Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 71 | October 1, 2013–March 31, 2014

Message from the Acting Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our accomplishments during the reporting period October 1, 2013–March 31, 2014. 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 115 reports and 18 memoranda on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $712 million in monetary benefits, for a return on investment of $14 for every dollar expended on OIG oversight. OIG investigators closed 418 investigations and made 208 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 566 administrative sanctions and corrective actions.

Our Office of Investigations, in a joint effort with the Federal Bureau of Investigation (FBI), uncovered the corruption activities of a former Director of the Cleveland and Dayton, OH, VA Medical Centers (VAMCs), who engaged in money laundering, fraud, and conspiracy to defraud VA by accepting thousands of dollars from contractors in exchange for inside information. Also, as part of the scheme, the former Director conspired with employees of a company to defraud VA by providing confidential information about VA contracts and projects the company was seeking to obtain, causing a potential loss to the Government of approximately $20 million. As the result of a 2-year investigation by OIG and the FBI, the former Director pled guilty to 64 corruption-related charges.

The Office of Investigations' ongoing efforts to combat identity theft continues to yield judicial and administrative results. During this reporting period, two additional individuals were arrested and seven were convicted after being charged with Federal crimes related to identity theft and tax fraud. These individuals, including a former Tampa, FL, VAMC clerk sentenced to 72 months' imprisonment and a volunteer awaiting sentencing, compromised VAMC medical records containing Veterans' personally identifiable information (PII) and sold the information for money, drugs, and guns. The Internal Revenue Service reported that nearly $3.4 million in tax refund fraud resulted from the actions of these particular defendants. OIG submitted recommendations to VA to prevent further compromises of Veterans' PII.

The Office of Healthcare Inspections (OHI) reviewed allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service at the William Jennings Bryan Dorn VAMC in Columbia, SC. Although OIG could not substantiate high general and vascular surgery complication rates or that contaminated surgical equipment led to surgical site infections, OIG found improper use of hard-copy logbooks, insufficient staffing in the surgery clinic, and several vacancies in the Anesthesia Service. Additionally, while OIG did not substantiate patients were being placed under extended anesthesia so residents could be trained in laparoscopic techniques, or that a power outage negatively impacted surgical patients, OIG determined that deficient surgical scheduling processes directly impacted operating room scheduling and

caused case delays resulting in the use of overtime. Furthermore, OIG found that the VAMC's Infection Control program was fragmented and inconsistent, surveillance data was rarely analyzed or trended, and Infection Control Sub-Council minutes lacked evidence of preventive and corrective measures. OIG also found issues in Reusable Medical Equipment Oversight Committee minutes, inconsistencies with high-level oversight and subordinate committees, a lack of necessary monitoring and oversight in the Quality Management program, issues in the Patient Safety and Peer Review programs, that the general surgery residency program is again in jeopardy, and that many key leaders at the VAMC were functioning in "acting" capacities.

OHI also conducted reviews of unexpected patient deaths at the Miami and Memphis VAMCs. At the Miami VAMC, OHI reviewed the unexpected death of a patient in the substance abuse residential rehabilitation treatment program (SARRTP). The patient had died in his room in the SARRTP from cocaine and heroin toxicity, and OIG found that the SARRTP security surveillance cameras were not functioning at the time of the patient's death. In addition, OIG found no alternative arrangements were made to conduct patient monitoring in the absence of a functioning surveillance camera. At the Memphis VAMC, OHI responded to allegations of inadequate care for three patient deaths in the Emergency Department of the facility. OIG substantiated that a patient was administered a medication, in spite of a documented drug allergy, and had a fatal reaction. OIG also substantiated that another patient was found unresponsive upon being administered multiple sedating medications and a third patient with critically high blood pressure who experienced bleeding in the brain was not aggressively monitored. Recommendations were made at both VAMCs to improve operations.

