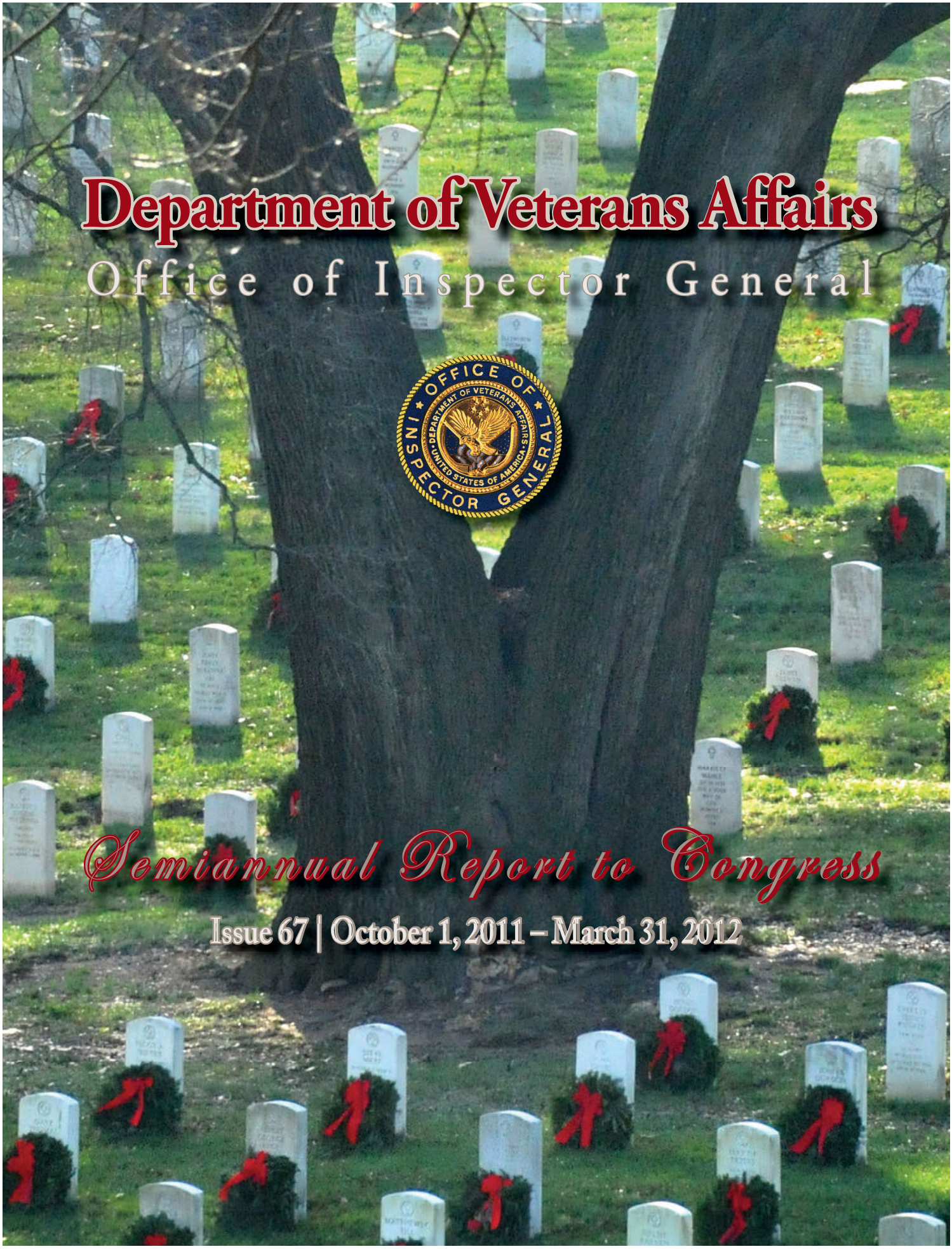

Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 67 | October 1, 2011 – March 31, 2012

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Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our most significant accomplishments during the reporting period October 1, 2011 – March 31, 2012.

During this reporting period, the Office of Inspector General (OIG) issued 140 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $1.5 billion in monetary benefits, for a return on investment of $32 for every dollar expended on OIG oversight.

OIG criminal investigators closed 553 investigations, and made 268 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work also resulted in 292 administrative sanctions and corrective actions.

Our Office of Investigations continues to aggressively pursue allegations concerning ineligible businesses that fraudulently obtain VA contracts set aside for Service-Disabled Veteran-Owned Small Businesses (SDVOSB). During this reporting period, seven individuals associated with four companies were arrested on a variety of Federal charges for their involvement in SDVOSB and related fraud. One of the defendants was a retired VA employee who pled guilty to accepting approximately $20,000 in cash, luxury baseball tickets, meals, and entertainment expenses from two Government contractors while he was steering $3.4 million in SDVOSB set-aside contracts to his co-defendants. All defendants and companies in these SDVOSB investigations have either been suspended or debarred from being awarded Federal contracts or have been referred to the Suspension and Debarment Committee for action.

Additional OIG investigative work, with significant assistance from our Office of Audits and Evaluations, resulted in the convictions of a former VA employee and a court-appointed fiduciary who embezzled nearly $900,000 from 10 separate Veteran beneficiary accounts. Both defendants were each sentenced to 36 months in prison. In another case, a multi-agency investigation led by OIG resulted in the conviction of an individual who was operating an Internet printing business that sold counterfeit military awards and training certificates from all service branches, as well as law enforcement awards and training certificates.

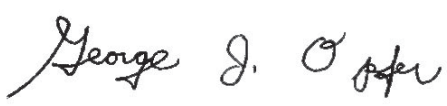
The Offices of Audits and Evaluations and Healthcare Inspections have made prosthetic limb management and care a primary focus of their work this reporting period. OIG published the first ever study to characterize the population of 1,288 Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND) service members with major traumatic amputations. OIG found Veterans with traumatic amputations are a complex population with a variety of medical conditions and are significant users of all VA health care services, not just prosthetic services. Furthermore, OIG found that OEF/OIF/OND Veterans generally were adapting to living with their amputations. However, Veterans with upper extremity amputations consistently did not fare as well as those Veterans with lower extremity amputations in their psychosocial adaptation, activity limitation, and prosthetic satisfaction.

Additional OIG work on prosthetics focused on evaluating the management and acquisition practices used by the Veterans Health Administration (VHA) to procure prosthetic limbs, and VA medical center (VAMC) management of prosthetic inventories. OIG found overpayments for prosthetic limbs were a systemic issue in VHA. If payment controls are not strengthened, VHA could continue to process improper payments over the next 4 years with potential overpayments totaling $8.6 million. OIG's work on prosthetic inventory management revealed that VHA cannot accurately account for prosthetic inventories. As a result, VAMCs spent about $35.5 million buying prosthetics in excess of current needs—increasing the risks of supply expiration and waste.

OIG's audit of VA's internal controls over the use of disability benefits questionnaires (DBQs) found that the Veterans Benefits Administration (VBA) needs more proactive measures to prevent and detect fraud. Although VBA has a quality assurance review process for DBQs, it verifies only a limited number of DBQs and does so after claims are awarded. These quality assurance reviews do not provide reasonable assurance that fraud will be detected in the DBQ program as it accepts claims. Given VBA's plans to deploy over 80 DBQs, it is important that adequate controls be put in place to protect future financial benefits payments.

OIG oversight work on VHA's Veterans Integrated Service Networks (VISNs) identified weaknesses in VISNs' stewardship of funds in the areas of travel, leased office space, and performance awards. OIG found that VHA lacked financial and budgetary controls and reliable staffing and expenditure data to monitor the VISN offices, evaluate their performance relative to their operational costs, and ensure the effective and efficient use of funds. As a result, VISN operating costs have increased over 500 percent above the original estimate of $26.7 million that VHA provided when it first established the VISN offices. Additionally, OIG found VHA lacked the management controls needed to oversee and evaluate the effectiveness of VISN staff and organizational structures. The VISN offices' autonomy allowed for unchecked lapses in office growth, the performance management system, and the evaluation of fundamental staffing data. This resulted in unprecedented growth in organizational structures and staffing levels, ineffective oversight and stewardship of VA funds, and significant differences in management and operations between each of the VISN offices.

I want to express my appreciation for the hard work performed by our dedicated OIG employees who strive to execute OIG's mission to improve the economy, effectiveness, and efficiency of VA programs; and to prevent and to detect criminal activity, waste, abuse, and fraud. I also thank the Secretary, Deputy Secretary, and other senior Department officials and their staffs for their support of our work and receptiveness to our recommendations for improving VA programs and operations. We look forward to continuing our partnership with the Department and Congress in the months ahead to meet the many challenges facing VA as it works to ensure our Nation's heroes receive the care, support, and recognition they have earned in service to our country. Most of all, we thank our Veterans who have sacrificed generously and selflessly to protect our freedom.



GEORGE J. OPFER
Inspector General

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October 1, 2011 – March 31, 2012	
Monetary Impact (in Millions)	
Better Use of Funds	$47.8
Fines, Penalties, Restitutions, and Civil Judgments	$461.9
Fugitive Felon Program	$103.3
Savings and Cost Avoidance	$925.2
Questioned Costs	$4.9
Dollar Recoveries	$6.1
Total Dollar Impact	**$1549.2**
Cost of OIG Operations[1]	$48.5
Return on Investment (Total Dollar Impact/Cost of OIG Operations)	**32:1**
Reports Issued	
Audits and Evaluations	17
Benefits Inspections	11
National Healthcare Reviews	3
Hotline Healthcare Inspections	21
Combined Assessment Program Reviews	24
Community Based Outpatient Clinic Reviews (encompassing 49 facilities)	10
Administrative Investigations	4
Preaward Contract Reviews	35
Postaward Contract Reviews	13
Claim Reviews	2
Total Reports Issued	**140**
Investigative Activities	
Arrests (Not including Fugitive Felons)	243
Fugitive Felon Arrests	25
Fugitive Felon Apprehensions by Other Agencies with OIG Assistance	16
Indictments	163
Criminal Complaints	98
Convictions	197
Pretrial Diversions and Deferred Prosecutions	26
Administrative Investigations Opened	15
Administrative Investigations Closed	18
Advisories Issued	6
Closing Reports on Unsubstantiated Allegations	13
Administrative Sanctions and Corrective Actions	292
Cases Opened	524
Cases Closed	553

Statistical Highlights

October 1, 2011 – March 31, 2012	
Healthcare Inspections Activities	
Clinical Consultations	2
Administrative Case Closures	7
Hotline Activities	
Cases Opened	526
Cases Closed	550
Administrative Sanctions and Corrective Actions	227
Substantiation Percentage Rate	36
Contacts	14,103

1. Beginning in 2009, the 6-month and annual cost of operations for the Office of Healthcare Inspections ($10.07 million and $20.14 million, respectively, for fiscal year 2012), whose oversight mission results in improving the health care provided to Veterans rather than saving dollars, is not included in the return on investment calculation.

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) 2012, VA is operating under a $124.2 billion budget, with over 317,000 employees serving an estimated 22.2 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, the Republic of the Philippines, and the U.S. Virgin Islands.

VA has three administrations that serve Veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration provides interment and memorial benefits. For more information, please visit the VA Internet home page at www.va.gov.

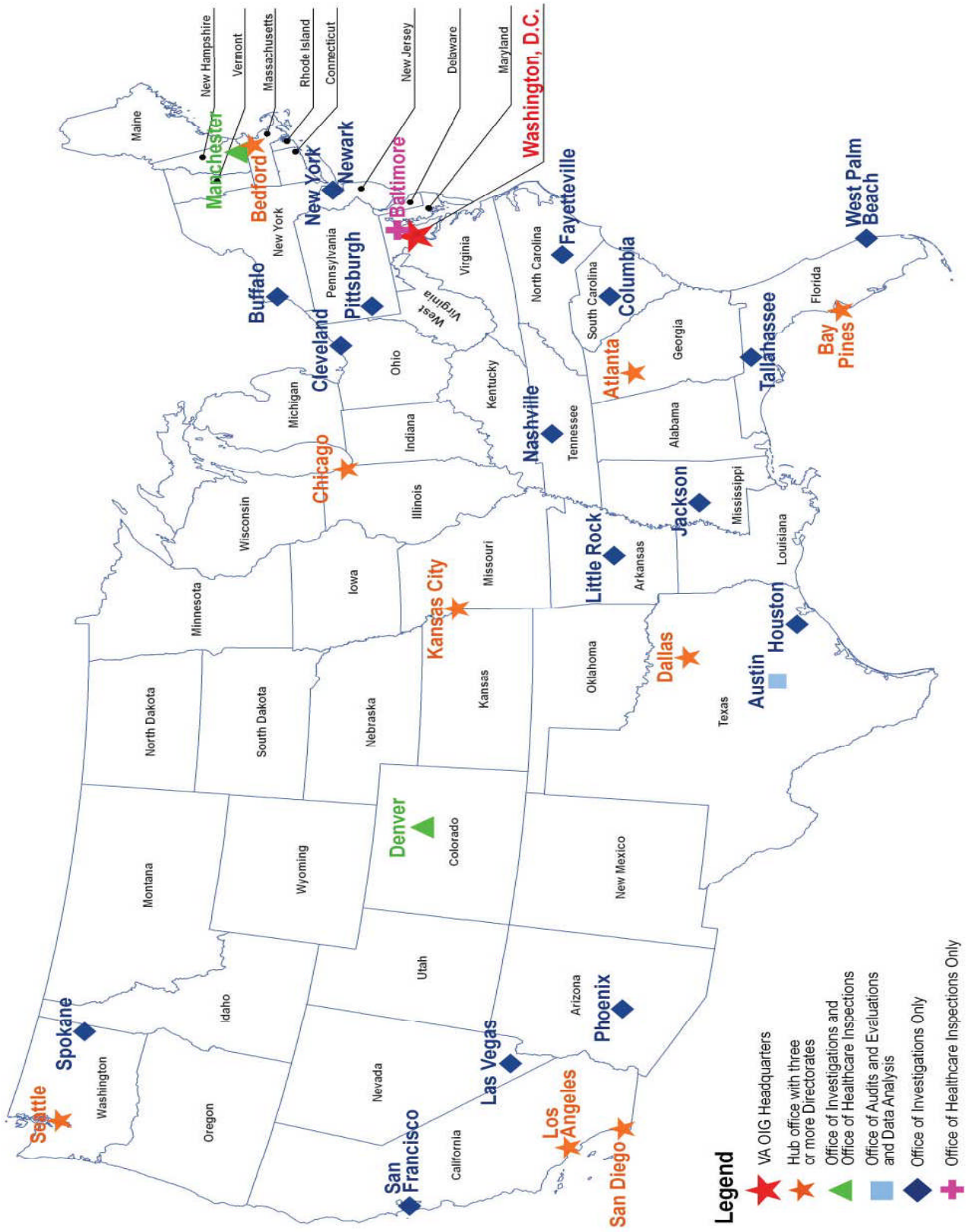
VA Office of Inspector General

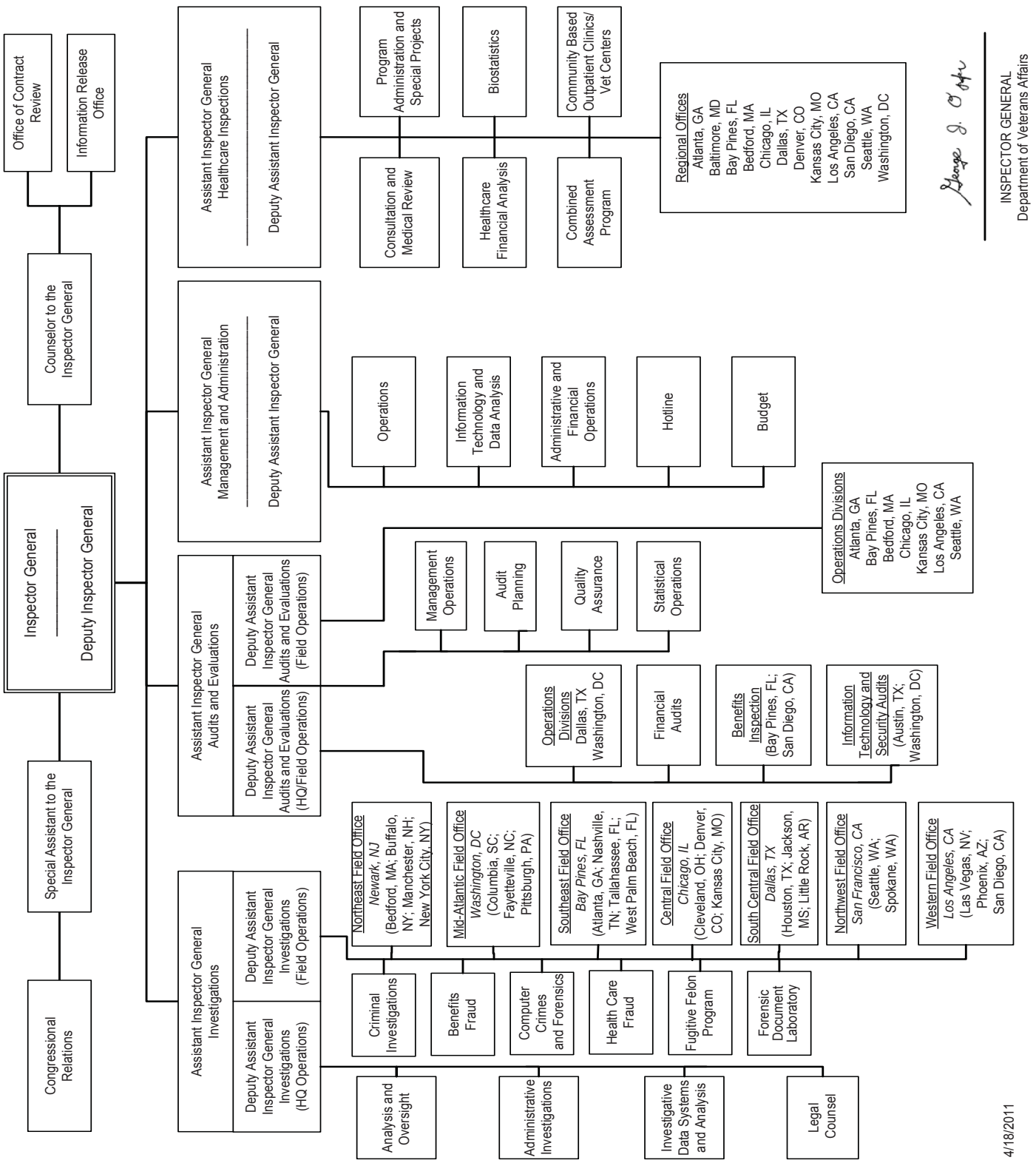
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (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 and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 609 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2012 funding for OIG operations provides $112.4 million from ongoing appropriations. The Office of Contract Review, with 25 employees, receives $4.7 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, construction, and health care provider 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 strive 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.

