Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 68 | April 1 – September 30, 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 accomplishments during the reporting period April 1 – September 30, 2012. I would like to take this opportunity to highlight just a few of the chief findings and conclusions that came to fruition during this reporting period.

The Office of Inspector General (OIG) issued 159 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified nearly $2 billion in monetary benefits, for a return on investment of $40 for every dollar expended on OIG oversight. OIG investigators closed 556 investigations and made 270 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 336 administrative sanctions and corrective actions.

OIG opened an administrative investigation after receiving allegations involving wasteful expenditures related to two 2011 Office of Human Resources and Administration (HRA) conferences held in Orlando, FL. Planning and execution of these conferences suffered from a broad scope of mismanagement and wasteful spending at the hands of HRA senior leadership, conference planners, and other employees. We questioned over $762,000 as unauthorized, unnecessary, and/or wasteful expenses and further identified 11 VA employees who improperly accepted gifts from contractors seeking to do business or already doing business with VA. As a result of our findings, the Assistant Secretary for HRA resigned from his position. VA's Secretary agreed to take action on our findings, and we will monitor the Department's progress on implementing all proposed corrective actions.

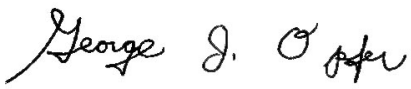
Our Office of Investigations prioritizes investigations of fiduciaries who embezzle VA benefits from incompetent Veterans. During the last 5 years, they conducted 203 investigations resulting in 97 arrests, $6.7 million in fines and restitution, and $1.4 million in monetary recoveries and cost avoidance. One such case involved an attorney who formerly served as a court-appointed guardian and Federal fiduciary for 54 Veterans. He recently pled guilty to conspiracy and filing a false tax return as a direct result of OIG investigative work, which determined that he stole approximately $2.3 million from the Veterans' bank accounts and subsequently failed to report the stolen funds to the Internal Revenue Service. The defendant's wife, who worked as his legal assistant, previously pled guilty to similar charges.

Additionally, the Office of Investigations' efforts to combat fraud in VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) Program continue to yield judicial and administrative results. During this reporting period, eight individuals were arrested after being charged with Federal crimes related to SDVOSB fraud. Convictions resulted in more than $1.7 million in court-ordered payment of fines, restitution, and penalties. Additionally, four individuals and one company were debarred from being awarded Federal contracts, and five additional referrals submitted to the Suspension and Debarment Committee are pending action.

OIG continues to pioneer groundbreaking research initiatives to advance our understanding of the needs and challenges facing today's Veteran. In the first ever study of its kind, OIG's Office of Healthcare Inspections followed more than 300,000 Veterans to determine the incidence and risk factors for becoming homeless after military service. OIG found that at 5 years after separation, 3.7 percent of those studied had experienced homelessness, with Operation Enduring Freedom/Operation Iraqi Freedom and women Veterans experiencing higher incidences of homelessness. Veterans who experienced homelessness were also younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and/or traumatic brain injury at the time of separation from active duty. OIG found that the presence of mental disorders (substance-related disorders and/or mental illness) is the strongest predictor of becoming homeless. Military sexual trauma is also a risk factor for becoming homeless, especially in women Veterans. Based on the study's findings, OIG recommended that the Veterans Health Administration (VHA) consider the risk factors identified in our report and adjust current Veteran homelessness preventive strategies as necessary.

The Office of Audits and Evaluations determined that opportunities still exist to improve VHA's Medical Care Collections Fund program. A 2011 OIG audit determined VA had missed opportunities to increase third-party revenue by $110.4 million annually or $552 million over 5 years. Although VHA reported improvements in collections by 43 percent between FYs 2007 and 2011, OIG's 2012 follow-up audit estimated that VHA missed further opportunities to increase third-party revenue by at least $152 million annually. Without actions to improve billing processes, VHA could miss opportunities to collect an estimated $760 million in third-party revenue over the next 5 years.

I want to express my sincere appreciation to our OIG employees for their steadfast commitment to accomplishing OIG's mission and identifying opportunities for improvement within VA. I also thank the Secretary, Deputy Secretary, and other senior Department officials and their staffs for their continued support of our work and receptiveness to our recommendations. 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

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total	Fiscal Year
Better Use of Funds	$502.5	$550.3
Fines, Penalties, Restitutions, and Civil Judgments	$1,156.6	$1,618.4
Fugitive Felon Program	$101.6	$205.0
Savings and Cost Avoidance	$148.8	$1,074.0
Questioned Costs	$2.1	$7.0
Dollar Recoveries	$15.7	$21.8
Total Dollar Impact	**$1,927.3**	**$3,476.5**
Cost of OIG Operations[1]	$48.15	$96.3
Return on Investment[2]	**40:1**	**36:1**

1 Beginning in 2009, the 6-month and fiscal year operating costs for the Office of Healthcare Inspections ($10 million and $20 million, respectively), 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.
2 Calculated by dividing Total Dollar Impact by Cost of OIG Operations.

Reports Issued	6-Month Total	Fiscal Year
Audits and Evaluations	12	29
Benefits Inspections	10	21
Joint Reviews	2	2
Peer Reviews of Other OIGs	1	1
National Healthcare Reviews	7	10
Hotline Healthcare Inspections	35	56
Combined Assessment Program Reviews	26	50
Community Based Outpatient Clinic Reviews	14[3]	24[3]
Administrative Investigations	4[4]	8[4]
Preaward Contract Reviews	31	66
Postaward Contract Reviews	14	27
Claim Reviews	3	5
Total Reports Issued	**159**	**299**

3 Encompassing 55 and 104 facilities for the 6-month and fiscal year periods, respectively.
4 Does not include one joint administrative investigation already counted under Joint Reviews.

Investigative Activities	6-Month Total	Fiscal Year
Arrests[5]	241	484
Fugitive Felon Arrests	29	54
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	4	20
Indictments	174	337
Criminal Complaints	86	184
Convictions	172	369
Pretrial Diversions and Deferred Prosecutions	21	47
Administrative Investigations Opened	7	22
Administrative Investigations Closed	14	32
Advisory Memos Issued	6	12
Administrative Memos Issued	6	19
Administrative Sanctions and Corrective Actions	336	628
Cases Opened[6]	549	1,088
Cases Closed[7]	556	1,127
Healthcare Inspections Activities	**6-Month Total**	**Fiscal Year**
Clinical Consultations	1	3
Administrative Case Closures	11	18
Hotline Activities	**6-Month Total**	**Fiscal Year**
Contacts	13,406	27,509
Cases Opened	693	1,219
Cases Closed	554	1,104
Administrative Sanctions and Corrective Actions	353	580
Substantiation Percentage Rate	44	40

5 Figure does not include Fugitive Felon arrests by OIG or other agencies.
6 & 7 Figures include administrative investigations opened/closed.

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Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by the *Inspector General Act of 1978*, as amended.

***Inspector General Act of 1978*, as amended, Reporting Requirements**	**Section(s)**
§ 4 (a) (2) to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA	• Other Significant OIG Activities
§ 5 (a) (1) a description of significant problems, abuses, and deficiencies relating to the administration of VA programs and operations disclosed during the reporting period	• Office of Healthcare Inspections • Office of Audits and Evaluations • Joint Reviews and Settlements • Office of Investigations • Office Of Management and Administration • Office of Contract Review • Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period	• Office of Healthcare Inspections • Office of Audits and Evaluations • Joint Reviews and Settlements • Office of Investigations • Office of Contract Review
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed	• Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted	• Office of Investigations
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided	• Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use	• Appendix A
§ 5 (a) (7) a summary of each particularly significant report	• Office of Healthcare Inspections • Office of Audits and Evaluations • Joint Reviews and Settlements • Office of Investigations • Office of Contract Review

(continued on next page)

Inspector General Act of 1978, as amended, Reporting Requirements	Section(s)
§ 5 (a) (8) and (9) Statistical tables showing the total number of reports and the total dollar value of both questioned costs and recommendations that funds be put to better use by management	• Appendix A
§ 5 (a) (10) a summary of each audit report issued before the commencement of the reporting period for which no management decision has been made by the end of the reporting period	• Appendix A
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period	• Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement	• Appendix A
§ 5 (a) (13) the information described under section 05(b) of the *Federal Financial Management Improvement Act of 1996*	• Office of Audits and Evaluations
§ 5 (a) (14) an appendix containing the results of any peer review conducted by another OIG during the reporting period or a statement identifying the date of the last peer review conducted by another OIG	• Other Significant OIG Activities
§ 5 (a) (15) a list of any outstanding recommendations from any peer review conducted by another OIG that have not been fully implemented	• Other Significant OIG Activities
§ 5 (a) (16) a list of any peer reviews conducted by the VA OIG of another OIG during the reporting period and a list of any recommendations made from any previous peer review that remain outstanding or have not been fully implemented	• Other Significant OIG Activities

VA and OIG Mission, Organization, and Resources

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 318,000 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 (NCA) provides interment and memorial benefits. For more information, please visit the VA Internet home page at www.va.gov.

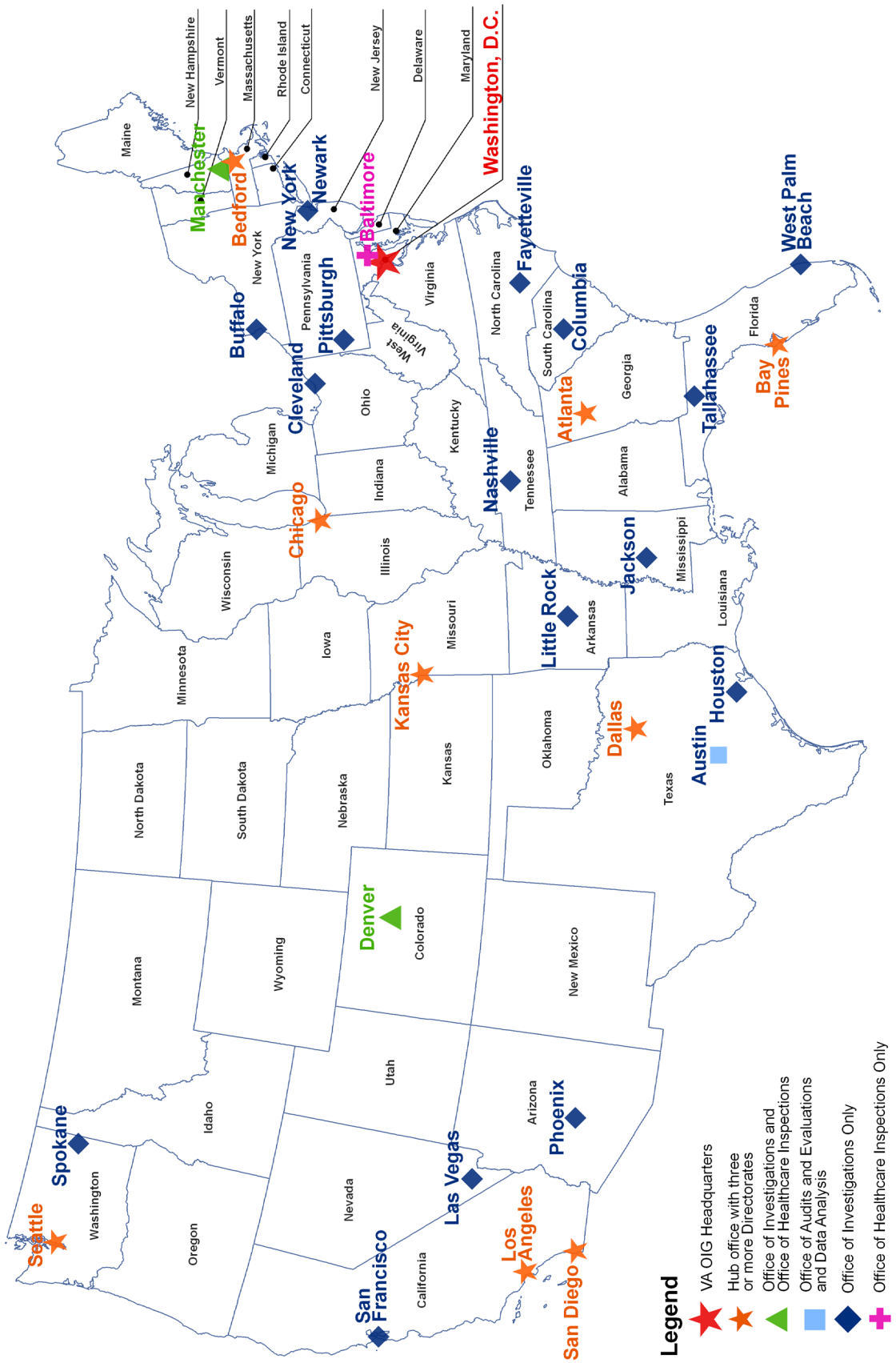
VA Office of Inspector General

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.

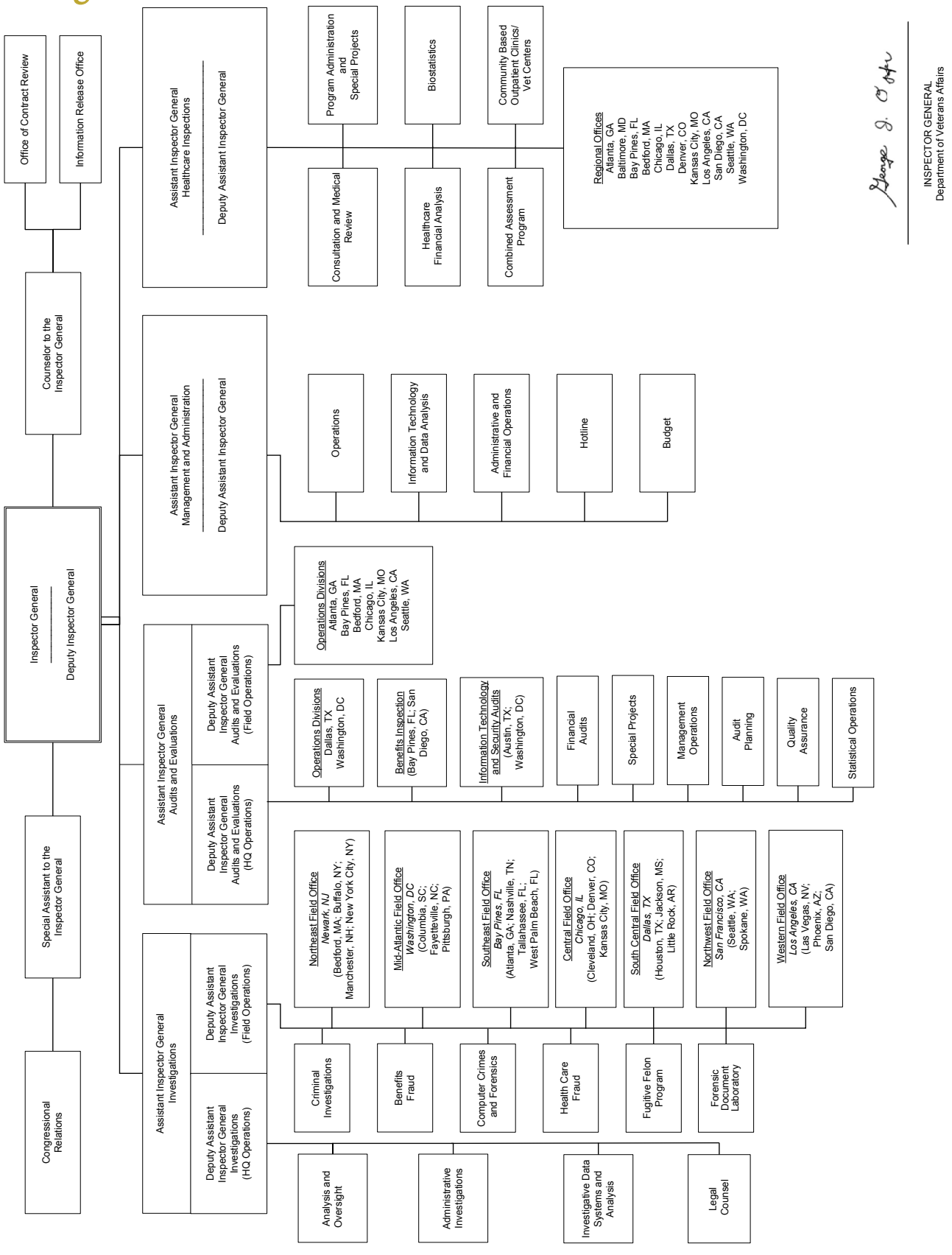
OIG, with 614 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2012 funding for OIG operations provided $112.4 million from ongoing appropriations. The Office of Contract Review, with 25 employees, received $3.9 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



OIG Organizational Chart



Office of Healthcare Inspections

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 7 national healthcare reviews; 35 Hotline healthcare inspections; 26 Combined Assessment Program (CAP) reviews; and 14 Community Based Outpatient Clinic (CBOC) reviews, covering 55 facilities, to evaluate the quality of care. All reports issued this reporting period 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 26 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 6–12 months. 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 four CAP summary reports.

CAP Topics Reviewed This Reporting Period

- Colorectal Cancer Screening
- Environment of Care
- Heart Failure
- Mental Health Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- Opiod Dependence Treatment
- Point-of-Care Testing (Blood Glucose)
- Poly Trauma
- Quality Management

Improvements Needed in Competency Assessments of VA Registered Nurses

OIG completed an evaluation of registered nurse (RN) competency processes in VHA facilities. The purposes of the evaluation were to determine whether facilities: (1) established policy/process requirements for initial and ongoing RN competency assessment and validation, (2) addressed key components in competency assessment and validation documentation, (3) completed RN competency assessment and validation in accordance with local policy, and (4) identified actions to be taken when an individual cannot demonstrate competency. OIG conducted this review at 29 facilities during CAP reviews performed from April 1 – September 30, 2011, and identified three areas where RN competency processes needed improvement. OIG recommended that specific RN competency assessment and validation requirements be established to ensure consistency among facilities, that competency validation documentation include all elements required by Joint Commission standards and local policy, that all competency documentation be present in competency folders and be current and validated, and that appropriate actions be taken when competency expectations are not met.

IG Makes Five Recommendations To Improve Management of Enteral Nutrition Safety Across VA Medical System

OIG completed an evaluation of the management of enteral nutrition (EN) safety in VHA facilities. The purposes of the evaluation were to determine whether facilities complied with Joint Commission standards and VHA requirements to: (1) establish and implement EN policies and practices, (2) manage and document EN care in the electronic health record (EHR), and (3) provide continuity of care for patients receiving EN. OIG also determined whether facilities incorporated selected safe EN practices as recommended by the American Society for Parenteral and Enteral Nutrition. OIG conducted this review at 27 facilities during CAP reviews performed from April 1 – September 30, 2011, and identified five areas with opportunities for improvement. OIG recommended that current VHA requirements be evaluated and revised to include applicable industry recommendations regarding EN safety practices and documentation. OIG also recommended that: (1) facility policies and practices address all VHA-required EN elements, (2) EHR documentation consistently include all VHA-required EN elements, (3) clinicians provide EN education for patients discharged on EN and/or their caregivers, and (4) facilities strengthen continuity of care processes for follow-up and monitoring of patients discharged on EN.

IG Issues Annual Summary on VHA's Quality Management Programs, Recommends Six Areas for Improvement

OIG completed an evaluation of the management of VHA medical facilities' quality management (QM) programs. The purposes of the evaluation were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. OIG conducted this review at 54 facilities during CAP reviews performed from October 1, 2010 – September 30, 2011, and identified six areas with opportunities for improvement. OIG recommended that VHA reinforce requirements for: (1) facility senior managers to actively participate in the review of well-integrated QM/performance improvement results, (2) Peer Review Committees to submit quarterly reports to their Medical Executive Committees, (3) completed corrective actions related to peer review to be reported to the Peer Review Committee, (4) EHR committees to provide oversight and analyze EHR quality and unauthenticated documentation at least quarterly and to include all services in EHR quality reviews, (5) routine monitoring of EHR entries for inappropriate copy and paste use and quarterly reporting to the EHR committee, and (6) all facilities with acute inpatient beds to have documented plans addressing patients who must be held in temporary beds and overflow locations.

OIG Makes Six Recommendations To Improve Management of Workplace Violence at VHA Facilities

OIG completed an evaluation of the management of workplace violence (WPV) in VHA facilities. The purpose of the evaluation was to determine the extent to which VHA facilities managed violent incidents. OIG conducted this review at 29 facilities during CAP reviews performed from April 1 – September 30, 2011, and identified six areas where VHA needed to strengthen requirements and facilities needed to improve compliance. OIG recommended that VHA's comprehensive national guidance for managing WPV be formalized in a directive or a handbook and that policy development include formalizing comprehensive national guidance for managing WPV that establishes procedures for managing disruptive or violent behavior by employees and others. OIG also recommended that facility managers monitor compliance with VHA policy related to WPV programs and management of disruptive behavior; that facilities periodically assess all work areas for risk of violence; and that facilities provide specialized WPV prevention training to all supervisors and employees who work in high-risk areas, assess competence annually, and provide refresher training as necessary.

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.

During this reporting period, OIG performed 55 CBOC reviews throughout 16 Veterans Integrated Service Networks (VISNs). These reviews were captured in 14 reports, which are listed in Appendix A. The topics reviewed this reporting period included Coordination of Care (Heart Failure), Credentialing and Privileging, Environmental Safety and Emergency Planning, Mammography Services for Women Veterans, Management of Diabetes Mellitus-Lower Limb Peripheral Vascular Disease, Management of Mental Health (MH) Emergencies, Management of Traveling Veterans, Primary Care and MH services at contracted CBOCs, and Short-Term Fee Basis for Selected Radiology consults.

