# Office of Inspector General
## Department of Veterans Affairs

## Semiannual Report to Congress
## April 1, 2007 - September 30, 2007

# 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, 2007, through September 30, 2007. 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 109 reports on VA programs and operations. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, budget processes, economy in procurement, and information security. OIG audits, investigations, and other reviews identified over $360 million in monetary benefits, for a return of $10 for every dollar expended on OIG oversight. Our criminal investigators have closed 513 investigations and made 275 arrests. OIG investigative work also resulted in 299 administrative sanctions.

OIG has particularly focused in this reporting period on assessing and improving VA efforts to support returning Operation Iraqi Freedom/Operation Enduring Freedom veterans. We have also worked to strengthen VA information management and security and improve VA stewardship in procurement.

Our Office of Healthcare Inspections (OHI) continued to review VA research programs, and conducted several inspections evaluating the effectiveness of VA's mental health efforts. OHI used VA and Department of Defense data to create an analytical database incorporating details about all service members discharged between July 1, 2005, and September 30, 2006, permitting independent analytical review of the transition of care for injured veterans. OHI also testified before congressional committees regarding health care issues in Hawaii, North Carolina, and rural VA facilities throughout the United States.

Our Office of Audit has focused on conducting national audits regarding veterans health care and benefits issues. In addition, Audit has reviewed VA's procurement acquisition strategies and controls. The recommendations we made in these audits will result in improved internal controls and will strengthen the VA's ability to provide needed health care and benefits to veterans and their families. Further, our newly published audit of VA information security noted some progress in resolving problems identified over the past several years while also disclosing additional security concerns.

The Office of Contract Review conducted preaward and postaward reviews. These reviews were specifically designed to improve VA's procurement process by protecting the interests of the Government and by identifying and resolving contractors' overcharges. Those efforts resulted in savings and dollar recoveries of nearly $75 million. On June 27, 2007, OIG testified on VA internal contracting oversight deficiencies before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. Our testimony highlighted areas where VA can improve controls over contract modifications, use of expired funds, and approval of projects to ensure the Department effectively serves America's veterans and taxpayers.

OIG appreciates the continuing support we receive from the Acting Secretary and senior management. We look forward to further cooperation 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 2007 |
|---|---|---|
| **DOLLAR IMPACT ($$$ in Millions)** | | |
| Better Use of Funds | $90.3 | $116.1 |
| Fines, Penalties, Restitutions, and Civil Judgments | $4.7 | $201.5 |
| Fugitive Felon Program | $245.7 | $303.9 |
| Savings and Cost Avoidance | $11.0 | $28.4 |
| Questioned Costs | $5.6 | $11.0 |
| OIG Dollar Recoveries | $2.7 | $9.3 |
| Contract Review Savings and Dollar Recoveries | $74.9 | $149.9 |
| **RETURN ON INVESTMENT** | | |
| Dollar Impact ($360.0)/Cost of OIG Operations ($35.3) | 10:1 | |
| Dollar Impact ($670.2)/Cost of OIG Operations ($70.6) | | 9:1 |
| Dollar Impact ($74.9)/Cost of Contract Review Operations ($1.7) | 44:1 | |
| Dollar Impact ($149.9)/Cost of Contract Review Operations ($3.4) | | 44:1 |
| **OTHER IMPACT** | | |
| Arrests* | 275 | 580 |
| Indictments | 157 | 336 |
| Criminal Complaints | 116 | 242 |
| Convictions | 177 | 389 |
| Pretrial Diversions | 24 | 45 |
| Fugitive Felon Apprehensions by Other Agencies Using VA OIG Data | 70 | 151 |
| Administrative Sanctions | 299 | 711 |
| **ACTIVITIES** | | |
| Reports Issued | | |
| CAP Reviews | 22 | 45 |
| Healthcare Inspections | 30 | 54 |
| Audits | 10 | 19 |
| Administrative Investigations | 4 | 13 |
| Joint Reviews | 0 | 1 |
| Contract Reviews | 43 | 85 |
| Investigative Cases | | |
| Opened | 467 | 1,089 |
| Closed | 513 | 1,181 |
| Healthcare Inspections Activities | | |
| Clinical Consultations | 2 | 3 |
| Administrative Case Closures | 1 | 13 |
| Hotline Activities | | |
| Cases Opened | 565 | 1,073 |
| Cases Closed | 607 | 1,199 |

* Includes the apprehension of 64 and 168 fugitive felons by OIG, respectively, for this period and FY 2007.

# 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) 2007, VA has a $76.9 billion budget and almost 220,000 employees serving an estimated 24 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, Public Law 95-452, the *Inspector General Act*, 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 470 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 2007 funding for OIG operations provides $70.6 million from appropriations. The Office of Contract Review receives $3.4 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 in 23 cities 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, including those recently returned from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), is consistently ranked among the best in the Nation. 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 22 cyclical Combined Assessment Program (CAP) reviews to evaluate quality of care issues in VHA medical facilities, and 30 hotline reports and national reviews.

### OIG Reviews the Care and Death of OIF Veteran in Minnesota

In January 2007, a U.S. Marine Corps OIF veteran committed suicide in a friend's home. This patient had received extensive health care over the previous 20 months from the VA Medical Center (VAMC) in Minneapolis, Minnesota. Although a patient of the Minneapolis VAMC, the veteran visited the St. Cloud VAMC, 75 miles to the northwest of Minneapolis, for the first time 5 days before his death, and started the process to be admitted to a St. Cloud VAMC elective residential treatment program. At the request of the Secretary and members of Congress, OIG performed a comprehensive inspection of the Minneapolis and St. Cloud VAMCs' health care provided to the patient, and examined the circumstances of the patient's death. OIG made recommendations to improve the screening process for the St. Cloud VAMC elective residential program. *(Healthcare Inspection, Review of the Care and Death of a Veteran Patient, VA Medical Centers, St. Cloud and Minneapolis, Minnesota)*

### Inspection Reviews VHA Mental Health Strategies for Suicide Prevention

OIG surveyed all VAMCs between December 2006 and February 2007 to assess the implementation of action items that pertain to suicide prevention within the VHA Mental Health Strategic Plan (MHSP). The report summarizes what is known about the characteristics, nature, and rates of suicide, as well as related reports from the Surgeon General of the United States, the Institute of Medicine, and the President's New Freedom Commission on Mental Health, as well as VHA's MHSP. OIG's report recommendations included arranging for 24-hour crisis and mental health care availability, and that all non-clinical staff who interact with veterans should receive mandatory training. Inspectors stated that VHA should establish a centralized mechanism to select emerging best practices for screening, assessment, referral, and treatment, as well as to facilitate system-wide implementation in order to ensure a single VHA standard of suicide prevention excellence. *(Healthcare Inspection, Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention)*

