



**OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF VETERANS AFFAIRS**



**SEMIANNUAL REPORT TO CONGRESS  
OCTOBER 1, 2007 - MARCH 31, 2008**



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## Message from the Inspector General

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This Semiannual Report to Congress focuses on the accomplishments of the VA Office of Inspector General (OIG) for the reporting period from October 1, 2007, through March 31, 2008. Issued in accordance with the *Inspector General Act of 1978*, as amended, it presents results based on OIG strategic goals, which cover the areas of health care delivery, benefits processing, financial management, procurement practices, and information management.

During this reporting period, OIG issued 69 reports on VA programs and operations. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, financial management, economy in procurement, and information security. OIG audits, investigations, and other reviews identified over \$175 million in monetary benefits, for a return of \$4 for every dollar expended on OIG oversight. Our criminal investigators have closed 501 investigations and made 277 arrests. OIG investigative work also resulted in 284 administrative sanctions.



The Office of Healthcare Inspections (OHI) continued to evaluate quality of care issues at several Veterans Health Administration (VHA) medical facilities. After VA's internal review process identified a high mortality rate at Marion, Illinois, VA Medical Center (VAMC), VA and Congress asked OIG to perform a comprehensive review of the surgical services at the facility. Our review concluded the surgical specialty care was in disarray and found specific problems with care provided to veteran patients. OHI also identified non-fatal complications and problems in non-surgical care, an ineffective Quality Management program, and deficiencies in credentialing and privileging of physicians. OHI made 17 recommendations to improve VA health care, both for the VAMC and for VHA nationally.

On the benefits side, two important audits of VBA operations have identified \$29 million in funds that could be put to better use. In delaying processing of certain compensation actions, VBA incurred overpayments of \$17 million. Avoidable delays in VBA actions on claims not requiring a rating action led to another \$12 million in overpayments. Our Office of Investigations also detected serious criminal activity directed at the benefits process. For example, OIG initiated 39 investigations concerning allegations of persons fraudulently receiving or applying for VA benefits using unearned military medals of valor to substantiate their claims. These "Stolen Valor" cases resulted in seven arrests, nine indictments, and seven convictions.

The Office of Contract Review (OCR) conducted preaward and postaward reviews specifically designed to improve VA's procurement process by protecting the interest of the Government and identifying and resolving contractor overcharges. OCR issued 36 reports that resulted in savings and dollar recoveries of over \$46.1 million.

OIG appreciates the ongoing support we receive from the Secretary, the Deputy Secretary, and senior management. We look forward to working with VA and Congress to make VA as effective as possible in caring for our Nation's veterans.

A handwritten signature in cursive script that reads "George J. Opfer".

GEORGE J. OPFER  
Inspector General



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## Statistical Highlights

### DOLLAR IMPACT (\$\$\$ in Millions)

Better Use of Funds.....	\$29.0
Fines, Penalties, Restitutions, and Civil Judgments.....	\$7.9
Fugitive Felon Program .....	\$120.7
Savings and Cost Avoidance .....	\$13.4
Questioned Costs .....	\$1.7
OIG Dollar Recoveries.....	\$2.6
Contract Review Savings and Dollar Recoveries .....	\$46.1

### RETURN ON INVESTMENT

Dollar Impact (\$175.3)/Cost of OIG Operations (\$40.3) .....	4:1
Dollar Impact (\$46.1)/Cost of Contract Review Operations (\$1.8) .....	26:1

### OTHER IMPACT

Arrests .....	277
Indictments.....	129
Criminal Complaints .....	68
Convictions .....	135
Pretrial Diversions .....	19
Fugitive Felon Apprehensions by Other Agencies Using VA OIG Data .....	23
Administrative Sanctions .....	284

### ACTIVITIES

#### Reports Issued

CAP Reviews.....	27
Healthcare Inspections.....	29
Audits.....	11
Administrative Investigations.....	2
Contract Reviews .....	36

#### Investigative Cases

Opened.....	480
Closed .....	501

#### Healthcare Inspections Activities

Clinical Consultations.....	1
Administrative Case Closures .....	3

#### Hotline Activities

Cases Opened.....	396
Cases Closed .....	436



## VA and OIG Mission, Organization, and Resources

### The Department of Veterans Affairs

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2008, VA has a \$90.3 billion budget and almost 230,000 employees serving an estimated 23.5 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Republic of the Philippines.

VA has three administrations that serve veterans:

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

For more information, please visit the VA Internet home page at [www.va.gov](http://www.va.gov).

### VA Office of Inspector General

The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. Inherent in every OIG effort are the principles of quality management (QM) and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 488 employees, is organized into 3 line elements: the Offices of Investigations, Audit, and Healthcare Inspections, plus a contract review office and a support element. FY 2008 funding for OIG operations provides \$80.5 million from appropriations. The Office of Contract Review, with 25 employees, receives \$3.5 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS) contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country.

OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strives to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG Internet home page at [www.va.gov/oig](http://www.va.gov/oig).



## Health Care Delivery

The health care that VHA provides veterans is consistently ranked among the best in the Nation, whether those veterans are recently returned from Operation Iraqi Freedom/ Operation Enduring Freedom (OIF/OEF) or are veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional QM program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events.

### OFFICE OF HEALTHCARE INSPECTIONS

The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses VHA services. During this reporting period, OHI published 27 cyclical Combined Assessment Program (CAP) reviews, and 29 hotline reports and national reviews to evaluate quality of care issues in several VHA medical facilities.

#### High Mortality Rate at Illinois VA Facility Prompts Health Care Review

As a result of a review of the high mortality rate at Marion, Illinois, VA medical center (VAMC) by VA's National Surgical Quality Improvement Program (NSQIP), inpatient surgery was halted, and VA and Congress asked OIG to perform a comprehensive review of the surgical services at the facility. OIG's review concluded that the surgical specialty care at Marion VAMC was in disarray, citing three mortality cases that did not meet the standard of care. Inspectors identified examples of non-fatal complications of care and substantiated allegations of poor non-surgical medical care. In addition, OIG found an ineffective QM program and deficiencies in the credentialing and privileging of physicians. These problems, as well as the quality of care issues identified in specific cases, are a reflection of facility leadership. OIG also concluded that NSQIP offers VA an opportunity of providing evidence-based monitoring and improvement in quality of surgical care. The review made 17 recommendations for improvement in VA health care, both for VHA nationally and specifically for Marion VAMC. ([Healthcare Inspection, Quality of Care Issues, VA Medical Center, Marion, Illinois](#))

#### Need for Diabetes Screening for Patients on Atypical Antipsychotics

The purpose of the OIG review was to evaluate the effectiveness of diabetes screening, monitoring, and treatment for mental health patients between the ages of 35 and 50, who received atypical antipsychotic medications at VHA facilities. OIG conducted the evaluations during 48 CAP reviews conducted throughout 2006. To improve patient outcomes, OIG recommended that VHA clinicians implement and document strategies and interventions for at-risk patients who are prescribed atypical antipsychotic medications, striving to achieve target blood glucose and blood pressure levels that are reasonable for their patients. ([Healthcare Inspection, Atypical Antipsychotic Medications and Diabetes Screening and Management](#))