OIG Field Offices Map




Inspector General
Deputy Inspector General
Office of Contract Review
Information Release Office
Counselor to the Inspector General
Special Assistant to the Inspector General
Congressional Relations
Assistant Inspector General Healthcare Inspections
Deputy Assistant Inspector General
Program Administration and Special Projects
Biostatistics
Community Based Outpatient Clinics/ Vet Centers
Consultation and Medical Review
Healthcare Financial Analysis
Combined Assessment Program
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Bay Pines, FL
Bedford, MA
Chicago, IL
Dallas, TX
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Dallas, TX
Washington, DC
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Benefits Inspection
(Bay Pines, FL; San Diego, CA)
Information Technology and Security Audits
(Austin, TX; Washington, DC)
Assistant Inspector General Investigations
Deputy Assistant Inspector General Investigations (Field Operations)
Deputy Assistant Inspector General Investigations (HQ Operations)
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(Bedford, MA; Buffalo, NY; Manchester, NH; New York City, NY)
Mid-Atlantic Field Office
Washington, DC
(Columbia, SC; Fayetteville, NC; Pittsburgh, PA)
Southeast Field Office
Bay Pines, FL
(Atlanta, GA; Nashville, TN; Tallahassee, FL; West Palm Beach, FL)
Central Field Office
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(Cleveland, OH; Denver, CO; Kansas City, MO)
South Central Field Office
Dallas, TX
(Houston, TX; Jackson, MS; Little Rock, AR)
Northwest Field Office
San Francisco, CA
(Seattle, WA; Spokane, WA)
Western Field Office
Los Angeles, CA
(Las Vegas, NV; Phoenix, AZ; San Diego, CA)
Criminal Investigations
Benefits Fraud
Computer Crimes and Forensics
Health Care Fraud
Fugitive Felon Program
Forensic Document Laboratory
Analysis and Oversight
Administrative Investigations
Investigative Data Systems and Analysis
Legal Counsel
INSPECTOR GENERAL
Department of Veterans Affairs
4/18/2011

The health care that VHA provides Veterans is ranked consistently among the best in the Nation, whether those Veterans are recently returned from Operations Enduring Freedom, Iraqi Freedom, or New Dawn (OEF/OIF/OND), 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. The OIG Office of Healthcare Inspections focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 3 national healthcare reviews; 21 Hotline healthcare inspections; 24 Combined Assessment Program (CAP) reviews; and 10 Community Based Outpatient Clinic (CBOC) reviews, covering 49 facilities, to evaluate the quality of care. These reports are listed in Appendix A.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities; their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 24 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission. Topics generally run for 6–12 months; the CAP topics under review from October 1, 2011 – March 31, 2012 were:

- Coordination of Care.
- Colorectal Cancer Screening.
- Environment of Care.
- Medication Management.
- Moderate Sedation.
- Poly Trauma.
- Psychosocial Rehabilitation and Recovery Centers.
- Quality Management.

When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use. During this reporting period, OIG issued one CAP summary report regarding VHA's management of multidrug-resistant organisms.

Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany House Resolution 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG initiated a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review.

The objectives of the reviews for the period October 1 – December 31, 2011, were to determine whether:

- Short-term fee-basis authorization and follow-up processes for selected outpatient radiology consults ensure quality and timely patient care.
- CBOCs comply with selected VHA requirements regarding the provision of mammography services for women Veterans.

- CBOC providers are appropriately credentialed and privileged in accordance with VHA policy.
- CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency planning.
- Primary care and mental health (MH) services provided at contracted CBOCs are in compliance with contract provisions and whether VA contract oversight was effective.
- CBOCs comply with selected standards in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers (VAMCs) and Clinics, regarding the management of MH emergencies.
- CBOCs have a skills competency assessment and validation policy and process in place.
- Primary care active panel management and reporting are in compliance with VHA policy.

The objectives of the reviews for the period January 1 – March 31, 2012, included the first five objectives listed above and added the following:

- Determine if CBOCs have implemented the management of Diabetes Mellitus-Lower Limb Peripheral Vascular Disease in order to prevent lower limb amputation.
- Assess the continuity of care for enrolled CBOC patients discharged from the parent facility in FY 2011 with a primary diagnosis of congestive heart failure.
- Determine if CBOC procedures regarding traveling Veterans are performed in accordance with VHA directives.

During this reporting period, OIG performed 49 CBOC reviews throughout 14 Veterans Integrated Service Networks (VISNs). These reviews were captured in 10 reports. We made recommendations for improvements at the following facilities:

- VISN 1: Framingham, New Bedford, and Springfield, MA; Littleton, NH; and Bennington, VT
- VISN 2: Catskill, Clifton Park, Elmira, Glens Falls, Jamestown, Lackawanna, and Schenectady, NY
- VISN 5: Hagerstown, MD, and Petersburg, WV
- VISN 7: Florence, Rock Hill, and Sumter (Sumter County), SC
- VISN 8: Ft. Pierce and Okeechobee, FL
- VISN 9: Charleston and Williamson, WV
- VISN 10: Mansfield and New Philadelphia, OH
- VISN 16: Pensacola (Joint Ambulatory Care Center), FL
- VISN 17: New Braunfels, San Antonio (North Central Federal Clinic), and Victoria, TX
- VISN 18: Durango, CO; Raton and Silver City, NM; and Odessa, TX
- VISN 19: Montrose and Pueblo, CO; and Gillette and Powell, WY
- VISN 21: Chico, McClellan, and Oakland, CA; Agana Heights, GU; and Hilo, HI
- VISN 22: Anaheim, Escondido, Laguna Hills, Lancaster, Oceanside, and Sepulveda, CA
- VISN 23: Bellevue, Lincoln, and Norfolk, NE

National Healthcare Reviews

OIG Publishes First Ever Study of VA's Capacity to Care for Veterans with Traumatic Amputations

At the request of the Chairman of the House Committee on Veterans' Affairs, OIG conducted a review to evaluate VA's capacity to deliver prosthetic care. By analysis of integrated data from VA and the Department of Defense (DoD) for nearly 500,000 Veterans, OIG found Veterans with traumatic amputations are a complex population with a variety of medical conditions and are significant users of all VA health care services, not just prosthetic services. Furthermore, this is the first ever study to characterize the population of 1,288 OEF/OIF/OND service members with major traumatic amputations. OIG found that OEF/OIF/OND Veterans generally were adapting to living with their amputations. However, Veterans with upper extremity amputations consistently did not fare as well as those Veterans with lower extremity amputations in their psychosocial adaptation, activity limitation, and prosthetic satisfaction. OIG recommended that VHA consider: (1) the wide-ranging medical needs of traumatic amputees beyond the prosthetic and MH concerns identified in this report; then adjust, if necessary, the provision and management of health care services accordingly; (2) evaluating the needs of Veterans with traumatic upper limb amputations to improve their satisfaction; and (3) Veterans' concerns with VA approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of Veterans with amputations. VHA concurred with our recommendations and provided acceptable action plans.

Clearer Risk Warnings Needed for Chronic Kidney Patients Undergoing Procedures with Contrast Media

The OIG assessed the extent to which informed consent was documented for Veterans with chronic kidney disease who underwent procedures that involved intravascular injection of contrast media, and described efforts to minimize kidney injury. OIG identified 107 patients with pre-existing kidney impairment who underwent cardiac catheterizations or peripheral vascular procedures during April 1–July 30, 2010. These patients needed to be aware of their higher risk of kidney injury in order to give informed consent. OIG found that, although 101 patients (94 percent) signed informed consent documents, only 24 informed consent documents (22 percent) included any information about the risk of kidney injury. Explicit reference to the increased risk of kidney injury associated with contrast media for patients with pre-existing kidney disease was present in only two informed consent documents. However, practitioners evidently were aware of the increased risk of kidney injury because they ordered interventions to mitigate kidney injury in 93 percent of these high-risk patients. OIG recommended that the Under Secretary for Health implement a plan to ensure that patients with chronic kidney disease who are undergoing procedures requiring contrast media be provided sufficient information to give informed consent.

Better Education Could Further Reduce Risk of Multidrug-Resistant Organism Infection

OIG evaluated the management of multidrug-resistant organisms (MDRO) in VHA facilities by determining whether facilities complied with applicable guidelines and standards regarding MDRO, hand hygiene, isolation, and environmental cleanliness and whether facilities adequately communicated about patients infected or colonized with MDRO. OIG conducted this review at 24 facilities during CAP reviews performed from October 1, 2010, through March 31, 2011. VHA facilities recognized the importance of establishing and maintaining measures to reduce the incidence of health care-associated infections due to MDRO. OIG identified three areas where compliance with MDRO requirements needed improvement and recommended that patients infected or colonized with MDRO and their families receive infection prevention strategies education, that facilities provide MDRO education to designated staff based on risk

assessment results, and that facilities develop policies and programs that control and reduce antimicrobial agent usage.

Hotline Healthcare Inspections

Kansas Clinic Faulted for Mismanaging Patient's Care; Reporting of Death, Triage, Physician Supervision Also Criticized

An inspection was conducted by OIG to determine the validity of allegations regarding the quality of care at the Salina, KS, CBOC. OIG substantiated the allegation that the care of the patient was mismanaged. OIG was unable to determine and did not assert that a more prompt medical response would have resulted in preventing the patient's death. OIG found lack of proper, timely reporting of this death at multiple levels, but could not substantiate that there was an institutional attempt by Salina CBOC or facility staff to "cover-up" the mismanagement of the patient's care; that the Root Cause Analysis (RCA) was perfunctory or lacking in sufficiently strong recommendations; and that facility management may have taken adverse action against the individual who reported the incident. OIG found inadequate triage practices, physician supervision, and physician availability on the day of the events in question; oversight reviews of all the relevant clinicians who were, or should have been, involved in the patient's care were not performed; and that adversarial staff relationships existed at the CBOC which may have impeded effective staff communication about the patient in this case. Additionally, OIG found that some issues identified during the RCA were not fully corrected. Six recommendations were made to improve operations.

OIG Finds Durham, North Carolina, VAMC Failed To Take Promised Actions To Help Veterans With Home Improvement Grants

The OIG performed a follow-up review of the Durham, NC, VAMC, based on a complaint that recommendations from our previous report, *Prosthetic and Sensory Aids Service Records Review* (Report No. 11-01416-212, July 7, 2011), had not been fully implemented. The original report, completed at the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs, made several recommendations to improve the management of the Prosthetics and Sensory Aids program. Due to additional allegations we conducted this second review. The facility response outlines significant steps to strengthen controls and oversight over the Prosthetic and Sensory Aids Service.

Delayed Lung Cancer Diagnosis Allegations Not Substantiated at Southern Arizona Clinic

At the request of Senator Jon Kyl, the OIG conducted an inspection to determine the validity of allegations concerning delay in cancer diagnosis and treatment at a Southern Arizona VA Health Care System (HCS) CBOC. OIG did not substantiate the allegation that a CBOC provider failed to address the patient's complaints of fatigue and shortness of breath. OIG substantiated the allegation that the patient did not receive a chest x-ray for a period between 2007 through his final CBOC visit in February 2011. OIG could not substantiate the allegation of delayed diagnosis of lung cancer because it is conjectural whether a chest x-ray would have revealed a lung cancer when the patient was seen in 2010. OIG determined that the provider did not fully evaluate the cause of the patient's shortness of breath once cardiac causes had been ruled out and did not directly address the patient's gradual weight loss. The Southern Arizona VAHCS had already implemented quality assurance measures to address the issues raised in our review. We made no recommendations.

OIG Did Not Substantiate Quality of Care Issues at Edward Hines, Jr. , VA Hospital, Hines, Illinois

At the request of Congressman Peter Roskam's office, the OIG conducted an inspection and oversight review to determine the validity of allegations regarding the quality of care received by a patient at the Edward Hines, Jr., VA Hospital, Hines, IL. OIG did not substantiate the allegations that the patient did not receive help with his activities of daily living, or receive ordered rehabilitative treatments during his respite care admission. OIG substantiated that the patient was seen by two staff physicians and a resident physician during his 5-hour stay in the emergency department (ED), but did not substantiate that the physicians did not communicate or coordinate care for the patient. OIG substantiated the allegation that the patient did not receive rehabilitative treatments during his inpatient stay and while acutely ill; however, he did not meet the criteria for an intervention. OIG did not substantiate the allegations that he had a Foley catheter inserted, or that discharge instructions and medication reconciliation were not provided. OIG made no recommendations.

VA Resolves Infection Control Issues at Dayton Dental Clinic, Ongoing Monitoring Processes Adopted To Ensure Patient Safety

A review was conducted by OIG to follow-up on the report, *Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, OH* (Report No. 10-03330-148, April 25, 2011). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented. In the past 18 months, facility managers have taken appropriate actions and the conditions identified in the 2011 OIG report were resolved. Monitoring processes are in place to ensure ongoing compliance with standards. OIG considers the recommendations closed.

OIG Reviews Circumstances Surrounding Veteran's Self-Extubation and Subsequent Death at Edward Hines Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection at the Edward Hines Jr. VA Hospital, Hines, IL, at the request of the Chicago, IL, OIG Office of Criminal Investigations Division. The inspection did not substantiate that substandard quality of care contributed to the self-extubation and subsequent death of a Veteran, and found that facility staff (the intensive care managers, respiratory care services manager, risk managers, and performance improvement managers) had reviewed the incident and developed performance improvement procedures. The inspection also revealed that the Biomedical Engineering Department installed metal cages to prevent tampering, silencing, and disabling the telemetry alarms at the central nurses' station in the medical and surgical intensive care units. However, the design of the cages does not prevent disabling of the alarms. OIG recommended reporting the incident to the VA National Center for Patient Safety to decrease the potential for poor patient outcomes. The VISN and Facility Directors agreed with the findings and recommendations.

Sacramento VA's Anesthesia Service Leadership, Staffing Found Lacking; Patient Privacy Breach Also Noted

OIG conducted an oversight inspection to review actions taken to address a complainant's allegations that an anesthesiologist provided inadequate care to two patients, leadership did not take effective actions to address Anesthesia Service operational issues, and providers breached patient privacy policy at the Sacramento VAMC, Mather, CA. OIG did not substantiate the allegation that the subject anesthesiologist provided inadequate anesthesia care. OIG substantiated the allegations that VAMC leaders had not taken effective actions to resolve Anesthesia Service's operational issues and that VAMC providers breached patient privacy and VA information security policies. OIG recommended that the VAMC Director: (1) comply with the Anesthesia Service's leadership and staffing requirements as detailed in the VISN Team report; (2) implement processes to formally monitor patient outcomes in the operating room (OR) and promote a culture of patient safety in the OR, and address the concerns raised by the

VISN team in its review of the Surgery and Anesthesia Services; and (3) consult with Regional Counsel to determine whether patient notification of a breach in privacy is required. Management agreed with the recommendations and provided acceptable action plans.

Pressure Ulcer and Privacy Incident Management Should Be Strengthened at Northport, New York, VAMC

The OIG conducted a review to determine the validity of allegations that residents were malnourished and abused, staff supported residents' sexual activities in inappropriate ways, and that staff removed confidential employee information from the medical center. OIG did not substantiate the allegations of malnutrition, abuse, or that staff supported resident's sexual activities in inappropriate ways. However, OIG did find the pressure ulcer rates at the facility were higher than benchmarks. OIG could not substantiate or refute the allegation that staff removed confidential employee information from the medical center, or the lack of Nurse Manager's action. However, OIG did find that medical center staff did not provide timely communication and follow-up for a breach of privacy related to resident identification bands. OIG recommended processes be strengthened to improve pressure ulcer management in the community living center units. OIG also recommended that privacy incidents be managed in accordance with VA policy related to timely follow-up and patient notification. The VISN and Medical Center Directors agreed with our findings and recommendations.

Quality of Care Allegations Against Northport, New York, VAMC ED Not Substantiated

OIG performed an inspection to determine the validity of allegations regarding quality of care in the ED at the Northport, NY, VAMC. Specifically, a complainant alleged that: (1) a Northport VAMC ED physician failed to diagnose an acute myocardial infarction; and (2) a Northport VAMC ED physician behaved unprofessionally. OIG did not substantiate the allegation that a VAMC ED physician failed to diagnose an acute myocardial infarction. While the patient in question was ultimately shown to have had an acute myocardial infarction, OIG found that the physician in question initiated an appropriate evaluation for a patient presenting to an ED with atypical chest pain. The physician obtained a targeted history and physical examination, an electrocardiogram, and appropriate blood tests. However, the patient refused to remain in observation and left against medical advice, cutting short his evaluation. OIG did not substantiate the allegation that the ED physician behaved unprofessionally. OIG did not find evidence that the physician yelled at another patient as alleged, nor did we find evidence of any other unprofessional behavior by the physician. OIG made no recommendations.

Triage, Communication, and Referral Practices Between ED and Primary Care in Need of Improvement at Dallas VAMC

OIG conducted an inspection to determine the validity of allegations concerning quality of care, safety, and management issues in the ED at the Dallas, TX, VAMC. OIG substantiated allegations of inadequate triage practices by registered nurses (RNs), poor communication, and inappropriate referrals of patients from the primary care clinics (PCCs) to the ED. OIG did not substantiate allegations of a delayed admission, poor surgery response to ED consultation requests, inadequate staffing, inappropriate scheduling of physicians, and excessive verbal and physical assaults on ED staff. Additionally, OIG identified improvement opportunities related to orthopedic consultations, the work environment, and the inter-facility transfer process. OIG recommended that the Facility Director ensure that: (1) RN triage practices are consistently performed and that training is completed; (2) communication between the ED and PCCs is improved; (3) managers monitor orthopedic surgery response timeliness; (4) ED managers and staff undergo training to help promote a positive work environment; and (5) the current inter-facility process is assessed and that appropriate administrative support is provided for required paperwork. Management agreed with the findings and recommendations and provided acceptable action plans.

Treatment Delays, Understaffing Found at Buffalo, New York, VAMC ED

The merit of allegations concerning quality of care and physician staffing were assessed in the ED of the VA Western New York HCS, Buffalo, NY. OIG substantiated the allegation that two patients did not receive adequate evaluation and management in the ED. The same physician evaluated both patients and both patients returned to the ED and required admission. OIG did not substantiate quality of care concerns for a third patient. Facility managers had identified quality of care concerns with this physician, yet they had not taken appropriate corrective actions in response to these concerns. OIG substantiated the allegation that the ED was understaffed and that physicians often worked excessive clinical hours. OIG also substantiated that the facility was on diversion overnight while two physicians were staffing the ED and inpatient beds were available. However, OIG did not identify any patients who were diverted to local hospitals. Four recommendations were made to improve quality of patient care and staffing in the ED, as well as to follow-up on quality of care concerns raised in specific cases. The VISN and Interim Facility Directors agreed with the findings and recommendations and provided acceptable action plans.

Emergency Calls to San Diego Call Center Not Properly Triaged, Staff Training and Better Management Oversight Needed

OIG conducted an inspection to determine the validity of multiple allegations regarding the management of emergency calls at the Primary Care Call Center (PCCC), VA San Diego HCS, San Diego, CA. OIG substantiated the allegations that PCCC agents were not following established procedures for referring emergency calls for triage, PCCC agents were inexperienced and lacked appropriate training, and managers did not evaluate the root causes of identified ongoing problems. OIG concluded that the PCCC had serious problems that put patients at risk. OIG recommended that the System Director ensure that Managers monitor PCCC agents' compliance with procedures, and re-evaluate processes to ensure all emergency calls are routed appropriately; PCCC agents receive initial training on required competencies and that competencies are confirmed annually thereafter; and RCA in response to patient event reports are completed and appropriate action taken as needed. The VISN and HCS Directors concurred with OIG's findings and recommendations and provided acceptable action plans.

Better Medical Documentation, Staff Training Could Reduce Risk to Patients on a Telemetry Unit at New York Harbor HCS

OIG conducted a review to determine the validity of an allegation regarding the quality of patient care on a telemetry unit at the Manhattan Campus of the New York Harbor HCS, New York, NY. OIG could neither confirm nor refute the allegation that a patient on the telemetry unit was not continuously monitored due to a disconnected telemetry lead, malfunctioning monitoring equipment, or short staffing. However, OIG identified two system weaknesses that increased the risk of patients not being adequately monitored: (1) medical record documentation by unit staff did not meet industry or facility requirements; and (2) telemetry unit nursing and biomedical engineering staff were not trained to properly use the telemetry monitoring equipment. OIG made two recommendations to address these system weaknesses. Management agreed with the findings and recommendations and provided acceptable improvement plans.

