# Department of Veterans Affairs

## Office of Inspector General

# Semiannual Report to Congress

Issue 70 | April 1–September 30, 2013

# 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, 2013. Highlighted below are some of the key findings and conclusions that were the result of our work during this reporting period.

The Office of Inspector General (OIG) issued 185 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $1.93 billion in monetary benefits, for a return on investment of $39 for every dollar expended on OIG oversight. OIG investigators closed 431 investigations and made 246 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 and Hotline activity oversight also resulted in 552 administrative sanctions and corrective actions.

Our Office of Investigations continues to combat fraud in VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) Program. One case involved a supervisory engineer formerly employed by the East Orange, NJ, VA Medical Center (VAMC), who pled guilty to various fraud charges. The guilty plea stems from a joint investigation conducted by VA OIG, the Federal Bureau of Investigation, and the Internal Revenue Service Criminal Investigation Division, which revealed the defendant accepted nearly $1.3 million in kickbacks over a 5-year period. The payments were provided in exchange for his official action and influence to direct VA construction contracts to particular companies with which he had outside relationships. The defendant falsely represented to VA that one of those companies was a SDVOSB, and VA ultimately awarded more than $3 million to this company. He also conspired to set up three companies that could be used to obtain VA work and then directed more than $6 million worth of VA construction projects to those companies.

OIG's Office of Healthcare Inspections (OHI) evaluated allegations regarding the Mental Health (MH) Service Inpatient Unit at the Atlanta VAMC, Decatur, GA, where a complainant alleged an inpatient's death was due to MH service leadership's negligence and mismanagement of unit policies, patient monitoring, and staffing, as well as a lack of care about patients. While OIG did not substantiate the allegations of staffing mismanagement or a lack of care about patients, OIG found the facility did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. OIG also found inadequate program oversight, including a lack of timely follow-up actions by leadership in response to patient incidents. OIG recommended the Under Secretary for Health (USH) develop national policies addressing OIG's findings and the Veterans Integrated Service Network (VISN) and Facility Directors ensure the inpatient MH unit develops these policies, strengthen program oversight and follow-up, improve communication with staff, and ensure functional and well-maintained life support equipment.

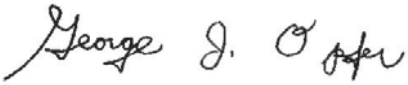
At the same facility, OHI assessed allegations of mismanagement and lack of oversight of an MH contract. OIG substantiated the mismanagement of contract administration and found facility managers did not provide

adequate staffing, training, resources, support, or guidance for effective oversight of contracted MH patient care. The lack of effective patient care management and program oversight led to problems with MH care access and "patients falling through the cracks." OIG recommended the USH rectify the deficiencies identified with respect to the provision of quality MH care and contract management, with the goal that Veterans receive the highest quality medical care from either VA or its partners.

OHI also conducted a review at the William Jennings Bryan Dorn VAMC in Columbia, SC, to determine whether deficient practices contributed to or caused delays in care, and whether facility leaders appropriately addressed clinical managers' concerns. In December 2011, the facility had a Gastroenterology (GI) consult backlog which had grown to 3,800 delayed consults. After having difficulty in reducing the backlog, an adverse event in May 2012 prompted facility, VISN, and Veterans Health Administration (VHA) leaders to reevaluate the GI backlog situation and initiate efforts to eliminate it by October 2012. A review of the GI consult backlog revealed 52 of 280 patients diagnosed with GI malignancies were associated with a delay in diagnosis and treatment. OIG found several factors contributed to the GI consult backlog and hindered reduction efforts. Though the GI consult backlog has been resolved, continued vigilance is needed to prevent reoccurrence.

The Office of Audits and Evaluations assessed VHA's management of non-institutional purchased home care services. Under purchased home care, contract agencies provide Veterans with home health aides or other skilled care services in their homes. OIG estimated VHA's waiting lists did not include at least 49,000 Veterans who had purchased home care needs in fiscal year 2012 and projected that 114 VA medical facilities limited access to purchased home care services through the use of more restrictive eligibility criteria than required by VHA policy, and by applying nonstandard review processes and relying upon inaccurate and nonstandard eligibility information. OIG also found VA facilities did not use required waiting lists to track eligible Veterans. In general, program management lacked standardization in both implementation and oversight. This severely affected the care received by Veterans and sometimes resulted in the denial of care. Without actions to strengthen controls, VHA could pay ineligible contract agencies approximately $893.5 million and make just over $13.2 million in improper payments over the next 5 years.

After 44 years of Federal service, I have decided to retire effective December 31, 2013. The last 8 years leading the dedicated men and women of the VA Office of Inspector General have been among the most personally rewarding of my career. At a time when Americans are asking for more efficient Government programs, reductions in waste, and greater accountability, we can all be proud that in these 8 years, OIG has achieved $21.3 billion in monetary impact, either through recommendations to VA in program efficiencies or in criminal fines, penalties, and sanctions representing a return on investment of $31 for every dollar invested in the OIG's budget. I want to express my deepest gratitude for the unwavering dedication of OIG employees in accomplishing our mission and identifying opportunities for improvement within VA. I also wish to express my appreciation to and respect for Secretary Shinseki and former Secretaries Peake and Nicholson, who supported the OIG's work as an independent oversight organization. Our tasks are different, but we are all committed to improving the lives of America's Veterans.



GEORGE J. OPFER
Inspector General

# Statistical Highlights

| Monetary Impact (in Millions) | 6-Month Total | Fiscal Year |
|---|---|---|
| Better Use of Funds | $1,559.1 | $1,855.6 |
| Fines, Penalties, Restitutions, and Civil Judgments | $17.4 | $737.0 |
| Fugitive Felon Program | $57.1 | $150.6 |
| Savings and Cost Avoidance | $170.1 | $695.6 |
| Questioned Costs | $122.8 | $127.9 |
| Dollar Recoveries | $7.4 | $23.7 |
| Total Dollar Impact | $1,933.9 | $3,590.4 |
| Cost of OIG Operations[1] | $49.2 | $98.4 |
| **Return on Investment[2]** | **39:1** | **36:1** |

1 The 6-month and fiscal year operating costs for the Office of Healthcare Inspections ($10.3 and $20.6 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 | 14 | 32 |
| Benefits Inspections | 16 | 20 |
| National Healthcare Reviews | 10 | 14 |
| Hotline Healthcare Inspections | 21 | 44 |
| Combined Assessment Program Reviews | 36 | 67 |
| Community Based Outpatient Clinic Reviews[3] | 35 | 49 |
| Administrative Investigations | 1 | 3 |
| Preaward Contract Reviews | 34 | 83 |
| Postaward Contract Reviews | 16 | 33 |
| Claim Reviews | 2 | 4 |
| **Total Reports Issued** | **185** | **349** |

3 Encompassing 194 and 259 facilities for the 6-month and fiscal year periods, respectively.

| Investigative Activities | 6-Month Total | Fiscal Year |
|---|---|---|
| Arrests[4] | 221 | 440 |
| Fugitive Felon Arrests | 25 | 58 |
| Fugitive Felon Arrests made by Other Agencies with OIG Assistance | 12 | 41 |
| Indictments | 158 | 310 |
| Criminal Complaints | 73 | 148 |
| Convictions | 169 | 373 |
| Pretrial Diversions and Deferred Prosecutions | 26 | 47 |
| Administrative Investigations Opened | 9 | 21 |
| Administrative Investigations Closed | 9 | 20 |
| Advisory Memos Issued | 4 | 9 |
| Administrative Memos Issued | 7 | 16 |
| Administrative Sanctions and Corrective Actions | 206 | 411 |
| Cases Opened[5] | 402 | 881 |
| Cases Closed[6] | 431 | 921 |

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

| Healthcare Inspections Activities | 6-Month Total | Fiscal Year |
|---|---|---|
| Clinical Consultations | 2 | 2 |
| Administrative Case Closures | 11 | 22 |

| Hotline Activities | 6-Month Total | Fiscal Year |
|---|---|---|
| Contacts | 14,146 | 27,420 |
| Cases Opened | 616 | 1,227 |
| Cases Closed | 614 | 1,190 |
| Administrative Sanctions and Corrective Actions | 346 | 704 |
| Substantiation Percentage Rate | 39 | 40 |

# Table of Contents



*(continued on next page)*

# 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.

| 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<br>Office of Audits and Evaluations<br>Office of Investigations<br>Office of Management and Administration<br>Office of Contract Review<br>Other Significant OIG Activities |
| **§ 5 (a) (2)** a description of the recommendations for corrective action made during the reporting period | Office of Healthcare Inspections<br>Office of Audits and Evaluations<br>Office of Investigations<br>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<br>Office of Audits and Evaluations<br>Office of Investigations<br>Office of Contract Review |
| **§ 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 |

*(continued on next page)*

| Reporting Requirements | Section(s) |
|---|---|
| **§ 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) 2013, VA is operating under a $135.5 billion budget, with over 331,000 employees serving an estimated 22.3 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.

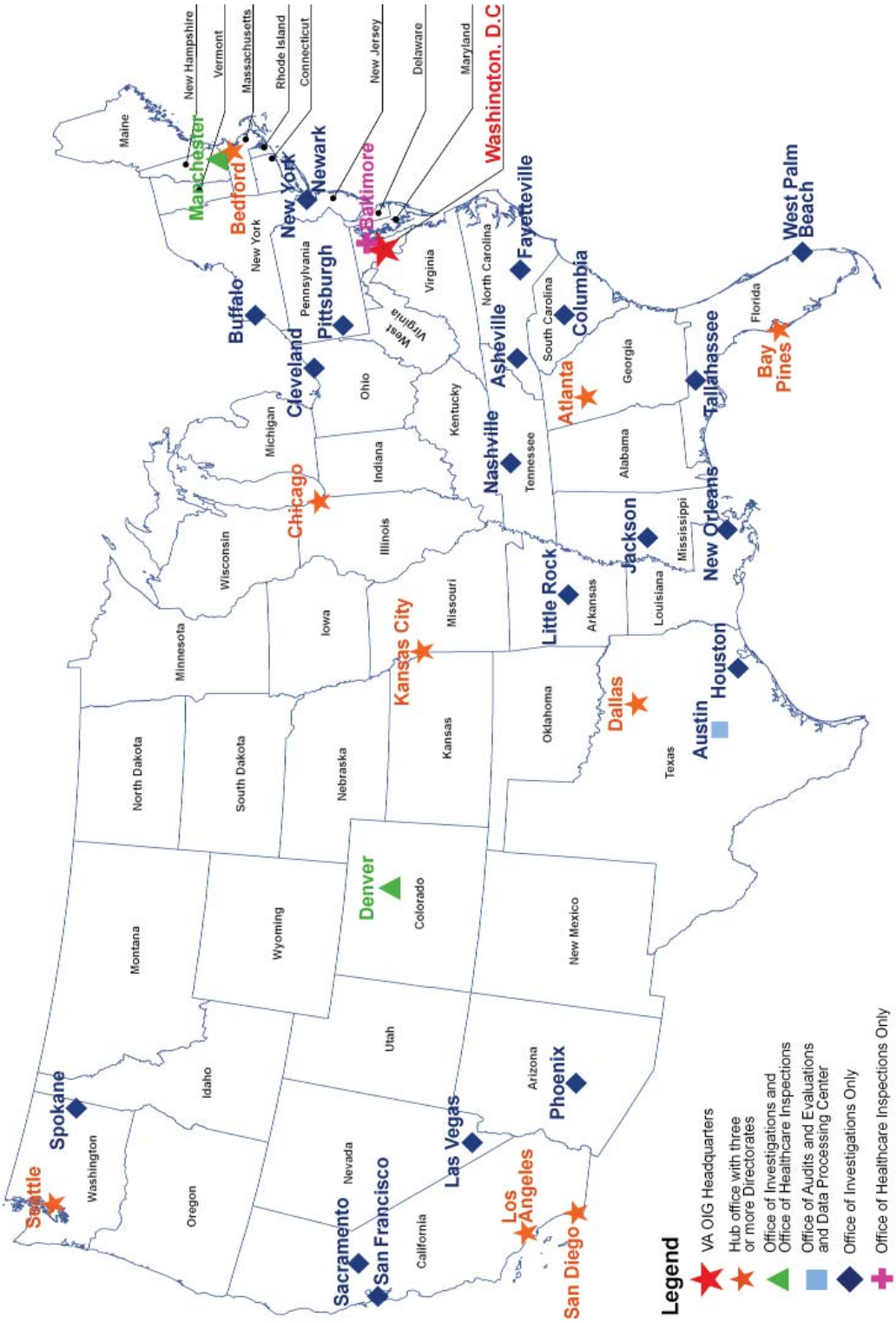
## VA Office of Inspector General

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.

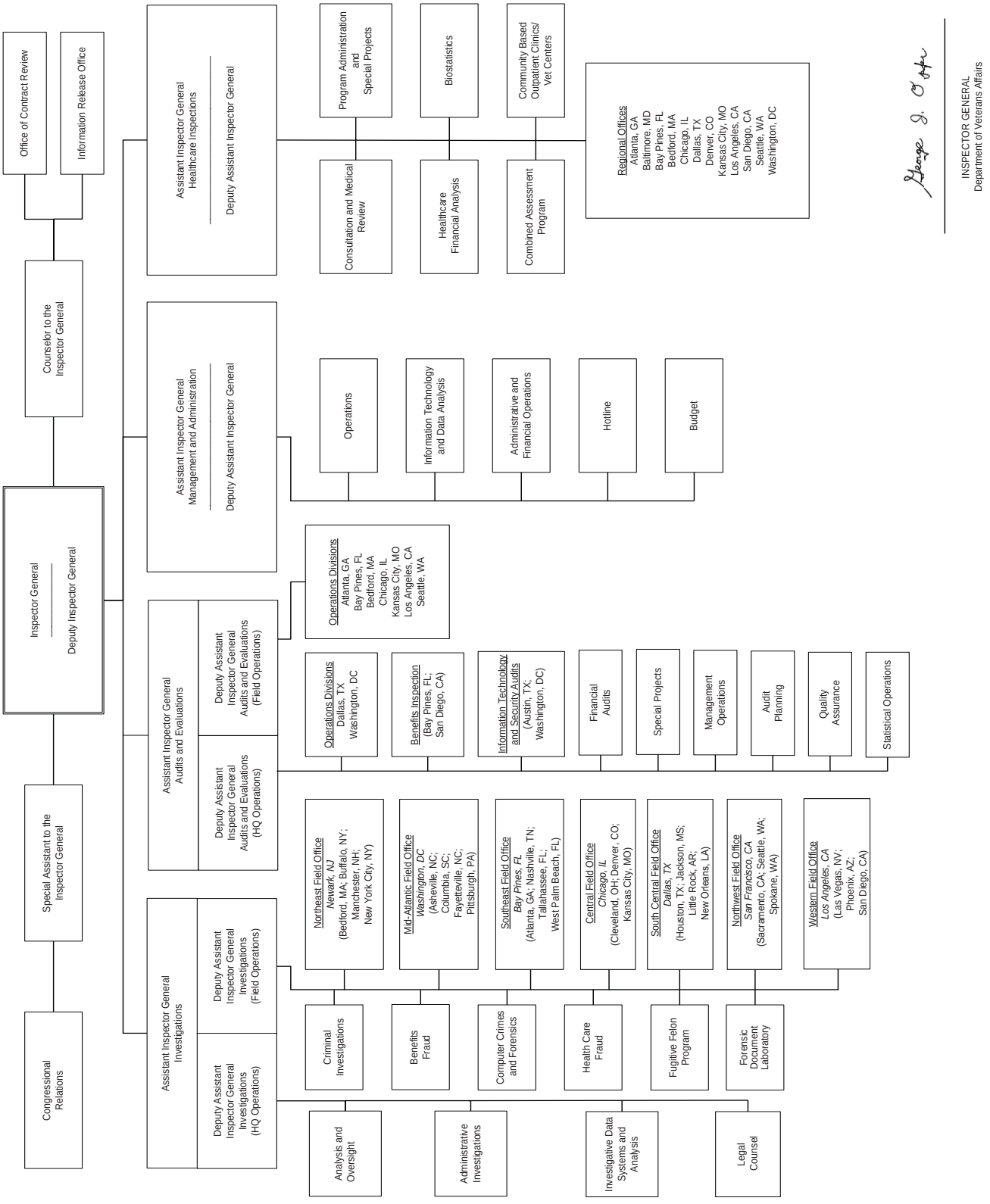
OIG, with 612 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2013 funding for OIG operations provides $114.8 million from ongoing appropriations. The Office of Contract Review, with 29 employees, received $4.2 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



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, 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 (OHI) focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 10 national healthcare reviews; 21 Hotline healthcare inspections; 36 Combined Assessment Program (CAP) reviews; and 35 Community Based Outpatient Clinic (CBOC) reviews, covering 194 facilities, to evaluate the quality of Veteran 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 36 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 6–12 months. The topics covered this reporting period include: Quality Management (QM), Environment of Care, Medication Management (Controlled Substances Inspections), Coordination of Care (Hospice and Palliative Care), Pressure Ulcer Prevention and Management, Nurse Staffing, and Construction Safety. 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 six CAP summary reports.

### CAP Review Summary Report Recommends Three Ways To Improve QM at VA Medical Centers

OIG completed an evaluation of QM in VHA facilities for FY 2012. 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, 2011, through September 30, 2012, and identified 3 areas where VHA facilities needed to improve compliance. OIG recommended that Facility Directors and Patient Safety Officers sit on the high-level committees that review QM results, that completed corrective actions related to peer reviews be reported to the Peer Review Committee, and that Focused Professional Practice Evaluations (FPPEs) for newly hired licensed independent practitioners be initiated and completed and that the results be reported to the Medical Executive Committee.

### CAP Review Summary Report Recommends Improvements in Post-Discharge Follow-Up for Mental Health Patients

OIG completed an evaluation of continuity of care for mental health (MH) patients at VHA facilities. The purpose of the evaluation was to determine whether patients who were discharged from acute MH units received timely follow-up. OIG conducted this review at 24 facilities during CAP reviews performed from April 1 through September 30, 2012, and identified 2 areas where VHA facilities needed to improve compliance. OIG recommended that facilities take action to improve post-discharge follow-up for MH patients, particularly those who were identified as high risk for suicide, and that clinicians consistently follow up with patients who do not report to their scheduled MH appointments and that all of these contacts be documented.

## CAP Review Summary Report Recommends VHA Fully Implement Nurse Staffing Methodology

OIG completed an evaluation of nurse staffing in VHA facilities. The purpose of the evaluation was to determine the extent to which VHA facilities implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit. OIG conducted this review at 27 facilities during CAP reviews performed from April 1 through September 30, 2012, and identified 2 areas where VHA facilities needed to improve compliance. OIG recommended that all facilities fully implement the staffing methodology and complete all required steps, and improve processes to use the available data to manage and provide safe, cost-effective staffing.

## OIG Makes Three Recommendations to Improve the Safe Provision of Moderate Sedation

OIG completed an evaluation of moderate sedation in VHA facilities. The purpose of the evaluation was to determine whether VHA facilities used safe processes for the provision of moderate sedation that complied with selected requirements. OIG conducted this review at 44 facilities during CAP reviews performed from October 1, 2011, through September 30, 2012, and identified 3 areas where VHA facilities needed to improve compliance. OIG recommended that clinicians consistently document all required elements of comprehensive pre-procedure assessments; that when there is a provider change, clinicians consistently document that the patient was informed of and agreed to the change; and that clinicians consistently discharge moderate sedation patients appropriately and safely.

## CAP Summary Report Recommends Four Ways VA Can Improve Detection of Colon Cancer

OIG completed an evaluation of colorectal cancer (CRC) screening and follow-up activities in VHA facilities. The purpose of the evaluation was to follow up on OIG's report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening program. OIG evaluated CRC screening, follow-up diagnostic testing, and patient results notification at 53 facilities during CAP reviews performed from October 1, 2011, through September 30, 2012, and identified 4 areas that needed improvement. OIG recommended that clinicians: (1) communicate positive CRC screening test, diagnostic test, and biopsy results to patients within 14 days and document notification in the electronic health record (EHR); (2) document follow-up plans or document that no follow-up is warranted within 14 days of positive CRC screening results; (3) discuss diagnostic testing options with patients and ensure desired testing is performed within 60 days of the positive CRC screening results; and (4) complete general or surgical evaluations within 30 days of positive CRC pathology.

## OIG Identifies Five Areas for Improvement in VHA Polytrauma Care

OIG completed an evaluation of polytrauma care in VHA facilities. The purpose of the evaluation was to determine whether VHA facilities complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma. OIG evaluated polytrauma care at 57 facilities during reviews conducted from October 1, 2011, through September 30, 2012. Fifty-four facilities had CAP reviews, and separate visits were made to three facilities. OIG identified five areas where VHA facilities needed to improve compliance. OIG recommended that: (1) VHA perform a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed; (2) Level IV sites performing comprehensive traumatic brain injury (TBI) evaluations have approved alternate plans; (3) clinicians consistently complete TBI evaluations within 30 days of positive screens; (4) the case management process meets requirements; and (5) staff caring for polytrauma patients have the documented competencies required for caring for these patients.

## Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany *HR 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 194 CBOC reviews throughout 17 Veterans Integrated Service Networks (VISNs). These reviews were captured in 35 reports, listed in Appendix A. The topics covered this reporting period include: Environment of Care, Emergency Management, Vaccinations (Tetanus and Pneumococcal Vaccines), Women's Health (Cervical Cancer Screening), and Credentialing and Privileging and Scopes of Practice. A roll up report for the CBOCs reviewed in FY 2012 was also published during this reporting period and is included below.

### OIG's Review of 92 VA Clinics Results in 10 Recommendations for Improvement

The purpose of OIG's evaluation was to assess if CBOCs provide Veterans with consistent, safe, and high-quality health care. OIG performed this review with inspections of 92 VHA CBOCs during FY 2012. These inspected CBOCs are a statistical sample of all VHA CBOCs with more than 500 patients aligned under selected parent VA facilities. OIG's review focused on four components: (1) FY 2012 CBOC-specific information gathering and review; (2) EHR reviews of care performed in FY 2011 for determining compliance with VHA policies; (3) on-site environment of care and emergency management inspections during FY 2012; and (4) CBOC contract reviews of quarter 3 of FY 2011. OIG recommended that: (1) CBOC clinicians document foot care education provided to diabetic patients in the EHR; (2) CBOC clinicians perform risk assessments and document risk levels for diabetic patients in the EHR; (3) CBOC clinicians document referrals for preventative foot care, including foot wear, as clinically indicated, for patients with diabetes in the EHR; (4) CBOC managers establish a process to consistently link breast imaging and mammography results to the appropriate radiology mammogram or breast study order for all fee basis and contract patients; (5) CBOC managers establish a process to notify patients of normal mammogram results within the allotted timeframe and that notification is documented in the EHR; (6) service chiefs' documentation in VetPro reflects documents reviewed and the rationale for privileging or re-privileging CBOC providers; (7) Facility Directors grant privileges consistent with the services provided at the CBOCs; (8) adequate resources and controls are in place to address deficiencies in the invoice validation process and to reduce the risk of overpayments; (9) the oversight of the contract acquisition process is compliant with VA Directives, including a thorough pre-award review and interim contract authority prior to contract approval; and (10) all new CBOCs undergo the required contract approval processes prior to initiating operations.

## National Healthcare Reviews

### Review Finds Legionella Prevention Compliance Varies Across VA System, OIG Makes Four Recommendations for Improvement

OIG conducted a review to assess how VHA medical facilities manage prevention of Legionnaires' Disease (LD) at the request of the VA Secretary, Senator Robert P. Casey, Jr., Congressman Tim Murphy, and the Chairmen and Ranking Members of the House Committee on Veterans' Affairs and the Senate Committee on Veterans' Affairs. VHA Directive 2008-010, *Prevention of Legionella Disease*, outlines specific measures that VA facilities should follow to monitor and reduce Legionella in the water distribution system.

OIG found that compliance with the directive was variable. VHA is currently in the process of revising Directive 2008-010. OIG recommended that the Under Secretary for Health (USH) address the reported compliance issues when revising the directive and provide a plan that simplifies and monitors its implementation. VHA Directive 2008-010's risk stratification criteria are based at the facility level and focus on transplant facilities. OIG recommended that the USH consider re-evaluation of the current stratification of facilities that focuses on transplant status. OIG also recommended that the USH institute a national-level water safety committee that will provide expert and technical assistance for collaborative decision-making at the local level in the control and prevention of waterborne disease. The USH concurred with the findings and recommendations and provided an acceptable action plan.

### National Review Finds No Widespread Systemic Reuse of Insulin Pens on Multiple Patients

OIG conducted an inspection to evaluate how VHA followed up on the inappropriate use of insulin pens at the VA Western New York Healthcare System (HCS), Buffalo, NY, and to determine what controls VHA has in place to minimize the risk of other incidents involving insulin pens and similar devices. OIG conducted the inspection at the request of the Ranking Member, Senate Committee on Veterans' Affairs. Although two other VHA facilities reported isolated incidents of nurses using insulin pens on multiple patients, OIG found no evidence of widespread, systemic reuse of insulin pens on multiple patients. Further, OIG found that VHA has processes in place to identify important patient safety alerts and disseminate this information to facility managers, and numerous policies and procedures in place to address infection prevention. OIG recommended that the USH implement procedures to ensure that future VHA internal assessments resulting from adverse events include clear guidance to facilities on minimal required steps and supporting documentation; require facilities to develop processes for assessing the risks and benefits of adopting new medical products or devices that may require significant changes in nursing procedures; and ensure that facility nursing education departments are sufficiently staffed to provide comprehensive and ongoing nursing education, especially when adopting new medical products or devices that may significantly change nursing procedures. The USH concurred with our findings and recommendations and provided an acceptable action plan.

### OIG Makes Four Recommendations to Improve Contracted Counseling Services at Vet Centers

OIG completed an evaluation of Vet Center contracted counseling services. The purpose of the evaluation was to: (1) determine if VA required contractors to complete specific components of client documentation in accordance with Readjustment Counseling Service (RCS) policy, (2) determine if managers provided appropriate oversight for the contracted clinicians' required client documentation, (3) assess the management and oversight of contracted care based on compliance with the contract, and (4) determine if invoicing practices complied with RCS contract requirements. OIG conducted onsite and remote reviews for a random sample of 30 Vet Centers during the weeks of June 11 and 18, 2012, and reviewed psychosocial assessments and initial treatment plans for clients who received contracted counseling services during the study period from April 1, 2011, through March 31, 2012. OIG identified six areas where Vet Centers needed improvement. OIG recommended that team leaders (1) receive, review, and approve psychosocial assessments and counseling plans prior to authorizing contracted counseling services; (2) conduct and document client assessments after 1 year of eligibility for contracted client services; (3) conduct annual onsite quality reviews for contractors who participate in the Contract for Fee Program; and (4) authorize contracted counseling services in accordance with RCS and VHA policy. OIG also recommended that RCS use a standard template that includes terms and conditions that are consistent with those in the RCS policy and maintains and monitors counseling service contracts in accordance with RCS and VHA policy.