CBOC Facilities Reviewed This Reporting Period		
VISN 3	Pine Plains, NY	Port Jervis, NY
VISN 4	Allentown, PA	Tobyhanna, PA
VISN 6	Wilmington, NC	Virginia Beach, VA
VISN 7	Columbus, GA Savannah, GA	Goose Creek, SC
VISN 8	Fort Pierce, FL Homestead, FL	Key West, FL Sebring, FL
VISN 9	Hopkinsville, KY Smithville, MS	Dyersburg, TN McMinnville, TN
VISN 10	Bellevue, KY	Hamilton, OH
VISN 11	Mattoon, IL Springfield, IL Flint, MI	Yale, MI Toledo, OH
VISN 12	Appleton, WI La Crosse, WI Union Grove, WI	Wausau, WI Wisconsin Rapids, WI
VISN 15	Emporia, KS Fort Dodge, KS Hutchinson, KS	Lawrence, KS O'Fallon, MO St. Joseph, MO
VISN 16	Fort Smith, AR	Lafayette, LA
VISN 17	Denton, TX	Tyler, TX
VISN 18	Payson, AZ	Show Low, AZ
VISN 20	Klamath Falls, OR La Grande, OR North Bend, OR	Bellevue, WA Mount Vernon, WA
VISN 22	Laguna Hills, CA	Long Beach, CA
VISN 23	Montevideo, MN St. James, MN Mission, SD Pierre, SD	Rapid City, SD Chippewa Valley, WI Hayward, WI

IG Releases Annual Report on VA CBOCs, Makes 13 Recommendations To Improve Operations

The purpose was to evaluate selected activities, assessing whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. CBOCs overall appear to be providing a quality of care that is not substantially different from parent VA Medical Centers (VAMCs). The CBOCs generally met VHA directives and guidelines. OIG made recommendations affecting Women's Health Liaisons, Computerized Patient Record System, Short-Term Fee Basis local policy, urban CBOCs' outsourcing services, MH emergency plans, competency assessments, auditory privacy, security of patients' personal information, security vulnerabilities in the allocated Information Technology (IT) network space, validation of invoices, contract provisions and acquisition planning, and contractors' awareness of VA standards for coordination of care for MH services. To improve operations, OIG made 13 recommendations to the Under Secretary for Health (USH).

National Healthcare Reviews

In addition to the reviews discussed below, the Office of Healthcare Inspections also issued a joint review, in conjunction with the Office of Audits and Evaluations, concerning Veterans' access to MH care. The summary for this report can be found under the Joint Reviews and Settlements section.

IG Publishes First-Ever Longitudinal Study on Incidence and Risk Factors of Becoming Homeless After Military Service

Using integrated data from VA and the Department of Defense (DoD), OIG conducted this first ever population-based longitudinal study to determine the incidence of becoming homeless (the newly homeless) after military separation, identify risk factors for Veterans becoming homeless, and describe utilization of VA specific homeless services by homeless Veterans. The study population consists of 310,685 Veterans who separated from the military from July 1, 2005, to September 30, 2006, and who had not experienced any homeless episodes before separation from DoD. OIG found that 3.7 percent of these Veterans had experienced their first episode of homelessness at 5 years after separation. Veterans of OEF/OIF and women Veterans experienced higher incidences of homelessness. Veterans who experienced homelessness were younger, enlisted with lower pay grades, and were more likely to be diagnosed with mental disorders and/or traumatic brain injury (TBI) at the time of separation from active duty. OIG found that the presence of mental disorders (substance-related disorders and/or mental illness) is the strongest predictor of becoming homeless. Military sexual trauma is also a risk factor for becoming homeless, especially in women Veterans. OIG noted that the percent of mental disorder diagnoses among newly homeless OEF/OIF Veterans was higher than those of their non-OEF/OIF counterparts prior to becoming homeless, although the percent of OEF/OIF Veterans diagnosed with mental disorders before discharge from DoD was generally lower than their non-OEF/OIF counterparts. The USH concurred with our findings and recommendation and provided acceptable action plans.

Review Supports Denial of Liver Transplant, But Policy Should Be Reconsidered

At the request of Congressman John Kline, OIG reviewed why a Veteran patient was "unable to receive a [liver] transplant through the VA system." The patient in question had chronic hepatitis C that had progressed to the point that without a liver transplant it would almost certainly be fatal. OIG found that the patient was indeed "unsuccessful in obtaining approval for a VA transplant." Two VA Transplant Centers (VATCs) did not accept the patient as a candidate for further evaluation, and on appeal, a third VATC also did not accept him as a candidate for further evaluation. Ultimately, the patient had a liver transplant at a non-VA facility. OIG found that each of the three reviewing VATCs made a decision based upon the clinical data presented and in a manner consistent with VHA policy. Nevertheless, OIG was concerned that while the VATC listed the presence of a cardiac stent (which this patient had) as an absolute contraindication to liver transplantation for the appeal, other VATCs do consider patients with cardiac stents. OIG concluded that when a patient has a condition regarded as an absolute contraindication at some but not all VATCs, the patient's case should be evaluated by VATCs that do not view that condition as an absolute contraindication. OIG recommended that VHA consider whether or not changes to their review process should be made to address facility specific absolute contraindications to transplants. In response, VHA reconsidered its policy but decided to continue its referral process as it is currently designed.

Hotline Healthcare Inspections

OIG Urges Greater Oversight, More Training To Correct Continuing Issues Cleaning Medical Equipment at St. Louis, Missouri, VAMC

OIG conducted a review to follow-up on our March 2011 report, *Reprocessing of Dental Instruments, John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri* (Report No. 10-03346-112, March 7, 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 corrective actions and some conditions identified in the 2011 OIG report have been resolved. However, recommendations 1 and 2 from our 2011 report will remain open until all action plans outlined by the facility are effectively implemented. These recommendations include: (1) monitoring for compliance of all appropriate elements of reusable medical equipment (RME) reprocessing, standard operating procedures (SOPs), staff training, and staff competencies; and (2) monitoring by the VISN Supply, Processing, and Distribution (SPD) Management Board to ensure that SOPs are in place and staff training and competencies are current. Recommendation 3 related to administrative actions was addressed and resolved. OIG made a new recommendation that the VISN Director require comprehensive baseline environment of care inspections of all SPD areas, and that identified deficiencies are promptly corrected and monitored for ongoing compliance. The VISN and Facility Directors concurred with our recommendations. OIG will follow up on planned corrective actions until they are completed.

IG Notes Vast Improvements in Dental Instrument Cleaning at St. Louis VAMC

OIG conducted a review to follow-up on our report, *Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies, St. Louis VAMC, St. Louis, Missouri* (Report No. 10-03346-152, April 5, 2012). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented. In the past several months, VISN and facility managers have taken multiple corrective actions and many of the conditions identified in the April 2012 OIG report have been resolved. Supply Processing Service (SPS) leadership positions have been filled, SPS has moved into its fully-renovated state-of-the-art space, and communication and oversight processes are improving. The facility has made vast improvements in its RME related policies and practices over the past 6 months and the central issue of patient safety during dental procedures has been addressed. While OIG identified some additional improvement opportunities, facility and VISN managers have verbalized their commitment to ongoing compliance with VHA requirements. Therefore, OIG considers the recommendations from the April 2012 report closed.

Closer Oversight Needed in HUD-VA Supported Housing Program for Homeless Veterans in Bay Pines, Florida

OIG reviewed allegations that a Veteran living in Housing and Urban Development (HUD)–VA Supported Housing (VASH) committed suicide; that he was considered high risk for suicide; that he did not have contact with a VA case manager (CM) for months prior to his death; that the CM supervisor only visited the Port Charlotte clinic once since being assigned to the position; and that the supervisor told a CM to "audit himself and get his charts straight" after learning of the suicide. OIG substantiated that the Veteran committed suicide, but not that he had been identified as high risk for suicide, or that the Veteran did not see or speak to a CM during 9 of 18 months in the program. OIG substantiated that a supervisor visited the Port Charlotte clinic only once, but not that this was inappropriate. OIG could neither substantiate nor refute that a CM was told by the supervisor to "audit himself and get his charts straight" after learning of the suicide. OIG found that network and system level oversight of the HUD–VASH program needed improvement and that 23 of 25 other Veterans in the program did not receive required case management services. We recommended that the System Director

ensure HUD–VASH program case management services are provided as required and that Network and System Directors implement measures to strengthen management controls and oversight.

Los Angeles, California, Healthcare System Cited for Transparency, Compliance with VA Policy in Response to Medication Errors

OIG conducted an oversight inspection to review actions taken to address and respond to adverse drug events (ADEs) that led to blindness in the treated eye of five patients at the VA Greater Los Angeles, CA, Healthcare System (HCS). OIG determined that VISN and facility leadership complied with VHA policy in taking immediate actions in response to these ADEs. They appropriately notified the patients and contacted the Food and Drug Administration (FDA) and VHA leaders while ascertaining the cause of the ADEs. The facility's action of disclosing to the patients that a medication error occurred is consistent with VA's commitment to transparency. In addition, the facility convened an administrative board of inquiry (ABI) to address other administrative and patient safety issues. OIG recommended that the Facility Director ensure that the recommendations from the local and external reviews are implemented and monitored, that the ABI is completed in a timely manner, and that corrective actions in response to the ABI are taken if indicated. Management agreed with the findings and recommendation and provided an acceptable action plan.

Improvements Needed in Quality of Care, Medical Record Completeness, and Peer Reviews at Sheridan, Wyoming, VAMC

OIG conducted an evaluation to determine the validity of allegations regarding poor quality of care and administrative issues at the Sheridan, WY, VAMC. OIG did not substantiate that the patient's care for his lung condition resulted in a terminal illness and permanent confinement in a hospice unit or that the level of care caused the patient's clinical deterioration, subsequent non-VA hospitalization, and need for prolonged inpatient care and rehabilitation. OIG substantiated that medical record documentation did not consistently include current clinical assessment of the respiratory problem, lung examinations, or follow-up information regarding the patient's response to antibiotic therapy. OIG substantiated that the treatment for the patient's elbow bursa infection was inadequate and the physician's documentation did not meet VHA standards. OIG did not substantiate that facility managers responded unprofessionally to the patient's or brother's concerns. OIG found that the cessation of prednisone did not meet the accepted practice in the management of long term, daily corticosteroid therapy and the facility did not conduct Peer Review for the lung and elbow issues. OIG made three recommendations. The VISN and Facility Directors concurred with our recommendations and provided acceptable action plans.

OIG Identifies Deficiencies in Hearing Aid Repair Processes at Atlanta, Georgia, VAMC

OIG conducted a review to determine the validity of allegations from a complainant regarding efficiency and timeliness of the hearing aid repair process at the Atlanta, GA, VAMC. The complainant alleged that: (1) Audiology Clinic staff mismanaged the process used to track and monitor hearing aid repairs, resulting in delayed repairs and the possible loss of hearing aids; (2) Audiology Clinic staff did not keep an accurate log reflecting the status of the complainant's hearing aid repairs resulting in delays; (3) Audiology Clinic staff and VAMC leaders were difficult to contact; and (4) VAMC leaders did not adequately respond to written complaints. OIG recommended that the VAMC Director ensure that staff: (1) monitor the status of outstanding repairs and assess the timeliness of vendor completed repairs, and (2) document reasons for lost and damaged hearing aids and develop risk mitigation strategies. The VISN and VAMC Directors concurred with our recommendations and provided an acceptable action plan.

Improvements Needed to Ensure Timely Access to MH Residential Programs at VA Eastern Colorado HCS

OIG assessed the merit of allegations concerning the quality of MH care at the VA Eastern Colorado HCS, Denver, CO. OIG did not substantiate the allegation that the patient was not provided or offered other treatment options in conjunction with medications. HCS providers, as well as providers at the other VHA facilities where the patient received services, offered the patient a variety of therapies in both outpatient and inpatient settings. OIG did not substantiate the allegation that VHA providers improperly managed the patient's psychiatric medications. The patient's medications were appropriate in terms of his diagnoses of bipolar disorder and post-traumatic stress disorder (PTSD), and the medications were managed appropriately. However, OIG found that the patient's admission to a MH residential rehabilitation treatment program was delayed for reasons that were not supported by VHA policy. OIG made one recommendation to ensure timely access to MH residential rehabilitation treatment programs. The VISN and Facility Directors agreed with the finding and recommendation and provided an acceptable action plan.

Marion, Illinois, VAMC Faulted for Privileging, Peer Review, and Lack of Qualified Staff Available 24/7 for Airway Emergencies

OHI received four complaints between October 2011 and January 2012 regarding the clinical practice of two physicians of the Marion, IL, VAMC. In February 2012, Senator Richard J. Durbin forwarded additional allegations concerning one of the physicians. In the care of one patient, the risk of complications requiring urgent intervention should have been discussed with the patient as part of the informed consent process prior to a procedure, at which time the patient's therapeutic preferences could have been clarified. OIG identified no deficiencies in quality of care for two other patients. OIG also found that a physician who was hired after not being in clinical practice for many years was granted clinical privileges with the understanding that his competence would be confirmed by direct observation. However, competence was never documented for invasive procedures that he subsequently performed. OIG recommended that the Facility Director ensure that VHA and local policies are followed when initial clinical privileges are granted, peer review processes comply with VHA policy, staff with demonstrated competence in airway management are available 24 hours a day, 7 days a week, an Intensive Care Unit (ICU) Director is appointed, and the facility adheres to local policy regarding the use of ICU beds. The Acting VISN Director and Facility Director agreed with our findings and recommendations and provided acceptable action plans.

Unauthorized Practice of Medicine at a VAMC Unsubstantiated

OIG conducted an oversight inspection to determine the validity of allegations of the unauthorized practice of medicine. A complainant alleged that a non-physician staff (subject staff) at a VAMC Emergency Department (ED) engaged in the unauthorized practice of medicine by representing himself as a doctor, and that the ED nurse manager was aware of this behavior but did not take action to correct it. The complainant also alleged that the subject staff intubated a patient during an emergency resuscitation causing the patient's death and that, in another instance, the subject staff pronounced a patient dead. The facility conducted an internal investigation and took corrective actions. The investigation found that the subject staff acted outside the scope of his duties by responding to and participating in a "code blue" event. The facility did not find that the subject staff engaged in the unauthorized practice of medicine. OIG reviewed all documents produced during the facility's investigation, pertinent medical records, and other administrative records, and interviewed facility staff. OIG concurred with the findings of the facility and found the corrective actions to be appropriate. OIG made no recommendations.

Northport, New York, VAMC Needs To Strengthen Pain Management and Clinical Disclosure Policies

OIG reviewed five allegations regarding a patient's fall at the Northport VAMC. Due to insufficient documentation, we were unable to confirm or refute the allegation that the staff member assigned to monitor the patient was not present when the patient fell. OIG also did not substantiate the allegations that the facility did not perform adequate tests after the patient's fall and that a surgical stapling procedure was performed at the patient's bedside. OIG substantiated that the patient did not receive effective and timely pain management and that the facility did not appropriately disclose clinical information and respond to the family's complaints. OIG recommended that the Medical Center Director strengthen processes to ensure that documentation for one-to-one monitoring of patients is accurate, the facility reassess the incident reporting process for effectiveness, the facility implement procedures to ensure that facility staff comply with VHA pain management policies and VHA and local clinical disclosure policies, and that facility responses to patient and family complaints are timely and facilitate resolution. The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans.

Allegations of Telemetry Equipment Deficiencies Unsubstantiated, But Improvements Needed in Patient Response Timeliness

OIG conducted an inspection to assess the merit of an allegation made by a complainant concerning quality of care of a patient on a telemetry unit at the Manhattan Campus, New York Harbor HCS. OIG did not substantiate that a telemetry equipment malfunction contributed to the patient's death. OIG found that the telemetry equipment was functioning properly and that biomedical engineering personnel conducted preventive maintenance in accordance with the manufacturer's specifications. OIG substantiated that staff on the telemetry unit failed to respond to a patient's disconnected telemetry lead in a timely manner; as a result, the patient's telemetry status was not effectively monitored at the time of his death. During the inspection, OIG reviewed progress on corrective actions taken to address deficiencies related to a prior incident addressed by OIG in an October 2011 report. Regarding both incidents, facility management had developed and initiated a comprehensive corrective action plan to address all deficiencies identified by internal review and the previous OIG inspection. OIG concluded that managers have made significant progress in all elements of the corrective action plan. OIG made no recommendations.

Improvements Needed in Patient Assessment at the William Jennings Bryan Dorn Columbia, South Carolina, VAMC

OIG evaluated allegations of inadequate patient care, poor communications with family, poor coordination of care, and inappropriate infection control practices. While OIG confirmed that some of the alleged conditions existed during a Veteran's hospitalization, in many cases, facility leaders had already taken actions to improve care and service delivery. OIG did not substantiate other allegations related to quality of care and environmental deficiencies. OIG recommended that patients assessed to be at nutritional risk are promptly evaluated by appropriate dietary staff, that nursing personnel are trained on the steps required to initiate consult requests through the electronic nursing assessment package, and that actions are taken to evaluate and revise the Do Not Attempt Resuscitation template note, as appropriate, to be more patient-specific and patient-centered. The VISN and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans.

Deficiencies Regarding the Surgery Program Are Reviewed at the Grand Junction, Colorado, VAMC

OIG conducted an oversight review to assess actions taken by VISN 19 and Grand Junction VAMC leadership regarding the VAMC's surgical program. Between May and September 2011, VHA surgery and Quality Management (QM) teams made onsite visits to the Grand Junction VAMC. They identified concerns related to the surgery program and other issues. After the October CAP review and Employee Assessment Review survey, OIG received allegations from facility staff. The allegations related to an increase in surgical infections and perforations, documentation, ED triage and surgical referral, resources, QM program, scheduling, RME, and safety. Because the VHA teams had previously reviewed most of the allegations, OIG conducted an oversight review to determine if the facility and VISN adequately addressed the concerns and allegations. OIG found that action plans had been developed to address these allegations and concerns. OIG recommended that the VISN Director continue to monitor facility action plans to ensure effective and complete follow up.

Nursing Care, Leadership Found Lacking at St. Louis Dialysis Unit

OIG conducted an inspection to determine the validity of allegations regarding the provision of nursing care in the hemodialysis (HD) unit of the John Cochran Division of the St. Louis VAMC. Specifically, a complainant alleged that a licensed practical nurse (LPN) did not provide appropriate care to two HD patients, resulting in their subsequent need for emergency care, and that the HD unit had nursing leadership issues that affected patient care. OIG substantiated that the subject LPN did not recognize and report changes in the condition of Patient 1 during HD but did not substantiate the LPN provided less than standard care for Patient 2. OIG did not substantiate the allegation that the HD nurse manager favored the subject LPN or that nursing practice changes unfairly affected HD nursing staff. The HD unit had multiple problems that required improvement. The unit was lacking a strong leadership presence in the nurse manager and charge nurse roles. It was difficult to differentiate between the role of the RNs and the LPNs. There was no defined responsibility for the charge nurse and no policy for reporting events to the charge nurse or a physician. OIG made six recommendations.

Allegations of Poor Surgical Care Not Substantiated at the West Palm Beach, Florida, VAMC

OIG conducted an inspection in response to an anonymous survey respondent's allegations of poor surgical care and inadequate follow-up of adverse outcomes at the West Palm Beach VAMC. OIG did not substantiate that three patients experienced adverse outcomes because an Ear, Nose, and Throat (ENT) surgeon did not possess the necessary qualifications or competence to care for otolaryngology patients. OIG also did not substantiate that the surgeon exercised poor judgment. The ENT surgeon met competency expectations, he was appropriately privileged to perform the surgeries in question, and his performance was periodically reviewed as part of the reprivileging process. OIG found that reporting and evaluation of adverse events needed improvement. Surgical staff did not appear to understand the requirement to report serious adverse events or to use the correct disclosure template. OIG made two recommendations related to staff training and disclosure of adverse events.

Allegations of Quality of Care Issues and Lack of Management Responsiveness Not Substantiated at the VA Caribbean HCS, San Juan, Puerto Rico

OIG reviewed allegations regarding quality of care issues and management responsiveness at the VA Caribbean HCS, San Juan, PR. OIG did not substantiate that improper technique during a cystoscopy caused an infection. OIG also could neither confirm nor refute that the resident who performed the procedure ignored the patient's complaints of pain. OIG did not substantiate that management was unresponsive to the patient's concerns. While not one of the complainant's allegations, OIG found that the informed consent process was not completed according to policy regarding the change in practitioner prior to the procedure. OIG recommended the System Director implement measures to ensure the informed consent process complies with VHA requirements.

Allegations Surrounding Surgical Care at Martinsburg, West Virginia, VAMC, Not Founded, but Improvements Needed in Management of Response Teams

OIG evaluated allegations regarding oversight and perioperative patient safety at the Martinsburg, WV, VAMC. OIG did not substantiate lack of facility action after observing discolored surgical instruments or intraoperative microfibers, a surgeon's responsibility for high or underreported blood loss, or facility failure to provide oversight of surgical events. Although OIG substantiated that a surgeon remained on duty following a sentinel event, no requirement was found for removal. OIG recommended conducting a risk assessment regarding temporary relief from duty. OIG did not substantiate delays in diagnosis or surgical mismanagement but did identify a lack of documentation and recommended that practitioners record treatment decision-making processes. OIG substantiated deficiencies in patient flow and recommended training for staff in perioperative locations on equipment and reporting near-miss patient safety incidents. OIG did not substantiate that the facility added surgery services without planning for support. While OIG substantiated canceled or delayed surgeries due to lack of beds, the facility acted to ensure bed availability. OIG also substantiated allegations of poorly managed Rapid Response Team (RRT) and Cardiac Arrest Team (CAT) activity, although lack of oversight of patient deaths was not confirmed. OIG recommended strengthening and monitoring adherence to local policies regarding response to changing clinical conditions, complying with VHA standards for ED physicians, and designating one committee with responsibility for reviewing CAT and RRT processes.

Minneapolis, Minnesota, VA HCS Criticized for Suicide Prevention, Monitoring, and Follow-Up Activities for High Risk Patient

OIG conducted a review at the request of Congressman Tim Walz regarding alleged improper medication management and discharge planning practices for a patient under the care of the Minneapolis, MN, VA HCS who ultimately committed suicide. OIG did not substantiate the complainant's allegations but did find that the facility did not complete suicide prevention activities as required. As a result, the patient in question did not receive the prescribed level of monitoring and follow-up. OIG found that the facility's review of the patient's death did not address the overall suicide risk management issues central to the case, and the facility did not adequately follow up on systems issues identified by the review. Further, facility policy lacked several important provisions for managing patients at high risk for suicide, and some staff were unaware of administrative requirements related to managing these high-risk patients. OIG made eight recommendations to improve quality of care and administrative processes related to suicide prevention.

Fayetteville, North Carolina, VA Physician with Prior Performance Deficiencies Misdiagnosed ED Patient, Privileging Process Also Faulted

OIG evaluated allegations of misdiagnosis and courtesy lapses in the Fayetteville, NC, VAMC ED. OIG's review substantiated that the patient did not receive an accurate diagnosis during his ED visit. Further, the ED physician did not complete a comprehensive evaluation and did not review the medical record or ask the patient about his current medications. The Service Chief did not adequately address the ED physician's history of performance deficiencies related to medication reconciliation, and responsible managers did not follow policy when they renewed the ED physician's clinical privileges. The medical center conducted quality of care reviews, but those reviews did not address the deficiencies identified in this report. OIG could not confirm or refute the allegation that the ED physician was rude during the patient's ED visit. OIG made three recommendations to improve care and processes.