The Office of Audits and Evaluations assessed the effectiveness of VA's administration of hearing aid order and repair services through VA's audiology services. Though hearing loss was one of the most prevalent service-connected disabilities for Veterans receiving compensation at the end of fiscal year (FY) 2012, VA was not timely in issuing new hearing aids to Veterans or in meeting its 5-day timeliness goal to complete repair services. Specifically, during the 6-month period from April–September 2012, the Veterans Health Administration issued 30 percent of hearing aids to Veterans more than 30 days from the estimated receipt date from their vendors. These delays were due to inadequate staffing and an increased workload at medical facility audiology clinics and among Denver Acquisition and Logistics Center (DALC) repair technicians. OIG observed and estimated approximately 19,500 sealed packages of hearing aids were waiting for repair and staff to record the date received into DALC's production system. According to management, staff did not record the date they received the packages because opening packages had the potential risk of losing small parts. However, without a timely recording system, staff cannot adequately respond to Veteran and medical facility inquiries.

These and the many other accomplishments discussed in this report would not have been possible without the sustained commitment of the dedicated men and women who comprise our outstanding workforce and who strive to ensure our Nation's Veterans and their families receive the best care, benefits, and services possible from VA. I am grateful for the continued support of our mission from Members of Congress, the Secretary, the Deputy Secretary, and VA senior management. We look forward to continuing these partnerships as we all continue to work to improve the lives of America's Veterans.

RICHARD J. GRIFFIN
Acting Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total
Fines, Penalties, Restitutions, and Civil Judgments	$53.7
Fugitive Felon Program	$116.3
Savings and Cost Avoidance	$532.5
Dollar Recoveries	$9.5
Total Dollar Impact	$712.0
Cost of OIG Operations[1]	$52.7
Return on Investment[2]	**14:1**

1. The 6-month operating cost for the Office of Healthcare Inspections ($10.8 million), 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.

Investigative Activities	6-Month Total
Arrests[3]	179
Fugitive Felon Arrests	29
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	1
Indictments	128
Criminal Complaints	79
Convictions	169
Pretrial Diversions and Deferred Prosecutions	25
Administrative Investigations Opened	9
Administrative Investigations Closed	7
Administrative Sanctions and Corrective Actions	221
Cases Opened[4]	475
Cases Closed[5]	418

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

Reports and Memoranda	6-Month Total
Reports Issued	
Audits and Evaluations	7
Hotline Healthcare Inspections	14
Combined Assessment Program Reviews	22
Community Based Outpatient Clinic Reviews[6]	24
Administrative Investigations	1
Preaward Contract Reviews	26
Postaward Contract Reviews	19
Claim Reviews	1
Contract Review Special Reports	1
Subtotal	**115**
Memoranda	
Administrative Investigation Advisories	2
Administrative Investigation Closures	6
Healthcare Closures	10
Subtotal	**18**
Total Reports and Memoranda	**133**

6. Encompassing 43 facilities for the 6-month period.

Hotline Activities	6-Month Total
Contacts	14,303
Cases Opened	487
Cases Closed	525
Administrative Sanctions and Corrective Actions	345
Substantiation Percentage Rate	40