#### Inspectors Review VHA Contract Community Nursing Home Program

VHA's contract community nursing home (CNH) program provides services through contracts with nursing homes to meet veterans' geographic preferences and institutional needs. OIG reviewed the quality and availability of CNH programs, and whether appropriate controls were in place to monitor that care. Inspectors visited 88 nursing homes, reviewing medical records and interviewing patients, families, guardians, and facility administrators/directors to evaluate oversight and monitoring, and to assess quality of care and patient safety. Also, OIG visited two VA medical facilities to investigate the closure of CNH programs and its impact on veterans and their families. The review recommended that the Under Secretary for Health take actions to improve compliance with VA policy, documentation, reporting of patient incidents, and oversight. ([Healthcare Inspection, Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program](#))

#### Salisbury VAMC Missed Opportunities To Diagnose Colorectal Cancer

An OIG review into allegations of inadequate care and failure to diagnose colorectal cancer (CRC) in a high-risk patient at the W. G. (Bill) Hefner VAMC in Salisbury, North Carolina, concluded that the patient's diagnostic testing was delayed on several occasions and providers missed multiple opportunities over several years to diagnose CRC. The





patient had two incomplete colonoscopies, neither of which was appropriately followed up. Inspectors recommended that managers ensure patients with known risk factors for CRC receive appropriate and timely diagnostic testing and referrals in accordance with professional practice guidelines. OIG also recommended that VA evaluate this case for possible disclosure to the patient's family. (*Healthcare Inspection, Quality of Care Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina*)

### **Health Care Inspection Notes Management and Safety Issues in Michigan**

OIG conducted a health care inspection at the VAMC in Battle Creek to review multiple allegations pertaining to mismanagement, safety issues, and undesirable outcomes for four patients. Inspectors recommended that management reassess inpatient mental health services, create appropriate plans and programs to optimize patient and staff safety, and review mental health provider staffing and workload based on patient care needs. The mental health staff needed to complete periodic training and comply with VHA policies regarding approvals for program restructuring, changes in program capacity, and patient safety. (*Healthcare Inspection, Alleged Mismanagement and Safety Issues, Battle Creek VA Medical Center, Battle Creek, Michigan*)

### **South Texas Veterans HCS Responds to Recommendations**

OIG's review of allegations of poor quality of care in the surgical intensive care unit at the South Texas Veterans Healthcare System substantiated the allegation that General Surgery did not follow consultative advice concerning fluid management for the patient cases reviewed for this inspection. However, inspectors found that this did not directly result in the patient deaths. Deficiencies in the management and organizational structure, patient advocacy program, and administrative nursing guidance prevented concerns from being adequately addressed in a systematic fashion. In recognition of the considerable improvements the system had already implemented, OIG made only six recommendations. (*Healthcare Inspection, Quality of Care in the Surgical Intensive Care Unit, South Texas Veterans Health Care System, San Antonio, Texas*)

### **VA Facility in Detroit Found Needing To Make Administrative Changes**

An inspection at the John D. Dingell VAMC in Detroit did not substantiate allegations that two patients scheduled for procedures in the surgical and endoscopy suite were inappropriate candidates for moderate sedation as defined by VAMC policy. However, OIG found that operating room nurses were insufficiently prepared to participate in the care of patients requiring moderate sedation and that inadequate training programs were in place. To improve operations, OIG recommended implementing administrative investigative board and VHA surgical site visit recommendations, making local policy reflect VHA policy on cardiopulmonary resuscitation and moderate sedation, and ensuring that policies and procedures specify requirements for independent supervisory review of incidents. (*Healthcare Inspection, Quality of Care and Management Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan*)

### **Review Finds Need To Improve Communication, Continuity of Care**

OIG conducted an inspection into allegations of a veteran's premature discharge from the VA Pittsburgh Healthcare System (VAPHS) and overall concerns about his care. The patient, a 25-year old Operation Iraqi Freedom veteran, was admitted to the VAPHS on a warrant for involuntary commitment for evaluation and treatment. He was discharged when it was determined he was not a danger to himself or others, and died approximately 3 weeks later of acute pneumonia. Inspectors found that the patient's treatment at the VAPHS and the clinical rationale for that treatment met the community standard of care, but concluded that communication between the VAPHS and the Vet Center needed improvement. The review made recommendations to improve the continuity of care. (*Healthcare Inspection, Alleged Premature Discharge of a Veteran, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania*)



### **West Virginia VAMC Institutes Mold Remediation Plan**

OIG's review of several allegations of deficiencies in the environment of care (EOC), administrative mismanagement, and poor quality of care at the Martinsburg VAMC substantiated that mold had been identified in multiple areas by the VAMC, which had instituted mold remediation. OIG did not substantiate other EOC allegations, but found that the radiology department did not have a quality review program. OIG recommended that management continue to monitor and implement recommendations made in a network-level quality task force report. (*Healthcare Inspection, Alleged Mismanagement and Patient Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia*)

### **End of Life Care Policies Found Unclear in Palo Alto Health Care System**

Inspectors found no evidence to substantiate that any clinician provided incorrect or unethical care to patients in the intensive care unit (ICU) or that three patient deaths on the same day were intentionally hastened to make room for the following Monday's surgical patients. Following the review of several allegations about the deaths of four patients in the ICU at the VA Palo Alto Health Care System, OIG concluded that the policies that discuss end of life care issues were not clear and recommended changes be made. (*Healthcare Inspection, Alleged End of Life Care Issues, VA Palo Alto Health Care System, Palo Alto, California*)

## **OFFICE OF AUDIT**

OIG audits of VA programs focus on the effectiveness of health care delivery for veterans. These audits identify opportunities for enhancing management of program operations and provide VA with constructive recommendations to improve health care delivery.

### **Home Respiratory Care Must Ensure Quality Care, Proper Payments**

OIG's audit of VHA's Home Respiratory Care Program (HRCP) found that medical facilities needed to strengthen HRCP oversight and contract administration to ensure the delivery of quality care and services and to reduce unsupported and improper payments. Chiefs of staff had not established home respiratory care teams or completed quarterly program reviews as required by VHA policy. Moreover, medical facility staff did not ensure the timely and consistent completion of patient reevaluations, patient home visits, and vendor quality assurance visits. OIG's review of a statistical sample identified 77 transactions or \$6,152 (12 percent) in improper or unsupported payments, projecting that VHA had \$3.4 million in unsupported costs and improper payments annually and that this could grow to \$16.8 million over the next 5 years if HRCP program administration practices are not strengthened. (*Audit of the Veterans Health Administration's Home Respiratory Care Program*)

## **OFFICE OF INVESTIGATIONS**

The OIG Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, facility security, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 132 cases, made 83 arrests, and obtained \$2.4 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

### **Former Fayetteville, NC, VAMC Nurse Sentenced for Drug Diversion, Must Pay Restitution**

A nurse was sentenced to 60 months' supervised probation and 100 hours' community service, fined \$1,000, and ordered to pay restitution of \$1,042 after pleading guilty to theft of Government property and illegal possession of controlled substances. An OIG investigation determined that the nurse diverted approximately 1,500 doses of narcotics by giving patients only a partial amount of their prescribed medications or, in some cases, no medication at all.