# Hotline Healthcare Inspections

## Review Shows Use of Camera for Patient Safety Concerns Reasonable at Tampa VA Medical Center

At the request of several members of Congress, OIG initiated a review that a hidden camera was placed in a brain-damaged patient's room without next-of-kin consent. In June 2012, the patient's family became aware of a video surveillance camera (VSC) in a smoke-detector-like cover that had been placed in the patient's room. The patient's family was aware when the VSC was activated 3 days after installation. OIG concluded that the use of the camera for patient safety concerns was reasonable. OIG conducted a survey of VSC usage in VHA health care facilities. VHA requires VSCs in MH Residential Rehabilitation Treatment Program (RRTP) facilities, pharmacy vaults and controlled substances storage areas, childcare facilities, and canteens. VSCs are standard in high traffic areas such as parking lots, building entrances, waiting rooms, stairwells, and research areas. VSCs were reported in clinical areas such as: MH Units, Emergency Departments (EDs), Intensive Care Units (ICUs), and Geriatrics/Extended Care Units. Half of the respondents had posted signs that VSCs were in use. No facility reported current use of a hidden camera. Seven facilities employed hidden VSCs in the past for law enforcement and/or suspected criminal activity. Ten medical centers reported current use of VSCs with audio capability in police interview rooms; sleep laboratories; MH seclusion rooms; and in the common area of the VA Manila, PI, Outpatient Clinic located on U.S. Embassy property. OIG recommended that the USH ensure that VHA policy addresses the clinical uses of covert and overt VSCs in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, health care operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered. The USH concurred with OIG's recommendation and provided an acceptable action plan.

## OIG Review Finds Six Factors Contributed to Misuse of Insulin Pens at Buffalo, New York, Facility

OIG conducted an inspection to evaluate the circumstances surrounding the reported inappropriate use of insulin pens at the VA Western NY HCS, Buffalo, NY. OIG conducted the inspection at the requests of the Chairmen and Ranking Members of the House Committee on Veterans' Affairs and the Senate Committee on Veterans' Affairs, Senator Charles Schumer, and Congressmen Brian Higgins and Chris Collins. This report addresses questions raised by Members of Congress regarding the specific circumstances at the HCS. OIG issued a separate report addressing broader questions pertaining to insulin pen use at other facilities, as well as VHA oversight and follow-up, which can be found under the National Healthcare Reviews section. OIG recommended that the USH finalize VHA's Clinical Operations Guideline for "Implementation of a Large Scale Disclosure Decision" and that the VISN Director review the facts that led to the misuse of insulin pens and take appropriate administrative action. OIG also recommended that the Facility Director implement a process to ensure the HCS's Medication Use, Nursing Practice, and Commodity Standards Committees and other relevant leadership evaluate the risks and benefits before introducing new medical products or supplies; strengthen nurse education practices when introducing new medical products or supplies; and ensure that all nurses are made aware of how to find and use the HCS's nursing practice procedures. The USH concurred with OIG's findings and recommendations and provided an acceptable action plan.

## Suspension of Inpatient Care at Fort Wayne Facility Shows Need for VHA Policy When Major Clinical Services Are Paused

OIG conducted an inspection at the request of Senator Joe Donnelly and Congressman Marlin Stutzman regarding the suspension (pause) of all inpatient admissions at the Fort Wayne campus (facility) of the

VA Northern Indiana HCS in October 2012. OIG was asked to review overall quality of care and management at the facility, define what issues led to suspension of inpatient care, and determine what measures need to be taken to return the facility to normal operations. As of May 2013, inpatient operations had not resumed at full capacity but were being phased in. OIG determined that the facility, VISN 11, and VHA could have improved communication to stakeholders regarding the pause. In view of recurring qualitative issues relating to patient care, lack of long-term stability in upper and mid-level leadership positions, and workload, VISN 11 may need to consider the scope of services the facility is capable of reliably providing, namely, the appropriate designation for ICU level care in the near term and whether an ICU is viable in the long term. OIG recommended that VHA develop policy and guidance for facilities when major clinical services are paused, that the VISN Director ensure the assigned ICU level of care is commensurate with facility capabilities, that the Facility Director ensure that recruitment efforts continue for vacant leadership positions, that nurse competencies are consistently completed and validated, and that the nurse staffing methodology is fully implemented. The USH, VISN, and Facility Directors concurred with the inspection results. OIG will follow up on the planned actions until they are completed.

### Alleged Negligent Care of a Patient with Medication-Induced Acute Renal Failure, Amarillo VA HCS, Amarillo, Texas

OIG conducted an inspection in response to Congressman Randy Neugebauer's request to review an allegation that a patient at the Amarillo VA HCS, Amarillo, TX, received negligent care resulting in permanent kidney damage, which led to multiple other medical problems. It was alleged that: (1) a patient with a history of renal cell carcinoma who had his right kidney removed was prescribed medication that led to a 4-day hospital admission for acute renal failure (ARF), (2) the patient now has permanent damage to his remaining kidney as a result, and (3) other medical problems have resulted from this kidney damage. OIG substantiated that a newly prescribed blood pressure and cardiac medication, lisinopril, contributed to or caused the patient to develop ARF. However, in view of the totality of the patient's medical condition, OIG concluded that the lisinopril prescription was justifiable. OIG did not substantiate that the patient has permanent damage as a result of the ARF or that the patient's current medical problems are a result of the ARF. OIG recommended that the System Director consult with Regional Counsel to determine if disclosure of the events related to the patient's episode of ARF, as discussed in this report, is indicated and that the Chief of Staff conduct a thorough review of the care provided to this patient by the system.

### OIG Recommends Chaperone Policy Education for Primary Care Clinic Staff at VA Puget Sound HCS, Seattle, Washington

At the request of Senator Patty Murray, OIG conducted an evaluation in response to allegations brought forth by a patient related to a dermatology examination the patient received at the Seattle Division of the VA Puget Sound HCS, Seattle, WA. OIG did not substantiate that the examination was unnecessary as alleged. However, OIG found the provider did not ensure a chaperone was present during the examination as required. OIG did not substantiate allegations that the provider nudged and pushed the patient, did not wash her hands, or had ragged and unkempt fingernails. OIG substantiated that the provider did not wear gloves during the examination as alleged but determined the use of gloves was not indicated and that this was appropriate practice. OIG substantiated that the window in the examination room was not covered but determined the window was not covered to aid the provider's diagnostic exam and it was unlikely the patient's privacy was breached. OIG found that system staff did not fully respond to the patient's concerns and did not report the patient's allegations in accordance with Federal regulation and VHA policy. OIG recommended the System Director ensure the Women Veterans Program Manager provides chaperone policy education to all primary care clinics.

OIG also recommended the System Director ensure all staff are informed about the VHA requirement to report allegations of patient abuse and educated on the processes for reporting the alleged abuse.

### Alleged Sterile Processing Service Deficiencies at VA Puget Sound HCS, Seattle, Washington

OIG conducted an inspection to assess allegations regarding operations within the Sterile Processing Service (SPS) at VA Puget Sound HCS, Seattle, WA. OIG substantiated that instruments were processed in a pan that was not approved for the sterilizer in use; however, OIG did not substantiate that this caused the instruments involved to be unsterile. OIG did not substantiate that leadership knowingly covered-up and failed to disclose processing problems associated with equipment. OIG did not substantiate that the HCS reused single-use devices; however, OIG did find that the HCS resterilized single-use devices that had not yet been used. OIG did not substantiate that standard operating procedures and staff competency folders are not accurate and current or that SPS had not provided sufficient staff training. However, OIG did find deficiencies in the manner in which the files were organized. OIG concluded that the HCS generally complied with clinical and administrative processes within SPS. OIG found areas needing improvement in the management of single-use devices and the maintenance and tracking of SPS staff competency files.

### Noncompliance with Safe Medication Management Cited in Review of Unexpected Death at Lyons, New Jersey, VA Medical Center

OIG conducted an inspection in response to a request by OIG's Office of Investigations to review the care of a patient who died unexpectedly while residing at the MH RRTP at the VA New Jersey HCS, Lyons, NJ. The Office of the State of New Jersey Medical Examiner's autopsy report listed "Acute intoxication due to the combined effects of cyclobenzaprine, tramadol, gabapentin, sertraline, hydroxyzine, and amlodipine" as the cause of death. The manner of death (suicide, homicide, accidental) was listed as undetermined and final diagnoses included hypertensive and atherosclerotic cardiovascular disease. OIG found that program staff did not comply with VHA and facility requirements for an effective, safe medication management program or document the resident's care sufficiently or timely. OIG also found that leadership did not provide sufficient professional support for a MH RRTP advanced practice registered nurse (mid-level provider). OIG recommended that the HCS Director ensures that the facility complies with MH RRTP safe medication management requirements, completes required EHR documentation, and provides appropriate follow-up to requests for professional support by MH RRTP mid-level providers.

### Alleged Inadequate Oversight at a Contracted Homeless Program, VA New Jersey HCS, East Orange, New Jersey

OIG conducted an inspection in response to allegations that Community Hope, Inc. (CH agency) and the Veterans in Early Transitions Services (VETS) Program contributed to the death of a Veteran because of a case manager's negligence and lack of supervision, lacked supportive services promised to stabilize Veterans; made inappropriate referrals for revenue generation based on payment earned for Veteran-occupied beds; provided inadequate breakfasts for their patients; mismanaged medication causing some homeless Veterans to overdose; violated CH agency policy by inappropriately discharging patients, for reasons which included positive substance abuse screening, rendering them homeless; and employed non-experienced staff for the population being served and employed a leader who did not have the education and experience required by the VA housing contract. OIG did not substantiate the complainant's allegations and found that following the two patients' deaths, the facility initiated a collaborative root cause analysis (RCA) with the CH agency. OIG concurred with the RCA team's findings, recommendations, and actions taken. OIG found that the CH agency and facility staff made improvements to the VETS Program referral and admission process, patient supervision, monitoring, and safety.

Furthermore, OIG's interviews with VETS Program patients showed that they all had positive comments about their experience in the program. OIG made no recommendations.

### Review Finds Mismanagement, Lack of Oversight, and Coordination of Contracted MH Care at Atlanta VA Medical Center

OIG conducted an inspection to assess the merit of allegations of mismanagement and lack of oversight of an MH contract. OIG substantiated mismanagement in the administration of the contract, and also substantiated additional allegations that there was inadequate coordination, monitoring, and staffing for oversight of contracted MH patient care. Facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the contracted MH program. MH Service Line managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. The lack of effective patient care management and program oversight by the facility contributed to problems with access to MH care and contributed to "patients falling through the cracks." OIG recommended that the USH rectify the deficiencies described in this report with respect to the provision of quality MH care and contract management, with the goal that Veterans receive the highest quality medical care from either the VA or its partners. The USH and the VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed.

### OIG Finds Need for National Policies on Contraband, Visitors, Drug Screening, and Escorts in Inpatient MH Units

OIG evaluated allegations regarding the MH Service Inpatient Unit at the Atlanta VA Medical Center (VAMC), Decatur, GA. Specifically, the complainant alleged that an inpatient's death was due to MH service leadership's negligence and mismanagement of unit policies, patient monitoring, staffing, and lack of caring about patients. OIG did not substantiate the allegations of inadequate staffing, inappropriate staff assignments, or that leadership did not care about patients. However, OIG substantiated that the VAMC did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. OIG found inadequate program oversight including a lack of timely follow-up actions by leadership in response to patient incidents. OIG recommended that the USH ensure that VHA develops national policies to address contraband, visitation, urine drug screening, and escort services for inpatient MH units. OIG also recommended that the VISN and Facility Directors ensure that the inpatient MH unit develops these policies; strengthen program oversight and follow-up; improve communication with staff; and ensure functional and well-maintained life support equipment.

### OIG Makes Five Recommendations To Mitigate LD at VA Pittsburgh HCS

OIG conducted a review of LD at the VA Pittsburgh Healthcare System (VAPHS). VAPHS has a long history of comprehensive mitigation efforts for LD, and following a recent outbreak, VAPHS instituted numerous additional measures. However, OIG found that VAPHS inadequately managed its water treatment systems during 2011–2012. OIG also found that VAPHS did not conduct routine flushing of hot water faucets and showers as recommended by the manufacturer of the water treatment systems. OIG found that VAPHS conducted environmental surveillance in accordance with VHA guidance. However, VAPHS responded to positive cultures with corrective actions inconsistent with VHA or Centers for Disease Control and Prevention guidance. In addition, VAPHS did not test all health care-associated pneumonia patients for Legionella as required by VHA for transplant centers with a history of health care-associated LD. OIG recommended that the VAPHS Director ensure that any disinfectant system in use for Legionella prevention is monitored and maintained in accordance with manufacturer's instructions, that hot-water faucets and showerheads

are routinely flushed, and that close coordination between the Infection Prevention Team and Facilities Management Service staff occurs. Additionally, OIG recommended that the VAPHS Director ensure that when environmental cultures are positive, actions taken comply with VHA guidelines, and that all health care-associated pneumonia patients are tested for Legionella infection.

### Delays Noted in Providing Patients with Biopsy Results at Salisbury, North Carolina, Facility

OIG conducted an inspection in response to a complaint concerning delays in reporting biopsy test results to patients and possible delays in treatment at the W.G. (Bill) Hefner VAMC, Salisbury, NC. OIG substantiated the allegation that the facility was not timely in notifying patients of biopsy test results. However, OIG did not substantiate that resulting treatments were delayed. In addition, OIG identified that notification procedures for new malignancies found during outpatient test biopsies were not included in the facility's critical biopsy policy. OIG recommended that procedures be implemented to ensure that patients receive timely notification of biopsy test results, notifications be documented in patients' EHRs, performance improvement procedures be adjusted to include periodic monitoring of test result communication to patients, and the facility's written policy for critical test results be revised to include outpatient biopsy test results. Management agreed with the findings and recommendations and provided an acceptable improvement plan.

### IG Recommends Improvements in Electronic Monitoring System, Nurse Training at Salisbury, North Carolina, Community Living Center

OIG conducted an inspection in response to a complainant's allegations of poor quality of care and patient safety concerns in the Community Living Center (CLC) at the W. G. (Bill) Hefner VAMC in Salisbury, NC. OIG generally did not substantiate that patients were improperly admitted to the CLC, and as a result, did not receive appropriate treatment and services. In one case, the resident did not receive care consistent with VHA's defined concept of Hospice and Palliative Care. OIG substantiated that a high-risk resident could wander or elope from a CLC unit because of an outdated electronic monitoring system, and policy, practices, and training deficits. OIG did not substantiate that, to increase Veterans Equitable Reimbursement Allocation funding, CLC leaders improperly admitted patients for rehabilitation, that CLC nurse practitioners were not supervised, or that the CLC Chief Nurse Executive does not adequately address and follow up on staff concerns. Facility leaders had not, however, conducted a risk assessment of the electronic monitoring system in spite of ongoing safety concerns. OIG made three recommendations.

### Quality of Surgical Technique of Specialty Service Surgeon Assessed at a VA HCS

OIG conducted an inspection in response to allegations that a VA HCS specialty service surgeon had licenses suspended in two states and had several near misses, with some related to wrong site surgeries, and that the Chief of Surgery declined to review two alleged sentinel event cases or take action on reported staff concerns. OIG did not substantiate that the surgeon had suspended medical licenses in two states or had several wrong site surgery "near misses." OIG identified and had concerns with one case regarding the quality of surgical technique. While the Chief of Surgery declined to review two alleged "near miss" cases as sentinel events, OIG concurred that the cases did not meet the definition of a sentinel event. The Chief of Surgery had taken multiple actions to address staff's concerns regarding the surgeon's surgical techniques. The HCS did not delineate the surgeon's privileges, the privileges were not facility or provider specific, and an initial FPPE was not completed as required. OIG recommended that the System Director ensure the two alleged "near misses" are referred to QM staff to determine if action should have been taken, consult with Regional Counsel regarding possible clinical disclosure to the patient for whom quality of surgical technique concerns were identified, ensure that initial FPPEs are completed on all newly hired providers, and that privileges are facility and provider

specific. The VISN and Facility Directors concurred with OIG's recommendations and provided acceptable action plans.

### Poor Recordkeeping, Nurse Understaffing Noted at VA Long-Term Spinal Cord Injury Unit in Cleveland, Ohio

OIG conducted an inspection to assess the merit of allegations regarding poor quality care and management on the long-term care (LTC) spinal cord injury (SCI) unit at the Louis Stokes VAMC in Cleveland, OH. OIG did not substantiate allegations regarding infection control infractions. However, OIG found that staff nurses did not consistently document resident care and nurse managers had not taken effective actions in response to conduct, absences, and other issues. OIG also found understaffing on all shifts and that float staff pulled from other units during staffing shortages lacked the training and competencies to work with this complex and challenging patient population. OIG recommended that the VAMC Director ensure that: staffing levels on the LTC SCI unit are consistent with VHA requirements and the VAMC's SCI Master Nurse Staffing Plan, LTC SCI nursing staff consistently provide and document resident care, LTC SCI nurse managers take action to investigate and address conduct related issues, and float staff assigned to the LTC SCI unit have the training and competencies required for the unit.

### Review Substantiates Missed Cancer Diagnosis Allegation at Erie, Pennsylvania, VAMC

OIG conducted an inspection to evaluate the care and services a patient received at the Erie VAMC, Erie, PA; the Warren CBOC, Warren, PA; and the VAPHS, University Drive Campus, Pittsburgh, PA. OIG substantiated the allegations that VA providers missed the patient's cancer diagnosis, did not manage his pain appropriately, and that there were scheduling delays in the patient's referrals and follow-up care. OIG could not confirm the allegation that an outpatient specialty care provider was rude to the patient and family during the patient's care visit. OIG found factors that contributed to the missed diagnosis as well as opportunities for improvement in system processes that affected this patient's care. The oversight of the patient's care continuum was lacking, and there was inadequate communication between primary and specialty care providers and VA and community health care facilities. OIG recommended that the Network Director initiate an RCA to evaluate system issues outlined in this report and evaluate the care of the patient discussed in this report with Regional Counsel for possible disclosure to the surviving family member(s) of the patient. The Network Director concurred with OIG's recommendations and provided an acceptable action plan.

### Continued Vigilance Needed To Ensure Gastroenterology Consult Backlog in Columbia, South Carolina, VA Facility Does Not Recur

OIG conducted a review at the William Jennings Bryan Dorn VAMC in Columbia, SC, to determine whether deficient practices contributed to or caused delays in care, and whether facility leaders appropriately addressed clinical managers' concerns. OIG substantiated the allegations and found additional factors that contributed to the events. In July 2011, VISN and facility leaders became aware of the gastroenterology (GI) consult backlog involving 2,500 delayed consults, 700 "critical." The VISN awarded the facility $1.02 million for fee colonoscopies in September 2011. Because facility leaders did not ensure a structure for tracking and accountability by December 2011, the backlog stood at 3,800. The facility developed an action plan in January 2012, but had difficulty making progress in reducing the backlog. An adverse event in May 2012 prompted facility, VISN, and VHA leaders to re-evaluate the GI situation and initiate efforts to eliminate it by October 2012. During the review "look-back," 280 patients were diagnosed with GI malignancies; 52 of these were associated with a delay in diagnosis and treatment. Several factors contributed to the GI backlog and hampered efforts to improve the condition. Specifically, the facility's Planning Council did not have a supportive structure; Nursing Service did not include GI nurses on their priority hiring list; Fee Basis care had

been reduced; low-risk patients were being referred for screening colonoscopies, thus increasing demand; staff members did not consistently and correctly use the consult management reporting and tracking systems; critical VISN and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities; and QM was not included in discussions about the GI backlogs.

### Laboratory Delays and Alleged Staff Training Issues at Memphis VAMC, Memphis, Tennessee

OIG conducted a health care inspection to determine the merit of allegations related to laboratory delays impacting patient care and a lack of staff training in the Pathology and Laboratory Medicine Service (PLMS) at the Memphis VAMC, Memphis, TN. OIG substantiated that urgent laboratory tests were not processed in a timely manner and that a patient experienced a lengthy delay in treatment while waiting for laboratory test results. OIG did not substantiate that there were delays in reporting test results with critical values to ordering providers. OIG also did not substantiate that PLMS staff were not trained on vital laboratory equipment and processes. The VISN and Facility Directors concurred with OIG recommendations to ensure that processes be strengthened to ensure that laboratory turnaround times adhere to facility and VISN expectations, and to ensure that policies and processes are put in place to establish consistent and appropriate methods for data collection and analysis of laboratory test processing times.

### Inadequate Staffing, Poor Patient Flow Found in the ED of VA Maryland HCS

OIG evaluated allegations regarding staffing and poor patient flow in the ED at the VA Maryland HCS, Baltimore, MD. A complainant alleged that patients were left unmonitored for extended periods of time and experienced prolonged ED stays due to severe bed and staff shortages. The complainant also described poor patient flow and problematic administrative processes. OIG substantiated that there were times when patients' monitoring was interrupted due to lack of specialty (telemetry and isolation) beds; however, the facility had already initiated plans to expand specialized bed capacity. OIG also found there were staff shortages and that the facility did not have contingency plans for ED staffing in times of increased patient care demand. OIG found problems with patient flow from the ED to inpatient areas, and noted that data used by the facility to address flow issues was inaccurate. OIG made five recommendations to improve specialty bed access, contingency staffing, and processes for patient flow.

### Follow-Up Review of Long Beach, California, VAMC Radiation Therapy Program Results in Four Recommendations for Improvement

OIG conducted a review of new allegations and a follow-up of its March 2011 report on radiation therapy. OIG found that for three prostate cancer patients treated in 2009 and 2010, therapists did not follow local policy when shifts in the field of delivered radiation occurred. However, appropriate corrections occurred and despite shifts, all patients received full treatment to tumor-containing tissue. Additionally, there was no evidence of complications attributable to errors in delivery of radiation therapy. A patient with vocal cord cancer had transient skin abnormalities resulting from misdirection of the radiation beam. This was corrected with no long-term adverse consequences and radiation was consistently delivered to the target lesion. For 27 patients treated in 2012, whose care OIG evaluated, radiation treatment was appropriate but in some cases treatment was delayed. EHR documentation was deficient. This deficiency had been cited in the 2011 OIG report and in two accreditation surveys. OIG found improvements in QM, but adverse event reporting did not occur as specified in the 2011 facility response action plan. Further, the facility was unaware of a radiation therapy complication managed at a referring facility 5 months after completion of radiation treatment. OIG recommended that radiation therapists adhere to local policy when shifts in the field of delivered radiation occur, deficiencies in patient care documentation are addressed, adverse events are reported as specified in the facility's 2011 report

action plan, and radiation complications managed at referring facilities are reported to the facility that provided the radiation therapy.

### Allegations Regarding Provider Availability, VA Roseburg HCS, Roseburg, Oregon

OIG conducted an inspection of the VA Roseburg HCS, Roseburg, OR. The purpose of the inspection was to determine the validity of allegations regarding provider availability. OIG did not substantiate the allegations. In summary, OIG found that the HCS admitted only those patients with an acuity level appropriate to that for which they were staffed and had the infrastructure/technology to handle and that the HCS had processes in place to manage the care of inpatients on all shifts. OIG made no recommendations.

# 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. Reviews address the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, Veterans' eligibility for benefits and benefits administration, resource utilization, financial management, forensic auditing, fraud, and information 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.

### VHA Could Pay Ineligible Agencies $893.5M, Make $13.2M in Improper Payments for In-Home Care for Veterans

OIG assessed whether VHA effectively managed non-institutional purchased home care services to ensure eligible Veterans receive entitled services. OIG audited these services because of their expected growth, budgeted to increase to $798 million in FY 2013. VHA's Non-Institutional Care program allows Veterans to receive VA and contractor-provided services in the least restrictive environment possible. Under purchased home care, contract agencies provide Veterans with home health aides or other skilled care services in their homes. OIG estimated VHA's waiting lists did not include at least 49,000 Veterans who had purchased home care needs in FY 2012. OIG projected that 114 VA medical facilities limited access to purchased home care services through the use of more restrictive eligibility criteria than VHA policy required, applying nonstandard review processes and relying on inaccurate and nonstandard eligibility information. OIG found VA facilities added requirements to limit Veterans' access and did not always use required waiting lists to track eligible Veterans. This occurred because VA medical facility officials limited the costs of services paid through fee service, relied on inaccurate eligibility information for skilled care services, and redirected funds towards higher priorities. VHA redistributed $76 million to other VHA healthcare areas, VA medical facilities spent $99 million less than VA had budgeted for these services, and VHA did not meet its target to increase the average daily census for these services in FY 2012. VA medical facilities' staff also did not identify 31 ineligible agencies and did not properly manage 19 high-risk agencies which were providing care to these Veterans. Fee staff did not always verify billings before paying for services, resulting in $67,000 in improper payments. Without actions to strengthen controls, VHA could pay ineligible agencies about $893.5 million and make just over $13.2 million in improper payments over the next 5 years. OIG recommended the USH standardize the application of eligibility reviews and criteria and strengthen controls to ensure eligible patients receive purchased home care services. OIG also recommended that VHA adequately review and monitor agencies, properly document orders, and review orders to verify payments. The USH concurred with OIG's recommendations and provided responsive action plans but had concerns about OIG's sampling methodology and statistical analysis.

### VHA Can Increase Rebates and Save $120 Million by Maximizing Use of Purchase Cards for Micro-Purchases

OIG conducted this audit to evaluate whether opportunities exist for VA medical facilities to increase purchasing efficiency and cost effectiveness by increasing purchase card use for micro-purchases. During FY 2012, VHA spent about $3 billion on micro-purchases of $3,000 or less for supplies and services. VA's Purchase

Card Program allows VHA to streamline the procurement process and earn rebates from purchase card use. Although VHA has increased purchase card use over the past 5 years, opportunities still exist for VHA to achieve significant procurement savings. OIG estimated VHA could decrease procurement-processing costs by about $20 million and receive additional rebates of about $4 million annually by maximizing purchase card use for micro-purchases. VHA did not identify micro-purchases and establish yearly goals for using purchase cards. Additionally, VHA did not implement mechanisms to ensure purchase card use or establish policies and procedures requiring VISNs to perform oversight of non-purchase card micro-purchases. As a result, VHA could miss opportunities to achieve procurement savings ranging from approximately $102 to $133 million over the next 5 years, with an estimate of $120 million. OIG recommended the USH work with the VA Office of Management (OM) to establish policies and procedures to regularly identify and evaluate micro-purchases, and establish annual and long-term strategic goals to increase the percentage of VA medical facility purchase card micro-purchases. Additionally, OIG recommended the USH collaborate with OM to implement procedures to ensure purchasers and approvers adequately consider purchase card use for micro-purchases, including requiring VISNs to perform oversight of non-purchase card micro-purchases. The USH concurred with our findings and recommendations and has a plan for corrective action.

