Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
April 1, 2008 - September 30, 2008

Message from the Inspector General

This Semiannual Report to Congress focuses on the accomplishments of the VA Office of Inspector General (OIG) for the reporting period from April 1, 2008, through September 30, 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 58 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 $215 million in monetary benefits, for a return of $5 for every dollar expended on OIG oversight. Our criminal investigators have closed 547 investigations and made 233 arrests. OIG investigative work also resulted in 368 administrative sanctions.

Reviews by the Office of Healthcare Inspections (OHI) of research studies at Veterans Health Administration (VHA) medical facilities showed persistent deficiencies in oversight provided by Institutional Review Boards, including documentation irregularities and violations of human subjects protections in the areas of informed consent and adverse event reporting. One review was the subject of a congressional hearing where OHI staff testified on the lack of adequate and timely notification of potentially harmful psychiatric effects of a smoking cessation drug in a study involving patients with Post Traumatic Stress Disorder. Another review conducted by the Office of Audit of VHA's surgical and anesthesiology clinical sharing agreements identified $59 million in funds that could be put to better use.

On the benefits side, an audit on the impact of additional resources at the Veterans Benefits Administration (VBA) showed that a large influx of new employees resulted in a short-term decrease in VBA's overall productivity in claims processing; as job proficiency increases, a substantial decrease in the claims backlog by 2011 is expected. Another audit found that a high percentage of benefits claims from seriously disabled veterans of Operations Enduring Freedom and Iraqi Freedom were not processed within VBA's 30-day goal and that outreach efforts to service members and veterans needed improvement.

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 48 reports that resulted in savings and dollar recoveries of $62 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.

George J. Opfer

GEORGE J. OPFER
Inspector General

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Statistical Highlights

	Reporting Period	FY 2008
DOLLAR IMPACT ($$$ in Millions)		
Better Use of Funds	$60.6	$89.6
Fines, Penalties, Restitutions, and Civil Judgments	$5.3	$13.2
Fugitive Felon Program	$111.7	$232.4
Savings and Cost Avoidance	$17.1	$30.5
Questioned Costs	$16.6	$18.3
OIG Dollar Recoveries	$4.5	$7.8
Contract Review Savings and Dollar Recoveries	$62.0	$108.1
RETURN ON INVESTMENT		
Dollar Impact ($215.8)/Cost of OIG Operations ($40.2)	5:1	
Dollar Impact ($391.8)/Cost of OIG Operations ($80.5)		5:1
Dollar Impact ($62.0)/Cost of Contract Review Operations ($1.7)	36:1	
Dollar Impact ($108.1)/Cost of Contract Review Operations ($3.5)		31:1
OTHER IMPACT		
Arrests*	233	510
Indictments	120	249
Criminal Complaints	70	138
Convictions	156	291
Pretrial Diversions	25	44
Fugitive Felon Apprehensions by Other Agencies Using VA OIG Data	25	48
Administrative Sanctions	368	652
ACTIVITIES		
Reports Issued		
CAP Reviews	18	46 **
Healthcare Inspections	27	56
Joint Reviews	1	1
Audits	9	19 **
Administrative Investigations	3	5
Contract Reviews	48	85 **
Investigative Cases		
Opened	528	1008
Closed	547	1048
Healthcare Inspections Activities		
Clinical Consultations	1	2
Administrative Case Closures	12	15
Hotline Activities		
Cases Opened	513	909
Cases Closed	438	874

* Includes the apprehension of 45 and 128 fugitive felons by OIG for this period and FY 2008, respectively.

** Corrected figures

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 had a $90.3 billion budget and almost 230,000 employees served 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.

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 three 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.

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 Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) or are veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional 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 18 cyclical Combined Assessment Program reviews, and 27 hotline reports and national reviews to evaluate quality of care issues in several VHA medical facilities.

Adverse Psychiatric Effects of Chantix® Inadequately Explained to PTSD Patients

Ranking Member Steve Buyer of the House Veterans' Affairs Committee requested an investigation into the circumstances surrounding the use of the smoking cessation medication varenicline (Chantix®) in a research study sponsored by VHA. A major issue was the facility's response to notices sent out by the Food and Drug Administration (FDA) related to a possible association between the medication and changes in mood, behavior, or suicidal thoughts. The investigation found that although the VA Medical Center (VAMC) in Washington, DC, responded appropriately to FDA communications concerning Chantix® in notifying providers of these newly defined risks, the Research Service did not ensure that Post Traumatic Stress Disorder (PTSD) patients enrolled in a smoking cessation study received adequate and timely notice of the risks.

Informed Consent, Other Deficiencies Identified in Research Projects in Little Rock

OIG substantiated allegations related to documentation irregularities and human subjects protection violations in research projects conducted at the Central Arkansas Veterans Healthcare System. Researchers obtained samples for certain tests on subjects without their consent, could not provide informed consent documents for all subjects enrolled in the protocols, and did not appropriately obtain witness signatures for demented patients enrolled in research protocols. In addition, four protocols were missing other key information and data related to the subjects recruited in the study. OIG discovered discrepancies in the number of subjects reported as being recruited to the Institutional Review Board (IRB) and to the Office of Research and Development, as well as the failure of principal investigators to obtain the requisite skills, training, and experience to conduct the research. The IRB was aware of many of these deficiencies well before this inspection and failed to suspend or terminate the researchers or research projects involved.

OIG Review Calls for Active Leadership in PTSD Program

Chairman Bob Filner of the House Veterans' Affairs Committee requested that OIG review allegations regarding PTSD program issues at the VA San Diego Healthcare System (VASDHS). OIG concluded that the substantial presence of a clinician-administrator is needed to provide overall coordination and leadership for PTSD treatment at all VASDHS sites. Additionally, considerable efforts are needed to improve database management used to track patients with PTSD and ensure that data-driven decisions can be made regarding treatment options and resource requirements.