### Inspectors Find Coronary Bypass Surgery Delays in Florida

An OIG review to determine the validity of allegations of poor care by a cardiologist and of mismanagement of cardiovascular services at the Bay Pines VA Healthcare System concluded that no patients suffered major long-term adverse outcomes resulting from actions of the cardiologist. However, the review did find that waiting times for coronary artery bypass surgery often exceeded 3 months, especially when patients were referred within the VA health care system. Inspectors also found evidence suggesting minimal involvement of cardiologists in consultations conducted by nurse practitioners. OIG recommended that the health care system director take appropriate steps to prevent undue delays for patients awaiting coronary bypass surgery and in the reporting of results of echocardiograms, and review specific expectations regarding the extent to which cardiologists are involved in the care of patients referred to cardiology and managed primarily by nurse practitioners. *(Healthcare Inspection, Quality of Care Issues in Cardiology, Bay Pines VA Healthcare System, Bay Pines, Florida)*

## Review Substantiates Research Improprieties at Arizona Facility

An OIG review of research impropriety allegations at the Carl T. Hayden VAMC in Phoenix substantiated that two unlicensed physicians performed medical activities. A nurse also performed functions not included in her "scope of practice" activities, and laboratory data was not reviewed in a timely manner. OIG also found significant problems with the accuracy of inventories of critical materials. Inspectors made recommendations to protect patient safety, establish procedures for ensuring that radioactive wastes are managed in compliance with all applicable VA and Federal regulations and policies, delineate the responsibilities of VA laboratories for patient notification of abnormalities, and define conflict of interest in terms applicable to research activities of VAMCs and VA-affiliated non-profit corporations. *(Healthcare Inspection, Research Practices at Carl T. Hayden VA Medical Center, Phoenix, Arizona)*

## Inspectors Review Facilities' Risk of Legionnaire's Disease

OIG conducted a survey of 159 acute-care and extended-care inpatient facilities to review steps VHA has taken to reduce the risk of Legionnaire's Disease (LD). The review revealed a wide range of practices, some with potential risk. Because the degree of risk to patients may vary considerably, OIG recommended that the Under Secretary for Health ensure that inpatient facilities where transplants are performed have a written plan to address the prevention of LD and that all inpatient facilities periodically assess local risk for LD using specific guidelines developed by VHA experts. *(Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities)*

## Contracting Errors Leave North Texas HCS Inadequately Managed

An OIG inspection of the VA North Texas Health Care System (HCS) and its medical school affiliate concluded eye clinic employees had been supervised and managed by a contractor-employed administrator in conflict with specific acquisition regulations. Contract terms did not call for the contractor to provide administrative oversight of clinics or VA staff. Acquisition planning for ophthalmology services offered no support for staffing requirements, and the agreement did not receive a required preaward review. OIG also found that eye clinic management kept a "shadow" system of medical records in violation of VHA and HCS policy regarding the computerized patient record system and patient privacy. The review recommended corrective action. *(Healthcare Inspection, Management of Government Resources and Personnel Practices, VA North Texas Health Care System, Dallas, Texas)*

## Inspectors Find Los Angeles Patient's Cancer Diagnosis Was Delayed

An OIG review found that a patient's colorectal cancer (CRC) diagnosis was delayed by clinicians of the VA Greater Los Angeles Healthcare System in Los Angeles, and concluded that he might have had a better outcome if efforts had been made to follow up with him during his initial presentation and if diagnostic procedures had occurred more expeditiously. OIG could not substantiate or refute allegations that several other patients experienced delays and that clinicians had not been fully informed about the procedures related to disclosing adverse events at the health care system. OIG recommended that management implement all planned actions to improve CRC prevention, diagnosis, and timely follow-up, and assess gastroenterology clerical efficiencies and staffing adequacy. *(Healthcare Inspection, Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California)*

## Review Substantiates Complaint of Contaminated Instruments in Phoenix

A review of allegations related to the delivery of contaminated instruments to the operating room of the Carl T. Hayden VAMC in Phoenix substantiated that the Supply, Processing, and Distribution (SPD) department had ongoing problems with contaminated instruments and packaging. However, OIG healthcare inspectors determined that no contaminated instruments were actually used in surgery. Medical center managers aggressively identified and corrected SPD issues by completing the SPD construction project, holding weekly meetings, providing consultative services by two established VA experts, hiring additional SPD staff, providing staff education and training, increasing sterilizer maintenance checks, and ensuring ongoing QM monitoring. *(Healthcare Inspection, Alleged Quality Control*

*Issues in Supply Processing and Distribution, Carl T. Hayden VA Medical Center, Phoenix, Arizona)*

### Augusta VAMC Did Not Ensure Safe Environment of Mental Health Care

OIG's review of a veteran's suicide at the Augusta VAMC found that the patient received appropriate clinical assessment and services, but determined that the VAMC did not ensure a safe environment of care. Inspectors recommended that the VAMC take appropriate action regarding responsible managers whose failure to identify safety hazards placed mental health patients at risk, and assure that all managers and employees conducting environment-of-care inspections are adequately trained and knowledgeable. OIG further recommended that the facility follow National Center for Patient Safety (NCPS) guidance when conducting internal reviews and notify NCPS when patient safety hazards may require nationwide alerts. *(Healthcare Inspection, Patient Suicide, VA Medical Center, Augusta, Georgia)*

### Review Confirms Improvements Were Made at North Carolina VAMC

OIG conducted a review to follow up on a 2005 VA Office of the Medical Inspector (OMI) report and a 2006 OIG CAP review, and to evaluate communication, quality of care, performance measures, and environment of care. Inspectors found that medical center managers in Salisbury implemented corrective actions that resolved or improved the deficiencies cited in the earlier reports, noting that communication processes between OMI and OIG needed improvement. OIG found that the medical center generally met or exceeded performance measure goals, except that private patient bathrooms on the locked mental health units had exposed pipes that could pose a safety risk to patients, and tunnels connecting buildings on the campus did not have emergency call systems accessible to patients or visitors. OIG made recommendations to address these issues, and has initiated communication improvement with OMI. *(Healthcare Inspection, Follow-Up Evaluation of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina)*

### Unlicensed Physicians Practiced Medicine at VA South Texas Facility

OIG conducted an inspection at the South Texas Veterans Health Care System in San Antonio to review the validity of allegations that unlicensed physicians hired as research assistants had engaged in clinical activities constituting the practice of medicine. Inspectors determined that certain unlicensed physicians functioned outside their scopes of practice, but a lack of adequate medical documentation impaired OIG's ability to determine the extent and magnitude of the problem. OIG recommended that management develop and implement policies to minimize the risk that research subjects might confuse unlicensed physician research assistants with licensed clinicians. A second recommendation was to ensure that research personnel function within their scope of practice. OIG also recommended that management require sufficient documentation in the medical record of research visits to permit the Research and Development Committee to determine whether research personnel are functioning within their scopes of practice as required by VA policy. *(Healthcare Inspection, Alleged Practice of Medicine by Unlicensed Research Assistants, South Texas Veterans Health Care System, San Antonio, Texas)*