**Defendant Sentenced for Theft of VA Medical Benefits through Fraud**

A former VAMC outpatient was sentenced to 24 months' probation and ordered to pay \$14,093 in restitution after having previously pled guilty to making false statements. A joint investigation by OIG and VA police determined that the subject, who is not a veteran, submitted several fraudulent applications and an altered military document in order to establish his veteran's status and receive VA medical benefits. The altered document claimed that the subject was awarded three Medals of Honor, six Purple Hearts, a Silver Star, a Bronze Star, and was a prisoner of war in Korea.

**Impersonator Arrested Applying for Position as Surgeon in Indiana**

A man applying for a surgical position at the Fort Wayne VAMC represented himself as a military surgeon with extensive educational and professional experience. Attempts by VA to verify his credentials revealed that he was not a physician and that multiple skills and training claimed in his resume and interview were false. The defendant admitted providing false statements and engaging in a scheme in which he stole money from two victims. He was arrested and indicted for false statements and wire fraud.

**Fraudulent Hero Arrested for Stealing Health and Disability Benefits**

After an OIG investigation revealed a veteran submitted a fraudulent discharge document claiming Korean War service and being the recipient of a Silver Star, Bronze Star, Purple Heart, and Korean Service Medal to the Portland VAMC to receive medical care and to the Seattle VA regional office (VARO) in support of a fraudulent claim for VA compensation benefits, he was charged with theft. He had also contacted a congressman, claiming he was a Korean War hero, in an attempt to pressure VA to award benefits. The loss to VA exceeds \$135,000.

**Altered Document Used To Obtain Medical Care and Pharmaceuticals**

A veteran was indicted for health care fraud and false statements after an OIG, the Federal Bureau of Investigation (FBI), and VA police investigation disclosed that he submitted an altered discharge document to the West Haven VAMC to obtain medical care and pharmaceuticals he was not entitled to receive because of his less-than-honorable discharge. The loss to VA is approximately \$100,000.

**OIG HOTLINE**

In the area of health care, the OIG Hotline receives allegations that include patient abuse, theft of VA pharmaceuticals or medical equipment, and false claims for health care benefits. The Hotline oversees the review and resolution of serious problems, and by doing so, contributes to raising the quality of care for the Nation's veterans.

**Sterilization Shortcomings at Dallas VAMC Lead to Surgical Delays, Remedial Actions**

VHA canceled all scheduled elective surgeries at a medical center to guarantee sterility of operative equipment. Engineering Service inspected the sterilization equipment, walked the steam lines, and found three valves that had been shut off and seven steam traps that were clogged. Any instrument sets sterilized before the system failure were reprocessed. Engineering Service will conduct monthly checks on the steam lines to ensure steam traps are clean and operating correctly.



## Benefits Processing

Many veterans, especially returning OIF/OEF veterans, need a variety of benefits and services in order to transition to civilian life. OIG works to improve the delivery of these benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing. In addition, OIG reduces criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.

### OFFICE OF AUDIT

OIG performs audits of veterans' benefits programs focusing on the effectiveness of benefits delivery to veterans, dependents, and survivors. These audits identify opportunities for enhancing the management of program operations and provide VA with constructive recommendations to improve the delivery of benefits.

#### Auditors Recommend Improvements in Vocational Rehabilitation

OIG audited program results and performance in VBA's Vocational Rehabilitation and Employment (VR&E) Program operations. The review assessed the accuracy of performance measurement and reporting, reasons veterans discontinue participation in the program and actions taken to reduce the probability of veterans dropping out of the program, and the effects of the statutory annual cap on veterans eligible for independent living benefits. To improve VR&E operations, auditors made four recommendations to the Under Secretary for Benefits. (*Audit of Vocational Rehabilitation and Employment Program Operations*)

#### Processing Delays Cost Beneficiaries \$15 Million in Underpayments, VBA \$17 Million in Overpayments

OIG audited VARO processing of compensation writeouts to determine if the process was effective for ensuring that veterans and their dependents receive entitled benefits. For the 6-month period reviewed, VARO delays in processing writeouts caused 16,158 beneficiaries to be underpaid a total of \$15 million and 9,503 to be overpaid a total of \$32 million, a net overpayment total of \$17 million. OIG recommended that VBA require VAROs to prioritize writeout actions that could prevent beneficiary underpayments and overpayments. (*Audit of the Effectiveness of Veterans Benefits Administration Compensation Writeouts*)

#### Eighty-Three Percent of Non-Rating Claims Have Avoidable Delays

OIG audited VBA's processing of non-rating claims—such as dependency status changes, claims for veteran burial benefits, and initial death pension claims for widows—which involve compensation and pension benefits, and can generally be processed without a rating decision at VAROs. Delayed processing can result in overdue retroactive benefit payments and overpayments, which can have a negative financial impact on veterans and their dependents. OIG found that 83 percent of claims selected in the sample had avoidable processing delays, which means about 21,400 beneficiaries nationwide would receive approximately \$45.4 million in delayed retroactive payments, and about 4,300 beneficiaries would be overpaid by approximately \$12 million because of claims processing delays. At the beginning of FY 2007, VA reported a 31 percent increase in pending claims over the previous FY. Without increased emphasis on improving the processing time of non-rating claims, beneficiaries will continue to experience avoidable delays in receiving entitled benefits, and VBA's backlog of pending non-rating claims will continue to grow. (*Audit of Veterans Benefits Administration Non-Rating Claims Processing*)

### OFFICE OF INVESTIGATIONS

VA administers a number of financial benefits programs for eligible veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the Compensation and Pension (C&P) Service. With respect to VA guaranteed loans, OI conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties.



C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program. OI also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. In this reporting period, the death match project recovered \$1 million, with another \$2 million in anticipated recoveries. Generally, family members of the deceased are responsible for this type of fraud. In the area of benefits processing, OIG opened 245 cases, made 107 arrests, and had \$16.4 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

#### **Suspect Arrested for Murder of Veteran after Foreclosure Investigation**

A suspect was arrested and subsequently indicted for the murder of a veteran as the result of an OIG, FBI, and local police investigation that began as an investigation into the foreclosure of the veteran's residence. VA Home Loan Guaranty Services notified OIG after the suspect contacted VA and stated that the veteran was in a psychiatric facility, had given her power of attorney, and wanted her to sell the veteran's residence. The suspect was unable to provide any documentation to VA to substantiate these claims. After further investigation, the body of the retired Air Force veteran was found buried in the backyard of his residence.

#### **Non-Veteran Arrested for Fraudulent Receipt of VA Pension Benefits**

An OIG investigation determined that VA granted approximately \$45,000 in VA pension benefits to a non-veteran after the subject claimed to have been a U.S. Marine who served in Vietnam. The investigation revealed the defendant—who was incarcerated during the time period he claimed to be in Vietnam—provided false information to VA that VA relied on in making the award.

#### **Fiduciary Charged for Misappropriating \$270,000 of Father's Benefits**

An OIG investigation determined that the son of an incompetent veteran, acting as his father's fiduciary, used his father's VA, Social Security, Government retirement, and private retirement benefits for his own personal use. The son also used the proceeds from the sale of his father's home for his own use, and is alleged to have misappropriated approximately \$270,000. He was charged with misappropriation by a fiduciary.