Systematic Improvement Needed for Venous Thromboembolism Prevention

OIG evaluated the extent to which VHA clinicians implement evidence-based recommendations to prevent venous thromboembolism (VTE) in hospitalized patients. VTE includes deep vein thrombosis, a blood clot in the deep veins of the leg or pelvis, and pulmonary embolism, a blood clot propagated to the lungs. Sixty-three percent of at-risk patients received recommended interventions, a rate similar to other non-VA settings.

These findings clarify the extent to which systematic improvement is needed and can serve to inform the design of prevention programs.

Significant Disabilities Continue for Veterans Following Completion of Traumatic Brain Injury Rehabilitation

At the request of the Chairman of the Senate Committee on Veterans' Affairs, Senator Daniel Akaka, OIG conducted a follow-up assessment to determine the extent to which VHA maintains involvement with a previously-studied group of service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI) sustained during or after tours of duty in Iraq or Afghanistan. OHI clinical staff reviewed data on VA health care utilization from electronic medical records and interviewed willing patients and family members. Three years after completion of initial inpatient rehabilitation for TBI, many patients continue to have significant disabilities. While case management has improved, long-term case management is not uniformly provided for these patients, and significant needs remain unmet. OIG will continue to monitor VHA's progress toward achieving consistent delivery of case management services for this select group of injured veterans.

Scopes of Practice for Unlicensed Research Physicians Not in Compliance with VHA Policy

OIG initiated a review to determine whether research activities performed by unlicensed physicians employed in VHA fell outside their scopes of practice. OHI did not find evidence that unlicensed physicians, with the exception of one, were performing activities that would constitute the practice of medicine. However, the majority of the scopes of practice were not in full compliance with VHA's 2003 guidance, and there was not uniform documentation of educational verification. OHI recommended the Under Secretary for Health ensure the scopes of practice for all research personnel engaged in research activities do not permit activities requiring licensure, and that the credentialing of unlicensed personnel engaged in research involving human subjects complies with VHA policy.

Quality Management Programs Generally Effective in VHA Facilities

OHI completed an evaluation of 46 VHA medical facilities' QM programs during FY 2007 to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts. In addition, the evaluation investigated whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. The evaluation noted two facilities with significant QM program weaknesses. OIG recommended that VHA continue to strengthen QM programs by improving compliance in adverse event disclosure, utilization management, National Patient Safety Goals, patient flow, and action item implementation and evaluation.

Review Reveals Compliance Deficiencies with *Out-of-Operating Room Airway Management* Directive

A national health care review was conducted to assess compliance with VHA Directive 2005-031, *Out-of-Operating Room Airway Management*. The directive addresses appropriate competencies of practitioners who perform urgent and emergent airway management outside of VHA operating rooms and the use of devices to confirm successful tube placement. Despite the fact that the National Center for Patient Safety provided all facilities a sample policy that met Directive requirements, facilities deleted elements or made changes that altered the intent of the Directive as developed locally. Only three facilities complied with all requirements of the Directive. OIG recommended that VHA require facilities to apply for a waiver from the Directive if they do not perform out-of-operating room airway management, maintain policies that comply with all elements of VHA Directive 2005-031, and collect provider-specific and aggregate data for airway management and discuss results at their designated oversight committee.

Funding Irregularities Found at Temple, TX, Research Facility

OIG received allegations of fiscal, scientific, and managerial wrongdoings in the operations of the Central Texas Veterans Health Care System Brain Imaging and Recovery Laboratory (BIRL). We partially substantiated the allegation of mismanagement of VA funds. There

was not sufficient BIRL research to support expenditures, and a consultant never signed the document purporting to be a contract. Due in part to this omission, the Research & Development Committee did not appropriately review expenditures made from appropriated funds for a principal investigator's project. OIG recommended that the Under Secretary for Health ensure that all BIRL expenditures were paid out of the correct appropriations, along with four other recommendations to the Veterans Integrated System Network (VISN) Director related to research and contract issues.

Report Finds Radiology Peer Review Process Ineffective

An OIG inspection was conducted at a VAMC to determine the validity of allegations regarding radiology issues. A complainant alleged that a radiologist had extremely high misread rates, causing life-shortening and life-threatening outcomes for patients. The complainant further alleged that a new process for monitoring radiology productivity does not contain quality standards but focuses on speed, leading to increased misread rates. The complainant alleged that the Relative Value Units (RVU) process is now the basis for performance pay and that some radiologists are not spending enough time reading films or are not reviewing all images. OIG did not substantiate that high misread rates affected patient outcomes, but concluded that the current radiology department peer review process was ineffective. OIG recommended that the VAMC request a VA Central Office radiology consultative visit to explain the RVU process and to assess other identified administrative issues, and that peer reviews be completed by another VAMC until administrative issues in the radiology department were resolved.

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.

Inaccurate Patient Waiting Times Remain a Problem for VHA

OIG reviewed allegations that the leadership of VISN 3 was manipulating procedures to misrepresent patient waiting times. OIG did not substantiate a willful manipulation of procedures with the intent to misrepresent waiting times. However, scheduling procedures were not followed, which affected the reliability of VISN 3 reported waiting times and caused the electronic waiting lists (EWLs) to be understated. OIG recommended that the Under Secretary for Health establish procedures to routinely test the accuracy of reported waiting times and the completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and those documented in the scheduling system. OIG's findings indicate VHA has still not implemented findings from earlier audits in 2005 and 2007 showing problems with outpatient scheduling, EWLs, and reported waiting times.

