management processes.

8. **Inspector General Authentication.** Each report defined in Sections 6 and 7 shall be provided to the agency's Inspector General (IG) for the purpose of expressing a conclusion about the reliability of each assertion made in the report. ONDCP anticipates that this engagement will be an attestation review, consistent with the *Statements for Standards of Attestation Engagements*, promulgated by the American Institute of Certified Public Accountants.

9. **Unreasonable Burden.** Unless a detailed report, as specified in Section 6, is specifically requested by ONDCP, an agency or bureau included in the National Drug Control Budget with prior year drug-related obligations of less than $50 million may submit through its CFO, or its accountable senior level executive, an alternative report to ONDCP, consisting of only the table highlighted in Section 6a., omitting all other disclosures. Such a report will be accompanied by statements from the CFO, or accountable senior level executive, and the agency IG attesting that full compliance with this Circular would constitute an unreasonable reporting burden. In those instances, obligations reported under this section will be considered as constituting the statutorily required detailed accounting, unless ONDCP notifies the agency that greater detail is required.

10. **Point of Contact and Due Dates.** Each agency CFO, or accountable senior level executive, shall transmit a Detailed Accounting Submission, consisting of the report(s) defined in Sections 6 and 7, along with the IG's authentication(s) defined in Section 8, to the attention of the Associate Director for Performance and Budget, Office of National Drug Control Policy, Washington, DC 20503. Detailed Accounting Submissions, with the accompanying IG authentication(s), are due to ONDCP by February 1 of each year. Agency management must submit reports to their Office of Inspector General (OIG) in sufficient time to allow for review and IG authentication under Section 8 of this Circular. ONDCP recommends a 31 December due date for agencies to provide their respective OIG with the required reports and information.

**Attachment C**

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Office of General Counsel
Assistant Secretary for Management
Chief Financial Officer for Veterans Health Administration

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
Office of National Drug Control Policy


# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Improper Funding of College Degrees, Failure to Administer and Follow Policy, and Misuse of Government Resources
# VHA Office of Finance

Report No. 07-00429-115

April 22, 2009

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Chief Financial Officer, Veterans Health Administration (17)

**SUBJECT:** Administrative Investigation – Improper Funding of College Degrees, Failure to Administer and Follow Policy, and Misuse of Government Resources, VHA Office of Finance, Washington, DC (2007-00429-IQ-0035)

## Summary

We substantiated that the (b)(7)(C) (b)(7)(C) improperly authorized the expenditure of $86,807.48 in VA funds to pay for academic (undergraduate and graduate) degrees for two employees and that he failed to administer VA policy. We also substantiated that a (b)(7)(C) misused his Government-issued purchase card; that he violated and directed a new employee at a lower grade to violate Federal acquisition regulations; and that he misused VA-owned computer systems to access sexually explicit or sexually oriented material. In addition, we substantiated that the (b)(7)(C) misrepresented facts and displayed a lack of candor to the VHA CFO, to a VHA Auditor, and to VA Office of Inspector General (OIG) investigators. Furthermore, we found two $2,400 purchase card payments which were not applied as intended or properly refunded to VA.

## Introduction

The VA OIG Administrative Investigations Division investigated allegations that (b)(7)(C) improperly approved the expenditure of $86,807.48 to pay for academic degrees for two employees and that he failed to properly administer VA policy pertaining to training and to Government-issued purchase cards. We also investigated whether (b)(7)(C) and a former VA Analyst improperly received their academic degrees at VA expense. Further, we investigated whether (b)(7)(C) misused his Government-issued purchase card; violated, and directed a new employee at a lower grade to violate, Federal Acquisition Regulations and VA purchase card policies; and whether he misused VA computer systems to access sexually explicit or sexually oriented materials. Finally, we

investigated whether (b)(7)(C) misrepresented facts and displayed a lack of candor to the VHA CFO, to a VHA Auditor, and to VA OIG.

To assess these allegations, we interviewed (b)(7)(C) and the former Analyst. We also interviewed the former and current VHA Chief Financial Officers and other VA personnel in Washington, DC; Boston, Massachusetts; Denver, Colorado; and Austin, Texas. We reviewed academic and financial records; VA purchase card transaction records; various VHA Office of Finance internal documents, to include a Purchase Card program audit report, policy statements, and VA contracting documents; email records, and applicable Federal laws, regulations, and VA policy.

## Results

### Issue 1: Whether Mr. Strong Authorized Improper Funding of Academic Degrees and Improperly Administered VA Training Policy

*Legal and Policy Requirements*

The Government Employee's Training Act of 1958 prohibits the use of training funds for the sole purpose of providing an employee with an academic degree, whether or not the degree was needed to qualify for a job, unless the training was needed to assist in the recruitment or retention of employees in shortage occupations. Public Law 85-507, 5 USC § 4107 (2002), 5 CFR § 410.308 (2002). The Homeland Security Act of 2002 amended the training Act by expanding an agency's authority to pay or reimburse an employee for the costs of academic degree training, if the training contributed to meeting an identified training need, resolved an identified staffing problem, or accomplished goals in the strategic plan of the agency. The amended statute continued to prohibit an agency from paying for academic degrees for employees for the sole purpose of providing an employee with an academic degree or qualifying the employee for an appointment to a position for which the academic degree is a basic requirement. 5 USC § 4107 (2003).

In November 2003, VA revised its Employee Development policy to authorize payment for academic degrees as provided by the Homeland Security Act. VA Directive 5015, Paragraph 2b (9), (November 13, 2003). The policy delegates the authority to approve academic degree training, from the VA Secretary to Under Secretaries, Assistant Secretaries, other Key Officials, and Deputy Assistant Secretaries or their designees. This authority may be further delegated to VISN, MSM, and VBA area directors, but it may not be delegated any further. *Id.*, (9) (d).

Before 2003, VA training policy delegated the authority to approve training by, in, or through a non-Government training facility to Administration Heads, Assistant Secretaries, Other Key Officials and their designees and requires that the authorization for non-Government training must be in writing and obtained in advance of the course.

VA Handbook 5015, Paragraph 8c, (2002). The training policy further required that before training through a non-Government source was approved, the authorizing official must have first determined that the training was related to the performance of the employee's official duties and that it benefited VA. Furthermore, VA needs must be specifically identified in determining the benefit to VA, and it was not sufficient that an employee had a high interest in the training or had a background related to the subject of the training. *Id.*, Paragraph 8c (a). The 2002 policy which required the authorizing official to determine that adequate training was not reasonably available by, in, or through a Government facility; that the training was the most practical and least costly to the Government; and that the prohibitions, limitations, and requirements, as stated in Part 410 of Title 5 of the Federal Code of Regulations was satisfied as to these three requirements. *Id.*, Paragraph 8c (b)–(e).

Furthermore, policy required that whenever training involved more than 80 hours of non-Government training, an agreement to continue in service (continued service agreement) must be obtained from the employee before training began, with a copy maintained in the employee's official personnel file. VA Handbook 5015, Paragraph 8c (2), (2002). The 2003 revision of the training policy set the minimum Departmental standard requiring service agreements for courses that are 40 hours in length and cost at least $500. Finally, policy required that the selection process of employees for training, which may give a competitive edge in applying for future openings, must be done in accordance with merit system principles. VA Handbook 5015, Paragraph 3a (2), (2002).

VHA Office of Finance (OF) training policy states that final approval for all training for OF employees will be made by the CFO and requires the use of Standard Form 182 (SF-182) *Request, Authorization, and Certification of Training* for college courses. VHA Office of Finance Training and Development Policy Guide, Chapter II, Paragraph 3, (June 2003). In addition, OF policy ranks college courses as the lowest priority in terms of determining whether the training would be provided to an employee within mission and budgetary constraints and requires the employee to submit documentation of the grade earned upon completion of the course. *Id.*, Chapter III, Paragraphs 2(a) and (b). OF policy also requires that whenever "long-term, high-cost, and highly desired training opportunities" (more than 120 hours and/or a cost exceeding $2,500) occurs that may result in increased opportunity for advancement, all eligible OF employees are to be notified and provided an opportunity to apply for the training with final selection made by the VHA CFO. *Id.*, Chapter III, Paragraph 5.

*Background*

(b)(7)(C) became the (b)(7)(C) in (b)(7)(C) and after being appointed to the Senior Executive Service in (b)(7)(C) he was permanently appointed to the position. (b)(7)(C) began working in DSO as a staff assistant in and he became (b)(7)(C)
(b)(7)(C) direct report in (b)(7)(C) In (b)(7)(C) obtained a

Bachelors of Science Degree in Business Management, and in (b)(7)(C) he obtained a Masters of Management Degree, (b)(7)(C)

The former Analyst began working in the VHA Office of Finance as a college intern in September 2001; was converted to a full-time Management Analyst in December 2001; and subsequently became a direct report to (b)(7)(C) In August 2004, the former Analyst obtained a Masters of Business Administration Degree from The George Washington University (GW), Washington, DC; and in July 2005, she resigned from VA to pursue employment in the private sector. (She died in September 2007.)

*Academic Degree Funding for* (b)(7)(C)

(b)(7)(C) educational records showed that (b)(7)(C) enrolled in their Business Management Undergraduate Degree Program in (b)(7)(C) and that between (b)(7)(C) (b)(7)(C) he took the 21 courses required to earn an undergraduate degree. He then enrolled in the (b)(7)(C) Masters of Management Degree Program, and between (b)(7)(C) (b)(7)(C) he took an additional 13 graduate level courses to obtain a graduate degree. According to purchase card and (b)(7)(C) records, (b)(7)(C) and another employee, a Program Analyst assigned to DSO in Bedford, Massachusetts, used their respective Government-issued purchase cards to pay for all 34 college courses. In total, VA paid $43,318.96 to (b)(7)(C) for (b)(7)(C) undergraduate and graduate degrees.

(b)(7)(C) told us that (b)(7)(C) verbally approved each of the 34 courses, prior to his taking them, but he said that he never submitted a written request for training. He said that (b)(7)(C) reviewed each course description, gave his verbal approval, and after completing each course, (b)(7)(C) showed (b)(7)(C) the grade he earned. (b)(7)(C) said that he asked the Program Analyst to use her purchase card to pay for some of his courses, because he was also using his purchase card to pay for tuition at GW for the former Analyst. He said he was also concerned about the spending limits on his purchase card. However, the Program Analyst told us that (b)(7)(C) requested that she use her card, because he said that his was not working properly. She said that she received a memorandum signed by (b)(7)(C) authorizing the expenditure of funds to pay for nine (b)(7)(C) college courses and that she received verbal authorization from her purchase card approving official to use the card to pay for these college courses.

(b)(7)(C) told us that one of his career goals was to become a manager and a member of the Senior Executive Service, and that he believed doing so would be an extension of his current position as a (b)(7)(C) He said that at the time he began pursuing his undergraduate degree, he spoke with someone at VHA Health Administration Center Human Resources Office in Denver, Colorado, to ask if it was appropriate for VA to pay for the courses. He said that this person told him that it was permissible, as along as the courses were relevant to his job and his supervisor approved them. (b)(7)(C) said that he did not document this conversation and could not remember the name of the person with whom he spoke.

told us that reviewed several different graduate degree programs for him, discussed the pros and cons of each, and recommended that he pursue the Masters of Management Degree Program. said that he discussed each course with to ensure that it was applicable to his job and that he approved each one individually, on a course by course basis, and that he authorized the use of VA funds for to obtain his academic degrees. However, told us that he did not use a competitive process to select for a degree program. He said that he authorized this expenditure so as to help better perform his job; because he expressed a desire to improve himself professionally; and so could pursue a higher education. acknowledged that position was not one that was hard to fill or that required special recruitment or retention incentives, and records indicated that a degree was not required for the position.

told us that he never required to submit a written request for this training, and he said that, at the time, he was not familiar with a requirement to do so. also said that he never required to sign a continued service agreement, because he believed that the only time one was required was if the coursework was completed on Government time. Although and said that each course was individually reviewed and verbally approved by we found an memorandum, *College Funding for* signed by wherein he approved the expenditure of funds to pay for nine undergraduate courses through over a 1-year period from To the contrary, the memorandum listed only the course titles and provided no detail on the content of each course, that there was an independent review of each, or that they were individually approved.

told us that senior leadership within VHA Office of Finance, to include the former VHA CFO and his Executive Assistant, were aware that the VA paid for education and that no one ever questioned it until when allegations against surfaced that he improperly used his purchase card to pay for his college courses. recalled a conversation that occurred during an performance awards meeting, attended by senior managers, and someone asked why the award proposed for was lower than his contemporaries. said he told them that given the amount of money VA paid for college courses he believed that the lower award amount was sufficient.

also said that he discussed the entire scope of Government funding for education with the former VHA CFO's Executive Assistant on other occasions, and he believed that the former VHA CFO should have known how many courses were paid for by VA. In an email message, the former VHA CFO's Executive Assistant wrote to that courses and award were discussed the previous year during the award vetting process; however, he said that it was "not a hot topic discussion." The former CFO's Executive Assistant told us that he

recalled that a meeting took place in either (b)(7)(C) when both the current and former VHA CFO were present, and someone asked why (b)(7)(C) annual bonus was less than his contemporaries. He said that (b)(7)(C) stated that the VHA Office of Finance paid for courses for (b)(7)(C) and that the premise of (b)(7)(C) statement was that in setting the award amount to be given to (b)(7)(C) he had taken into consideration the amount spent on his college courses. The former CFO's Executive Assistant said he did not recall whether (b)(7)(C) specified the number of courses (b)(7)(C) took at VA expense and that (b)(7)(C) response satisfied the original question.

The former VHA CFO told us that he had no knowledge that the VA paid for college courses for (b)(7)(C) or that he obtained a college degree at VA expense. He said that in (b)(7)(C) after learning that (b)(7)(C) used a Government purchase card to pay for numerous college courses for himself, he asked (b)(7)(C) why they spent so much money for (b)(7)(C) education. He said that (b)(7)(C) responded by saying that it was to improve his job performance.

(b)(7)(C) told us that he was not aware that (b)(7)(C) took college courses at VA expense until (b)(7)(C) purchase card expenditures were called into question. He said that when the allegations against (b)(7)(C) first surfaced, a meeting took place to discuss the matter, and the former VHA CFO asked (b)(7)(C) if he authorized (b)(7)(C) to take college courses at VA expense. The VHA CFO told us that (b)(7)(C) acknowledged that he gave his approval for (b)(7)(C) to take the courses. He further said that both he and the former VHA CFO were "shocked" to learn that (b)(7)(C) approved (b)(7)(C) to take so many courses at VA expense.

*Academic Degree Funding for the Former Analyst*

According to GW records, the former Analyst applied for admission to GW's Masters of Business Administration (MBA) degree program in March 2002. In August of that year, she cancelled a student loan she obtained, indicating on the cancellation form "employer funding" as the reason. Between September 2002 and August 2004, the former Analyst took 19 graduate level courses to obtain an MBA degree at GW, which was recognized as one of the 10 most expensive private colleges in 2004. According to purchase card records, (b)(7)(C) and four other VHA employees used their respective purchase cards to pay for the courses. In total, the VA spent $43,488.52 for the former Analyst's GW MBA education. Records further reflected that some of the expenditures to GW included items not normally allowed, such as interest, late payment fees, a graduation fee, and tuition for a course that was never completed. The participation by each of the other four card holders was limited in scope, independent of each other, and we found no evidence that any of them knew the full extent of expenditures made to GW on behalf of the former Analyst. All the card holders used their respective purchase cards only after receiving authorization, which in each case ultimately came from (b)(7)(C)

(b)(7)(C) told us that he approved funding for the former Analyst to obtain her MBA, but he said that the initial approval came from the former (retired) VHA Deputy CFO. (b)(7)(C) said that he was left "out of the loop" and was not involved in the former Analyst's decision to attend GW, but she instead discussed her education plans with the former Deputy CFO. (b)(7)(C) initially said that he could not recall how he came to believe that the former Deputy CFO approved the funding, only that he believed, at that time, that he did. He further said that when he (b)(7)(C) authorized the expenditures for the former Analyst, he believed he was only carrying out the former Deputy CFO's wishes. However, (b)(7)(C) later told us that the former Analyst told him that the former Deputy CFO authorized the expenditure of funds to pay for her education, but he never verified this information with the former Deputy CFO directly nor did he have any documents showing that the former Deputy CFO approved the funding. Furthermore, (b)(7)(C) said that he never required the former Analyst to submit written requests for training, to sign a continued service agreement, nor did he consider other training that would have been adequate but less expensive.

Initially, (b)(7)(C) told us that only (b)(7)(C) authorized the expenditures of VA funds for the former Analyst's GW coursework and that he (b)(7)(C) took care of payments. He later said that the former Deputy CFO also authorized the funding. To the contrary, the former Deputy CFO told us that when he was in that position, he and the former Analyst never discussed her education prior to her starting the GW degree program, and he said that he never authorized the expenditure of VA funds to pay for any of her education. In addition, he said that he did not know that (b)(7)(C) approved funding to pay for the former Analyst's education.

Prior to her death, the former Analyst said that (b)(7)(C) told her that VA would pay for her education. She also confirmed that before she knew this, she previously obtained approval for financial aid through GW. The former Analyst told us that (b)(7)(C) handled all the details of paying for the courses and that she personally did not have to pay for any part of her GW educational expenses. She said that her conversations with the former Deputy CFO were informal and that they never talked about VA paying for her education. She also said that she never discussed her course work with (b)(7)(C) because he was "too busy." The former Analyst provided us copies of training request forms and continued service agreements for 6 of the 19 graduate courses she took, and all contained (b)(7)(C) signature.

## Conclusion

We concluded that (b)(7)(C) improperly authorized the expenditure of $86,807.48 in VA funds to pay for academic degrees. His actions were an abuse of his authority in that they were arbitrary and capricious; resulted in personal gain, or advantage, being afforded to (b)(7)(C) and the former Analyst, over any other employee; and that final approval for all training for Office of Finance employees should have been made by the CFO. A

key component to any education program sponsored by the agency is that a competitive process be used to select who will be given an educational opportunity at Government expense. The scope and magnitude of the education offered to these two employees far exceeded any normal training offered to employees to improve individual job performance and was not a part of any agency sponsored educational program. Further, there was never a demonstrated need to pay for Bachelors and Masters degrees for (b)(7)(C) or the former Analyst for the purposes of meeting an identified VA training need, resolving an identified staffing problem, or accomplishing a goal of VA's strategic plan, as required by regulation and VA policy.

(b)(7)(C) approval of funding undergraduate and graduate academic degrees for these employees was excessive in nature and scope, allowing (b)(7)(C) to take 34 college courses at VA expense. He also approved funding for 19 college courses for the former Analyst at one of the country's most expensive private colleges. Additionally, (b)(7)(C) acknowledged that, by (b)(7)(C) obtaining his academic degrees at VA expense, he received something of value over and above other employees, as expressed by his reducing (b)(7)(C) performance award due to VA paying for his education. In the case of the former Analyst, we found no credible evidence to support (b)(7)(C) assertion that the former Deputy CFO approved educational funding, as both the former Deputy CFO and Analyst said that they never discussed VA paying for her education. There were no documents to support (b)(7)(C) assertion, and all the approval documents were signed by (b)(7)(C)

Moreover, (b)(7)(C) failed to fulfill the requirements of VA's training policy, such as obtaining and maintaining written requests; protecting the interests of the Government by getting continued service agreements; specifically identifying the VA benefit in paying for entire academic degrees; ensuring that the training was not provided because the employee had a high interest in it or had a background related to the subject of the training, and; by not using a competitive process to select who would receive the training. In addition, before authorizing training through a non-Government source, he failed to determine whether adequate training was reasonably available by, in, or through a Government facility; he failed to ensure that the training taken by the employees was the most practical and least costly to the Government, and; he failed to ensure that the prohibitions, limitations and requirements as stated in Part 410 of Title 5 of the Federal Code of Regulations were met.

**Recommendation 1.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for improperly authorizing the expenditure of $86,807.48 to pay for academic degrees.

**Recommendation 2.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to properly administer VA training policy.

**Recommendation 3.** We recommend that the VHA CFO ensure that a bill of collection for $43,318.96 be issued to (b)(7)(C) to recover funds improperly expended to pay for his undergraduate and graduate degrees.

## Issue 2: Whether (b)(7)(C) Violated Acquisition Regulations and (b)(7)(C) Improperly Administered VA Purchase Card Policy

The Federal Acquisition Regulation prohibits "splitting" a single procurement exceeding the micro-purchase threshold limit into two or more transactions of lesser amounts in order to avoid the requirement that applies to purchases exceeding the micro-purchase threshold. 48 CFR § 13.003 (c)(2). Prior to September 28, 2006, this threshold amount was $2,500. *Id.*, § 2.101; Federal Acquisition Circular 2005-13.

VA policy states that purchase card Approving Officials are responsible for monitoring the use of the Government purchase card by the cardholder to ensure purchases are within guidelines; certifying all transactions made by cardholders and ensuring applicable documentation is maintained; ensuring Federal, VA, and local acquisition regulations are followed; and certifying all procurements are legal and proper. VA Handbook 4080, Paragraph 3a, (2003, 2005) and VHA Handbook 1730.1, Paragraph 3h, (2000, 2005). Policy further states that Cardholders are responsible for complying with all Federal, VA, and local acquisition regulations, including the prohibition against splitting transactions to avoid the micro-purchase threshold limit and maintaining appropriate receipt records in accordance with VA Manual MP-4, Part X, Item 5-1, stating that procurement and voucher documentation must be kept for 6 years and 3 months. VA Handbook 4080, Paragraph 3c (2005); VHA Handbook 1730.1, Paragraph 3g (2000, 2005); VHA Office of Finance Operating Instructions for Government Purchase Card (17), February 9, 2006. VHA policy further provides that certification of inappropriate procurements will result in immediate revocation of approving authority, possible disciplinary action, and/or issuance of a bill of collection for the full cost of the procurement. VHA Handbook 1730.1, Paragraph 3h, (2000, 2005)

*Improper Splitting of Transactions*

Purchase card records associated with the payment of the former Analyst's education expenses at GW reflected that (b)(7)(C) used his purchase card to make 10 separate fragmented (split) payments totaling $17,205.81. (At the time he made these payments, Federal regulations prohibited splitting payments for expenditures over $2,500.) For example, records showed that (b)(7)(C) used the purchase card to pay the 2002 fall semester educational expenses in the amount of $4,916.00 by making three separate payments: $1,500.00 on August 8; $2,000.00 on September 17; and $1,416.00 on November 26. In another example, he paid the 2003 spring semester charges, totaling $5,033.47, by again making three separate payments: $1,304.00 on January 24; $1,304.00 on January 27; and $2,425.47 on April 3. In a third example, during the 2003 summer

and fall semesters, (b)(7)(C) made two split payments: $2,400.00 on August 6 and $2,400.00 on September 9.

Records also showed that a DSO junior staff assistant made three split payments in October 2003 to GW totaling $7,200.00. These included two payments of $2,400.00, each made on October 9, and a third of $2,400.00 made on October 16. The junior staff assistant told us that when he first started working in DSO in (b)(7)(C) who was his first-level supervisor, made it clear to him that he was to receive work assignments and take direction from (b)(7)(C) He said that in about (b)(7)(C) (b)(7)(C) directed him to obtain a purchase card, and in (b)(7)(C) instructed him to make several $2,400.00 payments to GW for the former Analyst's college courses. The staff assistant told us that he did not make payments to GW on his own initiative and that (b)(7)(C) told him when to make payments and for how much. He said that he was a new employee with less than (b)(7)(C) Federal service, and he acted upon instructions given to him by (b)(7)(C)

In a November 3, 2003, email message from a Chief Accountant at VA Denver Accounting Finance Office to the DSO junior staff assistant, the Chief Accountant restated a telephone conversation regarding the staff assistant making several split payments. In this message, she documented that she asked him why he made three charges against his purchase card totaling $6,000 when his limit was $2,500. She said that his reply was that (b)(7)(C) told him to do it that way and that "this is how he does it all the time." The Chief Accountant restated that she told him that it was illegal to fragment an order and that she asked him to contact the vendor and have the charges credited back to his purchase card.

Purchase card records reflected that in early 2004, after the above communication, (b)(7)(C) and the staff assistant together made four additional split payments to GW totaling $7,256.34. The staff assistant made two $2,400.00 split payments, with one on February 10 and the other on February 26. (b)(7)(C) then made two split payments, with one for $2,400.00 on March 31 and the other on April 6 for $56.34. The staff assistant said he made these payments even after the Chief Accountant told him that making them were improper; however, he said that he did so at (b)(7)(C) direction. (b)(7)(C) acknowledged that it was his practice to make split payments. He said that he knew he had to keep each payment under $2,500, but he thought that it did not matter how many payments he made to pay off the total amount owed, as long as he did not exceed his monthly spending limit. (b)(7)(C) also said that he instructed the staff assistant to make split payments, but he said that he did not realize he was directing him to violate acquisition regulations.

However, records reflected that (b)(7)(C) was aware that the Chief Accountant previously took issue with the staff assistant making split payments. The Director, Financial User Support for DSO in Bedford, Massachusetts, who at the time was the approving official for the staff assistant's purchase card account, told us that he also

received a copy of the Chief Accountant's November 3, 2003, email message and that his copy contained a note he inserted at the bottom documenting that a conference call took place regarding the split payment issue. The Director's note stated, "Resolved via conference call this AM with [*staff assistant's name*], (b)(7)(C) and [*chief accountant's name*]. Bottom line all we need to have is the delinquent memo signed which was read. 11/2/03."

(b)(7)(C) told us that he knew the staff assistant had a purchase card, but he said that he did not know that the staff assistant used the card to pay for the former Analyst's GW education. He also said that he was unaware that (b)(7)(C) made split transactions or that he directed the staff assistant to do the same. He further said that he was unaware that expenditures to GW included late fees and interest penalties, a graduation fee, and tuition for a course the former Analyst never completed. However, a Citibank Senior Client Account Manager told us that (b)(7)(C) was listed as the Approving Official for the purchase cards issued to Mr. Pappas.

*Unaccounted Purchase Card Refund and Erroneous Credit to VBA Account*

In her November 3, 2003, email message, the Chief Accountant instructed the staff assistant to obtain a refund to his purchase card from GW for the three $2,400 payments totaling $7,200. Purchase card records reflected that GW refunded only $2,400 to the staff assistant's purchase card account. However, we found no evidence that GW refunded the other two $2,400 payments to the purchase card or that they credited them to the former Analyst's GW account. A GW official told us that the $4,800 was instead applied to a Veterans Benefits Administration account set up to pay for courses taken by a veteran costing $4,525.04, leaving an unaccounted amount of $274.96.

## Conclusion

We concluded that (b)(7)(C) violated acquisition regulations on numerous occasions by making split payments that circumvented contracting requirements applying to purchases exceeding the micro-purchase threshold limit and that he inappropriately directed a subordinate staff assistant to make improper split payments. Even more egregious is that he continued to make and direct split payments after being told it was illegal With respect to (b)(7)(C) we found that he failed to properly administer VA purchase card policy when, as a purchase card Approving Official, he failed to ensure that expenditures made by (b)(7)(C) were compliant with Federal law, regulations and VA policy. With respect to the junior staff assistant, we found that he improperly made the split payments using his purchase card, even after being informed that it was improper; however, we recognize that he was a new employee with less than (b)(7)(C) of Federal service, and on all occasions, he was following (b)(7)(C) instructions. (b)(7)(C) were employees of the DSO Chief Financial Officer. They should know, follow, and provide guidance on legal and policy requirements relating to financial matters.

**Recommendation 4.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for misuse of a Government-issued purchase card and violating and instructing a new employee at a lower grade to violate acquisition regulations.

**Recommendation 5.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to properly administer VA purchase card policy.

**Recommendation 6.** We recommend that the VHA CFO confer with OGC to determine whether a bill of collection for $43,488.53 can be issued to (b)(7)(C) to recover the funds he improperly expended to pay for the Analyst's MBA degree, and ensure that a bill of collection in that amount is issued to (b)(7)(C) should it be determined that as the Approving Official he was responsible for the improper expenditure.

**Recommendation 7.** We recommend that the VHA CFO confer with OGC to review the matter of the two $2,400 payments erroneously credited to a VBA account and the unaccounted $274.96 to determine the appropriate action to recoup any monies owed to VHA and to properly account for the expenditures in the correct appropriation/budget records.

## Issue 3: Whether (b)(7)(C) Destroyed Documents, Misrepresented Facts, and Displayed a Lack of Candor

Federal regulations require employees to furnish information and testify freely and honestly in cases respecting employment and disciplinary matters. 38 CFR § 0.735-12. VA policy states that intentional falsification, misstatement, or concealment of material fact in connection with employment or any investigation, inquiry or proper proceeding; refusal to cooperate in same; or willfully forgoing or falsifying official Government records or documents warrants penalties from reprimand to removal. In addition, this policy states that the penalty for destroying a public record is removal. VA Handbook 5021, Part I, Appendix A.

*Improper Document Destruction*

We asked the VHA CFO for records pertaining to (b)(7)(C) purchase card transactions with GW, and he said that he was not aware of any GW transactions. (b)(7)(C) explained to him that the former Analyst obtained her degree from GW at VA expense. In a subsequent email message, the VHA CFO directed (b)(7)(C) (b)(7)(C) to provide the documents pertaining to transactions made to GW and other vendors in regards to the former Analyst's educational expenses. The VHA CFO also instructed them to produce monthly reconciliation documentation of the vendor invoices with the monthly purchase card statements, and he said that if the documentation was not available, to tell him whether it ever existed and its disposition.

(b)(7)(C) provided receipts for only a few of the numerous GW transactions. In his written response to the VHA CFO that accompanied these documents, (b)(7)(C) wrote that the documentation existed at one time; however, he shredded all credit card documents prior to 2006. He said that after a training class on the transition from hard copy statements to the new electronic system, all old paper records were shredded as per guidance given in the class. In addition, (b)(7)(C) told the VHA CFO that there were a few documents for GW that were kept in a different folder and that he obtained the receipts for [redacted] that were stored electronically on the [redacted] computer system. However, we later learned that two junior staff assistants who fell under (b)(7)(C) operational supervision, obtained purchase cards at his direction and used them to pay for books and tuition expenses at GW for the former Analyst. (b)(7)(C) did not include this fact in his response to the VHA CFO and did not attempt to obtain GW documentation from either of the staff assistants, or at minimum, inform the VHA CFO or the OIG, of the role the two junior staff assistants played and the possible existence of the documentation.

(b)(7)(C) told us that during a previous purchase card training session, the Purchase Card Program Coordinator said that purchase card receipts and statements no longer needed to be maintained and a day or two later, he shredded all of his purchase card documentation. In (b)(7)(C) written response to the VHA CFO, he said that paper copies of documentation prior to the transition to electronic processing were destroyed at the instruction of the purchase card trainer. (b)(7)(C) told us that he attended the same purchase card training as (b)(7)(C) that he (b)(7)(C) personally asked the Program Coordinator whether they needed to maintain old paper copies; and she said no.

The former Program Coordinator, currently appointed to a different position within VA Office of Finance, told us that VHA Office of Finance transitioned from using monthly paper statements to using electronic statements on-line. She said that on November 30, 2005, she facilitated a training session for card holders and approving officials to learn about the new on-line procedures for reconciling their monthly statements. She said that (b)(7)(C) among others, were in attendance. She said that during the training session, she gave everyone a handout called "Purchase Card Highlights," and that one of the talking points mentioned that purchase card receipts and supporting documentation must be kept for 6 years and 3 months. She said that she clearly stated the retention requirements, as an internal compliance review of the VHA Office of Finance's Purchase Card Program, conducted earlier that year, found that supporting documentation from purchase card transactions were not always retained as required.

Other employees who also attended the training session told us that they could not recall the details of the session; however, they all told us that they knew they were required to keep receipts and supporting documents from their purchase card transactions. One card holder, a former secretary to the VHA CFO, told us that she remembered the former Program Coordinator telling everyone to keep receipts, and she provided us with a copy of the handout she received at the training. This handout was identical to the one the

former Program Coordinator gave us. In discussing this contradictory information with (b)(7)(C) they both maintained that the former Program Coordinator told them that they did not need to keep purchase card supporting documentation and that they never received a copy of the handout.

*Misrepresentation*

In the summer of 2005, the former VHA CFO directed that an internal compliance review be done of VHA Office of Finance's Purchase Card Program. A subsequent report, *VHA Office of Finance (17), Government Purchase Card Program Review, Final Report*, dated September 30, 2005, reflected that the review took place at VA Central Office (VACO) from June 27 to July 1, 2005. The report identified several deficiencies and made appropriate recommendations. One area of deficiency was the retention of receipts and other supporting documentation for purchase card transactions. It stated:

> All cardholders were able to provide receipts for these purchases *except the cardholder in the DSO/coreFLS Project Office (175)*. Prior to May 2005, the cardholder shredded the receipts after reconciling the monthly statement. The cardholder provided FAS with a copy of a new internal policy for the DSO/coreFLS Project Office (175) dated May 1, 2005, stating that starting immediately, the receipts will be retained for 1 year, and then shredded. This new policy will not be in compliance with the VA records retention requirements. (Italics and underline emphasis added by OIG.)