### OIG Uses DoD and VA Data To Create Joint Analytical OIF/OEF Database

In July 2006, the Department of Defense (DoD) Inspector General and VA OIG agreed to jointly evaluate the medical care transition process for injured OIF/OEF service members from DoD to VA, because only a very limited quantitative characterization of care transition issues was possible using available Government data. OIG used relevant DoD and VA data files to create an analytical database incorporating details about all 494,147 service members discharged from July 1, 2005, to September 30, 2006. OIG released an informational report describing the database, providing background for understanding and interpreting ongoing and planned studies using this unique database. The report also presents selected descriptive statistics of veterans who comprise the database population. *(Informational Report, Quantitative Assessment of Care Transition: The Population-Based LC Database)*

## 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.

### Follow-up Finds VA Under Reporting Outpatient Waiting Times

At the request of the Senate Committee on Veterans' Affairs, OIG audited VHA outpatient waiting times to follow up on its 2005 report, *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures*. Conditions identified in the 2005 report still exist. VHA has established detailed procedures for schedulers to use when creating outpatient appointments but has not implemented effective mechanisms to ensure scheduling procedures are followed. As a result, the accuracy of VHA's reported waiting times cannot be relied on, and electronic waiting lists at the medical facilities reviewed are incomplete. VHA has not fully implemented five of the eight recommendations in the 2005 report. *(Audit of the Veterans Health Administration's Outpatient Waiting Times)*

## 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 127 cases, made 99 arrests, and obtained $1.4 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

### Houston VAMC Staff Psychiatrist Arrested for Sexual Assault

A former Houston VAMC staff psychiatrist was arrested after being indicted for sexual assault for having sexual relations with one of her veteran patients over a 20 month period in the psychiatrist's residence and VAMC office. The psychiatrist resigned from her position as a result of the investigation.

### Seattle VAMC Nurse Diverts Controlled Substances and Alters Records

A nurse employed at the Seattle VAMC pled guilty to unlawful possession of a Schedule II controlled substance after an OIG investigation determined that for approximately 1 year the former nurse diverted several controlled substances from the VAMC's ACUDOSE drug dispensing system and altered patient records in the computer database.

### Kidnapper Convicted after Mississippi Veteran Escapes during Katrina

A personal home caregiver was found guilty of kidnapping after an OIG investigation determined that the defendant and a second subject imprisoned a veteran in a mobile home in Mississippi for 5 months, including while the subjects fled the area due to Hurricane Katrina. The veteran escaped from the mobile home during the storm and was subsequently admitted to the Jackson VAMC.

### Memphis VA Employee Sentenced for Workers' Compensation Fraud

A former VA employee in Memphis, Tennessee, was sentenced to 42 months' incarceration and 36 months' supervised release, and was ordered to pay $357,100 in restitution after being found guilty of making false statements to obtain workers' compensation benefits and bankruptcy fraud. The defendant falsely reported he was unemployed and had no earned income, despite operating his own contracting business.

### Martinsburg VA Pharmacist Guilty of Stealing Patients' Pain Medication

A former VA pharmacist in Martinsburg, West Virginia, pled guilty to using his position to illegally obtain morphine after a multi-agency investigation conducted with Drug Enforcement Administration Diversion Control, Food and Drug Administration (FDA) Criminal Investigation Division, VA police, and a state regulatory agency determined that he was illegally accessing drug dispensing machines to steal oxycodone and morphine for personal use. The pharmacist admitted he removed several milliliters of the drugs from

various Pyxis medication dispensers and replaced the stolen amount with saline solution on approximately 76 occasions, resulting in patients receiving diluted pain medication.

### Texas VA Nurse and Co-conspirators Guilty in 9-Year Drug Theft

A joint OIG, VA police, and U.S. Postal Inspection Service (USPIS) investigation found that a Bonham VAMC nurse stole controlled and non-controlled substances from the VAMC for approximately 9 years, conspiring with another relative to distribute controlled substances through the nurse's incarcerated grandson. The nurse was sentenced to 180 days' home confinement and 2 years' probation. In addition, two co-conspirators pled guilty to theft of Government property and conspiracy to distribute a controlled substance.

## 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.

### VAMC Staffing Shortages Caused Inadequate Cleaning in Amarillo

A VHA review determined that staffing shortages in the housekeeping division of a medical center in Amarillo, Texas, prevented deep cleaning in nursing home rooms for approximately an 18-month period. Management augmented staff and resumed quarterly deep cleanings with stricter oversight to ensure an appropriate level of cleanliness is maintained. Additionally, the review revealed that, in response to persistent reports of black mold in various areas of a medical center, management developed a formalized plan to catalog and track all reported moisture intrusions with a rapid response team trained in mold assessment and abatement.

# 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.

### VBA Compensation Benefit Adjustment Controls Need Strengthening

OIG's audit of VBA controls to minimize avoidable overpayments determined that VBA did not have effective controls to ensure that VA Regional Office (VARO) staff took prompt action to adjust compensation benefits. Avoidable overpayments were identified at 46 of the 57 VAROs. Additionally, VBA did not effectively monitor and report its compensation benefit adjustment workload. OIG estimated that VBA and beneficiaries could have avoided $50.8 million in overpayments had VBA staff processed adjustments promptly. OIG recommended that the Under Secretary for Benefits develop improved standards on initiating action on compensation benefit adjustments, monitor timeliness, and take corrective action when necessary. *(Audit of VBA Controls to Minimize Compensation Benefit Overpayments)*

## 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 $2.8 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 260 cases, made 108 arrests, and had $16.4 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

### Ohio Husband and Wife Guilty in Taking Deceased Veteran's Checks

A Columbus, Ohio, man who pled guilty to theft of Government funds was sentenced to serve 1 year and 1 day incarceration plus 3 years' probation, and was also ordered to pay $156,759 in restitution. The man and his wife—who previously pled guilty to making false statements—received, forged, and negotiated VA pension checks issued to a deceased veteran who had lived with them.

### Wife and Son of Missing Virginia Veteran Convicted for Using His Benefits

The wife and son of a missing Spotsylvania County, Virginia, veteran were convicted on several charges after a joint investigation with Social Security Administration (SSA)

OIG, Federal Bureau of Investigation, U.S. Secret Service, and local police disclosed that despite the disappearance of the veteran in 1993, the wife and son continued to receive and personally use his VA and Social Security benefits. The total loss to VA and SSA is $366,434. Local police continue to investigate the disappearance of the veteran.