Glossary

ACGME	Accreditation Council for Graduate Medical Education
AIB	Administrative Investigation Board
AMI	area median income
ARRA	American Recovery and Reinvestment Act
AWOL	absent without leave
CAP	Combined Assessment Program
CBO	Chief Business Office
CBOC	Community Based Outpatient Clinic
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CIO	Chief Information Officer
CPRS	computerized patient record system
CSP	commerical sales practices
CT	computed tomography
DALC	Denver Acquisition and Logistics Center
DD 214	Certificate of Release or Discharge from Active Duty
DD 215	Correction to DD Form 214, Certificate of Release or Discharge from Active Duty
DIC	Dependency and Indemnity Compensation
DHA	direct hire authority
DOL	Department of Labor
DSS	Diplomatic Security Service
ED	emergency department
EHR	electronic health record
EMS	Environmental Management Services
EOC	environment of care
EUL	Enhanced Use Lease
FBI	Federal Bureau of Investigation
FCIP	Federal Career Intern Program
FFMIA	Federal Financial Management Improvement Act
FISMA	Federal Information Security Management Act
FPPE	Focused Professional Practice Evaluation
FSS	Federal Supply Schedule
FY	fiscal year
GSA	General Services Administration
HCC	Health Care Center
HCS	Healthcare System
HR	Human Resources
HSPD-12	Homeland Security Presidential Directive 12
HUD	Department of Housing and Urban Development
HVAC	Heating, Ventilation, and Air Conditioning
iEHR	integrated electronic health record
IG	Inspector General
IRS CI	Internal Revenue Service Criminal Investigation
IT	information technology
IU	Individual Unemployability
LOS	length of stay
MFC	most favored customer
MH	mental health
MM	medication management
NAC	National Acquisition Center
NCA	National Cemetery Administration
NRM	nonrecurring maintenance
NTE	not-to-exceed
OALC	Office of Acquisition, Logistics, and Construction
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHRA	Office of Human Resources and Administration
OIG	Office of Inspector General
OIT	Office of Information and Technology
OM	Office of Management
ONDCP	Office of National Drug Control Policy
OPM	Office of Personnel Management
OR	operating room
ORO	Office of Research Oversight
OSP	Office of Operations, Security, and Preparedness
OWCP	Office of Workers' Compensation Program
PII	personally identifiable information
P.L.	Public Law
PLO	Procurement and Logistics Office
PMAS	Project Management Accountability System
PRE	Pharmacy Reengineering
PTSD	post-traumatic stress disorder
QAR	Qualitative Assessment Review
RCA	root cause analysis
RVSR	Rating Veterans Service Representative
SARRTP	substance abuse residential rehabilitation treatment program

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SBA	Small Business Administration
SDVOSB	Service-Disabled Veteran-Owned Small Business
SOW	statements of work
SSA	Social Security Administration
SSN	social security number
SSVF	Supportive Services for Veteran Families
STFB	Short-Term Fee Basis
TAA	Trade Agreements Act
TBI	traumatic brain injury
tPA	tissue plasminogen activator
UPS	United Parcel Service
USH	Under Secretary for Health
USPIS	United States Postal Inspection Service
USPS	United States Postal Service
VAMC	Veterans Affairs Medical Center
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VetDev	Veterans Development, Limited Liability Company
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VOA	Volunteers of America
WCP	Workers' Compensation Program

Table of Contents

Message from the Acting Inspector General	1
Statistical Highlights	3
Glossary	4
Table of Contents	6
Reporting Requirements	8
VA and OIG Mission, Organization, and Resources	10
Department of Veterans Affairs	10
VA Office of Inspector General	10
OIG Field Offices Map	11
OIG Organizational Map	12
Office of Healthcare Inspections	13
Combined Assessment Program Reviews	13
Community Based Outpatient Clinic Reviews	13
Hotline Healthcare Inspections	13
Office of Audits and Evaluations	20
Veterans Health Administration Audits and Evaluations	20
Other Audits and Evaluations	21
Chief Financial Officers Act of 1990 Compliance	22
Federal Information Security Management Act Compliance	22
Federal Financial Management Improvement Act of 1996 Compliance	23
Office of Investigations	24
Veterans Health Administration Investigations	24
Veterans Benefits Administration Investigations	31
Other Investigations	38
Assaults and Threats Made Against VA Employees	44
Fugitive Felons Arrested with OIG Assistance	45
Administrative Investigations	46
Office of Management and Administration	47
Operations Division	47
Information Technology and Data Analysis Division	47
Administrative and Financial Operations Division	48
Budget Division	48
Hotline Division	48
Office of Contract Review	50
Preaward Reviews	50
Postaward Reviews	50
Claim Reviews	50
Special Review	51
Other Significant OIG Activities	52
Congressional Testimony	52
False Claims Act Settlements	52
American Recovery and Reinvestment Act of 2009 Oversight Activities	53