Most Allegations on Electroconvulsive Therapy at Boston HCS Unsubstantiated, But Machine Quality Checks Lacking

OIG conducted a review to determine the validity of allegations that patients were not medically optimized prior to electroconvulsive therapy (ECT) and that a patient underwent ECT without consent or the knowledge that ECT could be refused. OIG did not substantiate these allegations and other allegations related to improprieties in ECT research and inpatient MH unit census. OIG did substantiate that although local maintenance was performed annually, the ECT machine was not sent to the manufacturer every

2 years for a full quality control check, and that a psychiatrist initiated, but did not complete, electronic medical record notes for residents she supervised. OIG recommended that the HCS Director implement procedures to ensure that the manufacturer's recommended maintenance for the ECT machine is followed as prescribed.

Use of Restraints at Salem, Virginia, VAMC Found To Be Appropriate

OIG conducted an inspection to determine the validity of allegations regarding the use of restraints at the Salem, VA, VAMC. A complainant alleged that a nurse made comments that provoked a patient into striking two staff members, which resulted in the patient being kept in restraints as punishment for more than 24 hours. The complainant also alleged that facility leadership did not respond to past reported allegations of other patient mistreatment. OIG did not substantiate the allegations. OIG found no evidence that a nurse provoked the patient to act out, or that the patient was kept in restraints as a form of punishment. The initiation and continued use of restraints was appropriate and adequately documented to ensure the patient and staff members' safety. We found that facility leaders investigated the patient's mistreatment allegations and determined that no further action was required. OIG identified an opportunity to improve the observation and 15-minute check sheets used for patients in restraints. OIG discussed this with facility leaders while onsite. Therefore, we made no recommendations.

OIG Did Not Substantiate Discharge, Travel, and Treatment Issues at Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri

OIG evaluated allegations of premature discharge, excessively long travel distance, and unsuccessful treatment in a patient with end-stage liver disease. These complaints related to two episodes of VA fee-based care at a St. Louis area private-sector hospital. OIG did not substantiate the complainant's allegation that "someone dropped the ball" in the care of this patient. The patient was referred by providers at the Harry S. Truman Memorial Veterans' Hospital to a qualified private-sector specialist for a transjugular intrahepatic portosystemic shunt procedure. The patient and his wife were aware of the rationale for the procedure, location of the private sector hospital, and the potential complications. The patient was discharged in stable condition, and the medical record reflects adequate communication between the various medical providers to ensure continuity of care. OIG made no recommendations.

Poor Coordination of Care and Resource Allocation Not Substantiated for VISN 20 and Southern Oregon Rehabilitation Center and Clinics, White City, Oregon

OIG evaluated the validity of allegations regarding poor coordination and resource allocation within VISN 20 and at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. OIG did not substantiate allegations regarding poor coordination of care and resource allocation in regard to SORCC. While patients do encounter delays in gaining access to specialty services in non-emergent situations, we found that SORCC, in conjunction with VISN 20, is actively engaged in a process to improve timeliness of surgical and imaging services for its beneficiaries. OIG did not substantiate that care reviewed in orthopedic surgery, neurologic surgery, and imaging services was below VA standards. OIG found that the completion of consults and the delivery of recommended treatments at SORCC occurred in compliance with prioritization as outlined in VA's Federal Benefits for Veterans, Dependents, and Survivors. While timeliness of surgical specialty referral appointments and care is not always optimal, this does not equate to a breach in VA standards. OIG made no recommendations.

Veterans at Temple, Texas, Not Receiving Timely Specialty Medical Care, Accuracy of VA Wait Times Data Questioned

OIG conducted an inspection to determine the validity of allegations regarding patient care delays and reusable medical equipment (RME) concerns at the Olin E. Teague VAMC in Temple, TX. A complainant alleged that: (1) hundreds of scheduled gastroenterology (GI), mammogram, radiation oncology, and breast biopsy fee-basis consults dating back to 2009 place the health of patients at risk; (2) prolonged wait times for GI care lead to delays in diagnosis of colorectal and other cancers; and (3) RME issues have not been properly addressed, including unclean scopes that were almost used on patients, equipment failures, and use of new equipment without an approved standard operating procedure. OIG substantiated hundreds of fee-basis GI, mammogram, radiation oncology, and breast biopsy consults requiring action; however, OIG did not find evidence of patient harm due to delays in follow-up. OIG substantiated GI wait times in excess of VHA requirements following initial positive screenings. In addition, staff indicated that appointments were routinely made incorrectly by using the next available appointment date instead of the patient's desired date. OIG did not substantiate that RME issues have not been properly addressed. OIG made three recommendations.

OIG Reviews Allegations Regarding Minneapolis, Minnesota, Outpatient Dental Clinic

OIG conducted an inspection to determine the validity of allegations regarding a failure to obtain informed consent, communicate the plan of care to family and non-VA nursing home (NH) staff, and provide appropriate care after a dental procedure at the Minneapolis, MN, VAHCS outpatient dental clinic. OIG did not substantiate that the provider failed to obtain informed consent prior to extracting multiple teeth. The provider determined that the patient had decision-making capacity and was able to participate in the informed consent process on the day of the oral surgery procedure. OIG substantiated that family and NH staff were not aware of the planned extractions. Prior to OIG's arrival, the facility had taken steps to improve the content and flow of information between NHs and facility clinics. The facility subsequently established plans for additional improvement. OIG did not substantiate that VA failed to provide appropriate post-extraction care. OIG made no recommendations.

OIG Substantiated Delay in Hyperthyroidism Diagnosis, But Patient Outcome Not Negatively Impacted at Tennessee Valley HCS

The OIG evaluated allegations of a delay in Graves' disease diagnosis and treatment at a CBOC in the Tennessee Valley HCS. OIG substantiated that there was about a 6-week delay in initiating the appropriate work-up of a patient's hyperthyroidism. However, this delay did not cause a delay in treatment that harmed the patient or negatively impacted his outcome. OIG also found that other HCS providers failed to notify the patient of both abnormal and normal test results in a timely manner. OIG recommended that the HCS Director require that providers ordering laboratory, radiographic, and other tests and studies inform patients of test results and arrange for appropriate follow-up according to policy. The VISN and HCS Directors agreed with our report.

Veterans Health Administration Audits and Evaluations

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

Better Management of Prosthetics Inventories Could Save VA $35 Million and Avoid Disruptions to Patients

OIG conducted this audit to evaluate VAMCs' prosthetic inventory management. OIG found VHA cannot accurately account for prosthetic inventories. VAMC inventories exceeded current needs for almost 47 percent of approximately 93,000 specific prosthetic items and inventories were too low for nearly 11 percent of the items. As a result, VAMCs spent about $35.5 million buying prosthetics in excess of current needs—increasing the risks of supply expiration. Inaccurate inventories disrupt patient care due to shortages and lead to losses associated with diversion. OIG recommended the Under Secretary for Health develop plans to implement an improved inventory system and develop a training-to-certification program for prosthetic inventory managers. The Under Secretary for Health concurred with our findings.

VA Can Save Almost $11M with Better Controls Over Payments for Prosthetic Limbs

At the request of the House Veterans' Affairs Committee Chairman, OIG evaluated the management and acquisition practices the VHA used to procure prosthetic limbs. In each of the last 5 years, VHA has served nearly 12,000 amputees. VA procures prosthetic limbs or fabricates them in prosthetic labs. OIG found overpayments for prosthetic limbs were a systemic issue in VA. Of the 3,900 payments examined by OIG, 915 (23 percent) included overpayments. These overpayments were valued at about $2.2 million for FY 2010 and collection actions are in process to recover these overpayments. VHA could continue to process improper payments over the next 4 years if it does not strengthen controls over payments. OIG estimated the value of these potential overpayments at $8.6 million. Finally, VHA management did not know the current capabilities of their labs. Overall, VHA needs to strengthen management and acquisition practices to procure and fabricate prosthetic limbs. The Under Secretary for Health concurred with our findings and recommendations.

Homeless Veteran Program Lacks Safety, Security & Health Standards, Better Grant Evaluation Process & Oversight Needed

OIG conducted this audit to determine whether community agencies receiving funds from the Grant and Per Diem Program (GPDP) are providing services to homeless Veterans as agreed upon in their grant agreements. OIG also examined whether program funding is effectively aligned with program priorities. OIG found the VHA GPDP provided services to homeless Veterans and had successfully assisted Veterans to live independently in safe and affordable permanent housing. However, an incomplete grant application evaluation process; a lack of program safety, security, privacy, and health and welfare standards; and an inconsistent monitoring program impacted the program's effectiveness. As a result, VHA did not ensure homeless Veterans consistently received the supportive services agreed to in approved grants. In addition, funding was not aligned effectively with program goals. OIG recommended strengthening the grant application and evaluation process by publishing policies and standards, updating the inspection checklists, and implementing procedures to ensure grant providers have the capability to deliver services. The Under Secretary for Health concurred with OIG's findings and recommendations and provided appropriate action plans.

Weak Controls Over Non-VA Fee Care Results in $11.4 Million Budget Shortfall at Phoenix, Arizona, HCS

The Phoenix, AZ, HCS allegedly experienced a budget shortfall at the end of FY 2010 due to mismanagement of their Non-VA Fee Care Program. OIG substantiated that the Phoenix HCS experienced an $11.4 million budget shortfall, which was equivalent to 20 percent of the Non-VA Fee Care Program funds for that year. The shortfall was due to the lack of effective pre-authorization procedures. They also lacked adequate procedures to obligate sufficient funds to pay for all fee care services processed during this period, over $56 million. In addition, HCS staff did not determine if the patients could receive services in a VA inpatient facility to avoid using the Non-VA Fee Care program. Since the discovery of the budget shortfall, the HCS has initiated several corrective actions to reduce the risk of future shortfalls and strengthen the management of their Non-VA Fee Care Program.

Audit Finds Major Acquisition Reviews Performed Only on 32 Percent of VA Contracts, $2.9M Could Be Saved with Competition

This audit examined how well recent major acquisition process changes strengthened the quality of VHA's contracts. The changes were not effective because new Integrated Oversight Processes (IOP) were not followed consistently and VA and VHA acquisition management did not provide adequate guidance and oversight needed to implement these processes. While the quality of contracts improved when the IOP was used, VHA did not perform IOP reviews for an estimated 3,000 contracts, which were valued at $1.58 billion and awarded between June 2009 and May 2010. OIG also found that VHA needs management tools to effectively monitor contract workload and optimal staffing levels. Comparisons of Government cost estimates for noncompetitive contracts showed VA could have put about $2.9 million to better use through competitive procurements. Without these tools, VHA lacks the information needed to effectively manage its contracting activities.

VISNs Overseeing VA Medical Facilities Lack Adequate Financial Management, Fiscal Controls

OIG conducted this audit to determine whether VHA's VISN office management controls and fiscal operations promoted the proper stewardship of VA funds. OIG found VHA lacked budgetary controls and reliable data to monitor VISN offices, evaluate performance relative to operational costs, and ensure the effective and efficient use of funds. VHA allowed VISN offices to operate independently, believing required fiscal controls were in place. However, growth in the offices' costs and increases in operational costs show VHA needs stronger VISN office fiscal controls. OIG recommended VHA implement a financial management system and fiscal controls. The Under Secretary for Health agreed with OIG's findings and recommendations and provided appropriate action plans.

Unmonitored Staff Growth, Inadequate Performance Management Noted at VISNs Overseeing VA Medical Facilities

In a related audit, OIG found VHA lacked the management controls needed to oversee and evaluate the effectiveness of VISN staff and organizational structures. The VISN offices' autonomy allowed for unchecked lapses in office growth, a weak performance management system, and a lack of complete fundamental staffing data used in decision-making. This resulted in unjustified organizational structures and staffing levels, ineffective oversight and stewardship of VA funds, and significant differences in management and operations between each of the VISN offices. OIG recommended VHA strengthen the VISN offices' system for performance management and implement controls over organizational structures and staffing. The Under Secretary for Health agreed with the findings and recommendations and provided appropriate action plans.

Veterans Benefits Administration Audits

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

VBA Needs More Proactive Measures to Prevent and Detect Fraud in New Process to Obtain Medical Evidence from Private Physicians

This audit was conducted by OIG to provide an early assessment of VA's internal controls over the use of disability benefits questionnaires (DBQs). OIG wanted to determine whether adequate front-end controls to identify and minimize risks were in place before benefit payments were initiated. VA implemented the new DBQ process to reduce the claims backlog by changing the way VA collects medical evidence to support claims. VA expects DBQs to replace the current need for Compensation and Pension medical exams by relying on information from Veterans and private physicians. OIG expects the volume of claims processed using DBQs to increase significantly. OIG's review found VA has a quality assurance review process, but it verifies only a limited number of DBQs and does so after claims are awarded. These quality assurance reviews do not provide reasonable assurance that fraud will be detected in the DBQ program as it accepts claims. The Under Secretary for Benefits and Under Secretary for Health generally concurred with the report recommendations. OIG will follow-up on the implementation of corrective actions.

Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's Veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VA Regional Offices (VAROs), focusing on disability compensation claims processing and performance of Veterans Service Center operations. Our objectives are to evaluate how well VAROs are accomplishing their mission of providing Veterans with convenient access to high quality benefits services and report systemic trends in VARO operations. We also determine whether management controls ensure compliance with VA regulations and policies, assist management in achieving program goals, and minimize the risk of fraud, waste, and other abuses. Benefits inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

The Benefits Inspection Divisions issued 11 reports during the period October 1, 2011, through March 31, 2012, which are listed in Appendix A. Key results of our inspections are as follows:

- Claims Processing: 36 percent of benefit claims we reviewed requiring a rating decision were processed in error. These errors involved claims related to traumatic brain injury, herbicide exposure-related disabilities, and temporary 100 percent disability evaluations.
- Competency Determinations: 42 percent of final competency determinations were not completed timely. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to ensure the welfare of beneficiaries and effective funds management increases when competency determinations are not timely.
- Homeless Veterans Outreach: 45 percent of the VAROs inspected did not provide adequate outreach to homeless shelters and service providers.

Other Audits and Evaluations

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 Officers Act of 1990,* P.L. 101-576, audit requirements for Federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

OIG also performs audits of information management operations and policies, focusing on adequacy of VA information technology (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*, P.L. 107-347, as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit. These evaluations 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 VA with constructive recommendations needed to improve IT management and security.

Review of Alleged Contract Irregularities in VA's Office of Information and Technology Results in Termination of Underutilized Contract

OIG conducted an audit to determine whether the Office of Information and Technology's (OIT's) Office of Architecture, Strategy, and Design officials directed contractor personnel to perform work outside the scope of a task order. Although OIG substantiated the allegation, there was no evidence that this work was actually completed. However, OIG did find that the work the contractor was doing did not meet the overall intent of the task order—technical reviews of OIT systems. OIG's review questioned $1,651,215 for an underutilized task order for the first and second option years. Additionally, OIT could better use $786,840 by either exercising the third option year then having the contractor perform the required technical reviews of OIT systems, or terminating the task order altogether. OIG recommended OIT terminate the task order. The Principal Deputy Assistant Secretary (PDAS) for OIT agreed with OIG's findings and recommendations and terminated the contract.

Audit Finds 80 Percent of Retention Bonuses Poorly Justified, Questions $1.06 Million in VA Spending

This audit determined the adequacy of VHA and VA Central Office (VACO) processes for awarding retention incentives. In FY 2010, VA paid nearly $111 million in retention incentives to just under 16,500 employees. OIG found VHA and VACO approving officials did not adequately justify and document retention incentive awards valued at $1.06 million in accordance with VA policy. VA lacked clear guidance, oversight, and training to effectively support the program. Officials did not effectively use the Personnel and Accounting Integrated Data system to generate timely review notices and did not always stop retention incentives at the end of set payment periods. Based on these findings, OIG questioned the appropriateness of 96 (80 percent) of 120 VHA incentives and 30 (79 percent) of 38 VACO incentives OIG reviewed. These incentives totaled about $1.06 million in FY 2010. OIG recommended revised and clarified guidance, as well as controls to ensure proper documentation and training was applied throughout the program.

Failure to Disclose Relevant Selection Factors Shows Potential Bias in $133 Million IT Contract

OIG evaluated the Secure VA-Chief Information Security Officer Support Services acquisition process to determine whether the solicitation, proposal evaluation, and contract award processes were conducted in line with full and open competition requirements. OIG found the acquisition process demonstrated a

potential bias by using knowledge of VA procedures and practices as a significant selection factor without clear disclosure of its relative importance when asking for bids. As such, the technical evaluation process favored awarding the contract to the incumbent, Booz-Allen Hamilton, the same contractor who provided VA's Information Assurance and Information Technology Security Services for the past 2 years. VA awarded the contract for $133 million at a premium of 16 percent ($18 million) and 22 percent ($24 million) over the two other offerors.

Stronger Security Controls Needed to Check Unauthorized Access to VA Financial Dashboard Information

OIG evaluated the merits of allegations that VA did not use an appropriate contract vehicle to develop and implement the "Systems to Drive Performance" (STDP) dashboard, a system to track cost accounting data to facilitate senior leadership decision making. OIG did not substantiate the allegations regarding an inappropriate STDP contract vehicle, inadequate system testing, and system redundancy. However, OIG substantiated the allegation that VA did not adequately protect sensitive information from unauthorized access and disclosure. Specifically, OIG determined that more than 20 system users had inappropriate access to sensitive STDP information. VA's National Data Systems Group did not consistently approve requests for user access to STDP. Further, project managers did not report unauthorized access as a security event. STDP project managers were not fully aware of VA's security requirements for system development, nor had they formalized user account management procedures. Inadequate Information Security Officer oversight contributed to weaknesses in user account management and failure to report excessive user privileges as security violations. The PDAS for OIT and the Executive in Charge, Office of Management agreed with OIG's findings and recommendations.

VA Receives Unqualified Opinion on FYs 2011 and 2010 Consolidated Financial Statements

OIG contracted with the independent public accounting firm, Clifton Gunderson LLP, to audit VA's consolidated financial statements. This audit is an annual requirement of the *Chief Financial Officers Act of 1990.* Clifton Gunderson LLP provided an unqualified opinion on VA's FY 2011 and 2010 consolidated financial statements. With respect to internal control, Clifton Gunderson LLP identified one material weakness, information technology security controls, which is a repeat condition. They also reported two significant deficiencies, accrued operating expenses, which is a repeat condition, and loan guaranty reporting. The department has taken corrective actions sufficient to eliminate four other significant deficiencies previously cited last year. Clifton Gunderson LLP reported that VA did not substantially comply with the Federal financial management systems requirements of the *Federal Financial Management Improvement Act of 1996*. They also noted instances of non-compliance with the *Debt Collection Improvement Act of 1996.*

Management of VA Program to Lease Underutilized Property Criticized, New Policies, Better Oversight Needed

OIG conducted this audit to assess VA's implementation of the Enhanced-Use Lease program, through which VA manages and maintains its capital asset inventory. OIG found the management of the program needs improvement: undocumented major project decisions, an overall lack of transparency, and inaccurate accounting practices caused OIG to question whether certain agreements effectively served the best interests of VA and Veterans. In addition, justifications for delayed execution of lease agreements, which escalated maintenance costs, could not be substantiated. OIG recommended the Executive in Charge establish oversight mechanisms to ensure compliance, improve accounting procedures, and establish performance measures to gauge program success and timeliness. The Executive in Charge for the Office of Management agreed with our finding and recommendations. They are preparing a detailed implementation plan to address the audit recommendations. OIG will assess the

effectiveness of VA's proposed implementation plan and follow up as required on all actions.