#### **Widow Who Failed To Report Remarriage Is Sentenced to Incarceration**

The widow of a deceased veteran was sentenced to 6 months' incarceration, 36 months' probation, and payment of \$269,916 in restitution as the result of a joint OIG, Railroad Retirement Board OIG, and Office of Personnel Management OIG investigation revealing that she failed to inform the various agencies paying her benefits that she had remarried. The loss to VA is \$235,398, with a total loss to the Government of \$430,331.

#### **Veteran Charged with Theft of Government Funds for Benefits Fraud**

A joint OIG and Social Security Administration OIG investigation determined that a veteran fraudulently received compensation benefits, including individual unemployability, primarily based on his claim that he could not walk. The investigation found that the veteran was employed as a truck driver during the time period he received VA and SSA benefits, passing U.S. Department of Transportation (DOT) physicals on five separate occasions from 1999 to 2006. The loss to VA is approximately \$200,000 and the loss to SSA is approximately \$100,000. The veteran was indicted for theft of Government funds.

#### **Son of Deceased Veteran Sentenced for Benefits Theft**

An OIG investigation revealed that the son of a VA beneficiary used VA benefits issued after his mother's death from 1996 through 2005. He was sentenced to 1 day's incarceration, 3 years' probation, and payment of \$115,487 in restitution after pleading guilty to the unlawful conversion of public funds.





## Financial Management

VA needs to provide all its components with accurate, reliable, and timely information for sound oversight and decision making. Since 1999, VA has achieved unqualified ("clean") audit opinions on its consolidated financial statements (CFS). OIG audits and reviews identify areas in which VA can improve financial management controls, data validity, and debt management.

### OFFICE OF AUDIT

OIG performs audits of financial management operations, focusing on adequacy of VA financial management systems in providing managers information needed to efficiently and effectively manage and safeguard VA assets and resources. OIG oversight work satisfies the *Chief Financial Officer Act of 1990*, P.L. 101-576, audit requirements for Federal financial statements and provides timely, independent, and constructive reviews of financial information, programs, and activities. OIG reports provide VA with constructive recommendations needed to improve financial management and reporting throughout the Department.

#### VA Receives Unqualified FY 2007 Audit Opinion with Material Weaknesses

OIG contracted with the independent public accounting firm, Deloitte & Touche LLP, to audit the VA FY 2007 CFS. The report provided an unqualified opinion on VA's FY 2007 CFS. However, the report on internal controls identified four material weaknesses, three of which (financial management system functionality, information technology (IT) security controls, and financial management oversight) were repeat conditions from the prior year audit. The fourth material weakness, retention of computer-generated detail records in Benefit Delivery Network system, was identified in FY 2007. The report continued to show that VA was not in substantial compliance with requirements of the *Federal Financial Management Improvement Act of 1996* (FFMIA), P.L. 104-208, because of the material weaknesses in internal control over financial reporting. OIG will follow up and evaluate the implementation of corrective actions during the audit of the VA FY 2008 CFS. ([Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2007 and 2006](#))

### OFFICE OF INVESTIGATIONS

OIG conducts criminal and administrative investigations related to allegations of serious misconduct with regard to VA financial management. These investigations often indicate weaknesses and flaws in VA financial management.

#### Houston VAMC Manager Arrested for \$200,000 Embezzlement

A former Houston VAMC manager was arrested for allegedly misappropriating over \$200,000 in funds belonging to the Houston VAMC Employees' Association, DOT, and other agencies. The investigation was conducted by a joint OIG and District Attorney Public Integrity Section investigation.



## Procurement Practices

VA spends over \$15 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, IT, construction, and services. OIG contract audits focus on compliance with Federal and VA acquisition regulations and cost efficiencies, which result in recommendations for improvement. Preaward and postaward contract reviews have resulted in \$46.1 million in monetary benefits during this reporting period.

### OFFICE OF AUDIT

To improve VA acquisition programs and activities, OIG identifies opportunities to achieve economy, efficiency, and effectiveness for VA national and local acquisitions and supply chain management. In addition, OIG examines how well major acquisitions are achieving objectives and desired outcomes. The OIG efforts focus on determining whether the Department is taking advantage of its full purchasing power when it acquires goods and services. Auditors examine how well VA is managing and safeguarding resources and inventories, obtaining economies of scale, and identifying opportunities to employ best practices.

#### Controls Generally Effective for VA Purchases Made for DoD

OIG audited VA purchases made on behalf of the Department of Defense (DoD) to evaluate the effectiveness of internal controls over such purchases. In general, VA contracting activities had effective policies, procedures, and management controls in place to ensure that contracting officers complied with defense procurement requirements when making purchases on behalf of DoD. However, OIG found instances of noncompliance with procedural and documentation requirements, which increased the risk that DoD did not receive contracted goods and services on terms that were advantageous to the Government. (*Audit of VA Purchases Made on Behalf of the Department of Defense*)

### OFFICE OF INVESTIGATIONS

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened 3 cases, made 3 arrests, and had \$5.1 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

#### VA Contractor Pleads Guilty to FDA Violation and Obstruction

A VA contractor agreed to plead guilty to a Food and Drug Administration (FDA) violation and obstruction of an administrative proceeding and also to pay a criminal fine of \$4.5 million. A joint OIG, FDA, Internal Revenue Service, and U.S. Postal Inspection Service investigation determined that the corporation and its employees concealed from FDA that the company shipped a drug to hospitals, including many VA hospitals, called "sterile talc powder" and a medical device called "barium sulfate" without first having obtained FDA approval. The corporation also agreed to pay the Government \$485,300, plus interest, to resolve potential civil claims arising from this and other misconduct. The corporation's owner and former president was also indicted on related charges.

#### Pharmaceutical CEO Indicted under *Food, Drug, and Cosmetics Act*

The former CEO of a pharmaceutical company was indicted for wire fraud and felony violations of the *Food, Drug, and Cosmetics Act*. A 4-year joint investigation conducted with the FBI, FDA Office of Criminal Investigations, and OPM OIG revealed that under the direction of the CEO—a medical doctor—the company marketed and sold a drug for off-label use that was not approved by FDA as safe. The investigation revealed that the CEO and other senior officials were aware that a clinical trial involving this use of this drug failed, but when the trial results were publicized, the company issued a misleading press release indicating that patients lived longer using the drug. The company agreed to pay the Government nearly \$37 million to resolve criminal charges and civil liability in connection with its illegal marketing and sales; VA's portion of this civil settlement was approximately \$3.2 million.



### Pharmaceutical Company Manager Indicted for Obstruction of Justice

A former district manager for a major pharmaceutical company was indicted for obstruction of justice based on a joint investigation with the FBI, HHS OIG, and Postal Inspection Service. The investigation revealed that the manager altered and deleted documents from his own computer and directed sales representatives to alter or delete documents from their computers which reflected the off-label promotion of a drug, at a time when their employer was under investigation for promoting the drug for unapproved uses and they had been specifically instructed to preserve all such documents relating to the promotion of that drug.