Gainesville, Florida, Nurse Failed To Monitor and Adjust Patient's Insulin Dosage, Falsified Documentation

OIG reviewed allegations regarding a nurse's practice on a critical care unit at the Malcom Randall VAMC in Gainesville, FL. OIG substantiated the allegations that the RN falsified documentation and did not administer insulin as ordered for a patient. OIG did not substantiate the allegation that the RN was practicing medicine without a license or that patient care was not documented until the end of a shift. OIG did not substantiate the allegation that the RN failed to provide pain medication for a patient; however, the RN did not provide pain medication as ordered nor did she adhere to local policy for pain management. OIG substantiated the allegation that previous concerns about the RN were reported to the Nurse Manager (NM), but not that nothing was done. The review found that there was a pattern of quality of care issues associated with the RN and that the NM did not address the issues following appropriate managerial protocol. OIG recommended that the VAMC Director follow through with Administrative Investigative Board (AIB) recommendations and request that Regional Counsel evaluate relevant documents to determine if the RN's actions meet criteria to report them to State licensure governing boards. The VISN and VAMC Directors agreed with the findings and recommendation and provided an acceptable action plan.

Allegations Unfounded Surrounding Supervision of Dayton, Ohio, VAMC Nurse Anesthetists

An OIG inspection did not substantiate an allegation that the Anesthesia Section Chief at the Dayton, OH, VAMC did not provide oversight to Certified Registered Nurse Anesthetists (CRNAs). OIG found that all CRNAs were properly credentialed and privileged to perform their assigned duties within the scope of their licenses. In addition, the Anesthesia Section Chief assigned a preceptor anesthesiologist to assess each CRNA twice each month through observation and chart review of specific anesthesia procedures. OIG made no recommendations.

IG Finds Professional Staff Frustrated by Ineffectiveness of Senior Leadership at Iowa City HCS

OIG conducted a comprehensive review of the Iowa City VA HCS in response to a request from Senator Charles E. Grassley. OIG assessed the merit of allegations about quality of care and that concerns expressed by staff "have been largely ignored." OIG found that high quality medical care has been maintained. However, a pervasive lack of support for staff problem-solving is a potential threat to patient safety, and that several process deficiencies were identified. During a prolonged period when key leadership positions were held by individuals on a temporary basis, decisions were delayed or never made and a highly competent professional staff was frustrated by the persistent ineffectiveness of senior leadership. OIG recommended that the VISN Director ensure that system leaders take appropriate action in response to identified problems and communicate action plans to staff. OIG also recommended that system leaders clarify organizational lines of authority and responsibility and improve components of Environment of Care and Pharmacy management.

Probe Uncovers Lax Prescribing of Opiates at Calais VA Clinic

OIG conducted a review to determine the validity of allegations regarding management of chronic opioid therapy and opioid prescribing practices at the VA Maine HCS CBOC in Calais, ME. OIG substantiated the allegations that providers did not adequately assess patients who were prescribed opioids for chronic pain and did not adequately monitor patients for misuse or diversion of the opioid medications. OIG substantiated that managers asked providers to prescribe opioids for patients whom they had not assessed. OIG found that a chronic shortage in provider staffing at the clinic impacted the management of chronic opioid therapy. OIG made one recommendation to address these issues. Management agreed with the findings and recommendations and provided an acceptable improvement plan.

Lebanon VA Management React Quickly to Staff's Inadvertent Overexposure to Ultraviolet Light During Surgical Procedure

OIG conducted an inspection to determine the validity of allegations that a surgical patient and 10 Lebanon VAMC employees suffered injury due to Ultraviolet Germicidal Irradiation (UVGI) light overexposure. OIG substantiated the allegation that Operating Room staff were harmed on January 17, 2012, as a result of inadvertent UVGI light overexposure, but the patient was not because he was protected from ultraviolet light exposure by surgical drapes. Affected facility staff suffered temporary blindness, eye irritation, or skin burns. The extent of the overexposure was not known until the following morning when the staff noticed symptoms of overexposure from the UVGI lights. OIG found that facility leadership acted promptly by reporting the incident, notifying and referring employees for care, and disabling the UVGI light switch. OIG did not substantiate the allegation that facility management was previously warned about potential safety hazards from UVGI light overexposure. OIG substantiated the allegation that there were no warning labels on the UVGI light switch. Facility leaders took immediate action to disconnect UVGI lights the same day exposures were reported. OIG made no recommendations.

IG Inspection Finds That Veterans Experience Excessive Wait Times at Memphis VA ED

OIG reviewed allegations that census in the ED at the Memphis VAMC, Memphis, TN, exceeds bed capacity on a regular basis, compromising patient safety; that ED equipment and supplies were inadequate; and that management was unresponsive to these concerns. OIG substantiated that there were significant delays in the ED, but did not find that patients experienced negative outcomes as a result of excessive ED length of stay (LOS). OIG found that the facility's sustained performance for ED LOS is far below the VHA standard. With the exception of availability of ultrasound services, OIG found that ED resources were adequate. OIG found that Emergency Department Integrated Software and Veterans Health Information Systems and Technology Architecture data related to ED LOS times were unreliable. OIG substantiated that management was aware of these issues but had not taken adequate action for resolution. OIG recommended that the Facility Director ensure that actions are taken to reduce ED LOS, increase the availability of ultrasound services for ED patients, and improve the accuracy of ED flow data. The VISN and Facility Directors agreed with the findings and recommendations and provided an acceptable action plan.

Alleged Inadequate Airway Management Unsubstantiated at Muskogee, Oklahoma, VAMC

OIG evaluated allegations of inadequate airway management. OIG did not substantiate the allegation that providers were not competent in airway management. The facility's medical officer of the day (MOD) is responsible for airway management during non-administrative hours. All MODs had documented competence in airway management. OIG did not substantiate the allegation that RNs intubated outside their scopes of practice. VHA and local policy permit RNs with appropriate training and demonstrated competence to intubate patients in emergent situations outside of the operating room. OIG did not determine that intubation by an RN contributed to a patient's death. An RN intubated a patient at the request and under the supervision of the MOD, and the MOD checked placement of the endotracheal (ET) tube. Although autopsy revealed misplacement of the ET tube, OIG concluded that clinicians exercised appropriate diligence when they attempted intubation as part of resuscitative efforts and were unable to explain the autopsy finding. OIG did not substantiate the allegation that subsequent to the patient's death, the facility created a policy permitting RNs to intubate. The facility has had an emergency airway management policy in place since November 2005. The local policy, which is consistent with VHA policy, does not preclude RNs from performing ET intubation and airway management in a non-operating room setting. OIG made no recommendations.

Improvement Needed for Access and Coordination of Care at VA Texas Valley Coastal Bend HCS

OIG conducted an inspection to determine the validity of allegations made by a complainant related to access and coordination of care issues at the VA Texas Valley Coastal Bend HCS and the CBOC, both located in Harlingen, Texas. OIG substantiated that patients go to the CBOC for urgent and emergent medical care; cannot be seen in the time frame requested by the patient or their provider; have difficulty getting medications filled, refilled, or renewed; and that patients experience long wait times at the CBOC. OIG did not substantiate that providers were pressured into prescribing pain medications to drug-seeking patients. The VISN and Facility Directors agreed with our findings and four recommendations and provided acceptable improvement plans.

Staffing Ratio Adjustments Needed in Bronx, New York, VAMC

OIG evaluated allegations regarding the Dental Service at the James J. Peters VAMC in Bronx, NY. Specifically, the complainant alleged issues with infection control, oral surgery student oversight, and Dental Service leadership. OIG did not substantiate the allegations of inadequate infection control practices, that the dental clinic had not been thoroughly inspected for years, or that inspections were scripted. OIG did not substantiate or refute that students worked independently in the Oral Surgery Clinic. OIG did not substantiate the allegations of poor or indifferent Dental Service leadership. OIG found that the ratio of dental assistants to practitioners fell short of VHA's recommendations and impacted the work flow and patient volume handled by the clinic. Further, the low dental assistant staffing levels contributed to problems with availability, accountability, supervision, and morale. Therefore, OIG recommended that facility managers assess and adjust staffing ratios for dental assistants to practitioners to bring them into compliance with VHA recommendations.

OIG Determined Appropriate Medication Management at Lincoln, Nebraska, CBOC

OIG conducted a review of the medication management provided for a patient who received health care and prescriptions at the Lincoln CBOC of the VA Nebraska-Western Iowa HCS. The patient died unexpectedly, and a medical examiner determined that the patient's cause of death was accidental multidrug toxicity. The purpose of this review was to determine if the patient received appropriate medication management. The medication management was appropriate. The patient had a complex medical and MH history, which included acute and chronic pain. Providers documented appropriate assessments and evaluations, and considered the risks of medication, dependency, and side effects. Providers performed medication reconciliations, which included routine reviews of active VA and non-VA medications and the patient's compliance with his medication regimen. Providers monitored the patient for identified potential adverse medication interactions and performed annual blood chemistries, drug levels, and electrocardiograms. OIG made no recommendations.

IG Recommends Reevaluation of Inpatient Nurse Staffing and Overtime at Hot Springs, South Dakota, HCS

At the request of Senators Tim Johnson and John Thune and Representative Kristi Noem, OIG performed an inspection at the VA Black Hills HCS, Hot Springs, SD, to determine the validity of allegations they received regarding staffing, quality of care, and safety concerns. The complainants expressed concerns that only temporary staff were hired for critical clinical positions and that staffing issues may lead to quality of care issues and patient/staff safety concerns. While onsite, OIG also received allegations that the pharmacy and an inpatient unit (1E) were understaffed and 1E nursing staff were working excessive amounts of mandatory overtime. OIG did not substantiate that only temporary staff were hired for critical clinical positions, hiring temporary staff led to quality of care or safety issues, or 1E was understaffed with nursing staff working excessive amounts of mandatory overtime. OIG did not review pharmacy staffing due to unavailability of workload data. OIG recommended that the HCS Director reevaluate Hot Springs division 1E staffing and overtime and obtain a VA Pharmacy external review of the pharmacy workload and staffing needs.

IG Makes Six Recommendations To Improve Hampton VAMC ICU Operations

At the request of Senator Jim Webb, OIG conducted a review to determine the validity of 13 allegations regarding nurse orientation and training, medication integrity and security, security over patient information, availability of medical supplies, patient monitoring and staff response to patient care needs, and environment of care issues at the Hampton VAMC, Hampton, VA. The allegations largely focused on the ICU. OIG substantiated five of the allegations: (1) ICU medication refrigerator temperatures are frequently outside the appropriate range, (2) ICU medication carts do not always lock properly, (3) medical supplies are not adequately stocked in the ICU, (4) negative air pressure is not maintained in patient isolation rooms in the ICU and Step Down Unit, and (5) the ICU physician call schedule is not clear to nurses on the night shift. OIG did not substantiate six of the allegations and could neither confirm nor refute two of the allegations. In addition, OIG identified two issues related to telemetry monitoring. OIG made six recommendations that the VISN and Acting Facility Directors agreed with and provided acceptable improvement plans.

IG Recommends Reassessment of Nurse Staffing in Surgical Intensive Care Unit at Houston Facility

OIG conducted an inspection in response to anonymous complainants' allegations of unsafe patient care and delivery of services in the Surgical Intensive Care Unit (SICU) at the Michael E. DeBakey VAMC in Houston, TX. OIG found that the facility's average actual SICU nursing hours per patient day (NHPPD) staffing levels were below the unit's target NHPPD. OIG determined that the facility assigned nurses to units without proper training, tolerated disruptive behavior, and did not properly use nurse staffing methodology. OIG substantiated that the SICU cardiac monitors were outdated and in need of replacement, and that equipment was in short supply. OIG substantiated that the pharmacy placed SICU patients' medications in a bin in the medication room and was slow to fill requests for urgent medications. OIG recommended that the Facility Director ensure that: (1) SICU nursing management reassess the nursing methodology to ensure the target NHPPD is appropriate, (2) nursing staff receive unit-specific training for each unit they are assigned, (3) outdated monitors are replaced and equipment is in sufficient supply, (4) disruptive behaviors are addressed, and (5) medications are dispensed in a safe manner. The VISN and Facility Directors agreed with our findings and five recommendations and provided acceptable improvement plans.

IG Makes Four Recommendations at the VA Illiana HCS, Danville, Illinois

OIG conducted an inspection to determine the validity of allegations regarding pharmacy response, surgical and MH consultant response times, nurse staffing, deep dives (a process to assess and improve patient care), and inadequate leadership communication regarding proposed changes at the VA Illiana HCS in Danville, IL. OIG substantiated that the MH Service did not respond to "emergency," "within one hour," and "within 24 hour" consults for patients diagnosed with suicidal ideation within facility policy timeframes. Patients, however, are kept on a one-to-one observation basis until evaluated and cleared by a psychiatrist. OIG also substantiated that registered nurses were assigned to units without the required competencies validated as required by The Joint Commission. OIG did not substantiate that Surgical and Pharmacy Services are not providing timely services as required by VHA directives and facility policy, or that nursing leadership was deficient in its staffing plans. However, OIG did substantiate that nurse staffing on two units did not comply with unit staffing plans. OIG also did not substantiate that punitive action was taken against an employee based on results of a deep dive facility review, or that facility leadership has not communicated with staff proposed changes. The VISN and Facility Directors agreed with our findings and four recommendations and provided acceptable improvement plans.

St. Louis VAMC Takes Appropriate Action to Correct Medication Errors

OIG evaluated allegations regarding the quality of care provided by a nurse at the John Cochran Division, St. Louis VAMC, St. Louis, MO. A complainant alleged that a RN was involved in serious medication errors, and that management did not respond when complaints were brought to their attention. The facility took appropriate actions in response to the allegations by removing the subject RN from patient care and initiating an AIB to review the alleged medication errors. The AIB substantiated the allegation of substandard care and OIG concurred with their findings and recommendations. OIG did not substantiate the allegation that management did not respond to prior complaints. OIG also reviewed the facility's RN competencies, medication administration system, and quality and safety programs; OIG made no recommendations.

IG Notes Areas of Improvement at the Spokane VAMC, Spokane, Washington

OIG reviewed allegations of inappropriate consultation cancellation causing delays in care and potential harm to patients, poor communication between consultants and primary care providers (PCPs) and patients, and inappropriate requests for PCPs to order tests for consultants at the Spokane VAMC, Spokane, WA. OIG substantiated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms. OIG substantiated that there was poor communication between consultants and PCPs that resulted in requests for consultations being discontinued or cancelled. OIG did not substantiate that consultants inappropriately asked PCPs to order tests. However, OIG noted opportunities for improvement, such as the use of service agreements to define workflow processes and expedite efficient patient care. OIG recommended that the Medical Center Director: (1) ensure that there is a comprehensive consultation process in place and that staff are educated on the process; (2) ensure that all requests for consultations be appropriately generated, tracked to completion, and that consultation completion data is shared with clinical staff; and (3) ensure that persistent staff conflicts and communication issues are appropriately addressed and resolved. The VISN and System Directors agreed with the findings and recommendations and provided acceptable action plans.

Office of Audits and Evaluations

The Office of Audits and Evaluations provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, and inspections of VA programs, functions, and facilities. Our highly diversified reviews encompass the areas of program results, economy and efficiency, finance, fraud detection, and compliance. We report on current performance and accountability to foster good program management, ensuring effective government operations. Office of Audits and Evaluations staff are involved in reviews of such diverse areas as the delivery of medical care, Veterans' eligibility for benefits and benefits administration, resource utilization, financial management, forensic auditing, fraud, and computer security.

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.

In addition to the reports described below, the Office of Audits and Evaluations issued a joint review, in conjunction with the Office of Healthcare Inspections, concerning Veterans' access to MH care. The summary for this report can be found under the Joint Reviews and Settlements section.

Audit Estimates VHA Could Increase Third-Party Revenue by at Least $152 Million Annually

OIG conducted this audit to determine the extent to which VHA's Medical Care Collections Fund program identified third-party billing opportunities for VA-provided medical care. Our previous audit on Non-VA-provided medical care determined VA missed opportunities to increase third-party revenue by $110.4 million annually or $552 million over 5 years. VHA advised it improved its collections by 43 percent, from $1.3 billion in FY 2007 to $1.8 billion in FY 2011. However, our review of VA-provided care identified further opportunities to improve. Specifically, VHA lacked an effective review policy on unbilled care, did not adequately monitor insurance identification procedures, and needed increased training for staff. OIG estimated VHA missed opportunities to increase third-party revenue by at least $152 million annually. Without actions to improve billing processes, VHA could miss an estimated $760 million over the next 5 years. The USH agreed with our finding, recommendations, and monetary benefits.

Staff and Nuclear Medicine Machine Underutilized at VA Clinic in Marion County, Florida

A hotline complainant alleged the North Florida/South Georgia Veterans Health System of the VA Sunshine Healthcare Network underutilized The Villages Outpatient Clinic in Florida. OIG assessed the allegation that four operating rooms intended for minor surgeries and three procedure rooms had not been used since the clinic opened in October 2010. OIG substantiated the allegation that The Villages Outpatient Clinic was underutilized during the first 18 months of operation. OIG found primary care, MH, and specialty care were not being provided as planned. The surgical suite had not been used since the facility opened and the nuclear medicine suite was underutilized. As a result, VHA spent $1.9 million on this underutilized facility and equipment costs as well as on staff salaries and benefits. These funds represent a lost opportunity to provide Veterans with additional access to medical care in an underserved area of need. OIG recommended VHA conduct a utilization review to ensure facility resources efficiently meet the medical needs of the most underserved Veterans. VHA agreed with our finding and recommendations.

Veterans Benefits Administration Audits and Evaluations

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.

Opportunities Exist for VBA To Improve Processing of Rating Decision Appeals at VAROs

OIG determined whether opportunities exist to improve VA Regional Office (VARO) timeliness in processing appeals of rating decisions. The nationwide inventory of appeals increased over 30 percent to about 209,000 in FY 2010 and the inventory of compensation rating claims also increased by 40 percent to 532,000 claims. Opportunities exist to improve appeals processing at regional offices. Regional office managers did not assign enough staff to process appeals, diverted staff from appeals processing, and did not ensure appeals staff acted on appeals promptly because compensation claims processing was their highest priority. OIG found the *de novo* review process results in quicker decisions on Veterans' appeals because decision review officers can render new decisions without awaiting new evidence as required with traditional reviews. VARO staff did not properly record 145 appeals in the Veterans Appeal Control and Locator System that delayed processing for an average of 444 days. The Under Secretary for Benefits generally agreed opportunities exist to improve appeals processing and stated VBA was conducting a pilot program to assess the feasibility of implementing most of our recommendations. OIG will follow up on the implementation of the corrective actions.

IG Visit Prompts VBA To Take Immediate Action To Fix Inadequate Claims Folder Storage at Winston-Salem VARO

During the onsite benefit inspection of the Winston-Salem VARO, OIG observed an excessive number of claims folders stored on the top of, and around, filing cabinets. Based on our concerns, OIG issued a Management Advisory Memorandum to the Under Secretary for Benefits to ensure the VARO addressed management of Veterans' files and employee safety concerns immediately. The inadequate storage created an unsafe workspace for VARO employees and appeared to have the potential to compromise the integrity of the building. The Under Secretary for Benefits directed VARO leadership to take immediate action to find alternate temporary storage areas, obtain additional storage cabinets, and relocate excess cabinets and exposed folders to other floors. VARO management complied and submitted a long-range proposal to improve claim folder access and security.

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 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 10 reports during this reporting period, which are listed in Appendix A.

The inspection results of the three California VAROs showed the Los Angeles VARO to be one of the poorest performers, with an error rate of 97 percent in processing temporary 100 percent disability evaluations. The

San Diego VARO ranked near the middle of all VAROs inspected, with an error rate of 77 percent. Oakland's error rate was also high at 53 percent. Collectively, overpayments for these errors in the three California VAROs totaled over $1.5 million, while underpayments were about $21,000. Further, the San Diego VARO completed its review of VBA's temporary 100 percent disability evaluations, but did not take appropriate actions in 17 (22 percent) of 78 claims involving prostate cancer. VARO management erroneously reported to VBA's Western Area Officials that staff had requested VA medical reexaminations to determine whether the Veterans' disabilities warranted the continued evaluations. Evidence in the Veterans' claims folders revealed VARO staff had neither requested the medical reexaminations, nor put controls in place to manage these cases. Without appropriate action to justify the need for continued payments, these claims have the potential to cost just over $400,000 annually.

Other key findings included:

- Claims Processing: 36 percent of benefit claims we reviewed requiring a rating decision were processed in error. These errors involved claims related to TBI, herbicide exposure-related disabilities, and temporary 100 percent disability evaluations.
- Systematic Analysis of Operations (SAOs): 38 percent of SAOs were not completed timely and/or were incomplete.
- Homeless Veterans Outreach: for 10 percent of the VAROs inspected, there was no assurance the VARO was providing adequate outreach to homeless shelters and service providers.

VAROs Inspected This Reporting Period	
Eastern Area	Cleveland, OH
Southern Area	Winston-Salem, NC
Central Area	Lincoln, NE Little Rock, AR Sioux Falls, SD Wichita, KS
Western Area	Los Angeles, CA Oakland, CA Phoenix, AZ San Diego, CA

National Cemetery Administration Audit

OIG performs audits and evaluations on Veterans' memorial benefits programs focusing on the delivery of these benefits and how NCA manages and administers a nationwide network of National Cemeteries. These audits and evaluations identify opportunities for enhancing the processes and improving management of program operations. We provide VA with constructive recommendations to improve the delivery of benefits to deceased Veterans and their families.

Audit Shows Effective Planning, Use of National Cemetery Administration's FYs 2010/2011 Operations and Maintenance Budget

OIG determined NCA effectively budgeted and used operations and maintenance funds as intended. For FYs 2010 and 2011, the budget authority increased 38 percent from the FY 2009 budget for operations and maintenance. NCA effectively planned its FY 2010 budgetary process using appropriated operations and maintenance funds. In addition, the controls over budget implementation were adequate. OIG identified minor conditions that needed correction to improve equipment accountability. However, these issues were not considered significant or systemic. OIG discussed these minor conditions with NCA's local management on a site-specific basis, and NCA took actions to address OIG's concerns. OIG made no recommendations in this report and did not require a written response.

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.

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

OIG performs audits of IT and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and safeguarding Veterans and VA employees, facilities, and information. OIG's audit reports present VA with constructive recommendations needed to improve IT management and security. OIG oversight in this area also 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.