### OIG Recommends VHA Procurement & Logistics Office Conduct Annual Reviews of Duty Stations To Ensure Correct Salaries

OIG conducted this review to determine the merits of four allegations claiming VHA's Procurement and Logistics Office (P&LO) mismanaged travel, duty stations assignments, salaries, and funds. OIG substantiated two of the four allegations: P&LO did pay some employees the incorrect salaries for their duty station locations, and P&LO did improperly use the VA Supply Fund to pay for travel. However, OIG did not substantiate that P&LO authorized excessive, unnecessary travel or that employees were virtually stationed away from where they needed to work. OIG determined P&LO needs to strengthen internal procedures for approving travel. P&LO needs to ensure authorizing officials have direct knowledge of employee travel plans and only authorize travel after validating the necessity of the travel. P&LO paid three employees incorrect salaries due to inaccurate duty station assignments in FY 2010. Prior to OIG's review, P&LO identified the errors for two of the three employees and corrected the salaries and recouped related overpayments. The third employee was overpaid about $18,000 into FY 2013 because P&LO did not have standard procedures in place to ensure accurate duty station assignments. Finally, P&LO improperly augmented FY 2010 appropriations by using the VA Supply Fund to pay travel costs for an employee whose salary was funded through appropriations. P&LO did not have procedures in place to ensure appropriate use of the VA Supply Fund. OIG recommended the Chief Procurement and Logistics Officer implement controls to strengthen employee travel review and authorization. P&LO should initiate a periodic review of all employee duty station assignments to correct assignment errors and recoup incorrect payments as appropriate. While the USH concurred, the Principal Executive Director for the Office of Acquisitions, Logistics, and Construction (OALC) generally concurred with OIG's report 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.

## Changes Needed in Approval Methods for Veterans Retraining Assistance Program To Reach 99,000 Participants

During OIG's ongoing national audit of the Veterans Retraining Assistance Program (VRAP), OIG determined that if VBA continued to use the current method of counting authorized participants, Veterans' use of VRAP would not achieve the levels authorized by Congress. The *Veterans Opportunity to Work to Hire Heroes Act of 2011* authorized benefits for 99,000 participants from October 1, 2011, through March 31, 2014. In order not to exceed the authorized limit of participants, officials counted approved applicants as participants. However, not all approved applicants were actually participating in the program. As of February 2013, about 33 percent of the authorized participants were enrolled and receiving program benefits. OIG recommended VBA continue to accept applications until they have 99,000 Veterans enrolled in an approved training program or until October 1, 2013, the last date a Veteran may apply for program benefits. The Under Secretary for Benefits (USB) concurred with OIG's recommendations.

## VBA Needs To Do Better Job Verifying Payments on Foreclosure Maintenance, Closer Oversight Could Reduce Safety Risks

OIG conducted this audit to determine if the VBA Loan Guaranty Service (LGY) approved payments for allowable expenses submitted by VA's foreclosed property management contractor. In addition, the audit determined whether LGY ensured properties met safety, preservation, and maintenance requirements. LGY made payments for 528 of 890 individual expense items not supported by vendor invoices. This occurred because LGY did not ensure the contractor complied with the contractual requirement to provide the documentation necessary to demonstrate the appropriateness and legitimacy of expenses claimed for reimbursement. As a result, OIG found LGY made approximately $64,400 in payments from October 2010 through March 2012 for expense reimbursements submitted by the contractor without adequate supporting documentation. In addition, LGY did not timely notify the contractor of property maintenance exceptions that posed safety hazards or risk of immediate deterioration, or consistently ensure correction of these issues. This occurred because LGY policies did not require LGY staff to report maintenance exceptions and ensure correction. OIG recommended the USB ensure VBA's contractor provides vendor invoices to substantiate claimed expenses prior to reimbursement by LGY and determine whether it is cost effective to initiate recovery of improper payments. Additionally, OIG recommended the USB develop policies that ensure LGY staff report maintenance exceptions when identified and ensure contractor correction. The USB concurred with Recommendations 1 and 3 but did not concur with Recommendation 2. OIG revised Recommendation 2 to recognize that LGY can decide if recouping these improper payments from the prior property management contractor is cost effective. However, OIG reiterated that VBA paid some expenses that were not supported by sufficient evidence. Without adequate documentation to support expenses claimed, LGY cannot ensure prudent use of taxpayer funds in compensating the contractor for managing VA-owned foreclosed properties.

## VBA Pension Management Centers Need To Improve Timeliness of Payments to Low Income Veterans

OIG conducted this audit to determine if the Pension Management Centers (PMCs) processed pension payments accurately. VA paid nearly $5 billion in FY 2012 for pension benefits to over 500,000 low income Veterans or their beneficiaries. Delayed or incorrect payments have the potential to affect the economic status of eligible Veterans and beneficiaries. VBA can improve the timeliness, and therefore the accuracy, of pension payment processing. During a 1-year period, an estimated 93,000, or 18 percent of 514,000 Veterans and beneficiaries, experienced an average 15-month delay in receiving their new pension award or adjustments to their current payment. Delays resulted in $308 million in underpayments and $194 million in overpayments. This included

retroactive adjustments as early as 2006. Once PMC staff processed the claims, they correctly calculated pension payments for new awards and adjustments 96 percent of the time. The delays occurred for two primary reasons. First, PMCs did not process new awards and adjustments timely because of an increased workload and a lack of clear communication of priorities. Second, PMCs did not receive timely notification of changes that affected current pension benefits, and did not have an effective plan to reduce the time to collect income, expense, or dependency changes. In addition, VBA systems contained a small rate of duplicate pension records. VBA was aware of the potential for creating duplicate records and began taking action to control them. To reduce notification delays, the USB should ensure Pension and Fiduciary Service implement a plan to reduce under and overpayments due to changes in income and dependency, and establish and implement matching agreements. To reduce processing delays, the USB should ensure Pension and Fiduciary Service implement new triage and processing procedures at the PMCs. The USB should implement additional controls to identify and correct duplicate records. The USB concurred with OIG recommendations and provided plans for corrective actions.

### Weak Administration Could Cost VA $12M for Veterans' Not Meeting Full-Time Attendance Required for Retraining Program

OIG performed this audit to determine whether VBA's VRAP was administered to maximize Veterans' use of the program. Congress passed the *Veterans Opportunity to Work to Hire Heroes Act* authorizing VRAP in November 2011. As implemented by VA, VRAP offers training assistance to unemployed Veterans who are not eligible for any other VA education benefits program. Enrollment for this program expires in March 2014. Early in OIG's audit, OIG issued an interim report stating that VRAP would not achieve the participant levels authorized by Congress. The USB agreed with OIG recommendations to accept applications until VBA reached the enrollment limit for this program. This report identifies additional issues since the interim report. OIG found weak administration of the program allowed Veterans to enroll without complying with the program's full-time attendance requirements, and over half of those Veterans inaccurately certified their status as full-time students. OIG also identified situations where some school officials did not adequately monitor Veterans' academic progress or accurately report enrollment information. In addition, VBA could have better described the penalties for false certifications. VBA also approved one of the schools that did not have appropriate procedures as a training institution. OIG projected that VBA paid about $12 million to just over 2,300 Veterans who were not complying with VRAP attendance requirements. Without increased oversight and controls, VBA risks continuing inappropriate payments to Veterans who do not meet full-time attendance requirements. OIG recommended the USB reinforce the schools' requirement to monitor Veterans' progress and accurately report enrollments, clarify and establish procedures to manage VRAP, and warn Veterans of the penalty for incorrect certifications. If extended beyond March 2014, VBA needs stronger controls to ensure the long-term integrity of the program. The USB concurred with OIG recommendations and provided plans for corrective actions.

## Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's Veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VA Regional Offices (VAROs), focusing on disability compensation claims processing and performance of Veterans Service Center operations. The objectives of the Benefits Inspection Program 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. Benefits Inspections 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. These inspections may also examine issues or allegations

referred by VA employees, members of Congress, or other stakeholders. The Benefits Inspection Divisions issued 16 reports during this reporting period, which are listed in Appendix A.

Key findings included:

- Claims Processing: 39 percent of benefit claims reviewed requiring a rating decision were processed in error. These errors involved claims related to temporary 100 percent disability evaluations and TBI.
- Systematic Analysis of Operations (SAOs): 27 percent of SAOs reviewed were not completed timely and/or were incomplete.
- Homeless Veterans Outreach: 38 percent of VAROs inspected could not demonstrate adequate outreach efforts to homeless shelters and service providers.

## National Cemetery Administration Audit and Evaluation

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 NCA's program operations and provide VA with constructive recommendations to improve the delivery of benefits to deceased Veterans and their families.

### NCA Needs to Enforce Use of Competition, Make Full Use of Electronic Contracting System, and Fully Implement the Integrated Oversight Process Reviews

NCA transferred contract responsibilities from VHA to NCA's Office of Management Contracting Service in February 2008 to improve its acquisition process. NCA administered 574 contracts during calendar year 2012 with an estimated contract value of about $382 million. OIG conducted this audit to access the adequacy of contract development, award, administration, and oversight processes of the NCA Office of Management Contracting Services. OIG found that NCA did not have effective internal controls, or existing controls were not followed, to ensure adequate development, award, and administration of contracts. In a statistical sample of 50 competitive contracts and all 32 noncompetitive contracts, OIG found one or more contract deficiencies in each of the 82 contracts reviewed. Contract files did not always have sufficient evidence of acquisition planning, market research, and vendor past performance. NCA improperly awarded 16 of the 32 noncompetitive contracts, as opposed to competitively bid small business set-asides. Contracting officers did not consistently provide a complete history of contract actions in VA's mandatory Electronic Contract Management System (eCMS). Additionally, NCA did not conduct Integrated Oversight Process (IOP) reviews of 25 of the 36 competitive contracts and 24 of the 29 noncompetitive contracts that were required to be reviewed under this mandatory process. These deficiencies occurred because NCA did not have sufficient management staff in place to lead and manage the newly established organization. Without sufficient management oversight, NCA could not ensure internal controls were working properly or as planned when developing and awarding contracts. As a result, NCA cannot ensure awarded contracts consistently met the Federal Acquisition Regulation (FAR) and VA policies. OIG recommended NCA strengthen contracting processes and controls by enforcing the proper use of competition requirements, make full use of eCMS, and fully implement IOP reviews. The Under Secretary for Memorial Affairs agreed with OIG's recommendations and provided an appropriate action plan.

# 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, such as the use of funds for VA's minor construction program. OIG efforts focus on determining whether the Department is taking advantage of its full purchasing power when it acquires goods and services. Auditors examine how well VA is managing and safeguarding resources and inventories, obtaining economies of scale, and identifying opportunities to employ best practices.

OIG performs audits of Information Technology (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 also includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Management Act of 2002* (FISMA), P.L. 107-347, as well as IT security 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.

### VA in Compliance with Several Key Climate Change Mandates, but More Needed To Curb Greenhouse Emissions

In response to a February 25, 2013, request from the Congressional Bicameral Task Force on Climate Change, OIG assessed whether VA is doing all that it can to address this growing threat. OIG found VA partially complied with several key requirements but can do more to address climate change. VA has done considerable planning and met selected targets in the areas of energy management, water management, and green buildings sustainability. However, VA did not meet selected targets for reducing greenhouse gas emissions and fleet petroleum consumption. This was due to factors such as significant growth in VA programs, competing operational standards, and regulatory requirements. Since 2008, VA has increased staffing by 21 percent and expanded its fleet by 39 percent to better serve Veteran needs, but this has posed a challenge to meeting certain targets. Generally, VA had the authority needed to reduce heat trapping pollution emissions and strengthen its resiliency to climate change effects. OIG recommended the Executive in Charge for OM and Chief Financial Officer coordinate with the Acting Assistant Secretary of the Office of Human Resources and Administration (HR&A) to implement existing telework expansion plans and encourage VA employees to use alternative forms of commuting for reducing greenhouse gas emissions. The Executive in Charge should also identify additional strategies for meeting requirements to reduce both greenhouse gas emissions and fleet petroleum consumption. The Executive in Charge concurred with OIG's findings and recommendations and provided technical revisions that were incorporated in OIG's report as appropriate. HR&A planned to work with OM to address the report findings and recommendations.

## VA Could Spend Up to $17.5M for Excess Call Center Capacity and Duplicative Human Resource Services for Veteran Hiring Initiative

OIG evaluated whether HR&A had adequate controls to ensure its Veteran Employment Services Office (VESO) acquisitions were appropriate and justified. OIG found that HR&A acquired excess services to support VESO operations when it expanded an interagency agreement (IA) with the Office of Personnel Management (OPM) to provide two employment call centers operating 24 hours a day, 7 days a week. These call centers had call volumes so low during a 13-month period that each call center employee handled an average of 2.4 calls per day. Additionally, HR&A funded its IA to develop and maintain VESO's Veteran employment Web site, duplicating key components of existing HR&A and VBA employment Web sites. VESO also awarded a $4.4 million 1-year contract for human resources support services that duplicated its own internal capabilities and contracted for certain inherently Governmental functions. These acquisitions occurred because VESO did not conduct a thorough analysis to justify the need for the services. OIG estimated at least $13.1 million will be spent through FY 2015 on excess call center capacity unless corrective action is taken. These funds, and the estimated $4.4 million, could be better used to provide employment services to Veterans with greater efficiency and accountability. OIG recommended HR&A improve its acquisition practices by assessing program needs against VA's existing capacities and capabilities and by establishing program metrics. The Acting Assistant Secretary for HR&A concurred with OIG's findings and recommendations and provided an appropriate action plan.

## VA's Technology Acquisition Center Could Have Saved $108.7M By Competing Task Orders and Contracts for IT Services

The Technology Acquisition Center (TAC) awarded approximately 1,200 IT services contracts, valued at approximately $5.2 billion, from October 2010 through June 2012. OIG conducted this audit to determine whether the TAC awards and administers IT services contracts in accordance with the FAR and VA policy. OIG found no significant issues with 61 of 79 statistically selected IT services contracts. However, the TAC awarded 18 contracts that did not meet the FAR competition requirements. This occurred because the TAC did not adequately justify using an exception to the FAR competition requirements to award four of six task orders under two Indefinite Delivery/Indefinite Quantity (IDIQ) contracts valued at approximately $143.1 million. OIG extended its review procedures to include an additional 72 task orders processed under these contracts. The TAC used the same FAR exception for 16 of the 72 task orders valued at approximately $146.6 million. In addition, by not demonstrating IT services could not be obtained as conveniently or economically by contracting directly with a commercial source the TAC did not follow FAR requirements before awarding 14 Interagency Acquisitions valued at approximately $254 million. This occurred because VA's IOP reviews did not identify or prevent the TAC's noncompliance with the FAR requirements concerning competing task orders and using Interagency Acquisitions. OIG projects the TAC missed an opportunity to save approximately $57.9 million in acquisition costs by not competing IDIQ task orders. OIG also projects the TAC could have saved approximately $50.8 million by competing contracts among commercial sources instead of awarding Interagency Acquisitions. OIG made three recommendations to the Principal Executive Director for OALC to ensure that IDIQ task order awards and Interagency Acquisitions comply with FAR competition requirements. The Principal Executive Director for OALC concurred with the recommendations and provided an acceptable action plan.

## VA Incurred $13M Developing New System Functionality, Duplicating Existing Contract Management System

OIG conducted this review to assess the merits of an anonymous Hotline allegation that the Virtual Office of Acquisition (VOA) software development project was not managed under VA's Project Management Accountability System (PMAS) control and oversight. The complainant also alleged the VOA project was

unnecessary because VA already owned a system that met 95 percent of VOA's requirements. OIG substantiated the allegation that the VOA software development project was not managed under PMAS. TAC officials believed that because the OALC was managing VOA development, the project did not need PMAS oversight provided by VA's Office of Information and Technology (OIT). As such, the software development project was not centrally evaluated to ensure it would support the best mix of projects to minimize duplication and maximize VA's investment in IT. OIG partially substantiated the allegation that VOA development was unnecessary. OIG found VA owned eCMS, OALC's mandatory contract management system, which VOA functionality partially duplicated. The TAC did not develop a business case, as required under PMAS. Submitting a business case under PMAS could have minimized duplication and maximized VA's investment. By developing duplicative eCMS functionality, VA potentially incurred unnecessary costs of approximately $13 million. OIG recommended the Principal Executive Director for OALC implement controls to ensure that all future software developments fall under PMAS control. OIG further recommended the TAC be required to submit a business case justifying how the costs associated with duplicative system requirements and future system maintenance will be managed moving forward. The Principal Executive Director for OALC concurred with OIG recommendations and provided acceptable corrective action plans.

### OIG Questions Nearly $2M Spent on Separately Priced Items for Conferences, Recommends Discontinuing Agreements with OPM

VA reported spending approximately $15.5 million on three financial management training conferences in 2010 and 2011, using an IA with OPM. Of the $15.5 million VA reported spending on these conferences, about $6.7 million was spent on Separately Priced Item (SPI) purchases and related service fees. OIG conducted this review to assess VA's oversight of SPI purchases. Our review of three conferences found VA paid about $5.3 million of $6.7 million for goods and services the prime vendor should not have purchased as SPIs. Instead, VA and OPM should have identified essential goods and services and required the prime vendor to deliver them as firm-fixed-price tasks rather than as SPIs. VA and OPM did not approve all SPI purchases in advance, and VA paid the prime vendor for SPIs and service fees without adequate supporting documentation. VA paid the prime vendor about $697,000 in inappropriate service fees. Additionally, VA paid OPM about $132,000 in service fees associated with inappropriate SPI purchases. VA placed its trust and reliance on OPM to manage and administer the IA without establishing adequate oversight. This resulted in VA relinquishing its responsibility and accountability to sufficiently monitor and review conference-related expenditures. OIG questioned about $1.1 million in SPI purchases that could have been saved through competitive contracting. OIG also questioned $697,000 in prohibited service fees paid to the prime vendor and $132,000 in service fees paid to OPM associated with inadequate oversight. OIG recommended the Assistant Secretary for HR&A consider discontinuing the use of assisted acquisition IAs with OPM for training conferences and establish controls to improve oversight of SPIs purchased through existing assisted acquisition IAs with OPM. OIG recommended the Principal Executive Director for OALC update its policy to ensure a qualified individual with appropriate training in contracting is assigned to all IAs and take action to recover service fees paid to the prime vendor and OPM that were inappropriate or associated with inadequate oversight. The Assistant Secretary for HR&A and the Principal Executive Director for OALC concurred with OIG's recommendations and provided plans for corrective actions.

## *Federal Information Security Management Act* Compliance

In compliance with FISMA during this reporting period, OIG issued *VA's Federal Information Security Act Audit for Fiscal Year 2012*. 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 32 recommendations for improving VA's information security program. The Acting Assistant Secretary for OIT 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 consolidated financial statements for FY 2012 reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. This condition was due to one material weakness concerning IT security controls and one significant deficiency concerning undelivered orders. Also, the audit reported that VA's complex and disjointed financial system architecture resulted in a lack of common system security controls and inconsistent maintenance of critical systems. Consequently, VA continued to be challenged with consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and newly implemented systems. As a result, certain financial statement line items may not be readily re-created and supported by audit trails of detailed financial transactions. Not all current systems could be readily accessed and used without extensive manipulation, manual processing, and reconciliation.

## 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 181 cases; made 130 arrests; obtained nearly $2.9 million in fines, restitution, penalties, and civil judgments; and achieved over $2.1 million in savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, OIG opened 51 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Fifty defendants were charged with various crimes relating to drug diversion. These investigations resulted in $108,080 in fines, restitution, penalties, and civil judgments as well as $577,446 in savings, efficiencies, cost avoidance, and recoveries. OIG also initiated 14 investigations related to the fraudulent receipt of health benefits, which resulted in 20 defendants being charged with various related crimes. These investigations resulted in $810,099 in fines, restitution, penalties, and civil judgments as well as $26,649 in savings, efficiencies, cost avoidance, and recoveries. In addition, OIG initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, grossly inflating patient mileage to and from VA facilities to increase reimbursement for travel expenses. During this reporting period, judicial action related to these investigations included 5 arrests, 18 convictions, and 19 imprisonments as well as $632,471 in fines, restitution, penalties, and civil judgments along with $144,730 in savings, efficiencies, cost avoidance, and recoveries.

Additionally, during this reporting period, OIG opened 41 investigations regarding criminal activities by VHA employees (not including drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from Veterans, and theft of VA property or funds. Twenty-one defendants were charged with crimes; court ordered payments of fines, restitution, and penalties amounted to over $870,000 and over $1 million 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.

### East Orange, New Jersey, VAMC Former Supervisory Engineer Pleads Guilty to Fraud

A former supervisory engineer at the East Orange, NJ, VAMC pled guilty to a criminal information containing a variety of fraud charges. An OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service (IRS) Criminal Investigation Division (CID) investigation revealed that the defendant accepted kickback payments in connection with VA contracts awarded to companies he had relationships with and engaged in a scheme to defraud VA by falsely claiming one of the companies was owned by a service-disabled Veteran. The defendant also conspired with a partner to set up three companies that could be used to obtain VA contracts and then directed more than $6 million worth of VA construction projects to those companies. Of this amount, more than $3 million was paid to the falsely claimed Service-Disabled Veteran-Owned Small Business (SDVOSB). The defendant admitted to accepting approximately $1,275,000 in kickbacks in exchange for his official action and influence between 2007 and 2012.

## Cleveland, Ohio, VAMC Former Director Indicted on Multiple Charges

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Ex-director of VA hospital indicted on bribery charges

Contracts went to builder convicted of corruption

JAMES F. MCCARTY
*Plain Dealer Reporter*

The then-director of the Louis Stokes VA Medical Center in Cleveland accepted bribes and kickbacks from crooked contractor Michael Forlani in exchange for confidential information that helped Forlani receive VA contracts, according to a 36-count indictment released Wednesday.

Before retiring in 2010, William Montague used his influence as the medical center director to steer companies to lease office space from Forlani, the indictment states. The indictment also accuses Montague of performing consulting work for a private company seeking business from the VA at the same time he was employed by the VA.

The 51-page indictment also charges Montague, 61, with money laundering, wire fraud, mail fraud and conspiring to defraud the Department of Veterans Affairs in league with Forlani, the former owner of Doan Pyramid Electric and head of Veterans Development LLC.

Montague is one of more than 60 elected officials, public employees and contractors implicated in a federal investigation of corruption in Cuyahoga County. Among those convicted and serving prison terms are former County Commissioner Jimmy Dimora and former Auditor Frank Russo.

The latest indictment describes cash bribes totaling more than $200,000, including 18 separate transactions in which nearly $50,000 was emailed from an unidentified business in Texas to Montague in Reckaville.

Montague was arrested Wednesday and appeared in U.S. District Court in Cleveland, where he pleaded not guilty to the charges.

Assistant U.S. Attorney Antoinette Bacon said the charges carry potential maximum prison sentences of five, 10, 15 or 20 years each, plus tens of thousands of dollars in fines and forfeiture provisions.

SEE VA | A6

Montague

**William Montague**
Accused of money laundering, wire fraud, mail fraud and conspiring to defraud the Department of Veterans Affairs.

Forlani

**Michael Forlani**
Serving eight years in federal prison for racketeering, bribery and other corruption-related crimes, but none involving the VA.

Cleveland, OH, VAMC was arrested as the result of an OIG and FBI investigation that included the execution of a search warrant at the defendant's residence. The defendant was indicted for conspiracy to commit mail and wire fraud and honest services mail and wire fraud, bribery of public officials, disclosing public contract information, acts affecting a personal financial interest, activities of employees in claims against and other matters affecting the Government, false statements, a 1-year ban on communications, wire fraud, mail fraud, and money laundering. The investigation revealed that the defendant engaged in the fraudulent activity while he was the director at two different VAMCs and after his retirement from VA.

The suspects, veterans themselves, allegedly distributed heroin and crack cocaine at VA medical centers in Lyons and East Orange

SEVEN CHARGED WITH SELLING DRUGS TO VETS

Thomas Pearson, above left, and Christopher Shalaby, above right, leave the federal courthouse in Newark yesterday. They were among seven men arrested on charges of selling heroin and crack cocaine to veterans. The case grew out of a heroin overdose at the VA medical center at Lyons two years ago.

By Ted Sherman | STAR-LEDGER STAFF

In a case that grew out of a fatal drug overdose at the VA medical center at Lyons two years ago, federal authorities yesterday arrested seven men — including five hospital employees — on charges of selling heroin and crack cocaine to veterans in various treatment programs.

Those arrested, all veterans themselves, were charged with various counts of possession and distribution, including the sale of heroin, crack and hydromorphone, a narcotic for pain.

Many had records of serious substance abuse problems and all but two were held without bail after a brief preliminary hearing yesterday afternoon before U.S. Magistrate Judge Mark Falk in Newark.

Federal authorities said the men sold drugs to patients of the VA hospitals at both East Orange and Lyons in Bernards undergoing treatment for drug abuse.

"These seven men abused their access to VA medical facilities to peddle dangerous drugs to other veterans undergoing treatment," said U.S. Attorney Paul Fishman.

A spokeswoman for the VA hospitals would not comment on the arrests, or say whether any of those employed by Veter-

said Sandra Warren in a statement. "The safety and welfare of veterans in our care is of primary importance, and the VA New Jersey Health Care System is cooperating fully with the U.S. Attorney's Office, VA Office of Inspector General, and the FBI in this investigation."

Jeffrey Hughes of the U.S. Veterans Af-

## OIG, FBI Operation to Combat Sale of Heroin and Crack Cocaine at Two VAMCs in New Jersey Results in Seven Arrests

Seven Veterans were arrested on Federal drug distribution charges. The arrests were the result of a 2-year OIG, FBI, and VA Police Service investigation undertaken following the death of a Veteran at the Lyons, NJ, VAMC from a drug overdose. The subsequent investigation resulted in the purchase of various drugs including heroin, crack cocaine, and pharmaceuticals from the defendants on VA property. Following arraignment, five of the defendants were remanded into custody based on their extensive criminal histories.

## Former Lyons, New Jersey, VAMC Patients Plead Guilty to Concealing the Death of Veteran

A former Lyons, NJ, VAMC patient pled guilty to misprision of the felony of distribution of heroin. A second former VAMC patient pled guilty to obstruction of justice. An OIG investigation revealed that the defendants used heroin in the victim's room at the medical center. While using the drug, the Veteran collapsed and the defendants departed the room and failed to notify staff. The deceased victim's body was discovered the next morning, and the body's positioning

initially led OIG to investigate his death as an apparent accidental suicide. Subsequent information developed through a confidential source revealed that one of the defendants actually administered the heroin to the victim. After the victim died, the same defendant propped up the body to make it appear as though the Veteran had taken the heroin and overdosed on his own.

### Three Former New Orleans, Louisiana, VAMC Employees Sentenced for Health Care Fraud

Three former New Orleans, LA, VAMC employees were sentenced after pleading guilty to health care fraud for their role in a fraud scheme involving the billing of the medical center for services not rendered. The first defendant was sentenced to 24 months' incarceration and 3 years' supervised release. The second defendant was sentenced to 15½ months' incarceration and 3 years' supervised release. The third defendant was sentenced to 17 months' incarceration and 3 years' supervised release. All of the defendants were ordered to pay VA varying amounts of restitution totaling $563,986.