The VHA Financial Assistance Section (FAS) lead auditor, who conducted the review and authored the resulting report, identified (b)(7)(C) as the only cardholder who did not provide receipts and supporting documentation. She told us that as part of the review process, she asked (b)(7)(C) in a July 11, 2005, email message to provide documentation for several purchase card transactions on two purchases cards assigned to him. She said that (b)(7)(C) telephoned her 2 days later to explain why he did not have any receipts. She said that he then sent her, via facsimile, a copy of a new internal DSO purchase card policy. The policy document was typewritten on plain white (non-letterhead) paper, contained the title "Decision Support Office (175) Credit Card Policy," and was signed by (b)(7)(C) with a handwritten date of May 1, 2005.

The first paragraph of text described previous DSO purchase card procedures, stating that until the new policy, the procedure followed by DSO in regard to credit card certification was to shred receipts and keep no copies in the office. Subsequent text stated that the new procedures required that purchase card receipts be kept for 1 year. (b)(7)(C) told us that he authored, signed, and dated the policy memorandum.

In a forensic examination of (b)(7)(C) VA-issued desktop computer hard drive and a manual search of his VA-issued laptop computer; restored copies of his VA network

share drive dating back to May 1, 2005, and his archived email messages, we were unable to locate a copy of this policy memorandum on any VA systems assigned to him. However, we found a copy of the policy memorandum within a restored copy of (b)(7)(C) VA network share drive. The electronic document properties associated with the file showed that the name of the document was *'05 Credit Card Policy.doc* and that the author of the document was (b)(7)(C) which is (b)(7)(C) VA user name. Further, the file properties indicated that the document was created and last saved by (b)(7)(C) on June 22, 2005, which was over 50 days after the handwritten date at the top of the printed copy that he provided the lead auditor on or about July 13.

In a July 11, 2005, email message, the lead auditor identified four purchase card transactions for college courses (b)(7)(C) took at [redacted] but (b)(7)(C) made assertions to her that he did not have these purchase card records. However in 2003, (b)(7)(C) previously provided [redacted] receipts obtained from the internet to the Analyst in Bedford when she paid for six of his courses.

(b)(7)(C) initially told us that at the time the lead auditor made her request, copies of these invoices were not available on the internet; however, after we reminded him that in 2003 he provided these same documents to the Analyst in Bedford, he said that at the time the lead auditor asked him for invoices and receipts, he did not recall that they were available on-line and did not think of calling [redacted] to get them.

*Lack of Candor*

Purchase card records reflected that (b)(7)(C) received two separate Government-issued purchase cards with different account numbers and that he used one for office supplies and the other to pay for training. (b)(7)(C) told us that it was only recently that he learned that (b)(7)(C) possessed two separate purchase cards. He said that when he first took over as Acting Associate CFO in (b)(7)(C) his predecessor told him of only one purchase card, the supply card, being assigned to (b)(7)(C) He said that (b)(7)(C) never told him he had a second purchase card and never provided him with monthly statements for the second account. However, we obtained copies of monthly statements for both accounts for the May 2005 billing cycle, and both contained (b)(7)(C) signature as the Approving Official. When shown the statements, he acknowledged that he signed them, but he stated that he had no recollection of doing so. He further said that he must not have realized that the statements were for two separate accounts. (b)(7)(C) said that although he knew (b)(7)(C) used a purchase card to pay for his [redacted] courses, he never questioned him why the [redacted] charges did not appear on the purchase card statements.

(b)(7)(C) told us that both purchase cards were issued to him sometime in [redacted] when he was supervised by a now retired Associate CFO for DSO. He further said that although he obtained the two purchase cards prior to (b)(7)(C) becoming his supervisor, (b)(7)(C) was aware that he had both cards and that he routinely gave him the monthly

statements for both accounts to review and approve. (b)(7)(C) predecessor told us that she could not recall whether (b)(7)(C) had a purchase card while under her supervision or what she may have told (b)(7)(C) regarding a purchase card being issued to him. The former Associate CFO told us that he was unsure whether (b)(7)(C) was issued a purchase card while under his supervision.

We found an electronic document on (b)(7)(C) VA network drive with the name *Coop's-Weekly Activity Report-FY'02*. This appeared to be a detailed chronological journal prepared by (b)(7)(C) of his daily work activities during the time when he was under the prior supervisor, which was after the former Associate CFO retired and before (b)(7)(C) started working in DSO. A November 8, 2001, entry in the activity report reflected that (b)(7)(C) attended a 3-hour purchase card training class on that day so that he could receive a purchase card. A Citibank Senior Client Account Manager told us that the first purchase card issued to (b)(7)(C) account number ending in 7551, was opened on March 29, 2002, and the second, account number ending in 1725, was opened on July 3, 2002, and that (b)(7)(C) was the Approving Official for both accounts. Purchase card records further reflected that the first charge made with the card ending in 7551 was to Staples, an office supply company, posting to the account on April 9, 2002. Records also showed that the initial charges made on the second card, ending in 1725, posted on August 8, 2002, and that these charges were for college courses taken by (b)(7)(C) and the former Analyst.

## Conclusion

We concluded that (b)(7)(C) failed to fully cooperate with VHA and OIG officials in matters pertaining to their employment. (b)(7)(C) failed to provide invoices and receipts for six college courses, paid for by the Analyst in Bedford, in response to OIG's and the VHA CFO's first request to produce purchase card documents. (b)(7)(C) was less than candid in statements he made in response to the VHA CFO's second directive to provide documentation when he claimed that only a few GW documents existed, when he knew two subordinate staff assistants in his office had at one time used their respective purchase cards to pay for some of the former Analyst's education expenses at GW. He also failed to include their documentation in his response to the VHA CFO, or at minimum, inform the VHA CFO or the OIG, of the role the two junior staff assistants played and the possible existence of the documentation.

(b)(7)(C) was less than candid with a VHA Auditor and failed to fully cooperate during an official review ordered by the former VHA CFO of the Office of Finance's Purchase Card Program. (b)(7)(C) told the auditor that receipts and supporting documentation for his purchase card transactions did not exist when in fact he could obtain these receipts through other means. In addition, he misrepresented to the VHA Auditor that it was DSO policy to shred all receipts and supporting documentation and then provided her with a

false document, a fabricated policy memorandum prepared almost 2 months after the date on the memorandum, to support his claim.

Furthermore, (b)(7)(C) falsely claimed that he authored the DSO Credit Card policy memorandum, dated May 1, 2005; the evidence instead showed that (b)(7)(C) created the document over 50 days after the date written on it and signed by (b)(7)(C) Moreover, we noted that the policy memorandum was created just 5 days before the VHA Office of Finance's Purchase Card Program Review took place. It is problematic that (b)(7)(C) as the VHA Associate CFO for the Office of Finance Decision Support Office would create policy contrary to Federal regulations and VA policy.

During the July 2005 VHA Purchase Card Program Review, (b)(7)(C) claimed that it was DSO policy to shred receipts, but then also claimed to have shredded his documents within "a day or two" after the purchase card training session. At the onset of our investigation, when the VHA CFO ordered the production of purchase card records, neither (b)(7)(C) mentioned the DSO Credit Card Policy memorandum to the VHA CFO or that it was DSO's practice, as indicated in the policy memorandum, to shred purchase card records. Instead, they misrepresented to the VHA CFO and to OIG investigators that the documents were shredded because the Purchase Card Program Coordinator told them that they no longer needed to keep it, which was contrary to what she and others told us and contrary to her handout.

We found that (b)(7)(C) did not testify honestly or accurately when he said that he was issued two purchase cards prior to (b)(7)(C) becoming his supervisor. We also found that (b)(7)(C) did not testify honestly or accurately when he told us that he did not know about the second purchase card. Citibank records showed that the two purchase cards were issued to (b)(7)(C) after (b)(7)(C) became his supervisor, (b)(7)(C) was the approving official for each purchase card, and the first charges made to each card transacted after (b)(7)(C) became (b)(7)(C) purchase card Approving Official.

**Recommendation 8.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for his failure to testify freely and honestly and for falsification, misstatements, and/or concealment of material facts in connection with his employment.

**Recommendation 9.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to comply with Federal regulations and VA policy in maintaining proper purchase card documentation.

**Recommendation 10.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for his failure to testify freely and honestly and for falsification, misstatements, and/or concealment of material facts in connection with his employment.

**Recommendation 11.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to ensure the purchase cardholder maintained applicable documentation.

## Issue 4: Whether (b)(7)(C) Misused Government Resources

The Standards of Ethical Conduct for Employees of the Executive Branch state that an employee has a duty to protect and conserve Government property and shall not use such property, or allow its use, for other than authorized purposes. 5 CFR § 2635.704 (a). VA policy requires employees to conduct themselves professionally in the workplace and to refrain from using Government office equipment for activities that are inappropriate; and it expressly prohibits employees from using VA computer systems for creating, downloading, viewing, storing, copying, or transmitting sexually explicit or sexually oriented materials. VA Directive 6001, paragraph 2 (c)(5).

(b)(7)(C)

In a forensic analysis of the link files (user access files) on (b)(7)(C) desktop hard drive to identify references to the folder structure containing the sexually explicit files, we identified links from his desktop hard drive to the VA network drive that contained several of the sexually explicit essays. The most recent modification date associated with these link files was January 17, 2007, which was after we began our investigation and after our first interview of (b)(7)(C) on January 11.

These link files also referenced a folder structure on a removable device identified as F:, and the references for this device showed additional folders and file names. These file names, (b)(7)(C) (b)(7)(C) matched the folder location and file names of the files located on (b)(7)(C) recovered network drive, and they each contained sexually explicit material. This indicated that it was probable that (b)(7)(C) used a removable device – possibly a USB thumb drive – at some point to transfer files between the removable device, the desktop,

and the VA network drive. All identified references to the folder structure on the removable device were dated in March 2007, which again was after the initiation of our investigation and first interview of (b)(7)(C)

In addition to his assigned desktop, we found images of partially clad females and a nude male on (b)(7)(C) VA-issued laptop computer. On the laptop, we also found hyper text markup language files in the Temporary Internet Files folder of his user profile – (b)(7)(C) – identifying web pages of sexually explicit stories associated with (b)(7)(C) (b)(7)(C) which were last accessed between October 4 and November 23, 2006.

(b)(7)(C) told us that he used VA computers to read and download sexually explicit material. He said that he "looked up pornographic material" and that he removed sexually explicit material from his network drive after the OIG began its investigation, stating that he "probably" knew it was improper to have sexually explicit material on his VA computer systems.

## Conclusion

We found that (b)(7)(C) routinely used VA-issued computer systems to view, copy, transmit and store adult sexually explicit material. A computer forensic analysis determined that sexually explicit documents, images, and videos were stored on (b)(7)(C) assigned VA network drive and linked to his VA-issued desktop computer hard drive. Forensic analysis also determined that (b)(7)(C) VA-issued laptop computer contained sexually explicit materials including evidence that (b)(7)(C) accessed sexually explicit websites. Further, our analysis showed that he removed the materials from his VA network drive shortly after our investigation began. Also of concern is that even after (b)(7)(C) removed the inappropriate material from his VA network drive, and knowing that he was still under investigation by the OIG, he continued to go on-line using his VA-assigned computer to view sexually explicit material on the Internet.

**Recommendation 12.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for the misuse of VA computers systems.

**Recommendation 13.** We recommend that the VHA CFO conduct a follow up analysis of (b)(7)(C) current VA-assigned computer systems to ensure that he no longer accesses sexually explicit materials and that his VA-owned computer systems are set to block access to all inappropriate internet content.

## Comments

The VHA CFO concurred with the recommendations, stating that he will take appropriate administrative action against (b)(7)(C) after coordination with Office of General Council (OGC) and Office of Human Resources Management (OHRM). The VHA CFO's response is in Appendix A. We will follow up to ensure the recommended actions are taken.

(b)(7)(C)

Appendix A

# Chief Financial Officer Comments

Department of
Veterans Affairs

Memorandum

**Date:** April 9, 2009

**From:** Chief Financial Officer, Veterans Health Administration (17)

**Subject:** **Administrative Investigation – Improper Funding of College Degrees, Failure to Administer and Follow Policy, and Misuse of Government Resources, VHA Office of Finance, Washington, DC**

**To:** VA Office of Inspector General

See comments

## VHA Chief Financial Officer's Comments to Office of Inspector General's Report

The following VHA Chief Financial Officer's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommendation 1.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for improperly authorizing the expenditure of $86,807.48 to pay for academic degrees.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 2.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to properly administer VA training policy.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 3.** We recommend that the VHA CFO ensure that a bill of collection for $43,318.96 be issued to (b)(7)(C) to recover funds improperly expended to pay for his undergraduate and graduate degrees.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 4.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for misuse of a Government-issued purchase card and violating and directing a new employee at a lower grade to violate acquisition regulations.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 5.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to properly administer VA purchase card policy.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 6.** We recommend that the VHA CFO confer with OGC to determine whether a bill of collection for $43,488.53 can be issued to (b)(7)(C) to recover the funds he improperly expended to pay for the Analyst's MBA degree, and ensure that a bill of collection in that amount is issued to (b)(7)(C) should it be determined that as the Approving Official he was responsible for the improper expenditure.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 7.** We recommend that the VHA CFO confer with OGC to review the matter of the two $2,400 payments erroneously credited to a VBA account and the unaccounted $274.96 to determine the appropriate action to recoup any monies owed to VHA, and to properly account for the expenditures in the correct appropriation/budget records.

Concur **Target Completion Date:** June 30, 2009

We are seeking guidance of the OGC on how to go about recouping funds paid to George Washington University and erroneously credited by them to a VBA account.

**Recommendation 8.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for his failure to testify freely and honestly and for falsification, misstatements, and/or concealment of material facts in connection with his employment.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM, but we are also seeking guidance of the OGC regarding the degree to which he may have lacked candor in his testimony.

**Recommendation 9.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to comply with Federal regulations and VA policy in maintaining proper purchase card documentation.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 10.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for his failure to testify freely and honestly and for falsification, misstatements, and/or concealment of material facts in connection with his employment.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM, but we are also seeking guidance of the OGC regarding the degree to which he may have lacked candor in his testimony.

**Recommendation 11.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for failing to ensure the purchase cardholder maintained applicable documentation.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 12.** We recommend that the VHA CFO take appropriate administrative action against (b)(7)(C) for the misuse of VA computers systems.

Concur **Target Completion Date:** June 30, 2009

Will take appropriate administrative action after coordination with OGC and OHRM.

**Recommendation 13.** We recommend that the VHA CFO conduct a follow up analysis of (b)(7)(C) current VA-assigned computer systems to ensure that he no longer accesses sexually explicit materials and that his VA-owned computer systems are set to block access to all inappropriate internet content.

Concur **Target Completion Date:** March 31, 2009

The follow-up analysis of the VA-owned desktop and laptop computers have been completed by the Department of Veterans Affairs Enterprise Security Management Field Operations Network and Security Operations Center VA-NSOC Forensic Analysis Reports VA 22527, February 17, 2009 (desktop computer) and VA 22783, February 20, 2009 (laptop computer) did not show any additional misuse of these computers.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Linda Fournier - (b)(7)(C) |
| Acknowledgments | Charles Millard<br>Carrie O'Neill |

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principle Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Chief Financial Officer, Veterans Health Administration (17)
Management Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Failure to Satisfy Financial Obligations
# Battle Creek VA Medical Center

Report No. 07-02623-164

July 10, 2008

VA Office of Inspector General
Washington, DC 20420

Section 1
Report

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

July 10, 2008

**"RESTRICTED REPORT"**

The Office of Inspector General issued the enclosed report – **Administrative Investigation – Failure to Satisfy Financial Obligations Battle Creek VA Medical Center** (Report No. 07-02623-164) on July 10, 2008.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Deputy Under Secretary for Health for Operations and Management (10N)

**SUBJECT:** Administrative Investigation – Failure to Satisfy Financial Obligations, VA Medical Center, Battle Creek, Michigan (2007-02623-IQ-0159)

## Summary

We substantiated that the (b)(7)(C) failed to satisfy, in good faith, his just financial obligations, to include charges on his Government contractor-issued travel charge card, an automobile loan, real estate property taxes, and Federal and State income taxes. As a result of (b)(7)(C) failing to pay his travel card, the contractor revoked it, and his failure to pay his other debts resulted in the repossession of his automobile, the sale of his house at a delinquent tax auction, the referral of delinquent State income taxes to a collections agency, and aggressive bill collectors calling his VA office, creating a stressful work environment for his staff.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, received allegations that (b)(7)(C) (b)(7)(C) failed to satisfy his financial obligations. To assess these allegations, we interviewed (b)(7)(C) the VISN Chief Financial Officer (CFO); the Medical Center CFO; other VA Medical Center staff; and the Boone County, Missouri, Deputy Tax Collector. We reviewed (b)(7)(C) travel charge card account, (b)(7)(C) real estate tax records, an Affidavit from the Custodian of Records for the Missouri Department of Revenue, other relevant documents, and applicable laws, regulations, and VA policies. We addressed other allegations in separate memorandums and they will not be discussed further in this report.

## Results

### Issue 1: Whether (b)(7)(C) failed to satisfy his financial obligations

The Standards of Ethical Conduct for Employees of the Executive Branch require employees to satisfy in good faith their obligations as citizens, including all just financial obligations, especially those – such as Federal, State, or local taxes – that are imposed by law. 5 CFR § 2635.809. VA policy requires an employee to provide the contractor issuing the travel charge card (Citibank) with any change of address information within 30 days of the change, to pay their travel card bills in full by the statement due date, and that account delinquency is considered misconduct and subjects the cardholder to disciplinary actions ranging from reprimand to removal. VA Handbook 0631.1, Paragraphs 3(h), 18, and 19.

(b)(7)(C) told us that he became the (b)(7)(C) in (b)(7)(C) Records showed that, at that time, he was promoted into the Senior Executive Service, and that for years 2006 and 2007, he received monetary awards in the amounts of $9,125 and $3,134, respectively. (b)(7)(C) (b)(7)(C) The Medical Center CFO told us that (b)(7)(C) had oversight of all operations, including the achievement of targeted budget levels, and a summary of the Medical Center's fund sources dated September 11, 2007, as provided by the CFO, showed a budget of more than $147 million.

*Delinquent Government Contractor-Issued Travel Charge Card*

Citibank records showed that they closed (b)(7)(C) travel charge card account for non-payment of charges totaling $3203.39. The Medical Center CFO, who was also the travel card coordinator, told us that (b)(7)(C) name first appeared on Citibank's delinquency report in December 2006 and again on subsequent monthly reports for January and February 2007. He told us that he first notified (b)(7)(C) of the delinquent account after receiving the December 2006 report, and during that conversation, the CFO discovered that (b)(7)(C) never gave Citibank his change of address after moving from (b)(7)(C) The CFO said that he then contacted Citibank, updated (b)(7)(C) address, and provided (b)(7)(C) the most current statement for the account. The CFO also said that each time (b)(7)(C) name appeared on subsequent monthly delinquency reports, he reminded (b)(7)(C) that he must pay his bill in full and that each time (b)(7)(C) gave assurances that he would take care of the matter.

The Medical Center CFO said that when (b)(7)(C) name again appeared on a March 2007 Citibank delinquency report, he told (b)(7)(C) that as the CFO he would initiate a salary offset action against (b)(7)(C) pay. He said that not long after that conversation, (b)(7)(C) told him that he paid the outstanding balance; however, the CFO said that a short time later, a Citibank employee told him that (b)(7)(C) personal

check was not honored due to insufficient funds. The Medical Center CFO said that (b)(7)(C) subsequently told him that a relative paid the outstanding balance, and Citibank records reflected that the debt was paid on April 2, 2007.

(b)(7)(C) told us that all the charges to his travel card were valid and that he was indeed negligent regarding his travel charge card account. He said that he suffered a serious medical condition shortly after arriving at the Battle Creek VA Medical Center, and as a result of his medical condition, he forgot about this debt. He further said that it was no excuse for his failure to pay his travel card balance by the due date but that his failure to pay the account in a timely manner was an isolated occurrence. However, Citibank records showed that (b)(7)(C) was habitually delinquent in paying his travel card bill, and due to his poor payment history, Citibank denied his subsequent request for another travel card. Records showed that there were 35 times when (b)(7)(C) paid his bill late. Of those 35 times, he was 1 to 30 days past due on 22 occasions; 31 to 60 days past due on 8 occasions; and 61 to 90 days past due 4 times. When his account reached 150 days past due, Citibank closed it. (b)(7)(C) initially told us that he did not realize he was late paying this bill on so many occasions, but he later said that he recalled receiving monthly statements from Citibank that included "past due" notices.

The Network Director told us that she was not aware of (b)(7)(C) having financial issues before he became the (b)(7)(C) She said that after his appointment, she learned that he had some difficulties financially, due to his moving expenses, but she did not recognize it as something needing her personal attention. She said that she thought the medical center finance office was handling the issue and that she was not aware that (b)(7)(C) failed to pay his travel card bill or that the VISN CFO instructed the Medical Center CFO to speak to (b)(7)(C) about the delinquency. The VISN CFO told us that after he instructed the Medical Center CFO to speak to (b)(7)(C) about the delinquencies, he told the Network Director that there was an "issue" with (b)(7)(C) travel card, that he and the Medical Center CFO were "on top of it" and that they "didn't need her to do anything at that point." However, he said that he told her that if the matter was not resolved, he may ask her to speak to (b)(7)(C) The VISN CFO told us that after (b)(7)(C) name appeared a third time, he thought the Network Director spoke to (b)(7)(C) receiving assurances that the debt would be paid. He said that he later learned that (b)(7)(C) had a check returned for insufficient funds while trying to pay his bill and that he told the Network Director about the returned check. However, the Network Director told us that she thought (b)(7)(C) paid his bill and was unaware that (b)(7)(C) check was returned for insufficient funds.

*Other Financial Delinquencies*

(b)(7)(C) told us that his private automobile was recently repossessed, due to non payment on a $2,000 outstanding loan balance, and he also said that his real estate taxes were delinquent on his property in (b)(7)(C) He said that he addressed that delinquency by making small payments on the outstanding balance. However, (b)(7)(C)

(b)(7)(C) told us that monthly or partial payments were not accepted for delinquent real estate taxes; that (b)(7)(C) owed back real property taxes for tax years 2005 and 2006 totaling $4,882.42; and because (b)(7)(C) failed to pay the taxes he owed, his house was sold at a tax auction on (b)(7)(C) later told us that he thought his wife made small payments on his property taxes and that he was unaware that his house was sold at a delinquent property tax auction.

(b)(7)(C) said that his 2006 Federal income taxes were delinquent and that his wife was attempting to set up a payment plan with the Internal Revenue Service. Other than the aforementioned debts, (b)(7)(C) said that he had no other delinquent financial obligations. However, the (b)(7)(C) told us, in an Affidavit, that (b)(7)(C) had a past due delinquency for tax period 2005, which they referred to a collection agency, and that the (b)(7)(C) (b)(7)(C) issued (b)(7)(C) a Notice of Delinquency for tax year 2006.

Medical center staff told us that (b)(7)(C) financial difficulties adversely affected his administrative staff, resulting in a strained working environment within his immediate office. The Associate Director and Human Resources Service Chief said that the administrative staff told them that bill collectors called (b)(7)(C) office attempting to speak with him and that the staff were upset having to handle these types of telephone calls. The Associate Director told us that when he spoke to (b)(7)(C) about his creditors calling the office, (b)(7)(C) only response was that his transfer to the medical center created a financial hardship. The Network Director told us that she was not aware of (b)(7)(C) other financial delinquencies or that (b)(7)(C) staff received calls from bill collectors.

## Conclusion

We concluded that (b)(7)(C) failed to satisfy in good faith his just financial obligations, including his Government contractor-issued travel charge card, an automobile loan, real estate property taxes, and Federal and State income taxes. Although (b)(7)(C) travel charge card debt was paid in full, he was more than 5 months' delinquent. It was not until he learned that the finance office would generate a salary offset action that he wrote a check to Citibank; however, in doing so, his bank returned the check for insufficient funds. (b)(7)(C) then turned to a family member to pay the debt for him.

(b)(7)(C) told us that his wife managed their finances; however, he was aware that Citibank sent him overdue notices. Moreover, creditors called his office often enough that it adversely affected his staff. Due to (b)(7)(C) failing to satisfy his financial obligations, Citibank closed his Government-issued travel charge card account; his automobile was repossessed; his house was sold at a delinquent property tax auction; and he is delinquent in paying State and Federal taxes.

Although there was no evidence to suggest that (b)(7)(C) personal finances surfaced during the selection process for his current position, he nonetheless knew, or should have known, that his failure to satisfy his financial obligations violated ethics regulations and could possibly affect any future suitability determination. (b)(7)(C) responsibilities as (b)(7)(C) include the oversight of a budget of more than $147 million, and his position is one of significant public trust and affords him access and wide discretion in the expenditure of public funds and involves significant risk of causing damage or realizing personal gain.

**Recommendation.** We recommend the Deputy Under Secretary for Health for Operations and Management take appropriate administrative action, in accordance with VA policy, against (b)(7)(C) for his failure to satisfy in good faith his financial obligations.

## Comments

The Deputy Under Secretary for Health for Operations and Management concurred with the above recommendation. His response is in Appendix A. In his response, he said that the appropriate administrative action will be issued after concurrence by the Office of the General Counsel (OGC) and the Office of Human Resources Management (OHRM). We will follow up to ensure completion of the action.

JAMES J. O'NEILL
Assistance Inspector General for
Investigations

Appendix A

# Deputy Under Secretary's Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** July 3, 2008

**From:** Deputy Under Secretary for Health for Operations and Management (10N)

**Subject:** **Administrative Investigation, Failure to Satisfy Financial Obligations, VAMC, Battle Creek, Michigan**

**To:** Assistant Inspector General for Investigations

## Deputy Under Secretary's Comments to Office of Inspector General's Report

The following Deputy Under Secretary's comments are submitted in response to the recommendation in the Office of Inspector General's Report:

**OIG Recommendation**

**Recommendation.** We recommend the Deputy Under Secretary for Health for Operations and Management take appropriate administrative action, in accordance with VA policy, against (b)(7)(C) for his failure to satisfy in good faith his financial obligations.

Concur **Target Completion Date:** 8-31-2008

We are preparing an appropriate administrative action, which will be issued after receipt of concurrence by OGC and OHRM.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Linda Fournier, | (b)(7)(C) |
| Acknowledgments | Charles Millard | |

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principle Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Management Review Service (10B5)

**To Report Suspected Wrongdoing In VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

2007-00649-IQ-0074

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

June 19, 2008

~~"RESTRICTED REPORT"~~

The Office of Inspector General issued the enclosed report – **Administrative Investigation – Alleged Conflict of Interest Veterans Benefits Administration VA Central Office, Washington, DC** (Report No. 07-00649-150) on June 19, 2008.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Alleged Conflict of Interest
# Veterans Benefits Administration
# VA Central Office, Washington, DC

Report No. 07-00649-150

June 19, 2008

VA Office of Inspector General
Washington, DC 20420

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Associate Deputy Under Secretary for Policy & Program Management, Veterans Benefits Administration (20P)
Assistant General Counsel/Designated Agency Ethics Official (023)

**SUBJECT:** Administrative Investigation – Alleged Conflict of Interest
Veterans Benefits Administration, VA Central Office
Washington, DC (Report: 2007-00649-IQ-0074)

## Summary

We substantiated that the duties and responsibilities of the (b)(7)(C) at times, place him in conflicting roles with his position as the (b)(7)(C) We determined that serving in both positions did not in itself constitute a conflict of interest; however, we agree with the Office of General Counsel (OGC) that the situation was "fraught with possibilities for running afoul of the Standards of Conduct." We recommend the employee's activities be closely monitored and that he be instructed on what matters may require his recusal.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that there is a conflict of interest between (b)(7)(C) position as a Department of Veterans Affairs employee and his position as a DAV Officer. (b)(7)(C) is the (b)(7)(C) and has responsibility for oversight of program direction of the VBA business lines, to include Compensation and Pension, Education, Loan Guaranty, Vocational Rehabilitation, Employment, and Insurance. To assess this allegation, we interviewed (b)(7)(C) the VBA Associate Deputy Under Secretary for Policy and Program Management (ADUS), and an OGC Staff Attorney. We also consulted the VA Designated Agency Ethics Official (DAEO), who is the Assistant General Counsel (023). We reviewed (b)(7)(C) position description, performance plan, DAV Bylaws and Constitution, DAV strategic plan, Federal regulations, VA policies, and other relevant documents.

## Results

**Issue: Whether (b)(7)(C) position as a high level DAV official (b)(7)(C) (b)(7)(C) conflicted with his position as a VA employee**

The General Provisions of the Standards of Ethical Conduct for Employees of the Executive Branch state that employees shall not allow the improper use of nonpublic Government information to further any private interest, shall not use public office for private gain, shall act impartially and not give preferential treatment to any private organization or individual, shall not engage in outside activities that conflict with official Government duties and responsibilities, and shall endeavor to avoid any actions creating the appearance that they are violating the law or ethical standards. 5 CFR § 2635.101(b).

The specific regulation which states that an employee shall not engage in any outside activity that conflicts with their official duties goes on to caution employees that even though an outside activity may not be prohibited, it may violate other principles or standards or require employees to disqualify themselves from participation in certain matters. Additionally, specific regulations provide that an employee shall not use public office for private gain or for the private interest of another, and an employee shall not use Government property for other than authorized purposes. 5 CFR § 2635.502(a), 702, and 704.

(b)(7)(C) told us that he became a DAV member in (b)(7)(C) holding numerous Chapter and National positions. In (b)(7)(C) he was elected (b)(7)(C) and (b)(7)(C) and in that position, he represented the (b)(7)(C) when he was not available to serve as the (b)(7)(C) (b)(7)(C) and was responsible for voting on DAV organizational issues or amendments at the national level. (b)(7)(C) said that he planned to run for the position of (b)(7)(C) and we later found that (b)(7)(C) was elected to that position in (b)(7)(C)

(b)(7)(C) said that he was actively involved in DAV prior to being employed by VA, and that in (b)(7)(C) he became the (b)(7)(C) (b)(7)(C) He told us that in that position, he was responsible for oversight of the five VBA business lines and coordinated and facilitated the information technology reorganization. He told us that he occasionally reviewed policy and that policy written for his office's programs came through his office as a repository. However, the ADUS told us that (b)(7)(C) served as the (b)(7)(C) and he was responsible for the policies in the five VBA business lines: compensation and pension, education, loan guaranty, insurance, and vocational rehabilitation. His specific responsibilities related to VBA policy are contained in his position description.

The position description and performance plan for (b)(7)(C) reflected that he acted as an advisor and consultant to the ADUS on policy matters related to veterans' benefits programs; directed the development of VBA Strategic Management Plan; assisted in the development of policy, proposed legislation and specific changes to current laws; made recommendations on the impact of new laws, legislation, program initiatives, and policies to be implemented; and represented the ADUS on the interpretation of regulations, procedures, and standards.

DAV's *National Constitution Bylaws and Regulations* vested the executive power of DAV in the (b)(7)(C) It stated that the (b)(7)(C) was "hereby placed under a continuing mandate by these Bylaws to resist and oppose any changes in laws or regulations that would repeal or deprive disabled veterans or their dependents of benefits already provided by such laws or regulations." In a message posted on the DAV internet website, (b)(7)(C) stated that "it is absolutely crucial that veterans and their needs are not ignored as their government sets national policies and funding priorities... Our government must make veterans a national priority and make the necessary investment in programs to ensure that our nation's disabled veterans and their families receive the earned benefits and services that were promised them."

(b)(7)(C) told us that having knowledge of VA policies did not affect or compromise his DAV duties and that he never recused himself from any DAV activity because of his VA position. He said that he stood for both VA and DAV. He told us that he believed the VA and DAV missions were one and the same, both serving the Nation's veterans. However, (b)(7)(C) admitted that he never spoke to anyone from the Office of General Counsel or the Ethics Office regarding his DAV posts for a legal opinion as to whether any particular matter was a conflict of interest. (b)(7)(C) told us that, after we interviewed him, he met with a General Counsel Staff Attorney, along with the ADUS, to determine if there was a possible conflict between his two positions. He said the Staff Attorney discussed with him the ethics issues, determined there was not a conflict, but advised him that he could not use his position as (b)(7)(C) against the VA.