In addition to the reports described below, the Office of Audits and Evaluations issued a joint administrative investigation, in conjunction with the Office of Investigations, concerning wasteful expenditures related to two 2011 Office of Human Resources and Administration (HRA) conferences held in Orlando, FL. The summary for this report can be found under the Joint Reviews and Settlements section.

Audit Shows No Systemic Problem in Assignment of Duty Stations in VA Personnel Actions

At the request of Senator Charles Grassley, Ranking Member, Committee on the Judiciary, United States Senate, OIG conducted a VA-wide audit to determine whether VA has a systemic problem assigning incorrect duty stations and locality pay to employees. The Chairman and Ranking Member of the Committee on Veterans Affairs, United States Senate, also requested notification of our audit results. OIG determined VA does not have a systemic problem assigning incorrect duty stations and locality pay to employees across all VA organizations. OIG nonetheless identified 6 of 99 statistically sampled cases where VA assigned incorrect duty stations due to inadequately trained human resources personnel and lack of notification to supervisors of employee duty assignments. Consequently, VA overpaid a total of about $106,000 in locality pay from the time the errors first occurred. If problems assigning incorrect duty stations are not fixed, we project a total of approximately $1.4 million in potential incorrect payments over the next 5 years.

Better Oversight of Costs and Broader Impact Measures Can Improve VA's Corporate Workforce Development Program

The Chairman of the Senate Committee on Veterans' Affairs requested OIG assess how effectively VA manages its ADVANCE human capital program. OIG found VA achieved many of its human capital program goals with ADVANCE and its Corporate Senior Executive Management Office. Since FY 2010, VA met its annual goal by training over 135,000 employees. However, VA needs to strengthen management of its Office of Personnel Management (OPM) interagency agreements and better assess program impact. With the rapid deployment of

ADVANCE, VA did not establish adequate controls over interagency agreement costs and terms. OIG estimated, although data was limited, the standardized service fee applied during FY 2011 cost VA an additional $2.5 million. OIG recommended VA assess whether its relationship with OPM is in VA's best interest, take steps to improve management over ADVANCE interagency agreement costs and terms, and improve program impact measures. The Assistant Secretary concurred with the recommendations and provided acceptable corrective plans.

VA's Fast Pay System for Drugs Purchased from Prime Vendor Is Effective, But Quicker Fix of Pricing Differences Needed

At the request of the VA Secretary and the Chairman of the House Committee on Veterans' Affairs, OIG reviewed VA's Fast Pay system. This system processed $4.3 billion of pharmaceutical prime vendor purchases in FY 2011. OIG found Fast Pay consistently provided payments within 48 hours and VA paid accurate contract prices for purchased supplies. However, the National Acquisition Center had not resolved pricing differences of about $46.4 million for pharmaceutical prime vendor purchases from December 2009 through April 2011. In addition, inadequate segregation of ordering and receiving duties makes VA vulnerable to fraudulent activity. OIG recommended VA timely resolve and recover purchase pricing errors and timely completion of price analyses, as well as proper segregation of supply ordering and receiving duties, and adequate verification of supply receipts. The Department concurred with our findings.

VA Overstated $710 Million in Savings Under Office of Management and Budget's Acquisition Savings Initiative

OIG conducted this audit to determine if VHA reported accurate and supportable savings as part of Office of Management and Budget's (OMB's) acquisition savings initiative for FYs 2010 and 2011. VA set a 2-year savings goal of approximately $1.5 billion for FYs 2010 and 2011, which included a $721 million goal for VHA. OIG found VHA inaccurately reported $710 million (65 percent) of the approximately $1.1 billion in savings reported under the OMB acquisition savings initiative. Reported savings included errors like unreportable savings, duplicate transactions, and a lack of sufficient documentation. The overstatement occurred due to incomplete guidance or inadequate oversight. OIG recommended improved policy and controls to ensure more effective responses to future savings reforms and initiatives.

Ineffective Management by the Office of Operations, Security, and Preparedness at VA Security & Investigation Center Leads to Backlog in Contractor Background Investigations

OIG evaluated the merits of a Hotline complaint alleging VA had a backlog of contractor background investigations; was inappropriately requiring completion of contractors' background investigations before the contractors could begin work; and was not meeting its 20-day standard for starting investigations. OIG substantiated all three allegations. The Office of Operations, Security, and Preparedness (OSP) is the lead agent in VA's identity management and personnel suitability program. OSP is primarily responsible for managing the agency-wide process of ensuring that personnel (including contractors) who access VA systems are verified, trusted, and credentialed at the appropriate levels to carry out assigned work. Despite process improvements and a recent reduction in pending cases, VA had a backlog of 3,000 contractor background investigations, inappropriately prohibited contractors from working on contracts, and was not meeting its 20-day standard for starting background investigations with OPM. Delays were due to ineffective VA management within OSP's Security and Investigative Center; staff misunderstanding VA's personnel security requirements and investigative process; and the lack of a central system to monitor progress in addressing the backlog. OIG recommended VA implement improved policies and procedures and implement a central case management system to monitor contractor status and costs associated with the background investigation process.

VA's Measures to Protect Sensitive Data on Mobile Devices Meet Federal Security Standards, But Better Inventory Needed

In response to a confidential hotline allegation, OIG evaluated whether VA's approach for information system certification and storing sensitive data on Apple mobile devices circumvents information security requirements. Senator Kyl also requested OIG evaluate whether VA's approach for only storing sensitive data on encrypted mobile device applications meets Federal Information Security Management Act (FISMA) requirements. OIG determined VA was not circumventing FISMA certification and accreditation requirements by suspending security control testing and granting operational waivers for existing information systems. OIG also determined that VA's approach for allowing only certified applications to access sensitive data or storing encrypted data on the mobile device met FISMA information security requirements for data protection. However, OIG noted that VA could improve management controls by ensuring an accurate inventory and consistent configuration of mobile devices deployed enterprise-wide. The Assistant Secretary for Information and Technology concurred with our findings and recommendations.

Federal Information Security Management Act Compliance

In compliance with FISMA, this assessment determined the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. We found VA has made progress developing policies and procedures, but still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. We continued to identify significant deficiencies related to controls in system access, configuration management, continuous monitoring, as well as service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. This report provides 31 recommendations for improving VA's information security program. The Assistant Secretary for Information and Technology agreed with our findings and recommendations.

Federal Financial Management Improvement Act of 1996 Compliance

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.

Veterans Not Receiving Timely MH Evaluations and Treatment, Better Performance Metrics Needed

Congress and the VA Secretary requested OIG determine how accurately VHA records wait times for MH services for both new and established patient visits and if the wait time data VHA collects is an accurate depiction of the Veterans' ability to access those services. VHA policy requires all first-time patients referred to or requesting MH services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The review found VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to MH care services. VHA did not provide first-time patients with timely MH evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to MH care do not depict the true picture of a patient's waiting time to see a MH provider. The USH concurred with OIG's findings and recommendations.

IG Faults VA Senior Human Resource Leadership for Lax Financial Oversight of Multimillion Dollar Conferences

OIG opened an administrative investigation upon receiving allegations of wasteful expenditures related to Human Resource conferences held in Orlando, FL, in July and August 2011. While VA reported lower estimates of conference costs to Congress, OIG reconstructed the costs of the two conference events to be approximately $6.1 million, but could not gain reasonable assurance that this figure represents a complete accounting for these conferences. In our opinion, VA held these conferences to fulfill valid training needs. However, VA's processes and the oversight were too weak, ineffective, and in some instances, nonexistent. Thus, many conference costs were not sufficiently documented, which made them difficult to clearly justify, or identify whether they were accurate, appropriate, necessary, or even reasonably priced. In fact, OIG questioned about $762,000 as unauthorized, unnecessary, and/or wasteful expenses. Further, OIG found that 11 VA employees, tasked with conference management responsibilities, improperly accepted gifts from contractors seeking to do business or already doing business with VA. The VA Secretary agreed to take action on our findings and OIG will monitor the Department's progress on implementing all proposed corrective actions.

Drug giant Glaxo fined $3 billion

Pleads guilty in criminal, civil cases

Staff and wire reports

WASHINGTON — Drug giant GlaxoSmithKline will plead guilty and pay $3 billion to resolve federal criminal and civil inquiries arising from the company's illegal promotion of some of its products, its failure to report safety data and alleged false price reporting, the Justice Department said Monday.

The company agreed to plead guilty to three criminal counts, including two of introducing misbranded drugs — Paxil and Wellbutrin — and one count of failing to report safety data about the drug Avandia to the Food and Drug Administration.

The $3 billion fine will be the largest penalty ever paid by a drug company, Deputy Attorney General James Cole said.

GSK also agreed to be monitored by government officials for five years to ensure the company's compliance, Cole said.

Under the terms of the plea agreement, GSK will pay a total of $1 billion, including a criminal fine of about $957 million. The company also will pay $2 billion to resolve civil claims under the federal government's False Claims Act.

"Today's multibillion-dollar settlement is unprecedented in both size and scope," Cole said. "At every level, we are determined to stop practices that jeopardize patients' health, harm taxpayers, and violate the public trust — and this historic action is a clear warning to any company that chooses to break the law."

Prosecutors said GSK illegally promoted the drug Paxil for treating depression in children from April 1998 to August 2003, even though the FDA never approved it for anyone under age 18.

The company also promoted Wellbutrin from January 1999 to December 2003 for weight loss, the treatment of sexual dysfunction, substance addictions and attention deficit hyperactivity disorder, although it was approved only for treatment of major depressive disorder.

It is illegal to promote uses for a drug that have not been approved by the FDA — a practice known as off-label marketing.

GSK CEO Andrew Witty said the company has learned "from the mistakes that were made."

Crimes and civil violations like those in the GSK case have produced a series of hefty fines in the pharmaceutical industry.

By JB Reed, Bloomberg News

Avandia: GlaxoSmithKline didn't report safety info to FDA.

False Claims Act Settlements

During this reporting period, OIG's *False Claims Act* work resulted in five settlements totaling more than $103 million in recoveries paid to VA; the total collected by the Department of Justice on behalf of the Government in these five cases, including damages, fines, and penalties, was more than $2.3 billion. Two of the cases, one of which involved off-label marketing and anti-kickback violations and the other which involved safety and anti-kickback violations, were the result of *qui tam* filings. A third *qui tam* action involved a company's failure to comply with warranty guarantees for a medical device. The fourth settlement was the result of both a *qui tam*, which involved off-label violations for multiple drugs, and an affirmative civil claim under the *False Claims Act* for making false and misleading misrepresentations about a drug's safety profile. The fifth settlement was an affirmative action under the *False Claims Act* for medical device safety violations.

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 199 cases; made 152 arrests; obtained over $353.3 million in fines, restitution, penalties, and civil judgments; and achieved over $2 million in savings, efficiencies, cost avoidance, and recoveries. The monetary impact includes settlements in an investigative case brought under the *False Claims Act*, P.L. 111-148, which resulted in recoveries totaling $351,455,830.

During this reporting period, OIG opened 47 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Fifty-six defendants were charged with various crimes relating to drug diversion. These investigations resulted in $423,830 in fines, restitution, penalties, and civil judgments as well as $275,397 in savings, efficiencies, cost avoidance, and recoveries. OIG also initiated 14 investigations related to the fraudulent receipt of health benefits, which resulted in 26 defendants being charged with various related crimes. These investigations resulted in $558,669 in fines, restitution, penalties, and civil judgments as well as $243,000 in savings, efficiencies, cost avoidance, and recoveries. OIG opened 21 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 24 arrests, $287,838 in fines, restitution, penalties, and civil judgments along with $53,598 in savings, efficiencies, cost avoidance, and recoveries. The following entries provide a representative sample of the type of VHA investigations conducted during this reporting period.

Former West Los Angeles, California, VAMC Chief Accountant Pleads Guilty to Theft of Government Funds

A former West Los Angeles, CA, VAMC chief accountant pled guilty to theft of Government funds. An OIG investigation determined that the accountant embezzled $681,087 of VA funds. To date, $229,191 of the stolen funds are still missing.

Former St. Louis, Missouri, VAMC Employee and Coconspirators Sentenced For Accepting Illegal Gratuities

A former VA employee received a sentence of 15 months' incarceration for accepting illegal gratuities from Government contractors from 2007 to 2010 while 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 Service-Disabled Veteran-Owned Small Business (SDVOSB) set-aside contracts to their companies. 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. Both contractors previously pled guilty to charges in this case. The first defendant, who was the leader of the scheme, was sentenced to 2 years' incarceration, 1 year of probation, and a $50,000 fine. The other defendant was sentenced to 3 years' probation, a $60,000 fine, and ordered to pay VA $1,550,000 in restitution.

Former Cleveland, Ohio, VAMC Purchasing Agent Charged with Conspiracy

A former Cleveland, OH, VAMC purchasing agent working in the prosthetics department and the owner of a durable medical equipment provider were each charged by a criminal information with conspiracy to commit

health care fraud. The former VA employee used her position to provide competitor's bid information to the medical equipment provider and allowed for inflated payments for services provided. Also, in some instances the equipment was not installed by the provider, either because the Veteran refused delivery or because the Veteran died prior to delivery. The provider then charged VA as if the equipment had been installed. The loss to VA is $110,581.

Former Union President Indicted for Theft of Union Funds

A former New York, NY, VAMC employee and union president of an American Federation of Government Employee's local was indicted for theft of union funds while on U.S. 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.

Miami, Florida, VAMC Employee Sentenced for Identity Theft

A Miami, FL, VAMC employee was sentenced to 26 months' incarceration and 48 months' supervised release after pleading guilty to 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 22 Veterans' identities in two separate undercover operations at the medical center. The defendant further admitted to selling 3,000 Veterans' identities over the past 5 years that were linked to a larger conspiracy to use stolen VA and non-VA identities in furtherance of a credit card fraud scheme.

Former Detroit, Michigan, VAMC Nursing Assistant Sentenced for Sexual Assault

A former Detroit, MI, VAMC nursing assistant was sentenced to 6 months' incarceration, followed by 12 months' electronic monitoring, and 3 years' probation. The defendant must also register as a sex offender, have no contact with the victim, and pay an administrative fee of $1,453. The former employee provided a signed sworn statement during an OIG investigation in which he admitted to sexually assaulting a job corps student while working together at the medical center.

Former Columbia, South Carolina, VAMC Employee Sentenced for Assault of VA Patient

A former Columbia, SC, VAMC employee was sentenced to 36 months' probation with the first 6 months consisting of home confinement. The defendant pled guilty to assault after he admitted fondling an amputee patient at the medical center, while reportedly checking the patient's diaper for wetness. The defendant's employment was terminated approximately 6 months following his indictment.

Topeka, Kansas, VAMC Physician Arrested for Sexual Assault

A Topeka, KS, VAMC physician was arrested for aggravated sexual battery and sexual battery. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted multiple patients while working at the medical center. The defendant was placed on administrative leave in September 2011 pending the outcome of the investigation.

Daytona Beach, Florida, Outpatient Clinic Social Worker Arrested for Sexual Misconduct

A Daytona Beach, FL, outpatient clinic licensed social worker was arrested for sexual misconduct by a psychotherapist. An OIG and VA Police Service investigation revealed that the defendant engaged in an inappropriate relationship with a patient that resulted in at least one instance of sexual contact during a therapy session.

Roseburg, Oregon, VAMC Pharmacy Technician Charged with Theft of Government Property

A Roseburg, OR, VAMC pharmacy technician was charged with theft of Government property. An OIG investigation revealed that for 18 months the defendant diverted over 6,000 tablets of Schedule II narcotics from the VA pharmacy. As part of the scheme, the defendant used her position and access to a VA computer to remove Schedule II narcotics from the pharmacy inventory and avoided audit detection by designating that the narcotics were being transferred to an automated drug dispenser located elsewhere in the medical center. The defendant also manipulated other security protocols in order to divert the drugs. It is estimated that the stolen drugs had a "street value" of $250,000. The actual loss to VA is approximately $26,000. In February 2012, OIG forwarded a Management Implication Notification to VHA informing them of weaknesses in VA's control of narcotics located within controlled areas of the pharmacy.

Jackson, Mississippi, VAMC Associate Director Arrested for Fraudulently Obtaining Controlled Substances

An Associate Director at the Jackson, MS, VAMC was arrested for fraudulently obtaining controlled substances. An OIG and Drug Enforcement Administration (DEA) investigation revealed that the VA employee was receiving overlapping prescriptions for the same controlled substance from VA and non-VA prescribers.

San Diego, California, VAMC Employee Charged with Illegally Obtaining Narcotics

A San Diego, CA, VAMC employee, who is also a Veteran, was charged with illegally obtaining narcotics from the VA pharmacy and burglary. An OIG and drug task force investigation determined that for over 3 years the defendant forged a VA physician's signature on prescriptions in order to obtain oxycodone. In addition to obtaining narcotics, the defendant also received non-controlled medications which he mailed to his residence. At the deferndant's residence, agents seized drugs and VA medical records belonging to another Veteran.

Subjects Indicted for Drug Distribution at Richmond, Virginia, VAMC

An OIG, VA Police Service, and local police investigation resulted in the indictment of one VA employee, two Veterans, and two non-Veterans for the distribution of a controlled substance. To date, four of the five defendants have been arrested. The investigation revealed that the defendants were selling narcotics to other VA employees and Veterans in and around the Richmond, VA, VAMC. Also, one Veteran was allowing his nearby residence to be used to consume these drugs by employees and patients during working hours.

Multiple Subjects Prosecuted for Drug Distribution at Bedford, Massachusetts, VAMC

A subject was arrested for distribution of heroin. During the course of an OIG, DEA, VA Police Service, and local police investigation, the defendant sold heroin to an OIG informant on five different occasions, with four of the sales occurring at the Bedford, MA, VAMC. During one undercover operation, the defendant sold approximately 7.5 grams of heroin. In another investigation, three Veterans also pled guilty to distributing controlled substances after having previously been charged with selling buprenorphine and oxycodone and conspiring to distribute oxycodone on the grounds of the Bedford, MA, VAMC, a facility that has multiple services for substance abuse rehabilitation. In some of the cases, the defendants were selling drugs that had been provided to them by the VAMC.

West Palm Beach, Florida, Pharmacy Technician and Other Defendants Sentenced for Drug Possession

A VA pharmacy technician pled guilty to possession of oxycodone and was sentenced to 3 years' probation, 100 hours' community service, and forfeiture of $180,920. The pharmacy technician's son pled guilty to conspiracy and trafficking oxycodone and was sentenced to 5 years' incarceration with a 3-year mandatory

minimum and a $53,068 fine. Three other defendants were also sentenced to lesser incarceration times and fines. These sentences 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.

Former Lyons, New Jersey, VAMC Patient Arrested for Overdose Death of Veteran

A former Lyons, NJ, VAMC patient was arrested for administering a lethal dose of heroin to a fellow Veteran and obstructing the investigation into the Veteran's death. An OIG investigation revealed that the defendant and victim purchased heroin outside the medical center and returned to the VAMC, along with a third patient, to take the heroin in the victim's room. The Veteran collapsed while using the drug, and the defendant and third patient departed the room without notifying staff. The victim's body was discovered the next morning. Based on the body's positioning, OIG initially investigated the death as an apparent accidental suicide; however, a confidential source subsequently revealed that the defendant actually administered the heroin to the victim and propped the body to appear as though the victim had taken the heroin and overdosed on his own.

Defendants Charged with Passing Forged Prescriptions

Four defendants were charged with altering and passing forged VA oxycodone prescriptions. An OIG investigation revealed that one of the defendants, a Veteran receiving VA medical care, obtained and then forged VA prescriptions using the signature and Drug Enforcement Administration number of a VA contract nurse working at a local CBOC. The defendant then conspired with the other defendants to fabricate additional prescription orders using various fictitious names and addresses and then passed them at retail drug stores in several adjoining counties.

Veteran Sentenced for Setting Fire to Jacksonville, North Carolina, Clinic

A Veteran was sentenced to 10 to 12 months' incarceration and ordered to pay $2,494 in court costs after pleading guilty to felonious burning of a public building. An OIG, VA Police Service, and local police investigation revealed that the defendant broke into the Jacksonville, NC, CBOC in the early morning and set fire to an office in the facility. There were no injuries; however, the entire clinic has smoke and water damage. The defendant claimed to have set the fire because of dissatisfaction with his VA services.

Former Tampa, Florida, VAMC Employee Sentenced for Theft

A former Tampa, FL, VAMC employee was sentenced to 8 months' home detention, 60 months' probation, and ordered to pay VA $88,879 in restitution. An OIG investigation determined that the defendant ordered low vision-enhancing equipment in the form of iPads and Apple laptops, claiming that they were needed by vision-impaired Veterans. The defendant subsequently sold the equipment on Craigslist for his own personal gain.

VA Employee Charged with Theft of Government Property

The Information Security Officer at the Southern Oregon Rehabilitation Center (SORC) in White City, OR, was charged with theft of Government property. An OIG and VA Police Service investigation revealed that the defendant stole VA computers that were stored at the facility and were later reported missing. A report of survey conducted by the SORC failed to account for at least four computers and they were subsequently removed from the property book. Three years later, information was received by VA Police describing how the defendant had stolen the computers. Local county detectives working on an unrelated case had discovered two computers at the employee's home during a search warrant. The serial numbers on the seized computers matched those missing from a VA report of survey.

Former Reno, Nevada, VAMC Canteen Service Manager Sentenced for Theft

A former VA canteen service manager was sentenced to 5 years' probation, 100 hours' community service, and ordered to pay $40,567 in restitution to VA. An OIG investigation revealed that for approximately 18 months the defendant embezzled money from 13 vending machines located at the Reno, NV, VAMC. The defendant consistently under-reported the vending machine sales to conceal the embezzled funds used for gambling.

Patients Arrested for Theft of Government Property

Two Hines, IL, VAMC patients were arrested for theft of Government property. A VA OIG and VA Police Service investigation revealed that the two defendants stole computers, monitors, video cameras, and various items from the area of a patient lab room after having sexual intercourse in the room. Both defendants admitted to the theft and most of the equipment was recovered. The stolen items were valued at $37,066.

Former Fayetteville, North Carolina, Compensated Work Therapy Employee Indicted For Theft

A former Fayetteville, NC, compensated work therapy employee was indicted for theft-related violations. An OIG, VA Police Service, and local police investigation revealed that while working in the VAMC's information technology section, the defendant stole several new laptop computers. At least six of the computers were pawned in the local area, and three of those were recovered; however, nine of the stolen computers are still missing. The investigation also revealed that the defendant had an extensive criminal history, including burglary, fleeing custody, and fraud-related charges.