### Seattle, Washington, VAMC Travel Clerks and Veterans Sentenced for Travel Benefit Fraud

A Seattle, WA, VAMC travel clerk was sentenced to 42 months' incarceration and 3 years' supervised release. A second travel clerk in the same office was sentenced to 37 months' incarceration and 3 years' supervised release. Both defendants were also ordered to pay a total of $181,114 in restitution after pleading guilty to conspiracy to defraud the U.S. Government and bribery. Two Veterans, who cooperated during the investigation, were sentenced to 3 years' supervised release and ordered to pay restitution of $23,089 and $19,992, respectively. A third Veteran was sentenced to 4 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $21,260. An OIG investigation revealed a scheme in which the travel clerks recruited Veterans to submit inflated and fictitious travel benefit vouchers. The clerks then received kickback payments from the Veterans. The loss to VA is in excess of $188,000.

### Former Tampa, Florida, VA Employee Faces Prison, Fines If Convicted of Misusing Patient Information for Personal Financial Gain

A Tampa, FL, VAMC medical support assistant was indicted and subsequently arrested for wrongful disclosure of health information, access device fraud, and aggravated identity theft. An OIG and local police investigation revealed that the defendant stole patients' personal identifying information (PII) from the medical center and exchanged the information with another person for crack cocaine. The stolen information was subsequently used to file $575,261 in fraudulent tax returns.

In another case at the Tampa, FL, VAMC, two non-Veterans were arrested for aggravated identity theft, access device fraud, theft of Government funds, and conspiracy to defraud the United States. An OIG, IRS CID, and local police investigation revealed that one defendant, a former Tampa, FL, VAMC volunteer, stole patients' PII from the Tampa, FL, VAMC and traded the information with a second defendant for crack cocaine. The second defendant subsequently used the VA PII and additional PII to file approximately $550,000 in fraudulent tax returns.

### Philadelphia, Pennsylvania, VAMC Nursing Home Employee and Accomplice Sentenced After Pleading Guilty to Theft by Deception

A Philadelphia, PA, VAMC nursing home employee and her accomplice were sentenced after pleading guilty to theft by deception. The former employee was sentenced to 11½ to 23 months' house arrest and 5 years' probation. Additionally, the former employee's license as a Certified Nursing Assistant was ordered revoked. The co-defendant was sentenced to 4 years' probation. An OIG and local police investigation revealed that the perpetrators stole a Veteran's credit card, fraudulently charged purchases and attempted to make an additional

$5,000 of charges to the card. Additionally, the former VA employee admitted to stealing cash from various Veterans while being employed at the VA nursing home.

### Former Pittsburgh, Pennsylvania, VAMC Program Support Clerk Charged with Theft of Government Funds and False Statements

A former Pittsburgh, PA, VAMC program support clerk was charged in a criminal information with theft of Government funds and false statements. An OIG and VA Police Service investigation revealed that the defendant submitted to VA a fraudulent Special Order document from the PA Air National Guard. The Special Order stated that the defendant was being deployed for active duty, and as a result, VA placed the defendant into a military leave and pay status entitling the defendant to special leave and pay benefits. The investigation determined that the defendant accepted employment with a local township government and never reported for active duty. The defendant received $14,164 in special leave and pay benefits, which included health care benefits.

### Topeka, Kansas, VAMC Neurologist Sentenced for Sexual Battery

A Topeka, KS, VAMC neurologist was sentenced to 32 months' incarceration for aggravated sexual battery and 12 months' incarceration (concurrent) for sexual battery. The defendant was granted a suspended imposition of sentence and received 36 months' probation. An OIG, VA Police Service, and local police investigation revealed that the defendant administered full pelvic examinations, without a chaperone, to five patients without any medical necessity for such procedures.

### Augusta, Georgia, VAMC Nurse Arrested for Assault

An Augusta, GA, VAMC nurse was arrested for assault. An OIG and VA Police Service investigation revealed that the defendant entered a patient's room, while two other staff members attempted to treat the patient, and punched the patient causing fractured ribs.

### Long Beach, California, VAMC Health Care Technician Arrested for Theft and False Statements

A Long Beach, CA, VAMC health care technician was indicted and arrested for theft and false statements. An OIG investigation confirmed the results of an administrative investigation concerning time card fraud by the defendant, who was terminated from employment. The defendant submitted fraudulent attendance and overtime information to her timekeeper and was paid for 1,695 hours of overtime pay. The loss to VA is $55,502.

### Former Jamestown, New York, CBOC Nurse Indicted for Drug Violations

A former registered nurse at the Jamestown, NY, VA CBOC was indicted and arrested for conspiracy, possession with intent to distribute a controlled substance, and obtaining a controlled substance by fraud. An OIG and local police investigation determined that the defendant stole prescription forms from a nurse practitioner at the clinic and subsequently forged prescriptions for Oxycontin that she then sold to co-conspirators for cash. A friend of the defendant was also arrested and charged with possession of a controlled substance and possession of a forged instrument. The friend received multiple forged Oxycontin prescriptions in his name from the defendant and filled them at local pharmacies.

### Former Nashville, Tennessee, VAMC Nursing Assistant Sentenced for Elder Abuse

A former Nashville, TN, VAMC certified nursing assistant was sentenced to 12 months' incarceration (suspended), 12 months' supervised probation, and a $444 fine after pleading guilty to abuse or neglect of an impaired adult. The sentencing prohibits the defendant from working as a nursing assistant during the probationary period. An OIG investigation revealed that the defendant removed fentanyl patches from

terminally ill patients and either placed them on his own body or chewed them to support his drug addiction. The employee resigned from his position at the VAMC after conviction.

### Former Martinsburg, West Virginia, Registered Nurses Sentenced for Drug Diversion

A former Martinsburg, WV, registered nurse was sentenced to 14 days' incarceration after previously pleading guilty to acquiring and obtaining a controlled substance by fraud. An OIG and VA Police Service investigation revealed that on approximately 78 occasions the defendant retrieved controlled medication from the facility's automated Pyxis medication dispensers using the names of VA patients whose electronic medical records indicated they did not receive the drugs.

In another case at the Martinsburg, WV, VAMC, a former registered nurse pled guilty to acquiring and obtaining a controlled substance by fraud, deception, and subterfuge. An OIG and VA Police Service investigation determined that on approximately 23 occasions the defendant retrieved controlled medication from the facility's automated Pyxis medication dispensers using the names of VA patients whose electronic medical records indicated that they did not receive the medication.

### Former Roseburg, Oregon, VAMC Pharmacy Technician Pleads to Drug Diversion

A former Roseburg, OR, VAMC pharmacy technician pled guilty to receipt of stolen property. An OIG and Drug Enforcement Administration (DEA) investigation revealed that for over 18 months the defendant received a portion of over 6,000 tablets of controlled narcotics from another pharmacy technician. These thefts occurred through the posting of false drug orders in the Vista Database. The loss to VA is approximately $23,475.

### Former Palo Alto, California, VAMC Nurse Indicted for Drug Diversion

A former Palo Alto, CA, VAMC registered nurse was indicted for theft of Government property and obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant diverted approximately 1,200 syringes of hydromorphone by taking the doses that she claimed to have given to patients, logging in under the profiles of other nurses, or initiating false wasting entries under both her profile and those of the other nurses.

### San Francisco, California, Social Worker Resigns After Drug Theft

A former San Francisco, CA, social worker resigned her position after an OIG investigation determined that she entered a Veteran's room and stole his prescription morphine.

### Bristol, Virginia, Outpatient Clinic Practical Nurse Pleads Guilty to Drug Theft

A Bristol, VA, Outpatient Clinic licensed practical nurse pled guilty to acquiring and obtaining a controlled substance by misrepresentation, fraud, forgery, deception, and subterfuge. An OIG and VA Police Service investigation revealed that the defendant stole controlled substances from VA patients during scheduled medication counts.

### Manchester, New Hampshire, VAMC Physician Sentenced for Fraudulently Obtaining Controlled Substances

A Manchester, NH, VAMC physician was sentenced to 3 years' probation as a result of his conviction for fraudulently obtaining controlled substances. A VA OIG, DEA, and OPM OIG investigation disclosed that from June 2010 to January 2011, the defendant wrote approximately 17 prescriptions (68,760 total milligrams) for oxycodone and Oxycontin that were not documented in the medical records of one of his patients. Some of these prescriptions were written for the patient after the defendant went on workers' compensation leave. This

was in addition to 82,800 mg of oxycodone and Oxycontin that the patient received from VA during the same time period. The patient later provided some of these pills to the defendant. As part of his plea agreement, the defendant agreed to surrender his DEA registration and to never seek another one. The defendant also entered into a separate civil agreement to resolve allegations that he violated Federal regulations when he issued prescriptions that were not for a legitimate medical purpose and were outside the scope of his DEA registration. While not admitting to any wrongdoing, the defendant paid $25,000 to resolve his potential civil liability.

### Former Biloxi, Mississippi, VAMC Nurse Sentenced for Prescription Forgery

A former Biloxi, MS, VAMC nurse was sentenced to 3 years' probation and fined $1,300 after pleading guilty to prescription forgery. An OIG and state law enforcement investigation revealed that the defendant used the names and PII of two Veterans from the medical center in order to fraudulently obtain narcotics from retail pharmacies.

### Atlanta, Georgia, VAMC Pharmacist Arrested for Theft

An Atlanta, GA, VAMC pharmacist was arrested on theft charges. An OIG investigation revealed that the defendant stole pills from the VA pharmacy and attempted to conceal them in her personal bag. The defendant subsequently admitted that the drugs were stolen.

### Former Cleveland, Ohio, VAMC Nurse Sentenced for Theft of Dangerous Drugs

A former Cleveland, OH, VAMC nurse pled guilty to theft of dangerous drugs and was subsequently sentenced to 18 months' probation. An OIG and VA Police Service investigation revealed that the defendant stole vials of fentanyl, midazolam, and lidocaine, as well as syringes and needles from the medical center.

### Defendants Sentenced for Drug Violations

A Veteran entered into an 18 month Pre-Trial Diversion (PTD) program after being charged with the sale of schedule III substances. A non-Veteran pled guilty to attempted trafficking in oxycodone and was sentenced to 18 months' incarceration. A VA employee was sentenced to 6 months' incarceration, 5 years' probation, and 500 hours' community service after being convicted at trial for the sale of oxycodone. Operation Tango Vax, a 7-month multi-agency diversion task force operation, 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 by VA employees, Veterans, and their associates. The investigation identified that the majority of all criminal activity occurred at the medical center and resulted in the seizure of over 3,000 oxycodone pills, 2 vehicles, and $180,920.

### Veteran Arrested at VA Facility for Drug Trafficking

A Veteran was arrested at the Charlotte, NC, CBOC for drug trafficking and maintaining a dwelling in furtherance of narcotics trafficking. An OIG and local law enforcement investigation revealed that the defendant sold his VA-provided oxycodone to other people, to include an undercover officer. The Veteran was held on a $100,000 secured bond.

### Veteran Sentenced for Drug Trafficking

A Veteran was sentenced to 87 to 117 months' incarceration and ordered to pay a $50,000 fine and $2,254 in court costs after being convicted of trafficking in opium or heroin. An OIG and local drug task force investigation revealed that the defendant sold his VA-provided hydrocodone to other people, to include an undercover officer.

### Non-Veteran Sentenced for "Stolen Valor"

A non-Veteran was sentenced to 10 months' incarceration, 36 months' supervised release, and ordered to pay $100,012 in restitution after pleading guilty to theft of Government property. An OIG investigation revealed that the defendant never served in the U.S. Marine Corps and was previously removed from the Naval Reserve Officer Training Corps. The defendant admitted to lying about being a Marine Corps combat Veteran and receiving injuries from an improvised explosive device while serving in Afghanistan in order to fraudulently receive VA medical benefits.

### Former Rochester, New York, VA Employee Arrested for Workers' Compensation Fraud

A former Rochester, NY, CBOC employee was arrested for making false statements to obtain Federal employee compensation. An OIG and Department of Labor (DOL) OIG investigation revealed that the defendant, who claimed an on-duty back injury and that she could only work for VA a limited number of hours each day, failed to disclose to DOL or VA that she was working at a liquor store that she owned and operated. The defendant was observed on numerous occasions working at her store after her limited shift at VA.

### Former Miami, Florida, VAMC Chief of Canteen Service Arrested for Organized Fraud and Grand Theft

A former Miami, FL, VAMC chief of canteen service was arrested for organized fraud and grand theft. An OIG investigation revealed that the defendant stole VA property, cash, a laptop, a Blackberry, misused his Government issued travel card, and negotiated several bad checks. The loss to VA is $22,450.

### Texas Valley Coastal Bend HCS VA Nurse Educator Indicted for Forgery

A VA nurse educator at the Texas Valley Coastal Bend HCS was indicted for forgery, tampering with Government records, and misdemeanor perjury. An OIG investigation revealed that the defendant falsified training records by forging the signatures of several VA employees on fraudulent course rosters and posting the data to the VA Talent Management System in an attempt to obstruct a VHA audit of the Resuscitation Education Initiative Program. The defendant also lied to OIG special agents during the course of the investigation resulting in the misdemeanor perjury charge.

### Asheville, North Carolina, VAMC Employee Indicted for Obtaining Property Under False Pretenses

An Asheville, NC, VAMC employee was indicted for obtaining property under false pretenses. An OIG investigation determined that the defendant used a Government issued credit card to purchase items for personal use. This was the second time in 2 years that the defendant misused a Government credit card. The loss to VA is $4,293.

### Waco, Texas, VAMC Police Service Employee Arrested for Theft

A Waco, TX, VAMC Police Service employee was arrested and indicted for theft of Government property and access device fraud. A VA OIG and General Services Administration (GSA) OIG investigation revealed that the defendant fraudulently used the GSA fleet vehicle credit card to purchase gas and services for others in exchange for cash.

### Former Memphis, Tennessee, VAMC Employee Sentenced for Theft

A former Memphis, TN, VAMC employee was sentenced to 2 years' probation and ordered to pay $6,792 in restitution after pleading guilty to theft of property over $1,000. An OIG and VA Police Service investigation determined that the defendant used a Government issued credit card to purchase items for personal use.

### Veteran Sentenced to Prison for Travel Benefit Fraud

A Veteran was sentenced to 4 months' incarceration, 2 years' probation, and ordered to pay VA $9,173 in restitution after pleading guilty to fraudulent schemes. An OIG investigation revealed that the defendant submitted false travel claims to the Prescott, AZ, VAMC claiming that she was traveling over 500 miles roundtrip, when in actuality she was traveling only 180 miles.

### Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 4 months' incarceration, 36 months' probation, and ordered to pay VA $30,448 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant submitted approximately 150 fraudulent travel claims reporting 500 miles of round trip travel from Yuma, AZ, to the Tucson, AZ, VAMC. The defendant resided within a few blocks of the Tucson, AZ, VAMC.

### Veteran Sentenced for Travel Benefit Fraud

A Veteran, who previously pled guilty to filing false claims for travel benefits, was sentenced to 5 years' probation and ordered to pay VA $17,361 in restitution. An OIG investigation disclosed that from June 2009 to February 2012, the defendant submitted 156 false travel claims reporting that he was driving to the Togus, ME, VAMC from locations that were over 300 miles roundtrip, when in actuality he resided only 3 miles from the VAMC.

### Veterans Sentenced for Theft of VA Travel Benefits

A Veteran was sentenced to 60 months' probation, 100 hours' community service, and ordered to pay restitution of $57,535 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant had submitted fraudulent travel benefit vouchers to the Bay Pines, FL, VAMC since 1998. The defendant claimed that he resided in Sebring, FL, and traveled 224 miles roundtrip, when in actuality he lived in St. Petersburg, FL, and only traveled approximately 18 miles roundtrip to the medical center.

In another case at the Bay Pines, FL, VAMC, a Veteran was sentenced to 15 months' incarceration and ordered to pay restitution of $3,796 after pleading guilty to grand theft. An OIG investigation revealed that the defendant filed 101 fraudulent travel vouchers at the Bay Pines, FL, VAMC claiming that he traveled 55 miles roundtrip from Sarasota, FL, when in actuality he resided in St. Petersburg, FL, and only traveled approximately 18 miles per trip.

### Veteran Indicted for False Travel Claims

A Veteran was indicted for false claims after an OIG investigation revealed that he submitted 146 false travel claims to the Albuquerque, NM, VAMC. The investigation revealed that the defendant was certifying that he was traveling approximately 400 miles roundtrip when in actuality he was residing in Housing and Urban Development-Veterans Affairs Supportive Housing in Albuquerque, NM. The loss to VA is approximately $24,000.

### Veteran Sentenced to Incarceration for VA Travel Benefit Fraud

A Veteran was sentenced to 72 months' incarceration and ordered to pay VA $3,712 in restitution after pleading guilty to felony theft. An OIG and VA Police Service investigation revealed that the defendant claimed that he traveled 205 miles round trip to the Mountain Home, TN, VAMC, when in actuality he resided approximately 7 miles from the medical center.

### Veteran Sentenced to Incarceration for VA Travel Benefit Fraud

A Veteran was sentenced to 8 months' incarceration, 3 years' supervised release, 200 hours' community service, and ordered to pay restitution of $5,893 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant filed false travel claims for travel from Tallahassee, FL, to the Lake City, FL, VAMC. In actuality, the defendant resided in Lake City, FL. Also, the defendant committed an identical fraud in 2011.

### Veteran Indicted for VA Travel Benefit Fraud

A Veteran was indicted for false, fictitious, or fraudulent claims and fraudulent acceptance of payment after an OIG investigation revealed that he submitted 259 fraudulent travel claims utilizing 11 different addresses. The defendant and an unindicted co-conspirator also stole appointment slips from a fee basis provider and utilized the stolen documents for travel benefits. The loss to VA is $18,961.

### Veteran Sentenced for VA Travel Benefit Fraud

A Veteran was sentenced to 4 months' home detention, 5 years' probation, and ordered to pay $15,878 in restitution. An OIG investigation revealed that the Veteran filed multiple false travel claims for daily travel from Tallahassee, FL, to the Gainesville, FL, VAMC. The defendant actually drove to Gainesville at the beginning of the week, slept in a vehicle or at a motel each night, and then returned to Tallahassee at the end of the week.

### Veteran Sentenced for VA Travel Benefit Fraud

A Veteran was sentenced to 30 days' incarceration, 36 months' probation, and ordered to pay $8,882 in restitution after pleading guilty to organized scheme to defraud. An OIG investigation revealed that the defendant submitted fraudulent travel voucher claims with fictitious addresses to the Miami, FL, and West Palm Beach, FL, medical centers in order to obtain $8,882 in travel reimbursement payments.

## 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 Veteran 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 17,516 possible cases with over 3,249 investigative cases opened. Investigations have resulted in the actual recovery of $71.1 million, with an additional $24 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $158 million. To date, there have been 640 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 163 investigations, made 85 arrests, and had a monetary impact of over $6 million in fines, restitution, penalties, and civil judgments as well as more than $9.5 million in savings, efficiencies, cost avoidance, and recoveries during this reporting period. One hundred and thirty-four 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 70 defendants for these types of investigations, and OIG obtained over $4.6 million in court ordered payment of fines, restitution, and penalties and also achieved an additional $7.8 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.

### Veterans Sentenced for VA Compensation Fraud

A Veteran was sentenced to 12 months' home detention, 36 months' supervised release, 100 hours' community service, and ordered to pay $70,912 in restitution after pleading guilty to wire fraud. A second Veteran was sentenced to 12 months' home detention, 36 months' supervised release, and ordered to pay $73,737 in restitution after pleading guilty to wire fraud. A third Veteran was sentenced to 8 months' home detention, 36 months' supervised release, and ordered to pay $56,304 in restitution after pleading guilty to wire fraud. From 2003 to 2011, while working at the Maryland Department of Veterans Affairs, an employee created fraudulent doctor notes and amendment forms, commonly referred to as DD-215s, as part of claims for service connected disabilities. An OIG investigation revealed that the State employee solicited and received cash payments from the Veterans in exchange for assistance with their claims. The doctor's notes claimed that the Veterans had been diagnosed with diabetes and were insulin dependent. The fraudulent DD-215s were used as proof of service in Vietnam. The State employee also filed a fraudulent DD-215 form to increase his own rating for post-traumatic stress disorder (PTSD). A total of 17 Veterans received compensation benefits using the fraudulent forms. The loss to VA is $1,151,219. The State employee also assisted the Veterans in receiving $255,555 in property tax waivers from the state that they were not entitled to receive.

### Former VA Fiduciary Pleads Guilty to Immigration Charge

A former VA fiduciary pled guilty to harboring a foreign national. A female co-defendant also pled guilty to a similar immigration charge. An OIG investigation revealed that the VA fiduciary became romantically involved with the co-defendant and helped arrange a fraudulent marriage between the co-defendant and an incompetent Veteran. The VA fiduciary and co-defendant subsequently embezzled funds from the Veteran to help fund immigration fees and living expenses. The fiduciary has agreed to make full restitution.

### Three Former Veteran Caretakers Sentenced for Conspiracy and Theft of Government Funds

Three former Veteran caretakers were sentenced after pleading guilty to conspiracy and theft of Government funds. The first defendant was sentenced to 24 months' incarceration, and the other two defendants were sentenced to 16 months' incarceration. Additionally, all defendants were ordered to serve 3 years' supervised release. An OIG and U.S. Postal Inspection Service (USPIS) investigation revealed that the defendants applied for and received VA pension benefits without the knowledge of the Veteran while he resided in their personal care home. The defendants used a post office box to receive all of the Veteran's VA benefit checks from August 2003 to October 2010. The approximate loss to VA is $123,000.

### Former VA Fiduciary Arrested for Misappropriation by a Fiduciary

A former VA fiduciary was arrested for misappropriation by a fiduciary. An OIG investigation determined that the former fiduciary, who was a former attorney and former police officer, embezzled approximately $130,000 of VA benefits from his brother-in-law, a disabled Veteran.

### Former VA-Appointed Guardian Pleads Guilty to Misappropriation by a Fiduciary

A former VA-appointed guardian pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the defendant stole funds payable to his sister, who is the incompetent dependent of a deceased Veteran, and used the funds for his personal use. The loss is approximately $153,000.

### Former Fiduciary Arrested for Misappropriation

A former fiduciary was arrested after being indicted for misappropriation by a fiduciary. An OIG investigation revealed that from October 2004 to September 2010 the defendant embezzled approximately $251,534 by submitting fraudulent accountings and fictitious certificate of deposit forms to VA. In the accountings, the defendant claimed that $244,857 of the Veteran's assets were in savings and certificate of deposit accounts, when, in actuality, there was less than $100 in the accounts. The defendant admitted to fabricating the financial records to prevent VA from terminating her as the Veteran's fiduciary.

### Former Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 41 months' incarceration, 36 months' supervised probation, and ordered to pay $639,618 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant embezzled $460,679 of VA benefits and $176,246 of Social Security benefits from an incompetent Veteran. The defendant admitted to submitting fraudulent accountings to both VA and the court by altering reports and creating fraudulent certificates of deposit.

### VA Appointed Fiduciary Indicted for Misappropriation

A VA appointed fiduciary was indicted for theft of Government funds, misappropriation by a fiduciary, and false statements after an OIG investigation revealed he misused funds intended for his Veteran brother. As a result of his actions, the Veteran sustained a loss of approximately $50,000.

### VA Fiduciary Indicted for Misappropriation by a Fiduciary

A VA fiduciary was indicted for misappropriation by a fiduciary. An OIG investigation revealed that the defendant, who is the Veteran's sister, used the Veteran's VA funds for personal expenses and for approximately 2 years failed to pay the Veteran's mortgage payments. The Veteran's home subsequently entered into foreclosure status as a result of the defendant's actions.

### Former Chicago, Illinois, VARO Employee Sentenced for Theft

A former Chicago, IL, VARO employee, who was a union official, was sentenced to 24 months' probation and ordered to pay restitution of $18,662 after pleading guilty to theft. The defendant resigned prior to being terminated. An OIG and DOL investigation revealed that the defendant withdrew funds from a union account for personal use, forged the signatures of other union officials to checks written to himself, and purchased two computers for personal use with a union debit card.

### Veteran Indicted for VA Home Loan Guaranty Fraud

A Veteran was indicted for fraudulently obtaining a $58,000 VA Home Loan Guaranty. An OIG investigation determined that the defendant falsely certified to VA that he would occupy the home as his primary residence. The defendant provided a fraudulent lease agreement to VA and the lender regarding his primary residence in order to qualify for the home loan. In 2011, the defendant refinanced the home and again falsely certified that he had previously occupied the home as his primary residence. The defendant subsequently admitted that he never intended to occupy the home as his primary residence, and in fact, purchased the home for his son.

### Veteran Pleads Guilty to Theft and Making False Statements

A Veteran pled guilty to theft of Government funds and making false statements after a VA OIG, U.S. Postal Service (USPS) OIG, and DOL OIG investigation revealed that he was committing workers' compensation fraud against the Postal Service and disability fraud against VA by claiming he could not work due to his medical issues. The investigation further determined that the defendant was coaching little league sports, going on vacations, breeding and selling dogs for profit, and lifting heavy objects. The loss to VA is $51,269 and the loss to the Postal Service is in excess of $288,000.

### North Carolina Man Admits To Lying About Physical Condition to VA, Judge Orders $519K in Restitution and 2 Years in Prison

A Veteran was sentenced to 2 years' incarceration, 3 years' supervised release, and ordered to pay VA restitution of $519,293 and the Social Security Administration (SSA) restitution of $7,575. A VA OIG and SSA OIG investigation revealed that the defendant submitted false statements in order to receive various VA compensation benefits based on the loss of use of his hands and feet due to Reflex Sympathetic Dystrophy. The defendant, who received approximately $7,500 per month from VA, was able to ambulate without any human or mechanical assistance and carry out other self-sufficient daily activities.

### Veteran Indicted for Theft of Government Funds and Illegally Possessing Weapons, Wife Indicted for Theft of Government Funds

A Veteran and his wife were indicted for theft of Government funds after an OIG investigation revealed that he fraudulently received more than $7,000 per month in VA compensation benefits by claiming the loss of use of both legs. Surveillance video showed the Veteran ambulating freely on several occasions, driving an automobile unattended, moving hay bales, and driving a riding lawnmower. After the initial indictment, the defendant failed to register as a sex offender after moving back to North Carolina and was subsequently indicted for that as well. Police reports filed by the defendant in 2011 claimed firearms were stolen from his home. Subsequent investigation revealed the defendant's mother and stepfather had purchased over 23 firearms for him in 2011. As a result, a second superseding indictment was filed charging the defendant with being a convicted felon in possession of firearms and conspiracy. The defendant's mother and stepfather were also indicted for conspiracy and making material false statements intended to deceive Federal licensed firearms dealers.

### Veteran Indicted for Compensation Fraud

A Veteran was indicted and subsequently arrested for theft of Government funds and mail fraud. A VA OIG and USPS OIG investigation revealed that the defendant, who was in receipt of VA individual unemployability benefits as well as other Federal disability benefits, reported he was unemployed and had no income. The investigation determined that the defendant owned and operated an auto sales and laundromat business and also owned several rental properties. The loss to the Government is approximately $500,000, which includes VA's loss of approximately $125,000.