### Landscaper Sentenced for Unemployability Fraud in Florida

A Bradenton, Florida, veteran was sentenced to 15 months' incarceration and 36 months' probation, and was ordered to make restitution of $176,568, following a conviction for mail fraud related to a scheme to fraudulently obtain VA unemployability benefits and Social Security benefits. A joint investigation with SSA OIG and USPIS revealed that the veteran had been operating a landscaping business while falsely claiming to be incapable of gainful employment.

### Escaped Texas Convict Captured in Theft, Forgery of Pension Check

An OIG investigation determined that a suspect received, forged, and negotiated a VA pension check of a veteran whose identity he had assumed to gain access to VA health care benefits. The subject, who is not a veteran, was arrested after being indicted for forgery. Additional Federal charges of false statements and health care fraud are pending, based on the defendant fraudulently receiving approximately $100,000 in VA health care benefits at the Houston VAMC. Investigators also found that the defendant escaped from a prison in Alabama in 1978 and an additional warrant has now been issued.

### Wife of Deceased Beneficiary Indicted for Theft of Federal Funds in Mesa

The wife of a deceased VA beneficiary in Mesa, Arizona, was indicted for theft of Government funds after an OIG investigation determined that she failed to notify VA or SSA of her husband's death for approximately 8 years, continuing to use his VA and SSA benefits for her personal needs. The loss to VA is $192,175.

### New Hampshire Veteran Arrested for Fabricating Benefits Claim

Despite an Exeter, New Hampshire, veteran's claims of being partially paralyzed, an investigation revealed that he owned and worked at two businesses, work that included welding, bending, and lifting. The veteran used a cane and walked with a severe limp only when at his medical appointments. The total loss to VA and SSA is $185,000.

## OIG HOTLINE

The OIG Hotline receives numerous allegations of fraud related to monetary benefits programs. Many of these contacts result in investigations of criminal conduct that recover significant sums of money or provide veterans help they need.

### Field Examiners Come to Aid of Overcharged Texas Veterans

Many retirement community home housing veteran residents received notices of overpayments due to the false claims filed by the facility, which claimed their rent as unreimbursed medical expenses. The facility's physician also signed falsified physician statements for aid and attendance. Hotline contacted VARO field examiners, who conducted a meeting at the facility with the affected beneficiaries to define unreimbursed medical expenses and assist with requests for the waiver of their overpayments.

# Financial Management

VA must provide all its departmental activities 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*, Public Law 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.

### Audit Finds $5.4 Million in Questioned Costs in Boston Healthcare System

OIG conducted an audit to assess the validity of allegations of contract irregularities and the mismanagement and illegal use of funds at the VA Boston Healthcare System. The audit substantiated contract modifications were not within the scope of the original contracts, funding of contract modifications were not in accordance with appropriations law, and contract modifications did not comply with the Federal Acquisition Regulation. OIG made recommendations to address the issues its auditors found to the Veterans Integrated Service Network (VISN) 1 Director and the Deputy Assistant Secretary for Acquisition and Materiel Management. *(Audit of Alleged Mismanagement of Government Funds at the VA Boston Healthcare System)*

### Better Oversight and Stronger Controls Needed for CHAMPVA

An OIG audit evaluated the effectiveness of VHA's management of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The program, managed by VHA's Health Administration Center (HAC), provides health care benefits to dependents of veterans rated permanently and totally disabled or who died as a result of service-connected conditions. Auditors found the HAC needed to improve controls to prevent improper payments and identify overpayments requiring recovery. OIG estimated that the HAC made overpayments of about $12 million and did not identify $5.1 million in payments it should have recovered. OIG also found that the HAC's collection of CHAMPVA funds was not timely, and that the HAC inappropriately wrote off $114,276 in accounts receivable. *(Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs)*

## 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.

### Tampa Canteen Supervisor Indicted for Theft of Government Funds

An audit at the Tampa VAMC conducted by the Veteran Canteen Service's audit division revealed that a supervisor manipulated voids and merchandise refunds for personal gain. The supervisor was indicted for theft of Government funds. The loss to VA is $33,908.

### VA Employee in Tampa Creates Bogus Companies To Collect False Claims

A former employee in the Tampa VAMC travel benefits office pled guilty to a criminal information charging him with conflict of interest after an OIG investigation that included an in-depth audit revealed that the employee created and approved fictitious claims for patient transportation from four fictitious transportation companies between July 2001 and September 2002. The loss to VA is $205,000.

## Baltimore VAMC Employee Sentenced for Childcare Subsidy Fraud

A Baltimore VAMC employee was sentenced to 36 months' probation and ordered to pay $24,000 in restitution to VA after a joint OIG and VA police investigation determined she intentionally failed to report her spouse's income to remain eligible for Federal childcare subsidies from 2004 through 2006. OIG discovered this offense while conducting a review requested by VA of suspicious reimbursements associated with this employee benefits program.

# Procurement Practices

VA spends over $13 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 $74.6 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. 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.

### Better Management of Surgical Device Implants Can Save $21.7 Million

An OIG audit found that VHA could reduce procurement costs for selected surgical device implants (SDI) and needs to strengthen key SDI management controls in the areas of inventory, patient privacy, and recalls. Using national contracts and blanket purchase orders instead of the open market could reduce SDI costs by as much as $4.3 million annually or $21.7 million over 5 years. VHA facilities also need to improve inventory controls and strengthen patient safeguards related to SDI. Facilities could not effectively account for purchased devices because they lacked reliable inventory controls and records. Staff routinely provided SDI manufacturers more medical information and personal data than the manufacturers required, placing SDI patients at risk for identity theft or other misuse of information. *(Audit of the Acquisition and Management of Selected Surgical Device Implants)*

## OFFICE OF HEALTHCARE INSPECTIONS

OHI efforts to improve and evaluate quality of care in VHA include review of procedures related to procurement. Such reviews play an essential part in maintaining the quality of health care services for veterans.

### Reviewers Find Need To Complete Management Actions in Nevada

An OIG review concluded that the VA Sierra Nevada Health Care System's managers need to complete actions already initiated in complications reporting, business rules, and emergency airway management. Inspectors also found that contracting personnel did not adequately develop, award, or administer three contracts reviewed. Contracting personnel need to correct the identified deficiencies and change processes to prevent future occurrences. *(Healthcare Inspection, Quality of Care, Administration, and Contracting Issues, VA Sierra Nevada Health Care System, Reno, Nevada)*

## 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 five cases, made three arrests, and had $495,676 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

### Massachusetts Business Owner Arrested for Shipping Non-Sterile Product

A joint OIG, FDA Office of Criminal Investigations, and USPIS investigation determined that a Massachusetts medical products distributor shipped a drug claimed to be sterile although the product failed testing for sterility and FDA approval. The company's owner was

indicted for mail fraud, obstruction of an administrative proceeding, and various violations of the *Food, Drug and Cosmetic Act*.