(continued on next page)

Peer and Qualitative Assessment Reviews 54
Government Contractor Audit Findings 54
IG Act Reporting Requirements Not Elsewhere Reported 54
Employee Recognition 55
Appendix A: Reports Issued During Reporting Period 56
Appendix B: Unimplemented Recommendations 63

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 Office of Audits and Evaluations Office of Investigations Office of Management and Administration Office of Contract Review Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period	Office of Healthcare Inspections Office of Audits and Evaluations Office of Investigations Office of Contract Review
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed	Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted	Office of Investigations
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided	Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use	Appendix A
§ 5 (a) (7) a summary of each particularly significant report	Office of Healthcare Inspections Office of Audits and Evaluations Office of Investigations 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

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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) 2014, VA is operating under a $153.1 billion budget, with over 336,000 employees serving an estimated 22 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.

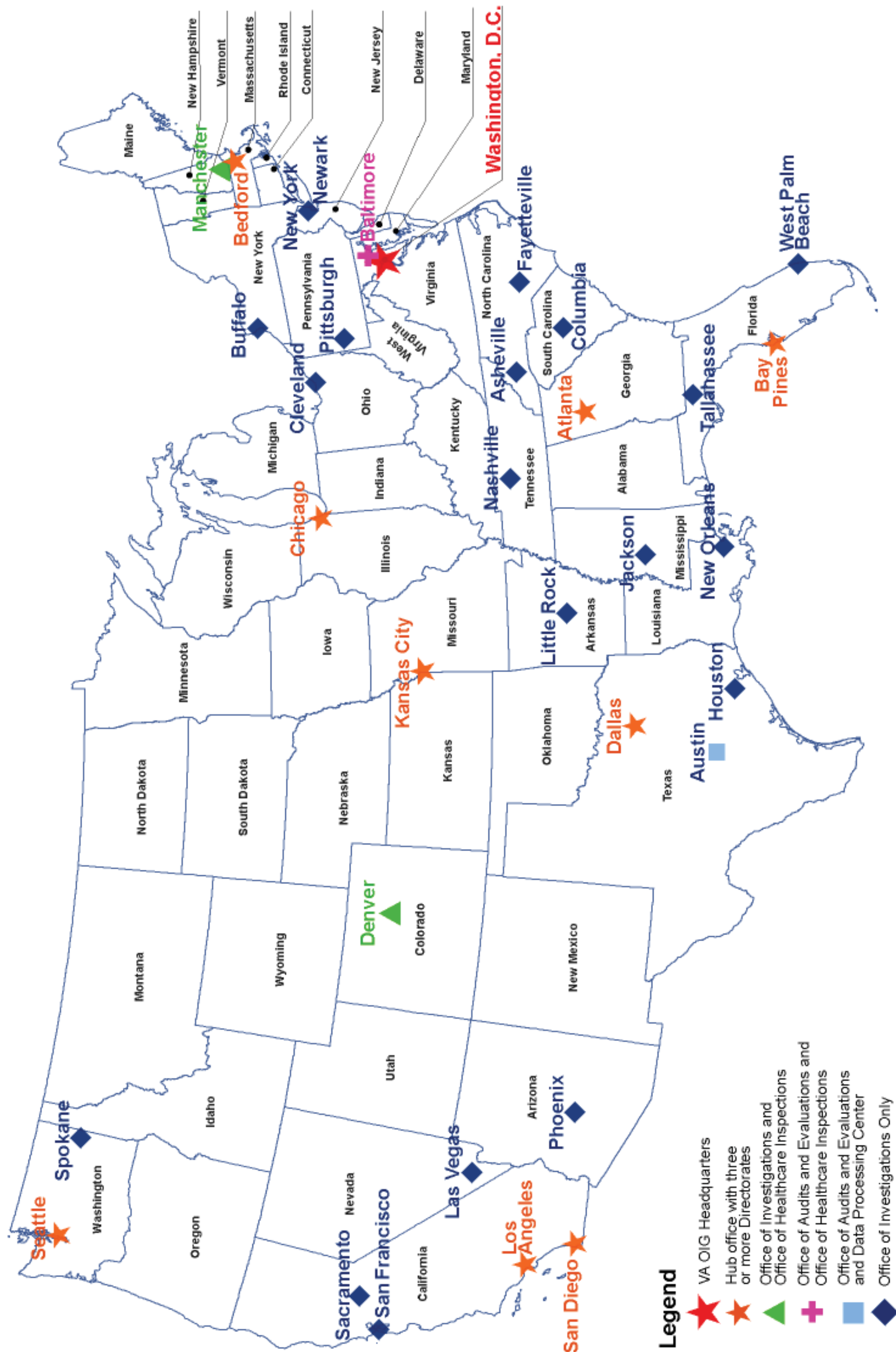
VA has three administrations that serve Veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