### Veteran Pleads Guilty to VA Compensation Fraud

A Veteran pled guilty to making materially false statements after an OIG and USPIS investigation determined that the defendant was employed while in receipt of VA individual unemployability benefits. The defendant purportedly created a medicinal remedy for several serious ailments and received monetary compensation as well as royalties for his product. The defendant subsequently sold stock in his product, which was later determined to be fraudulent. The loss to VA is $82,912.

### Veteran Pleads Guilty to Using a False Military Discharge Certificate

A Veteran pled guilty to using a falsely altered military discharge certificate. An OIG investigation revealed that the defendant applied for VA benefits in 2010 claiming PTSD from combat service in Vietnam. The Veteran submitted an altered DD-214 reflecting 2 years of combat service, multiple medals for valor, and injuries sustained in combat. The investigation determined that the Veteran never served in Vietnam and made multiple false statements for the purpose of receiving VA benefits.

### Veteran Sentenced for Theft of Government Benefits

A Veteran was sentenced to 18 months' incarceration, 3 years' supervised probation, and ordered to pay $221,500 in restitution to VA and $174,926 in restitution to SSA after pleading guilty to theft of Government funds and false statements to obtain Federal benefits. A VA OIG, USPS OIG, and SSA OIG investigation revealed that the defendant, who was in receipt of VA individual unemployability as well as other Federal disability benefits, reported that he was unemployed and had no income. In actuality, the defendant was employed as the Bishop of a church and also owned and operated a daycare business.

### Veteran Sentenced for VA and Workers' Compensation Fraud

A Veteran, who was a former civilian U.S. Navy employee, was sentenced to 24 months' incarceration and ordered to pay $357,977 in restitution. At sentencing, the defendant paid full restitution to VA. The defendant fraudulently received VA individual unemployability benefits and workers' compensation benefits while actively managing a landscaping business. The loss to VA was $143,195.

### Veteran Sentenced for VA Compensation Benefits Fraud

A Veteran was sentenced to 2 years' incarceration, 36 months' probation, and ordered to pay VA $654,081 in restitution. An OIG investigation revealed that the Veteran and his wife falsified the Veteran's service-connected disability to include dementia symptoms. The Veteran and his wife continued to fraudulently report the symptoms to VA for over 20 years in order to obtain VA compensation benefits, VA educational benefits, and Civilian Health and Medical Program of VA medical benefits for the family.

### Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to theft of Government funds. An OIG investigation revealed that from June 2004 to December 2012 the defendant used his brother's identity in order to fraudulently receive VA benefits and avoid being identified as a fugitive felon. The defendant's brother is a Veteran who has not resided in the U.S. since 1973. The defendant's deception allowed him to obtain unauthorized medical care and receive VA pension benefits. The loss to VA is approximately $178,600. The defendant is scheduled for sentencing in October 2013.

### Veteran Pleads Guilty to Threats and False Impersonation

A Veteran pled guilty to interstate threats against VA employees and false impersonation of an officer or employee of the United States. An OIG, Defense Criminal Investigative Service (DCIS), and Immigration and Customs Enforcement investigation revealed that the defendant submitted a fraudulent DD-214 to VA that misrepresented his true level of functioning. The defendant also impersonated military personnel, participated in civilian contracted military exercises, taught martial arts, and brought and sold military grade lasers overseas while fraudulently collecting VA compensation benefits. When the Veteran learned he was about to have his benefits reduced, he threatened to kill VA employees. The loss to VA is $120,093.

### Veteran Pleads Guilty to Theft of Government Funds

A Gulf War Veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant submitted false claims to VA, related to PTSD, in order to receive health care and compensation benefits that she

was not entitled to receive. The defendant, who claimed to be unemployable and housebound since 1996, earned a Bachelor's and Master's Degree in Education and worked full-time as a teacher. The loss to VA is $205,402.

### Veteran Indicted for Theft of Government Funds and Making False Statements

A Veteran was indicted for theft of Government funds and making false statements. An OIG investigation revealed that the defendant submitted an altered DD-214, which reflected service in Vietnam, a Purple Heart, and a Bronze Star, and then made false statements during a compensation and pension examination claiming that he had been an assassin in Vietnam. The investigation further disclosed that the defendant never served in combat and was never awarded a Bronze Star or Purple Heart. The loss to VA is $114,208.

### Veteran Arrested for Theft and Fraud

A Veteran was indicted and subsequently arrested for theft of Government funds, wire fraud, false statements, false claims, and failure to file a tax return. An OIG and IRS CID investigation revealed that the defendant received VA unemployability benefits while operating a Ponzi scheme that defrauded investors of over $3.5 million. The loss to VA is approximately $250,000.

### Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 3 years' probation and fined $2,500 after pleading guilty to theft of Government funds. An OIG and FBI investigation revealed that the Veteran fraudulently claimed the loss of use of both feet, which entitled him to Special Monthly Compensation. Prior to sentencing, the Veteran made full restitution of $61,686 to the VA Debt Management Center.

### Veteran Arrested for Theft of Government Funds

A Veteran was arrested for theft of Government funds relating to his fraudulent award of VA compensation benefits for PTSD. An OIG investigation revealed that the defendant was awarded compensation at the 100 percent rate based on false stressors he fabricated to support his claim. Some of these false stressors included his claimed participation in a dead body detail during Operation Desert Storm, his involvement in an incident where a fellow soldier's vehicle was fired upon causing the vehicle to crash, and being subjected to constant incoming rounds. The loss to VA is approximately $185,000. Also, the defendant was previously convicted in 1996 of defrauding VA's home loan guarantee program.

### Veteran Indicted for False Claims and False Statements

A Veteran was indicted for false claims and false statements. An OIG investigation, initiated as a result of a referral from a VBA employee, revealed that the defendant submitted fraudulent military documents to VA in order to receive VA compensation benefits for PTSD. The defendant claimed to be an Air Force Ranger, to have been under fire and engaged in hand-to-hand combat in Vietnam, to have 7 confirmed kills, and to have saved a comrade by carrying him for 6 miles to safety. The investigation revealed that the defendant was a carpenter in the military with no foreign service. These false statements were discovered early in the investigation and prevented the awarding of any VA compensation benefits.

### Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 25 months' incarceration and ordered to pay $4,824 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that for approximately 3 years the defendant assumed the identity of a deceased Veteran in order to obtain medical treatment at four different VAMCs. In addition to obtaining medical care, the defendant also applied for and received pension benefits under the assumed identity. When interviewed, the defendant stated that he assumed the identity of the

deceased Veteran because he knew he had an outstanding warrant and would not be able to obtain medical care from VA under his own name. The loss to VA is in excess of $182,000.

### Veteran Sentenced for Theft of VA Benefits

A Veteran was sentenced to 36 months' incarceration, 36 months' supervised release, and ordered to pay $142,668 in restitution after pleading guilty to theft of Government property. An OIG investigation disclosed that the defendant made false statements in order to fraudulently obtain VA disability benefits. From 2000 to 2012, the defendant received VA compensation payments for panic disorder with agoraphobia, a back injury, and aid and attendance. The defendant admitted that he exaggerated his disabilities and lied about his ability to work. Because the Veteran violated his probation on an unrelated case by committing this fraud, he was sentenced to an additional 8 months' incarceration to be served consecutive to the sentence imposed in this OIG case. The loss to VA is approximately $329,000.

### Veteran Indicted for Theft of Government Funds and Health Care Benefits Fraud

A Veteran was indicted for theft of Government funds and health care benefits fraud. The defendant falsely claimed compensation for disabilities to include pain in his back, ankle and shoulder pain that prevented him from lifting his child, pain that required him to walk with a cane, and depression so severe that he was unemployable and socially isolated. An OIG investigation revealed that the defendant frequented bars in the area, attended college, and played recreational men's softball at an extremely high athletic level. The loss to VA is $119,490.

### Veteran Arrested for Theft of Government Funds and False Statements

A Veteran was arrested for theft of Government funds and false statements. A VA OIG and SSA OIG investigation revealed that the defendant was awarded individual unemployability and Social Security Disability Insurance based on a false claim that he was unable to work due to service-related injuries. The defendant, a full-time treasurer of a Fire Department since 2007, had his salary paid to his wife in order to hide his income from VA and SSA. The loss to VA is $60,837, and the loss to SSA is $141,181.

### Defendant Sentenced after Pleading Guilty to Fraud

A defendant was sentenced to 30 months' incarceration, 36 months' supervised release, and ordered to pay VA $437,000 in restitution after pleading guilty to wire fraud. An OIG and Naval Criminal Investigative Service investigation revealed that the defendant submitted fraudulent science and engineering degrees to the U.S. Navy and was subsequently accepted into the nuclear program with the rank of Ensign. The defendant then used her fraudulently acquired military status to apply for a VA-backed home loan and submitted forged and fraudulent bank statements and military documents confirming her actual and anticipated income and assets. In 2010, after the investigation revealed that the defendant had never been awarded any of the degrees, she was court-martialed and incarcerated for the false representations relating to her enlistment. The defendant will serve her new sentence after her current period of imprisonment.

### Veteran Arrested for Defrauding Other Veterans

A Veteran was arrested for mail fraud after an OIG and IRS CID investigation determined that he fraudulently took payments from 16 Veterans with the promise of getting the Veterans VA compensation benefits at a 100 percent rating. The payments were allegedly used to pay an attorney to do research and file the claims with VA. The defendant stole over $400,000 from these Veterans and never filed a single claim on their behalf.

### Veteran and Business Owner Indicted for VA Education Fraud

A Veteran and a former business owner of a Veteran vocational training program were indicted for theft by deception, forgery in the first degree, and identity fraud. An OIG investigation revealed that the defendant forged signatures and submitted false certifications to the VA Education Program, falsely claiming that the co-defendant was an apprenticeship trainee in a training program operated by the defendant. The investigation also revealed that the co-defendant provided false statements regarding the receipt of VA funds generated by the false certifications. The loss to VA is approximately $14,169.

### Veteran Sentenced for VA Education and Health Care Fraud

A Veteran was sentenced to 12 months' incarceration, 3 years' supervised probation, and ordered to pay VA $10,051 in restitution. An OIG investigation determined that the defendant submitted fraudulent DD-214s to the Montana National Guard and the Ft. Harrison, MT, VAMC. Before being discharged from active duty as "Other than Honorable," the Veteran purchased eight fictitious DD-214s from a service member at the Miramar Air Force Base indicating an "Honorable" discharge. The Veteran then used an ink signature stamp to make the DD-214s appear more authentic. The Veteran submitted one of the fictitious DD-214s to re-enter the military, where he immediately made a claim for VA educational benefits under the GI Bill. The Veteran also submitted one of the fictitious DD-214s to the VAMC and began receiving VA health care benefits to which he was not entitled.

### Widow Sentenced for Theft of VA Benefits

The widow of a Veteran was sentenced to 15 months' incarceration, 3 years' supervised release, and ordered to pay VA restitution of $308,040. An OIG investigation revealed that the defendant repeatedly made false reports to VA by failing to report her April 1978 remarriage. The defendant filed the false reports in order to continue to receive Dependency and Indemnity Compensation (DIC) benefits.

### Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 15 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $77,850 after pleading guilty to theft of Government funds. An OIG investigation revealed that for over 4 years the defendant was receiving individual unemployability benefits while employed with the U.S. Coast Guard.

### VA Pension Beneficiary Sentenced for Theft of Benefits

A VA pension beneficiary was sentenced to 21 months' home confinement with electronic monitoring, 5 years' probation, and ordered to pay $351,000 in restitution to VA and New York City after pleading guilty to mail fraud and theft of Government funds. An OIG and local police investigation revealed that the defendant fraudulently received her deceased husband's teacher's pension, which she failed to report to VA, causing VA to pay her approximately $132,000 in VA pension benefits she was not entitled to receive.

### Veteran Arrested for VA Pension Benefits Fraud

A Veteran was arrested for theft of Government funds and false statements. An OIG investigation disclosed that the defendant fraudulently obtained a VA pension by falsifying his initial application and attempting to hide his assets from VA. The loss to VA is approximately $75,250.

### Non-Veteran Sentenced for Theft of VA Benefits

A non-Veteran, falsely claiming to be a Vietnam Veteran, was sentenced to 6 months' incarceration and ordered to pay $51,868 in restitution. An OIG and DCIS investigation revealed that the defendant submitted a fraudulent DD-214 to VA and subsequently obtained VA health care and pension benefits.

### Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA beneficiary was sentenced to 4 years' probation and ordered to pay $63,300 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA benefits that were direct deposited into a joint account after her mother's death in May 2007. The defendant admitted to converting the funds for personal use.

### Son of Deceased Veteran Sentenced for Theft of VA Funds

The son of a deceased Veteran was sentenced to 366 days' incarceration, 3 years' supervised release, and ordered to pay $202,662 in restitution. An OIG investigation determined that the defendant stole VA benefits that were direct deposited into a joint account after his father's death in March 2006. The defendant admitted to spending the stolen funds at nightclubs and golf courses.

### Nephew of a Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The nephew of a deceased VA beneficiary was arrested and subsequently pled guilty to theft of Government funds. An OIG and U.S. Secret Service investigation revealed that the defendant stole VA benefit payments issued after his aunt's death in January 2010. The loss to VA is $124,994.

### Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into her mother's bank account after her mother's death in May 2005. The loss to VA is $103,557.

### Granddaughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The granddaughter of a deceased VA beneficiary was sentenced to 3 months' incarceration, 12 months' probation, and ordered to pay VA restitution of $50,073 after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA DIC benefits that were direct deposited after her grandmother's death in April 2009. The defendant admitted to using the stolen funds for her own expenses. The loss to VA is $51,227.

### Daughter of a Deceased Veteran Sentenced for Theft of VA Benefits

The daughter of a deceased Veteran was sentenced to 6 months' home confinement, 2 years' probation, and ordered to pay VA $50,674 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits direct deposited into her father's bank account after his death in December 2009.

## 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. During this reporting period, in the area of procurement practices, OIG opened 20 cases, made 6 arrests, and obtained more than $629,000 in fines, restitution, penalties, and civil judgments. Over $143,000 was achieved in savings, efficiencies, cost avoidance, and recoveries.

OIG also investigates theft of IT equipment or data, network intrusions, and child pornography. During this reporting period, in the area of information management crimes, OIG opened two cases, made one arrest, and achieved $31,000 in savings, efficiencies, cost avoidance, and recoveries.

## Veteran Indicted for Murder of Another Veteran

A Veteran was indicted for first degree murder and conspiracy to commit first degree murder. A VA OIG, SSA OIG, Tennessee Bureau of Investigation, and a district attorney investigation revealed that the defendant and his current spouse conspired to murder her previous husband, a combat Veteran and VA beneficiary, by forcing him to overdose on prescription drugs. The defendant and spouse then staged a crime scene to make it appear that the victim committed suicide. The victim's former spouse then fraudulently applied for DIC benefits, claiming his drug overdose was related to his service connected PTSD. The defendant has agreed to fully cooperate with the upcoming prosecution against his wife in exchange for a reduced sentence. The loss to VA is over $100,000.

## Former Health Care Worker Pleads Guilty to Drug Possession and Tampering

A former health care worker, who provided contract services to VA in 2008, pled guilty to acquiring or obtaining possession of a controlled substance by fraud and tampering with consumer products with reckless disregard. A multi-agency investigation revealed that the defendant stole syringes of fentanyl that were prepared and intended for patients scheduled to undergo a medical procedure and replaced them with syringes that he had previously stolen and filled with saline. The defendant used the stolen syringes to inject himself, causing the syringes to become tainted with his blood that was infected with Hepatitis C. As a result of the defendant's conduct, over 40 patients became infected with Hepatitis C, to include three Veterans. Two of the Veterans became infected during procedures at a private hospital and one during a procedure at a VAMC. As part of the plea agreement, the defendant agreed to a sentence of between 30 and 40 years of incarceration.

## Construction Company Owner Pleads Guilty to Obstructing a Federal Grand Jury Investigation

The owner of a large construction company pled guilty to obstructing a Federal grand jury investigation by altering and deleting documents from his computer. A multi-agency investigation revealed that the defendant, a former minority owner of two SDVOSBs, received a grand jury subpoena for records relating to his business dealings with another company and claims that this other company was an SDVOSB. The defendant subsequently deleted documents on his computer that were relevant to the pending investigation.

Serial infector: I did it

Guilty of all charges: Prosecutors say they will press for 40-year sentence.

By PAT GROSSMITH
New Hampshire Union Leader

CONCORD — The former Exeter Hospital medical technician labeled a "serial infector" by prosecutors after infecting at least 46 people in three states with hepatitis C pleaded guilty Wednesday to 16 charges related to 33 New Hampshire infections and one in Kansas, where an elderly patient died.

KWIATKOWSKI

David Kwiatkowski, 34, will serve at least 30 years under the plea agreement, but U.S. Attorney John Kacavas said prosecutors will argue for the maximum 40 years when he is sentenced Dec. 3 in U.S. District Court.

Kwiatkowski, sitting in drab gray-green Strafford County jail garb next to attorney Jona-

See Hepatitis, Page A2

## New Jersey Construction Contractor Faces Up to 15 Years in Prison, $250K Fine for $5,000 Bribe to VA Official

A contractor pled guilty to bribing a VA official. An OIG and FBI investigation revealed that the contractor became affiliated with two businesses that were applying to be placed on a VA list known as the Multiple Award Task Order Contract (MATOC) and that certain VA construction projects were available only to contractors who were placed on this list. Between October 2012 and February 2013, the contractor offered to make a $5,000 bribe payment to a VA employee for assistance in having his two companies placed on the MATOC.

Subsequently, the contractor made two cash payments totaling $1,000 to the VA employee in exchange for the employee's assistance in placing the two businesses on the list.

### Georgia Contractor Sentenced for SDVOSB Fraud

A Georgia contractor was sentenced to 24 months' incarceration and 2 years' supervised release after pleading guilty to making false statements. As part of the plea agreement, the defendant paid $181,556 in restitution. Subsequent to a referral received from the U.S. Government Accountability Office (GAO), a VA OIG, Small Business Administration (SBA) OIG, U.S. Department of Agriculture OIG, and U.S. Army CID investigation revealed that the defendant fraudulently obtained five SDVOSB set-aside contracts worth over $2 million.

### Construction Company Owners Sentenced for SDVOSB Fraud

Two owners of a construction company were sentenced after pleading guilty to defrauding the SDVOSB and 8(a) Business Development Programs. The non-Veteran defendant, who actually founded and managed the construction company, was sentenced to 366 days' incarceration, 2 years' probation, and a criminal asset forfeiture of $399,000. The service-disabled Veteran defendant, who was listed as president and majority owner of the company but who actually worked full-time for an unrelated company, was sentenced to 6 months' home confinement, 2 years' probation, 200 hours' community service, and a criminal forfeiture of approximately $38,000. A multi-agency investigation revealed that the defendants conspired to create an SDVOSB using the service-disabled defendant's status knowing that he was essentially only a figurehead and that the non-Veteran defendant was actually managing the company. The defendants submitted false certifications to the Government regarding the company's SDVOSB status, and while seeking 8(a) status with SBA, submitted other false documents to support their claim of being eligible for that program. The defendants caused the company to receive more than $20 million in contracts from VA, the U.S. Army, and GSA that were set aside or preferred for SDVOSB or 8(a) entities. This case was one of the original fraudulent companies identified in GAO's 2009 report concerning SDVOSB fraud.

### Defendants Plead Guilty to Fraud in SDVOSB Investigation

A defendant pled guilty to mail fraud and a second defendant pled guilty to wire fraud and making material false statements. A multi-agency investigation determined that the owner of a company utilized Veterans for labor without paying them wages and utilized a service-disabled Veteran's name to apply for and receive Government contracts. Both of the above defendants were employed by this company. The company was awarded a painting contract under a set-aside SDVOSB solicitation and was paid $44,742 by the Buffalo, NY, VAMC. Criminal charges are still pending against the owner of the company and two additional defendants.

### Business Owner Pleads Guilty to Making False Statements

A business owner pled guilty to making false statements. A VA OIG and SBA OIG investigation revealed that the defendant used personal information from a service-disabled Veteran to form a joint venture. The defendant then signed the Veteran's name on bids and correspondence and was subsequently awarded two VA construction contracts for $1,029,598.

### Defendant Sentenced for Theft of Veterans' Identities

A defendant was sentenced to 65 months' incarceration, 36 months' supervised probation, ordered to pay $462,039 in restitution, and forfeit $159,265 after pleading guilty to wire fraud and aggravated identity theft. An OIG, IRS CID, and local police investigation revealed that the defendant used Veterans' PII stolen from VA medical records to file fraudulent Federal income tax returns. Additional stolen identities of non-Veterans obtained outside VA were also used by the defendant during this scheme. The defendant received approximately

$462,039 in illicit proceeds from fraudulent returns and attempted to file additional fraudulent income tax returns in an amount exceeding $600,000.

### Non-Veteran Sentenced for Identity Theft

A non-Veteran was sentenced to 152 days' incarceration and ordered to pay VA $19,072 in restitution after pleading guilty to fraud charges. An OIG, VA Police Service, and local police investigation revealed that the defendant stole a Veteran's identity and for 3 months fraudulently received VA medical care.

### Veteran Indicted for Fraud and Aggravated Identity Theft

A Veteran was indicted for wire fraud, mail fraud, and aggravated identity theft. A multi-agency investigation revealed that from 2007 to 2013 the defendant created a series of fraudulent charter schools in order to receive approximately $25,000,000 in surplus Government computer equipment under a GSA Computers for Learning program. The defendant subsequently obtained computers from VA facilities located in multiple states. The loss to VA is approximately $1,900,000.

### Veteran Arrested for Identity Theft and Fraud

A Veteran was indicted for aggravated identity theft, wire fraud, and mail fraud. A VA OIG, SSA OIG, Department of Treasury OIG, and Washington State Department of Social and Health Services investigation revealed that the defendant stole the personal identification of two Veterans in order to establish fraudulent VA e-benefits accounts and re-route VA compensation payments to prepaid debit cards. As part of the scheme, the defendant utilized Direct Express to set up fraudulent accounts with prepaid debit card issuing banks. Also, a recent search of the defendant's residence revealed numerous stolen and counterfeit Washington State drivers' licenses, social security cards, business checks, birth certificates, and debit and credit cards. A cursory examination of the evidence revealed that there are over 25 identity theft victims. At this time, the loss to VA is approximately $60,000.

### Non-Veteran Arrested for Identity Theft and Fraud

A non-Veteran was indicted and subsequently arrested for aggravated identity theft, wire fraud, and theft of Government funds. An OIG, IRS CID, and state police investigation revealed that the defendant used Veterans' PII obtained from stolen VAMC medical records and other individuals' information to file $630,783 in fraudulent tax returns.

### Veteran Sentenced for Using Stolen Identities to Defraud VA

A Veteran was sentenced to 3 months' incarceration, 3 months' home detention, 3 years' supervised release, and ordered to pay $18,000 in restitution. An OIG investigation determined that the defendant assumed the identities of six other Veterans in order to fraudulently receive advanced education payments under the GI Bill. While on active duty, the defendant obtained a personnel roster that contained PII of other service members. After the defendant's discharge, she assumed the identities of the six Veterans in order to request advance education payments online. The defendant had the checks mailed to her residence and created false powers of attorney in order to negotiate the checks. The loss to VA is $18,000.

### Veteran Sentenced for Identity Theft

A Veteran was sentenced to 140 months' incarceration, lifetime supervision, and ordered to pay $53,935 in restitution, $12,027 of this amount to be paid to VA. The defendant previously pled guilty to possession of child pornography, failure to register as a sex offender, health care fraud, and possession of firearms as a convicted felon. An OIG investigation revealed that for 7 years the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity and used the false identity to obtain a U.S. Passport, purchase firearms, vote, obtain

employment, and obtain VA medical care through the VA fee basis program. A computer analysis conducted by OIG's Computer Forensics Laboratory also linked the defendant to child pornography.

### Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft

A Veteran was indicted for theft of Government funds and aggravated identity theft. A VA OIG and SSA OIG investigation determined that the Veteran received VA individual unemployability benefits since 1997 while working as a golf professional, car salesman, Pentecostal preacher, mortgage loan specialist, and in a variety of other jobs. In an effort to hide earned income, the defendant used other individuals' Social Security Numbers (SSNs) for employment. The Veteran also used these SSNs to obtain automobile loans. The loss to VA is approximately $350,000, and the loss to SSA is approximately $407,000.

### Non-Veteran Arrested for Access Device Fraud and Theft of Government Funds

A non-Veteran was arrested for access device fraud and theft of Government funds. During an OIG, IRS CID, and local police investigation, the defendant used PII, supplied by an undercover officer, to file $126,793 in fraudulent tax returns. Also, during the investigation, the defendant sold illicit drugs and stolen firearms to an undercover officer. Illicit drugs, PII, a ballistic vest, and firearms were found during a search of the defendant's residence.

### Physician's Assistant Sentenced for Health Care Fraud

A physician's assistant was sentenced to 8 months' home confinement, 2 years' supervised probation, and ordered to pay VA restitution of $154,872 after pleading guilty to health care fraud and conspiracy to commit health care fraud. The defendant's wife was sentenced to 18 months' probation after entering into a PTD agreement as a co-conspirator to the health care fraud. An OIG investigation revealed that the defendant, his wife, and their medical director, who is a physician, were contracted to conduct disability rating examinations of Veterans in northern Mississippi. The contract with VA stipulated that the physician perform all disability rating examinations. The investigation determined that the defendant conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008. The defendant forged the doctor's signature on all of the reports and then submitted the reports and false claims to VA for payment.

### Former VA Contract Employee Sentenced for Possession of Child Pornography

A former VA contract employee was sentenced to 78 months' incarceration after pleading guilty to possession of child pornography and receipt of child pornography. An OIG investigation determined that the defendant accessed internet websites containing images of child pornography and then saved the images to his VA-issued computers while working at two VA clinics in New Mexico.

### 10-Year Prison Sentence, Lifetime Supervision for Dayton, Ohio, Man Involved in Online Exploitation of Children

A Veteran was sentenced to 120 months' incarceration and lifetime court supervision after pleading guilty to possessing and viewing sexually explicit images of minor children while he was an inpatient at the Dayton, OH, VAMC. An OIG investigation that included the issuance of three search warrants and a forensic analysis revealed more than 500 images and over a dozen videos of child pornography, including sadism and violence. The National Center for Missing and Exploited Children was able to identify 20 known child victims among the images retrieved.

### Home Health Aide of Disabled Veteran Sentenced for Theft

The home health aide of a service-connected disabled Veteran was sentenced to 15 years' incarceration, with the first 3 years to be served in confinement and the remainder to be served on probation. The defendant was also ordered to pay $17,500 in restitution, a $2,550 fine, and perform 40 hours' community service after pleading guilty to identity theft, exploitation of the elderly or disabled, felony theft by taking, and transaction card theft. An OIG investigation revealed that the defendant stole the Veteran's personal and financial information while acting as a caregiver for the Veteran. The defendant subsequently contacted VA and re-directed the Veteran's VA compensation benefit payments. To further the scheme, the defendant applied for and received several prepaid debit cards in the Veteran's name and used the prepaid debit cards for his personal use. The loss to the Veteran was $17,908.