Prior to his speaking to (b)(7)(C) the General Counsel Staff Attorney, in an electronic mail message, told us that (b)(7)(C) position with DAV, in and of itself, did not constitute a conflict of interest; however given the level of interaction between VBA and DAV, there existed a significant potential for (b)(7)(C) to "run afoul of the criminal conflict of interest laws and/or standards of conduct." He said that as a DAV officer, DAV's financial interests were (b)(7)(C) financial interests, so he may not participate as a VA employee in official particular matters that would directly and predictably affect DAV's interests. He also said that should this prohibition require (b)(7)(C) (b)(7)(C) to recuse himself from matters so central or critical to the performance of his official duties that his ability to perform his position would be materially impaired, then he would have to decide between his VA and DAV positions. He also said that law

prohibits (b)(7)(C) from representing DAV before any Federal agency or court, and when representing DAV before Congress, he must not use his official title or authority and he must be clear that any views he presents to Congress are on behalf of DAV and not VA.

The Staff Attorney later told us that when he spoke to (b)(7)(C) and the ADUS, he explained to them the criminal conflict of interest law and told them that there was no "per se conflict of interest" and that, should a situation arise where (b)(7)(C) had to recuse himself and there was no one to perform his duties, it was a management decision as to what they should do. The Staff Attorney said he could not recall if he went into detail with (b)(7)(C) concerning his VA responsibilities should DAV file litigation against VA. He said that as long as (b)(7)(C) name did not appear on the legal pleading, his position as the (b)(7)(C) did not conflict with his position at VA in the case of litigation. However, he said that (b)(7)(C) must clearly "disassociate the two positions" and that when working for VA, his loyalty was to VA.

In our opinion, as the (b)(7)(C) was the face of that organization and (b)(7)(C) outside activities with DAV could take precedence over his VA duties and his loyalty to VA, and at a minimum, created the appearance of a conflict of interest. (b)(7)(C) VA position provided him with nonpublic information that could be inappropriately provided to DAV for the political benefit of DAV. Furthermore, DAV is a veterans service organization whose primary purpose is to build better lives for America's disabled veterans and their families; however, VA is an agency that must use its limited resources for a much broader range of beneficiaries than just disabled veterans. DAV's mission does not appear to include the needs of non-disabled veterans and therefore, there could be a conflict between the missions of VA and DAV.

In addition, we believe that VA's broader mission may at times require that it prioritize resources and fund programs for non-disabled veterans at the expense of providing resources and funding for disabled veterans. While VA may initiate programs or policies that it believes benefit veterans, Veteran Service Organizations (VSO) often disagree with the specific initiatives. Certain VA initiatives and proposals result in efforts by DAV to lobby Congress in opposition to the VA proposal, and the issue is not whether VA or DAV are right about a specific issue, the issue is that DAV and VA are opposed on many issues. Furthermore, a VA employee in a senior policy and advisory role who is the (b)(7)(C) cannot serve "two masters who have conflicting positions." As an example, DAV sued VA over a regulation proposed by VA. The case was litigated in both the United States Court of Appeals for the Federal Circuit and, after it received an unfavorable decision, DAV appealed the ruling to the United States Supreme Court. One individual cannot reasonably be expected to provide senior level services to two adversarial entities engaged in litigation in the Federal court system. DAV has filed suit against VA on many occasions.

We found the following as examples of DAV litigation against VA:

- *DAV v. R. James Nicholson, Secretary of Veterans Affairs*, 547 U.S. 1162 (2006)
- *DAV, et. al. v. Secretary of Veterans Affairs*, 2005 U.S. App. Lexis 24132 (Fed. Cir. 2005)
- *DAV, et. al., v. Secretary of Veterans Affairs*, 327 F.3d 1339 (Fed. Cir. 2003)
- *DAV v. Principi, Secretary of Veterans Affairs, 10 Fed. Appx. 847 (Fed. Cir. 2001)*
- *DAV v. U.S. Department of Veterans Affairs, 962 F.2d 3 (2nd Cir. 1992)*
- *DAV v. Gober, Secretary of Veterans Affairs, 2001 U.S. App. Lexis 1314 (Fed. Cir. 2001)*

We consulted the VA Designated Agency Ethics Official (DAEO) to determine whether there was a conflict between (b)(7)(C) position in DAV and the duties and responsibilities of his VA position. The DAEO agreed that our identified concerns were significant and stated that the situation was "fraught with possibilities of running afoul of the Standards of Conduct." The DAEO recommended making (b)(7)(C) supervisor aware of the issues and identify matters from which (b)(7)(C) needs to recuse himself.

With respect to the apparent conflict with DAV's bylaws, the DAEO advised that, notwithstanding DAV's by-laws, (b)(7)(C) conduct as a VA employee was governed by the ethical principles, Standards of Conduct, and criminal conflict of interest laws, which supersede any obligations that an outside organization might impose upon him. Therefore, his first loyalty must be to the VA, even if there is a conflict with DAV's bylaws.

The DAEO agreed that (b)(7)(C) participation in certain matters would result in at least the appearance of a conflict of interest and cited the following Standard of Conduct:

> (a) Consideration of appearances by the employee. Where an employee knows that a particular matter involving specific parties is likely to have a direct and predictable effect on the financial interest of a member of his household, or knows that a person with whom he has a covered relationship is or represents a party to such matter, and where the employee determines that the circumstances would cause a reasonable person with knowledge of the relevant facts to question his impartiality in the matter, the employee should not participate in the matter unless he has informed the agency designee of the appearance problem and received authorization from the agency designee in accordance with paragraph (d) of this section. 5 CFR § 2635.502(a).

The DAEO noted that the prohibition was on participation in particular matters and not general policy issues. Hence, in order to avoid the appearance of a conflict of interest, if not an actual one, (b)(7)(C) should recuse himself from particular VA matters, where DAV was, or represented, a party, e.g. legislation on which DAV is providing comments. The DAEO also stated that (b)(7)(C) must also recuse himself from particular matters that would directly and predictably affect the financial interests of DAV. Assuming there was an appearance issue, the DAEO noted that the Standard only required the employee to refrain from participation unless he has informed the agency designee of the issue and received authorization under 5 CFR 2635.502(d).

The DAEO agreed that (b)(7)(C) may not use nonpublic information in performing his duties as (b)(7)(C) because it would be a violation of 5 USC 2635.705. In response to our concerns that given his senior level position involving policy issues, (b)(7)(C) has knowledge of nonpublic information about VA issues, positions, and initiatives and has the opportunity, or temptation, to use the nonpublic information to benefit DAV or to give them advance notice of what is forthcoming from VA, the DAEO stated that if the access to nonpublic information raises an appearance question, the matter should be evaluated as provided in 5 USC 2635.502(d).

*Improper Use of VA Electronic Mail Address and Phone Numbers*

We found that when (b)(7)(C) was the (b)(7)(C) he listed his VA electronic mail address (@vba.va.gov), which clearly identified him as a VA employee, and VA office telephone numbers on the 2006/2007 DAV National Officers roster as a means to contact him. The DAEO stated that (b)(7)(C) should not use his VA telephone number and electronic mail address as a point of contact as this could lead to confusion as to in what capacity he was communicating – as a VA or DAV official. Standards of Ethical Conduct for Employees of the Executive Branch state that an employee shall use official time to perform official duties and must protect and conserve Government property and not use such property for other than authorized purposes. Additionally, an employee shall not use or permit the use of his Government position or any authority associated with his public office in a manner that could reasonably be construed to imply that his agency or the Government sanctions or endorses his personal activities or those of another. 5 CFR § 2635.702 (b), 704 (a), 705.

## Conclusion

We concluded that (b)(7)(C) dual roles as a VA employee and as a high level DAV official were problematic. Because of the interactions between VA and DAV, there existed a significant potential for (b)(7)(C) to "run afoul of the criminal conflict of interest laws and/or standards of conduct." (b)(7)(C) VA position could provide him with nonpublic information that could be inappropriately provided to DAV for the political benefit of DAV. Although we found no circumstance or particular matter that

created a conflict of interest or the appearance thereof, (b)(7)(C) said that he stood for both VA and DAV and that the missions were one and the same. He clearly could not distinguish between these two distinct organizations which, at times, have adversarial or opposing viewpoints. While the DAEO stated that (b)(7)(C) first loyalty must be to VA, not DAV, (b)(7)(C) did not recognize that he must make VA his first priority. (b)(7)(C) was actively involved in DAV matters for over two decades, much longer than his employment with VA. He said his VA responsibilities did not affect or compromise his DAV duties and he never recused himself from any DAV matters due to his VA position. However, prior to our investigation, he never sought VA legal and/or ethics guidance as to whether his responsibilities at DAV created a conflict or the appearance of a conflict of interest with his VA official duties, nor did he seek guidance on whether he should recuse himself from particular VA matters or seek authorization from appropriate VA officials.

In addition, we found that (b)(7)(C) improperly listed his official VA electronic mail address and telephone numbers on a DAV National Officers roster as a means to contact him. We found no instance of (b)(7)(C) using VA-owned equipment to conduct non-VA business; however, it would seem that with this information listed on the DAV roster, he could be contacted concerning DAV matters during his VA workday. In addition, his official VA electronic mail address associated his public office in a manner that could imply that the VA endorsed his personal activities with the DAV.

**Recommendation 1.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management closely monitor (b)(7)(C) activities and set clear and precise boundaries to ensure (b)(7)(C) recuse himself from particular VA matters where DAV is or represents a party and from particular matters that would directly and predictably affect the financial interests of DAV.

**Recommendation 2.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management instruct (b)(7)(C) to remove his official VA electronic mail address and telephone numbers from all DAV rosters and to refrain from using them as a means of contact for DAV activities.

**Recommendation 3.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management counsel (b)(7)(C) on the official use of Government resources and official use of time while performing VA duties.

**Recommendation 4.** We recommend the Office of General Counsel instruct (b)(7)(C) on the differing missions of VA and DAV and what activities pose a possible conflict or the appearance of a conflict of interest in his dual roles at VA and DAV and provide in-depth advice on what particular matters may require his recusal.

## Comments

We found that (b)(7)(C) duties and responsibilities, at times, placed him in conflicting roles with his position as the (b)(7)(C) (b)(7)(C) and we recommended that his activities be closely monitored and that he be instructed on what matters may require his recusal. The Associate Deputy Under Secretary for Policy and Program Management and the Assistant General Counsel/Designated Agency Ethics Official both concurred with our recommendations. The Associate Deputy Under Secretary told us that he discussed these matters with (b)(7)(C) The Assistant General Counsel told us that although a staff attorney previously provided informal advice to (b)(7)(C) on the potential conflicts in his serving as the (b)(7)(C) he agreed that further counseling was needed.

(b)(7)(C)

Appendix A

# VBA Associate Deputy Under Secretary Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** May 29, 2008

**From:** VBA Associate Deputy Under Secretary for Policy & Program Management (20P)

**Subject:** **Administrative Investigation - Alleged Conflict of Interest, VBA, VA Central Office, Washington, DC**

**To:** Director, Administrative Investigations Division (51Q)

As Associate Deputy Under Secretary for Policy and Program and Management, I concur with the 3 recommendations in subject report that fall under the purview of my position (recommendations 1, 2, and 3). I have had a discussion with (b)(7)(C) and consider the actions necessary to carryout these recommendations to have been completed. Please let me know if any further actions on my part are necessary.

## VBA Associate Deputy Under Secretary's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommendation 1.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management closely monitor (b)(7)(C) activities and set clear and precise boundaries to ensure (b)(7)(C) recuse himself from particular VA matters where DAV is or represents a party and from particular matters that would directly and predictably affect the financial interests of DAV.

Concur **Target Completion Date:** Completed

**Recommendation 2.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management instruct (b)(7)(C) to remove his official VA electronic mail address and telephone numbers from all DAV rosters and to refrain from using them as a means for contact for DAV activities.

Concur **Target Completion Date:** Completed

**Recommendation 3.** We recommend the VBA Associate Deputy Under Secretary for Policy and Program Management counsel (b)(7)(C) on the official use of Government resources and official use of time while performing VA duties.

Concur **Target Completion Date:** Completed

Appendix B

# Assistant General Counsel Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 10, 2008

**From:** Assistant General Counsel/Designated Agency Ethics Official (023)

**Subject:** **Administrative Investigation - Alleged Conflict of Interest, VBA, VA Central Office, Washington, DC**

**To:** Inspector General (50)

1. You have submitted for our comment a draft report on an alleged conflict of interest arising from the fact that Robert Reynolds, the VBA Executive Management Officer for Policy and Program Management, also services at the (b)(7)(C) (b)(7)(C) one of my staff attorneys whom you interviewed in connection with this report, previously provided informal advice to (b)(7)(C) on the potential conflicts in his servicing as the (b)(7)(C) We concur in the report's conclusions and recommendations.

2. As to Recommended Action 4, while our office did previously advise (b)(7)(C) on the potential conflicts in his serving as (b)(7)(C) given his statements to your office that he stood for both VA and DAV and that distinguish between these two distinct organizations, we agree that further counseling is needed. We will endeavor to provide this counseling by June 30, 2008. [Edited for non substantive content]

(b)(7)(C)

## Assistant General Counsel's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommendation 4.** We recommend the Office of General Counsel instruct (b)(7)(C) on the differing missions of VA and DAV and what activities pose a possible conflict or the appearance of a conflict of interest in his dual roles at VA and DAV and provide in-depth advice on what particular matters may require his recusal.

Concur **Target Completion Date:** June 30, 2008

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Linda Fournier | (b)(7)(C) |
| Acknowledgments | Kristinn Watkins | |

Appendix D

# Report Distribution

## VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Acting Under Secretary for Benefits (20)
Deputy Under Secretary for Benefits (201)
Associate Deputy Under Secretary for Policy and Program Management (20P)
Deputy General Counsel (02A)
Assistant General Counsel/Designated Agency Ethics Official (023)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington DC 20420**

October 18, 2007

~~"RESTRICTED REPORT"~~

The Office of Inspector General issued the enclosed report – **Administrative Investigation – Misuse of Time, Resources, & Title, and Improper Remote Access VA Central Office** (Report No. 07-02423-10) on October 18, 2007.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Misuse of Time, Resources, & Title, And Improper Remote Access
# VA Central Office

Report No. 07-02423-10

October 18, 2007

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Assistant Secretary for Public and Intergovernmental Affairs (002)
Chief, Customer Support Division, ITSS (005N1B1)

**SUBJECT:** Administrative Investigations, Misuse of Time, Resources, and Title, and Improper Remote Access, VA Central Office (2007-02423-IQ-0140)

## Summary

We substantiated that the (b)(7)(C) (b)(7)(C) misused her official time, misused Government resources, and inappropriately used her official VA title, all in connection with outside employment. We also found that the (b)(7)(C) (b)(7)(C) improperly approved the installation of VA Virtual Private Network remote access software on the (b)(7)(C) non-VA owned computer.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated allegations that (b)(7)(C) (b)(7)(C) misused her official time, misused Government resources, engaged in outside employment during VA duty hours, and inappropriately used her official VA title in connection with this outside employment. We also investigated whether the Information Security Officer for her office improperly approved the installation of VA Virtual Private Network (VA-VPN) remote access software on (b)(7)(C) non-VA owned computer. To assess these allegations we interviewed the Assistant Secretary for Public and Intergovernmental Affairs, the (b)(7)(C) (b)(7)(C) We reviewed (b)(7)(C) VA electronic mail messages covering the time period from March to June 2007; her internet usage from January 16 to June 6, 2007; and her leave schedule from January to July 2007. We also reviewed (b)(7)(C) personal calendar, Federal regulations, VA policy, and other relevant documents.

## Results

**Issue 1: Whether (b)(7)(C) misused her official time, misused Government resources, and improperly used her official title.**

The Standards of Ethical Conduct for Employees of the Executive Branch states that an employee must use official time in an honest effort to perform official duties and shall not engage in outside employment or activities that conflict with their official duties and responsibilities. 5 CFR § 2635.101. Additionally, it states that employees have a duty to protect and conserve Government property and shall not use such property or allow its use for other than authorized purposes. Id., §§ 2635.704 and 2635.705. Employees are permitted limited personal use of Government office equipment; however, this limited use should take place during the employee's non-work time and must not interfere with the VA's mission or operation. VA Directive 6001, paragraph 2(a). Furthermore, employees are expected to conduct themselves professionally in the workplace and are required under the Standards of Conduct to refrain from using Government office equipment for activities that are inappropriate. Inappropriate use includes the use for commercial purposes or in support of "for profit" activities or in support of other outside employment or business activity. VA Directive 6001, paragraph 2 (c).

(b)(7)(C) told us that she provided oversight for a resource management team that oversaw the budget, equipment, and contracts for training. She said she was involved daily in a broad range of meetings which included public relations, communication strategies, and media statements, and she described herself as a personal assistant and technical and policy advisor. She said she worked a compressed tour of duty, working from 9:00 a.m. to 6:00 p.m. daily with every other Friday off; however, she said it was not unusual for her to leave work between 7:00 and 8:00 p.m., due to her workload, rarely taking her scheduled day off. (b)(7)(C) told us that she typically worked a 10 to 12 hour day and was on call 7 days a week by the nature of her position.

*Misuse of Time and Resources*

(b)(7)(C) told us that for the past (b)(7)(C) she has been a (b)(7)(C) (b)(7)(C) She currently works for (b)(7)(C) and she previously worked for (b)(7)(C) She explained that as a part time (b)(7)(C) she worked about 20 hours a week, mostly evenings and weekends. She said she had a business partner that worked full time during the day. She explained that she was always open about the fact that she worked in (b)(7)(C) and that during her interview for her current position, she disclosed that she had a (b)(7)(C) business on the side. (b)(7)(C) told us that she had a personal Blackberry (a wireless handheld device for electronic mail messages) which she used for her private business.

(b)(7)(C) initially told us that when she received phone calls on her personal Blackberry during the work day, she did not answer them; however, she later said she returned the messages and phone calls when going to the restroom, picking up her lunch, or during "5-minute" breaks throughout the workday. She said that she was "very watchful" of her time, and by her estimate, she spent less than an hour a day on her private business. (b)(7)(C) said that if she was unable to return a message or phone call in reference to her part time (b)(7)(C) business, she would refer the messages to her partner via a text message (short message sent from a mobile phone).

In a review of her computer usage, we found that (b)(7)(C) used her assigned VA-owned computer and VA provided internet access to go to websites in conjunction with her (b)(7)(C) business 56 out of 93 workdays between January 16 and June 7, 2007. On several occasions (b)(7)(C) spent a great deal of her workday on the internet visiting websites related to (b)(7)(C) A sampling of the websites included the (b)(7)(C) (b)(7)(C) (b)(7)(C) We also found that the two most common websites accessed, and where (b)(7)(C) spent the most time, were (b)(7)(C) (b)(7)(C) (b)(7)(C) confirmed that her access of these websites was for her (b)(7)(C) business.

Upon closer review, we found several workdays in which (b)(7)(C) internet logs indicated that she accessed the internet for her (b)(7)(C) business for a significant portion of the day. For example, on January 17 and 18, 2007, her logs showed she spent 223 minutes (almost 4 hours) and 188 minutes (over 3 hours), respectively, on her (b)(7)(C) email. On May 29 and 30, 2007, her logs showed she spent 160 minutes (almost 3 hours) and 155 minutes (over 2 hours), respectively, on the (b)(7)(C) website. However, (b)(7)(C) told us that she would open several windows on her computer, to include websites and her email, and they would remain open as she multitasked throughout the workday, going back and forth to them. Her internet logs verified that she accessed several websites numerous times on given workdays. As an example, (b)(7)(C) accessed (b)(7)(C) on the following dates and times:

- April 24, 2007 – 6:48 a.m., 7:32 a.m., 8:32 a.m., 8:47 a.m., 8:53 a.m., 9:01 a.m., 10:03 a.m., 10:33 a.m., 11:17 a.m., 12:21 p.m., 1:37 p.m., 2:09 p.m., and 2:21 p.m.

- May 8, 2007 – 5:41 a.m., 5:53 a.m., 6:11 a.m., 6:30 a.m., 7:35 a.m., 9:27 a.m., 10:10 a.m., 10:52 a.m., 11:36 a.m., 11:59 a.m., 12:23 p.m., and 1:40 p.m.

- June 4, 2007 – 6:45 a.m., 7:15 a.m., 9:21 a.m., 11:14 a.m., 1:06 p.m., 1:44 p.m., and 2:36 p.m.

Computer internet logs also documented (b)(7)(C) continued activity, recording the amount of time she remained active on each website. For example, the logs indicated the following total active time on (b)(7)(C) for the following days:

- January 22, 2007 – www.MRIS.com = 57 minutes

- April 24, 2007 – www.MRIS.com = 150 minutes

- May 29, 2007 – www.MRIS.com = 63 minutes

- May 30, 2007 – www.MRIS.com = 53 minutes

(b)(7)(C) told us that she checked her personal email once or twice a day, mostly during her lunch break; however, computer internet logs indicated she accessed her personal email numerous times throughout the workday. As an example, we found that she accessed her (b)(7)(C) email account on the following dates and times:

- January 17, 2007 – 11:41a.m., 11:45 a.m., 12:19 p.m., 1:35 p.m., 2:37 p.m., 2:40 p.m., and 3:24 p.m.

- February 14, 2007 – 11:09 a.m., 11:34 a.m., 11:53 a.m., 12:02 p.m., 1:52 p.m., and 4:22 p.m.

- March 20, 2007 – 6:27 a.m., 6: 56 a.m., 9:26 a.m., and 9:35 a.m.

- May 31, 2007 – 5:10 a.m., 6:26 a.m., 11:16 a.m., 1:50 p.m., 1:52 p.m., 1:53 p.m.

*Improper Use of Official Title*

The Standards of Ethical Conduct for Employees of the Executive Branch state employees shall not use public office for their own private gain nor should an employee use or permit the use of their Government position or title or any authority associated with their public office to endorse any product, service or enterprise. 5 CFR § 2635.702.

(b)(7)(C) initially told us that she did not use her VA email to send or receive messages concerning her real estate business, explaining that there may be times that she received a message from a friend asking her about (b)(7)(C) In reviewing her VA email messages; however, we found several messages she received and sent to both VA and non-VA employees discussing (b)(7)(C) admitted that she worked with a current VA employee to (b)(7)(C) but that she asked him to send any messages concerning the sale to her private [redacted] email address. She said that he did not comply with her request; however, she continually responded to his messages from her VA email. In numerous mail messages dated between March and April 2007, (b)(7)(C)

(b)(7)(C) conducted her (b)(7)(C) business with this employee using her VA email account, including her VA title and office in her email messages.

In addition, we found an email in her VA email account, dated April 25, 2007, in which (b)(7)(C) went into great detail describing payment and settlement options for a client of hers, a non-VA employee. We also found three emails stored in her VA email draft folder which discussed (b)(7)(C) and contained (b)(7)(C) (b)(7)(C) All these emails contained (b)(7)(C) official title of (b)(7)(C) (b)(7)(C) told us that leaving her title on these emails was an oversight and not an attempt to suggest an intimate knowledge of (b)(7)(C) (b)(7)(C)

In yet another email, dated March 20, 2007, (b)(7)(C) wrote that she was making between 60-70% of her Government salary in (b)(7)(C) In reviewing these emails, internet logs, and discussing her success in (b)(7)(C) told us that it was now apparent to her that she spent more time than she realized on her (b)(7)(C) (b)(7)(C) business during her VA tours of duty. (b)(7)(C) said that she was "appalled" by the amount of time she spent on (b)(7)(C) and that it apparently got "out of hand." Moreover, (b)(7)(C) told us that, as an (b)(7)(C) she was responsible for recommending to her supervisor appropriate disciplinary actions for employee misconduct. She told us that in a similar situation, if it were another employee, she would advise her supervisor to take appropriate administrative action with possible removal of the employee.

**Issue 2: Whether an (b)(7)(C) improperly approved VA-VPN remote access on a non-VA owned computer.**

VA employees are permitted to access and use VA data outside VA facilities only when such activities have been specifically approved by the employee's supervisor and where appropriate security measures are taken to ensure that VA information and services are not compromised; however, only VA-owned Government Furnished Equipment, including laptops and handheld computers, may be used when accessing the VA intranet remotely. (b)(7)(C) (b)(7)(C) (b)(7)(C) An October 5, 2006 Memorandum, titled *IT Directive 06-5, Use of Personal Computing Equipment*, from the Deputy Secretary to the Department, allows for non-VA Other Equipment to be used when accessing the VA intranet remotely but only to allow for uninterrupted delivery of healthcare and provision of benefits to veterans. It also indicates that the use of non-VA owned Other Equipment will be replaced with VA-owned Government furnished equipment during fiscal year 2007. Additionally, VA Remote Access Guidelines for VA-VPN usage states that where possible, only Government-owned computer equipment will be used when accessing

VA's Intranet remotely, and there should be no new remote access implementations that use privately-owned equipment. It further states that VA organizations should develop plans to migrate employees currently using privately-owned equipment to Government-owned equipment.

(b)(7)(C) told us that due to the nature of her position, she was issued a VA-owned laptop; however, because she never used it, she returned it to the information technology staff several months ago. Further, she said that she had not used her authorized VA-Virtual Private Network (VA-VPN) remote access account, and it was terminated for lack of use. She said that because of a recent emergency management exercise led by the Deputy Secretary, a need to update their office emergency management plans, and that her residence was identified as the main offsite operation center for her office in the event of a mass emergency, she needed to have VA-VPN remote access. Therefore, she requested the (7)(C) provide her software to install VPN access on her non-VA owned equipment. She told us that since then, she only logged into the system once briefly to ensure it was installed properly.

The (b)(7)(C) told us that sometime during the week of July 2, 2007, (b)(7)(C) contacted him by email or telephone to request installing VA-VPN remote access on her non-VA owned computer. He further stated that she relinquished her VA-issued laptop at about that same time, contrary to (b)(7)(C) assertion that she turned it in months ago. The (b)(7)(C) explained that he either directed (b)(7)(C) to an internet site or provided her a CD containing VA-VPN software to download to her personal computer. He also said that there was no need for (b)(7)(C) to request, through her supervisor, remote access or access from her non-VA equipment, as her authorization and access was automatic due to her being a member of the emergency team.

## Conclusion

We concluded that (b)(7)(C) misused her official time and Government resources on a regular basis to conduct work for her private real estate business. She routinely accessed websites and personal email accounts to research (b)(7)(C) and to communicate with customers throughout her work day. Computer internet logs indicated that she not only spent a significant amount of time conducting (b)(7)(C) business during her official VA tour, but it was an on and off activity throughout the day, such as on April 24, 2007, when she accessed one particular website 13 times, spending 150 total minutes on that site. It was apparent that (b)(7)(C) attempted to juggle two jobs during her VA tour of duty, and at times, her private (b)(7)(C) business overtook her time and attention. In addition, she used her official VA email to correspond with (b)(7)(C) customers, improperly leaving her official VA title at the close of her messages.

We also concluded that although (b)(7)(C) may need remote access to VA systems, due to her position and responsibilities, there was no need to establish this via VA-VPN remote access from her non-VA owned equipment. (b)(7)(C) had a VA-owned laptop assigned to her, which allowed for remote access, but because she did not use the laptop, she relinquished it. Additionally, the [ ] knowingly authorized installing the (b)(7)(C) software for remote access on (b)(7)(C) non-VA owned equipment, when he was well aware that she recently turned in a Government-owned laptop. Since an OIG investigation into a loss of VA data in 2006, VA has set forth clear policies and procedures in a concerted effort to restrict access to VA data while working in locations other than a VA facility. This guidance includes a policy that states only VA-owned Government Furnished Equipment may be used for remote access and that there should be no new remote access implementations that use privately-owned equipment.

**Recommended Action(s) 1.** We recommend the Assistant Secretary for Public and Intergovernmental Affairs, in accordance with VA policy, ensures that appropriate administrative action is taken against (b)(7)(C) for misuse of her official time, misuse of Government resources, and improper use of her official VA title.

**Recommended Action(s) 2.** We recommend the Chief, Customer Support Division, ITSS, in accordance with VA policy, ensures that appropriate administrative action is (b)(7)(C) taken against the [ ] for authorizing VA-VPN remote access on a non-VA computer.

**Recommended Action(s) 3.** We recommend the Chief, Customer Support Division, ITSS, in accordance with VA policy, ensures that VA-VPN remote access is removed from (b)(7)(C) non-VA computer that the computer is sanitized of any VA sensitive data, and that she be re-issued a Government laptop with VA-VPN access.

## Comments

The Assistant Secretary for Public and Intergovernmental Affairs and the Chief, Customer Support Division, ITSS, concurred with the above recommendations. The Assistant Secretary decided to initiate action to propose (b)(7)(C) removal from Federal service; however, (b)(7)(C) resigned before the action could be issued. The (b)(7)(C) Chief told us that the (b)(7)(C) was no longer an (b)(7)(C) and he was reassigned. She stated that (b)(7)(C) HR Employee Labor Relations Service recommended that the former (b)(7)(C) be issued a (b)(7)(C) letter of admonishment or reprimand, which is currently in review. She further stated that (b)(7)(C) did not gain remote access to the system and that all VA network and VPN accounts assigned to (b)(7)(C) were removed. In addition, the OI&T VACO IT Operations Service will reissue copies of Directive 6504 and any related addendums to ensure staff is aware of VPN protocols, and they plan to conduct an all-hands meeting to provide clarity to staff regarding the Directive.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

Appendix A

# Assistant Secretary Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** October 12, 2007

**From:** Assistant Secretary for Public and Intergovernmental Affairs (002)

**Subject:** **Administrative Investigation, Misuse of Time, Resources, and Title, & Improper Remote Access, VA Central Office**

**To:** Assistant Inspector General for Investigations (51)

## Assistant Secretary's Comments to Office of Inspector General's Report

The following Assistant Secretary's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend the Assistant Secretary for Public and Intergovernmental Affairs, in accordance with VA policy, ensures that appropriate administrative action is taken against (b)(7)(C) for misuse of her official time, misuse of Government resources, and improper use of her official VA title.

Concur **Target Completion Date:** See Below

The Office of Public and Intergovernmental Affairs, in consultation with the Office of Human Resources and Administration, decided to initiate action to propose (b)(7)(C) removal from Federal service. (b)(7)(C) resigned before the action could be issued. On (b)(7)(C) (b)(7)(C) submitted her resignation to be effective the same date (b)(7)(C)

No further action is anticipated.

Appendix B

# Chief's Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** October 12, 2007

**From:** Chief, Customer Support Division, ITSS (005N1B1)

**Subject:** **Administrative Investigation, Misuse of Time, Resources, and Title, & Improper Remote Access, VA Central Office**

**To:** Office of Inspector General (51Q)

There have been several turn of events since the report was issued to this office for a response: 1) (b)(7)(C) has been reassigned to the (b)(7)(C) (b)(7)(C) 2) (b)(7)(C) does not work in the capacity of an Information Security Officer (ISO); and 3) (b)(7)(C) is no longer employed with the Department of Veterans Affairs.

(b)(7)(C)

## Chief's Comments to Office of Inspector General's Report

The following Chief's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 2.** We recommend the Chief, Customer Support Division, ITSS, in accordance with VA policy, ensures that appropriate administrative action is taken against the [ ] for authorizing VA-VPN remote access on a non-VA computer.

(7)(C)

Concur **Target Completion Date:** 30 days

This organization has consulted with VACO's HR Employee Labor Relations Service regarding administrative actions, and have been advised to issue [(b)(7)(C)] a letter of admonishment or reprimand. This service is reviewing the HR recommendations.

**Recommended Action(s) 3.** We recommend the Chief, Customer Support Division, ITSS, in accordance with VA policy, ensures that VA-VPN remote access is removed from [(b)(7)(C)] non-VA computer, that the computer is sanitized of any VA sensitive data, and that she be re-issued a Government laptop computer with VA-VPN access.

Concur **Target Completion Date:** See below

All VA network and VPN accounts assigned to [(b)(7)(C)] have been deleted since her departure, access was not gained to the system, device is no longer available, and all VPN accounts have been removed.

The OI&T VACO IT Operations Service will reissue copies of Directive 6504 and any related addendums to ensure staff is aware of the protocols for installing VPN. Further, because of the overlapping guidance that has been issued, the Service will plan to conduct an all-hands meeting to provide clarity to staff regarding the directive.

Appendix C

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Linda Fournier | (b)(7)(C) |
| Acknowledgments | Carrie B. Lewis | |

Appendix D

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Chief, Customer Support Division, ITSS (005N1B1)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Misuse of Government Travel Card
# VA Central Office

Report No.