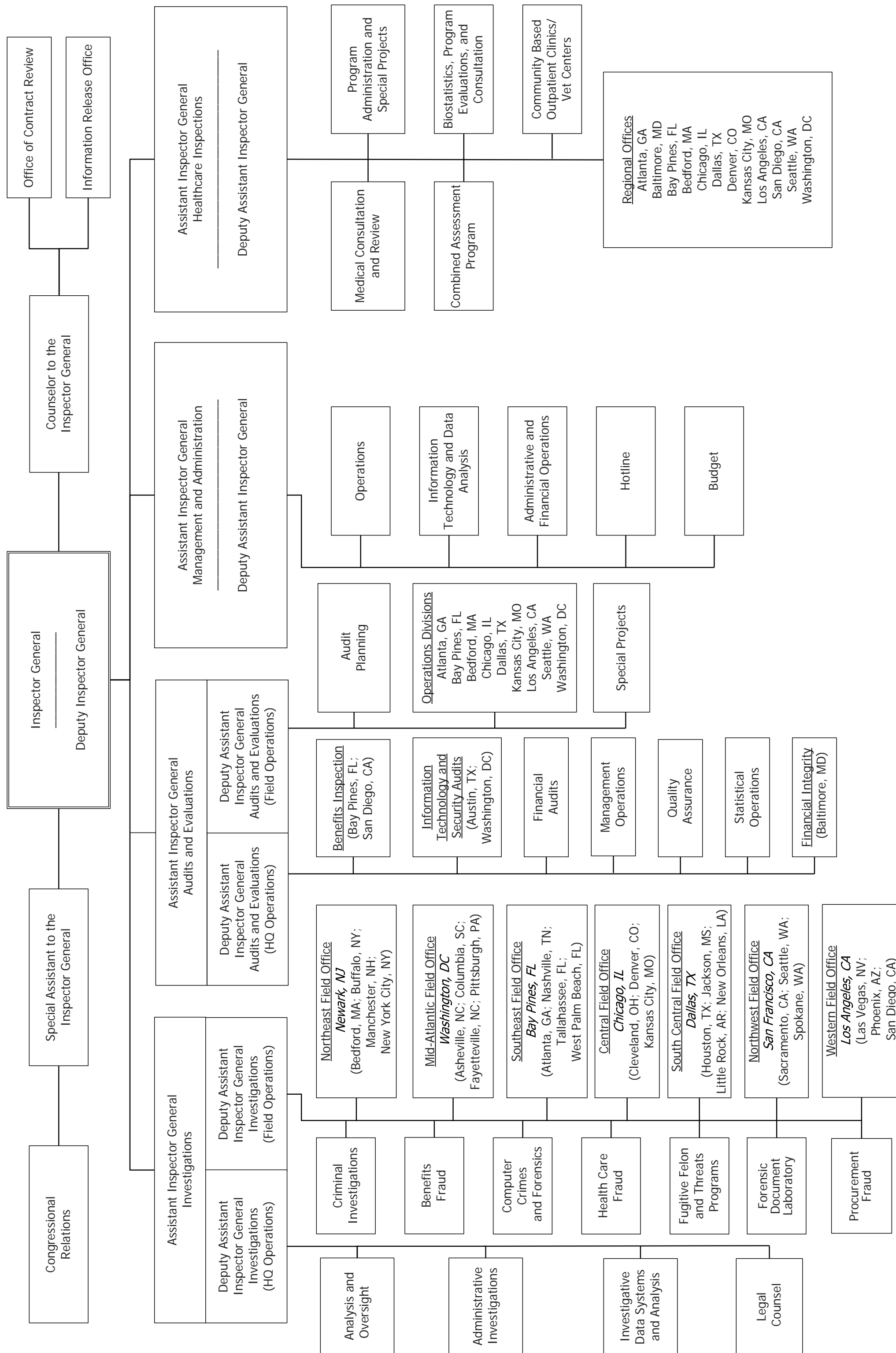
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (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. In addition, P.L. 100-322, passed on May 20, 1988, charged OIG with the oversight of the quality of VA health care. 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 610 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 2014 funding for OIG operations provides $121.4 million from ongoing appropriations. The Office of Contract Review, with 29 employees, received $5.65 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 Map