### Former VA Homeless Grant and Per Diem Program Participant Pleads Guilty to Making False Statements

A former participant in the VA Homeless Grant and Per Diem program pled guilty to making false statements to VA. An OIG investigation revealed that the defendant made false representations when applying for a grant to provide funds for the purchase of property to be used to house indigent Veterans. The defendant later admitted to keeping $25,000 of the $80,600 provided by VA and failing to make mortgage payments, which resulted in foreclosure. The defendant also received an additional $280,000 in grant funds for the purchase of an apartment building to house Veterans and a specialty van to provide transportation for indigent Veterans, neither of which was purchased.

### Health Care Worker Pleads Guilty to Theft

A healthcare worker at a VA contracted facility pled guilty to theft and was sentenced to 30 days' incarceration, ordered to have no contact with the Veteran for 10 years, to pay restitution of $9,303, and not to have any employment (paid or volunteer) with vulnerable adults for 10 years. An OIG and local police investigation revealed that the defendant stole VA compensation funds from an elderly Veteran's bank account.

### USPS Manager Pleads Guilty to Mail Theft

A USPS maintenance manager pled guilty to mail theft. A VA OIG and USPS OIG investigation revealed that from April to September 2012 the defendant stole approximately 17 VA parcels of controlled narcotics intended for disabled Veterans.

### Former USPS Employee Sentenced for Drug Theft

A former USPS employee was sentenced to 4 years' probation after pleading guilty to theft of mail by an employee. An OIG and USPS OIG investigation revealed that between January 2010 and May 2012 the defendant stole approximately 52 VA narcotic packages from the mail. The defendant admitted to stealing the controlled substances for personal use.

### Former USPS Employee Pleads Guilty to Mail Theft

A former USPS employee pled guilty to theft of mail by an employee. A VA OIG and USPS OIG investigation determined that between September 2012 and February 2013 the defendant stole approximately 85 VA drug packages from a USPS distribution facility. The defendant admitted to stealing the controlled substances for personal use.

### Former United Parcel Service Employee Arrested for Theft of VA Narcotics

A former United Parcel Service (UPS) employee was arrested after being charged with theft of Government property and possession of a controlled substance. The defendant was caught with a stolen VA narcotic package by OIG and UPS investigators and admitted to stealing VA narcotics from the Flagstaff, AZ, UPS for personal use.

### Former Employee of a VA Affiliated Non-Profit Research Institute Arrested for Theft

A former employee of a VA affiliated non-profit research institute was arrested for theft from programs receiving Federal funds. An OIG investigation revealed that the defendant fraudulently opened two corporate accounts in the name of a VA research group and deposited 20 checks totaling approximately $68,000. When arrested, the defendant was living approximately 100 miles away from the location of the crime and had obtained employment and housing using a fictitious name, social security number, date of birth, and passport.

### Former Calverton National Cemetery, New York, Mechanic Pleads Guilty to Theft of Workers' Compensation

A former Calverton National Cemetery, NY, mechanic pled guilty to a criminal information charging him with theft of Government funds. An OIG investigation revealed that the defendant, who filed a workers' compensation claim for an on-the-job injury in 2006, was working as a mechanic at an auto body shop. The earnings from this employment, which were not reported to DOL, Office of Workers' Compensation Program, were in excess of $10,000 for a period of 5 months. During this period, the defendant claimed he was unable to return to work for VA in any capacity. The defendant, who was receiving $3,200 per month in workers' compensation benefits, is no longer receiving any benefits.

## Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 32 criminal investigations resulting from assaults and threats made against VA facilities and employees. Twenty-four defendants were charged with related charges as a result of the investigations. OIG investigative work resulted in the following:

- A Veteran was sentenced to 18 months' incarceration and a $1,855 fine after being convicted at trial of disorderly conduct and sexually assaulting two VA staff members at the Great Falls, MT, CBOC. The defendant is facing additional charges of sexual assault as a result of this investigation.
- A Veteran was indicted for felony assault of a Federal officer after assaulting a Reno, NV, VAMC police officer. The defendant became upset after learning that his travel pay would not be issued in cash and began yelling racial slurs and profanities. VA Police responded and the defendant became combative. When the officers attempted to take the Veteran into custody, he punched one of the officers in the face and chest.
- A former Northport, NY, VAMC employee was sentenced to 2 years' probation after being found guilty at trial of assault. An OIG and VA Police Service investigation revealed the defendant assaulted a co-worker in a private office at the medical center and caused injuries to the victim's hand and wrist.
- A Veteran was indicted for making threats and assault of a Federal employee after assaulting a Poplar Bluff, MO, VAMC social worker. VA Police and local police officers responded to the assault and arrested the Veteran. After the defendant was taken into custody, VA Police observed evidence of weapons in the Veteran's vehicle. The Veteran had previously made threatening statements that he would bring firearms to the medical center and begin shooting VA employees. A shotgun, handgun, over 300 rounds of

ammunition, knives, and zip-cuffs were recovered from the defendant's vehicle. The defendant remains in custody pending trial.

- A Veteran pled guilty to assault of a Federal employee. An OIG and VA Police Service investigation revealed that the defendant, an inpatient at the Portland, WA, VAMC, assaulted a nurse and fractured her jaw. The defendant remains in custody pending sentencing.
- A Veteran was arrested for the assault of a Northport, NY, VAMC employee and patient. An OIG and VA Police Service investigation revealed that the defendant, while an inpatient, assaulted a VA pharmacy technician and a fellow patient, resulting in extensive head injuries to the employee. The defendant previously assaulted a VAMC nurse and VA police officer in the emergency room. The defendant was criminally charged based on the severity of the injuries sustained by the victims and the subject's past history of violence. The defendant is being held without bail pending a psychiatric evaluation.
- A Veteran was indicted for the assault of a VA psychiatrist at the Waco, TX, VAMC. An OIG and VA Police Service investigation revealed that the defendant choked the doctor while being admitted as a psychiatric inpatient.
- The daughter of a Veteran was sentenced to 12 months' probation and ordered to receive psychological counseling after assaulting a VA police officer at the Bronx, NY, VAMC. An OIG and VA Police Service investigation revealed that the defendant and her brother assaulted VA police officers in the medical center's emergency room. One officer required medical attention. The defendant's brother was previously sentenced in this case.
- A Veteran pled guilty to threatening to murder a Federal official. An OIG and FBI investigation revealed that during a VA compensation and pension appointment the defendant discussed his plan to execute a General with the Mississippi Army National Guard in Jackson, MS.
- A former Atlanta, GA, VAMC Compensated Work Therapy Program employee was indicted for making terroristic threats. An OIG and VA Police Service investigation revealed that the defendant threatened to assault his supervisor after he accused the supervisor of intentionally short-changing his salary. During the course of the investigation, the defendant also threatened to shoot law enforcement officers if they attempted to initiate contact with him.
- A Veteran was sentenced to 90 days' incarceration, $392 in court costs, and ordered to attend anger management counseling after being found guilty of the harassment of a VA employee. Seventy-six days of the incarceration were suspended contingent upon successful completion of the course. Also, the defendant was ordered to avoid contact with the VA employee and to not visit the Montgomery, AL, VARO. The OIG investigation determined that the defendant threatened to shoot a VA vocational rehabilitation employee.
- A Veteran was sentenced to time served, 1 year of probation, and ordered not to visit the Memphis, TN, VAMC for 3 years after pleading guilty to knowingly and recklessly causing fear of imminent bodily injury to another. The defendant was involuntarily committed for a mental evaluation after his arrest. An OIG investigation revealed that the defendant harassed and threatened a VA physician after he refused to prescribe pain medication to the defendant.
- A Veteran was sentenced to 10 years' incarceration (suspended), 3 years' probation, a $1,500 fine, and ordered to have no contact with the VA clinic in Dothan, AL, after pleading guilty to making terroristic threats. An OIG investigation revealed that the defendant threatened to use his .45 caliber handgun to kill 42 people at the Dothan, AL, CBOC. The initial contact with the defendant at his residence resulted

in a 2-hour standoff as he barricaded himself in his home with a firearm. The defendant was arrested without incident after he attempted to flee from the residence.

- A Veteran was arrested for making terroristic threats by telephone. An OIG and local sheriff's investigation was initiated after the Veteran called the VA Crisis Hotline and said he had 4 pounds of C-4 and ball bearings and that he was going to the Detroit, MI, VARO for payback after being denied benefits. Arrest and search warrants were subsequently obtained for the Veteran and his residence. The MI State Police Special Weapons and Tactics team executed the entry and took the Veteran, who resisted and attempted to flee, into custody. Two shotguns and a 30-06 scoped rifle were recovered from the Veteran's home.
- A Veteran, upset with his VA medical care, was arrested for making threats. An OIG and FBI investigation revealed that the defendant called a U.S. Congressman's office and threatened to physically assault a congressional staff member and a West Palm Beach, FL, VAMC patient advocate.
- A Veteran was arrested for making a terroristic threat. An OIG investigation revealed that the defendant contacted a VA call center and threatened to blow up the Buffalo, NY, VAMC after receiving a collections notice for an unpaid bill. The Veteran has a lengthy criminal record and was well known by local authorities.
- A Veteran was indicted for terroristic threats made towards the medical staff at the Atlanta, GA, VAMC. An OIG investigation revealed the Veteran threatened to kill the medical staff by shooting them in the head if he didn't receive his 100 percent disability pension.
- A Veteran was arrested and involuntarily committed for a psychological evaluation after making telephonic threats to VA employees. An OIG and local police investigation revealed that the defendant repeatedly called the Nashville, TN, VAMC and told staff members that he was going to kill everyone at the facility.
- A Veteran was arrested for aggravated harassment. An OIG and State Police investigation revealed that the Veteran made numerous telephonic threats to several employees at a VA call center relating to his attempts to obtain various medications, including methadone, from VA.

## 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, 51.7 million felony warrants have been received from the National Crime Information Center and participating states resulting in 64,852 investigative leads being referred to law enforcement agencies. Over 2,371 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 $1.01 billion in estimated overpayments with an estimated cost avoidance of $1.19 billion. During this reporting period, OIG opened 29 and closed 32 fugitive felon investigations, identifying $57.1 million in estimated overpayments. OIG investigative work resulted in the arrest of 25 fugitive felons, including 6 VA employees. Apprehension of VA employees includes the following charges: drug violations, child pornography, felony driving under the influence, and probation violations. Based on the information provided to OIG, at least 12 additional arrests were made by other law enforcement agencies.

- OIG and VA Police Service assisted the local police with the arrest of a Veteran at the Asheville, NC, VAMC. The fugitive was wanted for discharging a firearm into an occupied residence and assault with a deadly weapon with intent to kill.

- OIG assisted a local sheriff's office with the arrest of a Loma Linda, CA, VAMC housekeeping supervisor wanted for a dangerous drug violation. During a search of the subject incident to the arrest, agents found hidden inside the employee's sock a plastic bag containing a white substance and a glass pipe. A field test of the white substance tested positive for methamphetamines. The employee was transported by the local sheriff's office and a new charge was filed for possession of controlled substances. The employee has an extensive drug history and is pending judicial and administrative procedures.
- A Veteran was arrested at the Atlanta, GA, VAMC on outstanding warrants for aggravated child molestation, aggravated sodomy, child molestation, aggravated sexual battery, and incest. A U.S. Marshals Fugitive Task Force and local law enforcement arrested the fugitive with the assistance of OIG and VA Police Service.
- A Veteran wanted in Missouri for first degree assault, armed criminal action, and unlawful use of a weapon was arrested by local authorities at the Fayetteville, NC, VAMC with the assistance of OIG and VA Police Service.
- Another Veteran wanted for aggravated battery and aggravated assault with a firearm was arrested at the West Palm Beach, FL, VAMC with the assistance of OIG and VA Police Service.

## Administrative Investigation

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 nine and closed nine administrative investigations. The Division investigated 17 allegations, 8 of which were substantiated. This work resulted in the issuance of one report containing two recommendations for administrative or corrective action. This investigation concerned Conduct Prejudicial to the Government Veteran Employment Office.

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 issued four advisory memorandums and seven administrative memorandums. OIG also obtained $509,884 in dollar recoveries.

### Former VA Senior Human Resources Official and VA Contractor Misrepresented Veteran Hiring Results for 2012 VA Hiring Fair in Detroit, Michigan

A former (retired) VA Senior Official and a VA contractor employee knowingly misrepresented the results of the June 2012 Detroit, MI, VA for Vets Veterans Hiring Fair. Further, the former VA Senior Official did not properly manage the VA workforce, frequently used obscene and demeaning language, engaged in verbally abusive behavior toward VA staff and VA contractor employees, and engaged in the appearance of a conflict of interest. In addition, a contractor received over $500,000 for a data management system that was not designed to capture accurate data to support VA's needs.

# 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, GAO, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 14,146 contacts, 616 of which became OIG cases. An additional 384 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

614 cases during this reporting period, substantiating allegations 39 percent of the time. During FY 2013, external Hotline cases resulted in 704 administrative sanctions and corrective actions and $10 million in monetary benefits. The following cases were initiated as a direct result of Hotline contacts.

### Social Worker Falsifies Medical Records and Misuses Government Vehicle

A review by the VA Great Lakes HCS substantiated that a Chicago-area VA social worker systematically created bogus medical record entries to falsely indicate that he met, or performed services for, 6 Veterans on a total of 131 occasions between July 2011 and January 2013. The review also found that the social worker used a Government vehicle without authorization 12 times during FY 2013. As a result, the VAMC initiated action to remove the individual from Federal service.

### Philadelphia VAMC Paid Excessive Charges for Sleep Studies

A review by VISN 4 substantiated that the Philadelphia, PA, VAMC paid $287,958 in excessive charges for sleep studies by the affiliated Hospital of the University of Pennsylvania for FY 2009 through 2011. The overpayments occurred, in part, because the University continued to bill VA for studies at a flat annual contract rate, even though the contract had expired in FY 2008. As a result of the review, the VAMC discontinued services under the expired contract and initiated collection for the overpayments.

### Hotline Review Terminates Compensation for Unsupported Condition

A review conducted by the St. Petersburg, FL, VARO found that a Veteran's medical records did not support his claimed disability of Lou Gehrig's disease, for which he was receiving 100 percent disability compensation since January 2012. As a result, the VARO terminated the benefits resulting in an estimated cost savings of $238,859 over a 5-year period.

### Hotline Reviews in Minnesota Uncover Improper Receipt of VA Benefits

Hotline reviews by the St. Paul, MN, VARO identified improper payments to two persons that would have totaled $224,674 over a 5-year period if not reported and stopped. The first case identified a surviving spouse who improperly continued to receive DIC benefits because she concealed from VA her April 2007 common-law marriage. The second case involved a Veteran who improperly received VA pension benefits because he concealed from VA his Social Security income beginning in February 2010.

### VARO Reduces Compensation for Incarcerated Veteran Following Hotline Tip

A review conducted by the Houston, TX, VARO substantiated that a Veteran receiving disability compensation did not report his December 2011 incarceration and projected release date of May 2026 to the VARO. The case resulted in the reduction of his benefits and an estimated 5-year savings of $216,144.

# Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's 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 52 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-four preaward reviews identified approximately $150 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule (FSS) and Architecture/Engineering Services proposals, preaward reviews during this reporting period included seven health care provider proposals, accounting for approximately $38.3 million of the identified potential savings.

| Period | Preaward Reports Issued | Potential Cost Savings |
|---|---|---|
| October 1, 2012 – March 31, 2013 | 49 | $505,143,202 |
| April 1 – September 30, 2013 | 34 | $149,913,083 |
| **FY Total** | **83** | **$655,056,285** |

## 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 $4.9 million, including approximately $4.4 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 16 postaward reviews performed, 6 involved voluntary disclosures. In four reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

| Period | Postaward Reports Issued | Dollar Recoveries |
|---|---|---|
| October 1, 2012 – March 31, 2013 | 17 | $12,720,968 |
| April 1 – September 30, 2013 | 16 | $4,940,952 |
| **FY Total** | **33** | **$17,661,920** |

## Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period OIG reviewed two claims and determined that approximately $192,643 of claimed costs were unsupported and should be disallowed.

| Period | Claim Reports Issued | Potential Cost Savings |
|---|---|---|
| October 1, 2012 – March 31, 2013 | 2 | $1,860,602 |
| April 1 – September 30, 2013 | 2 | $192,643 |
| **FY Total** | **4** | **$2,053,245** |

## Congressional Testimony

### Deputy Inspector General Testifies on Challenges Facing VA

Richard J. Griffin, Deputy Inspector General, testified before the Subcommittee on Military Construction, Veterans' Affairs, and Related Agencies, Committee on Appropriations, United States Senate, on the recent results and recommendations of OIG reports on VA programs and operations in connection with VA's FY 2014 budget request. Specifically, he focused on OIG work in the area of claims processing and access to health care. Mr. Griffin was accompanied by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations (AIGAE), and Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections.

### AIGAE Discusses OIG's Recommendations to NCA To Improve Gravesite Reviews

Linda A. Halliday, AIGAE, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on the results of OIG's audit of NCA internal gravesite reviews. She discussed OIG's findings that NCA's Phase One review did not identify or report all misplaced headstones and unmarked gravesites. The audit also reported that NCA's review lacked controls to ensure an independent review was conducted; NCA did not allow adequate time or resources to conduct the review; and cemetery directors lacked updated gravesite layout maps. Ms. Halliday also commended the Under Secretary for Memorial Affairs for acting immediately when presented with OIG's findings. Ms. Halliday was accompanied by Ms. Cherie Palmer, Director of OIG's Chicago Office of Audits and Evaluations.

### OIG Offers Views on Draft Bill That Would Require VA to Report Managers Slow To Implement IG Recommendations

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 follow-up process and views on a draft bill that would require the VA Secretary to identify managers who do not implement OIG recommendations in a timely manner. OIG's statement explained the process for tracking recommendations and reporting on recommendations that are not implemented within 1 year. OIG also offered technical corrections to a draft bill by the Health Subcommittee Chairman.

### AIGAE Tells Congress That VA Systems Remain at Risk Due to Weaknesses in IT Security

Linda A. Halliday, AIGAE, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on OIG reports related to the security of VA's IT systems and Veterans' data. Ms. Halliday discussed IT security control weaknesses that OIG has reported on for over 10 years through the Audit of VA's Consolidated Financial Statements and in audits conducted under FISMA, as well as other audits and reviews recently conducted. VA's decentralized and complex system infrastructure poses significant challenges to implementing effective security measures. Until VA fully implements key elements of its information security program and addresses OIG's outstanding audit recommendations, VA's mission-critical systems and sensitive Veterans' data remain at increased and unnecessary risk of attack or compromise. Ms. Halliday was accompanied by Ms. Sondra McCauley, Deputy AIGAE, and Mr. Michael Bowman, Director, OIG's Information Technology and Security Audits Division.

### OIG's Testimony Outlines VA's Treatment and Care for Survivors of Military Sexual Trauma and How VA Can Improve

Dr. Michael L. Shepherd, Senior Physician, OHI, testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on a December 2012 OIG report dealing with inpatient and residential programs for female Veterans with conditions related to military sexual trauma (MST).

His testimony outlined the results of the report, which included program user demographics, VA treatment prior to admission, referrals to specialized programs, program structure and treatment characteristics, aftercare, outreach, access, and potential actions to enhance program utilization. To improve service to Veterans, he recommended that VHA establish a centrally coordinated, comprehensive, and descriptive MST program resource list; ensure that MST Coordinators have adequate time to fulfill their outreach role; and review existing travel funding for this population. Dr. Shepherd was accompanied by Ms. Karen McGoff-Yost, Associate Director, Bay Pines, FL, OHI.

### OIG Promises Vigorous Follow Up on Atlanta, Georgia, VAMC MH Services at Senate Veterans' Affairs Committee Field Hearing

Dr. Michael L. Shepherd, Senior Physician, OHI, testified at a field hearing of the Committee on Veterans' Affairs, United States Senate, in Atlanta, GA, on two April 2013 OIG reports on MH care at the Atlanta, GA, VAMC. His testimony outlined the findings of those reports which include deficiencies in the administration of the acute MH inpatient unit and deficiencies in administration, tracking, and monitoring of contract MH services and the clinical impact. Dr. Shepherd assured the Committee that OIG will continue to review actions by the Atlanta VAMC to implement our recommendations. Dr. Shepherd was accompanied by Mr. Murray Leigh, Director of the Healthcare Financial Analysis Division, OHI.

## *False Claims Act* Settlements

This reporting period, VA received over $7.8 million in funds from settlements in cases filed under the *qui tam* provisions of the *False Claims Act*. The amount represents VA's damages in four cases involving off-label marketing, two of which included anti-kickback violations. Another involved the sale of pharmaceuticals manufactured in unapproved plants, and the last case involved fraudulent billings for care. The total recovered for VA this fiscal year was over $18.3 million.

## *American Recovery and Reinvestment Act of 2009* 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 million for VHA Grants to States for extended care facilities.
- $50 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, 2013, 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 622 fraud awareness training and outreach sessions across the country attended by over 17,250 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 529 and closed 425 criminal investigations, including 120 convictions, 188 referrals for monetary reclamation, and $91,750 in recoveries related to ARRA-funded programs and projects.
- Received 64 Hotline complaints of potential fraud or waste related to ARRA programs or projects.
- Maintains the OIG Recovery Act Web Site, http://www.va.gov/oig/recovery, which provides access to the VA OIG Hotline and information on OIG ARRA reports, activities, plans, and fraud prevention training materials.

Under ARRA, an employee of any non-Federal employer receiving covered ARRA funds may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of: 1) gross mismanagement of an agency contract or grant relating to covered funds; 2) a gross waste of covered funds; 3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; 4) an abuse of authority related to the implementation or use of covered funds; or 5) a violation of law, rule, or regulation related to an agency contract or grant, awarded or issued relating to covered funds. Pursuant to the reporting requirements under this provision, OIG conducted no investigations such as those described above. Consequently, OIG did not request or receive an extension beyond the 180-day period for such investigations.

## 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. On March 21, 2013, DOL OIG completed their quality control peer review of VA OIG's system of quality control, and provided a peer review rating of 'pass.' There was one finding not considered of sufficient significance to affect the opinion expressed in their report.

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 did not complete any peer reviews on fellow OIGs for the period ending September 30, 2013. 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 operations was completed by the Environmental Protection Agency OIG in March 2013. The final report was issued on August 23, 2013, and contained no

recommendations. VA OIG conducted a CIGIE QAR of the SBA OIG's investigative operations 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 one report under this requirement concerning VA's Technology Acquisition Center Contract Operations. A summary of this report is available on page 29, and the report can be accessed at the following address: http://www.va.gov/oig/pubs/VAOIG-12-02387-343.pdf.

## 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 230 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

### OIG Special Agents Recognized for Achievements

- Christopher Algieri, Special Agent, Northeast Field Office, Newark, New Jersey, was recognized by the U.S. Attorney's Office, Eastern District of New York, in March 2013 for his outstanding work in the Amgen Inc. investigation that resulted in the successful prosecution of Amgen for the illegal misbranding of the drug Aranesp. The global settlement of $762 million represented the single largest criminal and civil fraud settlement involving a biotechnology company in U.S. history.
- Gerard Poto, Special Agent, Northeast Field Office, Newark, New Jersey, and Donna Neves, Resident Agent in Charge, Manchester, New Hampshire, received the Boston U.S. Attorney's Outstanding Collaborative Investigation award in May 2013 and the Department of Health and Human Services OIG's Inspector General Cooperative Achievement Award in June 2013 for their work on the U.S. v. GlaxoSmithKline, LLC investigation. In July 2012, GlaxoSmithKline agreed to plead guilty and pay $3 billion to resolve its criminal and civil liability arising from the company's unlawful promotion of certain prescription drugs, its failure to report certain safety data, and its civil liability for alleged false

price reporting practices. As a result, the resolution of this parallel criminal and civil investigation is the largest health care fraud settlement in the Department of Justice history and the largest payment ever by a drug company.

- Colin Davis, Special Agent, Southeast Field Office, Bay Pines, Florida, is a member of the Tampa Bay Identity Theft Alliance recently recognized by the International Association of Financial Crimes Investigators (IAFCI) with the Task Force of the Year Award in August 2013. The IAFCI recognized the Tampa Bay Identity Theft Alliance for investigative excellence of financial crimes, outstanding public service, and dedication. The Tampa Bay Identity Theft Alliance was formed in July 2012 and is comprised of 20 Tampa Bay Federal, state and local law enforcement agencies and prosecutors to investigate identity theft crimes and pinpoint vulnerabilities in personal and business transactions. Since its inception in July 2012, the Alliance has arrested dozens of individuals and stopped millions of dollars in fraudulent tax returns from being approved. Specifically, this award highlighted the arrest of 12 subjects who committed a combined $8.5 million in tax fraud and who were ultimately sentenced to a combined 860 months of incarceration. Successful investigations of thefts of PII from a VA medical facility which were used to file fraudulent tax returns were prominent accomplishments by the Alliance.

## 2013 Council of the Inspectors General for Integrity and Efficiency Award Recipients

- The Veterans Access to Mental Health Care Team was recognized for the collaborative efforts of the Office of Audits and Evaluations and the Office of Healthcare Inspections that determined data reported by VHA to Congress on Veterans' wait times for MH evaluations and treatment were not reliable or accurate. The team examined documentation for 700 appointments, interviewed hundreds of schedulers and MH providers, reviewed VHA clinic structure and patient flow, and researched private sector scheduling practices and metrics. This highly anticipated report was issued in only 4 months from the date of the request from Congress and the VA Secretary and led to VHA's commitment to make major changes to its performance metrics, the hiring of over 3,000 MH providers and administrative staff, two hearings before the Senate and House Committees on Veterans' Affairs, and extensive media coverage. Team members included Marilyn Barak, Beverly Carter, Lee Giesbrecht, Monika Gottleib, Lance Kramer, Brad Lewis, Russell Lewis, Claire McDonald, Karen McGoff-Yost, Daniel Morris, Ken Myers, Carla Reid, Larry Reinkemeyer, Jason Schuenemann, Michael Shepherd, Nelvy Viguera-Butler, Sarah White, and Oscar Williams.
- The CJMS Contracting LLC, SDVOSB Fraud Team was recognized for the successful investigation and prosecution of two Missouri commercial construction contractors and a VA employee who conspired to defraud the SDVOSB Program. The VA OIG team, along with members of the GSA and SBA OIGs, collected and analyzed evidence gathered from 23 subpoenas, 5 search warrants, and VA computer systems that proved the contractors used a "rent-a-vet" scheme to compete for set-aside Government contracts. They further proved that a VA employee improperly steered $3.4 million in contracts to the company in exchange for luxury box tickets at sporting events, lunches, and interest-free loans. As part of a plea agreement in Federal District Court, one contractor agreed to forfeit $1.5 million and a 2011 Jaguar Series XKR Model XK. He was sentenced to serve 3 years' probation and ordered to pay $1.55 million in restitution and a $60,000 fine. The other contractor was sentenced to 2 years in prison followed by 1 year of probation and ordered to pay a $50,000 fine. The now retired VA employee was sentenced to 15 months in prison and 12 months' probation. The companies and individuals involved were debarred from doing business with the Federal government. Team members included Greg Billingsley, Sally Stevens, and William Stumme.