### Owner of Company Pleads Guilty to Submitting False Cable Claims

An OIG investigation revealed that an optical cable installation and maintenance company billed VA facilities in California thousands of dollars for work that was never performed, was incomplete, or was subcontracted for a lesser amount while the company received payment in full. The estimated loss to VA is \$425,000. The owner was sentenced to 3 years' probation and ordered to pay VA restitution of \$281,696 after pleading guilty to making a material false representation.

## OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) operates under a reimbursable agreement with VA's Office of Acquisition and Logistics (OA&L) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OCR provides advisory services to OA&L contracting activities. OCR completed 36 reviews in this reporting period. The tables that follow provide an overview of OCR performance during this reporting period.

### PREAWARD REVIEWS

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Preaward reviews identified \$23.4 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included eight health care provider proposals—accounting for \$15.2 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For five reports, the sustained savings rate was 54 percent.

October 1, 2007– March 31, 2008	
<b>Preaward Reports Issued</b>	<b>14</b>
<b>Potential Cost Savings</b>	<b>\$23,431,497</b>

### POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the *Veterans Health Care Act of 1992*, P.L. 102-585, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling \$16.6 million, including nearly \$13 million related to Veterans Health Care Act compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 20 postaward reviews performed, 14 involved voluntary disclosures. In 5 of the 14 reviews, OCR identified additional funds due.





October 1, 2007– March 31, 2008	
Postaward Reports Issued	20
Dollar Recoveries	\$16,636,633

### Pharmaceutical Company's Policies Not Compliant with Law

OIG initiated a review of a major pharmaceutical manufacturer's policies and procedures used to calculate statutory Federal ceiling prices (FCPs) under the *Veterans Health Care Act of 1992*, P.L. 102-585. OCR determined that the manufacturer's procedures and methodologies used to calculate accurate non-Federal average manufacturing prices from which the FCPs were derived were not sufficient, causing incorrect FCPs. This resulted in \$10.8 million in overcharges to the Government during the period of January 1, 1998 through December 31, 2007. VA is taking action to recover the overcharges.

### SPECIAL REPORTS

October 1, 2007– March 31, 2008	
Special Reports	2
Dollar Recoveries	\$6,011,749

### Contracts with Resellers Found Duplicative, Inefficient, and Expensive

When major manufacturers use resellers to shield themselves from FSS pricing provisions designed to ensure fair and reasonable prices for Government customers, the result is inflated prices and lost pricing protections. An OCR report found FSS contract awards to resellers that were duplicative, inefficient, and expensive. OCR made recommendations to the Executive Director of the National Acquisition Center to define and clarify FSS policies as related to contracts with resellers, and to establish policies requiring contracting officers to adhere to existing General Services Administration policies regarding the negotiation, award, and administration of FSS contracts.

### Contract Review Finds Overcharges for Disability Examinations

OIG conducted an audit of a settlement offer by QTC Medical Systems, Inc. (QTC) to repay VA about \$3.2 million following an audit by a commercial Certified Public Accounting firm of a limited period of a contract in which QTC provided medical disability examinations for veterans with claims being evaluated by VBA. OIG determined that, over the entire contract period, QTC had overcharged VA \$6 million including \$2.6 million because QTC inappropriately increased the Medicare-based Contract Line Item Numbers each year even though the contract stipulated pricing was to be based and frozen at the 1998 Medicare rates. OIG made numerous recommendations to strengthen administration and oversight of the contract and to collect the \$6 million. VA officials concurred on all recommendations with the exception of collecting \$2.6 million citing a VA Office of General Counsel opinion.



## Information Management

OIG oversight work in the IT area reflects the critical role IT plays in all VA operations, and includes audits, criminal investigations, and reviews of IT security policies and procedures. The loss of significant amounts of VA data in May 2006 and January 2007 have highlighted challenges facing VA information security. VA continues to show increased awareness of IT security concerns and has completed some efforts aimed at improvement. OIG has particularly noted VA's commitment to centralizing IT functions, funding, and staff under the direction of the Department's Chief Information Officer. Serious problems remain, however, and OIG will continue close oversight of extensive VA IT activity.

### OFFICE OF AUDIT

OIG performs audits of information management operations and policies, focusing on adequacy of VA IT security policies and procedures for managing and safeguarding VA program integrity and patient information security. OIG oversight in IT includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Management Act of 2002*, as well as IT security reviews conducted as part of the CFS audit. These reviews have led OIG to report information security and security of data and data systems as a major management challenge for VA. OIG's audit reports present constructive recommendations needed for VA to improve its IT management and security.

#### **Audit Finds Delayed Blood Bank Modernization Project Mismanaged**

OIG audited the VHA's Blood Bank Modernization Project (BBMP) to determine whether a system development life cycle (SDLC) methodology was effectively employed and whether the project complied with capital investment requirements. VA initiated the BBMP in October 1999 to decrease the risk of errors and to improve the safety of blood component transfusions. VA officials initially planned to complete the BBMP by October 2004, but it is now scheduled for completion in September 2008. Initially, the cost estimate was \$12.8 million, but OIG estimates VA has spent approximately \$32.9 million on the project from FY 2000 through FY 2007. OIG found VA did not properly plan and manage the BBMP. Officials did not complete seven critical planning and management tasks required by the BBMP SDLC methodology, VA capital investment policies, and other project guidance. As a result, VA lacked reasonable assurance that it selected the best project alternative, used VA resources efficiently, and implemented effective controls to safeguard sensitive project information. ([Audit of Veterans Health Administration Blood Bank Modernization Project](#))

### OFFICE OF INVESTIGATIONS

OI investigates theft of IT equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened three cases, made one arrest, and had \$46,919 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

#### **Suspect Arrested For Theft of Computers and Other Equipment at Indianapolis VAMC**

A man was arrested for the theft of two desktop computers, a laptop computer, and other equipment from the Indianapolis VAMC. An OIG, VA police, FBI, and local police investigation identified the suspect through the VAMC's surveillance video and the suspect's subsequent attempt to sell items matching the description of the stolen equipment. To date none of the stolen equipment or data has been recovered. VA sent letters and offered credit monitoring to over 12,000 veterans who were affected by the data loss.



## Other Significant OIG Activities

### CONGRESSIONAL TESTIMONY

#### **Deputy Inspector General Testifies on Disparity in Disability Ratings**

Deputy Inspector General Jon A. Wooditch, accompanied by Deputy Assistant Inspector General for Management and Administration Joseph Vallowe, testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on October 16, 2007. He discussed OIG's May 19, 2005, report, *Review of State Variances in VA Disability Compensation Payments* and subsequent OIG activity relating to the report. "While VBA has made some progress," Mr. Wooditch summarized, "further efforts are needed to monitor and measure variations in award decisions by state. Unacceptable variations should be thoroughly evaluated to include in-depth reviews of individual claims that deviate from expected norms. Information obtained from these reviews should be used to improve consistency in rating decisions nationwide."

#### **Outpatient Waiting Times Subject of Two Hearings**

Kansas City Audit Operations Division Director Larry Reinkemeyer testified on VHA outpatient waiting times before the October 3, 2007, hearing of the Senate Special Committee on Aging and appeared with Assistant Inspector General (AIG) for Auditing Belinda J. Finn at a joint hearing of the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations and Subcommittee on Health regarding VHA outpatient waiting times, on December 12, 2007. They reported that OIG's July 2005 and September 2007 reports found that schedulers were not following established procedures for making outpatient appointments, causing VHA's reported performance on waiting times and waiting lists to be unreliable. The 2007 follow-up review showed that many data integrity weaknesses reported in 2005 were still impacting the reliability of patient waiting times.