VA Office of Inspector General
Washington, DC 20420

**WARNING**
**5 U.S.C. §552a, PRIVACY ACT STATEMENT**

**This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. §552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.**

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Deputy Assistant Secretary for Finance, VA Central Office (047)

**SUBJECT:** Administrative Investigation, Misuse of Government Travel Card, VA Central Office (2006-02434-IQ-0202)

## Summary

We substantiated that (b)(7)(C) violated Federal travel regulations and VA travel policy when she misused her Government travel card to procure conference rooms, reserve hotel rooms for others, pay to ship personal items to her residence, and withdraw cash advances without being in an official travel status. Additionally, she failed to use prudent travel practices when she routinely exceeded Government lodging and meal per diem rates and used rental vehicles rather than less expensive transportation. Furthermore, she frequently failed to pay the monthly statement for her travel card in a timely manner, resulting in delinquencies by as much as 60 days.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated allegations that (b)(7)(C) (b)(7)(C) (b)(7)(C) VA Central Office, Washington DC, engaged in a variety of travel irregularities and made inappropriate travel card purchases. To assess the allegations, we interviewed (b)(7)(C) her current and former supervisors, and other VA Central Office employees. We also conducted telephone interviews with employees at the Financial Services Center in Austin, Texas. We reviewed (b)(7)(C) travel vouchers for trips taken between January 2004 and September 2006, her Government travel card statements, Federal laws and regulations, and VA policies. Other allegations were not substantiated, and we do not discuss them further in this report

## Results

**Issue: Whether (b)(7)(C) misused her Government travel card**

Federal regulations require employees to conserve Government resources and to satisfy financial obligations, and it prohibits them from using their public office for personal gain. In addition, it requires agencies to pay only travel expenses that are essential to official business and employees to exercise prudence when incurring expenses on official travel, and it prohibits the payment of excess costs resulting from circuitous routes or services unnecessary in the performance of official business [5 CFR § 2635.101, 702, 704; 41 CFR § 301-2.2, 2.4]. VA policy states that misuse of the Government travel card and account delinquency are considered misconduct and subject the cardholder to disciplinary actions [VA Handbook 0631.1(18)(a)] and that cardholders must use prudent travel practices, observe the rules and regulations governing official travel, and may not use the card to make personal purchases or ATM withdrawals unrelated to official travel [VA Directive 0631.1]. Furthermore, VA policy states that employees are expected to minimize costs of official travel, prohibits excess costs and delays unnecessary for the performance of official business, and requires employees to pay for additional expenses incurred [MP-1, Part II, Chapter 2, Para. 2 (g)(1)].

In (b)(7)(C) was the (b)(7)(C) at the (b)(7)(C) Atlanta VA Medical Center, and in [redacted] she joined the Topeka Health Revenue Center as the (b)(7)(C) She became the (b)(7)(C) (b)(7)(C) and (b)(7)(C) As the (b)(7)(C) (b)(7)(C) was also the (b)(7)(C) (b)(7)(C) and she led the VA-wide Defense Finance Accounting Service (DFAS) conversion. To conduct training and test the new payroll system, (b)(7)(C) frequently traveled to DFAS Headquarters in Pensacola, Florida; the Financial Services Center in Austin, Texas; the Oakland VA Regional Office in Oakland, California; and the San Francisco VA Medical Center in San Francisco, California.

*Unnecessary expenses and circuitous routes while on official travel*

We found that on seven separate travel occasions, (b)(7)(C) charged a total of $554.46 in hotel internet and local area phone charges. In one instance, she incurred $427.52 in internet charges while on travel to (b)(7)(C) between (b)(7)(C) She told us that her VA-issued Blackberry (a wireless device used to receive electronic mail messages and cellular telephone service) was not charged at that time, so she used her VA-issued laptop to access the VA network through the hotel telephone service while working at night and to facilitate daily meetings. She also told us that she was not aware that there was a charge associated with accessing the network through the hotel. She added that her VA-issued laptop was not equipped with a toll free internet number but instead had preinstalled local numbers for several cities nationwide.

Additionally, we found (b)(7)(C) did not minimize her travel costs, obtained unnecessary services, and sought reimbursement for these expenses. On three occasions, she prepaid the rental car company for gasoline at a purported higher rate rather than filling the tank herself prior to returning the car, and on four occasions, she upgraded her rental car while on official travel.

We also identified several instances when (b)(7)(C) obtained a rental car for her own personal convenience rather than using less expensive transportation. For example, she paid $506.19 in charges on a trip to (b)(7)(C) which included $316.60 for a rental car, $164.16 for hotel parking, and $25.43 in gasoline charges. However; there were only 47 miles logged on the rental car, the official business meetings were held at her hotel, and the airport was only about 3 miles from the hotel. (b)(7)(C) said during the (b)(7)(C) trip she visited the Medical Center twice for meetings and told us that it would have been more cost effective to take an airport shuttle from the airport for $15.00 and a taxi to and from the Medical Center which was located 7 miles from her hotel.

During her official travel to (b)(7)(C) paid $353.58 in rental car charges, $129.00 in prepaid gasoline charges, and sought a $50.00 reimbursement for gasoline. Rental car receipts showed there were 811 miles logged on the car for the 5 day trip, yet her hotel was located about 3 miles from her temporary duty station and 10 miles from the airport. (b)(7)(C) was unable to explain the 811 miles placed on the rental car but suggested that other members of the group may have driven the car. However; her travel card records indicated that during that time period, (b)(7)(C) (b)(7)(C) used her card to charge a meal in Dallas, TX, which is over 180 miles from Austin.

Additionally, (b)(7)(C) chose to drive a rental car to (b)(7)(C) for temporary duty from (b)(7)(C) told us that, based on her cost analysis, it was more efficient to drive than fly; however, out of all the trips she took to (b)(7)(C) this was the only time she drove. Moreover, she was unable to provide travel documents for that trip. Her subsequent cost analysis showed a total cost of $2,468.91, including roundtrip airfare, but in using a rental car, her total cost was $2,547.26. Although this was not a significant cost difference, (b)(7)(C) told us that it took her 2 days to drive to (b)(7)(C) thereby spending 4 days driving roundtrip rather than 4 hours flying by airplane. (b)(7)(C) also told us that she stayed with a relative in (b)(7)(C) during this trip, so there was no lodging cost to the Government for that overnight stay.

On two other occasions, (b)(7)(C) used her travel card to pay charges associated with shipping items to her office and home. For example, a United Parcel Service store receipt, dated August 13, 2005, indicated that (b)(7)(C) used her travel card to pay the cost of shipping paperwork to her office at a cost of $105.86; however, her travel voucher for that same trip requested a reimbursement of $155.86 in miscellaneous expenses, $50 over the cost of the shipping. Another shipping receipt, dated November 17, 2005,

indicated that (b)(7)(C) used her travel card to pay $153.42 to ship shoes, purses, office/work papers, and luggage to her personal residence, yet her travel voucher showed a $53.42 expense for excessive baggage fees. (b)(7)(C) told us that she did not seek reimbursement for the entire charge, due to the majority of items being personal, yet she could not explain how she calculated what charges were to be reimbursed to her. On three additional occasions, (b)(7)(C) claimed a total of $100.00 in excess baggage fees. (b)(7)(C) told us that when she traveled, she chose to take two complete wardrobes for each day of travel, and in addition to her personal items, she at times also packed work documents in her luggage. (b)(7)(C) clarified that she hand-carried any sensitive documents on the airplane.

*Misuse of travel card for cash advances unrelated to official travel*

VA travel policy states that employees are expected to identify authorized miscellaneous expenses paid for in cash and ATM transaction and bank surcharges, and that they may not use the Government travel charge card to make personal purchases or ATM withdrawals unrelated to official travel [VA Handbook 0631.1, paragraph 12(c)].

On 22 separate travel assignments, (b)(7)(C) withdrew 17 cash advances totaling $1,820.00 and incurred $57.65 in cash advance fees. (b)(7)(C) did not identify cash purchases or surcharges on travel vouchers in these instances. Further, (b)(7)(C) could not identify specific expenses associated with the cash withdraws except for "snacks, drinks, and entertainment" while waiting in airports. Moreover, she could not explain why she needed cash advances when she placed most of her travel related expenses on her travel card. Additionally, she made two $100.00 withdrawals in (b)(7)(C) on April 9, 2004 and August 7, 2005, and she did not have authorization to travel on those occasions.

(b)(7)(C) told us that she was not familiar with travel card cash advance regulations; it was 6 or 7 years since she was versed in these regulations; and that the regulations did not exist during her tour as a (b)(7)(C) However, she told us that within the past year she attended travel card training, but she did not recall the details of the training, since she did not pay attention while in the class. We confirmed that (b)(7)(C) completed GSA Smart Pay Travel Card training on May 2, 2006.

*Misuse of travel card to reserve hotel rooms for other employees*

(b)(7)(C) authorized a Travel Clerk to use her (b)(7)(C) travel card to reserve blocks of hotel rooms for meeting attendees. The attendees were all VA employees with travel cards of their own, with the exception of one attendee whose card was revoked. In addition, the vendor charged (b)(7)(C) for rooms not occupied, as some employees did not attend the meetings. For example, on September 20, 2005, (b)(7)(C) reserved a block of hotel rooms at the Springhill Suites Marriott in (b)(7)(C) for $129.00 a

night, which was $56 over the daily per diem rate of $73.00. Three employees did not attend, and the hotel charged (b)(7)(C) $147.71 for each room. (b)(7)(C) told us she assumed she had authority to make hotel arrangements for the group because that was a past practice. She also said that once she brought the additional room charges to the hotel's management attention her travel charge card was appropriately credited. When asked why she exceeded the allowable per diem rate, her only explanation was that she assumed it was permitted and that the rooms would be charged appropriately.

*Misuse of travel card to procure conference/training rooms*

Federal travel regulations require agencies to minimize all conference costs, determine if a Government-owned or provided facility is available at a cheaper rate, determine conference expenditures by cost comparisons, and use approved accommodations [41 CFR §301-74]. Federal regulations and VA policy mandate that travel cards be used only for official travel related expenses [41 CFR §301.51.6; VA Handbook 0631.1(4)].

We identified three occasions when (b)(7)(C) used her travel card to pay for conference/training rooms totaling $3,020. For example, on August 7, 2005, she paid $1,000 for training rooms in (b)(7)(C) on February 27, 2006, she paid $1,620 in (b)(7)(C) (b)(7)(C) and on March 29 and April 3, 2006, she paid $200 on each date in (b)(7)(C) (b)(7)(C) for training rooms. (b)(7)(C) told us that the meetings were with short notice and coupled with a difficulty of securing meeting space at the (b)(7)(C) VA facilities, she opted to hold the two meetings at the hotel where the attendees stayed. (b)(7)(C) recalled the decision to hold the meeting in (b)(7)(C) was based on the most economical location in terms of per diem and the number of attendees. She told us that she was not aware that she could not use her travel card for this purpose.

*Exceeding per diem rates and failing to pay Government travel card in a timely manner*

Out of 22 official travel trips, we identified nine occasions totaling $868.00 where (b)(7)(C) exceeded the GSA allowable lodging rate; and on eight of those occasions she failed to obtain authorization to do so. She told us a Program Specialist was responsible for making her travel arrangements and she assumed the specialist knew the rules and followed them. (b)(7)(C) exceeded the allowable per diem rate for meals 17 times. For example, when she traveled to (b)(7)(C) the meal per diem rate was $43.00 a day and she spent $80.12 for a meal on (b)(7)(C) $66.62 on (b)(7)(C) and $80.97 on (b)(7)(C) In another example, while in a temporary duty status, she charged $326.96 to her Government travel charge card on March 30, 2006, for her meal and the meals of her dinner guests at Ruth Chris Steak House. She told us she did not know employees were limited to their meal cost and disputed the definition of excessive. She said the Ruth Chris Steak House would not give separate checks for each dinner guest, and as a result, she placed the entire bill on her

Government travel card and the others reimbursed her. In addition, (b)(7)(C) said she was unaware that paying for other employee's meals was a violation of card privileges.

We found that on 16 occasions, (b)(7)(C) failed to pay her travel card statement on time, and there were 10 billing cycles where she paid an additional fee to use a "speed pay" option to avoid the bill going overdue. Her travel vouchers showed that she did not seek reimbursement for any meals over the allowable per diem rate; however, the excessive meal charges may have contributed to her inability to pay her Government travel card account on time. She admitted not processing her travel vouchers and making timely payments and attributed the failure to satisfy her financial obligations to the aggressive project schedule, the amount of travel involved, and her hectic work schedule. In an attempt to resolve the payment issue, (b)(7)(C) said she implemented a "split pay" option so that the Government automatically paid her travel card bill in lieu of reimbursing her, thus eliminating delinquencies.

(b)(7)(C) had five travel reimbursement approving officials between January 2004 and September 2006; we interviewed three and two were no longer with VA. The Associate Deputy Assistant Secretary for Financial Systems and Operations became (b)(7)(C) immediate supervisor in (b)(7)(C) and approved eight of (b)(7)(C) travel vouchers. She told us if the Senior Budget Officer questioned or rejected a travel voucher, she was notified via electronic mail. She said she was not aware of (b)(7)(C) travel card charges particularly the large amount of charges at restaurants and ATM withdrawals. The Associate Deputy Assistant Secretary for Financial Systems and Operations was aware of (b)(7)(C) travel card delinquency issues and that (b)(7)(C) requested the "split pay" option, stating that (b)(7)(C) has not had a problem since.

The Deputy Director for the Office of Financial Systems and Operations approved five of (b)(7)(C) travel vouchers resulting in improper payments and reimbursements. He said he frequently questioned (b)(7)(C) travel vouchers and any improper claims approved on (b)(7)(C) vouchers were an oversight on his part. The Deputy Director said he never reviewed (b)(7)(C) travel card statements and therefore was not aware of any charges.

The Administrative Officer served as (b)(7)(C) immediate supervisor briefly, approving two of her travel vouchers. She told us she questioned both of (b)(7)(C) travel plans; the first occasion involved the cost of airfare and the other concerned a weekend stay and in each incident (b)(7)(C) provided justification for approval. The Administrative Officer said she was not aware of any charges on (b)(7)(C) travel card.

The Senior Budget Analyst told us that out of approximately 110 employees' travel plans and vouchers he reviewed, (b)(7)(C) plans were rejected most often, explaining she was an "expensive traveler" and notoriously late filing her travel vouchers. He added that he advised (b)(7)(C) to speak with a Contracting Officer or Acquisition Officer

concerning alternate ways to secure conference/training rooms while on official duty. He said that he warned (b)(7)(C) to have supporting documents to justify her travel expenses in the event the Inspector General audited her files. Although (b)(7)(C) supervisors approved her official travel they did not review her travel card billing statement and had no detailed knowledge of her spending habits.

## Conclusion

(b)(7)(C) routinely incurred unnecessary expenses and did not observe the rules and regulations governing official travel. We identified 84 instances that highlighted (b)(7)(C) failure to observe strict fiscal responsibility and minimize cost while on official Government travel. We found 16 times where (b)(7)(C) failed to satisfy her Government travel charge card financial obligations resulting in delinquencies up to 60 days. (b)(7)(C) made several ATM cash withdrawals with her Government travel charge card and was not in an official travel status. Finally, the pattern of excessive spending, failure to exercise strict fiscal responsibility and the repeated infractions of travel card delinquencies raise questions concerning (b)(7)(C) resolve to comply with Federal and VA travel regulations and her intent to personally gain from her official activities.

**Recommended Action(s) 1.** We recommend that the Deputy Assistant Secretary for Finance provide (b)(7)(C) detailed training on Federal travel regulations and VA policy.

**Recommended Action(s) 2.** We recommend that the Deputy Assistant Secretary for Finance ensure that appropriate administrative action is taken against (b)(7)(C) for not using prudent travel practices and observing regulations governing official travel.

## Comments

The Deputy Assistant Secretary for Finance, VA Central Office, concurred with the above recommendations. He told us that (b)(7)(C) will take a travel charge card training course that explains the proper use of the travel card, provides a competency test at the end of the training, and generates a certificate of completion as proof of successful completion. The Deputy Assistant Secretary further told us that he would take the appropriate administrative action against (b)(7)(C) for not using prudent travel practices and observing regulations governing official travel.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

Appendix A

# Deputy Assistant Secretary's Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** September 19, 2007

**From:** Deputy Assistant Secretary for Finance (047)

**Subject:** **Administrative Investigation Misuse of Government Travel Card, VA Central Office**

**To:** Assistant Inspector General for Investigations

I have reviewed the report and agree with the recommended actions. (b)(7)(C) will be required to take the travel charge card training offered on the GSA website. The training explains the proper use of the travel charge card. In addition, we will take the appropriate administrative action as outlined in VA Handbook 0631.1, paragraph 18a.

(b)(7)(C)

## Deputy Assistant Secretary's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Deputy Assistant Secretary for Finance provide (b)(7)(C) detailed training on Federal travel regulations and VA policy.

Concur **Target Completion Date:** 11/30/07

(b)(7)(C) will be required to take the travel charge card training offered on the GSA website. The training course explains the proper use of the travel charge card, provides a competency test at the end of the training, and generates a certificate of completion that can be provided as proof that she successfully completed the training on proper card useage.

**Recommended Action(s) 2.** We recommend that the Deputy Assistant Secretary for Finance ensure that appropriate administrative action is taken against (b)(7)(C) for not using prudent travel practices and observing regulations governing official travel.

Concur **Target Completion Date:** 11/30/07

VA Handbook 0631.1, paragraph 18a provides guidance on disciplinary actions for misuse of the government charge card. The disciplinary actions range from a reprimand to removal. We will work with Human Resources to determine the appropriate action based on the IG findings.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Linda Fournier | (b)(7)(C) |
| Acknowledgments | Kristinn Watkins | |

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Deputy Assistant Secretary for Finance, VA Central Office (047)

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Call the OIG Hotline – (800) 488-8244**

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

August 21, 2007

~~"RESTRICTED REPORT"~~

The Office of Inspector General issued the enclosed report – **Administrative Investigation – Misuse of Resources and Position VA Medical Center, Oklahoma City, Oklahoma** (Report No. 06-02081-189) on August 21, 2007.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Misuse of Resources and Position
# VA Medical Center
# Oklahoma City, Oklahoma

Report No. 06-02081-189

August 21, 2007

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Director, Veterans Integrated Service Network 16 (10N16)

**SUBJECT:** Administrative Investigation – Misuse of Resources and Position, VA Medical Center, Oklahoma City, OK (2006-02081-IQ-0185)

## Summary

We substantiated that the (b)(7)(C) at the Oklahoma City VA Medical Center erroneously recommended selling Veterans Health Administration (VHA) health care resources to a VA medical center physician so the physician could treat his daughter, an ineligible veteran, at that facility. Based on this recommendation, the former Medical Center Director authorized the treatment. Once the Chief learned that VHA policy prohibited such an arrangement, he failed to determine if corrective action was needed. We also substantiated that the physician, a cardiologist, misused his position by performing the procedure.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated the alleged unauthorized medical treatment of an ineligible veteran who was the daughter of a physician employed by the Oklahoma City VA Medical Center. According to the complainant, the former Medical Center Director approved the daughter's treatment even though other veterans were being denied care. Since the former Director retired, we did not investigate his accountability in this matter. We did investigate whether (b)(7)(C) provided the former Director erroneous advice concerning the propriety of treating the veteran at the Medical Center, and whether (b)(7)(C) the veteran's father and treating physician, a (b)(7)(C) misused his position when he treated her there. We interviewed (b)(7)(C) and other VA employees. We also reviewed documentation relating to the daughter's medical procedure and its cost, VHA policy and Federal regulations, and other relevant documents.

## Results

**Issue: Whether (b)(7)(C) improperly advised that it was appropriate to treat, and whether (b)(7)(C) improperly treated, an ineligible veteran**

VHA policy authorizes, in accordance with Federal law, the sale of VHA health care resources, including medical and surgical services, support and administrative resources, and the use of medical equipment and space, to other health care providers or to individuals. According to the policy, the medical center director must certify that contracts awarded under this authority do not diminish existing levels of services to veterans and that the contract is necessary to maintaining an acceptable level and quality of service to veterans (or results in improvement of services to veterans). The policy requires all contracts to be in writing and to undergo legal review. Contracts with VA employees are specifically prohibited. Finally, the policy permits, but does not require, VHA health care resources to be priced above full cost [VHA Directive 1660.1, paragraphs 1, 2, 3a, 3g, 3i, 4f]. As Chief of the Medical Administration Service, Mr. Morrison is responsible for providing the technical advice necessary to comply with policy and administrative requirements related to the care and treatment of patients.

The Standards of Ethical Conduct for Employees of the Executive Branch prohibit employees from using their public position for the private gain of relatives and require that they avoid actions giving the appearance they are doing so [5 CFR § 2635.101, 702]. Additionally, Federal regulations and VA policy state that employees shall not engage in conduct prejudicial to the Government. VA policy also states that employee conduct which reflects adversely on the Federal Government may be grounds for disciplinary action [5 CFR § 735.203; VA Handbook 5025, Part III, paragraph 5c].

VA uses a priority group system to balance demand and available resources, assigning veterans who apply for benefits to a priority group, numbered 1 through 8. Effective January 17, 2003, VA denied enrollment and medical care benefits to group 8, subgroups "e" and "g," veterans applying after that date. There were 256,416 veterans, nationwide, who applied for enrollment during the 2005 fiscal year but were determined to be in priority group 8g, therefore ineligible for VA healthcare.

(b)(7)(C) told us that in (b)(7)(C) he performed a medical procedure on his adult daughter at the Oklahoma City VA Medical Center to assist in further assessing her condition following a diagnosis by the daughter's private cardiologist. According to (b)(7)(C) he scheduled the procedure on a day when he had free time and the necessary laboratory was available. He said that when his daughter registered at the medical center, however, the two of them were told she was not eligible for VA medical care and treatment as a veteran because she was in priority group 8g.

According to (b)(7)(C) on the morning of the procedure, the former medical center Director told him (b)(7)(C) daughter was at the medical center and asked him if there was a way to allow her to undergo the procedure there. (b)(7)(C) said, in response, he recommended using VA's authority to sell health care resources on the basis that the sale would generate revenue for the medical center. (b)(7)(C) told us he was familiar with the revenue generation program at another VA medical center, involving the sale of services to the Department of Defense, and believed it was an appropriate option in this circumstance if they charged (b)(7)(C) a high enough fee to ensure the Oklahoma City Medical Center made a profit on the procedure. (b)(7)(C) said his understanding was that the procedure needed to be done immediately and, due to what he perceived to be an urgent need, he did not take time to research the applicable policy or to seek advice from the Regional Counsel's office. He said he contacted the facility's medical care cost recovery staff and they calculated that the bill to (b)(7)(C) would be $9,191. (b)(7)(C) told us he then advised (b)(7)(C) that the former Director would allow the procedure if he (b)(7)(C) was willing to pay the fee and that (b)(7)(C) verbally agreed to do so.

(b)(7)(C) told us that several days to a week later he reviewed the VHA policy, cited above, on selling health care resources. That policy did not authorize (b)(7)(C) to treat his daughter because (b)(7)(C) was a VA employee and thus could not contract with VA to purchase VHA resources, and because the agreement was not in writing and was not legally reviewed. (b)(7)(C) told us at this point he did not attempt to determine what, if any, action he should take to correct the improper agreement because the surgery had already taken place and (b)(7)(C) had verbally agreed to pay for it. Further, (b)(7)(C) noted that the services were provided to a veteran, no other veteran was displaced, and the medical center generated money that was now available for the facility to treat other veterans. Other personnel present for the procedure also told us no other veteran was displaced while (b)(7)(C) performed this procedure.

Similarly, (b)(7)(C) recalled that (b)(7)(C) told him that because his daughter was not eligible, the medical center could not bill her private insurance company and that she or (b)(7)(C) would have to pay for the services provided. (b)(7)(C) said (b)(7)(C) told him the bill could be as high as $9,000. He said he decided to deal with the bill at a later time but the procedure needed to be done. He acknowledged that other options were available, but said he wanted the procedure done at VA and done by him because he believed that would result in the best medical care for his daughter. (b)(7)(C) said his only concern was to give his daughter the best medical care he could and that he was not trying to gain from his position because he fully intended to pay the appropriate amount for the services. According to (b)(7)(C) in addition to the procedure he performed on his daughter, an echocardiographer performed a separate medical test on her, and a nurse and two technicians were present during the procedure. Further, a blood analysis was performed. (b)(7)(C) said the room he occupied would have been vacant, as he was not assigned to work there that day and the one other

physician in the laboratory was working in another room at the time of the daughter's procedure. He said he knew no other veteran was denied care while he treated his daughter because he was the one who scheduled the patients and he did not cancel or move any one to accommodate his daughter.

In (b)(7)(C) received a $9,191 bill for the cost of the procedure. He contested the amount as being unreasonably high because it included the cost of a procedure and a service he did not perform, the cost of a duplicate procedure, and excessive supply charges. However, in (b)(7)(C) he agreed in writing to pay the bill in monthly installments. At the time of our investigation, (b)(7)(C) had made some, but not all, of the installments.

During this investigation, we attempted to identify existing VA or VHA policy addressing the propriety of a VA physician treating an immediate family member, but could not identify any. A representative of VHA's National Center for Ethics in Health Care said she, too, knew of no policy prohibiting a physician from treating an immediate family member, but she noted that the practice could be ethically problematic, stating:

> The fact that VHA health care professionals in particular are committed to upholding the public trust makes it especially important to practice transparency. This would seem critically important in this case, to avoid the appearance that a special relation or conflict of interest allowed a patient to receive access to a VHA facility who might not otherwise have such access....[P]atients similarly situated must receive comparable access, unless there are compelling reasons to justify departures from the norm, and these justifications are made explicit.

Further, a July 2003 report by VHA's National Ethics Committee, *Ethical Boundaries in the Patient-Clinician Relationship*, stated that health care professionals should beware of interacting with any patient in ways that could reasonably be expected to create awkward situations for either party, compromise the professional's primary commitment to patient welfare, or call the professional's objectivity into question.

Another representative of VHA's National Center for Ethics in Health Care told us that the American Medical Association Code of Ethics (E-8.19) and the American College of Physicians Ethics Manual both hold that physicians should not generally treat members of their immediate family. He told us this was the "basis on which State Medical Boards and health care institutions may address issues of professionalism." In addition, he said that the May 1999 Oklahoma State Board of Medical Licensure publication *ISSUES and ANSWERS* stated that "the AMA ***Current Opinions*** regards any treatment of family members (except in emergencies) as unethical. This primarily is due to lack of physician objectivity and patient autonomy." Finally, the Oklahoma City VA Medical Center Bylaws state that medical staff are accountable for and have a responsibility to abide by high standards of ethics in professional practice and conduct [Article III, Section 3e].

## Conclusion

(b)(7)(C) erroneously advised the former Medical Center Director to use VA's authority to sell health care resources so that (b)(7)(C) could treat his daughter, an ineligible veteran. The policy, however, does not allow VA resources to be sold to VA employees. Further, (b)(7)(C) did not ensure the agreement was put in writing and submitted for legal review. When he read the policy, after the fact, he failed to follow-up to determine if corrective action was needed.

(b)(7)(C) misused his position as a VA employee when he treated his daughter, an ineligible veteran. Were it not for his position as a (b)(7)(C) at the VA Medical Center, we question whether the former Director would have approved his performing the procedure. Further, there was a requirement that (b)(7)(C) maintain high standards of ethics in a professional practice as a physician and VA employee. Moreover, had there been complications during or after this procedure, it would have been, and still could be, detrimental to the medical center and VA.

**Recommended Action(s) 1.** We recommend the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for failing to research VHA policy in a timely manner, thus providing erroneous information to the former Director, and for failing to determine if corrective action was necessary once he discovered policy did not authorize the sale of health care resources to VA employees.

**Recommended Action(s) 2.** We recommend the Director, Veterans Integrated Service Network 16, confer with Regional Counsel to determine the validity of the written agreement made with (b)(7)(C) including the amount of money (b)(7)(C) may owe or should be refunded.

**Recommended Action(s) 3.** We recommend the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for misuse of his position, violating ethics standards, and conduct prejudicial to the Government.

## Comments

The Director, Veterans Integrated Service Network 16, concurred with the above recommendations, and told us that appropriate administrative action would be taken against (b)(7)(C) Regarding the recommendation to obtain a Regional Counsel opinion to determine the validity of the written agreement made with (b)(7)(C) for the sale of VA health care resources to a VA employee, the Veterans Integrated Service Network Director told us that Regional Counsel concluded that the written agreement was legal. Additionally, Regional Counsel stated that (b)(7)(C) most likely agreed to pay too much for the medical services; however, he was responsible for the debt.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

**Appendix A**

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** August 14, 2007

**From:** Director, Veterans Integrated Service Network 16 (10N16)

**Subject:** **Administrative Investigation, Misuse of Resources and Position, VA Medical Center, Oklahoma City, Oklahoma**

**To:** Administrative Investigation Division VA Office of Inspector General

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for failing to research VHA policy in a timely manner, thus providing erroneous information to the former Director, and for failing to determine if corrective action was necessary once he discovered policy did not authorize the sale of health care resources to VA employees.

Concur **Target Completion Date:** 4/30/07

VISN 16 Comments 4/30/07: Human Resources prepared disciplinary aciton and it is being delivered to the employee on 4/30/07.

**Recommended Action(s) 2.** We recommend the Director, Veterans Integrated Service Network 16, confer with Regional Counsel to determine the validity of the written agreement made with (b)(7)(C) including the amount of money (b)(7)(C) may owe or should be refunded.

Concur **Target Completion Date:** 4/24/07

VISN 16 COMMENTS 4/30/07: Regional Counsel opinion concluded that most likely the physician probably agreed to pay too much, but that the written agreement made with (b)(7)(C) was not illegal. Therefore a payment plan will be established with (b)(7)(C)

**Recommended Action(s) 3.** We recommend the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for misuse of his position, violating ethics standards, and conduct prejudicial to the Government.

Concur **Target Completion Date:** 8.17.2007

VISN 16 COMMENTS 8/14/07: Administrative action will be taken on or before August 15, 2007.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Linda Fournier | (b)(7)(C) |

Acknowledgments

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 16 (10N16)
Management and Review Service (10B5)

---

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Reprisal and False Statements
# Acquisition Operations Service
# VA Central Office

Report No. 06-02238-136

May 22, 2007

VA Office of Inspector General
Washington, DC 20420

**WARNING**
**5 U.S.C. §552a, PRIVACY ACT STATEMENT**

**This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. §552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.**

# Contents

# Executive Summary

## Introduction

The VA Office of Inspector General (OIG), Administrative Investigations Division, investigated whether (b)(7)(C) (b)(7)(C) reprised against a subordinate contracting officer; whether he and two of his subordinate supervisors reprised against a contractor employee when they requested, without justification, that she be removed from her VA assignment; and whether (b)(7)(C) made false statements to OIG investigators.

On (b)(7)(C) and a warranted contracting officer, awarded a task order to Internet Security Systems, Inc. (ISS) without competition, citing urgent and compelling circumstances. The award was for the forensic analysis of 17 compact disks containing what was believed to be the same veteran information that had been stolen in May 2006 from a VA employee's residence. The task order was set to expire after 11:59 p.m., June 2. Early on June 2, VA officials determined additional time was needed to complete the analysis, and in the early morning hours of June 3, in anticipation of a signed blanket purchase agreement and associated task order, another AOS contracting officer authorized ISS to continue its work.

## Results

We substantiated that (b)(7)(C) engaged in a prohibited personnel practice, reprisal, when he, in effect, threatened (b)(7)(C) with a demotion and when he gave (b)(7)(C) a letter of counseling because (b)(7)(C) refused to award a second sole-source task order to ISS. (b)(7)(C) who instructed (b)(7)(C) to make the award, made the threat and issued the counseling letter even though by that time he knew, based on legal counsel, that his instruction was unlawful. (b)(7)(C) actions were also an attempt to usurp (b)(7)(C) authority as a (b)(7)(C)

We did not substantiate that (b)(7)(C) and two of his subordinate supervisors, (b)(7)(C) reprised against a contractor employee when they requested that her employer remove her from the contract. However, we found they did not have a well-documented basis for their actions. Individuals who worked more closely with the contractor employee told us they were pleased with her performance and said the problems that arose occurred while the contractor employee was following their instructions or trying to adhere to contracting regulations.

Finally, we found that (b)(7)(C) did not testify honestly during our interview with him. He falsely testified that he did not direct (b)(7)(C) to award a second, sole-source contract to ISS; did not intend that ISS would be awarded the second contract; did not remind (b)(7)(C) that he was still on probation; and was told by a senior VA official

that the Assistant Secretary for Information and Technology did not want (b)(7)(C) involved in the second contract action.

We recommended that the Deputy Assistant Secretary for Acquisition and Materiel Management ensure that appropriate administrative action is taken against (b)(7)(C) for engaging in a prohibited personnel practice against (b)(7)(C) for attempting to usurp (b)(7)(C) authority as a contracting officer, and for making false statements to OIG investigators.