- The OIG Reports and Financial Operations Technology Enhancement Team was recognized for developing three electronic tracking systems in SharePoint that have significantly improved management of report distribution, follow-up on report recommendations, and procurement actions. This 2-year effort was undertaken by a multi-disciplinary team from across the Office of Management and Administration (OMA) that developed approaches to track report recommendations in an integrated system accessible to OMA staff, other OIG directorates, and VA program offices; developed requirements pertaining to budget execution, fiscal control, acquisition, IT security, and property management; researched methods to publish OIG reports; and tested various prototypes. The new follow-up system has improved communication both within the OIG and with VA program offices, eliminated voluminous e-mail transmissions, and established real-time visibility on the status of report recommendations. The paperless procurement system has simplified the acquisition process for all OIG users and to date has processed over 2,500 actions. The electronic report distribution system has reduced the time to publish reports and improved coordination between OIG directorates and staff offices. Team members included Debra Beatty, Megan Beidler, Joyce Bowman, Jeff Brewer, Mark Cherry, Kimberly Cowins, Jess Del Mundo, Quintin Durden, Kara Francis, Jennifer Geldhof, Benny Gelillo, Kathy Hewlett, Ann Hively, Jay Johnson, Kyra Moore, Greg Mroz, Jim Schank, and Gracie Turner.
- The NCA's Internal Gravesite Review of Headstone and Marker Placement Audit Team was recognized for a report that will ensure gravesites in NCA cemeteries are accurately marked and that Veterans are honored with final resting places befitting their service to our country. Following the discovery that markers were offset by one gravesite at the Fort Sam Houston National Cemetery in San Antonio, TX, NCA initiated a review of nearly half of its 3.1 million gravesites to verify the placement of gravesite markers where raise and realign projects had been completed. The audit team found that NCA's procedures had not identified and reported all misplaced headstones and unmarked graves, and consequently NCA had reported unreliable and understated results to Congress. Recognizing the need for urgent corrective actions before NCA embarked on the second phase of its review, the team provided the Under Secretary for Memorial Affairs with a Management Advisory Memorandum with recommendations to use independent teams rather than local cemetery directors to conduct additional reviews. The revised procedures enabled NCA to identify many additional gravesite errors that initially went undetected. The final audit report was the subject of a House Committee on Veterans' Affairs hearing in April 2013. Team members included Alicia Castillo-Flores, Joseph DeAntonis, Kevin Gibbons, Lee Giesbrecht, Cynnde Nielsen, Cherie Palmer, Maria Stone, Nelvy Viguera-Butler, and Ora Young.
- The Veteran Homelessness Review Team was recognized for a first ever comprehensive analysis of the incidence and risk factors of service members for becoming homeless after military service. The team's study involved the analysis of VA and Department of Defense data for a population of almost 500,000 Veterans who separated from the military from July 2005 to Sept 2006, and followed a group of Veterans through treatment records who became homeless after military discharge. The study found that about half of the newly homeless became homeless after 3 years from discharge and that the presence of mental disorders, including substance-related disorders and/or mental illness, is the strongest predictor of becoming homeless. These findings will help VA improve its homeless strategy and program by focusing funding and assistance on those Veterans who are at elevated risk for homelessness during a window of opportunity for prevention of homelessness. The report was presented at the annual meeting of the American Public Health Association, publicized widely to state-level stakeholders by the Army OneSource project, and accepted for publication in the American Journal of Public Health. Team

members included Elizabeth Bullock, Lin Clegg, Nathan McClafferty, Karen McGoff-Yost, Patrick Smith, and Jarvis Yu.

## OIG Employees Currently Serving on or Returning From Active Military Duty

We extend our thanks to OIG employees listed below who are on or have returned from active military duty.

- John Moore, a Hotline Analyst at OIG Headquarters, was activated by the Army National Guard in March 2013.
- Kenneth Sardegna, an Auditor at OIG Headquarters, was activated by the U.S. Army in June 2007.
- Wessley Dumas, a Special Agent in the Little Rock, AR, Office of Investigations, was activated by the Army National Guard in July 2012. Wessley returned from active military duty in August 2013.
- Peter Moore, a Special Agent in the Dallas, TX, Office of Investigations, was activated by the Army Reserves in June 2012. Peter returned from active military duty in June 2013.

# 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 | | Questioned Costs |
| | | Recommended for Better Use by OIG | Agreed to by Management | |
| 4/15/2013<br>12-04524-171 | Interim Report - Participation in VBA's Veterans Retraining Assistance Program | | | |
| 6/25/2013<br>13-00644-231 | Review of VA's Acquisitions Supporting the Veteran Employment Services Office | $17,500,000 | $17,500,000 | |
| 6/27/2013<br>12-01712-229 | VA's *Federal Information Security Management Act* Audit for Fiscal Year 2012 | | | |
| 6/28/2013<br>13-01846-235 | Review of VA's Programs for Addressing Climate Change | | | |
| 8/9/2013<br>12-01860-237 | Audit of Non-Purchase Card Micro-Purchases | $120,000,000 | $120,000,000 | |
| 8/27/2013<br>12-01899-238 | Audit of Foreclosed Property Management Contractor Oversight | | | |
| 9/4/2013<br>12-00181-299 | Audit of VBA's Pension Payments | $502,000,000 | $502,000,000 | |
| 9/17/2013<br>12-04524-321 | Audit of VBA's Veterans' Retraining Assistance Program Participation | $12,000,000 | $12,000,000 | |
| 9/18/2013<br>12-02708-301 | Review of Alleged System Duplication in VA's Virtual Office of Acquisition Software Development Project | $13,000,000 | $13,000,000 | |
| 9/26/2013<br>12-00366-339 | Audit of NCA's Contracting Practices | | | |
| 9/27/2013<br>12-02387-343 | Audit of VA's Technology Acquisition Center Contract Operations | | | $108,700,000 |
| 9/30/2013<br>11-01653-300 | Review of VHA's Management of Travel, Duty Stations, Salaries and Funds in the Procurement and Logistics Office | | | $17,803 |
| 9/30/2013<br>11-00330-338 | Audit of Selected VHA Non-Institutional Purchased Home Care Services | $893,500,000 | $893,500,000 | $13,200,000 |
| 9/30/2013<br>13-00455-345 | Review of VA's Separately Priced Item Purchases for Training Conferences | $1,100,000 | $1,100,000 | $829,000 |
| | | **$1,559,100,000** | **$1,559,100,000** | **$122,746,803** |

## Appendix A
### List of Reports Issued

| Office of Audits and Evaluations \| Benefits Inspections | | |
|---|---|---|
| Issue Date | Number | Facility |
| 4/9/2013 | 12-03475-169 | VA Regional Office, Philadelphia, Pennsylvania |
| 4/11/2013 | 12-04179-167 | VA Regional Office, Baltimore, Maryland |
| 4/24/2013 | 12-04525-170 | VA Regional Office, Denver, Colorado |
| 4/29/2013 | 12-03885-168 | VA Regional Office, Boise, Idaho |
| 6/11/2013 | 12-04328-211 | VA Regional Office, Wilmington, Delaware |
| 6/24/2013 | 13-00367-226 | VA Regional Office, Houston, Texas |
| 7/1/2013 | 12-04456-232 | VA Regional Office, Roanoke, Virginia |
| 7/12/2013 | 13-00586-228 | VA Regional Office, San Juan, Puerto Rico |
| 7/29/2013 | 13-00709-257 | VA Regional Office, Jackson, Mississippi |
| 7/30/2013 | 13-00368-244 | VA Regional Office, Waco, Texas |
| 8/8/2013 | 13-01445-271 | VA Regional Office, Milwaukee, Wisconsin |
| 8/28/2013 | 13-01625-273 | VA Regional Office, Newark, New Jersey |
| 8/28/2013 | 13-00993-274 | VA Regional Office, Albuquerque, New Mexico |
| 9/3/2013 | 12-04326-275 | VA Regional Office, Muskogee, Oklahoma |
| 9/9/2013 | 13-01550-286 | VA Regional Office, St. Paul, Minnesota |
| 9/9/2013 | 13-02257-294 | VA Regional Office, Togus, Maine |

| Office of Healthcare Inspections \| Combined Assessment Program Reviews | | |
|---|---|---|
| Issue Date | Number | Facility |
| 4/4/2013 | 13-00278-164 | Dayton VA Medical Center, Dayton, Ohio |
| 4/12/2013 | 13-00431-173 | William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin |
| 4/12/2013 | 13-00374-174 | Manchester VA Medical Center, Manchester, New Hampshire |
| 5/2/2013 | 12-03746-161 | VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania |
| 5/9/2013 | 13-00893-195 | VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas |
| 5/20/2013 | 13-00433-199 | Robley Rex VA Medical Center, Louisville, Kentucky |
| 5/20/2013 | 13-00887-204 | Marion VA Medical Center, Marion, Illinois |
| 5/30/2013 | 13-00378-202 | Louis A. Johnson VA Medical Center, Clarksburg, West Virginia |
| 5/30/2013 | 13-00888-203 | VA Southern Nevada Healthcare System, Las Vegas, Nevada |
| 5/30/2013 | 13-00889-206 | Salem VA Medical Center, Salem, Virginia |
| 5/31/2013 | 13-00376-201 | Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois |
| 6/12/2013 | 13-00432-217 | Spokane VA Medical Center, Spokane, Washington |
| 6/13/2013 | 13-00886-210 | VA New Jersey Health Care System, East Orange, New Jersey |
| 6/18/2013 | 13-00894-216 | VA Manila Outpatient Clinic, Manila, Philippines |
| 6/19/2013 | 13-00274-224 | VA Pacific Islands Health Care System, Honolulu, Hawaii |
| 6/20/2013 | 13-00890-220 | Alaska VA Healthcare System, Anchorage, Alaska |
| 7/11/2013 | 13-00896-234 | VA Maryland Health Care System, Baltimore, Maryland |

| Office of Healthcare Inspections \| Combined Assessment Program Reviews | | |
|---|---|---|
| Issue Date | Number | Facility |
| 7/11/2013 | 13-01673-240 | Tuscaloosa VA Medical Center, Tuscaloosa, Alabama |
| 7/15/2013 | 13-00897-242 | VA Western New York Healthcare System, Buffalo, New York |
| 7/18/2013 | 13-01971-245 | James A. Haley Veterans' Hospital, Tampa, Florida |
| 7/25/2013 | 13-01674-256 | Sioux Falls VA Health Care System, Sioux Falls, South Dakota |
| 7/25/2013 | 13-01672-260 | VA Butler Healthcare, Butler, Pennsylvania |
| 8/5/2013 | 13-00899-261 | Hunter Holmes McGuire VA Medical Center, Richmond, Virginia |
| 8/7/2013 | 13-01675-266 | Kansas City VA Medical Center, Kansas City, Missouri |
| 8/7/2013 | 13-01670-269 | Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma |
| 8/9/2013 | 13-01671-262 | Sheridan VA Healthcare System, Sheridan, Wyoming |
| 8/16/2013 | 13-01669-270 | Jesse Brown VA Medical Center, Chicago, Illinois |
| 8/19/2013 | 13-01972-284 | Charlie Norwood VA Medical Center, Augusta, Georgia |
| 8/26/2013 | 13-01973-288 | Fargo VA Health Care System, Fargo, North Dakota |
| 8/27/2013 | 13-01975-292 | VA Central California Health Care System, Fresno, California |
| 9/11/2013 | 13-02312-304 | Cheyenne VA Medical Center, Cheyenne, Wyoming |
| 9/12/2013 | 13-01976-312 | VA Connecticut Health Care System, West Haven, Connecticut |
| 9/13/2013 | 13-02313-310 | Amarillo VA Health Care System, Amarillo, Texas |
| 9/23/2013 | 13-02316-322 | Richard L. Roudebush VA Medical Center, Indianapolis, Indiana |
| 9/26/2013 | 13-02315-332 | Edward Hines, Jr. VA Hospital, Hines, Illinois |
| 9/27/2013 | 13-01974-337 | Philadelphia VA Medical Center, Philadelphia, Pennsylvania |

| Office of Healthcare Inspections \| Community Based Outpatient Clinic Reviews | | |
|---|---|---|
| Issue Date | Number | Reports |
| 4/11/2013 | 13-00026-166 | Dayton VA Medical Center, Dayton, Ohio |
| 4/19/2013 | 12-03853-172 | Battle Creek VA Medical Center, Battle Creek, Michigan, and Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois |
| 4/24/2013 | 13-00026-176 | Central Arkansas Veterans Healthcare System, Little Rock, Arkansas, and G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi |
| 4/26/2013 | 13-00026-177 | Robley Rex VA Medical Center, Louisville, Kentucky |
| 5/2/2013 | 13-00026-185 | Manchester VA Medical Center, Manchester, New Hampshire |
| 5/2/2013 | 13-00026-189 | Northport VA Medical Center, Northport, New York |
| 5/7/2013 | 13-00026-190 | VA New Jersey Health Care System, East Orange, New Jersey |
| 5/8/2013 | 13-00026-191 | Cheyenne VA Medical Center, Cheyenne, Wyoming |
| 5/14/2013 | 13-00026-196 | Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts |
| 5/16/2013 | 13-00026-197 | VA Maine Healthcare System, Augusta, Maine |
| 5/17/2013 | 13-00026-198 | Sioux Falls VA Health Care System, Sioux Falls, South Dakota |
| 5/31/2013 | 13-00026-207 | North Florida/South Georgia Veterans Health System, Gainesville, Florida |

## Appendix A

### List of Reports Issued

| Office of Healthcare Inspections \| Community Based Outpatient Clinic Reviews | | |
|---|---|---|
| Issue Date | Number | Reports |
| 5/31/2013 | 13-00026-212 | Oklahoma City VA Medical Center, Oklahoma City, Oklahoma |
| 6/13/2013 | 13-00026-213 | Central Texas Veterans Health Care System, Temple, Texas, and VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas |
| 6/25/2013 | 13-00026-223 | VA Pacific Islands Health Care System, Honolulu, Hawaii |
| 7/15/2013 | 13-00026-233 | Jesse Brown VA Medical Center, Chicago, Illinois |
| 7/19/2013 | 13-00026-248 | VA Butler Healthcare, Butler, Pennsylvania |
| 7/22/2013 | 13-00026-251 | Edward Hines, Jr. VA Hospital, Hines, Illinois |
| 7/23/2013 | 13-00026-252 | Amarillo VA Health Care System, Amarillo, Texas, and Northern Arizona VA Health Care System, Prescott, Arizona |
| 7/24/2013 | 13-00026-259 | Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma |
| 7/26/2013 | 13-00026-258 | Hunter Holmes McGuire VA Medical Center, Richmond, Virginia |
| 8/15/2013 | 13-00026-279 | VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania |
| 8/15/2013 | 13-00026-281 | Louis A. Johnson VA Medical Center, Clarksburg, West Virginia |
| 8/19/2013 | 13-00026-285 | Charlie Norwood VA Medical Center, Augusta, Georgia |
| 8/19/2013 | 13-00026-290 | Carl Vinson VA Medical Center, Dublin, Georgia |
| 8/20/2013 | 13-00026-272 | VA Connecticut Healthcare System, West Haven, Connecticut |
| 8/20/2013 | 13-00026-276 | Coatesville VA Medical Center, Coatesville, Pennsylvania |
| 8/21/2013 | 13-00026-293 | VA Central California Health Care System, Fresno, California |
| 8/26/2013 | 13-00026-280 | Philadelphia VA Medical Center, Philadelphia, Pennsylvania |
| 8/29/2013 | 13-00026-302 | Chillicothe VA Medical Center, Chillicothe, Ohio |
| 9/11/2013 | 13-00026-306 | VA Maryland Health Care System, Baltimore, Maryland |
| 9/16/2013 | 13-00026-317 | Fargo VA Health Care System, Fargo, North Dakota |
| 9/18/2013 | 13-00026-314 | James A. Haley Veterans' Hospital, Tampa, Florida |
| 9/19/2013 | 13-00026-316 | Sheridan VA Healthcare System, Sheridan, Wyoming |
| 9/26/2013 | 13-00026-327 | Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio |

| Office of Healthcare Inspections \| National Healthcare Reviews | | |
|---|---|---|
| Issue Date | Number | Title |
| 4/25/2013 | 12-01480-183 | Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2012 |
| 4/29/2013 | 13-01742-188 | Combined Assessment Program Summary Report – Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities |
| 4/30/2013 | 13-01744-187 | Combined Assessment Program Summary Report – Evaluation of Nurse Staffing in Veterans Health Administration Facilities |
| 5/2/2013 | 13-01743-192 | Combined Assessment Program Summary Report – Evaluation of Moderate Sedation in Veterans Health Administration Facilities |

| Office of Healthcare Inspections \| National Healthcare Reviews | | |
|---|---|---|
| Issue Date | Number | Title |
| 6/12/2013 | 13-01741-215 | Combined Assessment Program Summary Report – Evaluation of Colorectal Cancer Screening and Follow-Up in Veterans Health Administration Facilities |
| 8/1/2013 | 13-01987-263 | Healthcare Inspection – Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities |
| 8/1/2013 | 13-01189-267 | Healthcare Inspection – Prevention of Legionnaires' Disease in VHA Facilities |
| 8/16/2013 | 12-00040-268 | Vet Center Contracted Care Program Review |
| 9/11/2013 | 12-01702-303 | Combined Assessment Program Summary Report – Evaluation of Polytrauma Care in Veterans Health Administration Facilities |
| 9/30/2013 | 13-00090-346 | Evaluation of VHA Community Based Outpatient Clinics Fiscal Year 2012 |

| Office of Healthcare Inspections \| Hotline Healthcare Inspections | | |
|---|---|---|
| Issue Date | Number | Title |
| 4/11/2013 | 12-03939-175 | Alleged Inappropriate Surveillance James A. Haley Veterans' Hospital Tampa, Florida |
| 4/17/2013 | 12-02955-178 | Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia |
| 4/17/2013 | 12-03869-179 | Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia |
| 4/23/2013 | 13-00994-180 | Legionnaires' Disease at the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania |
| 5/1/2013 | 12-03743-184 | Alleged Questionable Surgical Care in a VA Health Care System |
| 5/9/2013 | 13-01320-200 | Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York |
| 5/13/2013 | 13-00940-193 | Alleged Delays in Notifying Patients of Biopsy Results, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina |
| 6/27/2013 | 12-02186-227 | Nursing Care in the Community Living Center for Spinal Cord Injury, Louis Stokes VA Medical Center, Cleveland, Ohio |
| 7/16/2013 | 12-01344-243 | Alleged Inadequate Oversight at a Contracted Homeless Program, VA New Jersey Health Care System, East Orange, New Jersey |
| 7/18/2013 | 13-01241-250 | Provider Availability, VA Roseburg Healthcare System, Roseburg, Oregon |
| 7/22/2013 | 13-01123-249 | Quality and Patient Safety Concerns in the CLC, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina |
| 7/29/2013 | 13-01988-253 | Review of a Patient with Medication-Induced Acute Renal Failure, Amarillo VA Health Care System, Amarillo, Texas |
| 7/31/2013 | 13-00696-254 | Follow-Up Assessment of Radiation Therapy, VA Long Beach Healthcare System, Long Beach, California |
| 8/2/2013 | 13-00670-265 | Review of Circumstances Leading to a Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana |

## Appendix A
### List of Reports Issued

| Office of Healthcare Inspections \| Hotline Healthcare Inspections | | |
|---|---|---|
| Issue Date | Number | Title |
| 8/13/2013 | 13-02235-277 | Alleged Patient Rights, Quality of Care, and Other Issues, VA Puget Sound Health Care System, Seattle, Washington |
| 9/3/2013 | 13-01351-296 | Alleged Sterile Processing Service Deficiencies, VA Puget Sound Health Care System, Seattle, Washington |
| 9/6/2013 | 12-04631-313 | Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina |
| 9/16/2013 | 13-02599-311 | Laboratory Delays and Alleged Staff Training Issues, Memphis VA Medical Center, Memphis, Tennessee |
| 9/17/2013 | 13-01498-318 | An Unexpected Death in a Mental Health Treatment Program, VA New Jersey Health Care System, Lyons, New Jersey |
| 9/18/2013 | 12-03887-319 | Inadequate Staffing and Poor Patient Flow in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland |
| 9/25/2013 | 13-01855-336 | Quality of Care Issues, Erie VA Medical Center, Erie, Pennsylvania, and VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania |

| Office of Investigations \| Administrative Investigation | | |
|---|---|---|
| Issue Date | Number | Title |
| 6/25/2013 | 13-00235-225 | Conduct Prejudicial to the Government, Veteran Employment Services Office, Office of Human Resources and Administration, Washington, DC |

| Office of Contract Review \| Preaward Reviews | | | |
|---|---|---|---|
| Issue Date | Number | Title | Savings and Cost Avoidance |
| 4/16/2013 | 13-01473-182 | Review of Contract Extension Proposal Submitted Under an FSS Contract | $3,736,605 |
| 4/23/2013 | 13-01430-181 | Review of Proposal Submitted Under a Solicitation | $5,956,965 |
| 4/30/2013 | 13-01929-186 | Review of Proposal Submitted Under a Solicitation | $901,441 |
| 4/30/2013 | 13-01472-194 | Review of Proposal for Product Additions to an FSS Contract | $8,615,256 |
| 5/14/2013 | 13-00337-208 | Review of FSS Proposal Submitted Under a Solicitation | $143,608 |
| 5/16/2013 | 13-02232-209 | Review of FSS Proposal Submitted Under a Solicitation | $5,211,347 |
| 5/22/2013 | 13-01120-205 | Review of Proposal Submitted Under a Solicitation | $23,921,077 |
| 5/22/2013 | 13-01379-214 | Review of Proposal Submitted Under a Solicitation | |
| 5/30/2013 | 13-01359-218 | Review of Proposal Submitted Under a Solicitation | $1,049,934 |
| 6/4/2013 | 13-00482-221 | Review of Contract Extension and Production Addition Proposals Submitted Under an FSS Contract | |
| 6/4/2013 | 13-00844-222 | Review of Contract Extension Proposal Submitted Under an FSS Contract | $5,494 |

| Office of Contract Review \| Preaward Reviews | | | |
|---|---|---|---|
| Issue Date | Number | Title | Savings and Cost Avoidance |
| 6/19/2013 | 13-01380-230 | Review of Proposal Submitted Under a Solicitation | |
| 6/28/2013 | 13-02582-241 | Review of Proposal Submitted Under a Solicitation | $1,192,800 |
| 7/8/2013 | 13-01382-246 | Review of Proposal Submitted Under a Solicitation | |
| 7/9/2013 | 13-02250-247 | Review of Contract Extension Proposal Submitted Under an FSS Contract | $1,394,290 |
| 7/16/2013 | 13-02522-255 | Review of FSS Proposal Submitted Under a Solicitation | $1,054,744 |
| 8/6/2013 | 13-03209-283 | Review of FSS Proposal Submitted Under a Solicitation | $115,729 |
| 8/8/2013 | 13-02231-287 | Review of FSS Proposal Submitted Under a Solicitation | $7,410,580 |
| 8/8/2013 | 13-01314-289 | Review of FSS Proposal Submitted Under a Solicitation | |
| 8/13/2013 | 13-03478-291 | Review of Contract Extension Proposal Submitted Under an FSS Contract | |
| 8/14/2013 | 13-02956-295 | Review of FSS Proposal Submitted Under a Solicitation | |
| 8/20/2013 | 13-03258-298 | Review of Proposal Submitted Under a Solicitation | $66,619 |
| 8/28/2013 | 13-03317-282 | Review of FSS Proposal Submitted Under a Solicitation | $70,539,634 |
| 8/29/2013 | 13-03207-305 | Review of Proposal for Product Additions to an FSS Contract | |
| 9/10/2013 | 13-03572-320 | Review of FSS Proposal Submitted Under a Solicitation | $1,694,345 |
| 9/13/2013 | 13-04012-325 | Review of Product Additions Submitted Under an FSS Contract | |
| 9/17/2013 | 13-03205-329 | Review of Contract Extension Proposal Submitted Under an FSS Contract | $10,060,050 |
| 9/18/2013 | 13-03388-331 | Review of Proposal Submitted Under a Solicitation | $5,256,601 |
| 9/18/2013 | 13-03031-333 | Review of FSS Proposal Submitted Under a Solicitation | |
| 9/19/2013 | 13-03261-334 | Review of Product Additions Submitted Under an FSS Contract | |
| 9/19/2013 | 13-03479-335 | Review of FSS Proposal Submitted Under a Solicitation | |
| 9/23/2013 | 13-03263-328 | Review of FSS Proposal Submitted Under a Solicitation | $427,620 |
| 9/24/2013 | 13-03694-340 | Review of FSS Proposal Submitted Under a Solicitation | |
| 9/30/2013 | 13-02139-353 | Review of FSS Contract Extension Proposal Submitted Under a Solicitation | $1,158,344 |
| | | | **$149,913,083** |

| Office of Contract Review \| Postaward Reviews | | | |
|---|---|---|---|
| Issue Date | Number | Title | Dollar Recoveries |
| 6/4/2013 | 10-02206-219 | Review of Public Law Compliance Issues Under an FSS Contract | $425 |

| Office of Contract Review \| Postaward Reviews | | | |
|---|---|---|---|
| Issue Date | Number | Title | Dollar Recoveries |
| 6/26/2013 | 12-00078-236 | Review of Compliance with Public Law Under FSS Contracts | $307 |
| 7/23/2013 | 13-01454-264 | Review of Voluntary Disclosure and Refund Offer of Price Reductions Under an FSS Contract | $2,435 |
| 8/7/2013 | 13-00932-278 | Review of Drug Pricing Violations of Public Law Under FSS Contracts | $15,681 |
| 8/19/2013 | 13-03779-297 | Review of Compliance with Public Law Regarding an Acquisition | $1,520 |
| 9/3/2013 | 13-01814-309 | Review of Compliance with Public Law Under FSS Contracts | $5,961 |
| 9/6/2013 | 13-03716-315 | Review of Overcharges for Late Additions of Covered Drugs Under an FSS Interim Agreement | $7,707 |
| 9/16/2013 | 13-03751-324 | Review of Compliance with Public Law Under FSS Contracts | $29 |
| 9/16/2013 | 13-03599-326 | Review of Public Law Overcharges for the Late Additions of Covered Drugs | $278,211 |
| 9/17/2013 | 09-02278-330 | Review of Industrial Funding Fee Compliance | |
| 9/24/2013 | 13-00934-341 | Review of Voluntary Disclosure Submitted under FSS Contracts | $93,791 |
| 9/24/2013 | 12-00440-342 | Review of Voluntary Disclosure and Refund Offer under an FSS Contract | $230,407 |
| 9/25/2013 | 13-01036-344 | Review of Voluntary Disclosure and Refund Offer Under an FSS Contract | $330,774 |
| 9/26/2013 | 11-01848-347 | Review of Compliance with Public Law Under an FSS Contract | $113,881 |
| 9/30/2013 | 09-03739-323 | Review of Self-Audit of Public Law Drug Pricing Compliance Under Seven FSS Contracts | $3,057,200 |
| 9/30/2013 | 13-00913-351 | Review of Self-Audit of Public Law Drug Pricing Compliance Under an FSS Contract | $802,623 |
| | | | **$4,940,952** |

| Office of Contract Review \| Claim Reviews | | | |
|---|---|---|---|
| Issue Date | Number | Title | Savings and Cost Avoidance |
| 9/30/2013 | 13-03755-349 | Review of Self-Audit of Public Law Drug Pricing Compliance Under an FSS Contract | $109,128 |
| 9/30/2013 | 13-03755-350 | Review of Self-Audit of Public Law Drug Pricing Compliance Under an FSS Contract | $83,515 |
| | | | **$192,643** |

| Total Potential Monetary Benefits of Reports Issued | | | | |
|---|---|---|---|---|
| Report Type | Better Use of Funds | Questioned Costs | Savings and Cost Avoidance | Dollar Recoveries |
| Audits, Evaluations, and Reviews | $1,559,100,000 | $122,746,803 | | |
| Preaward Reviews | | | $149,913,083 | |
| Postaward Reviews | | | | $4,940,952 |
| Claims Reviews | | | $192,643 | |
| | **$1,559,100,000** | **$122,746,803** | **$150,105,726** | **$4,940,952** |

## Table 2: Resolution Status of Reports with Questioned Costs

| Resolution Status | Number | Dollar Value |
|---|---|---|
| No management decision made by commencement of reporting period | 0 | $0 |
| Issued during reporting period | 4 | $122,746,803 |
| **Total inventory this period** | **4** | **$122,746,803** |
| Management decisions made during the reporting period | | |
| Disallowed costs (agreed to by management) | 4 | $122,746,803 |
| Allowed costs (not agreed to by management) | 0 | $0 |
| **Total management decisions this reporting period** | **4** | **$122,746,803** |
| **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 |
|---|---|---|
| No management decision made by commencement of reporting period | 0 | $0 |
| Issued during reporting period | 7 | $1,559,100,000 |
| **Total inventory this period** | **7** | **$1,559,100,000** |
| Management decisions made during the reporting period | | |
| Disallowed costs (agreed to by management) | 7 | $1,559,100,000 |
| Allowed costs (not agreed to by management) | 0 | $0 |
| **Total management decisions this reporting period** | **7** | **$1,559,100,000** |
| **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, 2013, there are 223 total open reports and 1,106 total open recommendations. However, six reports and eight recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 47 reports and 136 recommendations that, as of September 30, 2013, remain open for more than 1 year. The total monetary benefit attached to these reports is $1,307,917,553.