Bay Pines, Florida, VAMC Employee Arrested for Theft of Government Funds

A Bay Pines, FL, VAMC employee was arrested for theft of Government funds and access device fraud. An OIG investigation revealed that the employee used a GSA fuel card, issued to a VA vehicle, for personal profit. The approximate loss to VA is $33,000.

Miami, Florida, Employee Arrested for Credit Card Fraud

A Miami, FL, VAMC employee was indicted and arrested for use or attempted use of unauthorized access device and aggravated identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant used stolen credit card numbers and identities to make online purchases from various retailers using the VA network and computers. The credit card loss is approximately $9,000.

Veteran Pleads Guilty to Falsifying a Military Discharge Certificate

A Veteran waived indictment and pled guilty to falsifying a military discharge certificate. An OIG investigation revealed that the defendant falsely claimed to have been awarded a Purple Heart Medal and submitted to VA, in relation to a claim for benefits, a fraudulent Purple Heart certificate, medical notes, and fraudulent military forms to include a DD-214.

Non-Veteran Charged with VA Health Care Fraud

A non-Veteran was charged in a criminal information with theft of Government funds. An OIG investigation determined that the defendant falsely represented himself as a Veteran in order to receive VA health care services. The defendant subsequently received approximately $32,500 in VA health care benefits.

Former Dallas, Texas, VAMC Employee Sentenced for Fraudulent Overtime Claims

A former Dallas, TX, VAMC employee was sentenced to 3 years' probation and ordered to pay VA restitution of $68,861. An OIG investigation revealed that from February 2007 to March 2010 the defendant submitted and was paid for numerous fraudulent overtime claims.

Cleveland, Ohio, VAMC Supervisor Charged for Selling Counterfeit Goods and Copyrighted Works

A Cleveland, OH, VAMC supervisor was charged in a criminal information with trafficking in counterfeit goods and infringement of copyrighted works. An OIG investigation revealed that the defendant solicited his employees to purchase bootlegged DVDs and counterfeit replicas of brand name purses on VA property during official duty hours. The total value of the counterfeit items seized from the defendant was $16,061.

Sixteen Veterans Charged with Travel Benefit Fraud

Sixteen Veterans were charged with theft of Government property and false statements. A VA OIG, VA Police Service, and HUD OIG investigation revealed that the defendants filed fraudulent travel vouchers at the Cleveland, OH, VAMC in order obtain travel benefits they were not entitled to receive. The loss to VA is over $242,000.

Veteran Sentenced for Submitting False Travel Benefit Claims and Threats

A Veteran was sentenced to 30 months' incarceration and ordered to pay $5,867 in restitution after pleading guilty to false statements and threats against a Government official. An OIG investigation revealed that between November 2008 and May 2011, the defendant submitted 181 fraudulent claims to the Hampton, VA, VAMC for travel benefits totaling $8,271. After the subject was interviewed and benefits were terminated, the Veteran made threats to harm the case agent.

THE PLAIN DEALER

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16 veterans accused of mileage scam

They got $240,000 in false VA reimbursements, U.S. says

PETER KROUSE
Plain Dealer Reporter

Sixteen Northeast Ohio veterans are accused of stealing more than $240,000 from the federal government by submitting bogus reimbursement claims for travel to local medical facilities.

The fraud is believed to be the largest of its kind uncovered in the country, said Gavin McClaren, resident agent in charge of the U.S. Department of Veterans Affairs' Office of Inspector General. The veterans were charged individually and are not suspected of being part of a conspiracy.

According to McClaren, the scam worked like this: Instead of stating the actual mileage traveled, the vets used made-up addresses or someone else's address many miles away. For example, some defendants were living in public housing in Cleveland but claimed on their reimbursement forms that they traveled from a Youngstown address to a Cleveland-area medical facility.

All the visits were to the Louis Stokes Cleveland Veterans Affairs Medical Center on East Boulevard or to its Brecksville location, which is now closed, McClaren said.

Among those charged with theft were brothers Scott and Mark Sheline, both of Lakewood.

Scott Sheline, 56, is accused of bilking the government out of the most money among those charged. According to an indictment filed Thursday by a federal grand jury, he submitted $36,979 in bogus reimbursement claims over six years.

Sheline submitted claims that gave departure addresses in Toledo, Maumee and Fairview Park, the indictment says.

SEE VETS | A4

Veterans Indicted for Travel Benefit Fraud

Two Veterans were indicted for bribery, conspiracy to defraud the U.S. Government, and false claims. Previously, five other Veterans and two Seattle, WA, VAMC travel clerks were charged in this case. An OIG investigation revealed that the seven Veterans participated in a scheme with the VAMC travel clerks to submit inflated and fictitious travel benefit vouchers. The VA employees processed the vouchers and then demanded kickbacks from the Veterans. The loss to VA is estimated to be over $150,000.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 6 months' incarceration, 36 months' probation, and ordered to pay $27,000 in restitution to VA after pleading guilty to theft. An OIG investigation revealed that the defendant submitted approximately 200 fraudulent claims for travel benefits.

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 3,092 investigative cases opened. Investigations have resulted in the actual recovery of $64.8 million, with an additional $21.5 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $150 million. To date, there have been 598 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 286 investigations, made 77 arrests, and had a monetary impact of over $6.1 million in fines, restitution, penalties, and civil judgments as well as more than $15.7 million in savings, efficiencies, cost avoidance, and recoveries during this reporting period. Two-hundred sixty-three of these investigations involved the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. Various criminal charges were filed against 60 defendants for these types of investigations. OIG obtained over $5.4 million in court ordered payment of fines, restitution, and penalties and also achieved an additional $15.5 million 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.

Fiduciary and Wife Plead Guilty to Conspiracy and Filing a False Tax Return in Theft of $2.3M from Veterans

An attorney pled guilty to conspiracy and filing a false tax return. The defendant, who served as a court appointed guardian and Federal fiduciary for 54 Veterans, stole approximately $2.3 million from the Veterans' bank accounts. The defendant also failed to report the stolen funds to the Internal Revenue Service. The defendant's wife, who worked as his legal assistant, previously pled to the same charges.

Fiduciary Sentenced for Exploitation of a Vulnerable Adult and Forgery

The sister-in-law of a Veteran, who was also his fiduciary, was sentenced to 7 years' incarceration and ordered to pay the Veteran $53,180 in restitution after pleading guilty to exploitation of a vulnerable adult and forgery. An OIG and local sheriff's office investigation revealed that the

HOUSTON CHRONICLE

Lawyer guilty of scamming disabled vets

Houstonian admits he and his wife conspired to steal $2.3 million

By Lise Olsen

A 73-year-old attorney pleaded guilty in Houston federal district court Tuesday to conspiring with his wife to steal $2.3 million from 49 disabled veterans and then hiding the thefts by creating fake reports, imaginary bank accounts and filing a bogus income tax return.

As part of his guilty plea to two of 21 charges against him, Joe B. Phillips admitted to transferring more than $1.36 million from veteran clients' accounts directly to a joint checking account that he shared with his wife between 2003 and 2007.

Phillips' wife, Dorothy, a self-described gambling addict, pleaded guilty to similar charges in April. The 72-year-old admitted to misusing some veterans' money to fund casino trips to Louisiana, where she often gambled at L'Auberge du Lac and Delta Downs, court

Phillips continues on A11

defendant stole VA and Social Security benefits intended for the Veteran and used the stolen funds for personal expenses.

Former Guardian Sentenced for Theft of Government Funds

A former VA approved guardian was sentenced to 27 months' incarceration and ordered to pay $305,126 in restitution ($197,678 to VA) after pleading guilty to theft of Government funds. A VA OIG, Social Security Administration (SSA) OIG, and local sheriff's investigation revealed that for 6 years the defendant embezzled funds from two Veterans and concealed her activity by transferring funds between the two Veterans' accounts when filing required documentation.

Fiduciary Sentenced for Embezzlement

The daughter of a Veteran, who was also his fiduciary, was sentenced to 18 months' incarceration, 2 years' supervised release, and ordered to pay $244,673 in restitution for her role in the embezzlement of VA compensation and Social Security benefits intended for her father. The defendant was previously charged in a criminal information with misappropriation by a fiduciary and conversion of Social Security benefits. A VA OIG and SSA OIG investigation revealed that the defendant became the Veteran's fiduciary in 2005 and embezzled from her father's savings for over 3 years. After initially claiming that a VA field examiner told her she could spend the money, she admitted to OIG agents that she fraudulently spent the money intended for the Veteran.

Former VA Fiduciary Sentenced for Embezzling $242,000 in VA Benefits

A former VA fiduciary received a sentence of 6 months' incarceration, 6 months' home confinement, 3 years' supervised release, and was ordered to pay $92,817 in restitution to her brother-in-law, a disabled Veteran. An OIG investigation revealed that from October 2003 to April 2010, the defendant misused her position as her brother-in-law's fiduciary to embezzle approximately $242,000 in VA benefits. The defendant used the stolen funds for unauthorized purposes, which included building an addition onto her house. The defendant falsified annual accountings submitted to VA by misstating the amounts of money on deposit in the Veteran's custodial bank accounts.

Defendant Sentenced for Identity Theft Spanning 25 Years, $201,000 Restitution Ordered

A defendant was sentenced to 74 months' incarceration, 48 months' supervised release, and ordered to pay $201,295 in restitution after pleading guilty to aggravated identity theft and theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant assumed the identity of an acquaintance and used this identity for approximately 25 years. This included the defendant fraudulently enlisting in the U.S. Army and subsequently obtaining VA and Social Security benefits using the false identity.

Loan Broker Sentenced for Fraud

A loan broker was sentenced to 63 months' incarceration, 3 years' supervised release, and ordered to pay restitution after pleading guilty to wire fraud, aggravated identity theft, making false statements on a loan application, and concealing assets in bankruptcy. A VA OIG and HUD OIG investigation determined that the defendant fabricated VA certification letters that were subsequently used to establish the credit worthiness of buyers for three different properties. These properties were subsequently listed as assets in bankruptcy filings. The loss to three banks was $1,033,500.

Huntington, West Virginia, VARO Employee Indicted for Forging U.S. Department and Agency Seals

A Huntington, WV, VARO employee was indicted for forging U.S. department and agency seals and applying them onto approximately 2,800 counterfeit military certificates. An OIG, Naval Criminal Investigative Service (NCIS), and Defense Criminal Investigative Service (DCIS) investigation revealed that from approximately July 2008 to October 2010 the defendant operated an Internet website and e-Bay store that sold the counterfeit military certificates bearing forged department and agency seals to the public. The investigation also revealed that the defendant was conducting some of the business related to this scheme from his assigned VA computer. The public fraud associated with this investigation has been determined to be approximately $50,000.

Puerto Rico Man Charged with Fraud, Used Fake Social Security Card to Obtain Over $650,000 in VA Benefits

A Veteran was arrested for aggravated misappropriation, misrepresentation, fraud, and possession and transfer of false documents. This investigation resulted in the securing of legal standing from the Commonwealth of Puerto Rico's Attorney General enabling OIG to become the first Federal law enforcement agency to have the ability to present criminal cases directly to the Commonwealth Attorney for prosecution. The investigation was initiated based on a referral from the St. Petersburg OIG Benefit Inspections Division, which identified the suspected fraud during an audit of the San Juan, PR, VARO. The investigation revealed that the defendant fraudulently received both VA compensation and pension benefits based upon multiple fraudulent enlistments in the U.S. Army and a fraudulent Social Security card. The loss to VA is $652,508.

Veteran Sentenced for Compensation Fraud after Submitting Fraudulent DD-214s

After pleading guilty to making false statements, a Veteran was sentenced to 10 months' incarceration, 3 years' supervised release, and ordered to pay restitution to VA and the Navy in the amounts of $26,367 and $93,029, respectively. An OIG and DCIS investigation revealed that the defendant submitted a fraudulent DD-214 to VA and the Navy indicating that he had been awarded a Purple Heart and a Combat Infantry Badge and that he served 6 years in the Army. The fraudulent DD-214 allowed the defendant to qualify for VA compensation benefits for PTSD. He then used the fraudulent DD-214 to generate a second DD-214, which was used as the basis to fraudulently receive a military retirement.

Veteran Arrested for Theft of Government Funds

A Veteran was indicted and subsequently arrested for theft of Government funds. A VA OIG, U.S. Postal Service (USPS) OIG, and SSA OIG investigation revealed that the defendant, who was in receipt of VA individual unemployability benefits as well as other Federal disability benefits, reported to VA that he was unemployed and had no income. The investigation determined that the defendant was employed as a bishop of a church and was the owner and operator of a daycare center. The total Government loss is approximately $900,000, with a loss to VA of approximately $221,500.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 48 months' incarceration, 3 years' supervised release, and ordered to pay $668,647 in restitution, to include $252,051 to VA. A VA OIG, IRS Criminal Investigation Division, SSA OIG, and Department of Education OIG investigation resulted in the defendant and his wife being convicted at trial of multiple charges of tax fraud, VA compensation fraud, Education fraud, and Social Security fraud. The defendant fraudulently received VA individual unemployability benefits since 1986.

Remarried Husband of Deceased Veteran Sentenced for Theft of VA Benefits

The remarried husband of a deceased Veteran was sentenced to 366 days' incarceration, 24 months' supervised release, a $10,000 fine, ordered to pay VA restitution of $185,458 (already paid), and to refrain from handling monetary or business affairs for any business or organization. The defendant had previously pled guilty to conversion of Government funds. An OIG investigation revealed that on three separate occasions the defendant falsely certified to VA that he had not remarried in order to continue to receive Dependency and Indemnity Compensation (DIC) benefits.

Veteran Sentenced for Fraudulent PTSD Claim

A Veteran pled guilty to health care fraud and was sentenced to 24 months' incarceration and ordered to pay $144,885 in restitution to VA, which included $123,520 paid to the Veteran for a fraudulent PTSD claim and additional funds paid to his daughter for education benefits that were not allowed by his subsequent 20 percent service-connected rating. An OIG investigation determined that the defendant fraudulently claimed to have PTSD and loss of the use of his extremities in order to receive additional VA benefits.

Veteran Charged with Making False Statements

A Veteran was charged with making false statements after a VA OIG and Department of Transportation OIG investigation revealed that while the defendant was receiving VA compensation benefits for chronic obstructive pulmonary disease (COPD), he had reported to the Federal Aviation Administration (FAA) that he was not diagnosed with a lung disease, had no other illness or disability, did not visit a health professional in the last 3 years, and did not receive medical disability benefits. The defendant's FAA license has been suspended and his VA compensation benefits for COPD were terminated. The loss to VA is $51,237.

Veteran Pleads Guilty to Theft of Government Funds after Making False Claims

A Veteran pled guilty to the theft of Government funds after an OIG investigation revealed that he submitted a false claim for PTSD to VA claiming that he was wounded during a mortar attack in Beirut, Lebanon. The defendant provided VA with a fraudulently obtained Purple Heart certificate to support his claim of having a combat-related injury. A review of the defendant's military records revealed that he was never deployed to a combat area. The defendant admitted that he purchased the Purple Heart certificate from an Internet vendor. The loss to VA is $24,488.

Veteran Arrested for Compensation Fraud

A Veteran was indicted and subsequently arrested for mail fraud, theft, false statements, and using a fictitious name or address. The defendant, who was receiving VA benefits for individual unemployability, reported to VA on multiple occasions that he was unemployed. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant falsely claimed to have developed a drug that provided a cure for various ailments including human immunodeficiency virus and cancer. In return for selling the rights of his product to a California-based pharmaceutical company, the defendant received $150,000 and several hundred shares in the company. The defendant received additional income by selling his shares to other Veterans and receiving consulting fees from the pharmaceutical company.

Widow Arrested for Grand Theft

The widow of a deceased active duty service member was arrested for grand theft. An OIG, NCIS, and local police investigation determined that the defendant failed to notify VA of her remarriages since the death of her third husband in 2005. The defendant further instructed her most recent husband to keep their marriage a secret so she would not lose her VA benefits. The defendant is also charged with stealing over $5 million from her former employer, former mother-in-law, and DoD. The loss to VA is $73,449.

Veteran Indicted for VA Compensation Fraud

A Veteran was indicted for theft of Government funds. The defendant had been rated to receive compensation at the 100 percent rate for PTSD based on her fraudulent reporting to VA that she was housebound and unable to function in society. An OIG investigation revealed that during this time the defendant attended classes, earned degrees in Education, and since 2006 was employed as an elementary school teacher. The loss to VA is $205,402.

Veteran and Spouse Indicted for Fraud

A Veteran and his spouse were indicted for conspiracy, false statements, theft of Government funds, and SSA fraud. A VA OIG, SSA OIG, Federal Bureau of Investigation (FBI), and U.S. Air Force investigation revealed that the defendants conspired to fraudulently obtain public money from VA and SSA by providing false statements and documents, which reflected that the Veteran had participated in Special Operations combat duty in Vietnam and Iran while a member of the U.S. Air Force. The loss to VA is approximately $330,000.

Veteran Charged with Mail Theft and Aggravated Identity Theft

A Veteran was charged with mail theft and aggravated identity theft after an OIG investigation revealed that she assumed the identities of six other Veterans in order to receive $18,000 in advanced education payments under the Post-9/11 GI Bill. When interviewed, the defendant confessed that while on active duty she obtained a personnel roster that contained personal identifiers of service members. After the defendant was discharged, she used the list to assume the identities of the Veterans in order to request advance education payments online. The defendant had the checks, in the names of the other Veterans, mailed to her address and then created false powers of attorney in order to negotiate the checks.

Veteran Sentenced for Attempting to Defraud VA

A Veteran was sentenced to 5 years' probation after pleading guilty to possession of a false document with intent to defraud the United States. An OIG investigation revealed that the defendant attempted to defraud a VA Educational Assistance Program. During the course of the investigation, the Veteran presented an altered DD-214 to an OIG agent posing as a VA benefits officer.

Veteran's Girlfriend Sentenced for Fraud

The girlfriend of a Veteran was sentenced to 5 years' probation and ordered to pay VA $167,317 in restitution after conspiring to structure a business in her name in order to conceal the Veteran's income from VA. An OIG investigation revealed that the Veteran and his girlfriend operated a business for over 8 years while the Veteran received VA pension benefits and co-pay exempt VA health care. The investigation further revealed that the Veteran was also selling his VA-prescribed morphine tablets. Drug charges are pending against the Veteran.

Son of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The son of a deceased VA beneficiary was sentenced to 6 months' confinement in a half-way house, 36 months' probation, and ordered to pay $46,000 in restitution after pleading guilty to theft of public money. An OIG investigation revealed that the defendant stole VA funds from his deceased mother's bank account after his mother's death in April 2003.

Son of Deceased VA Beneficiary Sentenced for Theft

The son of a deceased VA beneficiary was sentenced to 90 days' incarceration, 3 years' probation, and ordered to pay $103,866 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole $103,866 in VA funds that were issued after his father's death in February 2003.

Granddaughter of Deceased Beneficiary Arrested for Theft

The granddaughter of a deceased VA beneficiary was indicted and subsequently arrested for theft, wire fraud, and Social Security fraud. A VA OIG, OPM OIG, SSA OIG, HUD OIG, and U.S. Secret Service investigation revealed that the defendant fraudulently received, forged, and negotiated VA and OPM benefit checks issued after her grandmother's death in April 1986 until June 2007. In addition, the defendant failed to disclose her fraudulently obtained VA and OPM benefit income to the SSA and HUD from which she was also obtaining benefits. The total Government loss is approximately $222,641.

Friend of Deceased Veteran Sentenced for Stealing VA Funds

The friend of a deceased Veteran was sentenced to 12 months' incarceration, 3 years' probation, and ordered to pay $177,824 in restitution after an investigation conducted by OIG and FBI revealed that the defendant attempted to hide withdrawals from the deceased Veteran's bank account by transferring funds through two PayPal accounts into the defendant's bank account.

Girlfriend of Deceased Beneficiary Sentenced for Theft of VA Funds

The girlfriend of a deceased VA beneficiary was sentenced to 10 months' incarceration, 36 months' probation, and ordered to pay $56,000 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant obtained, forged, and negotiated VA checks intended for a Veteran after his death in October 2006 by submitting forged employment questionnaires to VA.

Defendant Sentenced for Theft of Government Funds

A defendant was sentenced to 35 months' incarceration, 3 years' supervised release, and ordered to pay $79,799 in restitution to the Government, including $18,360 to VA. The defendant previously pled guilty to a criminal information charging her with felony theft and theft of Government funds. An OIG, SSA OIG, and local police investigation determined that the defendant received benefits as part of several fraudulent schemes involving VA, SSA, Department of the Treasury, and the Missouri Department of Social Services. The defendant admitted to stealing funds from a deceased VA beneficiary who died in August 2008.

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 20 cases, made 10 arrests, and obtained nearly $739.8 million in fines, restitution, penalties, and civil judgments. The monetary impact includes $733,612,600 in recoveries resulting from an investigative case brought against GlaxoSmithKline under the *qui tam* provisions of the *False Claims Act*, P.L. 111-148.

OIG also investigates theft of IT equipment or data, network intrusions, and child pornography. In the area of information management crimes, OIG opened five cases, made two arrests, and achieved $45,258 in savings, efficiencies, cost avoidance, and recoveries.

Contractor Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

A VA contractor was sentenced to 41 months' incarceration, 36 months' supervised release, and ordered to pay a $30,000 fine and a $600 special assessment. The sentence was based on the defendant's conviction, following a 5 day trial, to major frauds against the Government, making false statements to a Federal law enforcement officer, and witness tampering. A VA OIG, Small Business Administration (SBA) OIG, and U.S. Army Criminal Investigation Command (CID) investigation determined that from June 2007 to June 2010 the defendant falsely

claimed that he was both a Veteran and/or a disabled Veteran in connection with VA or U.S. Army construction contracts that were set-aside for either Veterans or disabled Veterans and valued at approximately $16 million.

VA Contractor Charged with Conspiracy to Commit Wire Fraud

A VA contractor was charged in a criminal information with conspiracy to commit wire fraud and is subject to forfeiture of his assets in an amount not greater than $38,000. A VA OIG, General Services Administration OIG, SBA OIG, DOL OIG, and U.S. Army CID investigation revealed that the defendant falsely represented to various Government agencies that the company was owned and managed by a minority and service-disabled Veteran in order to get Federal government contract awards set aside for disadvantaged minority and service-disabled Veteran-owned and operated businesses.

Federal Contractor Sentenced for SDVOSB Fraud

A Federal contractor was sentenced as a corporation to 3 years' probation and a $5,000 fine after pleading guilty to wire fraud relating to a $218,241 Historically Underutilized Business Zone contract. An OIG investigation, conducted with eight other agencies, revealed that the contractor had been part of a fraudulent scheme that involved an additional $21,511,002 in SDVOSB contracts.