VA's Reporting on Improper Payments Not in Full Compliance with Improper Payments Elimination and Recovery Act

OIG conducted this review as required by the *Improper Payments Elimination and Recovery Act* (IPERA). OIG evaluated VA's accuracy, completeness of reporting, and performance in reducing and recapturing improper payments. OIG found VA did not fully comply with the IPERA requirements. VA reported improper payment rates greater than 10 percent for 3 VHA programs. OIG identified an additional fourth program also exceeded 10 percent. VHA's statistical sampling methodology did not achieve the required margin of error and VBA did not consult with a statistician, nor calculate margins of error. Further, OIG's calculated improper payment estimates did not match that reported in VA's Performance and Accountability Report for VBA's Compensation and Pension programs, likely due to the Pension program's significantly understated rate. In addition, VA's reduction targets for two programs were not met. OIG recommended VA take steps to ensure compliance with IPERA. OIG requested VA provide acceptable implementation plans within 30 days of this report to address the recommendations.

Veterans Health Administration Investigations

The Office of Investigations 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 235 cases, made 137 arrests, and obtained over $435.7 million in fines, restitution, penalties, and civil judgments, and achieved over $2 million in savings, efficiencies, cost avoidance, and recoveries. One case in particular resulted in a $321 million criminal fine and a $628 million civil penalty of which VA will receive $28,486,500 as a result of the civil settlement.

During this reporting period, OIG opened 58 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Fifty-eight defendants were charged with various crimes relating to drug diversion. These investigations resulted in $138,780 in fines, restitution, penalties, and civil judgments as well as $819,805 in savings, efficiencies, cost avoidance, and recoveries. OIG also initiated seven investigations related to the fraudulent receipt of health benefits, which resulted in three defendants being charged with various related crimes. These investigations resulted in $48,869 in fines, restitution, penalties, and civil judgments as well as $415,755 in savings, efficiencies, cost avoidance, and recoveries. OIG opened 49 beneficiary travel fraud investigations involving VA patients who grossly inflate their mileage to and from VA facilities to increase their reimbursement for travel expenses. These investigations resulted in 31 arrests, $168,556 in fines, restitution, penalties, and civil judgments. The following entries provide a representative sample of the type of VHA investigations conducted during this reporting period.

Former St. Louis, Missouri, VAMC Employee Pleads Guilty to Bribery and SDVOSB Fraud

A former VA employee pled guilty to a criminal information charging him with accepting illegal gratuities from Government contractors while he was employed at the St. Louis, MO, VAMC. The defendant admitted to accepting approximately $20,000 in cash, luxury baseball tickets, meals, and entertainment at a local club from two Government contractors while he was steering $3.4 million in SDVOSB set-aside contracts to their companies. Both contractors previously pled guilty to a criminal information charging them with conspiracy related to paying improper bribes and gratuities to a Federal official, mail fraud, wire fraud, and making false statements. The contractors established a front company, purportedly owned and operated by a service-disabled Veteran, when in actuality, it was controlled and managed by the contractors.

Miami, Florida, VAMC Employee Indicted for Identity Fraud

A Miami, FL, VAMC employee was indicted for aggravated identity fraud and access device fraud. An OIG, U.S. Secret Service, and U.S. Postal Inspection Service investigation revealed that the defendant sold personally identifiable information of 22 Veterans to an undercover law enforcement agent on two separate occasions.

Pharmaceutical Company Pleads Guilty to Off-Label Marketing

Merck, a major U.S. pharmaceutical company, pled guilty to distribution of a misbranded drug and also entered into a civil agreement with the Government. Under the terms of the plea agreements, the company will pay a $321 million criminal fine and a $628 million civil penalty. VA will receive $28,486,500 as a result of the civil settlement. The plea and settlements are the result of a multi-agency investigation involving the company's off-label marketing and promotion of the drug Vioxx and false statements about the drug's safety.

Company Pleads Guilty to Misbranding Drug, Ordered To Pay $85 Million Fine

Scios, Inc., a subsidiary of Johnson & Johnson, Inc. Biopharmaceutical Group, pled guilty to causing the introduction and delivery of a misbranded drug into interstate commerce. The company was ordered to pay an $85 million fine and was placed on organizational probation for 3 years. A VA OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, Federal Bureau of Investigation (FBI), and Defense Criminal Investigative Service (DCIS) investigation revealed that from August 2001 through June 2005, the company marketed and sold the drug Natrecor for off-label use. The drug was only approved by the FDA to treat acute heart failure, not chronic heart conditions. During the relevant period of time, VA purchased over $5 million of Natrecor; however, records only confirmed off-label use totaling approximately $100,000.

Five Veterans Arrested for Selling Heroin and Other Drugs at Bedford, Massachusetts, VAMC

Five Veterans were arrested for distributing and conspiracy to distribute controlled substances as the result of an OIG, Drug Enforcement Administration (DEA), and VA Police Service investigation. The defendants were charged with dealing drugs including heroin, oxycodone, Suboxone, and clonazepam at the Bedford, MA, VAMC. In some of the cases, the defendants were selling drugs that had been provided to them by the medical center. During the course of the investigation, an undercover OIG agent made several controlled buys of drugs from the defendants.

Defendants Plead Guilty to Drug Trafficking Charges at Cleveland, Ohio, VAMC

Three defendants pled guilty to felony drug trafficking charges for selling heroin and VA prescription medication at the Cleveland, OH, VAMC. Information was received that illicit drugs and VA prescription medication were being sold on VA property to Veterans in drug treatment programs. An OIG and local police investigation resulted in multiple controlled buys of heroin and prescription pain medication.

Former Bedford, Massachusetts, VAMC Employee Sentenced for Selling Cocaine to Veterans in Treatment Program

A former Bedford, MA, VAMC employee, who supervised Veterans undergoing substance abuse treatment at the medical center, was sentenced to 3 months' confinement in a halfway house and 3 months' home confinement after having previously pled guilty to distribution of controlled substances. During an OIG, VA Police Service, and DEA investigation the employee sold cocaine to a cooperating witness on three separate occasions while on VA property.

Veteran Sentenced and VA Employee's Son Arrested for Drug Distribution

A Veteran was sentenced to 14 days' incarceration and a $719 fine after pleading guilty to a drug sale. A VA employee's son was also arrested for conspiracy to distribute oxycodone in excess of 28 grams. Both judicial actions stemmed from a 7-month OIG and local drug diversion task force investigation. Operation Tango Vax focused on combating the sale and distribution of illicit and controlled prescription pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation determined that the majority of criminal activity occurred at the VAMC and resulted in the seizure of over 6,000 oxycodone pills and $180,920.

Veteran Sentenced for Drug Distribution

A Veteran was sentenced to 4 months' incarceration and 56 months' probation following a change of plea from not guilty to no contest. During a VA OIG, FBI, and local police investigation, the defendant sold controlled pharmaceuticals to an undercover OIG agent on three separate occasions.

Long Beach, California, VAMC Pharmacy Technician Charged with Drug Violations Over 15-Year Period

A Long Beach, CA, VAMC pharmacy technician was charged with possession of a controlled substance and obtaining controlled substances through fraud. An OIG investigation revealed that for approximately 15 years the defendant used fraudulent prescriptions to obtain more than 44,000 tablets of a controlled substance.

Veteran and Asheville, North Carolina, VAMC Nurse Arrested for Prescription Fraud

A Veteran and an Asheville, NC, VAMC nurse were arrested for obtaining prescription drugs by fraud. An OIG and local drug task force determined that while under the care of a VA physician, the Veteran obtained pain medication from non-VA pharmacies using assumed names. On one occasion, the Veteran posed as a VA physician and obtained pain medication for himself. The VA nurse assisted the Veteran in the scheme by picking up pain medications at non-VA pharmacies, which were dispensed by means of fraudulent prescriptions. A search of the nurse's residence resulted in the seizure of crack cocaine and various pill bottles.

Former Hines, Illinois, Consolidated Mail Outpatient Pharmacy Employee Sentenced for Drug Theft

A former contract employee at the Hines, IL, Consolidated Mail Outpatient Pharmacy (CMOP) was sentenced to 15 months' incarceration, 36 months' supervised release, and ordered to pay $52,972 in restitution to VA. An OIG investigation revealed that the defendant stole numerous vials of Viagra from the CMOP to sell for personal gain.

Former Providence, Rhode Island, Nurse Sentenced for Drug Diversion

A former intensive care unit nurse at the Providence, RI, VAMC was sentenced to 24 months' incarceration, 9 months' probation, and ordered to pay $2,500 in restitution. The defendant previously pled guilty to diversion of a controlled substance after an OIG and VA Police Service investigation revealed that he diverted hydromorphone and falsified VA controlled substance records to conceal the theft. The case was initiated after an internal VAMC analysis showed that the defendant had a high frequency of Pyxis system overrides when compared to other nurses on the ward.

Former Martinsburg, West Virginia, VAMC Registered Nurse Sentenced for Drug Diversion

A former Martinsburg, WV, VAMC registered nurse was sentenced to 14 months' incarceration, 12 months' probation, and 120 hours' community service after pleading guilty to obtaining oxycodone by fraud. An OIG and VA Police Service investigation determined that on approximately 56 occasions the defendant retrieved controlled medication from the facility's automated medication dispensers using the names of VA patients whose electronic medical records indicated they did not receive the medication.

Former Tucson, Arizona, CMOP Employee Sentenced for Drug Theft

A former Tucson, AZ, VA CMOP employee was sentenced to 18 months' incarceration (suspended) and 18 months' probation. An OIG investigation determined that the defendant stole over 500 Soma tablets for personal use while working as a pharmacy technician.

Former Salisbury, North Carolina, VAMC Pharmacist Sentenced for Drug Diversion

A former Salisbury, NC, VAMC pharmacist was sentenced to 4 years' probation and a $2,500 fine after pleading guilty to acquisition or obtaining possession of a controlled substance by misrepresentation and false statements. An OIG investigation determined that the defendant stole medication relinquished to the pharmacy by patients checking into the VAMC for in-patient stays.

Former Salem, Virginia, VAMC Nurse Sentenced for Drug Diversion

A former Salem, VA, VAMC registered nurse was sentenced to 30 days' incarceration, 5 months' home confinement, and 50 hours' community service after pleading guilty to obtaining controlled substances by fraud. As a special condition of her sentencing, the defendant was also prohibited from working in the health care field. An OIG investigation revealed that the defendant engaged in a variety of schemes in order to obtain over 6,000 micrograms of fentanyl from VAMC OmniCell machines as well as patients. The defendant admitted to using the narcotic while providing care to patients.

AmeriCorps Member Sentenced after Pleading Guilty to Burglary and Sexual Offense at Perry Point, Maryland, VAMC

An AmeriCorps member, formerly residing in leased housing at the Perry Point, MD, VAMC, was sentenced to 7 years' incarceration (4 years suspended), 3 years' supervised release, and ordered to register as a tier one sex offender after pleading guilty to burglary and a sex offense. An OIG and Maryland State Police investigation revealed that the defendant sexually assaulted a female AmeriCorps member at her residence, located on the grounds of the medical center.

Columbia, South Carolina, VAMC Nurse's Aide Pleads Guilty to Simple Assault

A Columbia, SC, VAMC nurse's aide pled guilty to simple assault following his indictment and arrest for fondling the genitals of an amputee patient. The victim was a resident in the VAMC's nursing home. As a condition of his plea, the defendant was barred from seeking future VA employment. The defendant initially gave a sworn statement denying the charges. Following an OIG polygraph exam, the defendant confessed to assaulting the patient.

Former New York, New York, VAMC Union President Arrested for Theft of $112,500 in Union Funds

A former New York, NY, VAMC employee and union president of an American Federation of Government Employee's local was arrested for theft of union funds while on Government property. An OIG and Department of Labor (DOL), Office of Labor Management Standards, investigation revealed that the defendant embezzled approximately $112,500 by writing 187 checks to himself from the union's checking account.

Fayetteville, North Carolina, VAMC Compensated Work Therapy Employee Arrested for Theft

A compensated work therapy employee, with an extensive criminal history, was arrested for theft after an OIG, VA Police Service, and local police investigation revealed that he stole new, unused laptop computers from the Fayetteville, NC, VAMC. At least six computers were pawned in the local area, and three of those have been recovered. Nine stolen computers remain missing.

Compensated Work Therapy Workers Charged with Grand Larceny

Two Compensated Work Therapy workers were charged with grand larceny as a result of an OIG and VA Police Service investigation which disclosed that they stole more than 20 cold weather modular sleep systems and other winter gear from the VA's Homeless Outreach Program. This specialized gear was intended specifically for homeless Veterans living in harsh cold weather conditions. One of the defendants was also charged with obstruction of justice because he threatened the other defendant for talking to investigators.

Seven Orlando, Florida, VAMC Employees and Volunteer Charged with Theft

Seven Orlando, FL, VAMC employees, to include a VA police officer, and an eighth individual who was a volunteer, were charged with the exploitation of an elderly or disabled adult and grand theft. An OIG and VA Police Service investigation revealed that the defendants solicited and received checks totaling

$55,000 from a resident of the VAMC's nursing home who suffers from dementia.

Former Reno, Nevada, Canteen Manager Indicted for Theft of Government Property

A former Reno, NV, VAMC canteen manager was indicted for theft of Government property. An OIG investigation revealed that during an 18-month period the defendant stole $42,111 from 13 medical center vending machines by under-reporting the vending machine sales in order to conceal the thefts. The defendant admitted to using the stolen money to fund his gambling addiction.

Former Bath, New York, VAMC Nurse Pleads Guilty to Bank Theft

A former Bath, NY, VAMC nurse pled guilty to a criminal complaint charging her with bank theft. As a condition of her plea, she agreed to pay full restitution of $7,375. An OIG investigation revealed that the defendant used her position to gain access to the bank card and personal identification number of a Veteran under her care and for over 3 months withdrew funds for her own personal use from the Veteran's bank account.

Three Jackson, Mississippi, VAMC Employees Sentenced for Theft of VA Property

Three Jackson, MS, VAMC facility maintenance workers were sentenced after pleading guilty to embezzlement. The first defendant was sentenced to 5 years' probation and ordered to pay $608 in restitution; the second defendant was sentenced to 5 years' probation and ordered to pay $2,294 in restitution; and the third defendant was sentenced to 6 months' incarceration, 6 months' probation, and ordered to pay a $500 fine. An OIG and local police investigation determined that for over 18 months the defendants stole VA property, including flat panel televisions, commercial cleaning supplies, commercial cleaning equipment, computer equipment, and other miscellaneous property from the VAMC. Judicial action against a fourth employee is pending.

Veteran Sentenced for Credit Card Fraud

A Veteran, who was the leader of a conspiracy to commit access device fraud and aggravated identity theft, was sentenced to 48 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $7,210. An OIG and VA Police Service investigation revealed that the defendant and two accomplices were responsible for the thefts of numerous Palo Alto, CA, VAMC employees' wallets. The investigation also revealed that the Veteran and his accomplices used credit cards from those stolen wallets to purchase thousands of dollars in gift cards, merchandise, and gas at local retail stores, with the gift cards being re-sold in an illegal gift card scheme. The two accomplices previously pled guilty to similar charges.

Eleven Veterans Indicted for Travel Benefit Fraud Against Columbia, South Carolina, VAMC

Eleven Veterans were indicted for false, fictitious, or fraudulent claims and fraudulent acceptance of payment after submitting numerous fraudulent travel vouchers for reimbursement. An OIG investigation determined that all of the defendants claimed to reside in areas that were a greater distance from the Columbia, SC, VAMC than they actually resided. The aggregate loss to VA is approximately $80,000.

Veteran Indicted for Travel Benefit Fraud at Gainesville, FL, VAMC

A Veteran was indicted for theft of Government funds after an OIG investigation revealed that, from February 2010 to July 2011, he filed 234 fraudulent travel claims at the Gainesville, FL, VAMC. The defendant claimed that he was traveling 152 miles round trip from St. Augustine, FL, when in reality he was residing in the local area. The loss to VA is $14,333.

Veteran Pleads Guilty to Theft of VA Travel Benefits at Montrose, New York, VAMC

A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he used an address where he was not residing in order to inflate the mileage reimbursement paid by VA for his travel to and from medical appointments at the Montrose, NY, VAMC. The loss to VA is $65,343.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 10 years' hard labor (suspended) and 5 years' supervised probation after pleading guilty to felony theft. An OIG and VA Police Service investigation determined that the defendant obtained a driver's license and identification card containing false addresses, and from 2009 until 2011 used the false identifications to submit 223 fraudulent beneficiary travel vouchers to the Alexandria, LA, VAMC. The loss to VA is $14,775.

Veterans Benefits Administration Investigations

VBA administers a number of financial benefits programs for eligible Veterans and certain family members, including VA guaranteed home loans, education, insurance, and monetary benefits. Investigations routinely concentrate on payments made to ineligible individuals. For example, a beneficiary may deliberately feign a medical disability to defraud the VA compensation program. With respect to VA guaranteed home loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. VA appoints fiduciaries for Veterans in receipt of VA benefits who are deemed incompetent and for minor children who are receiving VA benefits. OIG investigates allegations of fraud committed by these fiduciaries.

OIG's Information Technology and Data Analysis Division, in coordination with the Office of Investigations, conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. Since the inception of the Death Match project in 2000, OIG has identified 16,660 possible cases with over 2,915 investigative cases opened. Investigations have resulted in the actual recovery of $59.2 million, with an additional $20.9 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $142.2 million. To date, there have been 563 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 225 investigations, made 97 arrests, and had a monetary impact of over $5.2 million in fines, restitution, penalties, and civil judgments as well as more than $12.8 million in savings, efficiencies, cost avoidance, and recoveries during this reporting period. One-hundred ninety-eight of these investigations involved the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary, identity theft fraud, and beneficiaries fraudulently receiving these benefits. These investigations resulted in criminal charges filed against 35 defendants. OIG obtained over $1.5 million in court ordered payment of fines, restitution, and penalties and also achieved an additional $8.7 million in savings, efficiencies, cost avoidance, and recoveries. OIG opened an additional six "Stolen Valor" cases and arrested nine individuals. Convictions resulted in $591,462 in court ordered payment of fines, restitution, and penalties, and OIG achieved an additional $867,208 in savings, efficiencies, cost avoidance, and recoveries. The following entries provide a representative sample of the type of VBA investigations conducted during this reporting period.

Veteran Pleads Guilty to Theft of $900,000 in Benefits Over 15 Years

A Veteran pled guilty to theft of Government funds after an OIG investigation determined that he fraudulently received approximately $900,000 in VA compensation benefits for approximately 15 years. The defendant, who was treated by VA for numerous ailments, claimed to be wheelchair bound and required the need of an aide. The defendant gave various fabricated accounts to neighbors, the media, and VA staff on how his injury occurred, including being a U.S. Navy SEAL wounded during Operation Desert Storm, being injured during hand-to-hand combat training, falling down steps, and being shot by friendly fire while at Ft. Bragg. The investigation also revealed that while the defendant reported to VA that he was not ambulatory, he completed the North Carolina Basic Law Enforcement Training Program and later held jobs as a police officer and a child protective services officer.

Foreign National Arrested for Identity Theft

A Cuban national was arrested at the Phoenix, AZ, VAMC after being indicted for aggravated identity theft, false representation of a Social Security number, theft of Government property, and wire fraud. An OIG investigation revealed that the defendant used the identity of a Veteran from Puerto Rico to obtain VA compensation and medical care. The loss to VA is $414,745, which includes $251,321 in VBA benefits and $163,424 in medical benefits.