## Comments

The Deputy Assistant Secretary for Acquisition and Materiel Management concurred with the recommendations. We will follow up to ensure the recommendations are implemented.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

# Introduction

## Purpose

The VA Office of Inspector General (OIG), Administrative Investigations Division, investigated an allegation that (b)(7)(C) (b)(7)(C) in the Office of Acquisition and Materiel Management, reprised against a subordinate contracting officer. Based on information obtained during the course of this investigation, we also investigated whether (b)(7)(C) and two of his subordinate supervisors reprised against a contractor employee when they requested, without justification, that she be removed from her VA assignment. Finally, this report discusses that, while under oath, (b)(7)(C) made false statements to OIG investigators.

## Background

(b)(7)(C) and a warranted contracting officer, awarded a task order for the forensic analysis of 17 compact disks containing what was believed to be the same veteran information that had been stolen in May 2006 from a VA employee's residence. The purpose of the analysis was to determine what information may have been compromised. (b)(7)(C) (b)(7)(C) was the responsible program office official for the procurement. (b)(7)(C) recommended that Internet Security Systems, Inc. (ISS) be awarded the task order.

(b)(7)(C) awarded the task order to ISS without competition, citing urgent and compelling circumstances. The task order was set to expire after 11:59 p.m., June 2, 2006. Early on June 2, (b)(7)(C) and others determined additional time was needed to complete the analysis, and in the early morning hours of June 3, 2006, in anticipation of a signed blanket purchase agreement and associated task order, another AOS contracting officer authorized ISS to continue its work.

In July 2006, we initiated an administrative investigation into alleged improper procurement practices associated with the above procurements. The investigation also focused on an allegation that (b)(7)(C) reprised against (b)(7)(C) after (b)(7)(C) refused to award a second sole-source task order to ISS on the grounds that doing so violated the Federal Acquisition Regulation (FAR).

## Scope and Methodology

This report addresses issues relative to (b)(7)(C) conduct, and the conduct of two of his subordinate supervisors, (b)(7)(C) and (b)(7)(C) We interviewed (b)(7)(C) (b)(7)(C) and other VA officials and VA contractor employees knowledgeable of the circumstances relevant to the alleged inappropriate

conduct. (b)(7)(C) resigned from VA when we initiated this investigation and declined to be interviewed. We reviewed (b)(7)(C) and (b)(7)(C) written accounts of a June 2 contract strategy meeting, a letter of counseling (b)(7)(C) gave to (b)(7)(C) relevant electronic mail messages and other correspondence, and the Office of Acquisition and Materiel Management's contract for acquisition support services. We also reviewed applicable Federal law and regulations, and Merit Systems Protection Board rulings.

The results of our investigation into whether the procurements awarded to ISS were appropriate are addressed in a separate report.

# Results and Conclusions

## Issue 1: Whether Mr. Carlisi reprised against Mr. Mannion for refusing to award ISS a second sole-source task order

### Findings

We substantiated that (b)(7)(C) committed a prohibited personnel practice, reprisal, against (b)(7)(C) by threatening to demote him and by giving him a letter of counseling for failing to obey his instructions to award a second, follow-on sole-source task order to ISS. At the time of the reprisal actions, (b)(7)(C) knew a second sole-source award to ISS was prohibited by the FAR.

Federal statute prohibits a supervisor from taking, or threatening to take, a personnel action against an employee because the employee refused to obey an order that would violate the law [5 U.S.C. §2302(b)(9)]. The Competition in Contracting Act requires executive agencies to "obtain full and open competition through the use of competitive procedures in accordance with the...Federal Acquisition Regulation" [41 U.S.C. §253(a)(1)]. The FAR authorizes contracting officers to enter into contracts and to make related determinations and findings. Contracting officers are responsible for ensuring that all requirements of law and regulations have been met. Additionally, the FAR allows contracting officers wide latitude to exercise business judgment [FAR 1.602-1].

Under certain circumstances, the FAR exempts orders placed under a Federal Supply Schedule from the requirements to conduct full and open competition. One circumstance when this may apply is when the work is a "logical follow-on" to an original Federal Supply Schedule order, but only if the original order was not previously issued under sole-source or limited source procedures [FAR 8.405-6(b)(2)].

(b)(7)(C) a staff attorney assigned to the Office of General Counsel (OGC), Professional Staff Group 5, told us that on (b)(7)(C) he reviewed and, with minor changes, approved the justification for the initial sole-source task order to ISS. He said at approximately 7:30 p.m. that evening, (b)(7)(C) (b)(7)(C) a contractor employee working with AOS to provide acquisition support services, discussed that the FAR required competing additional contract needs beyond the first sole-source task order awarded to ISS. (b)(7)(C) told us everyone at the meeting understood that the initial contract was an urgent requirement limited to 48 hours, and any contracting efforts for additional services would have to be competed.

A second meeting was held the next day, June 2, at 12:45 p.m. In attendance, among others, were (b)(7)(C) (b)(7)(C) (b)(7)(C) told us he was not in the office at the time this meeting began, and

(b)(7)(C) attended in his place.) According to minutes of this meeting edited and approved by (b)(7)(C) explained in detail to those present that the FAR did not permit a "follow-on" contract to be issued to ISS without competition because the first contract was not competed. He said, rather, the follow-on action had to be competed. The minutes document that neither (b)(7)(C) nor (b)(7)(C) considered competing the procurement to be a viable option because they believed the data already collected would be lost, the learning curve required by another contractor would delay the project, and monies already obligated to ISS would be wasted. The minutes state that (b)(7)(C) told (b)(7)(C) he would not sign a contract that was not competed, but (b)(7)(C) directed him at least four times to sign such a contract (a modification to the original). In our interview with (b)(7)(C) he confirmed that his version of what happened in the meeting was as stated in the meeting minutes.

(b)(7)(C) confirmed that, at the June 2 meeting, (b)(7)(C) was "emphatic" that he did not believe a second sole-source procurement could be awarded to ISS, and that (b)(7)(C) nevertheless ordered him to do so. According to (b)(7)(C) told (b)(7)(C) he was relying on the advice (b)(7)(C) previously gave them. (b)(7)(C) told us he did not know what that previous advice was, but said at the time of this meeting he believed a sole-source award could be justified and voiced that opinion to (b)(7)(C) He said (b)(7)(C) relied on his opinion and ordered (b)(7)(C) to make a follow-on sole-source award. In (b)(7)(C) written account of the meeting, he acknowledged directing (b)(7)(C) to sign the procurement, noting "OGC involvement and approval."

Following the meeting, (b)(7)(C) and (b)(7)(C) went to (b)(7)(C) office to discuss the matter further. (b)(7)(C) said he reiterated what he had told them the previous day, and showed them the applicable section in the FAR. (b)(7)(C) told us that, at this point, he reversed his position and, instead, suggested that AOS process a request for a deviation from the FAR or comply with the requirement for competition.

(b)(7)(C) told us that later on June 2, around 5:30 p.m., (b)(7)(C) "threatened" him when, after he continued to refuse to award a second sole-source contract to ISS, (b)(7)(C) reminded him of his probationary status. According to (b)(7)(C) told him to "be very careful, after all, (b)(7)(C) you are on probation." (b)(7)(C) said (b)(7)(C) brought up the fact of his probation at least twice that day.

(b)(7)(C) denied commenting about (b)(7)(C) probationary status. However, two AOS program analysts told us they were standing nearby and overheard (b)(7)(C) remind (b)(7)(C) that he was on probation. One of the analysts told us she was standing in the area of the office fax machine when she heard (b)(7)(C) object to signing a sole-source document and then heard (b)(7)(C) tell (b)(7)(C) he was still on probation. The analyst said that when (b)(7)(C) made that comment, his voice was loud and she heard it clearly. The second analyst told us that, around 5:30 p.m. that

evening, she also was in the area of the office fax machine and overheard (b)(7)(C) and (b)(7)(C) talking about signing a contract. She said she heard (b)(7)(C) remind that he was on probation.

On (b)(7)(C) following the competitive award of the blanket purchase agreement and associated task order to ISS, (b)(7)(C) issued (b)(7)(C) a letter of counseling, stating that during the June 2 meeting, (b)(7)(C) "refused verbal instruction from me to be the Contracting Officer (CO) on an action that was deemed legally sufficient." (b)(7)(C) also cited (b)(7)(C) for disrespectful conduct. (b)(7)(C) told us that (b)(7)(C) was never disrespectful towards (b)(7)(C) but to the contrary, was subdued when refusing to obey (b)(7)(C) instruction to make the second award.

## Conclusion

(b)(7)(C) engaged in a prohibited personnel practice, reprisal, when he threatened (b)(7)(C) by reminding him that he was on probation and when he gave (b)(7)(C) a letter of counseling. (b)(7)(C) mention of probation in the context in which it was made amounted to a threat to demote (b)(7)(C) Both the threat and the counseling letter were in response to (b)(7)(C) refusal to award a second sole-source task order to ISS. (b)(7)(C) who instructed (b)(7)(C) to make the award, made the threat and issued the counseling letter even though by that time he knew his instruction was unlawful. (b)(7)(C) twice advised (b)(7)(C) that issuing a sole-source follow-on task order in this instance violated the FAR, and (b)(7)(C) though he initially believed a sole-source follow-on was appropriate, promptly sought clarification of the issue and then advised (b)(7)(C) he would have to seek approval to deviate from the FAR before proceeding with the second sole-source action.

Additionally, (b)(7)(C) instruction to (b)(7)(C) to award the sole-source task order constituted an attempt to usurp the authority given to a contracting officer under the FAR.

**Recommended Action(s) 1.** We recommend that the Deputy Assistant Secretary for Acquisition and Materiel Management ensure that appropriate administrative action is taken against (b)(7)(C) for engaging in a prohibited personnel practice against (b)(7)(C) and for attempting to usurp (b)(7)(C) authority as a contracting officer.

The Deputy Assistant Secretary concurred with the recommendation. (See Appendix A.) We will follow up to ensure that the recommended action is taken.

## Issue 2: Whether (b)(7)(C) reprised against a contractor employee when they requested her removal

### Findings

We did not substantiate that (b)(7)(C) reprised against (b)(7)(C) when they asked that she be removed from VA's contract with the company that employed her, (b)(7)(C) Federal law prohibits employees who have authority to take personnel actions from reprising against other employees or applicants for employment [5 USC §2302(b)(8)]. (b)(7)(C) is a contractor employee and is not protected under this statute. Additionally, whistleblower protections afforded to contractor employees under the FAR do not apply in this situation because the FAR protects contractor employees from reprisal by their own employers, but not by a Federal manager [FAR Part 3.9]. Nevertheless, we found that (b)(7)(C) (b)(7)(C) did not have a well-documented basis for their actions. (b)(7)(C) also misrepresented to us that they did not ask for (b)(7)(C) removal from the contract. On other matters, we substantiated that (b)(7)(C) inappropriately changed (b)(7)(C) work schedule and inappropriately questioned (b)(7)(C) about his contact with the OIG.

The contract between VA and (b)(7)(C) provides that personnel assigned by (b)(7)(C) to perform work under the contract must be acceptable to VA "in terms of personal and professional conduct and technical knowledge." The contract allows the VA contracting officer to request, at any time, that a (b)(7)(C) employee be immediately removed from the assignment if it conflicts with the interests of VA or if the employee's performance is deemed unsatisfactory.

VA contracted with (b)(7)(C) among other companies, to provide the Office of Acquisition and Materiel Management administrative and acquisition support. On (b)(7)(C) (b)(7)(C) the contracting officer for these support contracts, requested that each company designate one of its employees as its senior representative and single point of contact, responsible for monitoring all its other employees supporting VA. On July 7, (b)(7)(C) Senior Business Developer, (b)(7)(C) nominated (b)(7)(C) for the position and on July 17 (b)(7)(C) approved an increase in contract funds so (b)(7)(C) could be given an increase in salary to compensate for her additional responsibilities. (b)(7)(C) assignments at the time of our investigation were in support of (b)(7)(C) (b)(7)(C)

***(b)(7)(C) requested, without justification, that (b)(7)(C) be removed from YRCI's VA contract.***

On August 9, at (b)(7)(C) request, (b)(7)(C) met with (b)(7)(C) told us that at this meeting the three VA officials requested that he remove (b)(7)(C) from the VA contract. He said (b)(7)(C) specifically requested her removal, and that he was "absolutely certain" (b)(7)(C) concurred with their request because he (b)(7)(C) was party to every part of the conversation. According to (b)(7)(C) that conversation included discussing that he would call (b)(7)(C) to his office the next day, inform her she would not be returning to VA, and collect her VA identification badge. (b)(7)(C) said he shared with (b)(7)(C) the resume of a potential replacement for (b)(7)(C) and that the three VA officials discussed among themselves how they would redistribute her workload.

(b)(7)(C) told us (b)(7)(C) cited three performance issues as reasons for wanting (b)(7)(C) removed. The first was that there had been hearsay that (b)(7)(C) was previously transferred from her first VA assignment because she could not get along with others. The second issue was that (b)(7)(C) had not performed successfully on certain training contracts she was assigned and was uncooperative when those contract files were reassigned to another person. The third performance issue was that (b)(7)(C) as the newly appointed senior (b)(7)(C) representative, was being disruptive by holding (b)(7)(C) staff meetings without permission from VA managers and inviting non-(b)(7)(C) employees.

Regarding (b)(7)(C) departure from her first VA assignment, supporting the Veterans Benefits Administration (VBA), (b)(7)(C) the (b)(7)(C) (b)(7)(C) whom (b)(7)(C) supported at the time, told us (b)(7)(C) was reassigned after a complaint that she was difficult to work with. (b)(7)(C) said the incident that prompted the complaint concerned a written justification for a contracting requirement, which was improperly prepared by the VBA program office. (b)(7)(C) told us he reviewed the justification document and discovered that required elements were missing. Because it was the program office's responsibility to prepare the justification document, he told (b)(7)(C) to work with them to correct it. According to (b)(7)(C) program office staff resisted (b)(7)(C) efforts to work with them to make corrections. He said the program office was not correcting the document to his satisfaction, and (b)(7)(C) was caught in the middle. (b)(7)(C) told us program office officials advised him they wanted (b)(7)(C) transferred out of VBA, so he arranged the transfer to (b)(7)(C) (b)(7)(C) said (b)(7)(C) had done nothing to warrant her removal from VBA, and (b)(7)(C) told us he had gotten positive feedback from (b)(7)(C) regarding (b)(7)(C) performance. (b)(7)(C) told us they never talked to (b)(7)(C) about (b)(7)(C) before meeting with (b)(7)(C) and did not know the specifics of what prompted VBA to seek her transfer.

Regarding (b)(7)(C) work on training contracts, contracts for the Acquisition Training and Career Development (ATCD) Division in the Office of Acquisition were initially assigned to (b)(7)(C) team but then reassigned to (b)(7)(C) team. (b)(7)(C) told us that when the contracts were transferred from his team, (b)(7)(C) was assigned responsibility for them. (b)(7)(C) said he had a good working relationship with the ATCD Chief, but after the contracts were assigned to (b)(7)(C) the Chief began complaining to him about receiving poor service. On one occasion, the Chief complained about problems issuing contracts with hotels, and asked (b)(7)(C) to look into the matter. A June 27, 2006, electronic mail message from the Chief documents that one issue he was upset about was that the contracting staff required the hotel contracts be competed. (b)(7)(C) told us he took it upon himself to conduct an "unofficial" inquiry into the Chief's complaints and found that Ms. Roberts had not accomplished any work on those contracts.

As a result of his findings, (b)(7)(C) said he suggested to (b)(7)(C) and (b)(7)(C) that the contracts be reassigned back to his team. (b)(7)(C) said when the contracts were transferred back, (b)(7)(C) refused to cooperate with his staff. For example, (b)(7)(C) said that whenever anyone from his team called (b)(7)(C) to ask a question about a contract, her standard answer was, "it's in the file." He said as a result of her refusal to cooperate, and because of a lack of documentation in the contracting files, his team had to start from the beginning on all contract actions and redo all the paperwork.

(b)(7)(C) told us he learned about the problems with the training contracts indirectly through (b)(7)(C) told us that, although the Chief complained to him informally, he did not know the specifics of what the problems were.

(b)(7)(C) told us she never received a complaint against (b)(7)(C) for any work did on the training contracts and that she was very happy with (b)(7)(C) performance. She said if there was a problem transferring the files back to (b)(7)(C) then it was also her fault because she and (b)(7)(C) worked together. (b)(7)(C) denied that she was uncooperative during the transfer of the contracts. Both (b)(7)(C) and (b)(7)(C) told us they believed the ATCD Chief's complaints stemmed from insistence that the regulations be followed. On July 20, (b)(7)(C) submitted to (b)(7)(C) a summary of problems she was experiencing with ATCD, including that they submitted contract requests at the last minute and without adequate supporting documentation, and that they resisted following FAR requirements and guidelines of the Government Accountability Office.

Regarding the third performance issue, (b)(7)(C) told us that shortly after (b)(7)(C) became the senior (b)(7)(C) representative, she initiated staff meetings with [redacted] and non- (b)(7)(C) (b)(7)(C) employees without first coordinating with the VA managers. He said one non-employee who was assisting him was pulled away from a priority project and told to report to a different building for one of the meetings. He said when he tried contacting (b)(7)(C) to ask why she had invited that employee, she did not return his telephone

messages. We note, however, that (b)(7)(C) told us he tried contacting (b)(7)(C) only hours before he complained to (b)(7)(C) about her non-responsiveness. (b)(7)(C) also said that (b)(7)(C) did contact the non- employee that morning to explain why he was invited. (b)(7)(C) told us they had no first-hand knowledge that (b)(7)(C) was inappropriately convening staff meetings.

(b)(7)(C) said she held two staff meetings after she became the senior (b)(7)(C) representative. She said both meetings lasted less than 30 minutes and were used to allow her to "meet and greet" the (b)(7)(C) employees working on site, and to take care of certain administrative activities such as passing out application forms so the employees could obtain VA identification badges. (b)(7)(C) told us she mistakenly believed one individual was a (b)(7)(C) employee, and invited that person to the meetings. That individual was actually an employee of another VA contractor. In explaining this error, (b)(7)(C) told us he had several conversations with (b)(7)(C) after she was appointed as the senior representative and, during these conversations, he mistakenly referred to a new (b)(7)(C) employee by an incorrect first name, a name that was the same as the non-(b)(7)(C) employee (b)(7)(C) invited to the staff meetings. (b)(7)(C) said she thought the person she invited to the meeting was the same person (b)(7)(C) referred to during their earlier conversations. (b)(7)(C) also told us he was the one who asked (b)(7)(C) as senior representative, to convene meetings for the (b)(7)(C) employees supporting VA.

According to both (b)(7)(C) and (b)(7)(C) they only asked (b)(7)(C) to remove (b)(7)(C) as the senior representative; they said they did not ask for her complete removal from the contract. However, (b)(7)(C) confirmed that he, (b)(7)(C) and (b)(7)(C) asked (b)(7)(C) to remove (b)(7)(C) from the VA contract and place her on another (b)(7)(C) contract.

***(b)(7)(C) canceled (b)(7)(C) compressed work schedule.***

The Statement of Work for VA's contract with (b)(7)(C) states that the services (b)(7)(C) provides will be conducted consistent with the core working hours of the sponsoring Office of Acquisition and Materiel Management organization. AOS permits its employees to work compressed work schedules.

(b)(7)(C) told us she learned in mid-July that (b)(7)(C) cancelled her compressed work schedule. She said she asked (b)(7)(C) to reconsider, but he told her he needed someone in the office at all times. According to (b)(7)(C) he mentioned to (b)(7)(C) that he noticed from the time cards that (b)(7)(C) was working 9-hour days and suggested (b)(7)(C) look into the matter because he thought contractor employees were supposed to work 8-hour days. He told us the reason AOS used contractors was to ensure daily coverage in the office. (b)(7)(C) said it was his understanding that contractor employees could work a compressed work schedule but (b)(7)(C) directed him to change (b)(7)(C) schedule to an 8-hour day.

***(b)(7)(C) inappropriately questioned (b)(7)(C) about an OIG interview.***

During our investigation, (b)(7)(C) questioned (b)(7)(C) about (b)(7)(C) meeting with an OIG investigator. On the night of August 16, following our interview with (b)(7)(C) that day, (b)(7)(C) sent (b)(7)(C) an electronic mail message, chastising him for not letting him know that he met with the OIG that day. (b)(7)(C) said he learned of the interview through a third party. (b)(7)(C) asked (b)(7)(C) "What is going on?" and why he met with us. He told (b)(7)(C) he was relieving him of his role as acting (b)(7)(C) (b)(7)(C) for that week.

(b)(7)(C) said the next day he complained to (b)(7)(C) (b)(7)(C) confirmed this and said (b)(7)(C) suggested (b)(7)(C) was retaliating against him. However, (b)(7)(C) told us that after he spoke with (b)(7)(C) he met with (b)(7)(C) and said (b)(7)(C) was apologetic for having sent the electronic message and reinstated him as (b)(7)(C)

(b)(7)(C) told us he was following policy implemented by his predecessor when he questioned (b)(7)(C) about his meeting with the OIG. He provided us a February 16, 2005, electronic mail message written by the then acting AOS Director, in which she directed AOS staff to personally inform her of all contact with OIG and to brief her before speaking with any OIG staff regarding AOS acquisition issues. (b)(7)(C) subsequently rescinded that policy.

## Conclusion

While we did not substantiate that (b)(7)(C) reprised against (b)(7)(C) they did not have a sufficient basis to request that (b)(7)(C) remove her from the VA contract to which she was assigned. They did not sufficiently investigate the circumstances surrounding the incidents they cited as reasons for wanting her removal. Regarding her performance in VBA, the contracting specialist she supported there told us (b)(7)(C) was following his instructions and had done nothing to warrant her removal. However, (b)(7)(C) told us they did not talk to that contracting specialist before raising the incident with (b)(7)(C) performance on the training contracts was not problematic, according to (b)(7)(C) and the complaints the ATCD Chief made to (b)(7)(C) may have been more in response to the contracting staff's insistence on following FAR requirements than on (b)(7)(C) progress in servicing the Chief's needs. Neither (b)(7)(C) nor (b)(7)(C) had first-hand knowledge of the details of the disagreements. Finally, (b)(7)(C) staff meetings appear reasonable in light of her new additional responsibility for monitoring other contract employees supporting VA. Her explanation for the invitation she gave to a non-(b)(7)(C) employee to attend the meetings supports the conclusion that it was an honest mistake. Again, she was following instructions (from (b)(7)(C) when she convened the meetings. (b)(7)(C) and (b)(7)(C) misrepresented to us that they did not request

(b)(7)(C) removal from the VA contract when they testified that they requested only that she be removed as (b)(7)(C) senior representative.

(b)(7)(C) inappropriately changed (b)(7)(C) work schedule from 9-hour to 8-hour days, even though the 9-hour day was consistent with the schedule of AOS employees and therefore in compliance with the (b)(7)(C) contract. Finally, (b)(7)(C) inappropriately questioned (b)(7)(C) about his contact with the OIG. That situation was quickly resolved.

## Issue 3: Whether (b)(7)(C) made false statements to OIG investigators

### Findings

Federal regulations require VA employees to furnish information and testify "freely and honestly" in cases respecting employment and disciplinary matters [38 C.F.R. §0.735-12(b)].

While under oath on August 2, 2006, (b)(7)(C) made false statements to OIG investigators concerning his activities and conversations on June 2, 2006, involving the second procurement from ISS. For example, on several occasions during the interview, (b)(7)(C) denied that, from the time he realized a follow-on contract was needed, he intended to award it sole-source to ISS, and he denied that he directed (b)(7)(C) to award the second sole-source contract – or any contract – to ISS. Because several witnesses contradicted his testimony, we repeatedly questioned (b)(7)(C) on these points. He was steadfast in his denial. He denied that he ever implied or told anyone ISS was going to be awarded the second contract, that he understood ISS needed to be awarded that contract, and that he mandated or influenced the contract going to ISS. Finally, he denied that he and (b)(7)(C) disagreed about whether or not the procurement should be sole-sourced.

(b)(7)(C) provided sworn testimony contradicting (b)(7)(C) denials. They told us they heard (b)(7)(C) direct (b)(7)(C) to award the second sole-source contract to ISS on several occasions during the June 2 meeting. (b)(7)(C) documented this in the minutes of that meeting and testified that (b)(7)(C) on several more occasions after the meeting, directed him to sign the sole-source contract with ISS. Additionally, (b)(7)(C) testimony contradicted (b)(7)(C) assertion that it had not been his intent from the beginning to award the second contract to ISS. According to (b)(7)(C) twice told him senior VA officials did not want the second contract competed.

Documentary evidence also shows that (b)(7)(C) directed (b)(7)(C) to award a second sole-source contract to ISS and that (b)(7)(C) intentions were to ensure that ISS was awarded the second contract. On the afternoon of June 2, (b)(7)(C) sent an

electronic mail message to (b)(7)(C) directing him to prepare a "sole-source" justification, a deviation to the FAR, and a task order. Additionally, (b)(7)(C) letter of counseling to (b)(7)(C) discussed above, stated that (b)(7)(C) "refused verbal instruction from me to be the Contracting Officer." Finally, in (b)(7)(C) account of the June 2 meeting, he stated that (b)(7)(C) "was specifically required to make an urgent and compelling award....Awarding to another contractor would have delayed VA's efforts in continuing the forensic analysis of this sensitive veteran information."

During our second interview with (b)(7)(C) he told us that during the August 2 interview he had been under a great deal of stress as a result of the data loss incident and had simply forgotten that he directed (b)(7)(C) to award the second sole-source contract or that he always intended to award ISS the second contract.

(b)(7)(C) also gave false testimony regarding whether he threatened (b)(7)(C) probationary status. Both times we interviewed (b)(7)(C) he testified he did not make any statement to (b)(7)(C) regarding his probation. However, as discussed above, two AOS program analysts testified they overheard (b)(7)(C) make such a comment.

As a final example, (b)(7)(C) falsely testified that he was told the (b)(7)(C) (b)(7)(C) did not want (b)(7)(C) working on the second contract action. (b)(7)(C) said that, during the June 2 meeting, he and (b)(7)(C) disagreed on what procurement strategy to use and that (b)(7)(C) was loud and disrespectful. (b)(7)(C) said the meeting was interrupted by the VA Secretary and (b)(7)(C) and that before they entered the room, while standing outside the door, they overheard (b)(7)(C) comments. According to (b)(7)(C) after the Secretary and (b)(7)(C) entered the office, the meeting ended and everyone departed, but he was asked to remain. He said (b)(7)(C) then commented to him that he was upset over (b)(7)(C) lack of support. (b)(7)(C) said the (b)(7)(C) (b)(7)(C) later told him (b)(7)(C) also complained to him about (b)(7)(C) saying he did not want (b)(7)(C) working on the follow-on acquisition.

(b)(7)(C) told us he did not recall ever saying anything to (b)(7)(C) or to (b)(7)(C) about (b)(7)(C) According to (b)(7)(C) expressed his frustration and concern that the first contract would expire and the analysis work would stop, but said (b)(7)(C) never mentioned anything about (b)(7)(C) also denied ever making any remarks about (b)(7)(C) to (b)(7)(C) or in any way directing or suggesting to (b)(7)(C) that he replace (b)(7)(C) In a follow-up interview with us, (b)(7)(C) did not change his testimony even though we told him both (b)(7)(C) and (b)(7)(C) testimony contradicted his own.

## Conclusion

(b)(7)(C) did not testify honestly during our interview with him. He falsely testified that he did not direct (b)(7)(C) to award a second sole-source contract to ISS; did not

intend that ISS would be awarded the second contract; did not remind (b)(7)(C) that he was still on probation; and was told by (b)(7)(C) that (b)(7)(C) did not want (b)(7)(C) involved in the second contract action. Because the events in question were relatively recent and directly involved (b)(7)(C) we do not find credible his explanation that he forgot his instruction to (b)(7)(C) and forgot his intentions regarding the ISS follow-on contract. Regarding (b)(7)(C) other false statements, we find the testimony of the other witnesses we interviewed to be more objective and believable.

**Recommended Action(s) 2.** We recommend that the Deputy Assistant Secretary for Acquisition and Materiel Management ensure that appropriate administrative action is taken against (b)(7)(C) for making false statements to OIG investigators concerning matters relating to his employment.

The Deputy Assistant Secretary concurred with the recommendation. (See Appendix A.) We will follow up to ensure that the recommended action is taken.

Appendix A

# Deputy Assistant Secretary Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** March 8, 2007

**From:** Deputy Assistant Secretary for Acquisition and Materiel Management (049)

**Subject:** **Administrative Investigation - Reprisal and False Statements, Acquisition Operations Service, VA Central Office**

**To:** Office of the Inspector General

We have reviewed the subject report, and our responses to the recommendations for the Office of Acquisition and Materiel Management are attached. We concur with the recommendations.

SIGNED

Jan R. Frye

Attachment

## Deputy Assistant Secretary's Comments to Office of Inspector General's Report

The following Deputy Assistant Secretary's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Deputy Assistant Secretary for Acquisition and Materiel Management ensure that appropriate administrative action is taken against (b)(7)(C) for engaging in a prohibited personnel practice against (b)(7)(C) and for attempting to usurp (b)(7)(C) authority as a contracting officer.

Concur **Target Completion Date:** 03/30/2007

**Recommended Action(s) 2.** We recommend that the Deputy Assistant Secretary for Acquisition and Materiel Management ensure that appropriate administrative action is taken against (b)(7)(C) for making false statements to OIG investigators concerning matters relating to his employment.

Concur **Target Completion Date:** 03/30/2007

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Charles Millard |

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
General Counsel (02)
Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

March 28, 2007

~~"RESTRICTED REPORT"~~

The Office of Inspector General issued the enclosed report – **Administrative Investigation - Improper Payments to Physicians VA Medical Center, Tampa, Florida** (Report No. 06-00089-107) on March 28, 2007.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Improper Payments to Physicians
# VA Medical Center, Tampa, Florida

Report No. 06-00089-107

March 28, 2007

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Director, Veterans Integrated Service Network 8 (10N8)
Regional Counsel, Bay Pines, FL (516/02)

**SUBJECT:** Administrative Investigation – Improper Payments to Physicians, VA Medical Center, Tampa, FL (2006-00089-IQ-0016)

## Summary

We substantiated that management at the VA Medical Center in Tampa, FL, which includes the Orlando Healthcare Center and the Brevard Outpatient Clinic, improperly gave certain full-time physicians cash awards totaling $362,800 between January 2005 and January 2006 for working extended hours and weekends. Following the Tampa Medical Center Director's request for guidance on the propriety of this practice, a staff attorney in the Bay Pines Office of Regional Counsel advised him to continue giving the awards until the Office of Regional Counsel could render a decision but, due to miscommunications within that office, no one followed up to give the Director definitive advice. Even after the Bay Pines Regional Counsel advised the Orlando Chief of Staff that such awards were not authorized, the Chief of Staff chose to continue the practice.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that full-time physicians at the VA Medical Center in Tampa, FL, including at the Orlando Healthcare Center and the Brevard Outpatient Clinic, improperly received cash awards for working evenings and Saturday clinics. The Orlando Healthcare Center was converting to an independent medical center at the time of our investigation. We investigated but did not substantiate another related allegation, and do not discuss it further.

To assess the allegation, we visited the VA Medical Center in Tampa to interview the Medical Center Director, former Chief of Staff, and Chief of Human Resources; and visited the Office of Regional Counsel in Bay Pines, FL, to interview the Regional Counsel and a staff attorney. We also conducted telephone interviews with other VA employees, including the Orlando Healthcare Center's Chief of Staff and the former Tampa Medical Center Acting Director. We examined documentation of awards given to physicians between January 2005 and January 2006, relevant electronic mail and other correspondence, and VA policies.

## Results

### Issue: Whether physicians at the Tampa VA Medical Center improperly received cash awards

VA policy prohibits paying full-time physicians an extra amount (in addition to their regular annual rate) for duty on legal holidays, Saturdays, Sundays, at night, and overtime because they are employed on the basis of availability for duty 24 hours a day, 7 days a week [VA Handbook 5007, Part V, Chapter 2, paragraph 2a]. Further, VA policy does not authorize the use of cash awards as an incentive to encourage employees to work a particular shift [VA Handbook 5017, Part III, Appendix B].

According to the former Acting Director of the Tampa Medical Center, some time in 2004 the facility began asking physicians in certain specialties to work extended evening and Saturday clinics to help reduce a patient backlog that had recently worsened. Management compensated these physicians on a biweekly basis for the extra time they spent at the facility by giving them cash awards. Each award amount was calculated based on the number of hours the physician worked and the physician's hourly rate of pay. For example, radiologists received $150 for each hour they worked in the extended-hours clinic. The former Acting Director told us that the awards were the only mechanism the facility had for compensating the full-time physicians. The Human Resources Chief told us she did not consider this practice improper as long as the awards were based on hours worked and rates of pay, and noted that giving such awards was a common practice throughout VA.