VHA Oversight of Nonprofit Research and Education Corporations Needs Improvement

An audit was conducted to determine the effectiveness of VHA controls over the administration of funds used for research and education activities at Nonprofit Research and Education Corporations (NPCs). OIG auditors determined the NPCs did not implement adequate controls to properly manage funds, safeguard equipment, and guard against conflicts of interest. Recommendations were provided to the Under Secretary for Health to define, develop, and implement oversight authority and procedures; revise VHA Handbook 1200.17; and strengthen procedures for following up on recommendations.

OFFICE OF INVESTIGATIONS

The OIG Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, 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 145 cases, made 90 arrests, and obtained $1.8 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Former Atlanta Nurse Sentenced for Drug Diversion

A former nurse at the Atlanta VAMC was sentenced to 4 years' probation and a $1,000 fine after having previously pled guilty to a criminal information charging her with fraudulently acquiring controlled substances. An OIG investigation determined that on numerous occasions the nurse diverted pain medication from VA patients for her personal use. As part of the plea agreement, the nurse surrendered her nursing license for 5 years.

Veteran Indicted for Identity Theft

A veteran was indicted on multiple counts of forgery, theft, and identity theft after an OIG investigation determined that he assumed the identity of another veteran and fraudulently received treatment and medications from VA valued at $161,036. The defendant confessed to the details of the scheme and to also diverting, forging, and negotiating four VA benefit checks totaling $3,661, which were intended for the true veteran.

Mountain Home, TN, VAMC Nurse Pleads Guilty to Drug Diversion

A Mountain Home, TN, VAMC nurse pled guilty to possession of controlled substances after an OIG and VA Police investigation revealed that the nurse, who was assigned to a nursing home care unit, diverted for her own use pain medication prescribed to patients. Some of the diversion included draining liquid hydromorphone from the IV bags of terminally ill patients.

Non-Veteran Pleads Guilty to Theft in "Stolen Valor" Case

A non-veteran pled guilty to theft of Government funds after having fraudulently received VA pension and health care benefits. The defendant claimed to have been a U.S. Marine for 12 years and to have served in Vietnam. An OIG investigation determined the defendant was incarcerated in three different state prisons, under a different name, during the time he was allegedly a Marine. The loss to VA is approximately $45,000 in pension benefits and approximately $200,000 in health care benefits.

Former Asheville, NC, VAMC Nurse Arrested for Drug Diversion

A former Asheville, NC, VAMC nurse was arrested for embezzlement of a controlled substance and willful misrepresentation to obtain a controlled substance. A joint OIG and local drug task force investigation determined that the nurse diverted Oxycodone intended for patients under her care and consumed the diverted narcotics during working hours. She also obtained Hydrocodone by simultaneously requesting and receiving multiple prescriptions by withholding information from the prescribing physicians.

Veteran Arrested for Passing Counterfeit Checks at San Diego VAMC

A veteran and two other defendants were sentenced to 48 months', 32 months', and 16 months' incarceration, respectively, for the counterfeiting and passing of fraudulent checks at the San Diego VAMC Veterans Canteen Service (VCS). The second and third defendants were also ordered to pay $2,591 in restitution to VA. During the course of the investigation OIG agents, regional fraud task force officers, and a probation officer entered the subject's residence and discovered a counterfeit check-making plant. The veteran, who had a previous history of check fraud, possessed numerous identifiers of other persons, blank check stock, and banking information. During the search of the residence, agents also found methamphetamine, weapons, cash, and various forms of counterfeiting equipment.

Benefits Processing

Many veterans, especially returning OEF/OIF 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.

Deficiencies Noted in Transition Assistance Provided to OEF/OIF Service Members and Veterans

An OIG audit of transition assistance provided by the VBA found significant deficiencies in claims processing goals and outreach efforts. VA Regional Offices did not process 76 percent of compensation claims of seriously disabled veterans of OEF/OIF within VBA's 30-day claims processing goal. To improve outreach, the Department of Defense (DoD) and VBA needed to monitor and increase attendance at Transition Assistance Program briefings, and strengthen procedures for processing initial outreach letters. The OIG made eight recommendations to address the transition control deficiencies identified.

VBA Hiring Temporarily Slows Productivity, Long-term Gains Anticipated

OIG conducted an audit to determine the impact of VBA's hiring initiative to increase its claims processing workforce by 30 percent to reduce the claims backlog. OIG concluded that in the short term, the large influx of new employees resulted in a decrease in VBA's overall productivity. However, the long-term expectation is that the backlog will be substantially diminished by 2011 as job proficiency for new employees increases. OIG recommended that VBA redefine its rating claims backlog in a more meaningful method to determine if it is meeting processing performance targets.

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 $3.6 million, with another $1.3 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 316 cases, made 92 arrests, and had $22.5 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Veteran Indicted for Compensation Fraud

A veteran was indicted in two different judicial districts for wire fraud and making false statements. An OIG investigation revealed that between April 1976 and October 2007 the veteran feigned symptoms and exaggerated his injuries to include paraplegia and complete loss of lower bodily functions requiring daily aid and attendance, constant medical care, clothing reimbursement, and adaptive housing and transportation. The investigation determined that during the 31-year period the veteran owned an excavation company and operated heavy construction equipment, owned and operated a Federal Aviation Administration-approved repair station, and was the chief inspector and airframe/power plant mechanic. The veteran also obtained a private pilot's license and was a deputy sheriff in a local sheriff office's maritime division. The loss to VA is approximately $1,551,000.

Widow Pleads Guilty to Theft

A widow was charged with theft of Government funds after a VA OIG investigation revealed that she fraudulently received Dependency and Indemnity Compensation benefits after her remarriage in 1994. The loss to VA is $151,796.