### Former Fresno VAMC Employee and Contractors Charged with Bribery

A former Fresno VAMC employee, the owner of a construction company, and the owner of a heating, ventilation, and air conditioning (HVAC) company were indicted by a Federal Grand Jury for bribery charges. An investigation determined that the former VA employee, in his capacity as a contracting officer's technical representative, colluded with the owners of the construction and HVAC companies to submit inflated change orders in return for kickback payments. The employee also received bribes and gratuities consisting of cash payments from the owners of the companies in return for certifying payroll submittals and progress payments, and awarding of future contracts. The VA employee was also charged with soliciting a $10,000 kickback from another construction contractor in an inflated change-order scheme, which the contractor refused to pay.

## 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 has a staff of 25, and completed 43 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 $63.5 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule proposals, preaward reviews during this reporting period included 10 health care provider proposals—accounting for $9.7 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings; for the 16 reports resolved this period, the sustained savings rate was 66 percent.

| | April 1, 2007–<br>September 30, 2007 | Summary<br>FY 2007 |
|---|---|---|
| **Preaward Reports Issued** | **15** | **43** |
| **Potential Cost Savings** | **$63,523,017** | **$133,743,403** |

## POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with Public Law 102-585, the *Veterans Health Care Act of 1992*, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling $11.4 million, including nearly $5.4 million related to *Veterans Health Care Act* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate status of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 25 postaward reviews performed, 12 involved voluntary disclosures. In 8 of the 12 reviews, OCR identified additional funds due.

| | April 1, 2007–<br>September 30, 2007 | Summary<br>FY 2007 |
|---|---|---|
| **Postaward Reports Issued** | **25** | **39** |
| **Dollar Recoveries** | **$11,396,444** | **$16,123,982** |

## SPECIAL REPORTS

| | April 1, 2007–September 30, 2007 | Summary FY 2007 |
|---|---|---|
| **Special Reports** | **3** | **3** |
| **Total OCR Reports Issued** | **43** | **85** |

### Review Substantiates Health Services Contracts Awarded Improperly

A review of contracts related to the sole-source procurement of health services for non-affiliated entities substantiated that the contracts were not awarded or administered appropriately. The problems identified included poor contract formation, inadequate price reasonableness calculations, and the lack of adequate controls to ensure that VA paid the agreed-upon price for the services rendered. The VISN Director concurred with OIG's recommendation to ensure that all contracting officers, contract administrators, contracting officer's technical representatives, team leaders, chief logistics officers, directors, chiefs of staff, and others involved in the award and administration of contracts for services are provided training on contract formation, contract administration, and compliance with VA Directive 1663, *Health Care Resources Contracting—Buying, Title 38 U.S.C. 8153.*

### Review Finds NAC's Administration of Modification Requests Inadequate

OIG reviewed the National Acquisition Center's (NAC) administration of modification requests by a FSS reseller. Report recommendations were intended to correct deficiencies regarding the reseller's inadequate submission of required information, Price Reductions Clause Tracking customer omissions, the reseller's misrepresentations of contract price increases as price reductions, and insufficient actions by the contracting officer to collect potential monies owed VA for the reseller's late reporting of price reductions. The NAC concurred with all 10 recommendations and submitted implementation plans responsive to all of the issues.

# Information Management

IT plays a critical role in all VA operations. OIG oversight work in the IT area 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. Since the 2006 data loss, VA has shown 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* (FISMA), Public Law 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 the VA since FY 2000. OIG audit reports present constructive recommendations needed to improve IT management and security.

### FY 2006 FISMA Review Finds Old Issues Unresolved, Adds New Ones

Findings in the annual reviews of VA's compliance with FISMA have led OIG to report information security and security of data and data systems as a major management challenge for VA since FY 2000. The 2006 FISMA assessment again identified numerous unresolved recommendations from prior OIG reports and also identified new recommendations that need to be fully addressed to mitigate information security weaknesses. VA needs to implement a centralized IT program that ensures consistent administration and control of information and data; apply appropriate resources; establish, modify, and clarify IT policies and procedures; implement and enforce security controls, and institute a mechanism to ensure system vulnerabilities are evaluated and corrected across the Department. *(FY 2006 Audit of VA Information Security Program)*

## 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 nine cases, made one arrest, and had $68,931 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

### Birmingham Data Loss Reveals Weaknesses in Information Security

OIG's administrative review of the January 2007 disappearance of a VA-owned external hard drive from the VAMC in Birmingham, believed to contain personally identifiable information for over 250,000 veterans and 1.3 million medical providers, revealed a dysfunctional management structure that led to an overall breakdown of management oversight, controls, and accountability of the VAMC Birmingham research center. OIG recommendations included taking administrative action against the employee who failed to safeguard the missing data and deleted files to hide the extent of the problem, as well as against the managers of the research program and the VAMC Director. Other recommendations involved programmatic, policy, and organizational changes to alleviate identified weaknesses. The criminal investigation remains open and the missing external hard drive has not been recovered. To date, however, there is no indication that the data has been used to commit identity theft. *(Administrative Investigation, Loss of VA Information, VA Medical Center, Birmingham, Alabama)*

## Mississippi Veteran Receives Wrong Documents, Tries to Blackmail VA

An OIG investigation disclosed that a Jackson, Mississippi, VARO mistakenly mailed a veteran several service records and medical documents belonging to other veterans. The recipient acknowledged receipt of these documents, but she refused to disclose their location or return them to either VARO management or OIG. Using a search warrant, OIG investigators seized all VA records at the veteran's Gulfport residence not belonging to her. The veteran was indicted and convicted in an attempt to blackmail VA after she tried to coerce VA officials to provide her an appeal hearing and a potential favorable decision in exchange for not exposing VA's mistake to the news media.

# Other Significant OIG Activities

## CONGRESSIONAL TESTIMONY

### Testimony Highlights VA Contracting Oversight Deficiencies

Belinda J. Finn, Assistant Inspector General (AIG) for Auditing, accompanied by Maureen Regan, Counselor to the Inspector General, and Nicholas Dahl, Director of the Bedford Audit Operations Division, testified at a June 27, 2007, House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing on VA internal contracting oversight deficiencies, discussing OIG's May 31, 2007, report, *Audit of Alleged Mismanagement of Government Funds at the VA Boston Healthcare System*. OIG's testimony highlighted areas where VHA management can improve controls over contract modifications, use of expired funds, and approval of projects to prevent similar incidents from occurring elsewhere in VHA. As a result of the report, the VISN 1 Director initiated an administrative investigation to determine whether disciplinary action is warranted against VA Boston Healthcare System employees involved. In addition, the Deputy Assistant Secretary for Acquisition and Logistics revoked the Chief of the Purchasing and Contracting Section's warrant authority.