According to documentation of physicians' awards, between January 2005 and January 2006, 35 full-time physicians employed by the Tampa Medical Center, including the Orlando Healthcare Center and the Brevard Outpatient Clinic, received awards totaling over $362,800. Over half these physicians received $6,500 or more, and 5 of them received over $18,000. One physician, a radiologist at the Tampa Medical Center, received over $72,500. The physicians' supervisors recommended the awards and the former Chief of Staff in Tampa or the Chief of Staff in Orlando, the Human Resources Chief or a Human Resources Specialist, and the Deputy Director or Director concurred.

In late October 2005, the Medical Center Director, Mr. Forest Farley, learned that the Regional Counsel in Decatur, GA, advised the Director of the VA Medical Center there that the practice of using the incentive awards program to compensate physicians for volunteering to work beyond their tours of duty to reduce a backlog of new patients was contrary to Federal pay regulations governing physicians. The Regional Counsel in Decatur noted that the Office of General Counsel and the Compensation and Classification Service in VA Central Office concurred with his assessment. He suggested to the Decatur Medical Center Director that, as an alternative to receiving awards based on hours worked, physicians could be given performance pay under the new physician pay plan based on the results their extra work accomplished.

As a result of the Regional Counsel's advice to the Decatur Medical Center, the Tampa Chief of Staff issued an October 24, 2005, memorandum to all clinical service and section chiefs discontinuing the physician awards, and Mr. Farley sought guidance from the Regional Counsel's Office in Bay Pines, FL. In an October 27, 2005, electronic mail message, (b)(7)(C) a staff attorney in Bay Pines advised Mr. Farley to continue the practice until his office could obtain additional facts and render a decision. Based on this guidance, the Chief of Staff then issued another memorandum reinstating the physicians' awards. At the time of our review several months later, Mr. Farley told us he was still awaiting a decision from the Office of Regional Counsel on the matter.

Also in late October 2005, (b)(7)(C) (b)(7)(C) learned of the Decatur Regional Counsel's advice to the Decatur Medical Center Director and, independent of Mr. Farley's request for guidance, contacted the Bay Pines Regional Counsel for advice on the appropriateness of the Orlando facility's practice of giving awards to physicians. In a November 25, 2005, electronic mail message, the Bay Pines Regional Counsel responded, advising (b)(7)(C) that "the specific incentive and special pay salary enhancements *based upon hours of work* that your facility may currently be utilizing is not authorized by law or regulation...." Like the Decatur Regional Counsel, the Bay Pines Regional Counsel suggested that, under the new physician pay plan, physicians could be given performance pay in a lump-sum amount at the end of the fiscal year, tied to the accomplishment of goals. (The new physician pay plan limits performance pay to $15,000 a year.) The Regional Counsel also suggested that physicians could be given special contribution awards as long as they were not based on hours worked. (b)(7)(C) told us that, after receiving the Regional Counsel's advice, he learned from someone in Mr. Farley's office that (b)(7)(C) told Mr. Farley to continue the practice pending more detailed investigation. He said based on that, and on advice from staff in Orlando, he decided to continue giving physicians awards as he had in the past.

Both the Bay Pines Regional Counsel and (b)(7)(C) told us they were aware that (b)(7)(C) and Mr. Farley had discussed this issue, but said they did not share the Regional Counsel's November legal advice with them. (b)(7)(C) told us he did not share the legal advice with Mr. Farley because he believed that was Regional Counsel's responsibility. The Regional Counsel told us she was not aware there was an official request for legal advice from Tampa, noting that facility never provided her office particular facts. She said she was not aware that (b)(7)(C) told Mr. Farley to continue the practice of giving physicians awards, and was not aware Mr. Farley was awaiting a response from her office. (b)(7)(C) told us that in October 2005 he received a copy of an electronic mail message from the Regional Counsel to (b)(7)(C) assumed she was handling the requests for advice from both Mr. Farley and (b)(7)(C) and took no further action.

## Conclusion

Tampa Medical Center managers improperly approved giving certain full-time physicians at the Tampa Medical Center, including the Orlando Healthcare Center and the Brevard Outpatient Clinic, awards totaling over $362,800 for working evening and Saturday clinics to reduce patient backlogs. When Mr. Farley and (b)(7)(C) learned this practice could be improper, they separately sought advice from the Office of Regional Counsel in Bay Pines. Due to miscommunication, (b)(7)(C) was advised VA had no authority to give the awards, but Mr. Farley was not so advised. According to (b)(7)(C) own testimony, he ignored the written opinion of the Regional Counsel, his senior legal advisor. Instead, he chose to rely on hearsay about (b)(7)(C) advice and on advice from non-legal staff in Orlando, and continued providing awards to physicians based on the extra hours they worked. The miscommunication between and among VA attorneys and facility managers was clearly deficient and should be improved. In particular, in light of the Decatur Regional Counsel's advice, (b)(7)(C) should not have advised Mr. Farley to continue awarding cash to physicians for working extra hours, and should have followed up to ensure Mr. Farley's request for advice was satisfied.

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 8, ensure that appropriate administrative action is taken against (b)(7)(C) for improperly allowing physicians to be awarded cash based on the number of hours they worked in excess of their normal duty hours, after he received advice from the senior legal advisor in the region not to do so.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 8, direct Mr. Farley to immediately cease paying physicians at all facilities under his authority, including the Orlando Healthcare Center, cash awards based on hours worked in excess of normal duty hours.

**Recommended Action(s) 3.** We recommend that the Bay Pines Regional Counsel take appropriate action against (b)(7)(C) for advising the Tampa VA Medical Center Director to continue awarding cash to physicians based on hours worked in excess of normal duty hours, and not following up to ensure the Director's request for advice was satisfied.

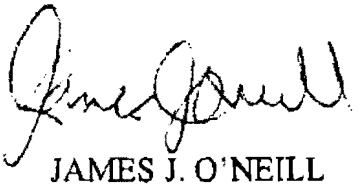
## Comments

The Director, Veterans Integrated Service Network 8, agreed to take, and stated that he did take, appropriate administrative action against (b)(7)(C) but he also noted that several advisors, including the Tampa Medical Center's Human Resources Officer, failed to either articulate clear direction or created confusion regarding recommending and approving the awards. Regarding the recommendation to immediately cease paying physicians cash awards based on hours worked in excess of normal duty hours, the

Network Director concurred and stated that the Tampa Medical Center stopped the awards when the Network Director received the draft report, and that Orlando had already stopped the practice. The Director's comments were responsive to our recommendations and we consider both recommendations resolved.

The Bay Pines Regional Counsel agreed to take, and stated that she did take, appropriate administrative action against (b)(7)(C) for not following up to ensure the Tampa Medical Center Director's request for advice was satisfied. We consider this part of the recommendation resolved. Regional Counsel did not agree that administrative action should be taken against (b)(7)(C) for advising the Tampa Director to continue awarding cash to physicians based on hours worked in excess of normal duty hours. She stated that the facts, issues, and applicable law were being developed so that a proper response could be provided. We disagree that (b)(7)(C) advice was appropriate. He was aware that an attorney at another regional counsel's office had advised that VA could not give incentive awards to physicians for volunteering to work beyond their tour of duty to reduce patient backlogs. We do not find it plausible that the particular facts of the two cases would be so different that they would change (b)(7)(C) preliminary advice to the Tampa Director. We are issuing our final report with this part of the recommendation unresolved.

The Network Director's comments and the Regional Counsel's comments are in Appendix A.



JAMES J. O'NEILL
Assistant Inspector General for
Investigations

Appendix A

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** February 16, 2007

**From:** Director, Veterans Integrated Service Network 8 (10N8)

**Subject:** **Administrative Investigation - Improper Payments to Physicians, VA Medical Center, Tampa, FL**

**To:** James J. O'Neill, Assistant Inspector General for Investigations

I have recently reviewed my November 13, 2006 response to you. While I stand by my original explanation, I have amended my original response from non-concurrence to concur.

*(original signed by:)*

George H. Gray, Jr.

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 8, ensure that appropriate administrative action is taken against (b)(7)(C) for improperly allowing physicians to be awarded cash based on the number of hours they worked in excess of their normal duty hours, after he received advice from the senior legal advisor in the region not to do so.

Concur, In Part **Target Completion Date:** Done

There are several advisors, such as the Tampa HR Officer, that failed to either articulate clear direction or through their lack of aggressive involvement created further confusion regarding recommending and approving the awards. In spite of these breakdowns I have taken the initiative to orally counsel (b)(7)(C) regarding your findings and your conclusions of improprieties.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 8, direct Mr. Farley to immediately cease paying physicians at all facilities under his authority, including the Orlando Healthcare Center, cash awards based on hours worked in excess of normal duty hours.

Concur **Target Completion Date:** 10/16/06

Upon receipt of the draft OIG report, the Directors of Tampa and Orlando were directed to immediately cease paying physicians cash awards based on hours worked in excess of normal duty hours. Tampa stopped the practice on October 16, 2006 and Orlando had stopped on May 11, 2006.

**Department of Veterans Affairs** **Memorandum**

**Date:** October 31, 2006

**From:** Regional Counsel, Bay Pines, FL (516/02)

**Subject:** **Administrative Investigation - Improper Payments to Physicians, VA Medical Center, Tampa, FL**

**To:** Judy Shelly, Director of Investigations (51Q), Office of Inspector General

## Regional Counsel's Comments to Office of Inspector General's Report

The following Regional Counsel's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 3.** We recommend that the Bay Pines Regional Counsel take appropriate action against (b)(7)(C) for advising the Tampa VA Medical Center Director to continue awarding cash to physicians based on hours worked in excess of normal duty hours, and not following up to ensure the Director's request for advice was satisfied.

Concur, In Part **Target Completion Date:** 01/19/07

Bay Pines Regional Counsel does not concur that action should be taken against (b)(7)(C) in relation to advising the Tampa VAMC to continue the award process status quo during such time as the facts, issues and applicable law were being developed in order to properly respond.

Regional Counsel does concur that action should be taken against (b)(7)(C) for not following up to obtain any needed information or facts and to ensure the Director's request for advice was satisfied. A written admonishment has been given to (b)(7)(C) regarding this failure.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Kristinn Watkins |

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 8 (10N8)
Management Review Service (10B5)
Regional Counsel, Bay Pines, FL (516/02)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

March 20, 2007

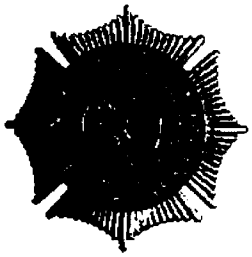
~~"RESTRICTED REPORT"~~

The Office of Inspector General issued the enclosed report – ***Administrative Investigation – Improper Recruitment Bonus VA Nebraska - Western Iowa Health Care System, Omaha, Nebraska*** (Report No. 06-01135-103) on March 20, 2007.

This unredacted report is being distributed to you for your information only. The information contained in the report is subject to the provisions of the Privacy Act of 1974 (5 U.S.C.§552a). Such information may be disclosed only as authorized by this statute. Questions concerning the release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

We are providing an unredacted copy for your information only.

Enclosure



# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Improper Recruitment Bonus
# VA Nebraska-Western Iowa
# Health Care System, Omaha, Nebraska

Report No. 06-01135-103

March 20, 2007

VA Office of Inspector General
Washington, DC 20420

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Director, Veterans Integrated Service Network 23 (10N23)

**SUBJECT:** Administrative Investigation – Improper Recruitment Bonus, VA Nebraska-Western Iowa Health Care System, Omaha, NE (2006-01135-IQ-0129)

## Summary

We substantiated that the Director of the VA Nebraska-Western Iowa Health Care System (NWIHCS) improperly approved a $12,834 recruitment bonus for an employee when the employee voluntarily transferred to NWIHCS. The facility's (b)(7)(C) (b)(7)(C) recommended approval of the bonus, thereby failing to provide the Director appropriate policy advice.

## Introduction

The VA Office of Inspector General (OIG), Administrative Investigations Division, investigated an allegation that Mr. Albert Washko, NWIHCS Director, and (b)(7)(C) (b)(7)(C) improperly approved a $12,834 bonus for an employee who accepted a downgrade to return to NWIHCS. We investigated but did not substantiate another related allegation and do not discuss it in this report.

Prior to (b)(7)(C) was the (b)(7)(C) (b)(7)(C) for the former VISN 14, stationed in Lincoln, NE. In (b)(7)(C) after VISNs 13 and 14 merged and he was not selected as the [redacted] for the combined Network, (b)(7)(C) (b)(7)(C) was detailed to NWIHCS in Omaha. He was assigned responsibility for improving data accuracy and management for the purpose of improving decision-making at the facility, and reported directly to Mr. Washko. In (b)(7)(C) was selected for a reassignment as the (b)(7)(C) in VISN 8, Bay Pines, FL. When he departed NWIHCS, Human Resources Management Service staff prepared a position description covering the duties (b)(7)(C) had performed, classified the position as a (b)(7)(C) (b)(7)(C) and began writing a vacancy announcement to advertise it. Approximately 2 weeks after (b)(7)(C) reported to VISN 8, and before the Health Systems Specialist position was advertised, he asked to return to Nebraska due to an immediate family member's unforeseen serious medical condition.

To assess the allegation, we interviewed Mr. Washko, (b)(7)(C) We reviewed documentation associated with (b)(7)(C) recruitment bonus, his personnel records, pertinent electronic mail messages, and applicable VA policy.

## Results

### Issue: Whether Mr. Peters improperly recommended, and Mr. Washko improperly approved, a recruitment bonus

In response to (b)(7)(C) request to return to NWIHCS, (b)(7)(C) advised him that he could fill the newly created (b)(7)(C) but that he would need to voluntarily accept a downgrade. According to (b)(7)(C) he was "more than willing to do that," and in a May 26, 2005, electronic mail message to Mr. Washko and (b)(7)(C) stated he was requesting "a voluntary change to lower grade - to (b)(7)(C) ...to support my personal desire to relocate to the Nebraska-Western Iowa Health Care System to meet family needs." His change to lower grade in Omaha was effective June 12, 2005. In conjunction with his return to NWIHCS, (b)(7)(C) recommended, and Mr. Washko approved, a $12,834 recruitment bonus for In return, (b)(7)(C) agreed to complete 12 months of service at NWIHCS. Although the initial documentation related to the bonus characterized it as a recruitment incentive, when we asked for that documentation, (b)(7)(C) told us he discovered it should have been a relocation incentive, and he "corrected" the paperwork.

VA policy assigns facility directors responsibility for the "fair, equitable, and fiscally responsible" administration of recruitment and relocation bonuses, and for ensuring that the bonuses are determined in accordance with the recommending and approving criteria defined in the policy. The policy assigns Human Resources Management Officers responsibility for advising management on the provisions of the policy, providing technical advice, and ensuring the completeness of requests. The policy prohibits paying a recruitment bonus to individuals who are already Federal employees. The policy in effect at the time (b)(7)(C) requested to return to NWIHCS required that, in order for an employee to be paid a recruitment or relocation bonus, the approving official must determine that without the bonus, "it would not be possible to fill the position with a high quality candidate." Current policy states that the approving official must determine that without the incentive "it would be difficult to fill the position with a high quality candidate." Both policies require the approving official to document that, in determining if an incentive should be authorized, he or she considered factors such as: (1) turnover and past success in filling similar positions; (2) differences between Federal and community pay for the position; (3) the work environment or location; (4) unique qualifications relevant to the position; and (5) labor market factors. Finally, the policies require that the amount of the bonus be reasonably correlated to the difficulty experienced in obtaining a high quality candidate. [VA Handbook 5007, Part VI, Chapter 2, April 15, 2002 and October 13, 2005]

(b)(7)(C) improperly recommended, and Mr. Washko improperly approved, the recruitment bonus for (b)(7)(C) The initial June 2005 recommendation and approval for a recruitment incentive did not include documentation that these officials considered the factors identified above when determining if the bonus should be given, but in response to our request for such documentation in April 2006, they noted that the position was new and the competencies required were significantly dissimilar to other positions at NWIHCS, and thus comparisons to other recruitments were meaningless. They further noted that the cost of living in Omaha was not a negative factor in filling the position, and no special work environment, location, or labor market considerations existed. Regarding relevant unique qualifications, they noted that (b)(7)(C) uniquely fit with the data management needs of NWIHCS as he had made significant improvements in the facility's data management while he was detailed to NWIHCS. In May 2006, when (b)(7)(C) and Mr. Washko amended the paperwork to reflect that (b)(7)(C) received a relocation incentive, rather than a recruitment incentive, they wrote that the position was unique to NWIHCS to meet the data requirements of the Director, and that (b)(7)(C) when previously detailed to the Director, established the current system of data management tools and reports. They wrote they did not anticipate that NWIHCS would be able to employ anyone else who possessed (b)(7)(C) unique knowledge, skills and abilities, at least without having to offer a full recruitment bonus to attract the individual.

(b)(7)(C) confirmed that he received the $12,834 bonus. He told us he was not aware Mr. Washko planned to offer it to him until the day he processed back in at NWIHCS. At the time we interviewed him in May 2006, he said that, had he not been given the bonus, he would have returned to NWIHCS but would not have stayed once his personal issues were resolved.

Mr. Washko told us attracting talented people to Omaha had been difficult, and he believed in particular that filling the newly created (b)(7)(C) position with someone as qualified as (b)(7)(C) would have been "very difficult." He said this, coupled with his knowledge that (b)(7)(C) had been periodically contacted by other organizations trying to recruit him, had already left NWIHCS once, and was looking for a (b)(7)(C) justified the bonus. Mr. Washko told us he wanted to demonstrate to (b)(7)(C) that he desired to retain his services. He noted that the bonus paid to was small compared to the moving and other expenses he might have had to pay someone else. Mr. Washko acknowledged that (b)(7)(C) never asked for a bonus and was surprised to receive it.

(b)(7)(C) told us that the motivation behind paying a bonus to (b)(7)(C) was "altruistic" in nature; however, he acknowledged that the bonus ensured (b)(7)(C) would remain at NWIHCS for at least a year and provide stability and progress in the area of data management. He confirmed that (b)(7)(C) had not asked for the bonus, but only wanted to return to NWIHCS. He said (b)(7)(C) was not in a position to "bargain" for any bonus because of his personal situation, and told us he and Mr. Washko believed it

was unconscionable to take advantage of (b)(7)(C) by not reimbursing him for the skills he brought to the position. (b)(7)(C) told us the amount paid to (b)(7)(C) was equal to the amount of salary he lost as a result of accepting the downgrade. He said, had (b)(7)(C) not taken the position, the facility almost certainly would have advertised it with a 25 percent recruitment bonus, and it could have taken up to a year to fill the position.

According to (b)(7)(C) resigned his NWIHCS position in (b)(7)(C) to accept employment in the private sector. (b)(7)(C) said (b)(7)(C) (b)(7)(C) position was then abolished.

## Conclusion

(b)(7)(C) improperly recommended, and Mr. Washko improperly approved, a $12,834 recruitment bonus for (b)(7)(C) Initially approved as a recruitment incentive, it was improper because VA policy prohibits giving recruitment incentives to individuals who are already Federal employees. Further, whether characterized as a recruitment or a relocation incentive, it was improper because (b)(7)(C) requested and voluntarily accepted the position, with the downgrade, absent the bonus. He did not know he was receiving it until he reported for duty. VA policy required Mr. Washko and (b)(7)(C) to demonstrate that it would not be possible to fill the position with a high quality candidate in the absence of a bonus, and current policy requires them to demonstrate it would be difficult to fill the position. In either case, the fact that (b)(7)(C) requested and accepted the position for his own benefit, and did not know he was going to be offered the bonus, negates any argument that the position was otherwise impossible, or even difficult, to fill. Mr. Washko failed to ensure the decision to offer the bonus complied with VA policy, and (b)(7)(C) failed to appropriately advise him.

**Recommended Action(s) 1.** We recommend that the Director, VISN 23, ensures that appropriate administrative action is taken against (b)(7)(C) for improperly approving a $12,834 recruitment bonus for (b)(7)(C)

**Recommended Action(s) 2.** We recommend that the Director, VISN 23, ensures that appropriate administrative action is taken against (b)(7)(C) for improperly advising Mr. Washko regarding the bonus paid to (b)(7)(C)

**Recommended Action(s) 3.** We recommend that the Director, VISN 23, ensures that a bill of collection is issued to (b)(7)(C) to recover the $12,834 improperly paid to him.

## Comments

The Director, VISN 23, concurred with the recommendations. His response is in Appendix A. We will follow-up to ensure the recommended actions are fully implemented.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

Appendix A

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** February 9, 2007

**From:** Director, Veterans Integrated Service Network 23 (10N23)

**Subject:** **Administrative Investigation, Improper Recruitment Bonus, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska**

**To:** Director, Administrative Investigations Div. (51Q)

Attached are the responses to Administrative Investigation Draft Report (2006-01135-IQ-0129)

*(original signed by:)*

ROBERT A. PETZEL, M.D.

Network Director

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, VISN 23, ensures that appropriate administrative action is taken against Mr. Washko for improperly approving a $12,834 recruitment bonus for (b)(7)(C)

Concur **Target Completion Date:** April 6, 2007

**Recommended Action(s) 2.** We recommend that the Director, VISN 23, ensures that appropriate administrative action is taken against (b)(7)(C) for improperly advising Mr. Washko regarding the bonus paid to (b)(7)(C)

Concur **Target Completion Date:** April 6, 2007

**Recommended Action(s) 3.** We recommend that the Director, VISN 23, ensures that a bill of collection is issued to (b)(7)(C) to recover the $12,834 improperly paid to him.

Concur **Target Completion Date:** April 6, 2007

Appendix B

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Judy Shelly | (b)(7)(C) |
| Acknowledgments | Charles Millard | |

**Appendix C**

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 23 (10N23)
Management and Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Call the OIG Hotline – (800) 488-8244**

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Improper Contracting Procedures
# Acquisition Operations Service
# VA Central Office, Washington, DC

Report No. 06-00797-34

November 29, 2006

VA Office of Inspector General
Washington, DC 20420

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Director, Acquisition Operations Service (049A3)

**SUBJECT:** Administrative Investigation – Improper Contracting Procedures, Acquisition Operations Service, VA Central Office, Washington, DC (2006-00797-IQ-0019)

## Summary

We substantiated that contracting officials in the Acquisition Operations Service, Office of Acquisition and Materiel Management, VA Central Office, circumvented the requirement for full and open competition by non-competitively issuing a task order under a blanket purchase agreement to a contractor after asking that contractor to subcontract with a subject-matter expert specifically identified by VA. We also substantiated that one of these officials issued an advisory and assistance task order without first obtaining the required approval.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated allegations regarding contracts for services to the Veterans Health Administration's (VHA) Chief Business Office in VA Central Office. We did not substantiate the specific allegations but during the course of the investigation, we determined that (b)(7)(C) (b)(7)(C) (b)(7)(C) and one of his subordinates, (b)(7)(C) (b)(7)(C) circumvented the requirement for full and open competition to acquire the services of a subject-matter expert the Chief Business Officer identified by name. We further determined that (b)(7)(C) did not obtain approval from the Deputy Secretary prior to issuing an advisory and assistance task order, as required. To conduct this investigation, we interviewed (b)(7)(C) the Chief Business Officer, a contractor representative, and others. We reviewed pertinent contract documentation and applicable Federal law and regulations, and VA guidance.

## Results

### Issue 1: Whether (b)(7)(C) properly competed a contract for the Chief Business Office

Federal acquisition regulations require contracting officers to ensure that all requirements of law, regulations, and other applicable procedures are met before entering into a contract [48 CFR §1.602]. In accordance with Federal law, the regulations require agencies to obtain full and open competition through the use of competitive procedures, unless expressly authorized by statute to do otherwise [48 CFR §6.101, 41 USC §253(a)(1)(A)].

On (b)(7)(C) responsible for supporting VHA's Chief Business Office, issued a task order in the amount of $224,998 to Native American Industrial Distributors, Inc. (NAID), an American Indian and service-disabled veteran-owned small business. The task order was for the services of a subject matter expert, (b)(7)(C) to evaluate VHA's private sector purchased care efforts. The Chief Business Officer told us he knew (b)(7)(C) prior to assuming his position, as they had previously worked together in the private sector and in the Air Force.

The task order for (b)(7)(C) services was issued under an existing blanket purchase agreement (BPA) that the Acquisition Operations Service had previously established with NAID on behalf of the Chief Business Office. Under the terms of the BPA, VA would issue NAID a task order and, in response, NAID would submit a proposal which identified the individuals or entities who would perform the work through a subcontracting or other arrangement with NAID. If the proposal was acceptable, VA would award the task order. NAID's technical proposal for the BPA stated that its success in satisfying customers' needs depended heavily on its ability to team with prime contractors and subcontractors to bring the best individual talent forward. Federal acquisition regulations authorize the use of contractor team arrangements [48 CFR §9.6].

(b)(7)(C) told us the Chief Business Officer requested procuring (b)(7)(C) services because of (b)(7)(C) background in private healthcare. (b)(7)(C) said he told the Chief Business Officer he would try to identify a means by which the Acquisition Operations Service could do this. He said he and (b)(7)(C) then discussed using the BPA with NAID to obtain (b)(7)(C) services. According to (b)(7)(C) the Chief Business Officer did not pressure him to accomplish this procurement.

(b)(7)(C) confirmed that the Chief Business Officer recommended the services of (b)(7)(C) and that he and (b)(7)(C) determined they would try to obtain those services by using the existing BPA with NAID. (b)(7)(C) told us the Chief Business Officer did not pressure him to procure (b)(7)(C) services. He said he discussed with NAID representatives the possibility of that company subcontracting with (b)(7)(C)

and said they agreed to do so. (b)(7)(C) told us his office did not compete the procurement because the BPA with NAID was already awarded competitively.

NAID's Vice President of Business Development told us (b)(7)(C) advised him that a VA program manager needed a particular expert, (b)(7)(C) and told him that if NAID could obtain (b)(7)(C) under a subcontract, then VA could issue NAID a task order using the existing BPA. (b)(7)(C) had no business relationship with NAID prior to (b)(7)(C) discussion with NAID regarding the potential task order.

**Issue 2: Whether (b)(7)(C) obtained approval for an advisory and assistance contract**

Federal acquisition regulations define contractual advisory and assistance services as including services that provide assistance or advice for the efficient and effective management and operation of Government organizations, activities, or systems. According to the regulations, examples include efforts that support or contribute to improved organization of program management, logistics management, project monitoring and reporting, and data collection. The regulations further define advisory and assistance services as including services that provide organized, analytical assessments or evaluations in support of policy development, decision-making, management, or administration. The outputs of advisory and assistance contracts may include information, advice, opinions, alternatives, analyses, evaluations, recommendations, and the day-to-day aid of support personnel. [48 CFR §2.101] Office of Acquisition and Materiel Management guidance requires that all VHA requests for advisory and assistance services estimated to cost $100,000 or more be approved by the Deputy Secretary [IL 049-04-08, paragraph 7a].

On June 8, 2005, (b)(7)(C) submitted a statement of objectives to a representative of Booz Allen Hamilton, Inc., requesting that company provide a quote to provide support in managing improvements to VHA's revenue program and in helping to determine the future revenue cycle business model to be implemented across VHA. The statement of objectives specifically sought support in completing an oversight review addressing the current state and future direction of the program, including a detailed assessment of capabilities and a set of recommendations for moving forward. Two days earlier, on June 6, 2005, the Chief Business Officer told (b)(7)(C) in an electronic mail message that key VHA officials were "ready to facilitate A&A approval."

On August 4, 2005, following the identification of additional funds, (b)(7)(C) issued a request for quotations for an expanded effort. The August request for quotations sought contractor support to the Chief Business Office in managing VHA's revenue-cycle metrics, goals, and business processes. According to the statement of work contained within the request for quotations, contractor support was needed to (1) review various components of the revenue cycle, to communicate areas of concern, and to provide recommendations for improvement; (2) develop economic analyses, return-on-investment

studies, and business cases for efforts related to the revenue cycle; and (3) develop a template for extracting data related to revenue-cycle metrics. On August 26, 2005, a representative of Booz Allen signed a $447,493 task order issued by Mr. Nale for a time and material effort to accomplish the above work.

(b)(7)(C) told us he did not consider the task order to be an advisory and assistance effort because specific technical deliverables, as opposed to advisory services, were specified, and the effort was not intended to improve a management process, but rather to maintain a process that was already established. He said that discussions with Booz Allen representatives disclosed that the contractor's analysis would be to determine the most effective tools to use in program management, rather than to develop recommendations on how to change the program. (b)(7)(C) noted that the technical deliverables were specified in Booz Allen's proposal, submitted in response to the statement of objectives. These deliverables included observations and recommendations; weekly program updates to the Chief Business Officer; preparation of the Chief Business Officer for monthly in-process reviews and advisory board meetings; a communication plan to increase understanding of the program; monthly status reports to the Chief Business Officer; and other support services as requested.

## Conclusion

With (b)(7)(C) concurrence, (b)(7)(C) circumvented the requirement for full and open competition by non-competitively issuing a task order under a BPA to NAID after asking NAID to subcontract with a subject-matter expert the Chief Business Officer specifically recommended. While the BPA with NAID envisioned that NAID would identify expert companies it needed to submit proposals responsive to VA's needs, in this case, (b)(7)(C) made the task order contingent on NAID subcontracting with the expert they wanted. We also substantiated that (b)(7)(C) issued Booz Allen an advisory and assistance task order without first obtaining the required approval. Although (b)(7)(C) contended the services did not constitute an advisory and assistance effort, we disagree. The statement of objectives and statement of work (b)(7)(C) issued sought support for improving program management and decision-making, and required deliverables such as recommendations, analyses, and studies, all of which are consistent with the regulatory definition of an advisory and assistance contract.

**Recommended Action(s) 1.** We recommend that the Director, Acquisition Operations Service, take appropriate administrative action against (b)(7)(C) for allowing (b)(7)(C) to circumvent the requirement for full and open competition by issuing a non-competitive task order to NAID after asking NAID to subcontract with a specific subject-matter expert.

**Recommended Action(s) 2.** We recommend that the Director, Acquisition Operations Service, take appropriate administrative action against (b)(7)(C) for

circumventing the requirement for full and open competition by issuing a non-competitive task order to NAID after asking NAID to subcontract with a specific subject-matter expert; and for not obtaining the required approval before issuing an advisory and assistance contract to Booz Allen Hamilton, Inc.

## Comments

The Director, Acquisition Operations Service, concurred with the recommendations. He did not provide additional comments. We will follow-up to ensure the recommendations are fully implemented.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

**Appendix A**

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** November 8, 2006

**From:** Director, Acquisition Operations Service

**Subject:** **Administrative Investigation – Improper Contracting Procedures, Acquisition Operations Service, VA Central Office, Washington, DC**

**To:** Assistant Inspector General for Investigations

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, Acquisition Operations Service, take appropriate administrative action against (b)(7)(C) for allowing Mr. Nale to circumvent the requirement for full and open competition by issuing a non-competitive task order to NAID after asking NAID to subcontract with a specific subject-matter expert.

Concur **Target Completion Date:** 12/15/2006

**Recommended Action(s) 2.** We recommend that the Director, Acquisition Operations Service, take appropriate administrative action against (b)(7)(C) for circumventing the requirement for full and open competition by issuing a non-competitive task order to NAID after asking NAID to subcontract with a specific subject-matter expert; and for not obtaining the required approval before issuing an advisory and assistance contract to Booz Allen Hamilton, Inc.

Concur **Target Completion Date:** 12/15/2006

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Nancy Solomon |

**Appendix C**

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Associate Deputy Assistant Secretary for Acquisitions (049A)
Director, Acquisition Operations Service (049A3)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

2005-02958-IQ-0009

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** Director, Veterans Integrated Service Network 22 (10N22)

**SUBJECT:** Administrative Investigation - Improper Acceptance of a Gift and Honorarium, and Misuse of Time, VA San Diego Healthcare System (2005-02958-IQ-0009)

## Summary

We substantiated that a part-time physician at the VA San Diego Healthcare System improperly accepted a gift from a prohibited source, a cardiovascular medical products company that does business with VA, when he allowed that company to pay for expenses valued at $748.96 associated with a trip he took to the VA Southern Nevada Healthcare System in Las Vegas to conduct official business. The physician also improperly accepted a $1,500 honorarium from that company for the dinnertime presentation he made in (b)(7)(C) Other members of the San Diego staff who traveled to (b)(7)(C) and members of the (b)(7)(C) staff who attended the dinner presentation, also improperly accepted gifts from the prohibited source. We also substantiated that the physician misused his official VA time to perform professional remunerated services for the company on seven occasions between 2003 and 2005.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that (b)(7)(C) a (b)(7)(C) at the VA San Diego Healthcare System, improperly accepted an expense-paid trip to (b)(7)(C) from Guidant Corporation, a cardiovascular medical products company that does business with VA. We also investigated whether (b)(7)(C) received honoraria from Guidant for performing his official duties and whether he appropriately took leave while performing professional services for Guidant. (b)(7)(C) is responsible for working 60 hours each biweekly pay period. We interviewed (b)(7)(C) other staff at the San Diego Healthcare System and the VA Southern Nevada Healthcare System, and a Guidant representative. We reviewed documentation provided by Guidant supporting payments the company made to (b)(7)(C) during calendar years 2003–2005, and (b)(7)(C) VA time and attendance records. We also reviewed relevant Federal regulations and VA policy.