**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 | 30 | 143 | **173** | 71 | 829 | **900** |
| Veterans Benefits Administration | 4 | 19 | **23** | 10 | 63 | **73** |
| National Cemetery Administration | 0 | 2 | **2** | 0 | 6 | **6** |
| Office of Acquisitions, Logistics, and Construction | 4 | 5 | **9** | 11 | 11 | **22** |
| Office of Management | 2 | 1 | **3** | 24 | 3 | **27** |
| Office of Information and Technology | 5 | 5 | **10** | 13 | 43 | **56** |
| Office of Human Resources and Administration | 3 | 4 | **7** | 7 | 13 | **20** |
| Office of Operations, Security, and Preparedness (OSP) | 3 | 0 | **3** | 2 | 0 | **2** |
| Office of General Counsel | 2 | 1 | **3** | 4 | 2 | **6** |
| Chief of Staff | 0 | 1 | **1** | 0 | 2 | **2** |
| **Total** | **53** | **181** | **234** | **142** | **972** | **1,114** |

## 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.* | | | | |
| 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.*<br><br>*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.*<br><br>*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.*<br><br>*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 [Federal Career Intern Program] appointments, failure to provide 2-year formal training programs, and subsequent conversions to career-conditional status of _____, and take such action.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *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.*<br><br>*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 [Direct Hire Authority] appointments of _____ and take such action.*<br><br>*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.*<br><br>*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.*<br><br>** 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.* | | | | |
| 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.* | | | | |
| 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.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC 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).*<br><br>*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.*<br><br>*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.*<br><br>*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.* | | | | |
| 09/30/10 | 10-01575-262 | VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12 | OSP | None |
| *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 [Homeland Security Presidential Directive 12] Program.* | | | | |
| 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.* | | | | |

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | | |
|---|---|---|---|---|
| **Issue Date** | **Number** | **Title** | **Responsible Organization(s)** | **Monetary Impact of Open Recommendations** |
| 07/21/11 | 09-00981-227 | Review of VHA Sole-Source Contracts with Affiliated Institutions | VHA | None |
| *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.*<br><br>*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.* | | | | |
| 07/27/11 | 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.* | | | | |
| 09/02/11 | 10-01744-265 | Audit of National Contract Awards at VA's National Acquisition Center | OALC | None |
| *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.* | | | | |
| 09/30/11 | 10-03850-298 | Audit of VHA's Workers' Compensation Case Management | VHA | $105,300,000 |
| *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).* | | | | |
| 11/01/11 | 11-01406-14 | Community Based Outpatient Clinic Reviews: Bennington, VT and Littleton, NH; Jamestown and Lackawanna, NY; Hagerstown, MD and Petersburg, WV | VHA | None |
| *Recommendation 7: We recommended that the copies of Short-Term Fee Basis reports of the Bennington CBOC patients are filed or scanned into the medical record.*<br><br>*Recommendation 11: We recommended that managers establish a process to ensure that patients at the Bennington and Littleton CBOCs are notified of mammogram results within the allotted timeframe and that notification is documented in the medical record.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 12: We recommended that managers ensure fee basis mammography results are received and scanned into CPRS [Computerized Patient Record System] at the Bennington and Littleton CBOCs.* | | | | |
| 11/02/11 | 11-01406-13 | Community Based Outpatient Clinic Reviews: Gillette and Powell, WY; Pueblo, CO; Anaheim and Laguna Hills, CA; Escondido and Oceanside, CA; Lancaster and Sepulveda, CA | VHA | None |
| *Recommendation 34: We recommended that the Facility Director and Contracting Officer ensure that there are performance incentive/penalty provisions in the contract, particularly those related to VHA quality of medical care standards.*<br><br>*Recommendation 35: We recommended that the VISN Director and VHA Sharing Office take appropriate steps to ensure that medical contracting is performed in accordance with applicable laws, regulations, and policies, and that interim contracts are approved in advance by VHA's Medical Sharing Office as required by VA Directive 1663.*<br><br>*Recommendation 36: We recommended that the VISN Director, Contracting Office, and Facility Director take the steps necessary to award a long-term contract to obtain required services for the Lancaster CBOC.* | | | | |
| 01/06/12 | 11-03941-61 | Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Temple, Texas | VHA | None |
| *Recommendation 2: We recommended that the Medical Center Director ensure that patients receive timely colorectal cancer screening follow-up as required by VHA Directive.* | | | | |
| 02/23/12 | 11-00733-95 | Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires | VBA | None |
| *Recommendation 2: We recommend the Under Secretary for Benefits develop front-end controls for the disability benefits questionnaire process to verify the identity and credentials of private physicians who submit completed disability benefits questionnaires, including those entered into the Fast Track Claims Processing System.*<br><br>*Recommendation 4: We recommend the Under Secretary for Benefits develop controls to electronically capture information contained on completed disability benefits questionnaires.*<br><br>*Recommendation 6: We recommend the Under Secretary for Benefits take steps to improve quality assurance reviews by focusing reviews on disability benefits questionnaires that pose an increased risk of fraud.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| 02/29/12 | 11-03668-107 | Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi | VHA | None |
| *Recommendation 1: We recommended that processes be strengthened to ensure that FPPEs [Focused Professional Practice Evaluations] are consistently initiated and completed and that results are reported to the Clinical Executive Board.*<br><br>*Recommendation 4: We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of the medical record quality review process and that all services and programs are included.*<br><br>*Recommendation 8: We recommended that processes be strengthened to ensure that patients with positive CRC [colorectal cancer] screening test results receive diagnostic testing within the required timeframe.*<br><br>*Recommendation 9: We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.*<br><br>*Recommendation 10: We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.*<br><br>*Recommendation 15: We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.* | | | | |
| 03/08/12 | 11-02254-102 | Audit of the Management and Acquisition of Prosthetic Limbs | VHA | None |
| *Recommendation 2: We recommend the Under Secretary for Health improve the guidance issued to Certified Prosthetists for their review of vendor quotes.*<br><br>*Recommendation 5: We recommend the Under Secretary for Health establish reasonable pricing standards for prosthetic limb items that Medicare has yet to classify.*<br><br>*Recommendation 6: We recommend the Under Secretary for Health identify and assess the adequacy of VA's in-house fabrication capabilities for prosthetic limbs.*<br><br>*Recommendation 7: We recommend the Under Secretary for Health implement procedures to ensure VISNs comply with VHA Handbook 1173.3 and identify an appropriate number of contract vendors needed to provide Veterans with prosthetic limbs.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| 03/08/12 | 11-02138-116 | Healthcare Inspection – Prosthetic Limb Care in VA Facilities | VHA | None |
| *Recommendation 3: We recommended that the Under Secretary for Health consider Veterans' concerns with VA approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of Veterans with amputations.* | | | | |
| 03/16/12 | 11-03653-106 | Community Based Outpatient Clinic Reviews: Durango, CO; Raton and Silver City, NM; Odessa, TX | VHA | None |
| *Recommendation 8: We recommended that the ordering practitioners, or surrogate practitioners, communicate the STFB [Short-Term Fee Basis] results to the patient within 14 calendar days from the date made available to the provider.* | | | | |
| 03/19/12 | 11-03653-112 | Community Based Outpatient Clinic Reviews: Pensacola (Joint Ambulatory Care Center), FL; New Braunfels, San Antonio (North Central Federal Clinic), and Victoria, TX | VHA | None |
| *Recommendation 10: We recommended that the JACC [Joint Ambulatory Care Center] CBOC ordering providers document in the medical record that they reviewed the STFB imaging report within 14 days from the date made available to the provider.*<br><br>*Recommendation 11: We recommended that the ordering providers, or surrogate providers, at the JACC CBOC communicate the STFB results of the imaging report to the patient within 14 days from the date made available to the provider.*<br><br>*Recommendation 12: We recommended that the JACC CBOC establish a process to ensure that patients with normal mammogram results are notified of results within the allotted timeframe and that notification is documented in the medical record.* | | | | |
| 03/30/12 | 11-00312-127 | Audit of VHA's Prosthetics Supply Inventory Management | VHA | $35,500,000 |
| *Recommendation 2: We recommended the Under Secretary for Health collaborate with the VA Office of Information and Technology to develop a detailed plan of the steps needed to replace Prosthetics Inventory Package and Generic Inventory Package with a comprehensive modern inventory system, including milestones for deliverables and a methodology for tracking progress.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 4: We recommended the Under Secretary for Health collaborate with the Executive Director, Office of Acquisition, Logistics, and Construction, to develop a VA Acquisition Academy curriculum and certification program for prosthetic supply inventory managers that includes training on the inventory management practices and techniques discussed in this report.*<br><br>*Recommendation 5: We recommended the Under Secretary for Health revise the Veterans Health Administration's Inventory Management Handbook to require at least one prosthetic supply inventory manager from each VA medical center to attend VA's Acquisition Academy's Supply Chain Management School and become Certified VA Supply Chain Managers.*<br><br>*Recommendation 6: We recommended the Under Secretary for Health establish a mechanism to identify surgical device implants stored in VA medical center inventories, perform cost/benefit analyses of using consignment agreements to procure identified surgical device implants, and when determined to be cost effective, establish surgical device implant consignment agreements.*<br><br>*Recommendation 7: We recommended the Under Secretary for Health discontinue using the metric of comparing prosthetic excess supply inventory and budgets and establish a mechanism to ensure VA medical centers submit the prosthetic inventory performance metrics required by the Veterans Health Administration's Inventory Management Handbook.*<br><br>*Recommendation 9: We recommended the Under Secretary for Health establish policies and procedures requiring Veterans Integrated Service Network Prosthetic Representatives to conduct cyclical reviews at VA medical centers within their jurisdiction to evaluate prosthetic supply inventory management practices and provide a comprehensive written report detailing the evaluation results to the Prosthetic and Sensory Aids Service Central Office and Veterans Integrated Service Network and VA medical center directors.* | | | | |
| 04/18/12 | 12-00371-157 | Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina | VHA | None |
| *Recommendation 11: We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.* | | | | |
| 04/19/12 | 11-04081-142 | Audit of VA's Duty Station Assignments | OHRA | $1,355,355 |
| *Recommendation 2: We recommend the Assistant Secretary for Human Resources and Administration issue policy requiring that at least annually, managers are notified of their employees' duty station assignments and validate the assignments.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 3: We recommend the Assistant Secretary for Human Resources and Administration establish an oversight mechanism to ensure that at least annually, managers are notified of their employees' duty station assignments and validate the assignments.*<br><br>*Recommendation 5: We recommend the Assistant Secretary for Human Resources and Administration establish a control mechanism to provide annual notification to supervisors regarding the requirement to submit a Request for Personnel Action, Standard Form 52, if an employee's duty station changes.* | | | | |
| 04/23/12 | 12-00900-168 | Review of Veterans' Access to Mental Health Care | VHA | None |
| *Recommendation 1: We recommend the Under Secretary for Health revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.*<br><br>*Recommendation 2: We recommend the Under Secretary for Health reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments.*<br><br>*Recommendation 3: We recommend the Under Secretary for Health conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the Veterans Health Administration's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.*<br><br>*Recommendation 4: We recommend the Under Secretary for Health ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decision makers throughout the organization.* | | | | |
| 05/01/12 | 11-03655-170 | Community Based Outpatient Clinic Reviews: Virginia Beach (Norfolk-Virginia Beach), VA; Bellevue, KY; Hamilton, OH | VHA | None |
| *Recommendation 1: We recommended that the Norfolk-Virginia Beach CBOC establish diabetic patient referral guidelines based on foot risk factors in accordance with VHA policy and that clinicians document education of foot care to diabetic patients in CPRS.* | | | | |

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | | |
|---|---|---|---|---|
| **Issue Date** | **Number** | **Title** | **Responsible Organization(s)** | **Monetary Impact of Open Recommendations** |
| 05/22/12 | 12-01531-187 | Combined Assessment Program Summary Report – Enteral Nutrition Safety 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 facilities' policies and practices address all VHA-required EN [enteral nutrition] elements.*<br><br>*Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that EHR [electronic health record] documentation consistently includes all VHA-required EN elements.* | | | | |
| 05/30/12 | 10-03166-75 | Audit of VA Regional Offices' Appeals Management Processes | VBA | None |
| *Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals.*<br><br>*Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.*<br><br>*Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.*<br><br>*Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.* | | | | |
| 06/14/12 | 12-00885-200 | Combined Assessment Program Review of the Alexandria VA Health Care System, Pineville, Louisiana | VHA | None |
| *Recommendation 1: We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.*<br><br>*Recommendation 2: We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 10: We recommended that processes be strengthened to ensure that normal test results are consistently communicated to patients within the specified timeframe.* | | | | |
| 06/19/12 | 12-00881-203 | Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico | VHA | None |
| *Recommendation 1: We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.*<br><br>*Recommendation 8: We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe and that EHRs contain documentation of testing or reasons why testing was not done.*<br><br>*Recommendation 13: We recommended that processes be strengthened to ensure that the EHR Committee provides consistent oversight and coordination of EHR quality reviews and that EHR quality reviews are analyzed and trended.*<br><br>*Recommendation 14: We recommended that processes be strengthened to ensure that EHR reviews include all providers and all required elements and that the copy and paste functions are monitored.* | | | | |
| 07/03/12 | 11-03655-214 | Community Based Outpatient Clinic Reviews Fort Smith, AR; Lafayette, LA; Denton and Tyler, TX | VHA | None |
| *Recommendation 3: We recommended that the Lafayette CBOC clinicians document education of preventative foot care to diabetic patients in CPRS.* | | | | |
| 07/06/12 | 12-00709-211 | Combined Assessment Program Review of the Washington, DC, VA Medical Center, Washington, DC | VHA | None |
| *Recommendation 4: We recommended that processes be strengthened to ensure that quarterly peer review reports are submitted to the Medical Executive Committee.*<br><br>*Recommendation 6: We recommended that the facility develop a Code Blue Committee policy and that processes be strengthened to ensure that actions recommended by the committee are implemented and evaluated for effectiveness.*<br><br>*Recommendation 7: We recommended that processes be strengthened to ensure that the Medical Record Committee provides oversight and coordination of medical record quality reviews and monitors the copy and paste functions.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| 07/27/12 | 12-00882-232 | Combined Assessment Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia | VHA | None |
| *Recommendation 1: We recommended that processes be strengthened to ensure that all discharged MH [mental health] patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.* | | | | |
| 08/02/12 | 11-02433-220 | Audit of ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs | OHRA | None |
| *Recommendation 3: We recommended the Assistant Secretary for Human Resources and Administration improve the management of ADVANCE interagency agreement terms by developing processes to collect timely and complete information including copies of signed interagency agreements.* | | | | |
| 08/13/12 | 12-01874-245 | Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas | VHA | None |
| *Recommendation 4: We recommended that processes be strengthened to ensure that EHR quality reviews include all services and programs.*<br><br>*Recommendation 19: We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.* | | | | |
| 08/15/12 | 11-04090-253 | Healthcare Inspection – Emergency Department Delays – Memphis VA Medical Center, Memphis, TN | VHA | None |
| *Recommendation 1: We recommended that the Facility Director take appropriate action to reduce ED [emergency department] LOS [length of stay].*<br><br>*Recommendation 2: We recommended that the Facility Director ensure that ultrasound services for ED patients are readily available by in-house or on-call staff 24 hours a day as required.*<br><br>*Recommendation 3: We recommended that the Facility Director ensure the accuracy of data entered in EDIS [Emergency Department Integrated Software] and VistA related to ED visits.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| 08/16/12 | 11-01406-247 | Healthcare Inspection – Evaluation of Community Based Outpatient Clinics, Fiscal Year 2011 | VHA | None |
| *Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that practitioners document a justification for the use of STFB care in the medical record, specifically at urban CBOCs.*<br><br>*Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure there is documentation in the medical record that the patient received written notification STFB consult approval, specifically at urban CBOCs.*<br><br>*Recommendation 10: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, implement measures to minimize IT network space vulnerabilities in accordance with VA policy.* | | | | |
| 08/20/12 | 12-01235-132 | Review of Enterprise Technology Solutions, LLC Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations | VHA | None |
| *Recommendation 6: We recommend that the Under Secretary for Health implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition or give former VA employees an unfair advantage.* | | | | |
| 08/23/12 | 12-00574-238 | Community Based Outpatient Clinic Reviews: Homestead and Key West, FL; Hopkinsville, KY; McMinnville, TN | VHA | None |
| *Recommendation 13: We recommended that the Facility Director determines, with the assistance of the Regional Counsel, the extent and collectability of the overpayments made since the inception of the contract.* | | | | |
| 08/27/12 | 12-00575-255 | Community Based Outpatient Clinic Reviews: Payson and Show Low, AZ; Long Beach (Cabrillo) and Laguna Hills, CA | VHA | None |
| *Recommendation 1: We recommended that the Show Low clinicians document, in CPRS, a complete foot screening for diabetic patients.*<br><br>*Recommendation 2: We recommended that the Payson and Show Low clinicians document, in CPRS, a risk level for diabetic patients in accordance with VHA policy.* | | | | |

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | | |
|---|---|---|---|---|
| **Issue Date** | **Number** | **Title** | **Responsible Organization(s)** | **Monetary Impact of Open Recommendations** |
| *Recommendation 14: We recommended that the VAMC Director ensures that access to MH services at the Payson CBOC complies with VHA directives.* | | | | |
| 09/07/12 | 12-00577-273 | Community Based Outpatient Clinic Reviews: Wilmington, NC; Columbus, GA; Goose Creek, SC; and Savannah, GA | VHA | None |
| *Recommendation 1: We recommended that Columbus CBOC clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.* | | | | |
| 09/26/12 | 12-00828-287 | Healthcare Inspection – Consultant Responses, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois | VHA | None |
| *Recommendation 1: We recommended that the Facility Director ensure that mental health consults are answered and documented within the timeframe specified by the referring provider.* | | | | |
| 09/27/12 | 12-00241-296 | Inspection of the VA Regional Office Cleveland, Ohio | VBA | None |
| *Recommendation 1: We recommend the Cleveland VA Regional Office Director conduct refresher training on the proper processing of traumatic brain injury claims involving coexisting mental conditions.*<br><br>*Recommendation 2: We recommend the Cleveland VA Regional Office Director ensure compliance with requirements for using the Control of Veterans Records System application.* | | | | |
| 09/28/12 | 12-00375-290 | Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC | OM/OGC | None |
| *Recommendation 4: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville EUL [Enhanced Use Lease] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 5: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem.*<br><br>*Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer immediately determine what services VOA is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA [Volunteers of America]. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.*<br><br>*Recommendation 8: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer take immediate steps to identify the security requirements for the administration building, parking, and domiciliary space and develop a plan of action to ensure the safety and security of VA employees, Veterans, and their families.* | | | | |
| 09/28/12 | 12-01012-298 | Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation | VHA/OALC | None |
| *Recommendation 2: We recommend that the Under Secretary for Health seek legislative changes to revise the annual FCP [Federal Ceiling Price] implementation date from January 1st to February 1st of each year to provide ample time to process the Non-FAMP [Non-Federal Average Manufacturer's Price] data.*<br><br>*Recommendation 7: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices.*<br><br>*Recommendation 8: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts.*<br><br>*Recommendation 10: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction require the PPV [Pharmaceutical Primve Vendor] to update its ordering system interface to work with the CMOPs' [Consolidated Mail Outpatient Pharmacies'] system and require all facilities, including the CMOPs, to use McKesson Connect when placing orders in the future.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.* | | | | |
| 09/30/12 | 12-00165-277 | Review of Alleged Delays in VA Contractor Background Investigations | OSP | None |
| *Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.* | | | | |
| 09/30/12 | 12-02525-291 | Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida | OALC/OM/ OIT/OHRA/ OGC | $762,198 |
| *Recommendation 6: We recommended the VA Secretary confer with Human Resources officials outside VA Central Office's Office of Human Resources Management and attorneys in the Office of General Counsel to determine the appropriate administrative action to take against Ms. Dudley and ensure that action is taken.*<br><br>*Recommendation 7: We recommended the VA Secretary confer with Human Resources officials outside VA Central Office's Office of Human resources Management and attorneys in the Office of General Counsel to determine the appropriate administrative action to take against _____ and ensure that action is taken.*<br><br>*Recommendation 14: We recommended the VA Secretary confer with Human Resources officials outside VA Central Office's Office of Human Resources Management and attorneys in the Office of General Counsel to determine the appropriate administrative action to take against Ms. Dudley and ensure that action is taken.*<br><br>*Recommendation 19: We recommended the VA Secretary establish a policy that VA will no longer solicit lodging accommodation upgrades as part of contracts.*<br><br>*Recommendation 20: We recommended the VA Secretary modify VA procedures to include a requirement for a detailed spend plan to ensure cost estimates are reasonable.*<br><br>*Recommendation 21: We recommended the VA Secretary implement policy to ensure conference managers obtain subsequent authorization from the Chief of Staff or the Deputy Secretary once they determine estimated costs have been exceeded or other major changes occur.* | | | | |

| Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old | | | | |
|---|---|---|---|---|
| **Issue Date** | **Number** | **Title** | **Responsible Organization(s)** | **Monetary Impact of Open Recommendations** |
| *Recommendation 22: We recommended the VA Secretary require an after-action report be provided to the Chief of Staff or the Deputy Secretary identifying planned-versus-actual costs, including justifications for significant differences.* | | | | |
| *Recommendation 23: We recommended the VA Secretary issue policy outlining requirements for authorizing, justifying, and conducting pre-planning site visits for conferences.* | | | | |
| *Recommendation 24: We recommended the VA Secretary establish requirements to support major conferences with contracting officers and other support resources to ensure conferences and the supporting acquisitions are planned and managed in accordance with applicable regulations.* | | | | |
| *Recommendation 25: We recommended the VA Secretary establish budgetary controls to ensure centralized accounting for individual conference expenditures.* | | | | |
| *Recommendation 26: We recommended the VA Secretary ensure conference budgets are authorized and monitored to ensure appropriate expenditures.* | | | | |
| *Recommendation 27: We recommended the VA Secretary establish controls to ensure senior officials exercise their responsibility and accountability for prudent management of conference funds.* | | | | |
| *Recommendation 28: We recommended the VA Secretary require travelers and approvers to comply with the requirement to not incur hotel taxes in states which offer tax exemption to the Government.* | | | | |
| *Recommendation 29: We recommended the VA Secretary require conference planning committees to identify, by name, individuals needed onsite for conference support before or after the conference and that this designation be provided to the traveler for inclusion in their travel receipts.* | | | | |
| *Recommendation 30: We recommended the VA Secretary require travelers and approving officials to comply with the requirement to include a cost comparison when choosing to use a privately owned vehicle instead of a government contracted mode of transportation.* | | | | |
| *Recommendation 34: We recommended the VA Secretary require that all VA program offices (Administrations, Boards, Centers, and Offices) that plan meetings, conferences, or events involving more than 50 staff identify and clearly state all event requirements to minimize contract modifications.* | | | | |
| *Recommendation 35: We recommended the VA Secretary develop a mechanism to ensure that commitments, expenditures, and combined liabilities exceeding $25,000 receive a legal and technical review.* | | | | |

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

| Issue Date | Number | Title | Responsible Organization(s) | Monetary Impact of Open Recommendations |
|---|---|---|---|---|
| *Recommendation 36: We recommended the VA Secretary ensure a Price Negotiation Memorandum be used to document negotiated agreements to minimize the possibility of future claims against the Government and to obtain a clear understanding from the contractor that all costs have been fully considered.*<br><br>*Recommendation 38: We recommended the VA Secretary ensure that only authorized contracting personnel make commitments or changes that affect price, quality, quantity, delivery, or other terms and conditions of a contract.*<br><br>*Recommendation 39: We recommended the VA Secretary ensure contract modifications are completed timely.*<br><br>*Recommendation 40: We recommended the VA Secretary establish oversight mechanisms to eliminate excessive and wasteful conference expenditures of public funds.*<br><br>*Recommendation 42: We recommended the VA Secretary take action to ratify any legal agreements made by VA employees where there was no previous authority to commit payments for goods and/or services with the Marriott.*<br><br>*Recommendation 43: We recommended the VA Secretary establish an effective cost system for credit card purchases that appropriately assigns costs to individual major VA events.*<br><br>*Recommendation 47: We recommended the VA Secretary ensure VA Learning University employees are trained on purchase card policies related to splitting purchases.*<br><br>*Recommendation 48: We recommended the VA Secretary ensure supervisors have the required documentation prior to approving purchase card transactions.*<br><br>*Recommendation 49: We recommended the VA Secretary require the Department to accomplish a special review of purchase card transactions made in support of VA Learning University conferences.* | | | | |
| **Total** | | | | **$1,307,917,553** |

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# Department of Veterans Affairs
## Office of Inspector General

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