Veteran Pleads Guilty to Theft of VA Benefits

A veteran pled guilty to making false statements, theft, and mail fraud after an OIG investigation determined that he had been fraudulently receiving VA pension benefits since 1983. The investigation further determined that the veteran lied on a VA Claim for Pension Benefits form, earned income through the purchase and delivery of livestock, and had rental income from property. Also, the investigation revealed that the veteran concealed large sums of cash and a search warrant executed at a local bank uncovered $110,000 in a safe deposit box. The veteran admitted that he hid his earnings and other assets to avoid detection by VA. The loss to VA is approximately $218,000.

Veteran Indicted in "Stolen Valor" Case

A veteran was indicted on theft charges after an OIG investigation revealed that he provided false information to the Portland VAMC and to the VA Regional Office in order to fraudulently receive VA benefits. The information included an altered discharge document in support of his PTSD claim, fraudulently claiming $2^{1/2}$ years' service in Vietnam and combat stressors he did not experience. The veteran obtained the narrative for the stressors by plagiarizing war stories written by other veterans. The loss to VA is approximately $193,000.

Son Sentenced for Theft of VA Funds

The son of a VA beneficiary was sentenced to 24 months' incarceration, 36 months' probation, and ordered to pay $172,622 in restitution after having previously pled guilty to theft of Government property. From March 1996 through November 2005, the son converted for his own use his mother's VA benefits that were issued after her death.

Personal Care Home Owner Sentenced for Neglect of Veterans

A Jackson, MS, personal care home owner was sentenced to 10 years' incarceration, 5 years suspended, and 5 years' probation after pleading guilty to the exploitation of a vulnerable adult. A joint OIG and State investigation revealed that the owner failed to provide adequate living conditions and medical care for veterans who were residents at the care home. In addition, the owner and his wife negotiated veterans' VA benefit checks without authorization. The home was subsequently closed and all of the residents, including the veterans, were relocated to other care homes in the local area.

Son Sentenced for Fiduciary Fraud

The son of an incompetent veteran, who was appointed as his father's fiduciary, was sentenced to 30 months' incarceration, 3 years' probation, and was ordered to pay restitution of $272,802 to his father's estate. An OIG investigation determined that the son used his father's VA funds for his own personal use.

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.

Unapproved and Improper Use of Expired VHA Funds Is Widespread

OIG conducted an audit to assess whether VHA obtained proper approval to use expired funds, as well as whether contract changes were within the scope of the original contracts. The audit identified unapproved and improper use of expired funds in at least 80 percent of VISN contracting activities nationwide amounting to a total of $16.4 million during FY 2007. This widespread improper use of expired funds occurred primarily because of a lack of policy clarity and other weaknesses in internal controls. Similar findings were reported in a May 2007 report of the Boston Healthcare System.

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.

Former Tampa Canteen Service Supervisor Sentenced for Theft

A former Tampa VCS supervisor, who previously pled guilty to theft of Government funds, was sentenced to 6 months' incarceration, 3 years' probation, and ordered to pay restitution of $30,000 to VA. In February 2006, the VCS initiated an audit after a year-end inventory resulted in a retail accountability shortage. The audit and subsequent OIG investigation revealed that the supervisor manipulated voids and merchandise refunds for personal gain.

Arizona VHA Employee Charged with Fraud and Theft

A criminal information was filed, charging a former Arizona VHA employee with wire fraud, mail fraud, and theft of Government funds. An initial VA audit indicated that the employee was "price splitting" on charges made with her VA purchase card. A more detailed follow-up OIG investigation determined that the employee created a fictitious company and then had this company bill VA for fictitious goods and services. Payment was made to the company using the Government purchase card and by direct payments. The defendant also used her Government purchase card to buy gift cards on the internet and subsequently used the cards to purchase personal items to include jewelry and clothing. The employee resigned her position at the initial stage of the investigation. The total fraud loss to VA was $365,816.

Procurement Practices

VA spends over $15 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology (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 $62 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 over Clinical Sharing Agreements Found Ineffective

An OIG audit evaluated whether performance monitoring controls over surgical and anesthesiology noncompetitive clinical sharing agreements were effective in ensuring that VHA received the services it paid for. OIG found performance monitoring weaknesses for all 58 surgical and anesthesiology sharing agreements reviewed at eight VAMCs. Strengthening controls could save VHA over $59 million over 5 years.

Defense Procurement Requirements Compliance Improves, Issues Remain

OIG conducted an audit to evaluate the effectiveness of internal controls over purchases made by VA contracting activities on behalf of the DoD to determine VA compliance with Defense procurement requirements. Compliance rates have increased since the audit of FY 2006 procurements; however, instances of noncompliance were present, increasing the risk that DoD did not receive contracted goods and services on terms that were the most advantageous to the Government. These deficiencies occurred primarily because contracting officers overlooked procurement requirements. OIG expects the contractual risk associated with these activities to lessen with VA's intended discontinuation of purchases for DoD in May 2009.

Purchase Card Controls Effective, Better Documentation Needed

An OIG audit found that VHA purchase card controls were generally effective at preventing or detecting questionable, improper, or fraudulent medical facility purchases. All 707 transactions reviewed were purchases for goods or services for valid medical facility needs. For purchases where cardholder documentation was sufficient, we determined that the purchases were reasonably priced; we were unable to assess purchase price reasonableness for 126 transactions because cardholder documentation was inadequate. VHA needed to ensure cardholders maintain documentation supporting purchases and medical facilities monitor compliance with policies addressing these deficiencies. This was previously recommended in a 2004 audit.