Veteran Indicted for "Stolen Valor" Fraud

A Veteran was indicted for fraudulent use of a military discharge certificate, false writing, false claims about receipt of military medals, mail fraud, and theft of Government funds. An OIG and DCIS investigation revealed that the defendant submitted an additional DD-214 to VA and the DoD that was fraudulently produced. The document falsely reflected that the defendant had been awarded a Purple Heart and a Combat Infantry Badge and that he had served 6 years in the U.S. Army. This additional DD-214 allowed the defendant to qualify for VA compensation benefits for post-traumatic stress disorder (PTSD) and military retirement. The loss to VA is approximately $38,000, and the DoD retirement overpayment is approximately $90,000.

Veteran Indicted for "Stolen Valor" Fraud

A Veteran was indicted for falsely claiming to have been awarded military medals and then using those medals to support his VA claim for compensation. An OIG and FBI investigation revealed that the defendant submitted a fraudulent DD-214 that reflected the defendant was a U.S. Navy SEAL and had been awarded a Purple Heart, Combat Action Ribbon, Joint Service Achievement Medal, and the Navy and Marine Corps Achievement Medal. As a result of this investigation, VA re-evaluated the Veteran's PTSD claim and his service-connection compensation was reduced from $1,478 to $580 per month. The loss to VA is $24,804.

Veteran Indicted for Making False Claim to VA

A Veteran was indicted for false statements and theft of Government funds after an OIG investigation revealed that she sustained a severe medical injury while participating in a burglary when she was on active duty. The defendant reported to medical personnel, the U.S. Army, and VA that the injury was sustained by falling down stairs. Additionally, the defendant made false statements to VA and the U.S. Army when applying for VA compensation benefits and a military disability retirement. The approximate loss to VA is $81,000.

Veteran Sentenced for Compensation Fraud

A Veteran was sentenced to 38 months' incarceration, 24 months' probation, and ordered to pay $161,418 in restitution to VA after an OIG investigation revealed that he provided false information to VA in support

of his claim for disability compensation benefits. Between 2003 and 2006, the defendant submitted VA forms along with pictures attesting to his claims and later made statements to VA examiners that he participated in combat activities while serving in the first Gulf War and suffered from PTSD. The Veteran's false assertions included hand-to-hand combat in the trenches, killing enemy combatants, seeing fellow soldiers die, seeing dead bodies inside burned-out tanks, and being under chemical attack. During the same period, the Veteran asserted his military service and fraudulent combat activities to the local police as a defense during subsequent court appearances on unrelated criminal and civil proceedings.

Former Togus, Maine, VAMC Employee Sentenced for Compensation Benefits Fraud

A former Togus, ME, VAMC employee was sentenced to 18 months' incarceration, 36 months' supervised release, and ordered to pay VA $47,229 in criminal restitution. An OIG investigation revealed that the defendant manufactured a fraudulent document that VA relied upon as the basis for an award of service-connected compensation benefits for a back condition. When interviewed, the former employee acknowledged creating the document that purported his involvement in a vehicle crash while running a roadblock in a foreign country, which he claimed caused injuries to his back and ribs. The sentencing included enhancements for obstruction after the judge agreed with the Government's contention that the defendant had manufactured another document in an attempt to exonerate himself from charges relating to dependency benefits fraud.

Veteran Sentenced for VA Compensation Fraud

A Veteran was sentenced to 5 months' incarceration, 5 months' home confinement, 3 years' supervised probation, and ordered to pay restitution of $92,399 to VA. An OIG investigation revealed that the defendant submitted several false statements to VA claiming that he was unable to work, resulting in the receipt of VA individual unemployability benefits. The investigation further determined that the Veteran was gainfully employed since 2003.

Former Fiduciary Indicted for Embezzling from Father

A former fiduciary was indicted for defrauding VA by embezzling her father's VA disability compensation. The defendant acted as her father's fiduciary from July 2007 until VA removed her in February 2009. During this time period, she misappropriated approximately $58,000.

Fiduciary Indicted for Misappropriating $190,000 from Incompetent Veteran

A VA fiduciary was indicted for misappropriation by a fiduciary after an OIG investigation determined that she diverted approximately $190,000 of her incompetent brother-in-law's VA funds for her personal use. The investigation determined that the defendant used the misappropriated funds to purchase a BMW and to make unauthorized investments. Although the VA field examiner reported that the Veteran was well cared for and living in excellent conditions, the investigation determined that the Veteran was being housed in a shed on the fiduciary's property. The investigation continues into the submission of the inaccurate field examiner reports.

Veteran's Daughter Pleads Guilty to Misappropriating Over $200,000

The daughter of a Veteran, who was also his fiduciary, pled guilty to misappropriation by a fiduciary and conversion of Social Security benefits. An OIG investigation disclosed that the defendant became the Veteran's fiduciary in 2005 and subsequently embezzled over $200,000 in VA compensation benefits and over $20,000 in Social Security benefits. After initially claiming that a VA field examiner told her that she could spend the funds, the defendant admitted to OIG agents that she fraudulently spent the money intended for her father.

Veteran's Daughter Pleads Guilty to Falsifying Business Records and Identity Theft

The daughter of a Veteran pled guilty to falsifying business records and identity theft after an OIG investigation revealed that she submitted fraudulent employment records in order to secure a VA home loan in her father's name. The loan was subsequently approved based on the false records and the home is now in foreclosure.

Veteran Indicted for VA Home Loan Guaranty Program Fraud

A Veteran was indicted for a felony charge of securing the execution of a document by deception. An OIG investigation revealed that the Veteran fraudulently obtained a $232,000 residential loan through the VA Home Loan Guaranty Program by presenting falsified tax documents that misrepresented his annual income. The defendant subsequently defaulted on the loan, resulting in a loss to the Government of $58,147.

Naval Officer Indicted for VA Home Loan Guaranty Fraud

An active duty naval officer was indicted for wire fraud after an OIG and Naval Criminal Investigative Service (NCIS) investigation revealed that she applied for and received a VA Home Loan Guaranty based on fraudulent income and asset documents that she provided to a bank to secure a home mortgage. The defendant is currently serving 30 months' incarceration in a U.S. Navy brig after being found guilty of making misrepresentations concerning her education at the time of her enlistment.

Veteran Sentenced for VA Pension Fraud

A Veteran, who is also a leader in a white supremacist organization, was sentenced to 6 months' home confinement, 2 years' supervised probation, and ordered to pay restitution of $192,837 after pleading guilty to false statements. The defendant was also given credit for time served towards 6 months' incarceration. A joint investigation conducted by the OIG and the FBI revealed that the defendant fraudulently received VA pension benefits by failing to report other income to VA.

Veteran Sentenced for VA Pension Fraud

A Veteran was sentenced to 2 years' probation, fined $500, and ordered to pay $6,969 in restitution after pleading guilty to a criminal information that charged him with theft of Government property. An OIG investigation revealed that the Veteran made a material false statement when he informed VA that he had no income, despite earning significant income in the scrap metal business. The Veteran admitted to OIG agents that he was not entitled to the pension benefits and that he knowingly submitted the false statement about his income to avoid detection by VA. The loss to VA is over $100,000.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 366 days' incarceration and ordered to pay $101,686 in restitution after pleading guilty to theft of Government funds and concealment of a material fact affecting Social Security disability payments. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant fraudulently received VA individual unemployability and SSA benefits by failing to report employment income. The loss to VA is $72,921.

Veteran's Girlfriend Pleads Guilty to Defrauding VA

The girlfriend of a Veteran pled guilty to misprision of a felony for her part in structuring a business in her name in order to hide the Veteran's income from VA. An OIG and local police investigation revealed that the defendant and the Veteran operated a business for over 8 years while the Veteran received monthly VA pension benefits and co-pay exempt VA health care. In addition, the Veteran was previously charged with illegal distribution of his VA prescribed narcotics. The loss to VA is $220,072, which includes

$127,888 in pension overpayments and $92,184 in disallowed medical benefits. Criminal charges are pending against the Veteran.

Veteran and Wife Indicted for Theft of Government Funds

A Veteran and his wife were indicted for theft of Government funds and for acting as principals in the commission of an offense against the Government. An OIG investigation revealed that the Veteran, who was receiving individual unemployability benefits, owned and operated two separate automobile-related businesses, while reporting to VA that he was unemployed and unable to work due to his disability. The Veteran's wife, who was also his VA fiduciary, provided documentation furthering his scheme of convincing VA that he was unable to obtain or maintain substantial, gainful employment. The loss to VA is approximately $107,000.

Wife of Deceased U.S. Navy Service Member Sentenced for VA Compensation Fraud

The wife of a deceased U.S. Navy service member was sentenced to 6 months' incarceration, 6 months' home confinement, 3 years' supervised release, and ordered to pay $115,759 in restitution after pleading guilty to theft of Government funds. An NCIS investigation, supported by OIG, resulted in a previous guilty plea by the defendant in 2008 to involuntary manslaughter related to her husband's 1993 death. The defendant was not entitled to VA benefits because she was held responsible for her husband's death.

Wife of Deceased Veteran Arrested for Theft of VA Benefits

The wife of a deceased Veteran was arrested for theft in the first degree. An OIG investigation revealed that the defendant failed to notify VA of her husband's death and subsequently stole VA benefits that were issued after his death in July 2007. The loss to VA is $206,284.

Son of Deceased Beneficiary Charged with Theft of VA Benefits

The son of a widow beneficiary was charged with theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after his mother's death in May 2005. The loss to VA is $74,093.

Son of Deceased Beneficiary Pleads Guilty to Theft of VA Benefits

The son of a deceased beneficiary pled guilty to theft of Government funds after an OIG investigation revealed that he used his trustee position to steal VA funds that were direct deposited after his father's death in February 2003. The loss to VA is $103,866.

Son of Deceased Beneficiary Pleads Guilty to Theft of VA Funds

The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation determined the defendant stole VA funds from a joint bank account after his mother's death in September 2005. The defendant admitted to using the VA benefits for personal expenses. The loss to VA is $87,894.

Son of Deceased VA Beneficiary Pleads Guilty to Theft of VA Funds

The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report to VA that his mother died in April 2006 and subsequently used her ATM card to steal $59,548 in VA benefits from her account.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to a joint account subsequent to the beneficiary's death in August 2005. The loss to VA is $79,192.

Deceased Beneficiary's Daughter Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 3 years' probation, 100 hours' community service, and ordered to pay restitution of $129,000 after pleading guilty to theft of Government funds. An OIG investigation revealed that between March 2001 and October 2009 the defendant failed to report the beneficiary's death to VA and stole VA benefit funds that were direct deposited to a joint account after her mother's death in February 2001.

Daughter of Deceased Veteran Sentenced for Theft of VA Funds

The daughter of a deceased Veteran was sentenced to 2 years' probation and ordered to pay $69,368 in restitution after being found guilty at trial of larceny for stealing VA compensation benefits. An OIG investigation revealed that the defendant stole VA benefit payments that were direct-deposited into a joint account after her father's death in November 2002.

Son of Deceased Beneficiary Sentenced for Theft of VA Funds

The son of a deceased beneficiary was sentenced to 13 months' incarceration, 3 years' probation, and ordered to pay restitution of $67,505 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds from a joint account after his mother's death in March 2006.

Other 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 26 cases, made 8 arrests, and obtained nearly $21 million in fines, restitution, penalties, and civil judgments.

OIG also investigates theft of IT equipment or data, network intrusions, and child pornography. In the area of information management crimes, OIG opened two cases, made one arrest, and achieved $23,421 in savings, efficiencies, cost avoidance, and recoveries.

Contractors Plead Guilty to Defrauding VA in Home Renovation Scheme

A former residential sales manager for a loan servicing company and a former contractor pled guilty to wire fraud. The loan servicing company managed foreclosed properties under a VA contract and hired construction companies to complete necessary repairs. The properties were then re-sold and the company was reimbursed for repair expenses by VA. The defendants, who are brothers, engaged in fraud by having the sales manager steer repair contracts to a company affiliated with the contractor in exchange for $14,000 in cash payments. The investigation resulted in the discovery of a separate scheme involving another residential sales manager with the same loan servicing company and two additional contractors who were indicted for conspiring to commit bribery and wire fraud. The contractors paid the sales manager as much as $147,258 to steer repair work on VA-owned houses to companies affiliated with the contractors. The sales manager recruited other loan servicing company employees into the scheme and paid them on behalf of himself and the other conspirators. One of these other sales managers previously pled guilty to wire fraud for his role in the conspiracy.

Construction Company Owner, Son-In-Law Indicted for Fraud Involving Nearly $11 Million in Contracts Intended for Veteran-Owned Businesses

The owner of a New Mexico construction company and his son-in-law were indicted for conspiracy, major fraud, and false statements. An OIG investigation determined that the owner of the company paid his

step-brother approximately $50,000 to use his status as a service-disabled Veteran in order to qualify and obtain $10.9 million in VA SDVOSB contracts. The owner's step-brother previously pled guilty to a criminal information charging him with conspiracy, major fraud, and wire fraud.

Business Owner Indicted for Service-Disabled Veteran-Owned Small Business Fraud

A business owner was indicted for wire and major fraud after a case referral from the Government Accountability Office resulted in the initiation of a multi-agency investigation conducted by the VA OIG, Small Business Administration (SBA) OIG, U.S. Department of Agriculture (USDA) OIG, and U.S. Army Criminal Investigations Division. The investigation determined the defendant used the status of a legitimate service-disabled Veteran to fraudulently create a SDVOSB company. The defendant subsequently created a joint venture by partnering his business with the SDVOSB to qualify and bid on SDVOSB set-aside contracts. The defendant also forged the signature of the service-disabled Veteran on VA contracts and other documents. The company received $1,085,207 in VA set-aside SDVOSB contracts to which it was not entitled. The defendant also received three additional fraudulent SDVOSB contracts from the U.S. Army, USDA, and the U.S. Coast Guard, totaling $1,761,625.

Fee-Basis Dentist Pleads Guilty to Wire Fraud

A former fee-basis dentist pled guilty to wire fraud after an OIG and FBI investigation revealed that she fraudulently billed VA for dental treatment on homeless Veterans that was never performed. The VA Palo Alto, CA, HCS authorized fee-basis dental treatment for 15 Veterans participating in the VA's Homeless Veterans Rehabilitation Program (HVRP) and the defendant billed VA for treatments that were never performed on 12 of these HVRP Veterans. Also, the investigation revealed that the dentist had a conscious sedation permit and was diverting narcotics from her practice for her personal use. The loss to VA is $27,898.

Former Executives Sentenced for Medical Device Fraud

Three former Synthes Inc. executives were sentenced pursuant to a plea agreement charging them with violation of the "responsible corporate officer" doctrine with the strict liability offense of introducing into interstate commerce medical devices that were adulterated. Two of the defendants were sentenced to 9 months' incarceration and 3 months' supervised release while the third defendant was sentenced to 5 months' incarceration and 7 months' supervised release. Each defendant was also ordered to pay a $100,000 fine. A fourth former Synthes Inc. executive was sentenced to 8 months' incarceration, 4 months' supervised release, and ordered to pay a $100,000 fine pursuant to a plea agreement charging him with the same offense. A multi-agency investigation determined that all of the defendants were involved in the unapproved trial of a bone-cement drug in which three patients died.

Company Nurse Sentenced for Making False Statements, VA Billed $2.6 Million as a Result

A nurse, who was formerly employed with a company that provided nursing home and home health care services to various Government agencies, including VA, was sentenced to 4 months' home confinement, 3 years' probation, and a $2,000 fine after pleading guilty to making false statements relating to health care matters. A multi-agency investigation determined that the defendant, who was responsible for performing periodic supervisory nursing visits to patients under her employer's care, falsely certified that visits were made. The defendant also misrepresented visit dates and forged the names of company nurses on the supervisory visit forms. The visits were subsequently billed for payment by the defendant's employer. The loss to VA is approximately $2.6 million.

Veteran Sentenced for Fraudulently Selling Certificates Bearing Forged U.S. Department or Agency Seals

A Veteran pled guilty to fraudulently selling certificates bearing forged U.S. department or agency seals and impersonating an officer or employee. Pursuant to the plea agreement, the defendant agreed to serve 36 months' incarceration, pay court ordered restitution to the victims, and abandon the property seized by OIG during the execution of a search warrant at his business. A multi-agency investigation, led by OIG, revealed that the defendant was operating an Internet printing business that sold counterfeit military awards and training certificates from all branches of the military, as well as law enforcement awards and training certificates. The fraud associated with this investigation is over $260,000.

Former Account Manager Sentenced for Fraud

A former account manager for a home health care company that provided services to individuals covered by various health care programs, to include Medicaid and VA, was sentenced to 3 months' home confinement, 2 years' probation, and a $1,000 fine after pleading guilty to knowingly and willfully making false statements relating to health care matters. A VA OIG, Health and Human Services (HHS) OIG, and FBI investigation resulted in the defendant admitting to altering documents detailing the credentials of his company's employees to make them appear compliant with state licensing regulations during audits of the employer's operations.

Defendants Sentenced for Home Health Care Fraud

A former regional account manager for a home health care services company was sentenced to 5 months' incarceration, 5 months' home confinement, 24 months' probation, and ordered to pay a $10,000 fine. The mother of a patient receiving services from the same home health care services company was also sentenced to 5 months' home confinement, 36 months' probation, and ordered to pay a $1,000 fine. In addition, a recruiter formerly employed by the same company was sentenced to 24 months' probation and ordered to pay a $500 fine. The judicial actions are the result of a previous deferred prosecution agreement resulting from a multi-agency investigation, which revealed various fraudulent activities related to services the company claimed to provide to various recipients of Federal and state benefits, including those provided by VA.

Veteran and Two Others Arrested for Unlawfully Obtaining Narcotics

A Veteran, his spouse, and a nurse, who works in a physician's office, were arrested for their part in a scheme to unlawfully obtain narcotics through doctor shopping and misuse of a physician's DEA control number. An OIG, FBI, and HHS OIG investigation revealed that since 2008 the three defendants fraudulently obtained more than 16,000 pills from local pharmacies and VA. This investigation is part of Operation Pharm Team, which is being coordinated by the U.S. Attorney's Office in Connecticut.

United Parcel Service Employee Indicted for Theft of VA Narcotics

A United Parcel Service employee was indicted for attempted possession with intent to distribute a controlled substance. An OIG and DEA investigation determined that for over 8 months the defendant stole Schedule II and III narcotics shipped from the Jackson, MS, VAMC and the Murfreesboro, TN, CMOP.

Former United Parcel Service Employee Sentenced for Drug Theft

A former United Parcel Service employee was sentenced to 36 months' incarceration and 3 years' supervised release after pleading guilty to possession of controlled substances with intent to deliver. An OIG and DEA investigation revealed that the defendant stole at least nine VA packages containing various controlled narcotics that were shipped to Veterans from a VA medical facility.

Former U.S. Postal Employee Sentenced for Drug Theft

A former U.S. Postal Service (USPS) employee was sentenced to 3 months' home confinement, 2 years' probation, and 150 hours' community service. A VA OIG and USPS OIG investigation determined that, between July 2009 and April 2011, the defendant diverted approximately 17 shipments of VA prescribed narcotics that were mailed to Veterans residing in the eastern Washington State area.

Former USPS Employee Sentenced for Stealing VA Narcotics

A former USPS employee was sentenced to 30 days' incarceration for stealing VA narcotics. Additional drug charges were deferred prosecution for 1 year. A VA OIG, USPS OIG, and local police investigation used real time and videotaped surveillance, in addition to the defendant's own statements, to determine that he stole Vicodin shipped from a VA CMOP.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG opened 15 and closed 18 administrative investigations. This work resulted in the issuance of 4 reports containing 18 recommendations for administrative or corrective action; 6 advisory memos with 14 suggestions for corrective action; and 13 administrative memos. OIG also obtained $21,274 in dollar recoveries. The Division investigated 38 allegations of which 22 were substantiated and 16 were not substantiated.