### OIG Testimony Highlights Challenges Facing VA Programs in Rural Areas

OHI Regional Director Julie Watrous, R.N., and Michael Shepherd, M.D., an OHI physician, appeared before the Senate Committee on Veterans' Affairs regarding health care and benefits for veterans in Hawaii. In hearings on August 21 and 23, 2007, OIG discussed challenges specific to the VA Pacific Islands Health Care System and to rural VA facilities throughout the United States. OIG reports identified problems in four general categories: physician vacancies and recruiting specialty physicians (such as cardiologists, gastroenterologists, and orthopedic surgeons); lack of support staff; insufficient space; and lack of equipment.

### OIG Testifies on Follow-Up to VAMC Salisbury, NC, Inspections

AIG for Healthcare Inspections Dr. David Daigh testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on April 19, 2007. He described the OIG evaluation of QM in VHA nationwide in FY 2004–2006, and the results of a September 25, 2006, OIG CAP review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina. He also described a June 2005 report by VHA's Office of the Medical Inspector (OMI) on the delivery of surgical services at the Salisbury medical center and OIG's follow-up inspection on that OMI report, conducted April 9–13, 2007. OIG committed to doing regular follow up of all published OMI reports.

## OTHER EMPLOYEE-RELATED INVESTIGATIONS

### Former Washington, DC, VA Employee and Volunteer Sentenced for Fraud

A former Washington, DC, VAMC employee was sentenced to 15 months' incarceration and 24 months' probation and a VAMC volunteer was sentenced to 33 months' incarceration and 24 months' probation. Both defendants were also ordered to jointly pay $20,500 in restitution. The investigation revealed that the volunteer conspired with the VA employee to have a fraudulent beneficiary form placed in a dying VA employee's personnel folder so that $20,500 from the Federal Employees Group Life Insurance would be paid to the volunteer instead of the rightful beneficiaries following the employee's death.

### Impostor at American Lake Wore Unauthorized Military Medals Illegally

An Army veteran in Washington State was sentenced to 500 hours' community service and 2 years' probation after pleading guilty to illegally wearing military medals and decorations. During sentencing, the judge ordered the community service to be performed at the Tahoma National Cemetery "to serve those who died serving this country." An OIG investigation revealed that between November 2005 and March 2006, the defendant falsely represented himself to veterans and active duty military as a U.S. Marine Corps chaplain and a counselor at the American Lake VAMC.

## Two Philadelphia Employee Union Officials Caught Embezzling $184,000

A joint investigation by OIG and the Department of Labor's Office of Labor Management Standards revealed that a VA employee, who was also the union president at the Philadelphia VAMC, and another VAMC employee, who was the secretary-treasurer of the same union local, embezzled union dues by depositing them into their personal and various union accounts they controlled and by co-signing checks drawn on the union's business account. The two pled guilty to embezzling $184,000 from members' dues payments. The union president retired and both left their union positions.

## Threats Made Against VA Employees

During this reporting period the OIG opened 15 criminal investigations resulting from threats made against VA facilities and employees. Among them were the following:

- A VA employee was arrested for threats to shoot Sacramento VAMC co-workers after telling certain co-workers that he would let them know when not to report to work, because on that day he was planning to come to work and start shooting.
- A veteran pled guilty to mailing numerous threats to VA employees in letters mailed to the Madison VAMC and the VA Outpatient Clinic in Rockford, Illinois. The veteran also mailed a letter to President Bush containing a substance later identified as brown sugar.
- A veteran who threatened two VA employees at the Little Rock VAMC before threatening a VA police investigator was indicted and arrested for threatening to assault a Federal law enforcement officer. The veteran was subsequently remanded to a Federal detention facility for a 45-day psychiatric evaluation.
- A veteran, disgruntled after being denied benefits numerous times for a post-traumatic stress disorder claim, e-mailed a threat to the Nashville VARO, giving a 10-day deadline to award his claim or he would explore his "homicidal ideations" on them. He was arrested and remanded into the custody of the U.S. Marshals Service pending further judicial action.
- A veteran was charged with intimidating a Government employee after admitting to OIG special agents that he left over 20 threatening voicemails on the work phone of a San Francisco VA employee within a 24-hour period. The calls threatened gang rape and other violent sexual acts.

## 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 20.4 million felony warrants have been received from the National Crime Information Center and participating states resulting in 35,577 investigative leads being referred to law enforcement agencies. Over 1,700 fugitives have been apprehended as a direct result of these leads. During this reporting period, the 100th VA employee was arrested. 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 murder and possession of a controlled substance arrested at the Bay Pines VAMC.
- A veteran arrested at the Bedford VAMC on charges of attempted murder and armed robbery.
- A Jackson VAMC employee arrested as a result of two felony warrants for sex crimes against a child.
- A Little Rock VAMC employee arrested on state charges of sexual assault.
- A Biloxi VAMC nurse wanted for conspiracy to smuggle drugs and other contraband into a state prison.

Since the inception of the program in 2002, OIG has identified $472.8 million in estimated overpayments, with an estimated cost avoidance of $529.5 million.

### Acquisition Manager Reprised Against Contracting Officer

An OIG administrative investigation substantiated that a VA acquisition manager engaged in reprisal, a prohibited personnel practice, when he issued a letter of counseling and threatened to demote a subordinate contracting officer for refusing to make an unlawful sole-source contract award. The manager also made false statements to investigators regarding his activities and conversations concerning the procurement. His actions attempted to usurp the contracting officer's authority under Federal Acquisition Regulation, and violated merit system principles established in Federal law. VA officials concurred with our recommendations and took administrative disciplinary action against the manager.

# 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** | | | | |
| 07-00060-121 4/27/2007 | Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin | | | |
| 07-00163-128 5/10/2007 | Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina | | | |
| 07-00472-138 5/29/2007 | Combined Assessment Program Review of the VA Southern Nevada Healthcare System, Las Vegas, Nevada | | | |
| 07-00282-140 6/1/2007 | Combined Assessment Program Review of the Carl T. Hayden VA Medical Center, Phoenix, Arizona | | | |
| 06-02820-141 6/15/2007 | Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Leavenworth, Kansas | | | |
| 06-02819-145 6/18/2007 | Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado | | | |
| 07-00604-148 6/19/2007 | Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas | | | |
| 07-00161-159 7/2/2007 | Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi | | | |
| 07-00917-163 7/6/2007 | Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio | | | |
| 07-00578-164 7/10/2007 | Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York | | | |
| 07-01229-165 7/11/2007 | Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan | | | |
| 07-00169-166 7/11/2007 | Combined Assessment Program Review of the Fargo VA Medical Center, Fargo, North Dakota | | | |

| Report Number/ Issue Date | Report Title | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|---|
| | | OIG | Management | |
| 07-00708-170 7/18/2007 | Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota | | | |
| 07-00577-171 7/19/2007 | Combined Assessment Program Review of the Northport VA Medical Center, Northport, New York | | | |
| 07-00990-172 7/19/2007 | Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington | | | |
| 07-01572-178 7/31/2007 | Combined Assessment Program Review of the Martinsburg VA Medical Center Martinsburg, West Virginia | | | |
| 07-00542-179 8/1/2007 | Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, Florida | | | |
| 07-01149-182 8/2/2007 | Combined Assessment Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio | | | |
| 07-01605-186 8/6/2007 | Combined Assessment Program Review of the VA Central California Health Care System, Fresno, California | | | |
| 07-01158-190 8/21/2007 | Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas | | | |
| 07-01408-197 9/11/2007 | Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee | | | |
| 07-01230-210 9/25/2007 | Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, Wisconsin | | | |