Federal Contractor Sentenced for Fraud

A Federal contractor was sentenced as a corporation to 3 years' probation and a $65,000 fine after pleading guilty to wire fraud relating to a $274,283 Historically Underutilized Business Zone (HUBZone) contract and making false statements relating to the Federal Surplus Property Program. An OIG investigation, conducted with eight other agencies, revealed that the contractor had been a part of a fraudulent scheme which involved $21,511,002 in SDVOSB contracts, $1,657,231 in HUBZone contracts, $613,915 in minority 8(a) contracts, and $1,200,000 in fraudulently secured Federal surplus property.

VA Contractor Charged with Conspiracy to Commit Wire Fraud

Authorities filed a criminal information against a VA contractor, charging him with conspiracy to commit wire fraud. If convicted, the contractor is also subject to a criminal forfeiture of up to $400,000 of his assets. OIG took part in a multiagency investigation that revealed the defendant submitted statements to SBA and other Government agencies falsely representing that the business was owned and managed by a service-disabled, minority Veteran in order to qualify for contracts set aside for such Veteran-owned and operated businesses.

Veteran Sentenced for Sale of Counterfeit Agency Seals

A Veteran was sentenced to 36 months' incarceration, 36 months' supervised release, and ordered to pay $43,780 in restitution to over 600 victims for possession and sale of counterfeit U.S. agency seals and impersonating a Federal officer or employee. The defendant was also ordered to abandon all property previously seized by OIG during the execution of a Federal search warrant. 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 military service branches, as well as law enforcement awards and training certificates.

Former West Los Angeles, California, VAMC Employee Convicted of Possession of Child Pornography

A former West Los Angeles, CA, VAMC employee was found guilty at trial of possession of child pornography, which was found in his residence located on the grounds of the West Los Angeles VAMC. The defendant is currently incarcerated after having previously pled guilty to the sexual abuse of his daughter.

Former Northport, New York, VAMC Employee Arrested for Child Pornography

A former Northport, NY, VAMC employee was arrested after being indicted for making a false statement and accessing child pornography with intent to view. An OIG and local police investigation revealed that the defendant was viewing child pornography on his VA computer and lied to investigators about his activity. The defendant was arrested without incident following an appointment with his probation officer relating to a previous conviction for molesting a family member who was a minor.

Veteran Pleads Guilty to Possession of Child Pornography at Phoenix, Arizona, VAMC

A Veteran pled guilty to possession of child pornography after an OIG investigation revealed that he was viewing child pornography on his personal computer at the Phoenix, AZ, VAMC. A search warrant and subsequent forensic examination of the defendant's laptop and related memory card devices identified approximately 110 digital images and 77 digital videos depicting child pornography. The defendant remains in custody pending sentencing.

Physician Sentenced for Possession of Child Pornography and Health Care Fraud

A physician who owned a medical services company was sentenced to 72 months' incarceration after pleading guilty to possession of child pornography and health care fraud. A VA OIG, OPM OIG, FBI, Health and Human Services OIG, and DCIS investigation revealed that the defendant defrauded VA and other Federally funded insurance programs by submitting false claims and fraudulent invoices for the remote monitoring of nerve conduction studies. The investigation revealed that the physician was paying untrained, non-medical personnel to monitor the procedures and impersonate him on internet chat logs to make it appear as though he was present. During the course of the investigation, agents executed search warrants and seized several computers. Forensic analysis of the defendant's computer revealed that he was spending most of his time viewing child pornography while he was allegedly monitoring nerve conduction studies. The loss to VA is $64,759. A global settlement is currently being negotiated.

Defendant Pleads Guilty to False Statements

A defendant pled guilty to making a false statement relating to a credit application. A VA OIG and HUD OIG investigation revealed that the defendant purchased homes under false pretenses and then sold them to individuals who were unaware of the existing mortgages. The loss to the Government is over $400,000, with approximately $48,000 in losses to VA.

U.S. Postmaster Pleads Guilty to Theft of Mail Containing Controlled Substances

A U.S. Postmaster pled guilty to theft of mail after a VA OIG and USPS OIG investigation revealed that he intercepted 14 packages containing controlled substances being shipped from the Murfreesboro, TN, Consolidated Mail Outpatient Pharmacy to Veterans in Louisiana. A search incident to arrest disclosed a satchel in the defendant's locker containing additional VA narcotic bottles.

USPS Contract Employee Arrested for Theft of VA Drugs

A USPS contract truck driver was indicted and subsequently arrested for theft of mail. A VA OIG and USPS investigation revealed that during a 6 month period the defendant stole approximately 9,600 pills of VA controlled medication and more than 3,000 prescription pills from a non-VA hospital located in Asheville, NC. The defendant admitted to stealing the drugs for his own use and to sell.

Former USPS Employee Pleads Guilty to Possession of a Controlled Substance by Fraud and Theft of Mail

A former USPS employee pled guilty to possession of a controlled substance by fraud and theft of mail. During a VA OIG and USPS OIG investigation, the defendant was found in the parking lot of a USPS processing plant with opened VA packages containing controlled substances. The VA had reports of lost and missing controlled medications processed through the same plant for a number of years.

Subject Arrested for Theft of VA Gravesite Markers

An OIG and State police investigation resulted in the arrest of a subject who stole bronze VA gravesite markers from his employer and then sold them to a scrap yard. The defendant was employed by a local funeral home and was not given permission by his employer to dispose of the markers. The markers were returned to the funeral home and properly placed at the appropriate Veteran gravesites in time for Memorial Day.

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 7 and closed 14 administrative investigations. The Division investigated 35 allegations, 25 of which were substantiated. This work resulted in the issuance of 5 reports containing 67 recommendations for administrative or corrective action, including one joint administrative investigation conducted in cooperation with OIG's Office of Audits and Evaluations concerning wasteful expenditures related to two 2011 HRA conferences held in Orlando, FL. The summary for this report can be found under the Joint Reviews and Settlements section.

The Administrative Investigations Division issues advisory memoranda when an allegation has been substantiated and VA needs to take some action, but where the violation does not rise to the level of a formal recommendation. The Division also issues administrative memoranda in cases where one or more of the allegations were not substantiated. During this reporting period, the Administrative Investigations Division also issued 6 advisory memos with 10 suggestions for corrective action and 6 administrative memos. OIG also obtained $19,080 in dollar recoveries.

Senior VHA Official Engaged in Improper Contracting Activities and Was Not Candid with Investigators, Health Administration Center, Denver, Colorado

An administrative investigation found that a VHA Senior Official engaged in improper contracting activities when she instructed her subordinates to issue sole-source task orders to one specific contractor and in a conflict of interest when she failed to maintain an arm's-length relationship with two VA contractors. She also violated VA policy when she sent VA contract proprietary information to her personal home computer and when she e-mailed a VA OIG draft audit report to one of the contractors about 1 month prior to her program office awarding them a task order that was consistent with the audit report. Further, she did not testify freely and honestly concerning her relationship to contractors and her involvement in the decision to award and administer the task orders. The investigation also disclosed that a VHA Senior Contracting Officer did not comply with Federal Acquisition Regulations pertaining to orders placed against Federal Supply Schedule contracts.

VAMC Senior Official Failed to Promptly Report Possible Felony to OIG and Interfered with OIG Investigation

An administrative investigation found that a VAMC Senior Official failed to ensure that information about a possible criminal matter involving a felony was promptly referred to the OIG Office of Investigations. In addition, the Senior Official interfered with the OIG investigation when he asked a subordinate to provide him key information about events that he reasonably knew OIG would ask him about during his interview, and he did not testify freely and honestly in connection with the OIG investigation.

Falsification of Employment Record, Failure to Follow Policy, and Misuse of Position Substantiated in VALU

An administrative investigation found that a VA Learning University (VALU) Senior Official falsified an Optional Form 306 (OF306) as part of his VA employment when he failed to disclose pertinent information, including a proposed removal and subsequent mutual agreement associated with his former Federal employment. In addition, VA management officials failed to follow VA policy when they did not conduct pre-employment checks on the Senior Official prior to appointing him to a senior leader position; the Senior Official failed to follow requirements related to official travel; and he misused his position when he forwarded a fraternity brother's resume to a VA contractor doing business within VALU.

Investigation Finds Office of Research and Development Locality Pay and Travel Claims Improper

An Office of Research and Development (ORD) employee lived and worked outside of Washington, DC, yet received the higher Washington, DC, locality pay, resulting in $19,080 of improper pay. An ORD senior official was aware for 2 years of the improper pay and did not take timely action. In addition, ORD employees failed to follow Federal travel regulations concerning travel claims.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 28 criminal investigations resulting from assaults and threats made against VA facilities and employees. Twenty-one defendants were charged with related charges as a result of the investigations. OIG investigative work resulted in the following:

- A Veteran was sentenced to 5 years' probation and ordered to write a letter of apology to the victim after having previously pled guilty to assaulting a VA police officer at the Seattle, WA, VAMC. An OIG and VA Police Service investigation revealed that the defendant 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 his weapon until subdued by the officer and other responders. The assault resulted in injuries to the officer.
- A Veteran pled guilty to forcibly touching a VA nurse. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted a VA RN during an appointment at the Rochester, NY, CBOC. 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 pled guilty to assaulting the Reno, NV, VAMC Police Chief. 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 scene, identified himself to the defendant, and attempted to calm the situation. The defendant subsequently struck the chief in the face causing injuries.

- As a result of an OIG and VA Police Service investigation, a Veteran was sentenced to time served and 2 years' supervised release, ordered to participate in a substance abuse and MH treatment program, and banned from seeking treatment at the White River Junction, VT, VAMC. The defendant previously pled guilty to felony assault with a dangerous weapon. The investigation revealed that while in the VAMC ER, the defendant locked the door, took a scalpel from a hospital cart, and used the scalpel to gain control of a nurse by holding it to her throat. VA Police Service officers were able to subdue the defendant, and the nurse sustained no injuries.
- Authorities indicted the grandson of a Veteran for assaulting a Jackson, MS, VAMC police officer. An OIG investigation revealed that the defendant grazed the VA police officer with his vehicle as he attempted to flee the scene while the officer was in the process of issuing him a traffic citation for a moving violation. Subsequent to grazing the officer, the defendant continued his attempt to flee, accelerating at a high rate of speed and steering towards the officer, who had repositioned himself in an attempt to stop the defendant. The officer was able to move out of the way and avoid serious injury. The defendant fled the medical center but returned after a few hours and was arrested by OIG and VA Police Service for felony assault on a Federal officer.
- A Veteran pled guilty to assault on a Federal employee after an OIG investigation revealed that he physically assaulted and attempted to sexually assault a female VA social worker at the Phoenix, AZ, VAMC. The Veteran removed his clothing while in the employee's office and used physical force to prevent the employee from leaving the office. The defendant remains in custody pending sentencing.
- A VA employee was indicted for making terroristic threats. An OIG investigation revealed that the defendant told several staff members at a private medical center that he intended to kill his VA supervisors and the acting Assistant Director at the Atlanta, GA, VAMC if he did not receive a favorable decision regarding his pending Equal Employment Opportunity complaint. The defendant threatened to shoot and kill the supervisors during the medical center's weekly staff meeting and to kill the acting Assistant Director in his office. The defendant also stated that he would kill anyone else, including VA Police Officers, if they attempted to stop him.
- A Veteran was sentenced to 15 months' incarceration, 1 year of supervised release, to include mandatory "no victim" contact during the entire time, after having previously been convicted of threatening two VA employees. An OIG investigation revealed that the defendant made a series of threatening phone calls to two VA employees at their residences.
- A Veteran was sentenced to 18 months' incarceration, 36 months' supervised probation, and ordered to attend MH treatment programs after pleading guilty to influencing, impeding, or retaliating against a Federal official. An OIG investigation determined that the defendant telephoned the National Call Center in Muskogee, OK, angry about a benefits issue, and threatened VA employees working at the Columbia, SC, VARO. The defendant threatened to wait outside the facility and "bash in the face" of whoever was stealing his money and kill them. The defendant stated he was willing to go to jail for his actions.
- A Veteran was arrested and subsequently indicted for intentionally intimidating and impeding a Federal employee engaged in his official duties. An OIG and VA Police Service investigation revealed that the defendant threatened to return to the Spokane, WA, VAMC with a firearm after being denied an unscheduled refill of his narcotics. This was the third such incident in the past 2 years involving the defendant referencing firearms in an effort to intimidate VA staff. The defendant's criminal history included a previous arrest and conviction for bringing an assault rifle and two handguns onto the medical center property in 2005.

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, 47.2 million felony warrants have been received from the National Crime Information Center and participating states resulting in 60,658 investigative leads being referred to law enforcement agencies. Over 2,272 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 $942.2 million in estimated overpayments with an estimated cost avoidance of $1.08 billion. During this reporting period, OIG opened 32 and closed 34 fugitive felon investigations. Investigative work resulted in the arrest of 29 fugitive felons, including 4 VA employees. Based on the information provided by OIG, at least four additional arrests were made by other law enforcement agencies. Apprehensions included the following:

- A Veteran was arrested without incident at the Orange City, FL, VA Outpatient Clinic by local police with the assistance of OIG. The defendant was wanted by the Albany, OR, Police Department on a felony warrant for luring a minor, furnishing sexually explicit material to a child, private indecency, online sexual corruption of a child, and sexual abuse.
- OIG assisted a U.S. Marshals Service Fugitive Apprehension Task Force with locating and apprehending a Veteran at the Little Rock, AR, VAMC. The Veteran was wanted for Failure to Appear for Felony Sexual Assault in the Second Degree.
- OIG and VA Police Service arrested a Bonham, TX, VAMC employee for a probation violation stemming from an assault by strangulation charge.
- A Bonham, TX, VAMC domiciliary resident was arrested by the local police with the assistance of OIG and VA Police Service. The Veteran was wanted on an outstanding warrant for felon in possession of a weapon.

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 13,406 contacts, 693 of which became OIG cases. An additional 448 of

the Hotline contacts became OIG non-case referrals. The Hotline makes non-case referrals to the appropriate VA organization if the allegation does not rise to the level of a case but appears to warrant VA action.

The Hotline also closed 554 cases during this reporting period, substantiating allegations 44 percent of the time. During FY 2012, external Hotline cases resulted in 550 administrative sanctions and corrective actions and $6.8 million in monetary benefits. The following cases were initiated as a direct result of Hotline contacts.

Review of Allegations Results in Security Improvements at Puget Sound HCS

The VA Office of Security and Law Enforcement reviewed hotline allegations concerning the Police Service at the VA Puget Sound HCS, Seattle, WA. Office of Security and Law Enforcement agents substantiated problems related to radio equipment, facility alarms, law enforcement information systems, police procedures, and staffing. As a result, they made numerous recommendations to improve the security of Veterans, family members, and staff on System campuses.

VBA Delays Reviewing Initial Post-9/11 GI Bill School Transactions

A complainant reported that during FY 2012, VBA suspended retroactive Post-9/11 GI Bill school compliance surveys for the 2009-2010 academic year, which was the first year VBA began making payments to students and schools under the new program. At that time, VBA was using a software system that required claims examiners to perform extensive manual actions, such as transferring or calculating data, which increased the risk that processing errors would occur. For example, a VBA survey at a Colorado university found school errors in 819 (62 percent) of the 1,319 students' records reviewed. The complaint alleged that suspending the reviews would result in undetected overpayments or underpayments. VBA's response indicated that the scope of its surveys was reduced in FY 2012 to focus on for-profit schools, but that review of 2009-2010 enrollments would resume in FY 2013.

VA Ends Leases for Unused Information Technology Centers

As a result of a Hotline contact, the Office of Information and Technology (OIT) terminated two leases originated in FY 2010 for unused data storage centers in Pennsylvania and Colorado. OIT planned to store electronic medical records in both locations as part of its National Data Center Consolidation Program. However, in FY 2011, VA elected to shift planned data storage to DoD facilities in Missouri and Georgia as part of the VA-DoD joint Integrated Electronic Health Record initiative. The inconsistent data storage strategies pursued by OIT resulted in VA paying $3.7 million for the unused centers.

Inadequate Advanced Planning Threatens VISN 18 Patient Care Procurements

The VA Southwest Health Care Network, Mesa, AZ, concluded that during FY 2011, many contracts affecting the continuity of patient care had expired or would have expired without urgent interventions. Network officials said this occurred because program offices did not submit their requirements on a timely basis or submitted inadequately supported requests for limiting competition. To address these problems, the VISN provided additional training to responsible program officials.

VARO Reduces Compensation for Incarcerated Veteran Following Hotline Tip

The results of a Seattle, WA, VARO review found that a service-connected Veteran continued to receive full compensation payments during his incarceration. As a result of the improper payments, the VARO took action to reduce the Veteran's compensation, which resulted in a cost savings of $51,000 over a 3-year period.

Hotline Complainants Help End Improper Payments to Ineligible Beneficiaries

A review conducted by the Philadelphia, PA, VARO and Insurance Center found that a claimant concealed a common-law marriage in effect since 1999 in order to improperly continue receiving DIC benefits awarded based on a previous marriage to a Veteran. The case resulted in savings of $229,911, including the avoidance of 5 years of additional benefits the claimant would have received had the complainant not disclosed the impropriety. In a similar case, a review conducted by the St. Paul, MN, VARO found that another claimant, who remarried in 2003, continued to receive DIC benefits improperly because the claimant failed to notify VA of the remarriage. The case resulted in a savings of $181,456 over a 5-year period.

VHA Employee Caught Moonlighting During Official VA Tour of Duty

A review conducted by the VA Central California HCS, Fresno, CA, found that between January 2009 and March 2012, an employee misused official time to perform remunerated teaching duties for a non-VA employer. The HCS estimated that the misused official time was valued at $17,802. As a corrective action, the HCS reported the employee retroactively used 384 hours of annual leave.

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 48 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. Thirty-one preaward reviews identified approximately $123.8 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule proposals, preaward reviews during this reporting period included eight health care provider proposals—accounting for approximately $18.1 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2011 – March 31, 2012	35	$910,967,770
April 1 – September 30, 2012	31	$123,847,453
FY Total	**66**	**$1,034,815,223**

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. Postaward reviews resulted in VA recovering contract overcharges totaling over $11.7 million, including approximately $1.8 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 14 postaward reviews performed, 5 involved voluntary disclosures. In all five reviews, OIG identified additional funds due. OIG recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2011 – March 31, 2012	13	$3,136,820
April 1 – September 30, 2012	14	$11,755,791
FY Total	**27**	**$14,892,611**

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 three claims and determined that approximately $5.7 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2011 – March 31, 2012	2	$397,810
April 1 – September 30, 2012	3	$5,696,079
FY Total	**5**	**$6,093,889**

VA Overpaid for Space and Services at Cleveland Facility, Increased Security Risks Also Noted

VA Management inappropriately used VA's Enhanced Use Lease (EUL) authority to procure office space, parking, and domiciliary services at the Louis Stokes VAMC. The space and services procured through the EUL with Veterans Development, LLC, significantly exceeded any in-kind consideration for the Brecksville campus. By using VA's EUL authority, VA Management was able to circumvent the normal rules and processes for procuring space and services, including health care services. This eliminated competition and caused VA to overpay for space and services and caused an increased risk in security. VA Management largely disagreed with our findings; however, our review of their response found it to be unsupported and unresponsive to our concerns and findings.

IG Recommends 15 Steps To Improve Pricing Accuracy, Reduce Open Market Purchases in Pharmaceutical Prime Vendor Contract

OIG conducted a review of open market purchases and to a limited extent contract purchases under VA's Pharmaceutical Prime Vendor contract with McKesson Corporation (McKesson). The review determined that open market purchases were overstated due to inconsistencies in McKesson's ordering system, many of which were due to delays by VA in updating prices. Ultimately price adjustments were made over time to reflect correct contract prices through McKesson's credit and rebill process and internal pricing reviews conducted by VHA's Pharmacy Benefits Management. In general, VA open market purchases are increasing due to the growing number of product shortages and allocation issues, problems that are not unique to the VA. In addition, the lack of training and the use of known workarounds by VA staff using McKesson's purchasing system led to open market purchases over contract purchases. OIG made 15 recommendations to VHA and the Office of Acquisition, Logistics, and Construction to improve pricing accuracies under the Pharmaceutical Prime Vendor contract and to minimize open market purchases.

VA Cancels Five Set-Aside Contracts for Claims Re-Pricing After IG Finds Improper Subcontracting to Large Business

OIG determined that Enterprise Technology Solutions, LLC (ETS) was not in compliance with the contract provisions limiting subcontracting. OIG found that ETS, a SDVOSB concern owned by a former VA employee, subcontracted the re-pricing requirements to Health Net, a large business for all five of its contracts. All five contracts were awarded as SDVOSB set-asides. The USH and the Chief Procurement and Logistics Officer agreed with our recommendation to terminate ETS's five contracts and to conduct an assessment to determine the value, if any, of re-pricing claims from non-VA providers. VA also concurred with our recommendation that VA ensure requirements are written to ensure former VA employees are not given an unfair advantage and that competition is achieved to the maximum extent practicable.

Congressional Testimony

Assistant Inspectors General Tell Senate Veterans' Affairs Committee That Veterans Are Not Receiving Timely MH Evaluations and Treatment, Better Performance Metrics Needed

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, and John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States Senate, on the results of a recent OIG report, *Veterans Health Administration – Review of Veterans' Access to Mental Health Care*. OIG found that VA's performance metrics are not a reliable measurement of Veterans' access to MH care. VHA did not provide first-time patients with timely MH evaluations and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. As a result, performance measures used to report patient's access to MH care do not depict the true picture of a patient's waiting times to see a MH provider. While no measure will be complete, meaningful analysis and decision-making requires reliable data. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of OIG's Kansas City Office of Audits and Evaluations. Dr. Daigh was accompanied by Michael Shepherd, M.D., Senior Physician in OIG's Office of Healthcare Inspections.

House Veterans' Affairs Committee Hears from AIGs on Findings That Veterans Are Not Receiving Timely Mental Health Evaluations and Treatment

Ms. Halliday and Dr. Daigh testified before the Committee on Veterans' Affairs, United States House of Representatives on the results of a recent OIG report, *Veterans Health Administration – Review of Veterans' Access to Mental Health Care*. OIG found that the VA's performance metrics are not a reliable measurement of Veterans' access to MH care. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer and Dr. Daigh was accompanied by Michael Shepherd, M.D.