#### **OIG Testifies on Implementation of Suicide Prevention Initiatives**

OIG Senior Physician Michael Shepherd, M.D., testified before an October 3, 2007, hearing of the Senate Special Committee on Aging regarding VA's implementation of suicide prevention initiatives from its Mental Health Strategic Plan (MHSP) and submitted a written statement in connection with a House Committee on Veterans' Affairs December 12, 2007, hearing. Dr. Shepherd noted that OIG's May 10, 2007, report, *Healthcare Inspection, Implementing VHA's MHSP Initiatives for Suicide Prevention*, surveyed all VAMCs between December 2006 and February 2007 to assess implementation of MHSP action items pertaining to suicide prevention. He discussed OIG recommendations that included arranging for 24-hour crisis and mental health care availability, that all non-clinical staff who interact with veterans should receive mandatory training, and that VHA should establish a centralized mechanism to select emerging best practices for screening, assessment, referral, and treatment.

#### **Healthcare AIG Reports to Congress on Disarray at Marion VAMC**

Assistant Inspector General for Healthcare Inspections John D. Daigh, Jr., M.D., testified at a January 29, 2008, hearing of the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on OIG's review of the Marion VAMC's surgical services and high mortality rate. Dr. Daigh's written statement noted "overall, we concluded that the Surgical Specialty Care Line at Marion VAMC was in disarray," as described in the report, *Healthcare Inspection, Quality of Care Issues, VA Medical Center, Marion, Illinois*. OIG's comprehensive review cited three mortality cases which did not meet the standard of care. He also outlined OIG's 17 recommendations for health care improvement at both the affected facility and nationwide. Dr. Daigh was accompanied by George Wesley, M.D., and Jerome Herbers, M.D. (OIG's Director and Associate Director of Medical Assessment), Senior Physician Andrea Buck, M.D., and Statistician Limin Clegg, Ph.D.



### **Deputy Inspector General Testifies on OIG FY 2009 Budget**

Deputy Inspector General Jon A. Wooditch testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, on February 13, 2008, concerning the OIG FY 2009 budget. He highlighted OIG accomplishments over the past year, presented key issues facing VA, and discussed how OIG would invest budget resources made available to the OIG in addressing these issues in FY 2009.

### **OIG Officials Appear before House Appropriations Subcommittee**

Counselor to the IG Maureen Regan and Assistant Inspectors General John Daigh, James O'Neill, and Belinda Finn testified on the OIG FY 2009 budget before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, House Committee on Appropriations, on February 27, 2008. They outlined recent accomplishments in their respective areas, and discussed how OIG would invest budget resources in FY 2009 to provide independent and objective oversight of VA mission-critical activities and programs in health care delivery, benefits processing, financial management, procurement practices, and information management.

## **OTHER VA EMPLOYEE-RELATED INVESTIGATIONS**

### **Former Fayetteville, NC, VAMC Pharmacy Technician Sentenced for Murder**

A former VA pharmacy technician was sentenced to life in prison and ordered to pay a \$34,000 fine after pleading guilty to the murder of a VA pharmacist. A joint OIG, FBI, VA police, and local police investigation revealed that the VA pharmacy technician shot and killed the pharmacist in the facility pharmacy. The victim had been attempting to end a long-term romantic relationship with the technician.

### **Veteran Is Charged with Assault Against Phoenix VAMC Nurse**

A veteran was indicted for assaulting a VAMC nurse, who sustained a fractured jaw. The veteran said he assaulted the nurse because he did not receive his pain medications in what he perceived to be a timely manner.

### **VA Employee Sentenced for Distributing Drugs at Boston VARO**

A VA employee was sentenced to 6 months' home confinement with a monitoring device and 3 years' supervised probation after pleading guilty to the distribution of a controlled substance. The sentencing was the result of a joint investigation by OIG, VA police, the Drug Enforcement Administration, the Federal Protective Service, and local police involving the distribution and use of morphine and oxycodone by employees of the Boston VARO.

### **Former VA Pharmacist at Dallas VAMC Sentenced for Drug Diversion Fraud**

A Dallas VA pharmacist and 10 co-defendants were convicted of health care fraud and conspiracy to distribute controlled substances. A multi-agency investigation disclosed that the defendants fraudulently obtained controlled substances from pharmaceutical wholesalers and sold them over the Internet, without prescriptions, through 23 rogue Internet pharmacies. The former pharmacist was sentenced to 8 years' incarceration and 3 years' probation for his involvement.

### **Former Wichita VAMC Employee Indicted for "Stolen Valor" Fraud**

An OIG investigation determined that a Wichita VAMC employee, who was also a veteran, submitted a fraudulent discharge document to reflect that he was awarded a Combat Infantry Badge and used it to support his claim for benefits based on post-traumatic stress disorder. He also fraudulently augmented his original document to indicate that he had received additional awards, submitting false general orders to show receipt of these medals. The employee resigned from his position during the investigation and was indicted for making false statements and a false claim about receipt of military medals.



### Threats Made Against VA Employees

During this reporting period the OIG opened nine criminal investigations resulting from threats made against VA facilities and employees. Among them were the following:

- An OIG, VA police, and FBI investigation determined that a veteran telephoned the VA clinic in Oxford, Alabama, and told the staff that after he buried his mother, he was coming to the VA clinic with his carbine to kill his doctor and anyone who tried to stop him. Later, when contacted by VA police, the veteran threatened to kill VA police officers and FBI agents. During a search incident to the arrest, a fully loaded carbine and an additional fully loaded magazine were discovered in the veteran's vehicle.
- An OIG investigation revealed that a veteran left a voicemail message at the office of a U.S. senator threatening to blow up the Houston VARO with C-4 explosive. In a second message, the subject made a threat against the director of the VARO. Both threats followed a letter sent from the VARO advising that the veteran's claim for VA benefits had been denied.
- A veteran in Florida was arrested by OIG and FBI agents for making threats against VA officials. An OIG, VA police, and FBI investigation determined that the veteran sent an e-mail to a congressman's office "declaring war against VA," and declaring VA to be a "domestic terrorist organization." The veteran further threatened to go to Washington and "capture VA officials, place them on trial, and then execute them." The subject was ordered held pending further judicial action.
- An OIG investigation determined that a veteran left over 20 voicemails threatening sexual violence against a San Francisco VAMC social worker. The veteran was arrested, pled guilty, and is awaiting sentencing.
- A veteran was arrested for making harassing phone calls and communicating threats after an OIG, VA police, and local law enforcement investigation determined the veteran telephoned the Durham, North Carolina, VAMC and threatened to kill the VAMC Director. After his arrest, the veteran consented to a search of his residence, and several rifles, pistols, shotguns, thousands of rounds of ammunition, and incendiary explosive components were seized.