Office of Healthcare Inspections

The health care that VHA provides Veterans is ranked consistently among the best in the Nation, whether those Veterans are recently returned from Operations Enduring Freedom, Iraqi Freedom, or New Dawn, 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 14 Hotline healthcare inspections; 22 Combined Assessment Program (CAP) reviews; and 24 Community Based Outpatient Clinic (CBOC) reviews, covering 43 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 22 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 12 months. The topics covered this reporting period include: Quality Management, Environment of Care (EOC), Medication Management (MM), Coordination of Care, Nurse Staffing, Pressure Ulcer Prevention and Management, and Community Living Center Resident Independence and Dignity.

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 reviews at 43 CBOC facilities throughout 14 Veterans Integrated Service Networks (VISNs). These reviews were captured in 24 reports. The topics covered this reporting period include: EOC, Alcohol Use Disorder, MM of Flouroquinolones, and Designated Women's Health Provider Proficiencies.

Hotline Healthcare Inspections

Improvements Needed in Surgical Scheduling, Infection Control, Resident Supervision, and Quality Management at Columbia, South Carolina, VA Medical Center

OIG conducted a review in response to allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service at the William Jennings Bryan Dorn VA Medical Center (VAMC) in Columbia, SC. OIG could not substantiate high general and vascular surgery complication rates or that contaminated surgical equipment contributed to surgical site infections. OIG substantiated

improper use of hard-copy logbooks, insufficient staffing in surgery clinic, and several vacancies in Anesthesia Service. OIG did not substantiate patients being placed under extended anesthesia so residents could be trained in laparoscopic techniques, or that a power outage negatively impacted surgical patients. OIG determined that deficient surgical scheduling processes had a direct impact on operating room (OR) scheduling and caused case delays resulting in the use of overtime. The VAMC's Infection Control program was fragmented and inconsistent, surveillance data were rarely analyzed or trended, and Infection Control Sub-Council minutes lacked evidence of preventive and corrective measures. Also, Reusable Medical Equipment Oversight Committee minutes did not include required elements. OIG confirmed that the University affiliate had removed general and orthopedic surgery residents from the VA training rotation at different times; after some improvements, the general surgery residency program is again in jeopardy. The Quality Management program did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective. High-level oversight and subordinate committees did not consistently receive required reports, act on identified conditions, or follow-up to resolution. The VAMC's Patient Safety and Peer Review Programs did not comply with VHA requirements, and many of the VAMC's key leaders were functioning in "acting" capacities. OIG made 12 recommendations.