AIGs Testify on VA's Prosthetics Clinical and Purchasing Practices Before the House Veterans' Affairs Subcommittee on Health

Ms. Halliday and Dr. Daigh testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives on three OIG reports dealing with prosthetics and the delivery of care, and contracting and supply issues, *Healthcare Inspection – Prosthetic Limb Care in VA Facilities; Veterans Health Administration – Audit of the Management and Acquisition of Prosthetic Limbs;* and *Veterans Health Administration – Audit of Prosthetics Supply Inventory Management*. On the clinical side, OIG found that VA prosthetics staff were appropriately certified and that Veterans with amputations adjusted to life with their artificial limbs as well as those in the civilian population. The study also found that Veterans with amputations are significant users of VA health care services. OIG found that VA needs to improve contract management and inventory management practices. Ms. Halliday was accompanied by Mr. Nick Dahl, Director of OIG's Bedford Office of Audits and Evaluations, and Mr. Kent Wrathall, Director of OIG's Atlanta Office of Audits and Evaluations. Dr. Daigh was accompanied by Robert Yang, M.D., Physician in OIG's Office of Healthcare Inspections.

VA Prosthetics Contracting Practices Are Subject of House Veterans' Affairs Subcommittee on Oversight and Investigations Hearing

Ms. Halliday testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on contracting and inventory issues facing VA's Prosthetics program, focusing on two OIG reports, *Veterans Health Administration – Audit of the Management and*

Acquisition of Prosthetic Limbs, and *Veterans Health Administration – Audit of Prosthetics Supply Inventory Management.* Our reports found that better management and oversight of contracts could save VA over $35 million and avoid disruptions to patients. Ms. Halliday was accompanied by Mr. Dahl and Mr. Wrathall.

OIG Updates House Veteran Affairs' Committee on Reviews of VA's Prime Pharmaceutical Vendor Contract

Ms. Halliday and Maureen Regan, Counselor to the Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the results of a recent OIG report, *Review of the Controls for the Pharmaceutical Prime Vendor Fast Pay System*, and provided an update on ongoing work to review alleged contract violations. OIG found that VA implemented controls to provide timely and accurate payments for pharmaceutical items processed through VA's Fast Pay system and complied with applicable laws, regulations, and policies; however, quicker corrections of pricing differences is needed. OIG's review of open market purchases found that the open market purchases were significantly less than originally believed. OIG found that the PPV was doing a good job of adjusting prices through credits and rebillings to ensure that contract items are purchased at contract prices when VA provides data. Ms. Halliday was accompanied by Mr. Gary Abe, Director of OIG's Seattle Office of Audits and Evaluations. Ms. Regan was accompanied by Mr. Michael Grivnovics, Director of OIG's Federal Supply Schedule Division.

Accuracy and Timeliness Continue to Challenge VBA in Processing Disability Claims for Veterans, AIG Tells House Committee on Veterans' Affairs

Ms. Halliday testified before the Committee on Veterans' Affairs, United States House of Representatives, on OIG reports related to VBA's operations. These included a series of inspections of VAROs and OIG's reports on *Veterans Benefits Administration - Audit of 100 Percent Disability Evaluations; Audit of VA Regional Offices' Appeals Management Processes*; and *Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires.* OIG's inspections and audit work have consistently shown that VAROs do not always comply with VBA's national policy and struggle with implementing effective workload management plans and clear and consistent guidance to accomplish their benefits delivery mission. While VBA has made some incremental progress through its own initiatives and in response to OIG's prior report recommendations, more work remains to be done. Ms. Halliday was accompanied by Mr. Reinkemeyer, Mr. Dahl, and Mr. Brent Arronte, Director of OIG's Bay Pines Benefits Inspections Division.

AIG for Investigations Testifies on VA's Veteran-Owned Small Business and SDVOSB Programs

James J. O'Neill, AIG for Investigations, testified before the Subcommittee on Oversight and Investigations and the Subcommittee on Economic Opportunities, Committee on Veterans' Affairs, United States House of Representatives, on OIG's investigative work related to VA's Veteran-Owned Small Business and SDVOSB programs. Mr. O'Neill discussed the current case load of OIG investigations involving the SDVOSB program, suspension and debarment actions that will exclude wrongdoers from receiving future contract awards, and significant prosecutions resulting from OIG investigations, including one where the defendant forfeited $1.5 million and a 2011 Jaguar Series XKR Model XK, was sentenced to serve 3 years' probation, and ordered to pay $1.55 million in restitution and a $60,000 fine. He concluded that by bringing criminals to justice, economic opportunities for legitimate service-disabled Veterans should increase.

Statement by the Office of Inspector General on VA Fee Basis Program

OIG provided a statement for the record for a hearing before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on OIG's work related to VA's purchase of health care services from non-VA providers. Our statement focused on the seven reports that OIG issued in the last 3 years

on this topic that identified weaknesses and inefficiencies. OIG reported that VA had not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly contracted and billed.

American Recovery and Reinvestment Act Oversight Activities

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 September 30, 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 598 fraud awareness training and outreach sessions across the country attended by over 17,200 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 449 and closed 293 criminal investigations, including 82 convictions, 143 referrals for monetary reclamation, and $71,000 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.

Peer and Qualitative Assessment Reviews

The *Restoring American Financial Stability Act of 2010,* P.L. 111-203, requires VA OIG to report the results of any peer review conducted of VA OIG's audit operation by another OIG during the reporting period or to identify the date of the last peer review conducted by another OIG, in addition to any outstanding recommendations that have not been fully implemented. No peer reviews were conducted on VA OIG by another OIG during this reporting period. The last peer review was conducted by the U.S. Department of Agriculture OIG on December 23, 2009, and contained no recommendations. The next peer review of VA OIG will be initiated in October 2012 by the DOL OIG.

The Act also requires VA OIG to report the results of any peer review it conducted of another OIG's audit operation during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period. VA OIG completed a peer review of the SSA OIG and issued the final report on August 16, 2012, which contained no recommendations.

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 this reporting period. 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.

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.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 359 proposals and made 31 comments.

Refusals to Provide Information or Assistance

The *Inspector General Act of 1978*, as amended, authorizes OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes OIG to request information or assistance from any Federal, State, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to OIG in the Act. OIG is required to provide a summary of instances

when such information or assistance is refused. OIG reports no such instances occurring during this reporting period.

Employee Recognition

2012 CIGIE Award Recipients

CIGIE selected four VA OIG projects as recipients of the 2012 CIGIE "Awards for Excellence." This award recognizes the most significant achievements of the IG community over the past year. VA OIG staff continue to distinguish themselves as leaders in the IG community, exemplified by their outstanding work and positive impact on VA programs and on the lives of America's Veterans. Selected VA OIG projects include:

- **Mark Lazarowitz,** Special Agent, Northeast Field Office, Newark, New Jersey, is recognized for his work as lead OIG agent on a multiagency investigation of Syntheses, Inc., and Norian Corporation for illegally marketing Norian XR, a bone cement drug for treatment of spine fractures commonly suffered by the elderly that was not approved by the FDA. The 6-year investigation determined that Syntheses employees trained spine surgeons to use the drug to treat vertical compression fractures of the spine, then deceived them into unknowingly participating in unauthorized clinical trials for the company. Three patients died on the operating table after spine surgeons used Norian XR. As a result of the investigative team's efforts, the company paid $23.8 million in criminal and civil fines and forfeitures and four corporate executives were incarcerated following guilty pleas. It is one of a few cases in which company executives have been sentenced to a term of imprisonment for violation of T*he Food, Drug, and Cosmetic Act*.
- **Brent Arronte,** Director, Benefits Inspection Division, Bay Pines, Florida, is recognized for his outstanding leadership in establishing a new congressionally-mandated inspections capability of VBA regional office operations. As the first Director of the Benefits Inspection Division, he developed inspection processes and guidelines, identified high risk protocol areas for review, and hired and trained a cadre of highly qualified staff. His office's high-impact reports have influenced changes in VBA policy and disability claims processing practices and resulted in wide-ranging improvements in VARO operations. Congress' recognition of the value and success of the Bay Pines office led to the creation of a second benefits inspections office in San Diego, CA, which he was instrumental in standing up. His staff's inspection reports have sparked considerable media interest and prompted congressional briefings and hearings on VBA claims processing and service delivery challenges.
- **The VHA Office of Rural Health Audit Team** is recognized for a report that had a major impact on rural Veterans' access to readjustment services, primary care, specialty care, MH care, and long term care. The audit found that VHA's Office of Rural Health did not adequately manage the use of funds for non-VA provided care and the selection process for rural health funded projects, and did not monitor project obligations and performance measures. As a result, VHA lacked assurance that $273.3 million of the $533 million in funding for FYs 2009 and 2010 improved access and quality of care for rural Veterans. The team's recommendations to strengthen the management of rural health care funding were supported by congressional appropriations committees, which held back funding for FY 2012 until the audit team verified that the Office of Rural Health had implemented all of the audit's recommendations. The team's report led to sweeping changes in the review and funding prioritization of rural health initiatives and ensured that funds were aligned with strategic program goals. Team members include Gary Abe, Maria Afamasaga, Kevin Day, Lee Giesbrecht, Marisa Harvey, Barry Johnson, Issa Ndiaye, Thomas Phillips, and Melinda Toom.

- **The Homeless Grant and Per Diem Program Audit Team** is recognized for identifying serious risks in VA's largest program providing services to homeless Veterans. During the team's visit to a Chicago facility, they discovered that VA had been placing female homeless Veterans—many with histories of sexual trauma—for over a decade in a facility that was designed for a male-only population. Following this discovery, VA immediately removed the women from this facility, evaluated facilities nationwide, and implemented controls to prevent reoccurrence. The audit, which included onsite visits to 26 facilities, uncovered other instances of risk to Veterans' safety, security, and privacy, to include instances where Veterans' medications were not securely stored and special dietary needs were not adequately addressed. The team's report led VA to strengthen grant application and evaluation processes, update inspection checklists, and establish new procedures to ensure homeless facilities have the capability to deliver services. The audit results were highlighted at a Senate Veterans' Affairs Committee hearing in March 2012. Team members include Gary Abe, Maria Afamasaga, Kevin Day, Sophia Demco, Chris Enders, Todd Groothuis, Marisa Harvey, Thomas Phillips, Ronald Stucky, Steven Toom, and Nelvy Viguera Butler.

OIG Employees Currently Serving on or Returning From Active Military Duty

We extend our thanks to the OIG employees listed below who are currently serving on active military duty.

- Wess Dumas, a Special Agent in the Little Rock, AR, Office of Investigations, was activated by the Army National Guard and is stationed at Camp Shelby, MS.
- Peter Moore, a Special Agent in the Dallas, TX, Office of Investigations, was activated by the Army Reserves and is stationed at Ft. Belvoir, VA.
- Yaree Parker, an IT Specialist in Bay Pines, FL, is stationed at MacDill Air Force Base, Tampa, FL.
- Ken Sardegna, an Auditor at OIG Headquarters, was deployed by the U.S. Army in June 2007 and is currently stationed in Washington, DC.

Appendix A
List of Reports Issued

Table 1: List of Reports Issued by Type

Office of Audits and Evaluations | Audits, Evaluations, and Reviews

Issue Date and Report Number	Title	Dollar Value of Funds		
		Recommended for Better Use by OIG	Agreed to by Management	Questioned Costs
4/6/2012 11-00320-138	VA's Federal Information Security Management Act Assessment for FY 2011			
4/19/2012 11-04081-142	Audit of VA's Duty Station Assignments			$1,355,355
5/17/2012 12-01008-185	Review of VA's Controls for the Pharmaceutical Prime Vendor Fast Pay System			
5/23/2012 12-00089-182	Review of VA's Alleged Circumvention of Security Requirements for System Certifications and Apple Mobile Devices			
5/30/2012 10-03166-75	Audit of VA Regional Offices' Appeals Management Processes			
6/20/2012 11-03060-193	Audit of NCA's Appropriated Operations and Maintenance Funds Oversight			
8/2/2012 11-02433-220	Audit of VA's ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs	$2,500,000	$2,500,000	
8/7/2012 12-00319-240	Review of Alleged Mismanagement of The Villages Outpatient Clinic, Marion County, Florida			
8/9/2012 12-00244-241	VBA's Claims Folder Storage at the VA Regional Office Winston-Salem, North Carolina			
8/30/2012 12-00333-254	Audit of VHA's Medical Care Collections Fund Billing of VA-Provided Care	$500,000,000	$500,000,000	
9/30/2012 12-00165-277	Review of Alleged Delays in VA Contractor Background Investigations			
9/30/2012 11-03217-293	Audit of VA's Savings Reported Under OMB's Acquisition Savings Initiative			
	See Joint Reviews for additional report.			
		$502,500,000	**$502,500,000**	**$1,355,355**

Joint Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		
		Recommended for Better Use by OIG	Agreed to by Management	Questioned Costs
4/23/2012 12-00900-168	Review of Veterans' Access to Mental Health Care			
9/30/2012 12-03698-291	Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida			$762,198
				$762,198

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Title
5/10/2012	12-00247-175	VA Regional Office, Oakland, California
5/10/2012	12-00245-176	VA Regional Office, Los Angeles, California
5/10/2012	12-00242-177	VA Regional Office, San Diego, California
7/10/2012	12-00243-219	VA Regional Office, Lincoln, Nebraska
7/17/2012	12-00246-226	VA Regional Office Phoenix, AZ
7/26/2012	12-00240-236	VA Regional Office Little Rock, Arkansas
8/29/2012	12-00248-250	VA Regional Office, Sioux Falls, South Dakota
9/5/2012	12-00249-266	VA Regional Office Wichita, Kansas
9/13/2012	12-00244-276	VA Regional Office Winston-Salem, North Carolina
9/27/2012	12-00241-296	VA Regional Office Cleveland, Ohio

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Title
4/3/2012	11-04569-141	VA Puget Sound Health Care System, Seattle, Washington
4/10/2012	11-04568-148	VA Eastern Kansas Health Care System, Topeka, Kansas
4/17/2012	12-00370-156	South Texas Veterans Health Care System, San Antonio, Texas
4/18/2012	12-00371-157	William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
4/20/2012	12-00368-161	Phoenix VA Health Care System, Phoenix, Arizona
4/23/2012	11-04566-163	James J. Peters VA Medical Center, Bronx, New York
4/27/2012	12-00708-171	Providence VA Medical Center, Providence, Rhode Island
5/21/2012	11-04567-179	Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
5/30/2012	12-00883-189	Beckley VA Medical Center, Beckley, West Virginia
6/12/2012	12-00884-197	Bay Pines VA Healthcare System, Bay Pines, Florida
6/14/2012	12-00885-200	Alexandria VA Health Care System, Pineville, Louisiana
6/19/2012	12-00881-203	New Mexico VA Health Care System, Albuquerque, New Mexico
6/22/2012	12-00886-204	VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Title
7/6/2012	12-00709-211	Washington, DC, VA Medical Center, Washington, DC
7/16/2012	12-00373-221	VA Sierra Nevada Health Care System, Reno, Nevada
7/27/2012	12-00882-232	Martinsburg VA Medical Center, Martinsburg, West Virginia
8/1/2012	12-01336-235	Bath VA Medical Center, Bath, New York
8/6/2012	12-01876-239	St. Cloud VA Health Care System, St. Cloud, Minnesota
8/13/2012	12-01874-245	VA North Texas Health Care System, Dallas, Texas
8/14/2012	12-01875-249	Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington
9/4/2012	12-01334-261	Erie VA Medical Center, Erie, Pennsylvania
9/5/2012	12-01337-267	Tomah VA Medical Center, Tomah, Wisconsin
9/6/2012	12-02191-274	Ralph H. Johnson VA Medical Center, Charleston, South Carolina
9/18/2012	12-02190-281	Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
9/20/2012	12-02187-282	VA Boston Healthcare System, Boston, Massachusetts
9/27/2012	12-02185-288	Tennessee Valley Healthcare System, Nashville, Tennessee

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	Number	Title
5/1/2012	11-03655-170	Virginia Beach (Norfolk-Virginia Beach), VA; Bellevue, KY; Hamilton, OH
5/31/2012	11-03655-178	Fort Pierce and Sebring, FL; Dyersburg, TN; Smithville, MS
6/18/2012	11-03655-198	Yale, MI; La Crosse, Wausau, and Wisconsin Rapids, WI
6/28/2012	11-03655-210	Fort Dodge and Hutchinson, KS; O'Fallon (St. Charles), MO; Emporia, KS
7/3/2012	11-03655-213	Mission, Pierre, and Rapid City, SD
7/3/2012	11-03655-214	Fort Smith, AR; Lafayette, LA; Denton and Tyler, TX
7/6/2012	11-03655-215	Pine Plains (Eastern Dutchess) and Port Jervis, NY; Allentown and Tobyhanna, PA
8/2/2012	12-00572-237	La Grande and Klamath Falls, OR; Bellevue (King County) and Mount Vernon, WA; North Bend, OR
8/23/2012	12-00574-238	Homestead and Key West, FL; Hopkinsville, KY; McMinnville, TN
8/27/2012	12-00575-255	Payson and Show Low, AZ; Long Beach (Cabrillo) and Laguna Hills, CA
8/28/2012	12-00573-242	Mattoon and Springfield, IL; Lawrence, KS; St. Joseph, MO
9/7/2012	12-00577-273	Wilmington, NC; Columbus, GA; Goose Creek, SC; and Savannah, GA
9/14/2012	12-00576-264	Chippewa Valley and Hayward, WI; St. James (South Central) and Montevideo, MN
9/14/2012	12-00579-268	Flint, MI; Toledo, OH; Appleton and Union Grove, WI

Office of Healthcare Inspections | National Healthcare Review		
Issue Date	Number	Title
4/20/2012	12-00956-159	Combined Assessment Program Summary Report: Evaluation of Registered Nurse Competency Processes in Veterans Health Administration Facilities

Office of Healthcare Inspections | National Healthcare Review		
Issue Date	Number	Title
5/4/2012	11-03428-173	Healthcare Inspection: Homeless Incidence and Risk Factors for Becoming Homeless in Veterans
5/17/2012	11-00104-186	Combined Assessment Program Summary Report: Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2011
5/22/2012	12-01531-187	Combined Assessment Program Summary Report: Enteral Nutrition Safety in Veterans Health Administration Facilities
6/14/2012	11-00215-194	Combined Assessment Program Summary Report: Management of Workplace Violence in Veterans Health Administration Facilities
6/27/2012	11-03671-207	Healthcare Inspection: Liver Transplant Denial, Veterans Health Administration
8/16/2012	11-01406-247	Healthcare Inspection: Evaluation of Community Based Outpatient Clinics Fiscal Year 2011
		See Joint Reviews for additional report.

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	Number	Title
4/4/2012	12-00602-147	Alleged Quality of Care and Administrative Issues, Sheridan VA Medical Center, Sheridan, Wyoming
4/5/2012	10-03346-152	Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri
4/12/2012	12-01515-151	Oversight Review of Ophthalmology Adverse Drug Events, VA Greater Los Angeles Healthcare System, Los Angeles, California
4/18/2012	11-04156-160	Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, Florida
4/18/2012	11-04461-162	Delay in Hearing Aid Repairs, VA Medical Center, Atlanta, Georgia
4/23/2012	11-03068-165	Quality of Mental Health Care, VA Eastern Colorado Health Care System, Denver, Colorado
5/14/2012	12-00206-180	Oversight Review of Quality of Care and Other Issues at the Grand Junction VA Medical Center, Grand Junction, Colorado
5/14/2012	12-00918-181	Alleged Telemetry Unit Deficiencies, VA New York Harbor Healthcare System, New York, NY
5/24/2012	12-01077-188	Alleged Quality of Care and Communication Issues, Northport VA Medical Center, Northport, NY
5/29/2012	12-00496-191	Clinical Privileges and Airway Management, Marion VA Medical Center, Marion, Illinois
5/29/2012	11-04130-192	Oversight Review, Unauthorized Practice of Medicine at a VA Medical Center
5/31/2012	12-00675-190	Quality of Care, Communication, and Infection Control Issues, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
6/11/2012	11-02314-196	Hemodialysis Nursing Care Issues at the John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	Number	Title
6/13/2012	11-02756-201	Quality of Care and Patient Safety Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia
6/22/2012	12-01287-208	Alleged Poor Surgical Care and Mismanagement of Adverse Events, VA Medical Center, West Palm Beach, Florida
6/22/2012	11-03896-209	Alleged Quality of Care and Responsiveness Issues, VA Caribbean Healthcare System, San Juan, Puerto Rico
7/16/2012	12-01475-222	Patient Safety on a Critical Care Unit, Malcom Randall VA Medical Center, Gainesville, FL
7/16/2012	12-01431-223	Supervision of Nurse Anesthetists in the Anesthesia Section, Dayton VA Medical Center, Dayton, OH
7/17/2012	12-00002-199	Misdiagnosis and Alleged Lapses in Courtesy, Fayetteville VA Medical Center, Fayetteville, NC
7/19/2012	12-01760-230	Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, Minnesota
8/10/2012	12-01543-243	Issues Related to Ultraviolet Germicidal Irradiation Light Exposure in an Operating Room, Lebanon VA Medical Center, Lebanon, PA
8/10/2012	12-02274-244	Review of a Patient's Medication Management, Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska
8/15/2012	12-02618-252	Alleged Inadequate Airway Management, Jack C. Montgomery VA Medical Center, Muskogee, OK
8/15/2012	11-04090-253	Emergency Department Delays – Memphis VA Medical Center, Memphis, TN
8/21/2012	12-01872-258	Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic, Calais, ME
8/22/2012	12-01906-259	Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, TX
8/29/2012	12-02263-269	Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa
8/30/2012	12-01342-263	Dental Service Infection Control and Leadership Issues, James J. Peters VA Medical Center Bronx, New York
9/11/2012	12-02957-272	Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, SD
9/12/2012	10-03346-270	Effectiveness of Actions to Correct Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri
9/12/2012	12-00835-271	Quality of Care Provided by a Nurse, John Cochran Division, St. Louis VA Medical Center, St. Louis, Missouri
9/17/2012	12-02516-280	Alleged Patient Safety, Medication Management, and Environment of Care Deficiencies in the Intensive Care Unit, Hampton VA Medical Center, Hampton, VA
9/25/2012	12-01731-284	Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, WA

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	Number	Title
9/24/2012	12-00823-285	Patient Equipment and Medication Safety in the Surgical Intensive Care Unit, Michael E. DeBakey VA Medical Center, Houston, Texas
9/26/2012	12-00828-287	Consultant Responses, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois

Office of Investigations | Administrative Investigations		
Issue Date	Number	Title
4/11/2012	11-03720-153	Failure to Properly Report a Felony to OIG, Interference with an OIG Investigation, and Lack of Candor, Lebanon VA Medical Center, Lebanon, Pennsylvania
4/12/2012	10-02328-154	Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado
6/19/2012	11-04049-205	Falsification of Employment Record, Travel Irregularities, and Misuse of Position, VA Learning University, VA Central Office
6/28/2012	11-03461-217	Improper Locality Pay and Failure to Follow Federal Travel Regulations, Technology Transfer Program, VA Central Office
		See Joint Reviews for additional report.