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 seven cases, made four arrests, and had $37,925 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Former Contractor Pleads Guilty to Fraud

The former owner of a company that contracted with VA has agreed to plead guilty to engaging in mail fraud in connection with the shipment of medical drugs that were not approved for distribution by the FDA. A joint OIG, FDA, Internal Revenue Service, and

Postal Inspection Service investigation determined that the corporation and its employees concealed from the FDA that the company shipped to hospitals, including VA hospitals, a drug called "sterile talc powder" and a medical device called "barium sulfate" without first having obtained FDA approval. The former owner admitted that between 1997 and 2000, he caused his company to ship its "sterile talc powder" drug with improper labeling and shipped certain lots after the product had failed sterility testing. The company previously pled guilty and was sentenced in December 2007.

Director Pleads Guilty to Acceptance of Illegal Gratuities

The director of the Hines, IL, Consolidated Mail Outpatient Pharmacy (CMOP) pled guilty to a criminal information charging him with conspiracy and the acceptance of illegal gratuities. An OIG investigation determined that the director conspired with a subordinate VA employee and his spouse to provide temporary pharmacists to the CMOP at a higher pay rate than employees were previously paid. The director also submitted false and fraudulent statements to VA officials and legal counsel that misrepresented his subordinate's true role within the company as well as his activities on behalf of the company. Additionally, the director accepted approximately $4,500 worth of cash and gifts as gratuities from another supplier. The director repeatedly used his influence to award contracts to this vendor even though another company was awarded a contract to provide goods to the CMOP. Furthermore, $659,788 in "buy ahead" items were purchased from the favored company just prior to a new contract taking effect.

University of Kentucky Settles with Government

The University of Kentucky and the United States Attorney's Office for the Eastern District of Kentucky announced the settlement of a case involving the Lexington VAMC and the University over contractual and related obligations for the provision of medical care by University faculty and residents to VAMC patients. The University, as part of its affiliation with the VAMC, was required to provide a substantial number of medical faculty and residents to support the VAMC facility each year. For certain periods prior to January 2004, evidence indicated that VA had not received all of the services to which it was entitled. After substantial review and negotiation, the University agreed that it would, through its support organization, reimburse VA $3 million to resolve the dispute. This settlement followed extensive investigative work and audit support performed by OIG.

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 48 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 $18.8 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included 28 health care provider proposals—accounting for $39.6 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For 34 reports, the sustained savings rate was 57 percent.

	April 1, 2008–September 30, 2008	Summary FY 2008
Preaward Reports Issued	**32**	**46**
Potential Cost Savings	**$58,441,952**	**$81,873,449**

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 over $3.5 million, including $193,219 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 15 postaward reviews performed, 8 involved voluntary disclosures. In one of the eight reviews, OCR identified additional funds due.

	April 1, 2008–September 30, 2008	Summary FY 2008
Postaward Reports Issued	**15**	**35**
Dollar Recoveries	**$3,523,086**	**$20,159,719**

Special Reports

	April 1, 2008–September 30, 2008	Summary FY 2008
Special Reports	**1**	**3**
Dollar Recoveries	**$0**	**$6,011,749**

Desktop Computer Contract Found Not to be in VA's Best Interest

In response to a request from Chairman Harry Mitchell of the Subcommittee on Oversight and Investigations within the U.S. House of Representatives Committee on Veterans' Affairs, OIG reviewed the contract awarded by VA to Dell Marketing, L.P., to standardize personal computers, as well as installation and other services in VA. OIG concluded that the contract award complied with Federal Acquisition Regulation and was awarded properly; however, the contract was neither necessary nor in the best interest of VA. The award approach employed by VA limited competition, did not fully consider the needs of VA customers, and failed to achieve one of the stated goals of VA-wide standardization. Moreover, the decision to lease with the option to purchase was based on a faulty pricing analysis thereby making purchasing a more cost effective option than leasing. OIG also determined that the contract language was not clear in establishing specific criteria and goals to measure Service-Disabled Veteran-Owned Small Business compliance.

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 (CIO). 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 (FISMA),* P.L. 107-347, 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.

Information Security Compliance Challenges Remain According to Independent Assessment

OIG contracted with the independent firm Deloitte & Touche LLP to conduct the annual FISMA assessment for FY 2007 to determine the extent to which VA complies with FISMA requirements. VA has consolidated the vast majority of its IT resources under the CIO, including a reorganization of functions from the VA Administrations to the Office of Information and Technology. The CIO issued policy and procedural guidance to assist VA in implementing an effective information security program. In addition, VA data centers and selected program offices have taken actions to remediate security control weaknesses reported in OIG audits. While improvements have been made in information governance, annual CFS and information security program audits continue to report IT security control deficiencies, which place sensitive information at risk of unauthorized use and disclosure. VA also needs to better plan and manage its IT capital investments. Overall, VA has made little progress toward eliminating the material weakness in IT security controls and little progress in remediating the major deficiencies in IT security.

Other Significant OIG Activities

CONGRESSIONAL TESTIMONY

AIG for Healthcare Inspections Testifies on Notifications of Risks in Clinical Trial

Assistant Inspector General for Healthcare Inspections John D. Daigh, Jr., M.D, testified at a July 9, 2008, hearing before the House Committee on Veterans' Affairs. The topic of the hearing was the use of Chantix® and its side effects in a VA clinical trial involving patients with PTSD. Dr. Daigh discussed the results of an OIG review of issues of informed consent, patient notification of potential adverse effects associated with Chantix®, and the tracking and reporting of adverse events that occurred during the course of the research study. Dr. Daigh was accompanied by Senior Physician Andrea Buck, M.D., and Randall Snow, Associate Director, Washington, DC, Regional Office, Office of Healthcare Inspections.