## HEALTHCARE INSPECTIONS

| Report Number/ Issue Date | Report Title | OIG | Management | Questioned Costs |
|---|---|---|---|---|
| 07-00589-118 4/20/2007 | Healthcare Inspection, Research Practices at Carl T. Hayden VA Medical Center, Phoenix, Arizona | | | |
| 06-01732-119 4/24/2007 | Healthcare Inspection, Quality of Care Issues in Cardiology, Bay Pines VA Healthcare System, Bay Pines, Florida | | | |
| 06-03671-120 4/25/2007 | Healthcare Inspection, Quality of Polytrauma Care, Environmental and Safety Issues, Minneapolis VA Medical Center, Minneapolis, Minnesota | | | |
| 07-01349-126 5/10/2007 | Healthcare Inspection, Implementing VHA’s Mental Health Strategic Plan Initiatives for Suicide Prevention | | | |

| Report Number/ Issue Date | Report Title | Funds Recommended for Better Use OIG | Management | Questioned Costs |
|---|---|---|---|---|
| 06-03706-127 5/10/2007 | Healthcare Inspection, Review of the Care and Death of a Veteran Patient, VA Medical Centers, St. Cloud and Minneapolis, Minnesota | | | |
| 06-03742-142 6/6/2007 | Healthcare Inspection, Alleged Quality of Care Issues, VA Medical Center, Atlanta, Georgia | | | |
| 07-00050-146 6/18/2007 | Healthcare Inspection, Appointment Scheduling and Administrative Issues, Carl T. Hayden VA Medical Center, Phoenix, Arizona | | | |
| 07-02191-147 6/18/2007 | Healthcare Inspection, Quality of Care and Patient Safety Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia | | | |
| 07-00029-151 6/20/2007 | Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities | | | |
| 07-01159-153 6/25/2007 | Healthcare Inspection, Review of Recommendations, El Paso VA Health Care System, El Paso, Texas | | | |
| 06-01319-156 6/29/2007 | Healthcare Inspection, Management of Government Resources and Personnel Practices VA, North Texas Health Care System, Dallas, Texas | | | |
| 06-01472-158 6/29/2007 | Healthcare Inspection, Nursing Shortage and Management Issues, VA Medical Center, Oklahoma City, Oklahoma | | | |
| 07-00561-167 7/11/2007 | Healthcare Inspection, Patient Suicide VA Medical Center, Augusta, Georgia | | | |
| 07-02121-168 7/13/2007 | Healthcare Inspection, Alleged Quality Control Issues in Supply Processing and Distribution, Carl T. Hayden VA Medical Center, Phoenix, Arizona | | | |
| 07-01749-169 7/17/2007 | Healthcare Inspection, Quality of Care and Communication Issues, VA Medical Center, Louisville, Kentucky | | | |
| 07-01305-177 7/24/2007 | Healthcare Inspection, Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California | | | |
| 07-00654-176 7/25/2007 | Healthcare Inspection, Alleged Suspicious Death St. Louis VA Medical Center St. Louis, Missouri | | | |
| 07-01796-181 8/2/2007 | Healthcare Inspection, Follow-Up Evaluation of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina | | | |
| 07-01923-183 8/6/2007 | Healthcare Inspection, Alleged Delay in Diagnosis and Treatment, VA Eastern Colorado Health Care System, Denver, Colorado | | | |

| Report Number/ Issue Date | Report Title | Funds Recommended for Better Use | | Questioned Costs |
|---|---|---|---|---|
| | | OIG | Management | |
| 07-01219-194 8/29/2007 | Healthcare Inspection, Alleged Practice of Medicine by Unlicensed Research Assistants, South Texas Veterans Health Care System, San Antonio, Texas | | | |
| 07-01551-195 9/11/07 | Healthcare Inspection, Quality of Care, Administration, and Contracting Issues, VA Sierra Nevada Health Care System, Reno, Nevada | | | |
| 07-01119-196 9/13/07 | Healthcare Inspection, Quality of Care Issues Involving Manchester VA Medical Center and VA Boston Healthcare System | | | |
| 07-00380-202 9/13/07 | Informational Report, Quantitative Assessment of Care Transition: The Population-Based LC Database | | | |
| 07-00457-206 9/14/2007 | Healthcare Inspection, Delay in Treatment and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida | | | |
| 07-00562-209 9/25/2007 | Healthcare Inspection, Quality of Care Issues at the Dayton VA Medical Center, Dayton, Ohio | | | |
| 07-00569-212 9/26/2007 | Healthcare Inspection, Quality of Care Issues, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin | | | |
| 06-03175-208 9/28/2007 | Healthcare Inspection, Alleged Inappropriate Treatment and Patient Abuse, Edward Hines, Jr. VA Hospital, Hines, Illinois | | | |
| 07-01915-214 9/27/07 | Healthcare Inspection, Patient Safety Issues and Privacy Act Violations, Fargo VA Medical Center, Fargo, ND | | | |
| 06-00980-217 9/28/2007 | Healthcare Inspection, Comparison of VA and University Affiliated IRB Compliance with VHA Handbook 1200.5 | | | |
| 06-02663-218 9/28/2007 | Healthcare Inspection, Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania | | | |
| **INTERNAL AUDITS** | | | | |
| 06-00931-139 5/31/2007 | Audit of Alleged Mismanagement of Government Funds at the VA Boston Healthcare System | | | $5,396,398 |
| 06-03637-191 8/22/2007 | Audit of Veterans Health Administration Vehicle Fleet Management | $89,081 | $89,081 | |
| 07-00616-199 9/10/2007 | Audit of the Veterans Health Administration's Outpatient Waiting Times | | | |