Office of Contract Review | Preaward Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
4/10/2012	12-00261-155	Review of FSS Proposal Submitted Under a Solicitation	
4/10/2012	12-01405-158	Review of FSS Proposal Submitted Under a Solicitation	$4,232,620
4/11/2012	12-01714-146	Review of Proposal Submitted Under a Solicitation	$2,063,278
4/12/2012	12-01488-130	Review of Proposal Submitted for Neurosurgical Services	$965,418
4/16/2012	12-00797-164	Review of FSS Proposal Submitted Under a Solicitation	
4/18/2012	12-00976-166	Review of FSS Proposal Submitted Under a Solicitation	
5/1/2012	11-04470-174	Review of a Contract Extension Under a FSS Contract	$268,906
5/9/2012	12-01088-183	Review of FSS Proposal Submitted Under a Solicitation	$24,329,925
6/11/2012	12-02069-202	Review of FSS Proposal Submitted Under a Solicitation	$24,102,180
6/19/2012	12-02077-206	Review of Proposal Submitted Under a Solicitation	$1,004,450
6/22/2012	12-02020-212	Review of FSS Proposal Submitted Under a Solicitation	$15,497,774
6/26/2012	12-02097-216	Review of FSS Proposal Submitted Under a Solicitation	
7/6/2012	12-02630-224	Review of FSS Proposal Submitted Under a Solicitation	
7/9/2012	12-01984-225	Review of Contract Extension Proposal Submitted Under a FSS Contract	$22,359,239
7/12/2012	12-02156-229	Review of Proposal for a Change Order Request Submitted Under a Contract	$1,827,362

Office of Contract Review | Preaward Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
7/13/2012	12-02411-228	Review of Proposal Submitted Under a Solicitation	$340,052
7/13/2012	12-02019-231	Review of Proposal Submitted Under a Solicitation	$535,958
7/18/2012	12-02267-233	Review of FSS Proposal Extension	$3,307,570
8/12/2012	12-02142-248	Review of FSS Proposal Submitted Under a Solicitation	$94,421
8/20/2012	12-01791-262	Review of a Contract Extension Proposal Under a FSS Contract	$7,281,400
8/23/2012	12-02322-260	Review of Proposal Submitted Under a Solicitation	$2,921,341
8/23/2012	12-03305-265	Review of Proposal Submitted Under a Solicitation	$1,418,040
8/31/2012	12-02261-251	Review of Proposal for a Change Order Request Submitted Under a Contract	$1,517,689
9/5/2012	12-01989-279	Review of FSS Proposal Submitted Under a Solicitation	
9/7/2012	12-02837-278	Review of Proposal Submitted Under a Solicitation	$8,916,010
9/12/2012	12-03332-283	Review of FSS Proposal Submitted Under a Solicitation	
9/20/2012	12-03960-289	Review of FSS Proposal Submitted Under a Solicitation	$863,820
9/26/2012	12-01720-300	Review of Subcontractor Proposal Submitted Under a Solicitation	
9/27/2012	12-01723-295	Review of Subcontractor Proposal Submitted Under a Solicitation	
9/27/2012	12-01722-301	Review of Proposal Submitted Under a Solicitation	
9/27/2012	12-01724-302	Review of Subcontractor Proposal Submitted Under a Solicitation	
			$123,847,453

Office of Contract Review | Postaward Reviews			
Issue Date	Number	Title	Dollar Recoveries
4/18/2012	12-00937-167	Review of Compliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract	$1,245,059
4/23/2012	12-02424-169	Review of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract	$134,752
4/25/2012	05-02463-172	Review of Proposed Settlements Submitted Under Federal Supply Schedule Contracts	$5,374,072
5/31/2012	09-02480-195	Review of Voluntary Disclosure and Refund Offers Under a Federal Supply Schedule Contract	$4,216,694
6/27/2012	10-00372-218	Review of Compliance with Public Law 102-585 Section 603 Under Federal Supply Schedule Contracts	$364,539
7/9/2012	12-01422-227	Review of Compliance with Public Law 102-585 Section 603 Under Federal Supply Schedule Contracts	$2,178

Office of Contract Review | Postaward Reviews			
Issue Date	Number	Title	Dollar Recoveries
7/18/2012	12-01420-234	Review of Late Addition of Covered Drugs Under Federal Supply Schedule Contracts	
8/15/2012	12-03229-256	Review of Compliance with Industrial Funding Fee Reporting Under a Contract	$130,255
8/20/2012	12-01235-132	Review of Enterprise Technology Solutions, LLC Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations	
8/22/2012	12-03127-257	Review of Compliance with Public Law 102-585 Section 603 Under a Contract	$54,656
9/19/2012	11-00418-286	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$227,234
9/25/2012	12-04194-299	Review of Compliance with Public Law 102-585 Section 603 Under a Contract	$6,352
9/27/2012	12-00375-290	Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC	
9/28/2012	12-01012-298	Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation	
			$11,755,791

Office of Contract Review | Claim Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
5/10/2012	12-01755-184	Review of a Construction Claim	$222,780
8/2/2012	12-00531-246	Review of a Payment Claim Under a VA Contract Number	$2,451,970
9/25/2012	12-02437-297	Review of a Claim Submitted Under a VA Contract	$3,021,329
			$5,696,079

Total Potential Monetary Benefits of Reports Issued				
Report Type	BUOF	Questioned Costs	Savings and Cost Avoidance	Dollar Recoveries
Audits, Evaluations and Reviews	$502,500,000	$1,355,355		
Joint Reviews		$762,198		
Preaward Reviews			$123,847,453	
Postaward Reviews				$11,755,791
			$5,696,079	
	$502,500,000	**$2,117,553**	**$129,543,532**	**$11,755,791**

Table 2: Resolution Status of Reports with Questioned Costs

Resolution Status	Number	Dollar Value (In Millions)
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	2	$2,117,553
Total inventory this period	**2**	**$2,117,553**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$2,117,553
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**2**	**$2,117,553**
Total carried over to next period	**0**	**$0**

Table 3: 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 made by commencement of reporting period	0	$0
Issued during reporting period	2	$502,500,000
Total inventory this period	**2**	**$502,500,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$502,500,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**2**	**$502,500,000**
Total carried over to next period	**0**	**$0**

OIG reports that there were no significant revised management decisions made during the reporting period, nor any significant management decisions with which the Inspector General is in disagreement.

Appendix B
Unimplemented Reports and Recommendations

Table 1 identifies the number of open OIG reports and recommendations with results sorted by action office. As of September 30, 2012, there are 177 total open reports and 1,140 total open recommendations. However, 13 reports and 16 recommendations are double or triple counted in Table 1 because they have actions at more than one office. Table 2 identifies the 33 reports and 93 recommendations that, as of September 30, 2012, remain open for more than 1 year.

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

	Reports Open More Than 1 Year	Reports Open Less Than 1 Year	Total Reports Open	Recommendations Open More Than 1 Year	Recommendations Open Less Than 1 Year	Total Recommendations Open
Veterans Health Administration	15	124	139	39	883	922
Veterans Benefits Administration	4	13	17	11	36	47
Office of Management	0	3	3	0	13	13
Office of Information and Technology	8	2	10	22	33	55
Office of Operations, Security, and Preparedness	3	2	5	12	3	15
Office of Acquisitions, Logistics, and Construction	5	4	9	10	16	26
Office of Human Resources and Administration	1	4	5	3	21	24
Office of Small and Disadvantaged Business Utilization	1	0	1	1	0	1
Office of General Counsel	0	3	3	0	54	54
Total	**37**	**155**	**192**	**98**	**1,059**	**1,157**

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/11/06	06-02238-163	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OSP	None
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.				
07/30/09	08-00921-181	Audit of VA Electronic Contract Management System	OALC	None
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.				
08/18/09	09-01123-195	Administrative Investigation Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices Office of Information & Technology Washington, DC	OIT	None
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.				
08/18/09	09-01123-196	Administrative Investigation Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC	OIT	None
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.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations

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.*

09/30/09	09-01239-232	Department of Veterans Affairs System Development Life Cycle Process	OIT	None

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.

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
12/03/09	09-01849-39	Healthcare Inspection, VistA Outages Affecting Patient Care Office of Risk Management and Incident Response Falling Waters, WV	OIT	None
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.				
03/17/10	09-02135-107	Audit of VA's Efforts to Provide Timely Compensation and Pension Medical Examinations	VHA	None
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.*				
05/03/10	09-02815-143	Review of Brachytherapy Treatment of Prostate Cancer, Philadelphia, Pennsylvania and Other VA Medical Centers	VHA	None
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.				
05/13/10	09-01968-150	Audit of National Call Centers and the Inquiry Routing and Information System	VBA	None
Recommendation 2: We recommend the Acting Under Secretary for Benefits establish a national performance target for blocked call rate.				
05/17/10	09-01958-155	Audit of Oversight of Patient Transportation Contracts	VHA	None
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.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
06/07/10	08-02969-165	Review of Federal Supply Schedule 621 I--Professional and Allied Healthcare Staffing Services	OALC	None

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.

09/17/10	10-00969-248	ARRA Oversight Advisory Report: Review of Efforts to Meet Competition Requirements and Monitor Recovery Act Awards	OALC	None

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.

09/30/10	10-01575-262	VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12	OIT/OSP	None

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.

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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 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.				
01/20/11	10-01937-68	Review of Retention Incentive Payments at VA Medical Center Providence, Rhode Island	VHA	$894,790
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.				
01/24/11	09-03359-71	Veterans Benefits Administration Audit of 100 Percent Disability Evaluations	VBA	$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.				
02/18/11	09-03850-99	Veterans Benefits Administration - Audit of the Veterans Service Network	OIT	$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.				
03/30/11	10-00639-135	Veterans Benefits Administration Review of Pension Management Centers	VBA	None
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.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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. *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.*				
05/09/11	11-00027-162	Combined Assessment Program Review of the Kansas City VA Medical Center, Kansas City, MO	VHA	None
Recommendation 7: We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and documented.				
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 4: We recommend the Under Secretary for Health develop and provide comprehensive standardized training on the requirements of VA Directive 1663 to non-procurement staff who have responsibilities relating to sole source contracting with affiliates. *Recommendation 5: We recommend the Under Secretary for Health ensure VHA contracting staff adhere to all policy requirements contained in VA Directive 1663.* *Recommendation 6: We recommend the Under Secretary for Health develop a standard that accurately defines the expected hours and workload from one FTE [full-time equivalent] for each specialty that can be applied by the contracting staff to determine the number of FTE and hours to be procured under the contract.* *Recommendation 7: We recommend the Under Secretary for Health develop clear and well defined national standard SOWs [statements of work] for each specialty that can be tailored as needed to address specific procurement requirements if needed.* *Recommendation 8: We recommend the Under Secretary for Health develop and require the use of a standard pricing schedule for procedure based contracts that require the listing of all CPT [Current Procedure Terminology] codes with estimated quantities and proposed prices for each code.* *Recommendation 9: We recommend the Under Secretary for Health conduct an evaluation to determine the feasibility of using an administrator or intermediary to process billings for procedure based contracts performed at the affiliate similar to those used by Medicare administrators.*				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 10: We recommend the Under Secretary for Health develop a more robust process to ensure compliance with conflict of interest laws and regulations and their applicability to all Title 38 employees who have a relationship with affiliates.				
Recommendation 11: We recommend the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.				
07/25/11	10-02436-234	Audit of the Veteran-Owned and Service-Disabled Veteran-Owned Small Business Programs	VHA/OALC/ OSDBU	$2,500,000,000
Recommendation 1: We recommended the Deputy Under Secretary for Health develop and implement a review strategy for active, high-dollar VOSB and SDVOSB contracts to determine if Federal subcontracting performance requirements have been met, and if the requirements have not been met, to research and pursue remedies.				
Recommendation 3: We recommended the Executive Director of the Office of Acquisition, Logistics, and Construction coordinate with the Deputy Under Secretary for Health and the Executive Director of the Office of Small and Disadvantaged Business Utilization to develop and mandate training for contracting officers on VOSB and SDVOSB ownership and control requirements and the assessment of subcontracts and joint venture agreements for compliance with FAR, VAAR, and Federal regulations.				
Recommendation 4: We recommended the Executive Director of the Office of Small and Disadvantaged Business Utilization coordinate with the Executive Director of the Office of Acquisition, Logistics, and Construction and the Deputy Under Secretary for Health to monitor VOSB and SDVOSB contracts to ensure contracting officers have complied with applicable FAR and VAAR requirements; documented their review of subcontracting, partnering, and joint venture agreements; and properly used the Electronic Contract Management System.				
07/27/11	10-03516-229	Review of Alleged Unauthorized Access to VA Systems	OIT	None
Recommendation 5: We recommend the Assistant Secretary for Information and Technology review contractor system security controls and practices to ensure compliance with VA's information security requirements.				
08/29/11	10-03162-262	Audit of the Project Management Accountability System Implementation	OIT	None
Recommendation 1: We recommended the Assistant Secretary for Information and Technology develop a detailed plan of the steps needed to complete implementation of the Project Management Accountability System program, including milestones for deliverables, performance measures, and a methodology for tracking progress.				
Recommendation 4: We recommended the Assistant Secretary for Information and Technology modify the Project Management Accountability System Dashboard to maintain original baseline data and issue guidance to ensure project performance is measured against both the original and current baselines.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 5: We recommended the Assistant Secretary for Information and Technology designate personnel and provide them with detailed written procedures to perform periodic independent reviews of the Project Management Accountability System Dashboard to ensure data reliability and completeness.				
Recommendation 6: We recommended the Assistant Secretary for Information and Technology designate personnel and provide them with detailed written instructions to perform Project Management Accountability System planning, outcome, and compliance reviews and track project budgets and costs.				
09/02/11	10-01744-265	Audit of National Contract Awards at VA's National Acquisition Center	OALC	None
Recommendation 1: We recommend the Executive Director for the Office of Acquisition, Logistics, and Construction establishes controls to monitor the use of the Electronic Contract Management System.				
Recommendation 3: We recommend the Executive Director for the Office of Acquisition, Logistics, and Construction establishes controls to monitor and ensure the timely completion of the Electronic Contract Management System upgrade, including the National Acquisition Center's Contract Management system functions to eliminate the duplication of effort in data entry.				
09/06/11	11-00334-267	Safety, Security, and Privacy Issues for Female Veterans at a Chicago, IL Homeless Provider Facility	VHA	None
Recommendation 4: We recommend the Under Secretary for Health relocate female homeless veterans found in male-only approved provider facilities or other inappropriate housing situations to ensure safe and secure housing appropriate for veterans.				
09/07/11	11-02869-272	Combined Assessment Program Summary Report Management of Test Results in Veterans Health Administration Facilities	VHA	None
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities' written policies are comprehensive and define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients.				
Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that ordering practitioners notify patients of all critical results within the defined timeframes.				
Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that practitioners notify patients of normal results and that managers monitor compliance.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/13/11	11-03361-274	Combined Assessment Program Summary Report – Evaluation of Infection Prevention Practices in Veterans Health Administration Facilities	VHA	None

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that UVGI fixtures are turned on and functional.

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that negative pressure is monitored and within acceptable levels in occupied AII rooms and that results are documented.

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that employees with occupational exposure risk complete annual OSHA Bloodborne Pathogens Rule training and that compliance is monitored.

Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that designated employees complete annual N95 respirator fit testing and that compliance is monitored.

09/13/11	11-01610-278	Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, MN	VHA	None

Recommendation 8: We recommended that processes be strengthened to ensure that all components of written AD [advance directive] notification are provided to patients and that AD notification and screening are documented in the medical record.

09/13/11	11-01606-277	Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, MO	VHA	None

Recommendation 4: We recommended that processes be strengthened to ensure that all components of written AD notification and screening are provided to patients and documented in the medical record.

Recommendation 14: We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

09/21/11	11-01997-289	Management of Patient Abuse Cases, Charlie Norwood VA Medical Center, Augusta, GA	VHA	None

Recommendation 4: We recommended that the Medical Director ensure that the appropriate process is followed when SLB [State Licensing Board] reporting is indicated.

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/27/11	09-03154-271	Audit of Compensation Program Claims Brokering	VBA	None

Recommendation 1: We recommended the Under Secretary for Benefits revise brokering policies and procedures to require Veterans Service Centers to include steps in their work plans that ensure prompt claims brokering using a bimonthly shipment schedule.

Recommendation 3: We recommended the Under Secretary for Benefits revise policies and procedures to require area offices to broker claims to one resource center or Veterans Service Center for all claims-processing phases except establishment and to document any exceptions with evidence showing that the originating Veterans Service Center would take longer to process the claim.

Recommendation 4: We recommended the Under Secretary for Benefits revise policies and procedures to require area offices to stop brokering claims to resource centers and Veterans Service Centers with accuracy rates that are significantly lower than originating Veterans Service Centers.

Recommendation 6: We recommended the Under Secretary for Benefits revise claims brokering policies and procedures to require area offices to approve and document informal VARO brokering decisions.

Recommendation 7: We recommended the Under Secretary for Benefits require area offices to assess compliance with revised claims brokering policies and procedures during annual VA Regional Office site visits.

09/30/11	11-00308-294	Follow-Up Audit of VHA's Part-Time Physician Time and Attendance	VHA	None

Recommendation 1: We recommend the Under Secretary for Health reinstitute the requirement that all part-time physicians (including those on fixed schedules) who have duties other than clinical activities complete a written agreement detailing the approximate amount of time that will be spent on VHA clinical, research, education, and administrative activities.

Recommendation 2: We recommend the Under Secretary for Health require VA medical center management to establish procedures to periodically monitor the activities of all part-time physicians to ensure consistency with written employment agreements.

Recommendation 3: We recommend the Under Secretary for Health clarify procedures requiring staff to establish and use baseline levels to monitor part-time physicians' activities for an entire pay period during the month.

Recommendation 4: We recommend the Under Secretary for Health clarify procedures including documentation requirements to ensure semi-annual physical reviews are random and reviewers make visual verification when the part-time physician is at VA.

Recommendation 5: We recommend the Under Secretary for Health require VA medical center management to establish oversight procedures to ensure staff follow the requirements in VA Handbook 5011/12 to maintain accurate schedules for part-time physicians.

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 6: We recommend the Under Secretary for Health require VA medical center management to establish oversight procedures to ensure staff follow the requirements in VA Handbook 5011/12 to promptly record actual hours worked and leave taken by part-time physicians.				
09/30/11	10-03850-298	Audit of VHA's Workers' Compensation Case Management	VHA/HRA	$334,100,000
Recommendation 1: We recommended the Under Secretary for Health establish Workers' Compensation Program case file documentation standards so that specialists ensure all case files are complete.				
Recommendation 2: We recommended the Assistant Secretary for Human Resources and Administration coordinate with the Under Secretary for Health to develop and implement standard procedures for VA to question the validity of claims lacking adequate supporting evidence.				
Recommendation 3: We recommended the Under Secretary for Health establish clear reporting lines with delegated authority for overseeing and enforcing Workers' Compensation Program policy (repeat recommendation from the 2004 VA OIG audit report.)				
Recommendation 4: We recommended the Under Secretary for Health establish a plan outlining the roles, responsibilities, procedures, and training needed for the Director of Safety, Health, and Environmental Compliance to accomplish Workers' Compensation Program oversight and enforcement control.				
Recommendation 5: We recommended the Under Secretary for Health implement oversight mechanisms and documentation standards to ensure workers' compensation staff maintains complete and up-to-date case files.				
Recommendation 7: We recommended the Under Secretary for Health ensure facility directors assign adequate staff to manage WCP [Workers' Compensation Program] cases (repeat recommendation for the Department in the 2004 VA OIG audit report).				
Recommendation 8: We recommended the Assistant Secretary for Human Resources and Administration coordinate with the Under Secretary for Health to develop and implement fraud identification and referral procedures.				
Recommendation 9: We recommended the Assistant Secretary for Human Resources and Administration propose that the Department of Labor, Office of Workers' Compensation Programs present for congressional consideration a legislative change requiring that at a pre-determined retirement age Workers' Compensation Program claimants' transition from agency chargeback rolls to more appropriate retirement programs.				

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/30/11	10-04037-295	Audit of VA's Enrollment Centers' Implementation of Personal Identity Verification Requirements	OSP	None

Recommendation 2: We recommended the Assistant Secretary for Operations, Security, and Preparedness direct VA Enrollment Centers to evaluate information supporting the eligibility of Personal Identity Verification credential holders and take action to deactivate Personal Identity Verification credentials of individuals who did not satisfy processing requirements.

Recommendation 3: We recommended the Assistant Secretary for Operations, Security, and Preparedness implement Enrollment Center monitoring procedures, such as implementing operations plan maintenance and annual life-cycle walkthrough procedures in accordance with National Institute of Standards and Technology Special Publication 800-79-1.

Recommendation 4: We recommended the Assistant Secretary for Operations, Security, and Preparedness develop and issue guidance to ensure Registrars screen all Personal Identity Verification credential applicants against the Terrorist Screening Database prior to issuing Personal Identity Verification credentials.

Recommendation 6: We recommended the Assistant Secretary for Operations, Security, and Preparedness issue guidance to ensure Registrars authenticate the source and integrity of identity documents used during the Personal Identity Verification credential enrollment process through official Federal and State databases.

Recommendation 7: We recommended the Assistant Secretary for Operations, Security, and Preparedness make appropriate changes to the Personal Identity Verification System to prevent Enrollment Center staff from performing more than one role in the Personal Identity Verification credential issuance process.

Total	**$3,999,994,790**

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On the Cover

Retired U.S. Army Command Sgt. Maj. Sterling R. Cale, 90-year-old Pearl Harbor survivor, takes a moment in the shrine room of the USS Arizona Memorial to honor the 1,177 service members who lost their lives during the attack on the USS Arizona on December 7, 1941. Cale, along with active duty military and civilian leaders, gathered at the USS Arizona Memorial on May 27, 2012, for the USS Arizona Memorial 50th anniversary commemoration ceremony in Honolulu, HI. The memorial was dedicated on Memorial Day in 1962. Since its construction, the memorial has stood as a place to remember the tragedy and honor the dead. Photos by the Department of Veterans Affairs and Stockvault.

Department of Veterans Affairs
Office of Inspector General

Semiannual Report to Congress

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