OIG Testifies on Implementation of Suicide Prevention Initiatives

An OIG Senior Physician testified before a May 6, 2008, hearing of the House Committee on Veterans' Affairs regarding the implementation of suicide prevention initiatives from its Mental Health Strategic Plan (MHSP). Dr. Michael Shepherd noted that OIG's May 10, 2007, report, *Healthcare Inspection, Implementing VA'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 this report as well as individual cases that the OIG reviewed and reported on involving veteran suicides and accompanying mental health issues. He also provided observations of other changes VA could make to fully implement suicide prevention initiatives from the MHSP.

OTHER VA EMPLOYEE-RELATED INVESTIGATIONS

Seattle VAMC Employee Charged with Embezzlement

A VA employee, who was the former local American Federation of Government Employees union treasurer at the Seattle VAMC, pled guilty to a criminal information charging her with making false statements. An OIG and Department of Labor investigation revealed that the employee used her position to embezzle union funds that she used to purchase a time share property and electronic equipment. The employee attempted to cover the theft by falsifying monthly and annual expense reports. The loss to the union is approximately $120,000.

Former Tomah, WI, VAMC Nursing Assistant Sentenced for Sexual Assault

A former Tomah, WI, VAMC nursing assistant was sentenced to 90 days' incarceration and 2 years' probation after pleading no contest to sexual assault and other related charges. The defendant was also ordered to refrain from employment in any health care facility, to surrender all nursing-related licenses, and to register as a sex offender. A VA OIG investigation revealed that the nursing assistant had sexually abused a VA patient at the VAMC.

Former Salisbury, NC, VAMC Technician Sentenced for Patient Assault

A former Salisbury, NC, VAMC patient care technician was sentenced to 75 days' incarceration and 12 months' probation after pleading guilty to assault and battery on a handicapped person. An OIG and local police investigation determined that the employee slapped a patient in a wheelchair multiple times and verbalized threats of continued abuse. The employee, who was employed by VA for 29 years, resigned her position during the investigation.

Former Asheville, NC, Pharmacist Arrested for Embezzlement

An Asheville, NC, VAMC pharmacist was arrested after an OIG investigation revealed that he stole approximately 10,000 pills of non-controlled prescription medication from the VAMC pharmacy during the past 2 to 3 years. As a result of the investigation, the employee also surrendered his pharmacist's license to the state and retired from his position at the VAMC.

Former Dallas VAMC Employee Sentenced for Sexual Assault of Child

A former Dallas VAMC employee was sentenced to 20 years' incarceration after being convicted of aggravated sexual assault of a child. An OIG investigation determined that the defendant sexually assaulted his girlfriend's daughter on a number of occasions while on VAMC property. The defendant is also currently facing additional charges of possession of child pornography.

Fayetteville, NC, VAMC Employee Arrested for Sexual Offenses

A former Fayetteville, NC, VAMC certified nursing assistant was arrested for sexual battery, assault on a handicapped person, and indecent exposure. A joint OIG and VA Police investigation revealed that the employee forced two VAMC patients to inappropriately touch him, while allegedly obtaining their blood pressure readings. The employee is also accused of fondling the victims.

Diploma Fraud Committed by VA Employees

The remaining four of nine defendants pled guilty to conspiracy to commit wire fraud and mail fraud, while one defendant pled guilty to misprision of a felony, for their role in the manufacture and the sale of fraudulent educational documents through an online internet "Diploma Mill." A multi-agency investigation revealed that some of the approximately 6,000 fraudulent high school and college diplomas were sold to VA employees, who included the bogus degrees in their VA employment applications and fraudulently completed internal VA forms attesting to their education level. Some employees also included the "diploma" information as part of their application for a security clearance. As a result of the investigation, six VA employees resigned, retired, or received disciplinary action.

Former VAMC Employee Sentenced for Taking Money to Write-Off Accounts

A former Washington VAMC employee was sentenced to 36 months' probation, 100 hours of community service, and ordered to pay a $1,000 fine after having previously pled guilty to the receipt of illegal supplementation of salary. A joint OIG and Federal Bureau of Investigaion (FBI) investigation revealed that the former employee solicited and received money from VAMC patients to write-off their accounts.

Threats Made Against VA Employees

During this reporting period, the OIG opened 14 criminal investigations resulting from threats made against VA facilities and employees. Among them were the following:

- A veteran in Florida was sentenced to 13 months' incarceration and 3 years' probation after having previously pled guilty to making a threat against a Federal official. A joint VA OIG and FBI investigation determined that the veteran sent an e-mail to his Congressman threatening to kidnap and execute VA officials. The veteran was subsequently interviewed and stated that he intended on executing VA officials and blowing up VA Headquarters building with a truck bomb.
- A San Francisco VAMC nursing home employee pled guilty to a criminal information charging him with intimidating Government employees. The employee, who is also a veteran, made statements indicating that he might buy a machine gun and "kill everyone in the nursing home."
- A veteran was indicted for making threats over interstate commerce and making threats with the intent to extort a thing of value after an OIG investigation revealed that the veteran made multiple telephone calls threatening the life of a Mountain Home, TN, VAMC employee who had revoked his fee basis benefits. The veteran has been on home confinement with electronic monitoring since his arrest.

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, 26.4 million felon warrants have been received from the National Crime Information Center and participating states resulting in 41,843 investigative leads being referred to law enforcement agencies. Over 1,882 fugitives have been apprehended as a direct result of these leads. Since the inception of the program in 2002, OIG has identified $576.3 million in estimated overpayments with an estimated cost avoidance of $658.4 million. Among the arrests made by OIG, VA police, U.S. Marshals, and local police during this reporting period were the following:

- A veteran wanted for a rape charge in Pennsylvania was arrested at the Orlando VAMC by local police with the assistance of OIG and VA Police. The veteran was held by local authorities pending extradition.
- A VA employee was arrested at the Houston VAMC by local police officers with the assistance of VA OIG based on a recently issued warrant for aggravated sexual assault.
- Deputy U.S. Marshals arrested a veteran listed on Utah's Top Ten Most Wanted list for a parole violation based on a previous murder conviction. The arrest was made after an OIG agent located the veteran in Reno, NV, and provided this information to the local U.S. Marshals office.