South Texas HCS Official's Hiring of Business Partner at VA a Conflict of Interest, OIG Investigation Shows

An administrative investigation substantiated that an employee of the South Texas Veterans HCS engaged in a conflict of interest when the employee approved the appointment of the employee's private business partner to a VA position and recommended the business partner for a $21,274 recruitment incentive. In addition, the appointed employee misused official VA time to conduct tasks for the private business, and Title 38 full-time physicians at the Medical Center held a general misperception on the proper use of leave.

Manager Interfered With Hiring Process, Then Failed To Tell the Truth About It

An administrative investigation found that an Office of Business Oversight (OBO) senior official, as part of a recruitment process, attempted to pressure a subordinate into making a false representation concerning an interview score and the proper standing of a preferred job applicant. In addition, another OBO senior official failed to properly discharge his duties and responsibilities as a supervisor when he, after receiving two separate complaints alleging serious misconduct, failed in both instances to investigate and take the appropriate corrective action. Furthermore, both OBO senior officials failed to testify freely and honestly in connection with the investigation.

VA Researchers in Waco, Texas, Worked for Texas A&M University on Government's Time, Drew Salaries from Both

An administrative investigation found that a Senior Official at the VISN 17 Center of Excellence, Waco, TX, misused official time when she took and approved authorized absences for her subordinates to conduct non-VA grant work for a non-VA entity during their VA duty hours, receiving remuneration from the entity. The Senior Official also created the appearance of preferential treatment when she loaned $7,000 to a subordinate to cover monies not yet paid to the subordinate by the entity and engaged in a conflict of interest when she recommended approval for Joint Employment Agreements between VA and

the entity. OIG further found that the Center of Excellence did not maintain time and attendance records that accurately reflected the time delegated to VA versus tasks associated with the entity during employee tours of duty to alleviate improper salary supplementation.

Tampa Clinician Engaged in Conflict of Interest, Referred VA Radiology Patients to Private Business Associate

Another administrative investigation found that a medical center clinician at the James A. Haley Veterans' Hospital, Tampa, FL, engaged in a conflict of interest when the clinician referred VA patients to a VA fee-for-service provider, while the clinician also had a private working relationship with the provider as the owner of a private company. OIG also found that the clinician improperly accepted gifts from the provider, misused VA time and resources to conduct tasks for the private business during the VA workday, and improperly used VA time and resources to develop a smartphone application for personal gain. OIG further found that the clinician failed to follow VA policy when the clinician sent VA patient radiology and photograph images from a VA-assigned e-mail account to private e-mail accounts and accessed them on non-VA issued equipment. Finally, OIG found that the clinician also violated VA policy when the clinician asked other VA employees to log onto the VA network using the clinician's username and password to falsely reflect that the clinician was at a VA duty station when the clinician was not.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 19 criminal investigations resulting from assaults and threats made against VA facilities and employees. Seventeen defendants were charged with related charges as a result of the investigations. The following summaries provide representative samples of threats made against VA facilities and employees.

- A Veteran was arrested for sexual abuse in the first degree after an OIG, VA Police Service, and local police investigation revealed that he sexually assaulted a VA registered nurse during an appointment at the Rochester, NY, VA outpatient clinic. When interviewed, the defendant admitted to placing the nurse's hand on his genitals while the nurse was performing a blood draw at the phlebotomy clinic.
- A Veteran was arrested by OIG agents for assaulting the Reno, NV, VAMC Chief of Police. The defendant, while intoxicated, became disruptive in the medical center waiting area, made threats toward his primary care physician, and intimidated staff and patients. The chief arrived on the scene, identified himself to the defendant and attempted to calm the situation. The defendant subsequently punched the chief in the face, causing injuries.
- A Veteran pled guilty to assaulting a VA police officer at the Seattle, WA, VAMC. An OIG and VA Police Service investigation revealed that the Veteran checked into the emergency room (ER) and informed an ER nurse that he was having suicidal thoughts to include "suicide by cop." When a VA police officer attempted to conduct a security screening, the defendant failed to comply with the officer's instructions and assaulted the officer. During the struggle, the defendant was able to obtain the officer's baton and attempted to take the officer's weapon until subdued by the officer and other responders. The assault resulted in injuries to the officer.
- A Veteran pled guilty to assault of a Federal employee with a dangerous weapon. An OIG and VA Police Service investigation revealed that while in the ER of the White River Junction, VT, VAMC, the defendant locked the door, then took a scalpel from a hospital cart and gained control of a nurse by holding the scalpel to her throat. VA Police officers were able to subdue the defendant and the nurse sustained no injuries.

- A Veteran was sentenced to 40 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $300,411 to VA for reimbursement of Office of Workers' Compensation Program and other related costs. An OIG investigation revealed that the defendant physically assaulted two Spokane, WA, VAMC nurses during a visit to the ED. The assault resulted in serious bodily injury to both nurses.
- A Veteran was arrested after threatening to come back "shooting" at the Asheville, NC, VAMC after being denied beneficiary travel pay. An OIG investigation determined that approximately 2 hours after making his threat the defendant purchased an M-4 assault rifle and had the rifle in his home, along with several other firearms, when interviewed by OIG agents and local police. The defendant was released pending further judicial action and is under the supervision of the probation department.
- A Veteran was arrested for making terroristic threats to a call agent at the VA National Call Center, Phoenix, AZ. An OIG and local police investigation revealed that the defendant informed the call agent that he was going to go to the Atlanta, GA, VARO and shoot the first 3,000 people he saw if he did not receive a permanent rating decision within 5 business days. A search of the defendant revealed a fully loaded 10mm handgun concealed in a shoulder holster with an additional magazine of bullets in his front pocket.
- A former VA employee was arrested for violating a protective order and stalking. The defendant was charged in Federal court with sending communications to a current VA employee at work and was charged in state court with stalking the male employee outside of VA facilities. An OIG, VA Police Service, and local sheriff's investigation revealed that the defendant, who worked for VA in 2006, had never met the VA employee and stated that God had told her that the VA employee had to be with her.
- A Veteran was found guilty at trial of threatening VA employees. An OIG investigation revealed that the defendant made a series of threatening phone calls to two Memphis, TN, VA vocational rehabilitation employees at their residences. Due to the violent nature of the offense, the judge remanded the defendant into custody until his sentencing.
- A Veteran pled guilty to making threats against a Federal government official and making false statements. An OIG investigation determined that from 2008 to 2011, the defendant provided a false address for his travel benefit claims to the Hampton, VA, VAMC. The defendant reported that he traveled from North Carolina, while really travelling from Norfolk, VA. Following an interview of the subject and termination of excess travel reimbursement, the defendant threatened to assault the case agent. The loss to VA is approximately $8,000.
- A Veteran initially charged with extortion pled guilty to an amended charge of disorderly conduct and was sentenced to 30 days' incarceration (suspended), 30 days' probation, and ordered to stay away from VA facilities unless on official business. An OIG investigation revealed that the defendant sent a series of threatening correspondence to the Nashville, TN, VARO in an attempt to intimidate and coerce VA employees into processing his claim. The defendant's criminal history included numerous weapon violations.
- A Veteran was sentenced to 10 days' incarceration and 1 year of probation after pleading guilty to threatening and intimidation. An OIG and local law enforcement investigation revealed that the defendant threatened his VA fiduciary and also threatened to go to the Phoenix, AZ, VARO and "Shoot everyone if the VA doesn't give me my money."
- A Veteran was sentenced to 2 years' probation after pleading guilty to disturbing the peace by electronic communication on Federal property. An OIG and VA Police Service investigation

revealed that the defendant sent an e-mail, which threatened physical harm, to the director of the White River Junction, VT, VAMC. The defendant, a former medical center employee, previously sent numerous harassing e-mails to VA personnel, including one that caused a 6-hour facility shutdown in anticipation of his arrival.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive Veterans and VA employees as a direct result of the OIG Fugitive Felon Program. To date, 44.5 million felony warrants have been received from the National Crime Information Center and participating states resulting in 58,270 investigative leads being referred to law enforcement agencies. Over 2,239 fugitives have been apprehended as a direct result of these leads. Since the inception of the OIG Fugitive Felon Program in 2002, OIG has identified $899.3 million in estimated overpayments with an estimated cost avoidance of $1.03 billion. During this reporting period, OIG opened 36 and closed 35 fugitive felon investigations. Investigative work resulted in the arrest of 25 fugitive felons, including 4 VA employees. Based on the information provided by OIG, at least 16 additional arrests were made by other law enforcement agencies. Apprehensions included the following:

- Local law enforcement officers arrested a Veteran at the Nashville, TN, VAMC with the assistance of OIG. The Veteran had outstanding felony warrants for possession of schedule II narcotics, possession of drug paraphernalia, criminal trespass, and failure to appear.
- A VA employee was arrested at the Atlanta, GA, VAMC by local law enforcement officers with the assistance of OIG and VA Police Service. The fugitive was wanted on an outstanding felony warrant for a probation violation related to a previous conviction for armed robbery.

Office of Management and Administration

The Office of Management and Administration provides comprehensive support services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support, and through products and services that promote the overall mission and goals of OIG.

Operations Division

The Operations Division conducts follow-up reporting and tracking of OIG report recommendations; provides strategic, operational, and performance planning; prepares and publishes OIG-wide reports, such as the Semiannual Report to Congress; develops OIG policies and procedures; and electronically distributes all OIG oversight reports. The Operations Division also promotes organizational effectiveness and efficiency by managing all OIG contracting and providing reliable, timely human resources management, and related support services.

Information Technology and Data Analysis Division

IT staff promote organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to VA databases and e-mail by all authorized employees; providing internet document management and control; and providing support to all OIG components.

Data Analysis staff provide automated data processing technical support of OIG and other Federal and governmental agencies requiring information from VA files. Data Analysis Division products facilitate the identification of fraud-related activities and support OIG comprehensive initiatives that result in solutions beneficial to VA.

Administrative and Financial Operations Division

The Administrative and Financial Operations Division promotes OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support services such as employee travel, credit card purchases, and property management.

Budget Division

The Budget Division promotes organizational effectiveness by providing a full complement of budgetary formulation and execution services to management and organizational components, including formulation of submissions and operating plans; monitoring allocations, expenditures, and reserves; conducting financial analyses; and developing internal budget policies.

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 9:00 AM to 4:00 PM Eastern Time. OIG receives phone calls, letters, and e-mails from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 14,103 contacts, 526 of which became OIG cases. An additional 883 of the Hotline contacts became OIG non-case referrals. The

Hotline makes non-case referrals to the appropriate VA facility or office if the allegation does not rise to the level of a case but appears to warrant some action on that facility's or office's part. The Hotline also closed 550 cases during this reporting period, substantiating allegations 36 percent of the time. The following cases were initiated as a direct result of Hotline contacts:

Review Prompts Increased Monitoring of Nursing Home Contracts at Iowa City, Iowa, VAHCS

A review conducted by the Iowa City, IA, VAHCS found numerous deficiencies in the administration of the facility's community nursing home contracts. Problems included: (1) inadequate monitoring of placed Veterans by VA nursing staff, (2) untimely renewal for 7 of 17 contracts, (3) improper placement of Veterans into facilities that did not have a contract with VA, (4) maintaining relationships with poorly rated facilities, (5) and deficient medical documentation for placed Veterans. The facility initiated several actions to address the identified deficiencies, including reassigning staff and forming a new workgroup to monitor the contracts and related program activities.

Lack of Medical Justifications for Plastic Surgeries at Long Beach, California, VAHCS Prompts Increased VISN Oversight

A review conducted by the VA Long Beach HCS, Long Beach, CA, which was initiated as the result of a Hotline case, concluded that documentation for half of the plastic surgery procedures performed at the facility between 2005 and 2011 (163 of 320) did not demonstrate that the purpose was clearly reconstructive and medically necessary, as required. Despite the documentation gaps, the review did not identify instances of "egregious misuse" of resources treating Veterans. The results of the review prompted VISN-level leadership to implement higher-level reviews for plastic surgeries, improved documentation methodologies, and 100 percent audits of plastic surgeries for 6 months.

Hotline Tip Reveals Veteran's Income from Selling Drugs, Results in Terminated VA Pension and Overpayment Collection

A Hotline tip from a law enforcement agency resulted in the retroactive suspension of a Veteran's non-service connected pension, which VA began paying to the Veteran in 1998. A review conducted by the St. Paul, MN, VARO found that the Veteran failed to report to VA substantial, regular income from selling illegal drugs. As a result, the VARO terminated the Veterans' pension and began collecting $126,276 in overpayments.

Veteran's Failure to Disclose Income Results in 26-Year Overpayment

A review conducted by the Philadelphia, PA, VARO determined that a Veteran receiving a non-service connected pension failed to report a source of income since 1986. As a result, the VARO terminated the Veteran's pension and initiated recovery of $104,858 in overpayments.

Review Finds Veteran Continued to Receive Unreduced Benefits During Incarceration

A review conducted by the Muskogee, OK, VARO determined that a Veteran inappropriately received unreduced VA benefits while incarcerated between June 2008 and August 2011. In response to the review, the VARO began collecting $82,558 in benefit overpayments.

South Texas Veterans HCS Cancels Improper Retention Incentive for Physician

A review conducted by the South Texas Veterans HCS, San Antonio, TX, substantiated that the facility improperly authorized retention incentive pay in 2010 and 2011 for a physician who agreed to work only a minimum number of hours in another department experiencing a staff shortage. As a result of the review, the facility cancelled the incentive pay and began collecting approximately $41,500 in unauthorized pay.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's Office of Acquisition, Logistics and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 50 reviews in this reporting period. The tables that follow provide an overview of OIG 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 approximately $911 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule proposals, preaward reviews during this reporting period included seven health care provider proposals—accounting for approximately $14.8 million of the identified potential savings.

October 1, 2011 – March 31, 2012	
Preaward Reports Issued	35
Potential Cost Savings	$910,967,770

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. OIG reviews resulted in VA recovering contract overcharges totaling over $3 million, including approximately $1.5 million related to *Veterans Health Care Act* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 13 postaward reviews performed, 4 involved voluntary disclosures. In two of the four reviews, OIG identified additional funds due. OIG recovered 100 percent of recommended recoveries for postaward contract reviews.

October 1, 2011 – March 31, 2012	
Postaward Reports Issued	13
Dollar Recoveries	$3,136,820

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period OIG reviewed two claims and determined that $397,810 of claimed costs were unsupported and should be disallowed.

October 1, 2011 – March 31, 2012	
Claim Reports Issued	2
Potential Cost Savings	$397,810

Congressional Testimony

Assistant Inspector General Belinda Finn Outlines Potential VA Budgetary Savings at House Veterans' Affairs Committee Hearing

Belinda J. Finn, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on OIG work related to recommendations made by the Veterans Service Organizations (VSOs) for budgetary savings. Ms. Finn discussed OIG work in several areas raised by the VSOs including fee-basis care and VA's claims brokering system. She also discussed OIG work related to savings in VA management of the rural health initiative, information technology contracts, and acquisition process. Ms. Finn was accompanied by Ms. Linda Halliday and Ms. Sondra McCauley, Deputy Assistant Inspectors General for Audits and Evaluations.

Open Market Purchases at VA Not a New Issue, Deputy AIG for Audits and Evaluations Tells House Veterans' Affairs Committee

Linda A. Halliday, Deputy AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the scope and methodology of OIG's ongoing reviews of the VA's administration of the Pharmaceutical Prime Vendor contract. She described OIG's past reporting on open market purchases over the last 12 years and OIG's concerns that the Government was not sufficiently aggregating its buying power to obtain fair and reasonable prices. She was accompanied by Mr. Michael Grivnovics, Director, Federal Supply Service Division, and Mr. Mark Myers, Director, Healthcare Resources Division, in OIG's Office of Contract Review.

Veteran-Owned Small Business Contracts Subject of House Committee on Oversight and Government Reform Hearing

Belinda J. Finn testified before the Subcommittee on Technology, Information Policy, Intergovernmental Relations, and Procurement Reform, Committee on Oversight and Government Reform, United States House of Representatives, on OIG's work related to VA's Veteran-Owned Small Business (VOSB) and SDVOSB programs. An OIG report, released in July 2011, found that 76 percent of the businesses OIG reviewed were ineligible for the program and/or the specific VOSB or SDVOSB contract award, potentially resulting in $2.5 billion awarded to ineligible businesses over the next 5 years. Ms. Finn was accompanied by Mr. James J. O'Neill, AIG for Investigations, whose office's work resulted in the successful prosecution of the Chief Executive Officer of a business that had been awarded over $16 million SDVOSB set-aside construction contracts for which the company was not eligible.

Deputy Assistant Inspector General Tells Senate Panel Homeless Veteran Program Lacks Safety, Security, and Health Standards

Linda A. Halliday testified before the Committee on Veterans' Affairs, United States Senate, on the results of a recent OIG report, *Audit of the Veterans Health Administration's Homeless Providers Grant and Per Diem Program*. The report found a lack of program safety, security, privacy, and health and welfare standards; an incomplete grant application evaluation process; and an inconsistent monitoring program that impacted the program's effectiveness. Ms. Halliday was accompanied by Mr. Gary Abe, Director of OIG's Seattle, WA, Office of Audits and Evaluations.

Special Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

Ben LaBuz was deployed by the U.S. Army in January 2012. He is currently stationed in Ft. Dix, NJ.

Ken Sardegna, an Auditor at OIG Headquarters, was deployed by the U.S. Army in June 2007 and is currently stationed in Washington, D.C.

Deputy Inspector General Receives Presidential Rank Award of Meritorious Executive

Each year, the President recognizes and celebrates a small group of career Senior Executives with the Presidential Rank Award. Recipients of this prestigious award are strong leaders who achieve results and consistently demonstrate strength, integrity, industry, and a relentless commitment to excellence in public service. Deputy Inspector General Richard Griffin was recognized with the Presidential Rank Award of Meritorious Executive.