| Report Number/ Issue Date | Report Title | Funds Recommended for Better Use OIG | Funds Recommended for Better Use Management | Questioned Costs |
|---|---|---|---|---|
| 06-02860-215 9/28/2007 | Audit of VA's Response to Hurricane Katrina | | | |
| 06-03541-219 9/28/2007 | Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs | $17,200,000 | $17,200,000 | |
| 06-01623-220 9/28/2007 | Audit of Veterans Benefits Administration Controls to Minimize Compensation Benefit Overpayments | $50,800,000 | $50,800,000 | |
| 06-03677-221 9/28/2007 | Audit of the Acquisition and Management of Selected Surgical Device Implants | $21,750,901 | $21,750,901 | $197,261 |
| 06-00035-222 9/28/2007 | FY 2006 Audit of VA Information Security Program | | | |
| **OTHER OFFICE OF AUDIT REVIEWS** | | | | |
| 07-00061-123 5/2/07 | Peer Review of Department of State and Broadcasting Board of Governors, Office of Inspector General, Office of Audits | | | |
| 07-01816-175 9/10/2007 | Independent Review of VA's Fiscal Year 2006 Special Disabilities Capacity Report (Attestation as of July 13, 2007) | | | |
| **ADMINISTRATIVE INVESTIGATIONS** | | | | |
| 06-02238-136 5/22/2007 | Administrative Investigation, Reprisal and False Statements, Acquisition Operations Service, VA Central Office | | | |
| 07-01083-157 6/29/2007 | Administrative Investigation, Loss of VA Information, VA Medical Center, Birmingham, Alabama | | | |
| 06-01385-188 8/21/2007 | Administrative Investigation, Misuse of Time, Resources, and Title, and Failure to Administer Policy, VA Medical Center, Lincoln, Nebraska | | | |
| 06-02081-189 8/21/2007 | Administrative Investigation, Misuse of Resources and Position VA Medical Center, Oklahoma City, Oklahoma | | | |
| **TOTAL:** | **66 Reports** | **$89,839,982** | **$89,839,982** | **$5,595,659** |

# APPENDIX B

## STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994*, Public Law 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, 2006, 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 9/30/06 and Earlier** | |
| | Reports | Recommendations | Reports | Recommendations |
| VHA | 66 | 226 | 12 | 42 |
| VBA | 1 | 3 | 0 | 0 |
| OI&T[1] | 5 | 53 | 2 | 18 |
| OM[2] | 1 | 3 | 1 | 3 |
| OSP[3] | 1 | 6 | 0 | 0 |

[1] Office of Information and Technology (OI&T)
[2] Office of Management (OM)
[3] Office of Operations, Security, and Preparedness (OSP)

| Reports Unimplemented for Over 1 Year | | | | | |
|---|---|---|---|---|---|
| Report Number | Date of Issue | Title | Responsible Organization(s) | Open Recommendations | Monetary Impact |
| 02-01339-85 | 4/23/2003 | Audit of VHA's Part-Time Physician Time and Attendance | VHA | 3 of 17 | |
| 03-00391-138 | 5/3/2004 | Healthcare Inspection, VHA's Community Residential Care (CRC) Program | VHA | 1 of 11 | |
| 04-01371-177 | 8/11/2004 | Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS) | VHA | 1 of 67 | |
| 04-02887-169 | 7/8/2005 | Audit of the Veterans Health Administration's Outpatient Scheduling Procedures | VHA | 5 of 8 | |
| 04-00235-180 | 8/4/2005 | Healthcare Inspection, Inspection of Veterans Health Administration Patient Transportation Services | VHA | 9 of 9 | |
| 04-02330-212 | 9/30/2005 | Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study | VHA | 1 of 3 | |
| 04-03178-139 | 5/5/2006 | Audit of VA Acquisitions for Other Government Agencies | OM | 3 of 20 | |
| 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 | 3 of 6 | |
| 05-03281-168 | 7/17/2006 | Combined Assessment Program Review of the VA Medical Center Huntington, WV | VHA | 1 of 12 | |
| 06-01128-201 | 9/11/2006 | Combined Assessment Program Review of the VA New Jersey Health Care System, East Orange, New Jersey | VHA | 5 of 25 | |
| 04-00888-215 | 9/20/2006 | Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program | VHA | 11 of 29 | |

| Reports Unimplemented for Over 1 Year | | | | | |
|---|---|---|---|---|---|
| Report Number | Date of Issue | Title | Responsible Organization(s) | Open Recommendations | Monetary Impact |
| 05-00055-216 | 9/20/2006 | FY 2005 Audit of VA Information Security Program | OI&T | 15 of 17 | |
| 05-01978-226 | 9/27/2006 | Review of Selected Financial and Administrative Operations at VISN 1 Medical Facilities | VHA | 1 of 29 | |
| 06-00035-222 | 9/28/2007 | FY 2006 Audit of VA Information Security Program* | OI&T | 28 of 30 | |
| **TOTALS** | | | | **91** | **$6,000,000** |

* Although this FY 2006 FISMA audit is not yet over 1 year old, it contains 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 of 1978*, Public Law 95-452, as amended by the *Inspector General Act Amendments of 1988*, Public Law 100-504, and the *Omnibus Consolidated Appropriations Act of 1997*, Public Law 104-208.

The *Federal Financial Management Improvement Act of 1996*, Public Law 104-208, 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. VA reported that it substantially met its milestones for FY 2007 based on its most recent status reports (August and September).

| IG Act References | Reporting Requirements | Status |
|---|---|---|
| Section 4 (a) (2) | Review of legislative, regulatory, and administrative proposals | Commented on 595 items |
| Section 5 (a) (1) | Significant problems, abuses, and deficiencies | See pages 7-23 |
| Section 5 (a) (2) | Recommendations with respect to significant problems, abuses, and deficiencies | See pages 7-23 |
| Section 5 (a) (3) | Prior significant recommendations on which corrective action has not been completed | See pages 29-31 |
| Section 5 (a) (4) | Matters referred to prosecutive authorities and resulting prosecutions and convictions | See pages 7-23 |
| 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 24-28 |
| Section 5 (a) (7) | Summary of each particularly significant report | See pages 7-23 |
| Section 5 (a) (8) | Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports | See page 33 |
| 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 33 |
| 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 33 |
| 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 the *Federal Financial Management Improvement Act of 1996* (Public Law 104-208) | 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 3/31/07 | 0 | $0 |
| Issued during reporting period | 1 | $0.2 |
| **Total inventory this period** | **1** | **$0.2** |
| Management decisions during the reporting period | | |
| Disallowed costs (agreed to by management) | 1 | $0.2 |
| Allowed costs (not agreed to by management) | 0 | $0 |
| **Total management decisions this reporting period** | **1** | **$0.2** |
| **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 3/31/07 | 0 | $0 |
| Issued during reporting period | 4 | $89.8 |
| **Total inventory this period** | **4** | **$89.8** |
| Management decisions during the reporting period | | |
| Agreed to by management | 4 | $89.8 |
| Not agreed to by management | 0 | $0 |
| **Total management decisions this reporting period** | **4** | **$89.8** |
| **Total carried over to next period** | **0** | **$0** |

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**Washington, DC 20420**

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