LEGISLATIVE CHANGE

A joint DoD/OIG report found that VA's inability to provide Home Improvements and Structural Alterations (HISA) grants to injured service members who had not yet been discharged from active duty hindered continuation of their treatment during their transition from DoD to VA health care. These grants support structural alterations to their home to assure access to the home or to essential sanitary facilities. The report recommended that VA "should promote enaction of an amendment to section 1717, title 38, United States Code to allow the Secretary of Veterans Affairs to provide...HISA grants to eligible veterans prior to discharge from military service." This legislation was passed as part of P.L. 110-289, thus permitting VA to offer HISA grants to service members prior to their discharge.

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	
COMBINED ASSESSMENT PROGRAM REVIEWS				
08-01088-111 04/10/2008	Combined Assessment Program Review of the Chalmers P. Wylie Independent Outpatient Clinic, Columbus, OH			
08-00529-112 04/14/2008	Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center, Charleston, SC			
07-03172-114 04/21/2008	Combined Assessment Program Review of the VA Boston Healthcare System, Boston, MA			
08-00786-116 04/23/2008	Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California			
08-00399-131 05/29/2008	Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan			
08-00401-133 05/29/2008	Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana			
08-00001-134 05/29/2008	Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, Missouri			
08-01089-137 06/04/2008	Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, Pennsylvania			
08-00819-143 06/10/2008	Combined Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah			
07-03173-145 06/12/2008	Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island			
08-01459-174 07/31/2008	Combined Assessment Program Review of the Alaska VA Healthcare System, Anchorage, Alaska			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
08-01266-176 08/01/2008	Combined Assessment Program Review of the Oklahoma City VA Medical Center, Oklahoma City, Oklahoma			
08-00988-181 08/13/2008	Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon			
07-03174-184 08/13/2008	Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut			
08-00400-190 08/26/2008	Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri			
08-00777-200 09/10/2008	Combined Assessment Program Review of the Miami VA Healthcare System, Miami, Florida			
08-01745-201 09/11/2008	Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, California			
08-00916-204 09/15/2008	Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia			
HEALTHCARE INSPECTIONS				
07-02369-107 04/03/2008	Healthcare Inspection, Medical Device Recall Process in Veterans Health Administration Medical Centers			
07-03379-110 04/04/2008	Healthcare Inspection, Resident Credentialing and Supervision, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas			
07-02063-109 04/08/2008	Healthcare Inspection, Radiology Issues at a VA Medical Center			
08-00338-115 04/22/2008	Healthcare Inspection, Veterans Integrated Service Network Oversight of Peer Review Processes			
08-01023-119 05/01/2008	Follow-Up Healthcare Inspection, VA's Role in Ensuring Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation			
07-01202-124 05/07/2008	Healthcare Inspection, Scopes of Practice for Unlicensed Physicians Engaged in Veterans Health Administration Research			
07-00060-126 05/14/2008	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2007			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
08-00437-135 06/03/2008	Healthcare Inspection, Colonoscopy Management, El Paso VA Health Care System, El Paso, Texas			
08-01299-144 06/11/2008	Healthcare Inspection, Clinic Appointment Scheduling Issues, VA San Diego Healthcare System, San Diego, California			
08-01380-154 06/27/2008	Healthcare Inspection, Alleged Patient Neglect During a Magnetic Resonance Imaging Exam, Michael E. DeBakey VA Medical Center, Houston, Texas			
07-03359-156 07/07/2008	Healthcare Inspection, Staffing, Quality of Care, and Access Issues, Central Alabama Veterans Health Care System, Tuskegee, Alabama			
08-01383-161 07/10/2008	Healthcare Inspection, Emergency Care, Patient Discharges, and Staffing Issues, Central Alabama Veterans Health Care System, Tuskegee, Alabama			
08-01777-163 07/10/2008	Healthcare Inspection, Alleged Medication Overdose and Poor Communication, VA Boston Healthcare System, Boston, Massachusetts			
08-01359-165 07/11/2008	Healthcare Inspection, Quality of Care, Courtesy, and Communication Issues, VA Medical Center, St. Louis, Missouri			
08-01484-168 07/14/2008	Healthcare Inspection, Credentialing and Privileging Issues, VA Medical Center, Fayetteville, North Carolina			
08-01369-172 07/25/2008	Healthcare Inspection, Quality of Care Issues, VA Gulf Coast Health Care System, Biloxi, Mississippi			
08-01105-171 07/29/2008	Healthcare Inspection, Alleged Research Funding Irregularities at the Central Texas Veterans Health Care System, Temple, Texas			
08-01130-173 07/29/2008	Healthcare Inspection, Out-of-Operating Room Airway Management in Veterans Health Administration Medical Centers			
08-01993-177 07/31/2008	Healthcare Inspection, Alleged Inpatient Care Issues, Tennessee Valley Healthcare System, Alvin C. York Campus, Murfreesboro, Tennessee			
07-03042-182 08/06/2008	Healthcare Inspection, Human Subjects Protections Violations at the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
07-01922-180 08/12/2008	Healthcare Inspection, Oversight of the Community Nursing Home Program, VA North Texas Health Care System, Dallas, Texas			
08-01377-185 08/14/2008	Healthcare Inspection, Quality of Care of Two Deceased West Virginia Veterans			
08-01297-187 08/26/2008	Healthcare Inspection, Post-Traumatic Stress Disorder Program Issues, VA San Diego Healthcare System, San Diego, California			
08-02346-191 08/28/2008	Healthcare Inspection, Human Subjects Protections in One Research Protocol, VA Medical Center, Washington, DC			
08-01989-196 09/09/2008	Healthcare Inspection, Alleged Physician Privileging Issues, Sioux Falls VA Medical Center, Sioux Falls, South Dakota			
07-02599-199 09/10/2008	Healthcare Inspection, Quality of Care Issues, Huntington VA Medical Center, Huntington, West Virginia			
06-02459-209 09/26/2008	Healthcare Inspection, Prevention of Venous Thromboembolim in VA Hospitals			
JOINT DoD/VA HEALTHCARE INSPECTIONS				
06-02857-127 06/12/2008	DoD/VA Care Transition Process for Service Members Injured in OIF/OEF			
INTERNAL AUDITS				
07-00564-121 05/05/2008	Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations			
07-03505-129 05/19/2008	Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3			
07-00608-162 07/09/2008	Fiscal Year 2007 Federal Information Security Management Act Assessment			
06-03552-169 07/17/2008	Audit of Veterans Benefits Administration Transition Assistance for Operations Enduring and Iraqi Freedom Service Members and Veterans			
08-01559-193 09/05/2008	Audit of the Impact of the Veterans Benefits Administration's Special Hiring Initiative			
07-02796-203 09/11/2008	Audit of Veterans Health Administration's Government Purchase Card Practices	$799,997	$799,997	
08-00456-207 09/24/2008	Audit of FY 2007 VA Purchases Made on Behalf of the Department of Defense			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
08-00477-211 09/29/2008	Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements	$59,800,000	$59,800,000	$95,666
08-00244-213 09/30/2008	Audit of Procurements Using Prior-Year Funds To Maintain VA Healthcare Facilities			$16,477,619
ADMINISTRATIVE INVESTIGATIONS				
07-00649-150 06/19/2008	Administrative Investigation, Alleged Conflict of Interest, Veterans Benefits Administration, VA Central Office, Washington, DC			
07-02623-164 07/10/2008	Administrative Investigation, Failure to Satisfy Financial Obligations, Battle Creek VAMC, Battle Creek, Michigan			
08-01383-205 09/23/2008	Administrative Investigation, Preferential Treatment, Improper Travel Vouchers, Misuse of Resources, and Interference with an OIG Investigation, Central Alabama Veterans Health Care System			
TOTAL:	**58 Reports**	**$60,599,997**	**$60,599,997**	**$16,573,285**
CONTRACT REVIEW SPECIAL REPORT				
08-02213-138 06/04/2008	Review of Enterprise - Wide PC Lease Awarded to Dell Marketing, L.P.			