Table 1: List of Reports Issued by Type			
Office of Audits and Evaluations **Audits and Evaluations**			
Report Title, Issue Date, and Number	**Funds Recommended for Better Use**		**Questioned Costs**
	by OIG	**Agreed to by Management**	
Review of Alleged Contract Irregularities in the Office of Information and Technology 10/13/2011 | 11-01708-02	$786,840	$786,840	$1,651,215
Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System 11/8/2011 | 11-02280-23			
Audit of VA's Consolidated Financial Statements for Fiscal Years 2011 and 2010 11/10/2011 | 11-00343-26			
Audit of Retention Incentives for Veterans Health Administration and VA Central Office Employees 11/14/2011 | 10-02887-30			$1,061,000
Audit of VHA's Veterans Integrated System Network Contracts 12/1/2011 | 10-01767-27	$2,948,968	$2,948,968	
Review of VA's Secure VA-Chief Information Security Officer Support Services Acquisition Process 12/20/2011 | 11-01508-24			
Review of Alleged Mismanagement of Systems to Drive Performance Project 2/13/2012 | 11-02467-87			
Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires 2/23/2012 | 11-00733-95			
Audit of the VA's Enhanced-Use Lease Program 2/29/2012 | 11-00002-74			
Audit of VHA Acquisition and Management of Prosthetic Limbs 3/8/2012 | 11-02254-102	$8,607,540	$8,607,540	$2,151,885
Audit of VHA's Homeless Providers Grant and Per Diem Program 3/12/2012 | 11-00334-115			
Review of VA's Compliance with the Improper Payments Elimination and Recovery Act (IPERA) 3/14/2012 | 12-00849-120			

Appendix A: List of OIG Reports Issued

Office of Audits and Evaluations Audits and Evaluations			
Report Title, Issue Date, and Number	Funds Recommended for Better Use by OIG	 Agreed to by Management	Questioned Costs
Independent Review of VA's FY 2011 Performance Summary Report to ONDCP 3/22/2012 | 12-01072-121			
Independent Review of VA's FY11 Detailed Accounting Summary Report to the ONDCP 3/22/2012 | 12-01071-122			
Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices 3/27/2012 | 10-02888-128			
Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices 3/27/2012 | 10-02888-129			
Audit of VHA's Prosthetics Supply Inventory Management 3/30/2012 | 11-00312-127	$35,500,000	$35,500,000	
Total Monetary Impact	**$47,843,348**	**$47,843,348**	**$4,864,100**

Office of Audits and Evaluations Benefits Inspections
VA Regional Office Fort Harrison, Montana 11/3/2011 | 11-03211-12
VA Regional Office, Manchester, New Hampshire 11/22/2011 | 11-03384-31
VA Regional Office, Indianapolis, Indiana 11/29/2011 | 11-03134-32
VA Regional Office Providence, Rhode Island 1/3/2012 | 11-03465-58
VA Regional Office, White River Junction, Vermont 1/17/2012 | 11-00518-54
VA Regional Office, Fargo, North Dakota 1/25/2012 | 11-03724-73
VA Regional Office, Montgomery, Alabama 2/1/2012 | 11-04432-77
VA Regional Office, St. Petersburg, Florida 2/8/2012 | 11-04243-86
VA Regional Office, Pittsburgh, Pennsylvania 2/27/2012 | 11-04216-103

Office of Audits and Evaluations Benefits Inspections
VA Regional Office, Manila, Philippines 3/1/2012 | 12-00156-110
VA Regional Office, Honolulu, Hawaii 3/26/2012 | 12-00151-123

Office of Healthcare Inspections Combined Assessment Program Reviews
San Francisco VA Medical Center, San Francisco, California 10/14/2011 | 11-02089-05
Orlando VA Medical Center, Orlando, Florida 10/17/2011 | 11-02084-01
VA Butler Healthcare, Butler, Pennsylvania 10/19/2011 | 11-02083-06
Veterans Health Care System of the Ozarks, Fayetteville, Arkansas 10/26/2011 | 11-02085-10
Fayetteville VA Medical Center, Fayetteville, North Carolina 10/27/2011 | 11-02081-09
VA Central Iowa Health Care System, Des Moines, Iowa 11/17/2011 | 11-02086-28
Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts 12/6/2011 | 11-02712-37
William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin 12/7/2011 | 11-02713-43
Robert J. Dole VA Medical Center, Wichita, Kansas 12/8/2011 | 11-02716-42
Charles George VA Medical Center, Asheville, North Carolina 12/22/2011 | 11-02721-47
VA San Diego Healthcare System, San Diego, California 1/6/2012 | 11-03658-64
Hampton VA Medical Center, Hampton, Virginia 1/11/2012 | 11-02718-50
Grand Junction VA Medical Center, Grand Junction, Colorado 1/12/2012 | 11-03657-62
Memphis VA Medical Center, Memphis, Tennessee 1/19/2012 | 11-03654-66
VA Black Hills Health Care System, Fort Meade, South Dakota 1/31/2012 | 11-03661-76
Cincinnati VA Medical Center, Cincinnati, Ohio 2/13/2012 | 11-03666-79
VA Illiana Health Care System, Danville, Illinois 2/14/2012 | 11-03665-78

Appendix A: List of OIG Reports Issued

Office of Healthcare Inspections Combined Assessment Program Reviews
Samuel S. Stratton VA Medical Center, Albany, New York 2/16/2012 | 11-03664-88
VA Hudson Valley Health Care System, Montrose, New York 2/17/2012 | 11-03656-89
West Palm Beach VA Medical Center, West Palm Beach, Florida 2/21/2012 | 11-03669-97
VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi 2/29/2012 | 11-03668-107
VA Roseburg Healthcare System, Roseburg, Oregon 3/13/2012 | 11-03667-108
Central Alabama Veterans Health Care System, Montgomery, Alabama 3/14/2012 | 11-03663-111
VA Ann Arbor Healthcare System, Ann Arbor, Michigan 3/15/2012 | 11-03660-114

Office of Healthcare Inspections Community Based Outpatient Clinic Reviews
Bennington, VT, and Littleton, NH; Jamestown and Lackawanna, NY; Hagerstown, MD, and Petersburg, WV 11/1/2011 | 11-01406-14
Gillette and Powell, WY; Pueblo, CO; Anaheim and Laguna Hills, CA; Escondido and Oceanside, CA; Lancaster and Sepulveda, CA 11/2/2011 | 11-01406-13
Ft. Pierce and Okeechobee, FL; Charleston and Williamson, WV; Mansfield and New Philadelphia, OH; Agana Heights, GU, and Hilo, HI 12/9/2011 | 11-01406-38
Montrose, CO; Bellevue, Lincoln, and Norfolk, NE 1/18/2012 | 11-03653-67
Catskill, Clifton Park, Glens Falls, and Schenectady, NY 2/17/2012 | 11-03653-71
Chico, McClellan, and Oakland, CA 3/12/2012 | 11-03653-105
Framingham, New Bedford, and Springfield, MA; Elmira, NY 3/12/2012 | 11-03655-109
Florence, Rock Hill, and Sumter (Sumter County), SC 3/16/2012 | 11-03653-104
Durango, CO; Raton and Silver City, NM; Odessa, TX 3/16/2012 | 11-03653-106
Pensacola (Joint Ambulatory Care Center), FL; New Braunfels, San Antonio (North Central Federal Clinic), and Victoria, TX 3/19/2012 | 11-03653-112

Office of Healthcare Inspections National Healthcare Inspections
Management of Multidrug-Resistant Organisms in Veterans Health Administration Facilities 10/14-2011 | 11-02870-04
Informed Consent and Prevention of Disease Progression in Veterans with Chronic Kidney Disease 12/19/2011 | 10-03399-51
Prosthetic Limb Care in VA Facilities 3/8/2012 | 11-02138-116

Office of Healthcare Inspections Hotline Healthcare Inspections
Alleged Quality of Care Issues in the Electroconvulsive Therapy Program, VA Boston Healthcare System, Boston, Massachusetts 10/24/2011 | 10-03535-11
Alleged Telemetry Unit Deficiencies, VA New York Harbor Health Care System, New York, New York 10/27/2011 | 11-02545-15
Emergency Department Quality of Care, Safety, and Management Issues, Dallas VA Medical Center, Dallas, Texas 12/1/2011 | 11-02051-39
Alleged Quality of Resident Care Issues, Northport VA Medical Center, Northport, New York 12/2/2011 | 11-01437-41
Delay in Cancer Diagnosis and Treatment at a Southern Arizona VA Health Care System Community Based Outpatient Clinic 12/5/2011 | 11-03545-40
Alleged Delay in Diagnosis and Treatment at a Community Based Outpatient Clinic, Nashville and Murfreesboro, TN 12/15/2011 | 11-02828-52
Review of Referral and Consultation Processes in VISN 20 and Southern Oregon Rehabilitation Center and Clinics at White City, OR 12/20/2011 | 11-01209-53
Management of Emergency Calls Primary Care Call Center, VA San Diego Healthcare System, San Diego, California 12/21/2011 | 11-03074-57
Follow-Up Prosthetic and Sensory Aids Service Records Review Durham VA Medical Center, Durham, North Carolina 12/22/2011 | 11-01416-56
Oversight Review of Quality of Care Issues Edward Hines, Jr. VA Hospital Hines, Illinois 1/5/2012 | 11-03921-63
Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas 1/6/2012 | 11-03941-61
Oversight Review of Anesthesia and Management Issues, Sacramento VA Medical Center, Mather, California 1/9/2012 | 11-02238-65

Appendix A: List of OIG Reports Issued

Office of Healthcare Inspections Hotline Healthcare Inspections
Discharge, Travel, and Treatment Issues, Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri 1/20/2012 | 11-04228-72
Alleged Mismanagement of Care and Delayed Adverse Event Reporting, Robert J. Dole VA Medical Center Wichita, Kansas 2/9/2012 | 11-02826-94
Follow-Up Evaluation of Infection Control Deficiencies in the Dental Clinic, Dayton VA Medical Center, Dayton, OH 2/14/2012 | 10-03330-91
Alleged Quality of Care and Staffing Issues VA Western New York Healthcare System, Buffalo, New York 2/16/2012 | 11-02637-90
Quality of Care Issues Edward Hines, Jr. VA Hospital 3/8/2012 | 11-01485-117
Use of Restraints Salem VA Medical Center Salem, Virginia 3/20/2012 | 12-00221-125
Alleged Mental Health Access and Treatment Issues at a VA Medical Center 3/21/2012 | 11-03021-133
Alleged Quality of Care Issues in the Emergency Department, Northport VA Medical Center, Northport, NY 3/27/2012 | 12-00999-135
Alleged Failure to Obtain Informed Consent and Provide Appropriate Dental Care Minneapolis VAHCS, Minneapolis, MN 3/28/2012 | 11-04564-140

Office of Investigations Administrative Investigations
Conflict of Interest and Misuse of Leave, South Texas Veterans Health Care System, San Antonio, Texas 10/18/2011 | 10-02814-08
Abuse of Authority, Prohibited Personnel Practices, Failure to Properly Supervise, and a Lack of Candor, Office of Business Oversight, VA Central Office 12/12/2011 | 11-02258-46
Improper Time and Attendance and Preferential Treatment, Center of Excellence, VISN 17, Waco, Texas 2/3/2012 | 10-03822-80
Conflict of Interest, Misuse of Resources, Gratuities, and Failure to Follow Policy, James A. Haley Veterans' Hospital, Tampa, Florida 2/3/2012 | 11-00561-81

Office of Contract Review Preaward Reviews	
Report Title, Issue Date, and Number	**Savings and Cost Avoidance**
Review of Proposal Submitted Under Solicitation Number VA-250-10-RP-0049 10/4/2011 | 11-03375-03	$411,372
Review of Proposal Submitted Under Solicitation Number VA-248-10-RP-0464 10/21/2011 | 11-03568-07	$2,796,501
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-04-R2 10/27/2011 | 11-04080-16	$103,616,505
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 10/27/2011 | 11-03612-17	$10,446,401
Review of Contract Extension Proposal Submitted Under a FSS Contract 10/27/2011 | 11-03936-18	$3,371
Review of FSS Proposal Submited Under Solicitation Number M5-Q50A-03-R2 10/28/2011 | 11-03191-19	$0
Review of FSS Proposal Submitted Under Solicitation Number 797-FSS-99-0025-R6 10/31/2011 | 11-02202-20	$4,204,350
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R2 10/31/2011 | 11-03860-21	$3,703
Review of FSS Proposal Submited Under Solicitation Number M5-Q50A-03-R4 11/8/2011 | 11-03425-25	$0
Review of Proposal Submitted Under Solicitation Number VA-250-10-RP-0070 11/9/2011 | 11-04196-22	$1,751,076
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 11/9/2011 | 11-03640-29	$0
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R2 11/10/2011 11-03190-33	$0
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R2 11/10/2011 | 11-03617-34	$0
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R2 11/16/2011 | 11-03763-36	$0
Review of Contract Extension Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 11/29/2011 | 11-03448-35	$702,051,174
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 12/9/2011 | 11-03318-49	$42,928,388
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 12/15/2011 | 11-03973-55	$0
Review of Proposal Submitted Under Solicitation Number VA-258-11-RP-0097 12/29/2011 | 12-00476-59	$3,852,929

Appendix A: List of OIG Reports Issued

Office of Contract Review Preaward Reviews	
Report Title, Issue Date, and Number	**Savings and Cost Avoidance**
Review of Proposal Submitted Under Solicitation Number VA-247-11-RP-0121 12/29/2011 | 12-00477-60	$187,541
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 1/5/2012 | 11-04468-68	$0
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 1/10/2012 | 11-04316-69	$0
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 1/12/2012 | 11-04469-70	$0
Review of Proposal Submitted Under Solicitation Number VA-101-10-RP-0142 1/31/2012 | 12-00730-82	$14,080
Review of Proposal Submitted Under Solicitation Number VA-101-10-RP-0142 1/31/2012 | 12-00734-83	$469
Review of FSS Proposal Submitted Under Solicitation Number 797-FSS-99-0025-R7 1/31/2012 | 12-00117-84	$1,821,542
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 2/2/2012 | 11-04390-85	$2,566,492
Review of FSS Proposal Submitted Under Solicitation Number M5-Q50A-03-R4 2/13/2012 | 12-00196-96	$0
Review of Proposal Submitted Under Solicitation Number VA-101-10-RP-0142 2/13/2012 | 12-00694-98	$327,499
Review of FSS Proposal Submitted Under Solicitation Number 797-FSS-99-0025-R7 2/15/2012 | 12-00796-99	$2,111,860
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R7 2/15/2012 | 12-00654-101	$14,700,000
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 3/5/2012 | 11-03616-118	$293,149
Review of FSS Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R7 3/6/2012 | 12-00798-119	$8,348,716
Review of FSS Proposal Submitted Under Solicitation Number 797-652C-04-0001-R1 3/22/2012 | 11-04184-139	$2,736,020
Review of Proposal Submitted Under Solicitation Number VA-243-10-RP-0436 3/29/2012 | 12-01627-145	$1,000,993
Review of Proposal Submitted Under Solicitation Number VA-248-11-RP-0508 3/29/2012 | 12-01812-150	$4,793,639
Total Monetary Impact	**$910,967,770**

Office of Contract Review Postaward Reviews	
Report Title, Issue Date, and Number	**Dollar Recoveries**
Review of Compliance with Public Law 102-585 Section 603 Under a FSS Contract 12/5/2011 | 10-00289-44	$1,319,720
Review of Voluntary Disclosure Submitted Under a FSS Contract 12/7/2011 | 10-03167-45	$33,460
Review of Voluntary Disclosure Submitted Under a FSS Contract 12/9/2011 | 11-03319-48	$264,235
Review of a VA Contract 2/15/2012 | 11-00782-100	$1,339,657
Review of Overcharges for Late Additions of Covered Drugs Under a FSS Contract 2/22/2012 | 12-00080-92	$8,119
Review of Compliance with Public Law 102-585 Section 603 Under a FSS Contract 3/1/2012 | 12-01220-113	$2,346
Review of a Late Addition of a Covered Drug Under a FSS Interim Agreement 3/21/2012 | 12-01415-131	$0
Review of a Product Addition Under a FSS Contract 3/21/2012 | 11-03835-134	$0
Review of Public Law Pricing Errors Under a FSS Contract 3/22/2012 | 10-01772-136	$15,053
Review of a Voluntary Disclosure of a Drug Pricing Error Under a FSS Contract 3/22/2012 | 12-01521-137	$7,340
Review of Compliance with Public Law 102-585 Section 603 Under a FSS Contract 3/27/2012 | 10-01769-143	$145,432
Review of Public Law Pricing Issues Under a FSS Contract 3/27/2012 | 11-03834-144	$244
Review of Overcharges Due to a Late Addition of a Covered Drug Under a FSS Contract 3/29/2012 | 12-00082-149	$1,213
Total Monetary Impact	**$3,136,820**

Office of Contract Review Claim Reviews	
Report Title, Issue Date, and Number	**Savings and Cost Avoidance**
Review of Settlement Proposal on a Task Order 2/9/2012 | 11-03505-93	$195,316
Review of Proposed Claim Submitted Under a VA Contract 3/19/2012 | 12-00511-126	$202,494
Total Monetary Impact	**$397,810**

Appendix A: List of OIG Reports Issued

Table 2: Total Potential Monetary Benefits of Reports Issued				
Report Type	**Funds Recommended for Better Use**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits and Reviews	$47,843,348	$4,864,100	N/A	N/A
Preaward Reviews	N/A	N/A	$910,967,770	N/A
Postaward Reviews	N/A	N/A	N/A	$3,136,820
Claim Reviews	N/A	N/A	$397,810	N/A
Total	**$47,843,348**	**$4,864,100**	**$911,365,580**	**$3,136,820**

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 1 year after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. Table 1 summarizes the status of all unimplemented OIG reports and recommendations. Results are sorted by the action office responsible for implementation. Additionally, Table 2 identifies each OIG report and recommendation open for more than 1 year.

As of March 31, 2012, there are 156 total open reports and 1,037 total open recommendations. Thirty-four of these reports and 79 of these recommendations remain unimplemented for over 1 year. Table 1 lists all unimplemented OIG reports and recommendations by action office. Some reports and recommendations are counted more than once because they have actions at more than one office. Of the reports open less than 1 year, 7 reports and 11 recommendations have actions at two or more offices. Of the reports open more than 1 year, one report and four recommendations have actions at two offices. Table 2 identifies the reports and recommendations that remain unimplemented for over 1 year.

Table 1: Number of Unimplemented OIG Reports and Recommendations by Office

	Reports Open Less Than 1 Year	Reports Open More Than 1 Year	**Total Reports Open**	Recommendations Open Less Than 1 Year	Recommendations Open More Than 1 Year	**Total Recommendations Open**
Veterans Health Administration	104	16	**120**	855	35	**890**
Veterans Benefits Administration	14	6	**20**	68	13	**81**
Office of Management	3	0	**3**	9	0	**9**
Office of Information and Technology	3	9	**12**	9	20	**29**
Office of Operations, Security, and Preparedness	1	1	**2**	6	7	**13**
Office of Acquisitions, Logistics, and Construction	3	3	**6**	7	8	**15**
Office of Human Resources and Administration	2	0	**2**	9	0	**9**
Corporate Senior Executive Management Office	1	0	**1**	4	0	**4**
Office of Small and Disadvantaged Business Utilization	1	0	**1**	2	0	**2**
Total	**132**	**35**	**167**	**969**	**83**	**1052**

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans 7/11/2006 | 06-02238-163	OIT	1 of 6	-

Recommendation d: We recommend that the Secretary ensure that all position descriptions are evaluated and have proper sensitivity level designations, that there is consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.

Audit of VA's Management of Information Technology Capital Investments 5/29/2009 | 08-02679-134	OIT	1 of 5	-

Recommendation 4: We recommend that the Acting Assistant Secretary for Information and Technology clearly define the roles of the IT governance boards responsible for providing oversight and management of VA's IT capital investments.

Audit of VA Electronic Contract Management System 7/30/2009 | 08-00921-181	OALC	2 of 8	-

Recommendation 1: We recommend the Executive Director, Office of Acquisition, Logistics, and Construction develop and implement VA-wide eCMS policy and handbook to ensure consistent use and compliance with system requirements.

Recommendation 7: We recommend the Executive Director, Office of Acquisition, Logistics, and Construction coordinate with the Assistant Secretary for Management and the Assistant Secretary for Information and Technology to determine the feasibility of integrating eCMS with the IFCAP or FMS systems in order to eliminate or minimize duplicate data entry and streamline the procurement process.

Administrative Investigation, Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC 8/18/2009 | 09-01123-195	OIT	1 of 11	-

Recommendation 5: We recommend that the Assistant Secretary for Information and Technology confer with the Office of Human Resources to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such corrective action.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Administrative Investigation, Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC* 8/18/2009 | 09-01123-196	OIT	8 of 34	-

Recommendation 6: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such action.

Recommendation 10: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s improper VA appointment, and take such action.