## Results

### Issue 1: Whether (b)(7)(C) improperly accepted a gift and honorarium from Guidant Corporation

Federal ethics regulations generally prohibit employees from accepting a gift from a prohibited source, defined as a person or corporation doing business, or seeking to do business, with the employee's agency. According to the regulations, gifts include lodging, meals, and transportation [5 C.F.R. §2635.202-204]. The ethics regulations further prohibit an employee from receiving compensation from any source other than the Government for teaching or speaking that relates to the employee's official duties [5 C.F.R. §2635.807(a)]. According to the facility's training records, (b)(7)(C) attended ethics training on several occasions beginning in June 2003.

On Friday, (b)(7)(C) traveled to (b)(7)(C) to make a presentation that evening to Southern Nevada Healthcare System staff in an effort to improve that facility's procedures for referring certain cardiology patients to the San Diego Healthcare System. (b)(7)(C) returned to San Diego the next day, Saturday, (b)(7)(C) Five other San Diego Healthcare System clinical staff also traveled to (b)(7)(C) None of the five are currently VA employees. According to (b)(7)(C) both he and some of the other San Diego staff were accompanied by a guest. (b)(7)(C) told us the presentation to the (b)(7)(C) staff was prompted by the fact that patients frequently were making several trips each from the (b)(7)(C) area to San Diego because (b)(7)(C) staff were not ensuring that all the preparatory tests and paperwork were completed. According to (b)(7)(C) he and the (b)(7)(C) decided that a face-to-face meeting between the two staffs would be helpful. (b)(7)(C) identified ten physicians, nurses, and technicians from the (b)(7)(C) facility who attended the meeting, including himself. A former (b)(7)(C) nurse, who tracked the staff's attendance at the meeting, confirmed that ten (b)(7)(C) staff attended. Several are no longer VA employees.

Guidant Corporation paid for (b)(7)(C) trip to (b)(7)(C) including his air fare ($188.00), taxicab expenses ($98.00), and one night's lodging ($325.91). (b)(7)(C) spouse, who is not a VA employee, flew to (b)(7)(C) at her own expense.) The company also paid for dinner on Friday night for all attendees from both VA facilities ($3,056.79) and for a meal on Saturday for the San Diego staff ($158.19). Although we did not identify additional attendees at the Friday dinner, the Guidant representative's expense report noted 30 people were in attendance, at a cost of $101.89 per person. Also according to the Guidant representative's expense report, nine people participated in the Saturday meal, including the San Diego staff, (b)(7)(C) spouse, and the Guidant representative, at a cost of $17.58 per person. (Although ethics regulations allow employees to accept gifts valued at $20.00 or less, we consider the amount spent by Guidant on (b)(7)(C) and his spouse during the (b)(7)(C) trip to constitute one gift.)

According to (b)(7)(C) Guidant also paid the air fare and/or lodging for the other San Diego staff. Finally, Guidant records document that the company paid (b)(7)(C) a $1,500 honorarium for making the presentation in (b)(7)(C)

(b)(7)(C) told us he did not recall how the decision was made that Guidant would pay for the (b)(7)(C) trip, but denied he solicited the funding. He noted that Guidant representatives were frequently present at the San Diego Healthcare System and may have heard conversations about the need for the meeting and offered to pay for it. (b)(7)(C) told us he probably did not attempt to obtain VA funding because he believed money was not available and said such trips were frequently sponsored by the private sector. (b)(7)(C) acknowledged that the meeting in (b)(7)(C) was VA mission-related.

(b)(7)(C) supervisor, (b)(7)(C) told us he was aware of the problems with referrals from (b)(7)(C) and agreed it would be useful to have a face-to-face meeting with the staff there. Both he and the Chief of Staff told us the meeting was mission-related, but the Chief of Staff said she did not learn about it until after it occurred. A nurse formerly employed at the San Diego Healthcare System, who helped arrange the trip and traveled with (b)(7)(C) to (b)(7)(C) told us she did not know how Guidant became involved in the funding. (b)(7)(C) told us he was not involved in arranging the meeting and was not aware that Guidant funded the dinner. Rather, he told us he thought the dinner was paid by grant funds. The former nurse who tracked the (b)(7)(C) staff's attendance at the meeting also said she did not know how the dinner was funded. Finally, the Guidant representative involved in this event told us he did not recall the specifics of it, but considered it a legitimate educational activity that Guidant appropriately supported.

**Issue 2: Whether (b)(7)(C) misused his official time to perform remunerated professional services for Guidant**

VA policy requires part-time physicians to be engaged in VA work during their duty hours unless they are in an approved leave status [VHA Directive 2003-001, paragraph 2f]. We identified seven occasions between 2003 and 2005 when (b)(7)(C) did not take annual leave from VA while he was performing professional, remunerated services for Guidant during his VA duty hours. For example, on Monday, (b)(7)(C) (b)(7)(C) traveled to (b)(7)(C) to speak at a private medical facility. He departed San Diego at 8:10 am and returned at 7:00 pm. Guidant paid (b)(7)(C) a $2,000 honorarium and $145 in travel expenses for the day. However, (b)(7)(C) VA duty hours that day were 10:00 am to 4:00 pm. His time and attendance records document that he took no leave.

As described below, on four occasions in 2003, [b)(7)(C)] traveled on behalf of Guidant to participate as an educator for a market research program. Each time, Guidant paid him a $2,000 honorarium and travel expenses.

- On Wednesday, [b)(7)(C)] traveled to [b)(7)(C)] and returned on the morning of Thursday, [b)(7)(C)] His VA duty hours on [b)(7)(C)] were from 8:00 am to 2:00 pm, but he took no leave for the portion of that time he was traveling for Guidant. Further, on [b)(7)(C)] was inappropriately granted an authorized absence when he should have taken annual leave for his scheduled hours, 8:00 am to 2:00 pm.

- On Monday, [b)(7)(C)] took annual leave to travel to [b)(7)(C)] [b)(7)(C)] His San Diego airport parking receipt documents that, upon his return the next day, [b)(7)(C)] he left the airport shortly after 10:00 am. Although his VA duty hours on October 7 began at 10:00 am, he took no leave.

- On [b)(7)(C)] Monday through Wednesday, [b)(7)(C)] traveled to [b)(7)(C)] He took annual leave for [b)(7)(C)] but not for [b)(7)(C)] His San Diego airport parking receipt documents that, upon his return on [b)(7)(C)] he left the airport at 11:17 am. [b)(7)(C)] VA duty hours on [b)(7)(C)] began at 10:00 am, but he took no leave.

- On [b)(7)(C)] a Wednesday and Thursday, [b)(7)(C)] traveled to [b)(7)(C)] The program was held Wednesday, [b)(7)(C)] and [b)(7)(C)] returned to San Diego the next day, Thursday, [b)(7)(C)] He took annual leave on [b)(7)(C)] but took no leave on [b)(7)(C)] His VA duty hours that day were from 10:00 am to 4:00 pm.

On those dates when [b)(7)(C)] returned to San Diego following travel on behalf of Guidant, we could not determine when or if he reported for duty at the San Diego Healthcare System. Finally, we identified two instances in 2005 when [b)(7)(C)] performed professional remunerated services for Guidant during his VA duty hours and was granted authorized absence to do so. The [b)(7)(C)] told us that during this time he was on extended sick leave and the physician who was acting for him erroneously approved the two absences. These charges were corrected during our investigation.

## Conclusion

[b)(7)(C)] improperly accepted a gift valued at $748.96 from Guidant Corporation, a prohibited source, when he allowed that company to pay for his air fare, lodging, meals for himself and his spouse, and other expenses associated with an [b)(7)(C)] trip he and other San Diego Healthcare System officials took to the Southern Nevada Healthcare System in [b)(7)(C)] to conduct official business. He also improperly

accepted from Guidant a cash honorarium of $1,500 for presenting information to the (b)(7)(C) staff. Other members of the San Diego staff who traveled to (b)(7)(C) and members of the (b)(7)(C) staff who attended the (b)(7)(C) dinner, also improperly accepted a gift. As (b)(7)(C) of their respective facility's (b)(7)(C) (b)(7)(C) should have known that Guidant paid the expenses of the meeting and should not have allowed the employees to accept the gifts.

(b)(7)(C) also misused his official VA time while performing professional remunerated services for Guidant on seven occasions between 2003 and 2005. He either did not take annual leave at all, took an insufficient amount of leave, or was granted authorized absence rather than taking annual leave.

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that appropriate administrative action is taken against (b)(7)(C) for accepting a gift from Guidant Corporation, a prohibited source; for accepting an honorarium from Guidant for performing his official duties; and for misusing his official VA time to perform professional remunerated services for Guidant.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that (b)(7)(C) returns $748.96 to Guidant, representing the value of the gift he received associated with the (b)(7)(C) trip to (b)(7)(C) and returns the $1,500 honorarium he accepted for speaking to other VA employees about his official duties.

**Recommended Action(s) 3.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that (b)(7)(C) takes appropriate amounts of annual leave for the time he performed professional remunerated services for Guidant during his official VA duty hours, or is charged absent without leave and billed for the value of the time he misused.

**Recommended Action(s) 4.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that appropriate administrative action is taken against (b)(7)(C) for allowing VA staff to accept a gift from a prohibited source.

**Recommended Action(s) 5.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that current employees at the VA Southern Nevada Healthcare System who attended the (b)(7)(C) meeting in (b)(7)(C) return to Guidant the value of the gift (dinner) they received from that company.

## Comments

The Director, Veterans Integrated Service Network 22, concurred with the above recommendations, and told us that appropriate administrative action would be taken against (b)(7)(C) and that he would be directed to reimburse Guidant for all monies

and benefits he received in connection with the (b)(7)(C) trip to (b)(7)(C) The Director further stated that (b)(7)(C) would be allowed to request 27 hours of annual leave to correctly account for the official VA time he misused performing professional remunerated services for Guidant. Finally, the Veterans Integrated Service Network Director told us appropriate administrative action would be taken against (b)(7)(C) and (b)(7)(C) and that employees who attended the (b)(7)(C) meeting in (b)(7)(C) would return the value of the dinner they received. The Director's comments were responsive to the recommendations and we will follow-up to ensure they are fully implemented.

JAMES J. O'NEILL
Assistant Inspector General for
Investigations

**Appendix A**

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** October 31, 2006

**From:** Director, Veterans Integrated Service Network 22 (10N22)

**Subject:** **Administrative Investigation - Improper Acceptance of a Gift and Honorarium, and Misuse of Time, VA San Diego Healthcare System**

**To:** Assistant Inspector General for Investigations (51)

## Director's Comments
## to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that appropriate administrative action is taken against (b)(7)(C) for accepting a gift from Guidant Corporation, a prohibited source; for accepting an honorarium from Guidant for performing his official duties; and for misusing his official VA time to perform professional remunerated services for Guidant.

Concur **Target Completion Date:** 11/17/06

A Letter of Reprimand will be issued to Dr. Narayan concerning the acceptance of a gift from a prohibited source, and for misusing his official VA time to perform professional remunerated services for Guidant Corporation. In addition the Letter of Reprimand will direct (b)(7)(C) to complete the training courses Ethical Conduct for Federal Employees and Compliance and Business Integrity (CBI) Program on or before October 30, 2006.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that (b)(7)(C) returns $748.96 to Guidant, representing the value of the gift he received associated with the (b)(7)(C) (b)(7)(C) trip to (b)(7)(C) and returns the $1,500 honorarium he accepted for speaking to other VA employees about his official duties.

Concur **Target Completion Date:** 11/17/06

The Letter of Reprimand described in Recommended Action 1, will direct (b)(7)(C) to reimburse Guidant Corporation for all monies and/or benefits received in connection with the (b)(7)(C) trip to (b)(7)(C)

**Recommended Action(s) 3.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that (b)(7)(C) takes appropriate amounts of annual leave for the time he performed professional remunerated services for Guidant during his official VA duty hours, or is charged absent without leave and billed for the value of the time he misused.

Concur **Target Completion Date:** 11/17/06

(b)(7)(C) will be allowed to request Annual Leave in the amount of 27 hours to correctly account for his time on the days referenced in this recommendation. The dates for which annual leave should be requested are (b)(7)(C) - 6 hours, (b)(7)(C) 6 hours, (b)(7)(C) - 1 hour, (b)(7)(C) (b)(7)(C) - 2 hours, (b)(7)(C) 6 hours, (b)(7)(C) (b)(7)(C) - 6 hours.

**Recommended Action(s) 4.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that appropriate administrative action is taken against (b)(7)(C) for allowing VA staff to accept a gift from a prohibited source.

Concur **Target Completion Date:** 11/17/06

(b)(7)(C) will both receive counselings which will reiterate the necessity for them to properly advise their subordinate employees regarding proper procedures with regard to traveling and or speaking on behalf of the VA.

**Recommended Action(s) 5.** We recommend that the Director, Veterans Integrated Service Network 22, ensures that current employees at the VA Southern Nevada Healthcare System who attended the (b)(7)(C) meeting in (b)(7)(C) return to Guidant the value of the gift (dinner) they received from that company.

Concur **Target Completion Date:** 11/17/06

Employees who attended the August 2003 function will return the value of the gift (DINNER) they received.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Guy Durand |

**Appendix C**

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 22 (10N22)
Management Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

2005-01545-IQ-0155

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Misuse of Official Time by a Physician
# VA Medical Center, Oklahoma City, OK

Report No.

VA Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Director, Veterans Integrated Service Network 16 (10N16)

**SUBJECT:** Administrative Investigation – Misuse of Official Time by a Physician, VA Medical Center, Oklahoma City, OK (2005-01545-IQ-0155)

## Summary

We substantiated that between July 1, 2003, and June 30, 2005, (b)(7)(C) at the VA Medical Center in Oklahoma City, OK, misused authorized absences, sick leave, and his official duty time on 18 days to participate in a pharmaceutical company's lecture bureau, primarily as a presenting speaker. The company paid the psychiatrist for his services.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that (b)(7)(C) at the Oklahoma City VA Medical Center, misused authorized absences and his official duty time to participate, for compensation, in the speakers program of a pharmaceutical company, Eli Lilly and Company. To assess the allegation, we interviewed (b)(7)(C) the former Chief, Mental Health Service; the Chief of Staff; and other facility staff. We reviewed (b)(7)(C) time and attendance records from July 2003 to June 2005, his request for authorized absences, a summary of his compensated activity on behalf of Eli Lilly during this time period, and Federal law and VA policy. We did not substantiate a related allegation concerning (b)(7)(C) relationship to Eli Lilly.

## Results

**Issue: Whether (b)(7)(C) misused official VA time by performing professional services on behalf of a pharmaceutical company**

Federal law requires that full-time VA physicians who engage in outside professional activities for remuneration fulfill a minimum 80-hour, biweekly VA tour of duty [38 U.S.C. §7423(a)]. VA policy allows physicians to be absent without charge to leave to attend professional meetings and education and training activities that benefit VA and the employee. Physicians authorized to be absent for such purposes are on official business and are paid. The policy requires physicians to charge leave in 1-day increments. Finally, the policy allows employees to charge sick leave when they are incapacitated for the performance of their duties because of personal illness, necessary medical examinations, or when a family member requires the care of the employee [VA Handbook 5011, Part III, Chapter 3].

Eli Lilly records document that on 60 days between July 2003 and June 2005, (b)(7)(C) participated in one or more activities, for compensation, in that company's lecture bureau, primarily as a presenting speaker. On most of these occasions, (b)(7)(C) charged annual leave or made presentations after his VA duty hours, 8:00 am to 4:30 pm. However, (b)(7)(C) VA leave records document that on 18 of these days he was either authorized to be absent from duty for another purpose, was supposed to be on duty or, in one instance, was in a sick leave status when he made one or more presentations. Eli Lilly paid (b)(7)(C) between $750 and $1,500 for each presentation.

(b)(7)(C) VA leave records document that he was authorized to be absent from duty on (b)(7)(C) In an August 22, 2003, memorandum from (b)(7)(C) through the former Chief, Mental Health Service, to the Chief of Staff, (b)(7)(C) requested these absences so that he could make presentations, including travel time, to the (b)(7)(C) and to unspecified "inpatient psychiatry staff and trainees" in (b)(7)(C) and in (b)(7)(C) (b)(7)(C) stated in the memorandum that he was not receiving honoraria for making these presentations. Although the copy of the memorandum we received contained no signatures, the former Chief, Mental Health Service, told us he recommended approval of the absences and the Chief of Staff said he likely approved them. (b)(7)(C) told us he requested the absences to make a community service presentation in (b)(7)(C) and to speak at the VA medical centers in (b)(7)(C)

Eli Lilly records document that on the above dates (b)(7)(C) also made presentations for its lecture bureau, for which he was compensated, including a presentation each day at noon and again between 5:30 pm and 7:00 pm, and a presentation on two of those days at 9:00 am. The presentations were made at various locations in (b)(7)(C) (b)(7)(C) (outside the (b)(7)(C) area) at mental health and counseling centers, hospitals, physician offices, restaurants, and a health insurance

provider's office. (b)(7)(C) made the two morning presentations and four of the noon presentations on days he was authorized to be absent solely to travel. In addition, (b)(7)(C) VA leave records document that on (b)(7)(C) the day prior to being authorized to speak in (b)(7)(C) he left work at 1:45 pm without charge to leave, but with the former Mental Health Service Chief's approval. That evening at 6:30 pm, (b)(7)(C) made a presentation in (b)(7)(C) on behalf of Eli Lilly. (b)(7)(C) told us the presentation in (b)(7)(C) was 3 hours from (b)(7)(C) Thus, he used his official VA time to travel for Eli Lilly.

Eli Lilly records also document that (b)(7)(C) made noon presentations on eight other occasions, without charge to annual leave, during the time period we reviewed. Six of the presentations were in (b)(7)(C) including at the (b)(7)(C) (b)(7)(C) and a community mental health center; one was in (b)(7)(C) and one was by telephone. (b)(7)(C) told us he takes 5 to 10 minutes to reach the (b)(7)(C) (b)(7)(C) and 10 to 15 minutes to reach the community center, and that his presentations were 45 to 60 minutes long. (b)(7)(C) told us the presentation in (b)(7)(C) was 30 minutes away, and that the former Chief, Mental Health Service, approved his absence. Regarding the presentation made by telephone, (b)(7)(C) told us the call lasted about 45 minutes and during that time, he interrupted his presentation to answer a page and tend to other official VA business.

Eli Lilly records document that on another occasion, (b)(7)(C) made a lecture bureau presentation at 2:00 pm in (b)(7)(C) According to (b)(7)(C) VA leave records, however, he was in a sick leave status at the time. (b)(7)(C) told us he did not recall the event. Finally, (b)(7)(C) told us he participated in an Eli Lilly speaker training session on (b)(7)(C) He told us he recalled arriving late for a reception that evening. Eli Lilly records document that (b)(7)(C) departed (b)(7)(C) (b)(7)(C) that day on a 2:15 pm flight. According to his VA leave records, he charged no leave for his absence.

(b)(7)(C) acknowledged that on the days he was authorized to be absent in (b)(7)(C) he also made presentations for Eli Lilly, and that he made other presentations for that company at noon time. He told us he did not realize it was improper for him to generate income while on authorized absence and said he used his lunch break for all noon time presentations. (b)(7)(C) VA duty day includes 30 minutes for a lunch break. Further, (b)(7)(C) said the Chief of Staff and the former Chief, Mental Health Service, were aware of his activities. These two officials told us they knew (b)(7)(C) was making presentations for Eli Lilly, but were not aware he was doing so while on authorized absence or when he was supposed to be on duty. The former Chief, Mental Health Service, also told us he knew (b)(7)(C) was paid by Eli Lilly. He denied he approved (b)(7)(C) making the presentations while on authorized absence or at noon.

## Conclusion

On 18 days between July 2003 and June 2005, (b)(7)(C) misused his authorized absences, sick leave, and official duty time to make presentations, for compensation, as a participant in Eli Lilly's lecture bureau. Since physicians who are in an authorized absence status are on official business and are paid, (b)(7)(C) is prohibited by law from generating income for himself while on such absences. (b)(7)(C) misled his supervisors when he requested authorized absences for purposes that also included generating income for himself. While (b)(7)(C) used part of his lunch break to make many of the presentations, by his own testimony these events exceeded the 30 minutes he is allowed for lunch. Finally, he improperly charged sick leave to make one presentation, and failed to charge annual leave when he left work early to attend speaker training. The former Chief, Mental Health Service, and the Chief of Staff were aware (b)(7)(C) participated in the lecture bureau, but they were not aware he used official duty time to do so.

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for misusing his authorized absences, sick leave, and official time; and ensure that (b)(7)(C) either takes annual leave or is charged absent without leave and billed for the 18 days in question.

## Comments

The Veterans Integrated Service Network 16 Director concurred with the recommendation, but noted that (b)(7)(C) had resigned his VA appointment. He stated that Dr. Dennis was issued a bill of collection in the amount of $7,882.17. The Director's comments are in Appendix A. They were responsive to the recommendation. We will follow up to ensure collection action is taken.

Daniel R. Petrole

DANIEL R. PETROLE
Assistant Inspector General for
Investigations

**Appendix A**

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** April 27, 2006

**From:** Director, Veterans Integrated Service Network 16 (10N16)

**Subject:** **Administrative Investigation - Misuse of Official Time by a Physician, VA Medical Center, Oklahoma City**

**To:** Daniel R. Petrole

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 16, ensure that appropriate administrative action is taken against (b)(7)(C) for misusing his authorized absences, sick leave, and official time; and ensure that (b)(7)(C) either takes annual leave or is charged absent without leave and billed for the 18 days in question.

Concur **Target Completion Date:** 4-27-06

(b)(7)(C) has resigned his appointment as a (b)(7)(C) at this medical center and entered private practice. Based on this report a bill of collection has been issued to (b)(7)(C) (b)(7)(C) for a total amount of $7,882.17.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Stephanie A. Robinson |

Appendix C

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 16 (10N16)
Management Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

2004-02900-IQ-0101

**DEPARTMENT OF VETERANS AFFAIRS**
Office of Inspector General
Washington, DC 20420

**TO:** Director, Veterans Integrated Service Network 22 (10N22)

**SUBJECT:** Administrative Investigation – Misuse of Position, VA Greater Los Angeles Healthcare System, West Los Angeles, CA (Case 2004-02900-IQ-0101)

## Summary

We substantiated that an (b)(7)(C) at the VA Greater Los Angeles Healthcare System used her position for personal gain by living in Government quarters while she earned money leasing her own house.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that (b)(7)(C) at the VA Greater Los Angeles Healthcare System, improperly lived in VA on-station housing while she leased her own house to generate income. To assess the allegation, we obtained sworn, taped testimony from Mr. Charles Dorman, the Healthcare System Director; (b)(7)(C) (b)(7)(C) supervisor; and other Healthcare System officials. We reviewed request and authorization for VA quarters; income and expense data pertaining to the leasing of her house; and applicable Federal law and regulations, and VA policy.

## Results

**Issue 1: Whether (b)(7)(C) used her position for personal gain by living in VA quarters while she earned money leasing her own house**

The Standards of Ethical Conduct for Employees of the Executive Branch prohibit employees from using their public office for their personal gain [5 CFR §2635.702]. Federal law allows agencies to provide employees with quarters when warranted by conditions of employment or availability [5 USC §5911]. The law, however, prohibits an employee whose pay is fixed by statute or regulation from receiving additional pay or allowance, unless specifically authorized [5 USC §5536]. Thus, Office of Management and Budget policy prohibits Federal agencies from using Government rental quarters as a subsidy to employees [OMB Circular A-45, paragraph 5].

In (b)(7)(C) submitted a request to rent quarters at the West Los Angeles campus, and Mr. Dorman approved it. At the time, (b)(7)(C) and her spouse owned a house valued, according to (b)(7)(C) at over $2 million. That house was located (b)(7)(C) told us she requested to move into VA quarters when a neighbor asked if he could lease her house while his was undergoing construction. She said she had been trying to sell the house because it was too expensive to maintain, but had been unsuccessful and so agreed to the lease. (b)(7)(C) said that after she began leasing the property and had moved into VA quarters, her house was damaged by flooding and she was repairing it while the renters remained living there. (b)(7)(C) told us she informed both her immediate supervisor and Mr. Dorman of the circumstances prompting her request to move into VA quarters. She also said she asked the former Facilities Management Chief if she was eligible to live on-station and he told her she was. Based on financial data (b)(7)(C) provided to us, her monthly rental income exceeded her monthly mortgage payment by $5,364, or a total of $96,552 over the 18-month period between January 2004 and June 2005. During this time, (b)(7)(C) paid $1,481 monthly to rent on-station quarters.

Mr. Dorman told us he did not recall (b)(7)(C) telling him she planned to lease her house. He said he approved her request to move on-station because he understood that her house was undergoing reconstruction. He said, had he known the true circumstances, he would not have approved it. According to Mr. Dorman, he relied on a recommendation by the former Facilities Management Chief, who told him he (the Chief) and (b)(7)(C) supervisor supported (b)(7)(C) request. Mr. Dorman said that, after he approved the rental, Ms. Weintraub's supervisor told him she did not support it. He said at that point, however, he did not want to rescind his commitment to (b)(7)(C) Mr. Dorman also noted that he thought it would be beneficial to have (b)(7)(C) living on-station because she was a (b)(7)(C) VA policy allows employees at certain duty stations to reside in Government quarters if the organizational mission requires providing service to the community or to VA beneficiaries on a 24-hour basis [VA Directive 7631, paragraph 2].

(b)(7)(C) supervisor told us she did not support (b)(7)(C) request to live in quarters because she thought it was inappropriate to offer a perquisite to one (b)(7)(C) (b)(7)(C) and not the others, particularly since (b)(7)(C) already lived closer to the campus than the other Associates did. According to the supervisor, other (b)(7)(C) complained to her about the decision. The former Facilities Management Chief told us he did not recall recommending to Mr. Dorman that he approve (b)(7)(C) request.

During this investigation, we noted that the rental amount deducted from (b)(7)(C) biweekly pay remained constant from (b)(7)(C) until at least (b)(7)(C) (b)(7)(C) Veterans Health Administration policy requires that rental rates for quarters be adjusted annually [VHA Handbook 7631.2, paragraph 9a]. We further noted that, compared to similar private rental property in the (b)(7)(C) area, Healthcare

System officials charged (b)(7)(C) significantly less for the on-station quarters she occupied.

## Conclusion

Based on financial data (b)(7)(C) submitted, she enjoyed a significant financial gain by living in VA quarters. (b)(7)(C) requested to live on-station because she found her own nearby house too expensive to maintain. Her request to do so while she earned money from the lease of that house constituted a misuse of her public office for personal gain. Additionally, Healthcare System officials may have charged (b)(7)(C) a rental rate significantly lower than the prevailing market rate.

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 22, ensure that appropriate administrative action is taken against (b)(7)(C) for using her public position for personal gain, and give her appropriate notice to vacate VA quarters.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 22, ensure that the rental rates charged to employees living in quarters at the West Los Angeles campus are up-to-date and properly calculated.

## Comments

The Director, Veterans Integrated Service Network 22, concurred with the recommendations, noting that appropriate administrative action was taken against (b)(7)(C) and that she vacated the quarters in October 2005. The Network Director further stated that he would review the facility's compliance with Veterans Health Administration policy regarding establishing rental rates for quarters, and provide a copy of those findings to us. The Network Director's comments were responsive to the recommendations, and we will follow up to ensure they are fully implemented.

FOR DANIEL R. PETROLE
Assistant Inspector General for
Investigations

Appendix A

# Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** March 31, 2006

**From:** Director, Veterans Integrated Service Network 22 (10N22)

**Subject:** **Administrative Investigation - Misuse of Position, VA Greater Los Angeles Healthcare System, West Los Angeles, CA**

**To:** Assistant Inspector General for Investigations (51)

## Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Director, Veterans Integrated Service Network 22, ensure that appropriate administrative action is taken against (b)(7)(C) for using her public position for personal gain, and give her appropriate notice to vacate VA quarters.

Concur **Target Completion Date:** April 7, 2006

We have concluded that although (b)(7)(C) experienced a personal gain using her public position, it was unintentional. (b)(7)(C) vacated VA quarters on (b)(7)(C) (b)(7)(C) was instructed to complete web based training found on www.usoge.gov, entitled, Misuse of Position Interactive WBT (2001). In addition we have formally counselled her regarding the findings of the OIG report.

**Recommended Action(s) 2.** We recommend that the Director, Veterans Integrated Service Network 22, ensure that the rental rates charged to employees living in quarters at the West Los Angeles campus are up-to-date and properly calculated.

Concur **Target Completion Date:** May 30, 2006

We will review compliance with VHA Handbook 7631.2, Requirements for the Continued Operation of Quarters and Establishing Quarters Rental Rates, dated October 1, 2003. A copy of our findings will be provided to your office.

**Appendix B**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly, (b)(7)(C) |
| Acknowledgments | Linda Fournier |

**Appendix C**

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Principal Deputy Under Secretary for Health (10A)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network 22 (10N22)
Management Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**

2004-02823-IQ-0157

**DEPARTMENT OF VETERANS AFFAIRS**
**Office of Inspector General**
**Washington, DC 20420**

**TO:** VA Secretary (00)

**SUBJECT:** Administrative Investigation – Alleged Reprisal of a Contract Employee by the Contractor, Asheville, North Carolina, 2004-02823-IQ-0157

## Summary

We investigated an allegation that MedQuist, Inc., a VA contractor, reprised against one of its employees, terminating her, because she made disclosures to VA officials, an agent of the Federal Bureau of Investigation (FBI), and a U.S. Senator. We found that the allegation was not credible because of compelling evidence that MedQuist would have terminated the employee in the absence of such disclosures.

## Introduction

On June 16, 2004, (b)(7)(C) formerly an employee of (b)(7)(C) a VA contractor, alleged in a letter to the VA Inspector General that she had been reprised against by (b)(7)(C) for disclosures she made to VA officials, an FBI agent, and then-Senator John Edwards. At about the same time, (b)(7)(C) filed a similar complaint with the Occupational Safety and Health Administration (OSHA). OSHA is authorized by the Sarbanes-Oxley Act to investigate certain allegations of reprisal. Except for interviewing (b)(7)(C) and obtaining some documentary evidence, we suspended action on her allegations pending OSHA's completion of its investigation. On July 15, 2005, OSHA notified (b)(7)(C) it had completed its investigation and was dismissing the case as unfounded. OSHA advised (b)(7)(C) of her right to file an objection to its findings within 30 days, but she did not do so. Subsequently, we independently reviewed documentary evidence submitted by (b)(7)(C) as well as documentary evidence OSHA shared with us, including its investigative report and (b)(7)(C) written response to the allegation. We concluded that (b)(7)(C) allegation of reprisal was unfounded.

## Results

**Issue: Whether (b)(7)(C) officials reprised against (b)(7)(C)**

Federal law prohibits a Government contractor from discharging, demoting, or otherwise discriminating against its employees as a reprisal "for disclosing to a Member of Congress or an authorized official of an executive agency or the Department of Justice information relating to a substantial violation of law related to a contract..." According to the law, an employee who believes he or she has suffered such reprisal may submit a complaint to the executive agency's Inspector General. The law requires that office to investigate the complaint and submit a report of findings to the complainant, the contractor concerned, and the head of the agency [41 USC §265(a), (b)].

(b)(7)(C) became an employee of (b)(7)(C) a medical transcription services company, in (b)(7)(C) (b)(7)(C) continued using the technology the acquired company had developed for transferring transcriptions to VA, a system called (b)(7)(C) which transferred data 24 hours a day, 7 days a week. (b)(7)(C) was the (b)(7)(C)

(b)(7)(C) (b)(7)(C) told us that in [redacted] she contacted the VA official who was then the Integrated Data Communication Utility Security Officer, to discuss concerns she had about (b)(7)(C) practice of sending VA dictated medical records to India and possibly Pakistan via the Internet for transcription. She said she was concerned about the security implications of sending personal information about veterans (and active duty personnel) to those countries. The former Security Officer confirmed that in approximately mid-(b)(7)(C) contacted him and reported security concerns regarding (b)(7)(C) handling of VA records. Around this time, (b)(7)(C) also contacted one or two other VA information security officials. She suggested that (b)(7)(C) management learned of her disclosures to VA officials about 2 weeks later because at that time company managers called and read to her an electronic mail message from a VA contracting officer asking if (b)(7)(C) outsourced transcription work. (b)(7)(C) said the managers told her she would be fired if she talked to anyone about the outsourcing or security violations.