### Fugitive Felons Arrested with Assistance of OIG

Veterans and VA employees continue to be identified and apprehended as a direct result of the OIG Fugitive Felon Program. To date 24.9 million felon warrants have been received from the National Crime Information Center and participating states resulting in 39,933 investigative leads being referred to law enforcement agencies. Over 1,800 fugitives have been apprehended as a direct result of these leads. Among the arrests made by OIG, VA police, U.S. Marshals, and local police during this reporting period were the following:

- OIG and local police arrested a fugitive felon at the Houston VAMC on an outstanding felony drug possession warrant. The fugitive's criminal history includes previous arrests for aggravated assault, sexual assault, kidnapping, and possession of controlled substances.
- A veteran identified as a result of the OIG Fugitive Felon Program was arrested for aggravated rape after eluding apprehension for over 6 months. The veteran is being held pending extradition to Texas.
- OIG and members of the U.S. Marshals Service Gulf Coast Regional Fugitive Task Force arrested a Jackson VAMC contract employee wanted for a probation violation stemming from his prior felony conviction for possession of cocaine. He had used several names, dates of birth, and social security numbers with various employers to avoid apprehension for over 3 years.
- A VA employee was arrested at the Leavenworth VAMC by VA police and local police with OIG assistance. The employee was wanted for making criminal threats.
- A veteran and prospective employee arrested during employee orientation at the Dallas VAMC was wanted on a probation violation stemming from a previous conviction of assaulting a police officer.

Since the inception of the program in 2002, OIG has identified \$522.6 million in estimated overpayments, with an estimated cost avoidance of \$600.4 million.



## APPENDIX A

### DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL REPORTS

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
<b>COMBINED ASSESSMENT PROGRAM REVIEWS</b>				
07-01753-07 10/16/2007	Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia			
07-00543-08 10/18/2007	Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois			
07-00766-11 10/23/2007	Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York			
07-01248-13 10/24/2007	Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida			
07-00171-15 10/29/2007	Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, Montana			
07-02081-17 10/30/2007	Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon			
07-02271-20 11/6/2007	Combined Assessment Program Review of the VA Medical Center, Louisville, Kentucky			
07-00167-22 11/13/2007	Combined Assessment Program Review of the VA Nebraska Western Iowa Health Care System, Omaha, Nebraska			
07-01731-28 11/27/2007	Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas			
07-02349-29 11/27/2007	Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico			
07-00767-34 12/7/2007	Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois			
07-03443-46 12/19/2007	Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina			
07-02705-49 1/2/2008	Combined Assessment Program Review of the Sioux Falls VA Medical Center, Sioux Falls, South Dakota			





Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
07-02557-50 1/3/2008	Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona			
07-02498-52 1/4/2008	Combined Assessment Program Review of the Philadelphia VA Medical Center, Philadelphia, Pennsylvania			
07-03081-54 1/8/2008	Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania			
07-02946-55 1/9/2008	Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California			
07-02836-66 2/4/2008	Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri			
07-03341-73 2/11/2008	Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington			
08-00137-74 2/12/2008	Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas			
07-03184-77 2/19/2008	Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan			
07-02948-81 2/21/2008	Combined Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico			
07-03185-82 2/25/2008	Combined Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne and Marion, Indiana			
07-02837-83 2/26/2008	Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri			
08-00054-84 2/27/2008	Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana			
07-03445-97 3/17/2008	Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania			
08-00373-99 3/20/2008	Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California			



Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
<b>HEALTHCARE INSPECTIONS</b>				
06-02868-14 10/25/2007	Healthcare Inspection, Alleged Mismanagement and Safety Issues, Battle Creek VA Medical Center, Battle Creek, Michigan			
07-01400-16 10/29/2007	Healthcare Inspection, Quality of Care and Management Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan			
06-03145-23 11/7/2007	Healthcare Inspection, Quality of Care Issues, VA Ann Arbor Healthcare System, Ann Arbor, Michigan			
07-03023-32 11/30/2007	Healthcare Inspection, Importation of Blood Products for Research Purposes, New Mexico VA Health Care System, Albuquerque, New Mexico			
07-01181-36 12/11/2007	Healthcare Inspection, Quality of Care Issues, Tennessee Valley Healthcare System, Nashville and Murfreesboro, Tennessee			
05-00680-37 12/12/2007	Healthcare Inspection, Atypical Antipsychotic Medications and Diabetes Screening and Management			
07-02106-38 12/13/2007	Healthcare Inspection, Alleged Quality of Care Issues, VA Medical Center, Birmingham, Alabama			
05-00266-39 12/13/2007	Healthcare Inspection, Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program			
06-02509-40 12/17/2007	Healthcare Inspection, Quality of Care in the Surgical Intensive Care Unit, South Texas Veterans Health Care System, San Antonio, Texas			
07-03037-43 12/18/2007	Healthcare Inspection, Alleged Quality of Care Issues, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska			
07-02296-44 12/19/2007	Healthcare Inspection, Pain Management Concerns, Primary Care Clinic, Richard L. Roudebush VA Medical Center, Indianapolis, Indiana			
07-03298-48 12/20/2007	Healthcare Inspection, Infusion Clinic Closure and Patient Notification, VA Southern Nevada Healthcare System, Las Vegas, Nevada			
07-02405-51 1/4/2008	Healthcare Inspection, Vascular Laboratory Quality of Care Issues at the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia			
07-03010-53 1/7/2008	Healthcare Inspection, Alleged Administrative Review Issues, VA Nebraska Western Iowa Health Care System, Omaha, Nebraska			





Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
07-02655-56 1/10/2008	Healthcare Inspection, Surgery Quality of Care Issues, VA Eastern Kansas Health Care System, Leavenworth, Kansas			
07-03292-60 1/16/2008	Healthcare Inspection, Alleged Quality of Care Issues, VA Loma Linda Healthcare System, Loma Linda, California			
07-01622-62 1/24/2008	Healthcare Inspection, Alleged Premature Discharge of a Veteran VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania			
07-03386-65 1/28/2008	Healthcare Inspection, Quality of Care Issues, VA Medical Center, Marion, Illinois			
07-02335-67 1/31/2008	Healthcare Inspection, Alleged Certification Irregularities of Licensed Clinical Social Workers, VA Western New York Healthcare System, Buffalo, New York			
07-02388-68 1/31/2008	Healthcare Inspection, Alleged Mismanagement and Patient Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia			
07-01912-72 2/8/2008	Healthcare Inspection, Quality of Care Issues, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina			
07-03087-75 2/14/2008	Healthcare Inspection, Alleged Quality of Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia			
07-03382-76 2/14/2008	Healthcare Inspection, Questionable Medical Treatment and Suspicious Deaths, VA Medical Center, Alexandria, Louisiana			
07-02902-78 2/20/2008	Healthcare Inspection, Supply, Processing, and Distribution Issues and Quality of Care Concerns, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina			
07-01876-80 2/20/2008	Healthcare Inspection, Diagnostic Radiopharmaceutical Management, VA North Texas Health Care System, Dallas, Texas			
08-00183-94 3/20/2008	Healthcare Inspection, Alleged Quality of Care Issues James A. Haley Veterans Hospital Tampa, Florida and Bay Pines VA Health Care System, Bay Pines, Florida			
08-00509-103 3/25/2008	Healthcare Inspection, Alleged End of Life Care Issues, VA Palo Alto Health Care System, Palo Alto, California			
08-00869-102 3/26/2008	Healthcare Inspection, Additional Quality of Care Issues' Marion VA Medical Center, Marion, Illinois			



Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
07-00773-106 3/31/2008	Healthcare Inspection, Surgical Care Improvement Project			
<b>INTERNAL AUDITS</b>				
05-01670-04 10/15/2007	Final Report, Special Review of Federal Supply Schedule Medical Equipment and Supply Contracts Awarded to Resellers			
07-01016-21 11/15/2007	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2007 and 2006			
06-03540-24 11/19/2007	Audit of VA Purchases Made on Behalf of the Department of Defense			
06-00801-30 11/28/2007	Audit of the Veterans Health Administration's Home Respiratory Care Program			\$1,676,777
06-00493-42 12/17/2007	Audit of Vocational Rehabilitation and Employment Program Operations			
06-01791-45 12/19/2007	Audit of the Effectiveness of Veterans Benefits Administration Compensation Writeouts	\$17,000,000	\$17,000,000	
06-03537-69 2/7/2008	Audit of Veterans Benefits Administration Non-Rating Claims Processing	\$12,000,000	\$12,000,000	
06-03424-70 2/8/2008	Audit of Veterans Health Administration Blood Bank Modernization Project			
<b>OTHER OFFICE OF AUDIT REVIEWS</b>				
08-00782-93 3/17/2008	Independent Review of VA's Fiscal Year 2007 Detailed Accounting Submission To the Office of National Drug Control Policy			
08-00782-100 3/26/2008	Independent Review of VA's Fiscal Year 2007 Performance Summary Report To the Office of National Drug Control Policy			
07-00972-105 3/31/2008	Independent Review of Department of Veterans Affairs Fiscal Year 2007 Special Disabilities Capacity Report			
<b>ADMINISTRATIVE INVESTIGATIONS</b>				
06-02434-03 10/9/2007	Administrative Investigation, Misuse of Government Travel Card, VA Central Office			
07-02423-10 10/18/2007	Administrative Investigation, Misuse of Time, Resources, & Title, and Improper Remote Access, VA Central Office			
<b>TOTAL:</b>	<b>69 Reports</b>	<b>\$29,000,000</b>	<b>\$29,000,000</b>	<b>\$1,676,777</b>



## APPENDIX B

### STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994*, P.L. 103-355, requires Federal agencies to complete final action on each OIG report recommendation within 12 months after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2007, and earlier). Four reports open less than 1 year on the following chart have actions at two offices.

Unimplemented OIG Reports and Recommendations				
VA Office	Total		Issued 3/31/07 and Earlier	
	Reports	Recommendations	Reports	Recommendations
VHA	66	268	9	23
VBA	4	8	0	0
OI&T <sup>1</sup>	6	87	2	30
OM <sup>2</sup>	1	1	0	0
OSP <sup>3</sup>	1	2	0	0



Reports Unimplemented for Over 1 Year					
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
03-00391-138	5/3/2004	Healthcare Inspection, VHA's Community Residential Care (CRC) Program	VHA	1 of 11	
04-02887-169	7/8/2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	VHA	5 of 8	
04-02330-212	9/30/2005	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	VHA	1 of 3	
05-03028-145	5/17/2006	Review of Access to Care in the Veterans Health Administration	VHA	2 of 9	
04-00018-155	6/14/2006	Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services	VHA	2 of 4	\$6,000,000
06-02238-163	7/11/2006	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OI&T	2 of 6	
05-03281-168	7/17/2006	Combined Assessment Program Review of the VA Medical Center Huntington, WV	VHA	1 of 12	\$48,294
04-00888-215	9/20/2006	Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program	VHA	5 of 24	
05-01234-25	11/15/2006	Audit of VA Disbursement Agreements for Senior Residents	VHA	4 of 4	\$591,016
05-00081-36	12/8/2006	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Years 2004 and 2005	VHA	2 of 3	
06-00035-222	9/28/2007	FY 2006 Audit of VA Information Security Program*	OI&T	28 of 30	
<b>TOTALS</b>				<b>53</b>	<b>\$6,639,310</b>

\*Although this FY 2006 audit, conducted in compliance with the *Federal Information Security Management Act of 2002 (FISMA)*, is not yet over 1 year old, it contains 15 unimplemented OIG recommendations from earlier FISMA audits, which is the basis for including it in this presentation.



## APPENDIX C

### INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

The table below cross-references the specific pages in this Semiannual Report to the reporting requirements where they are prescribed by the *Inspector General Act*, as amended by the *Inspector General Act Amendments of 1988* (P.L. 100-504), and the *Omnibus Consolidated Appropriations Act of 1997* (P.L. 104-208).

FFMIA requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. FFMIA requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. The FY 2007 audit of VA's consolidated financial statements reported that three of four identified material weaknesses indicated VA's financial management systems did not substantially comply with Federal financial management systems requirements. Two of the material weaknesses were repeated from the prior year and one is new. VA has not fully developed all parts of its remediation plan in response to the FY 2007 audit, but remedial actions are underway.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	Commented on 285 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 7-20
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 7-20
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 26-27
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 7-20
Section 5 (a) (5)	Summary of instances where information was refused	None
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 21-25
Section 5 (a) (7)	Summary of each particularly significant report	See pages 7-20
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 29
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	See page 29
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See page 29
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 5(b) of FFMIA	See top of this page

**Table 1: Resolution Status of Reports with Questioned Costs**

<b>RESOLUTION STATUS</b>	<b>Number</b>	<b>Dollar Value (In Millions)</b>
No management decision by 9/30/07	0	\$0
Issued during reporting period	1	\$1.7
<b>Total inventory this period</b>	<b>1</b>	<b>\$1.7</b>
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	1	\$1.7
Allowed costs (not agreed to by management)	0	\$0
<b>Total management decisions this reporting period</b>	<b>1</b>	<b>\$1.7</b>
<b>Total carried over to next period</b>	<b>0</b>	<b>\$0</b>

**Table 2: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management**

<b>RESOLUTION STATUS</b>	<b>Number</b>	<b>Dollar Value (In Millions)</b>
No management decision by 9/30/07	0	\$0
Issued during reporting period	2	\$29.0
<b>Total inventory this period</b>	<b>2</b>	<b>\$29.0</b>
Management decisions during the reporting period		
Agreed to by management	2	\$29.0
Not agreed to by management	0	\$0
<b>Total management decisions this reporting period</b>	<b>2</b>	<b>\$29.0</b>
<b>Total carried over to next period</b>	<b>0</b>	<b>\$0</b>



## **APPENDIX D**

### **GOVERNMENT CONTRACTOR AUDIT FINDINGS**

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each Inspector General appointed under the *Inspector General Act of 1978* to submit an annex on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of \$10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued no contract review reports under this requirement.





Copies of this report are available to the public. Written requests should be sent to:

**Office of the Inspector General (53A)**  
**Department of Veterans Affairs**  
**810 Vermont Avenue, NW**  
**Washington, DC 20420**

The report is also available on our website:

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Department of Veterans Affairs  
Office of Inspector General  
Semiannual Report to Congress

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