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 (September 30, 2007, and earlier). The FY 2007 FISMA audit, which contains unimplemented OIG recommendations from previous years' FISMA audits, is included in the total of unimplemented reports and recommendations, but because it was issued after September 30, 2007, it is not included in the reports that are over 1 year old on the right side of the table. Some reports are counted more than once because they have actions at more than one office. Of the reports open less than 1 year, one report has actions at two offices. Of the reports open more than 1 year, one report has actions at two offices.

Unimplemented OIG Reports and Recommendations				
VA Office	**Total**		**Issued 9/30/07 and Earlier**	
	Reports	Recommendations	Reports	Recommendations
VHA	68	235	10	20
VBA	4	9	0	0
OI&T[1]	3	52	2	2
OM[2]	1	3	0	0

[1] Office of Information and Technology (OI&T)
[2] Office of Management (OM)

Reports Unimplemented for Over 1 Year					
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
04-02887-169	07/08/2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	VHA	5 of 8	
04-02330-212	09/30/2005	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	VHA	1 of 3	
05-03028-145	05/17/2006	Review of Access to Care in the Veterans Health Administration	VHA	2 of 9	
06-02238-163	07/11/2006	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OI&T	1 of 6	
05-00081-36	12/08/2006	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Years 2004 and 2005	VHA	1 of 3	
06-03706-126	05/10/2007	Healthcare Inspection, Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention	VHA	2 of 6	
07-01083-157	06/29/2007	Administrative Investigation, Loss of VA Information VA Medical Center Birmingham, AL	VHA/OI&T	2 of 18	
07-01796-181	08/02/2007	Healthcare Inspection, Follow-Up Evaluation of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina	VHA	1 of 2	
07-00616-199	09/10/2007	Audit of the Veterans Health Administration's Outpatient Waiting Times	VHA	4 of 5	
06-00980-217	09/28/2007	Healthcare Inspection, Comparison of VA and University Affiliated IRB Compliance with VHA Handbook 1200.5	VHA	1 of 3	
06-03677-221	09/28/2007	Audit of the Acquisition and Management of Selected Surgical Device Implants	VHA	2 of 7	$21,948,162
TOTALS			**11**	**22**	**$21,948,162**

Note: Although the FY 2007 FISMA audit contains 16 unimplemented OIG recommendations from previous years' FISMA audits, it is not included in the table above because the report was issued after September 30, 2007.

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.

The *Federal Financial Management Improvement Act of 1996*, 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. 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 340 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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/08	0	$0
Issued during reporting period	2	$16.6
Total inventory this period	**2**	**$16.6**
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	2	$16.6
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**2**	**$16.6**
Total carried over to next period	**0**	**$0**

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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/08	0	$0
Issued during reporting period	2	$60.6
Total inventory this period	**2**	**$60.6**
Management decisions during the reporting period		
Agreed to by management	2	$60.6
Not agreed to by management	0	$0
Total management decisions this reporting period	**2**	**$60.6**
Total carried over to next period	**0**	**$0**

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.


OFFICE OF
INSPECTOR GENERAL

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
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Department of Veterans Affairs
Office of Inspector General
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