OIG Makes Four Recommendations in Response to Patient Deaths at Memphis VAMC Emergency Department

OIG conducted an inspection in response to an allegation of inadequate care for patients who died in the Emergency Department (ED) at the Memphis VAMC, Memphis, TN. The complainant alleged that a patient died after a physician ordered a medication for which the patient had a known drug allergy, another patient died after being administered multiple sedating drugs and not being monitored properly, and a third patient died after delays in getting treatment for very high blood pressure. OIG substantiated that a patient was administered a medication, in spite of a documented drug allergy, and had a fatal reaction; another patient was found unresponsive after being administered multiple sedating medications; and a third patient had critically high blood pressure that was not aggressively monitored and experienced bleeding in the brain. OIG found that the VAMC had completed protected peer reviews of the care for all three patients. Two of the deaths were also evaluated through root cause analyses (RCAs); however, OIG found that RCA action plan implementation was delayed and incomplete. OIG recommended that the Facility Director confer with Regional Counsel for possible disclosure to the surviving family member(s) of Patient 3 and ensure that processes are strengthened to monitor RCA action plans. OIG also recommended that processes be strengthened to improve patient monitoring in the ED and that unit specific competency assessments be completed for ED nursing staff. The VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan.

Miami VAMC Residential Rehab Program Cited for Lapses in Patient Monitoring, Drug Screening, and Contraband Detection

OIG conducted a review of an unexpected patient death in the substance abuse residential rehabilitation treatment program (SARRTP) at the Miami VAMC, part of the Miami VA Healthcare System (HCS). OIG found that a patient died in his room in the SARRTP, and autopsy results indicated the patient died from cocaine and heroin toxicity. This patient had a history of multiple positive urine drug screens while in the SARRTP. OIG found that the SARRTP security surveillance camera was not working at the time of the patient's death and was still not working at the time of the site visit, and no alternative arrangements were made to monitor patients in the absence of an operational camera. OIG found that evening, night, and weekend SARRTP staff often sat in a back room where they had an extremely limited view of the unit and no view of the unit's entrance/exits. OIG also found that staff were not consistent in their methods of contraband searches and did not monitor patient whereabouts or unit visitors as required.

VHA mandates that there be one staff member on the SARRTP unit at all times. OIG found that staff was not present at all times as required. OIG reviewed the electronic health records (EHRs) of other SARRTP patients to determine the frequency of illicit substance use among program participants. Not including potential false positives due to prescribed medication, we found that 7 of 21 patients had a positive urine drug screen or Breathalyzer test while in the SARRTP. OIG concluded that the current system of surveillance and supervision of patients did not adhere to VHA policy. OIG made four recommendations.

OIG Review Reveals Problems with Physician Qualifications, Practitioner Oversight, and Morale at Des Moines, Iowa, HCS

OIG conducted an inspection in response to a request by Senators Charles Grassley and Tom Harkin, both of whom received allegations of administrative irregularities, leadership lapses, and quality of care concerns at the VA Central Iowa HCS. OIG did not substantiate that a physician was not qualified for his/her position; however, the physician did not meet Accreditation Council for Graduate Medical Education (ACGME) standards for a position he/she filled temporarily. OIG did not substantiate that a physician had inappropriately performed skin biopsies, that a physician obstructed the cardiology consult process, nor that the nursing staff turnover rate was high and due to discontent with facility leadership. OIG substantiated that a physician did not follow ACGME standards in the selection process of physician staff whose duties would include teaching, the facility did not complete Focused Professional Practice Evaluations (FPPEs) as required, and there was a decline in staff morale. OIG also substantiated that staff were unclear as to who was authorized to perform out of OR airway management. OIG recommended that the VISN Director ensure that staff meet ACGME requirements and that the Facility Director ensure: (1) that the selection of physicians participating in medical educational activities is within the standards of the ACGME's Residency Review Committee, (2) a standardized process for the management of cardiology consults is implemented, (3) FPPEs are consistently completed, and (4) a comprehensive list of staff authorized to perform out of OR airway management is maintained.