In (b)(7)(C) 2002, (b)(7)(C) reported (b)(7)(C) overseas outsourcing of transcription services to the FBI, and the following month, she notified (b)(7)(C) officials in writing that she had done so. In (b)(7)(C) after learning that the FBI closed the issue as a criminal matter, (b)(7)(C) reported the activity and her security concerns to then-Senator John Edwards. We do not know if management was aware (b)(7)(C) wrote to Senator Edwards. (b)(7)(C) also filed complaints with OSHA. OSHA dismissed an initial complaint, filed April 2003, because it was untimely and not protected under the Sarbanes-Oxley Act, and because the evidence did not demonstrate she suffered a material adverse action or had been subjected to a hostile work environment. (b)(7)(C)

was aware of this complaint by May 14, 2003, the date it responded to the allegations. In [redacted] 2 months after [redacted] was terminated, she filed a second complaint with OSHA, which, as noted above, OSHA investigated.

[redacted] told us that beginning in September 2002, when she notified [redacted] of her contact with the FBI, she was shunned and treated poorly at work. For example, she said the air conditioning in her office was turned off and she was forbidden to open a window, the lock on her office door was taped so that she could not lock it, her office was the only one not painted, her food was stolen from the refrigerator, employees whistled under their breath at her, and she was ignored by other staff at work. She alleged that the reprisal culminated on [redacted] when MedQuist management eliminated her position and terminated her from the company. [redacted] said that, although management promised to help her find another position within the company, they did nothing.

In its response to OSHA regarding [redacted] allegations, MedQuist argued that it would have terminated her even in the absence of her disclosures because (1) MedQuist eliminated the Autotype technology, and (2) because the company closed its [redacted] office.

Regarding the [redacted] technology, beginning in [redacted] communicated with VA via the Department's virtual private network, "One-VPN." VA required that a single individual have security access to One-VPN. For MedQuist, that person was [redacted] [redacted] use of [redacted] was problematic because VA required that the person accessing One-VPN be the person who actually held the security access. In fact, however, multiple transcribers at MedQuist were accessing One-VPN through [redacted] with [redacted] access scripted into the program. This arrangement required that [redacted] be present at all times while [redacted] was operational. Electronic mail messages show that throughout [redacted] complained she was working excessive hours to avoid having to disable her security access and leave [redacted] without connectivity to VA, except by a time-consuming manual method. VA officials gave [redacted] interim authority to access One-VPN this way, acknowledging it was a security risk. In [redacted] noted that she was aware [redacted] was trying to find an alternative to [redacted] And, in [redacted] officials, including [redacted] met with VA's Office of Cyber Security to discuss the company's plans to move to a new communication technology, which would negate the need for [redacted]

A [redacted] incident brought the problem using [redacted] to a head. At that time, [redacted] took 2 weeks off and told [redacted] employees they could not operate [redacted] in her absence. When [redacted] contacted VA to confirm this, VA ordered the contractor not to access One-VPN in [redacted] absence. According to [redacted] this had the immediate effect of shutting down all computer communications to VA for all the medical centers it serviced. [redacted] implemented an emergency manual system but stated that the backlog of transcripts "exploded," resulting in a 2-week "disaster." According to [redacted] the incident accelerated its need to find a new technology

platform. In [redacted] discontinued using [redacted] As a result, [redacted] had no duties to perform.

Regarding the closure of [redacted] office, [redacted] stated that due to the Small Business Administration Act of 2000, that office lost a significant amount of revenue because the company could no longer qualify as a small business and thus could not renew contracts it previously had. According to [redacted] revenue dropped from $8 million to approximately $1.5 million and by 2002 it could no longer justify maintaining its Asheville office. [redacted] stated it gave notice that it would lease its office month-to-month, and said the building owners accepted an offer to sell the building to an unrelated party. [redacted] was terminated the same day the office closed, [redacted]

In response to [redacted] allegations of changes in her work environment, [redacted] stated it had no idea what she was referring to when she alleged her air conditioning was turned off. Her office also housed a significant number of computers, and [redacted] argued that if it turned off the air conditioning (which it denied doing), its equipment would have been damaged. OSHA's report of [redacted] initial [redacted] allegations to the agency states that, according to [redacted] the day she complained about the air conditioning being off it was corrected. Further, according to [redacted] the reason [redacted] was asked to stop opening a certain window was because that window was broken, and the reason her office was not painted was because it would have been difficult to continue using the computer servers, which were in her office, while the painting was in progress. [redacted] denied allegations that [redacted] work environment became more hostile, and OSHA determined that electronic mail messages she submitted as evidence of harassment did not appear to represent anything more than the disputes and disagreements found in a typical workplace. Finally, OSHA stated that [redacted] believed most of the harassment was orchestrated by the former office manager, but said [redacted] did not provide sufficient evidence demonstrating the manager had discriminatory motives and noted that the two did not have a good relationship prior to her disclosures.

In response to [redacted] allegation that [redacted] did little to help her find other employment within the company, [redacted] argued it made numerous efforts. [redacted] noted that its Regional Vice-President made inquiries to identify suitable positions for [redacted] including distributing her resume to technical groups within [redacted] and meeting with a Regional Applications Specialist to discuss jobs posted on [redacted] intranet. [redacted] said it had no other facility that used [redacted] so it could not transfer [redacted] and allow her to continue with that technology. In any case, [redacted] told [redacted] she could not leave the [redacted] area and could do only limited travel. In its investigation, OSHA did not substantiate that [redacted] made little effort to find [redacted] employment.

(b)(7)(C) was not the only (b)(7)(C) employee of the (b)(7)(C) office terminated when that office closed. The office's billing and payroll coordinator told OSHA investigators that she was terminated from the company on or about March 31, 2004. She attributed her termination to the transfer of her responsibilities to another (b)(7)(C) office. In addition, both she and a (b)(7)(C) representative noted that three other positions in the (b)(7)(C) office were eliminated. The (b)(7)(C) representative stated that these were part-time clerical positions. He said one of the clerical employees resigned in anticipation of the office closing and the other two were terminated. The employees who remained on (b)(7)(C) payroll were account managers, who began working from their homes when the Asheville office closed. Account managers are liaisons between (b)(7)(C) transcribers and its clients.

## Conclusion

The evidence demonstrates that (b)(7)(C) termination of (b)(7)(C) was unrelated to the disclosures she made to VA, the FBI, or Senator John Edwards. Although (b)(7)(C) management was aware in (b)(7)(C) of (b)(7)(C) disclosure to the FBI, and may have known of her disclosures to VA and Senator Edwards, they terminated her because they no longer needed her services as the (b)(7)(C) The (b)(7)(C) system did not have the security features VA required to allow it to properly monitor who was accessing its One-VPN network. Although VA allowed, as an interim measure, multiple (b)(7)(C) transcribers to use (b)(7)(C) with (b)(7)(C) access scripted into the program, this was problematic for both (b)(7)(C) because (b)(7)(C) had to be present when (b)(7)(C) was operating. Electronic mail messages submitted by both parties disclose that (b)(7)(C) relationship with company officials significantly deteriorated because of her (correct) insistence that only she was authorized access to One-VPN and had to monitor the system whenever it was operating. (b)(7)(C) apparently did not contact VA to determine the validity of her assertions until (b)(7)(C) at which time they were directed not to access One-VPN in her absence. The incident in (b)(7)(C) when (b)(7)(C) took 2 weeks of leave accelerated (b)(7)(C) desire to abandon (b)(7)(C) and they did so within the next 2 months. If (b)(7)(C) officials harbored any ill-will towards (b)(7)(C) it is reasonable to assume such ill-will was because of their frustration, or at least misunderstanding, over her refusal to breach her security with One-VPN. This issue loomed so large throughout (b)(7)(C) that to assert (b)(7)(C) officials terminated (b)(7)(C) for any other reason is not credible.

Concurrent with (b)(7)(C) decision to discontinue use of (b)(7)(C) was its decision to close the (b)(7)(C) office. Four other positions, in addition to (b)(7)(C) were eliminated. (b)(7)(C) was unwilling to relocate outside the (b)(7)(C) area. Regardless of whether (b)(7)(C) could have made a greater effort to find her other employment in the company, such as a position she could have performed from her home, its business decision to close the office appears to be legitimate and credible.

(b)(7)(C) allegation that she was terminated by (b)(7)(C) for disclosing information to VA, the FBI, and Senator Edwards is not credible in light of compelling evidence that (b)(7)(C) would have taken that action absent such disclosures. (b)(7)(C) had a legitimate business reason for discontinuing the (b)(7)(C) system. Since (b)(7)(C) was the (b)(7)(C) her duties and position were necessarily affected. Regarding (b)(7)(C) allegation that she was treated poorly at work as reprisal for making disclosures, OSHA previously determined that the evidence represented nothing more than the disputes and disagreements found in a typical workplace.

Daniel R. Petrole

DANIEL R. PETROLE
Assistant Inspector General for
Investigations

**Appendix A**

# OIG Contact and Staff Acknowledgments

| | | |
|---|---|---|
| OIG Contact | Judy Shelly, | (b)(7)(C) |

**Appendix B**

# Report Distribution

## VA Distribution

VA Secretary

## Non-VA Distribution

MedQuist, Inc.
Ms. Susan Purdue

# Department of Veterans Affairs
# Office of Inspector General

# Administrative Investigation
# Financial Irregularities
# VA Medical Center
# Washington, DC

Report No. 06-00209-80

February 6, 2006

VA Office of Inspector General
Washington, DC 20420

## WARNING
## 5 U.S.C. §552a, PRIVACY ACT STATEMENT

**This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. §552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.**

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

**TO:** Under Secretary for Health (10)

**SUBJECT:** Administrative Investigation, Financial Irregularities, VA Medical Center, Washington, DC

## Summary

We substantiated that the former (b)(7)(C) at the VA Medical Center in Washington, DC, instructed a subordinate to remove aged financial records from VA's central accounting system and that the Medical Center (b)(7)(C) was aware this action was being discussed but, despite having been advised it was improper, allowed the records to be removed. We concluded the removal was intentional and was done to improve the facility's financial indicators. Although we found no evidence that the manipulation of the financial records resulted in misappropriations, we did determine that some accounts needed management attention.

## Introduction

The VA Office of Inspector General, Administrative Investigations Division, investigated an allegation that managers at the Washington, DC, VA Medical Center were responsible for the intentional removal of certain financial records from VA's accounting system in order to meet applicable performance standards. The allegation was raised during a Deloitte & Touche audit at the medical center. To assess the allegation, we interviewed the medical center's current and former (b)(7)(C) managers, the (b)(7)(C) the Director, other knowledgeable VA employees, and members of the Deloitte & Touche audit team. We reviewed the Deloitte & Touche draft report, a prior relevant VA Management Quality Assurance Service report, pertinent correspondence, and Federal law and VA policy. Following the Deloitte and Touche audit, we also reviewed cash receipts and deposit procedures, and unapplied deposit Suspense Account activities to determine whether funds were misappropriated.

## Results

### Issue 1: Whether managers at the Washington, DC, VA Medical Center directed staff to remove financial records from the accounting system

Federal law requires executive agencies to establish internal accounting controls that assure revenues and expenditures are properly recorded and accounted for [31 USC §3512(c)]. VA policy provides that the financial accounts of the Department are the official source of all financial statements and reports, and that accounting policies and procedures must provide full disclosure of the results of financial operations through an orderly system for controlling and recording financial transactions on the accrual basis [MP-4, Part V, Chapter 1, Section 1A.01 - 1A.03]. The policy requires that when undelivered orders and accrued services have been outstanding for an unreasonable length of time, the fiscal activity must notify the initiating office, which in turn must determine and report back on the status of each authorization or order [MP-4, Part V, Chapter 3, Section 3B.03j]. Regarding accounts receivables, VA policy requires that when collection action has been suspended or referred elsewhere for collection, the receivable is to remain part of the total outstanding receivable balance of the Department [VA Directive 4669, paragraph 2g].

This issue was presented to a US Attorney and criminal prosecution was declined.

In April 2005, during Deloitte & Touche's audit of VA's fiscal year 2005 consolidated financial statements at the Washington, DC, Medical Center, the medical center's then-(b)(7)(C) advised the auditors that senior management at the facility had recently instructed her office to remove certain records relating to aged accounts receivables, undelivered orders, and accounts payables from the central accounting system in order to obtain favorable financial indicators. Based on this disclosure, Deloitte & Touche's November 2005 draft report (see Appendix A) identified a "distinct" reduction that occurred in March 2005 in the reported balances of the medical center's non-medical care collection fund accounts receivables, accounts payables, and undelivered orders. The auditors reported that the balances in these three categories between February 2005 and April 2005 decreased by a total of over $22.8 million, and involved the removal of 1,126 records. They said this action raised the medical center from a "red light" indicator (more than 30 percent of the account balance is more than 90 days old) to a "green light" indicator (at least 70 percent of the account balance is 60 days old or less). The Deloitte & Touche draft report concluded that this "manipulation" of the balances appeared to be intentional in order to present to the users of the information a more favorable circumstance than was the case, and that the action compromised the integrity of VA's financial reporting mechanisms.

Prior to this incident, in July 2004, VA's Management Quality Assurance Service conducted a revenue review at the Washington, DC, Medical Center and found a similar situation, in that aged medical accounts receivable records had been removed from the

central accounting system at the time those claims were referred to an outside source for collection. In a Management Letter to the Deputy Under Secretary for Health for Operations and Management and to the Veterans Health Administration's Chief Financial Officer, the Service Director communicated concern about this practice and noted that it was contrary to VA policy.

(b)(7)(C) became (b)(7)(C) at the Washington, DC, Medical Center effective (b)(7)(C) and was promoted to (b)(7)(C) her current position, (b)(7)(C) Prior to (b)(7)(C) she was employed at another VA facility. (b)(7)(C) told us that, at one or more meetings in March 2005 with (b)(7)(C) Associate Director; and others, the participants discussed the large number of aged records in the system, their effect on the facility's financial indicators, and how to immediately move to a more favorable position. She said she explained that to properly improve the indicators, her office needed to first determine, through researching each aged record in the system, whether that record should, in fact, be written off. She said she explained that the only way to improve the indicators immediately was to remove all the aged records and research each one at a later date. (b)(7)(C) told us she was not suggesting that the latter option be taken, but was only explaining how to get a "green light" indicator. She said, following this discussion, she asked (b)(7)(C) what he wanted her to do, and said he told her to remove the aged records.

(b)(7)(C) provided us an electronic mail message, which (b)(7)(C) sent to her (with a copy to (b)(7)(C) on March 24, 2005. According to the message, (b)(7)(C) directed her to "close out all aging obligations and payables that are greater than 120 day[s]." He noted that the process was a temporary measure and that a complete review of all the affected records needed to be provided to him and to (b)(7)(C) by June 30, 2005. (b)(7)(C) attached to this message an earlier set of electronic messages, dated February 22, 2005, in which (b)(7)(C) authorized (b)(7)(C) to "decrease purchase order[s] that are over 120 day[s] old where the vendor has not invoiced for payment and attempts have been made to contact the vendor." (b)(7)(C) told us she did not recall receiving this set of messages until we asked her to research her electronic mail account, and said she could not comment on how she may have interpreted (b)(7)(C) March 24 instructions to her in the context of the February 22 messages.

The following day, March 25, (b)(7)(C) sent another electronic message to (b)(7)(C) directing her to remove certain accounts receivable records, again as a temporary measure, and to review the records and report to him and to (b)(7)(C) by June 30. The accounts receivables referenced in this message represented funds owed to the medical center by employees who had been on leave without pay and had not repaid their share of the cost of health insurance benefits they received during that time. According to a Deloitte & Touche auditor, these records were part of the 1,126 records removed from the accounting system in March and April 2005.

(b)(7)(C) currently a (b)(7)(C) (b)(7)(C) told us he left his position as (b)(7)(C) (b)(7)(C) at the Washington, DC, Medical Center in (b)(7)(C) He acknowledged he instructed (b)(7)(C) to remove from the accounting system aged accounts receivable records relating to employees who had been on leave without pay, but repeatedly told us he did not recall instructing her to remove other aged records. He said that, during multiple meetings with (b)(7)(C) stated that the large number of aged records needed to be reduced and repeatedly asked how that could be done. Further, according to (b)(7)(C) asked what the Washington, DC, Medical Center was doing wrong, as other facilities were meeting their performance expectations. In early 2005, (b)(7)(C) gave (b)(7)(C) a written counseling regarding his performance on the financial indicators, and (b)(7)(C) said that, by the end of March 2005, his office was reporting weekly or bi-weekly to (b)(7)(C) on its progress and plans for reducing the balances. Three times during our initial interview with (b)(7)(C) he testified that (b)(7)(C) directed him to remove aged records relating to employees who had been on leave without pay. However, during a second interview with him 9 days later, he told us (b)(7)(C) did not specifically direct that to happen but told him to "fix" the problem.

(b)(7)(C) told us it was possible that he did instruct (b)(7)(C) to remove aged records from other account balances, but if he did so, he said it would have been only after many discussions with (b)(7)(C) He told us he knew it was wrong to remove the records without first determining on an individual basis if that was the appropriate course of action. He noted that the (b)(7)(C) and (b)(7)(C) engaged in a "heated" discussion because she was adamant that aged records not be removed from the accounting system without first properly researching the appropriateness of doing so. He said he was aware that in 2004 the Management Quality Assurance Service raised concerns about aged medical accounts receivables being improperly removed from the central accounting system, and noted that as a result, those transactions had to be reversed. (b)(7)(C) said the (b)(7)(C) was severely understaffed and not able to do the research required to remove aged records. He said he did not intend to violate VA policy in March 2005, but wanted to remove the records to obtain a more accurate reflection of the medical center's financial status.

(b)(7)(C) confirmed that he and the (b)(7)(C) staff had many meetings discussing financial indicators and the need to take action to improve them. He did not recall any discussions specifically focused on accounts receivable records relating to employees who had been on leave without pay. He said the staff discussed with him the need to research individual records to determine if each should properly be written off and recalled a group discussion about removing aged records and researching them later. He said he did not recall anyone advising him that researching the records after they were removed was wrong or problematic. (b)(7)(C) told us he did not know the fiscal staff was going to remove the records, and said he expected improvement in the indicators would be a

lengthy and gradual process. He said he did not learn the records were removed until the Network Chief Financial Officer called to discuss the situation in early April 2005. Finally, (b)(7)(C) acknowledged he was familiar with the findings of the Management Quality Assurance Service's 2004 review at the Washington, DC, Medical Center and knew the practice of removing medical accounts receivable records from the accounting system was wrong, but he said he did not relate the concerns from that review to other (non-medical care) aged records at the time.

The (b)(7)(C) during the time in question told us that, during a meeting with (b)(7)(C) staff around (b)(7)(C) (b)(7)(C) instructed the staff to improve the financial indicators "by any means." She said that, in the presence of (b)(7)(C) discussed that they would remove the records and conduct the appropriate research at a later date. She said the discussion concerned all aged records, not just those relating to employees who had been on leave without pay. Finally, she told us she argued against removing the records prematurely and, as a result, (b)(7)(C) was "so upset with me during the month of (b)(7)(C)

A medical center employee who was temporarily detailed to the (b)(7)(C) during the time in question told us she was in a meeting near the end of March 2005 with (b)(7)(C) the (b)(7)(C) and others. She said (b)(7)(C) told the group they needed to improve the financial indicators, and that the (b)(7)(C) explained to (b)(7)(C) the proper procedures that needed to be followed before removing an aged record. She said she did not hear (b)(7)(C) specifically direct that the records be removed. Further, she told us that, during one meeting, the (b)(7)(C) and (b)(7)(C) were engaged in a conflict because the (b)(7)(C) told him it was not proper to remove records without first researching the appropriateness of doing so. She said it was her impression (b)(7)(C) did not want to hear that.

### Issue 2: Whether the Manipulation of Financial Records Resulted in Misappropriations

The results of the VA Consolidated Financial Statement Audit for fiscal year 2005 showed that the VA medical center in Washington D.C. intentionally manipulated financial records in an effort to secure a favorable performance metric. The Veterans Health Administration (VHA) used the "red light-green light" system to measure key operational elements in fiscal operations. Green lights are assigned to facilities who report that 70 percent of their accounts receivable balances are 60 days old or less. Red lights are assigned to facilities who report more than 30 percent of their accounts receivable to be more than 90 days old. Audit tests conducted by Deloitte and Touche confirmed that the VA medical center closed long outstanding accounts receivable, accounts payable, and undelivered order accounts from official records and retained unofficial records to keep track of these accounts (See Appendix A to review Deloitte and Touche's draft report). The VA medical center manipulated this data to achieve a green-light performance metric. These actions compromised the integrity of the VA's financial

reporting process, and placed the accounts that were removed at risk of being lost to recovery or needed follow-up actions.

There was no evidence of misappropriations but some accounts needed management attention. During our review, we determined that the balances recorded in the unofficial accounting records for Accounts Receivable that were inappropriately reduced during the period February to April 2005 were consistent with the balances recorded in the Financial Management System (FMS) as of January 30, 2005. Receipts for Federal Employee Health Benefit (FEHB) Accounts Receivables that were reduced were recorded in the Suspense Account. Vendor Accounts Receivables that were reduced were offset by the Austin Finance Center and were not recorded in the Suspense Account. The following conditions were identified:

- Accounts Receivables that were removed from official records or inappropriately reduced had not been reestablished in VA's accounting system.
- Cash receipts recorded in the Suspense Account during fiscal year 2005 were deposited in the medical center's Federal Reserve account.
- Amounts transferred from the Suspense Account were not misappropriated.
- Procedures for verifying Federal Reserve deposits needed to be improved.

**Accounts Receivables Need To Be Reestablished**

During the period February to April 2005, (b)(7)(C) inappropriately decreased 269 long outstanding Accounts Receivables valued at about $263,230 in order to achieve favorable indicators in the monthly financial reports.[1] These long outstanding accounts were removed from official fiscal records and recorded on an in-house electronic spreadsheet. At the time of our review, these accounts had not been reestablished in FMS for current employees or vendors, or in the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement for former employees. As a result, the Accounts Receivables are still not being controlled by VA's accounting system.

**Cash Receipts Were Deposited**

We validated that cash receipts collected by the Agent Cashier in fiscal year 2005 were deposited in the Federal Reserve Account. We reviewed 80 cash receipts totaling $93,424.11 and the corresponding deposits by the Agent Cashier. We identified 20 cash receipts totaling $40,121.37 that were recorded as unapplied deposits in the Suspense

[1] This amount varied from the contractor's reported $237,000 in accounts receivable because we included accounts for deceased employees, employees that had returned to the medical center rolls, and employees with debts that were subsequently waived, which the contractor excluded.

Account. Our review also included six receipts totaling $1,081.66 relating to the Accounts Receivables that were reduced in FMS.

Federal Employee Health Benefits – Our review of Field Service Receipts (VA Form 1027) prepared by the Agent Cashier disclosed that six employees with Accounts Receivable, totaling $1,081.66, that were reduced in FMS made cash payments to the Agent Cashier. The payments were made to satisfy debts that were created when the medical center paid the employees' contribution for FEHB while the employees were on Leave With-out Pay. The receipt amounts posted in the manual accounting records were consistent with the amounts recorded on the Field Service Receipts and the Deposit Tickets (Standard Form 215). To verify that the deposits were made to the Federal Reserve Bank, we compared the amounts from the Deposit Tickets with the CashLink II screens available through the Federal Reserve Bank's online customer access system. The CashLink II system tracks all deposits using predetermined numbers from the deposit tickets. The bank's records concerning the deposits were consistent with the medical center's records.

**Unapplied Deposits Were Not Misappropriated**

We found no evidence to show that funds were misappropriated. An unapplied deposit (UD) is created in Suspense Account F3875 in FMS when the purpose of a remittance, the appropriation, fund, or receipt account to be credited cannot be determined at the time of receipt. The remittance is deposited to the UD account until disposition can be determined. VHA financial performance standards require that all UDs are researched and credited to the appropriate account within 90 days. If a deposit remains in the Suspense Account for more than 90 days, the financial indicator on the monthly financial report for the entire Suspense Account will turn red.

As of November 8, 2005, the medical center Suspense Account contained 65 UDs totaling $89,041. We reviewed each UD to determine the source of the deposits, appropriateness of the credits to each UD, and the current status of the UD. While we did not identify any misappropriations of funds from the Suspense Account, we identified four payments to a Federal employee health benefits plan that were made in error. Also, some UDs had been in the Suspense Account since FY 2003. Our review disclosed that UDs occurred as a result of cash collections from employees and vendors, payroll deductions, returned checks, and transfers from the Austin Finance Center and other medical facilities.

We traced all disbursements from the UD Suspense Account to associated public vouchers or the transfer of the funds to the VA appropriation. For all cash disbursements to employees we verified that reimbursements were mailed to the employees' addresses of record.

Our review of the 65 UD found that 37 had been applied to the appropriation, or returned to the employee or vendor as shown below:

| Returned To | Number | Amount |
|---|---|---|
| Appropriation | 21 | $ 19,607.51 |
| Employee | 11 | 14,841.71 |
| FEHB Plan | 4 | 2,262.64 |
| Canteen | 1 | 96.03 |
| **Total** | 37 | **$37,806.89** |

The four payments totaling $2,262.64 to the FEHB Plan were made in error. The payments should have been returned to the appropriation. On December 1, 2005, the Fiscal Officer told us that an Accounts Receivable for this amount would be established and a bill of collection issued in order to get the funds back from the FEHB Plan. The remaining 28 UDs, totaling $51,234.11 had still not been applied to the appropriation and are currently under review.

We also reviewed cash received by the Agent Cashier that could not be identified at the time of receipt and was posted to the Suspense Account. During the period October 1, 2004, through October 30, 2005, the medical center Agent Cashier received cash from 20 employees or vendors totaling about $40,121.37 that was recorded in the Suspense Fund. Our review of the Federal Reserve deposit records showed that these receipts were deposited in the Federal Reserve account, and that the amounts deposited were consistent with the amounts recorded on the Field Service Receipts and Deposit Tickets prepared by the Agent Cashier.

**Procedures for Depositing Receipts Needed Improvement**

During our review, we learned that the medical center was using an armored car contractor to make deposits to the bank but no formal consignment of the receipts was made to the contractor. For example, the contractor was only required to sign a log indicating the number of items received from the Agent Cashier, with no reference to the dollar value of the receipts. Additionally, the Agent Cashier was not routinely reconciling the medical center's deposits with records from the Federal Reserve Bank.

The Fiscal Officer stated that the bank provided deposits slips to VA Central Office along with the deposits slips for all other VA medical facilities. However, the Agent Cashier could not locate anyone in VA Central Office that was receiving the deposit slips. Therefore, neither the Agent Cashier nor Fiscal Service could provide copies of any deposit slips from the bank, nor bank statements certifying that the amounts deposited by the armored car contractor were true and correct. The Agent Cashier could have performed the reconciliations by using the CashLink II system but did not have access to

the system. The Fiscal Officer stated that the Agent Cashier would be provided access to the CashLink II system and will be required to reconcile medical center deposits with the bank's receipts.

## Conclusion

(b)(7)(C) directed (b)(7)(C) who was his subordinate at the time, to remove aged fiscal records from VA's accounting system, knowing that such action was wrong. In writing, he instructed her to remove accounts receivable records relating to employees who had been on leave without pay, and a reasonable interpretation of the March 24, 2005, electronic message he sent to (b)(7)(C) is that he also instructed her to remove all accounts payable records more than 120 days old. Further, while we could not conclusively determine whether (b)(7)(C) knew (b)(7)(C) was removing aged records at the time it was happening, according to his own testimony, he was aware it was an option being discussed. He was also aware that concerns about similar activity relating to aged medical accounts receivables had been raised less than a year earlier and was in violation of VA policy. We question (b)(7)(C) statement that no one advised him that researching the records after they were removed was wrong, as several (b)(7)(C) (b)(7)(C) staff told us he and the (b)(7)(C) had a heated discussion about the proper procedures for removing records. At the time the option of removing aged records from the accounting system was discussed in meetings with (b)(7)(C) he should have specifically directed (b)(7)(C) staff not to follow through with it or, at least, directed them to discuss the propriety of that option with the Network Chief Financial Officer. We concluded that the removal of the aged records was intentional and, according to everyone we interviewed, was done to improve the facility's financial indicators.

Regarding whether the manipulation of financial records resulted in misappropriations, we concluded that it did not. However, we determined that some accounts needed management attention.

**Recommended Action(s) 1.** We recommend that the Under Secretary for Health ensures appropriate administrative action is taken against (b)(7)(C) for directing a subordinate to remove aged records from the VA accounting system, an action he knew to be improper.

**Recommended Action(s) 2.** We recommend that the Under Secretary for Health ensures appropriate administrative action is taken against (b)(7)(C) for allowing aged records to be removed from the VA accounting system, an action his staff advised him was improper and that he should have known was improper.

**Recommended Action(s) 3.** We recommend that the Under Secretary for Health require that the VISN and Medical Center Directors ensure that: (a) inappropriately reduced accounts are reestablished in VA's accounting system; (b) Accounts Receivables are established and bills of collections are issued for the four erroneous payments to the

FEHB plan; and (c) procedures are established to verify all deposits to the Federal Reserve account.

## Comments

The Under Secretary for Health concurred with the above findings and recommendations. Regarding the recommendations to take appropriate administrative action against (b)(7)(C) the Under Secretary stated that he would conduct an administrative board of investigation and take appropriate action based on the results. A member of the Under Secretary's staff told us the administrative board of investigation would determine the level of administrative action warranted. The Under Secretary's comments are responsive to the recommendations, and we will follow up to ensure the planned actions are implemented.

Daniel R. Petrole

DANIEL R. PETROLE
Assistant Inspector General for
Investigations

Page 11 of 19

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information and Privacy Act

Page 12 of 19

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information and Privacy Act

Page 13 of 19

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information and Privacy Act

Page 14 of 19

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information and Privacy Act

Page 15 of 19

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information and Privacy Act

# Under Secretary for Health Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** January 26, 2006

**From:** Under Secretary for Health (10)

**Subject:** **Administrative Investigation – Financial Irregularities, VA Medical Center, Washington, DC**

**To:** Assistant Inspector General for Investigations (51)

1. I have reviewed the draft report and I concur with your findings and recommendations. My response to the recommendations is enclosed.

2. Thank you for the opportunity to review the draft report.

*(original signed by)*

Jonathan B. Perlin, MD, PhD, MSHA, FACP

## Under Secretary for Health's Comments to Office of Inspector General's Report

The following Under Secretary for Health's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

**OIG Recommendation(s)**

**Recommended Action(s) 1.** We recommend that the Under Secretary for Health ensures appropriate administrative action is taken against (b)(7)(C) for directing a subordinate to remove aged records from the VA accounting system, an action he knew to be improper.

Concur **Target Completion Date:** 02/28/2006

VHA will conduct an Administrative Board of Investigation on the financial irregularities at the VAMC Washington, DC. The Under Secretary for Health will take appropriate administrative action based on those results.

**Recommended Action(s) 2.** We recommend that the Under Secretary for Health ensures appropriate administrative action is taken against (b)(7)(C) for allowing aged records to be removed from the VA accounting system, an action his staff advised him was improper and that he should have known was improper.

Concur **Target Completion Date:** 02/28/2006

VHA will conduct an Administrative Board of Investigation on the financial irregularities at the VAMC Washington, DC. The Under Secretary for Health will take appropriate administrative action based on those results.

**Recommended Action(s) 3.** We recommend that the Under Secretary for Health require that the VISN and Medical Center Directors ensure that: (a) inappropriately reduced accounts are reestablished in VA's accounting system; (b) Accounts Receivables are established and bills of collections are issued for the four erroneous payments to the FEHB plan; and (c) procedures are established to verify all deposits to the Federal Reserve account.

Concur **Target Completion Date:** 02/28/2006

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Judy Shelly (b)(7)(C) |
| Acknowledgments | Guy Durand, James Hudson, Willie Toomer |

# Report Distribution

## VA Distribution

Deputy Secretary (001)
Chief of Staff (00A)
Executive Secretariat (001B)
Under Secretary for Health (10)
Management Review Service (10B5)

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Call the OIG Hotline – (800) 488-8244**