Recommendation 13: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s improper VA appointment, to include her appointment at a rate above the minimum, and take such action.

Recommendation 26: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper FCIP appointments, failure to provide 2-year formal training programs, and subsequent conversions to career-conditional status of _____, and take such action.

Recommendation 27: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine whether OI&T managers made additional improper FCIP appointments, failed to provide a 2-year formal training program, and subsequently converted employees to career-conditional status, and take appropriate corrective action.

Recommendation 29: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper DHA appointments of _____ and take such action.

Recommendation 30: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to identify any additional improper VA appointments made using DHA, and take appropriate corrective action.

Recommendation 33: We recommend that the Assistant Secretary for Information and Technology ensure that a review of OI&T retention incentives is conducted to ensure that they are necessary and support the mission and program needs and that they fully comply with law, OPM regulations, and VA policy.

* OIG disagrees with the Office of General Counsel's (OGC's) legal opinions finding that a violation of the nepotism statute did not occur and no legal basis exists for collecting funds from individual employees, but closed recommendations 1, 3, and 18-24 because OIT is planning no further action in light of OGC's legal opinions. OIG stands by the recommendations, but will not waste any more resources in pursuit of corrective action.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Veterans Benefits Administration's Control of Veterans' Claim Folders 9/28/2009 | 09-01193-228	VBA	2 of 9	-

Recommendation 2: We recommended the Under Secretary for Benefits establish a mechanism to identify and track the number of claims folders regional office personnel rebuild.

Recommendation 9: We recommended the Under Secretary for Benefits establish a mechanism to ensure regional office personnel enforce the maximum 60 day search established in recommendation 8 and take corrective actions to meet the standard where improvement is needed.

Department of Veterans Affairs System Development Life Cycle Process 9/30/2009 | 09-01239-232	OIT	2 of 4	-

Recommendation 1: We recommend the Assistant Secretary for Information and Technology require OI&T develop and issue a directive that communicates, VA-wide, the mandatory requirements of VA's SDLC process outlined in the existing Program Management Guide to ensure consistent management of VA's IT investment portfolio.

Recommendation 4: We recommend the Assistant Secretary for Information and Technology require OI&T establish and maintain a central data repository to store all program artifacts, including cumulative cost and schedule data.

Healthcare Inspection, VistA Outages Affecting Patient Care, Office of Risk Management and Incident Response, Falling Waters, WV 12/3/2009 | 09-01849-39	OIT	1 of 5	-

Recommendation 3: We recommend that the Assistant Secretary for Information and Technology ensure that the Office for Information Protection and Risk Management performs and reports on risk management for essential medical IT systems.

Inspection of VA Regional Office, Roanoke, VA 1/14/2010 | 09-01995-63	VBA	1 of 6	-

Recommendation 6: We recommend the Roanoke VA Regional Office Director research alternative locations to store and safeguard Veterans' claims folders and expeditiously relocate these folders to reduce the risk of structural damage to the building and ensure employee safety.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Report Title, Issue Date, and Number	Responsible Organization	Number of Open Recommendations	Monetary Impact
Healthcare Inspection, Hospitalized Community-Dwelling Elderly Veterans: Cognitive and Functional Assessments and Follow-up after Discharge 3/4/2010 | 09-01588-92	VHA	1 of 1	-

Recommendation 1: We recommended that the Under Secretary for Health develop and implement a plan to ensure that vulnerable elders admitted to hospitals have a documented assessment of cognitive functioning.

Audit of VA's Efforts to Provide Timely Compensation and Pension Medical Examinations 3/17/2010 | 09-02135-107	VHA	2 of 10	-

Recommendation 3: We recommend the Acting Under Secretary for Health establish procedures to measure productivity by identifying the number of full-time equivalents who conduct VHA compensation and pension medical examinations and establishing standard times to complete each type of compensation and pension medical examination.

Recommendation 4: We recommend the Acting Under Secretary for Health utilize and monitor data on VHA workload, costs, and productivity to ensure sufficient and appropriate resources are dedicated to completing compensation and pension medical examination requests sent to VA medical facilities.

Review of Brachytherapy Treatment of Prostate Cancer, Philadelphia, Pennsylvania, and Other VA Medical Centers 5/3/2010 | 09-02815-143	VHA	1 of 5	-

Recommendation 3: VHA should review the controls that are in place to ensure that VA contracts for health care comply with applicable laws and regulations, and where necessary, make the required changes in organization and/or process to bring this contracting effort into compliance.

Audit of National Call Centers and the Inquiry Routing and Information System 5/13/2010 | 09-01968-150	VBA	4 of 7	-

Recommendation 2: We recommend the Acting Under Secretary for Benefits establish a national performance target for blocked call rate.

Recommendation 3: We recommend the Acting Under Secretary for Benefits establish a national performance standard for productivity at the call agent level.

Recommendation 4: We recommend the Acting Under Secretary for Benefits conduct a review of call agent productivity and call demand to determine what changes in the call center structure and/or additional staffing are needed to ensure performance standards are met.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Recommendation 7: We recommend the Acting Under Secretary for Benefits establish consistent accuracy performance measures and national performance standards for call agents and the IRIS [Inquiry Routing and Information System] manager.			
Audit of Oversight of Patient Transportation Contracts 5/17/2010 | 09-01958-155	VHA	1 of 8	-
Recommendation 6: We recommend the Under Secretary for Health automate patient transportation billing information in order to maintain and retain data needed to efficiently perform invoice reconciliation.			
Review of Federal Supply Schedule 621 I – Professional and Allied Healthcare Staffing Services 6/7/2010 | 08-02969-165	OALC	5 of 7	-
Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable.			
Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).			
Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.			
Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.			
Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.			
Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York 7/21/2010 | 10-00471-201	VHA	1 of 9	-
Recommendation 9: We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.			

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Report Title, Issue Date, and Number	Responsible Organization	Number of Open Recommendations	Monetary Impact
Healthcare Inspection, Community Based Outpatient Clinic Reviews: Corpus Christi and New Braunfels, TX; Long Beach (Cabrillo) and Santa Fe Springs (Whittier), CA; San Diego (Mission Valley) and El Centro (Imperial Valley), CA; and Commerce (East Los Angeles) and Oxnard, CA 7/27/2010 | 10-00627-208	VHA	1 of 21	-

Recommendation 19: We recommended that the VISN 22 Director ensure that the Greater Los Angeles HCS Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract for the East Los Angeles CBOC. The Greater Los Angeles HCS should research the overpayments attributable to inactive patients and seek reimbursement for those overpayments.

Audit of Community-Based Outpatient Clinic Management Oversight 7/28/2010 | 09-02093-211	VHA	1 of 6	-

Recommendation 2: We recommended that the Under Secretary for Health develop a set of comprehensive monitoring mechanisms to evaluate CBOC performance and hold quarterly CBOC reviews with the Networks to discuss CBOC performance results, and as needed, corrective actions.

American Recovery and Reinvestment Act Oversight Advisory Report: Review of Efforts to Meet Competition Requirements and Monitor Recovery Act Awards 9/17/2010 | 10-00969-248	OALC	1 of 5	-

Recommendation 2: We recommended the Executive Director of the OALC develop and issue a comprehensive policy that clearly defines the appropriate procedures for the proper completion of adequate contractor responsibility determinations and related justifications.

VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12 9/30/2010 | 10-01575-262	OSP/OIT	7 of 11	-

Recommendation 1: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, develop a plan to ensure the PIV [Personal Identity Verification] System interfaces with internal and external systems to electronically verify PIV credential applicant information.

Recommendation 4: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, ensure the PIV System is modified to provide effective monitoring of System users for unlawful, unauthorized, or inappropriate activities.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Recommendation 5: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, ensure the required Privacy Impact Assessment for the PIV System is prepared and approved annually. Recommendation 6: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, define the extent to which PIV credentials will be required to access VA facilities and information systems and develop plans to test and implement the infrastructure necessary to establish these controls. Recommendation 7: We recommend the Assistant Secretary for Operations, Security, and Preparedness staff program vacancies in the HSPD-12 Program Management Office. Recommendation 8: We recommend the Assistant Secretary for Operations, Security, and Preparedness finalize the VA Directive and VA Handbook defining the roles, responsibilities, and processes for implementation and ongoing operations of the HSPD-12 Program. Recommendation 10: We recommend the Assistant Secretary for Operations, Security, and Preparedness implement a formal oversight process to monitor progress in achieving compliance with the requirements of HSPD-12.			
Administrative Investigation, Improper Locality Rate of Pay Office of Information & Technology VA Central Office 10/14/2010 | 10-02858-07	OIT	1 of 4	-
Recommendation 4: We recommend that the Principal Deputy Assistant Secretary for OI&T confer with the Office of Human Resources to determine if there are other VACO OI&T employees with similar situations and take appropriate corrective action to determine their duty stations, recoup any monies improperly paid to them, adjust any improper payments to their retirement annuities and Thrift Savings Plans, and make any other necessary corrections.			
Healthcare Inspection, Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 10/21/2010 | 10-03103-12	VHA	2 of 7	-
Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, collects and appropriately uses PI [performance improvement] data in the medical staff reprivileging process. Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that a vulnerability assessment is conducted at all CBOCs to determine if a panic alarm system is required and ensures a system is implemented if one is deemed necessary.			

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits 12/16/2010 | 10-01640-45	VBA	1 of 4	-

Recommendation 1: We recommend the Acting Under Secretary for Benefits, in ongoing efforts to modernize the Rating Board Automation data system, develop reporting capabilities to capture longitudinal data on Veterans' claims activity.

Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas 1/12/2011 | 10-02983-55	VHA	1 of 6	-

Recommendation 6: We recommended that normal results be communicated to patients within the specified timeframe.

Review of Retention Incentive Payments at VA Medical Center, Providence, Rhode Island 1/20/2011 | 10-01937-68	VHA	3 of 5	$894,790

Recommendation 1: We recommend the Under Secretary for Health conduct an independent, 100 percent review of retention incentives paid to VA Medical Center Providence employees to assess appropriateness and stop unnecessary payments.

Recommendation 2: We recommend the Under Secretary for Health review and determine the need to continue payment of a retention incentive to the VA Medical Center Providence Director and other medical center directors in Veterans Integrated Service Network 1.

Recommendation 3: We recommend the Under Secretary for Health establish a management certification that requires the Veterans Integrated Service Network 1 Director to review and certify the appropriateness of all retention incentives paid to senior managers and supervisors in medical facilities within Veterans Integrated Service Network 1.

Audit of VBA's 100 Percent Disability Evaluations 1/24/2011 | 09-03359-71	VBA	1 of 7	$1,130,000,000

Recommendation 7: We recommended the Acting Under Secretary for Benefits conduct a review of all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the Veterans' electronic records.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Combined Assessment Program Summary Report, Evaluation of Magnetic Resonance Imaging Safety in Veterans Health Administration Facilities 1/26/2011 | 09-01038-77	VHA	4 of 4	-

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that all employees who may need to enter the MRI [magnetic resonance imaging] suite receive initial and annual MRI safety training.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that employees screen patients prior to MRI scans, obtain necessary signatures on screening forms, retain screening forms in patient medical records, and document follow-up on potential contraindications for MRI.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that informed consents specific to MRI with contrast are completed for all high-risk patients and documented in the medical records.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that physical barriers are in place, call systems are tested and maintained, risk assessments are completed, and emergency drills are conducted.

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia 1/31/2011 | 10-02987-78	VHA	1 of 5	-

Recommendation 4: We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Audit of the Veterans Service Network 2/18/2011 | 09-03850-99	OIT	1 of 9	$35,000,000

Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Community Based Outpatient Clinic Reviews: Spring City and Springfield, PA; Sarasota and Sebring, FL; Paragould, AR, and Salem, MO; Cottonwood and Lake Havasu City, AZ 2/28/2011 | 11-00840-104	VHA	1 of 18	-

Recommendation 14: We recommended that normal test results at the Lake Havasu City CBOC be communicated to patients within the specified timeframe.

Healthcare Inspection, Radiation Safety in Veterans Health Administration Facilities 3/10/2011 | 10-02178-120	VHA	2 of 5	-

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers clarify the current expectations for frequency of physician peer review practices in RT *[radiation therapy]*.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers ensure that the fluoroscopy handbook is implemented.

Combined Assessment Program Summary Report, Evaluation of Reusable Medical Equipment Practices in Veterans Health Administration Facilities 3/14/2011 | 10-00135-121	VHA	5 of 6	-

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that SOPs [standard operating procedures] are current, consistent with manufacturers' instructions, and located within the reprocessing areas.

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that employees consistently follow SOPs, that supervisors monitor compliance, and that annual training and competency assessments are completed and documented.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that flash sterilization is used only in emergent situations, that supervisors monitor compliance, and that managers complete and document annual competency assessments for employees who perform flash sterilization.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that appropriate PPE [protective personal equipment] is donned before entering and worn in decontamination areas.

Recommendation 6: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that processes for consistent internal oversight of RME [va] activities are established to ensure senior management involvement.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana 3/23/2011 | 10-03092-129	VHA	8 of 22	-

Recommendation 1: We recommended that moderate sedation documentation include all required components and that supervisors monitor compliance.

Recommendation 3: We recommended that required annual bloodborne pathogens training, radiation safety training, and N95 respirator fit testing be completed by designated employees and documented.

Recommendation 9: We recommended that at least two requests to verify physicians' currently held or most recently held clinical privileges be made and documented.

Recommendation 11: We recommended that FPPEs [Focused Professional Practice Evaluations] be initiated for all physicians who have been newly hired or have added new privileges.

Recommendation 12: We recommended that service-specific competency criteria be created, approved, and implemented.

Recommendation 13: We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

Recommendation 14: We recommended that ordering providers document patient notification and treatment actions in response to critical results.

Recommendation 19: We recommended that advance directives developed using the VA form be appropriately witnessed and that a copy of the completed document be provided to the patient.

Review of VBA's Pension Management Centers 3/30/2011 | 10-00639-135	VBA	4 of 4	-

Recommendation 1: We recommend the Acting Under Secretary for Benefits establish an operational plan to ensure Pension Management Centers efficiently and effectively manage the workload to achieve timeliness standards.

Recommendation 2: We recommend the Acting Under Secretary for Benefits modify the Performance and Accountability Report to provide separate performance measures for significant Pension Management Center processing actions, such as original death pensions and Income Verification Matches.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Issue Date, and Number	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Recommendation 3: We recommend the Acting Under Secretary for Benefits establish specific performance goals for Income Verification Matches and implement controls to ensure timely processing to reduce overpayments, including exploring alternative measures such as assigning a dedicated claims processor or team to process Income Verification Matches. Recommendation 4: We recommend the Acting Under Secretary for Benefits explore opportunities to obtain Internal Revenue Service and Social Security Administration data quicker to ensure Income Verification Matches are processed timely to reduce overpayments.			
TOTAL		**79**	**$1,165,894,790**

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* (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 FFMIA. The audit of VA's FY 2011 consolidated financial statements reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. This condition was due to a material weakness in information technology security controls and two significant deficiencies concerning accrued operating expenses and loan guaranty reporting. Also, the audit noted that VA's underlying financial systems were complex and disjointed legacy applications and operating platforms that sometimes did not readily support financial amounts or sometimes required manual processing and reconciliation.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	295 total reviews commented on 33 times
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 9-44
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 9-44
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 56-68
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 24-40
Section 5 (a) (5)	Summary of instances where information was refused	None
Section 5 (a) (6)	List of reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 46-55
Section 5 (a) (7)	Summary of each particularly significant report	See pages 9-44
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 70
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 70
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 70
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 page 69

Table 1: Resolution Status of Reports with Questioned Costs		
Resolution Status	**Number**	**Dollar Value (In Millions)**
No management decision by 03/31/2011	0	$0
Issued during reporting period	3	$4,864,100
Total inventory this period	3	$4,864,100
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	3	$4,864,100
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	3	$4,864,100
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 03/31/2011	0	$0
Issued during reporting period	4	$47,843,348
Total inventory this period	4	$47,843,348
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	4	$47,843,348
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	4	$47,843,348
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 IG appointed under the *Inspector General Act of 1978* to submit an appendix 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.

Enacted in February 2009, the *American Recovery and Reinvestment Act of 2009* (ARRA) requires OIG to conduct oversight of the VA projects, programs, grants, and initiatives that received a total of $1.4 billion in funding under the Act. OIG's program of oversight includes audits, evaluations, investigation, fraud awareness and prevention training, and other monitoring activities covering the major VA programs that received ARRA funding. The VA programs and the amounts of their ARRA funding include:

- $1.0 billion for VHA medical facility nonrecurring maintenance (NRM) and energy projects.
- $150.0 million for VHA Grants to States for extended care facilities.
- $50.0 million for NCA headstone, marker, gravesite, and monument repairs; NRM, energy, and road repair projects; and equipment upgrades.
- $150 million for VBA claims processing hiring initiative and support of Veterans economic recovery payments.
- $45 million for OIT support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

Additionally, the Act provided for an estimated $700 million for the one-time $250 economic recovery payments to Veterans and their survivors or dependents.

As of March 31, 2012, OIG has expended $2.5 million (the entire $1.0 million OIG received under ARRA and $1.5 million from regular appropriations) in conducting its comprehensive program of ARRA oversight. OIG's ARRA-related accomplishments and activities completed to date include:

- Issued seven final audit and evaluation reports and one interim advisory report on VA management of ARRA program activities.
- Conducted 570 fraud awareness training and outreach sessions across the country attended by over 16,600 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 337 and closed 181 criminal investigations, including 55 convictions, 82 referrals for monetary reclamation, and $48,750 in recoveries related to ARRA-funded programs and projects.
- Received 64 Hotline complaints of potential fraud or waste related to ARRA programs or projects.
- Maintains the OIG Recovery Act Web Site, http://www.va.gov/oig/recovery, which provides access to the VA OIG Hotline and information on OIG ARRA reports, activities, plans, and fraud prevention training materials.

Under ARRA, an employee of any non-Federal employer receiving covered ARRA funds may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of: 1) gross mismanagement of an agency contract or grant relating to covered funds; 2) a gross waste of covered funds; 3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; 4) an abuse of authority related to the implementation or use of covered funds, or 5) a violation of law, rule, or regulation related to an agency contract or grant, awarded or issued relating to covered funds.

Pursuant to the reporting requirements under this provision, OIG conducted no investigations such as those described above. Consequently, OIG did not request or receive an extension beyond the 180-day period for such investigations.

Pursuant to the *Restoring American Financial Stability Act of 2010*, P.L. 111-203, OIG reports that no peer reviews were conducted by another OIG during the reporting period ending March 31, 2012. The last peer review was conducted by the USDA OIG on December 23, 2009, and contained no outstanding recommendations. The next peer review will be initiated in September 2012 by the DOL OIG. VA OIG completed an external peer review of the Department of Transportation OIG and issued the final report on March 3, 2010, which contained no recommendations. In March 2012, VA OIG initiated a peer review for SSA OIG.

Additionally, OIG reports that no Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review (QAR) was conducted by another OIG during the reporting period ending March 31, 2012. The last CIGIE QAR conducted on VA OIG's investigative operation was completed by the Department of Education OIG in 2009. The report contained no recommendations. VA OIG conducted a CIGIE QAR of the SBA OIG's investigative operation and issued the final report on December 21, 2011, which contained no recommendations.

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On the Cover

Thousands of people gathered at National Cemeteries nationwide to participate in Wreaths Across America, an annual event that placed over 90,000 wreaths on headstones. Wreaths were placed at 740 cemeteries worldwide, including over 100 VA national cemeteries. The event was held on December 10, 2011. Photos courtesy of the Department of Veterans Affairs.

United States Department of Veterans Affairs
Office of Inspector General

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