Issues with Pressure Ulcer Prevention, Communications with Family Found at Augusta, Georgia, VAMC

OIG conducted an inspection at the Charlie Norwood VAMC in Augusta, GA, in response to allegations received through OIG's Hotline Division and from Congressman Doug Collins' office concerning poor patient care, lapses in communication between facility staff and the patient's family, inadequate physician/nurse staffing, loss of the patient's personal property, and failure to provide medical information to another facility. OIG substantiated that the patient developed pressure ulcers on his sacrum and coccyx after admission to the hospital and that documentation of care rendered to prevent ulcers was inconsistent. Since the facility is in the process of improving the prevention of pressure ulcer program and progress will be monitored through the CAP review follow-up, OIG made no recommendations concerning this allegation. OIG substantiated that facility staff and physicians failed to effectively communicate with the patient's family regarding the patient's condition and treatment needs. OIG substantiated that facility staff did not securely safeguard the patient's personal belongings during the patient's hospitalization. OIG did not substantiate the allegation that staff members expressed concern regarding inadequate nurse staffing levels. OIG found that nurse staffing levels in the intensive care unit met or exceeded target levels. OIG addressed the physician staffing levels in the context of resident physician communications with the family. OIG did not substantiate the allegation that the facility did not provide the private rehabilitation center with current patient health records. OIG recommended that the Facility Director (1) ensure that patient information is shared with patients, families, and significant others in an appropriate manner that protects patient privacy and (2) ensure that processes be strengthened for inventory, documentation, storage, and retrieval of patient belongings, and that compliance is monitored.

IG Recommends Improvements in OR Cleanliness and Management of Infectious Patients at West Haven, Connecticut, HCS

OIG conducted an inspection in response to allegations about deficiencies in the EOC in the OR at the VA Connecticut HCS, West Haven, CT. OIG found that cleanliness of the OR could not be assured due to inadequate staff resources, incomplete and inconsistent procedures, poor supervision and training of Environmental Management Services (EMS) staff, and lack of oversight. OIG also found that safeguards were inadequate for ensuring patient and employee safety when infectious patients requiring special precautions were scheduled for OR procedures concurrently with noninfectious patients. OIG also identified issues related to maintenance of the Heating, Ventilation, and Air Conditioning (HVAC) system and insect control in the OR. Although OIG's findings substantiated an increased risk to patients and staff, OIG found no conclusive evidence that the EOC deficiencies in the OR resulted in negative patient outcomes. OIG recommended that the Facility Director strengthen procedures for OR cleaning and develop and implement policies and procedures to address management of infectious patients, the HVAC system preventive maintenance, and insect control in the OR. OIG also recommended that the Facility Director reassess EMS staffing needs in the OR, assign personnel requisite to the workload, and ensure that EMS staff and supervisors receive training on OR EOC requirements. Additionally, OIG recommended that the Facility Director implement procedures to monitor the OR EOC and to address identified deficiencies.

OIG Makes Two Recommendations To Improve Opioid Prescription Practices at San Francisco VAMC

OIG conducted an inspection concerning improper opioid prescription renewal practices in the Medical Practice Clinic (clinic) at the San Francisco VAMC. The complainant alleged that attending physicians on-duty are tasked with evaluating numerous opioid renewal requests for patients with whom they are unfamiliar, providers do not routinely document patients' opioid prescription renewal problems in the EHR, and there have been patient hospitalizations and deaths related to opioid misuse. OIG substantiated that attending physicians on-duty are tasked with evaluating numerous opioid renewal requests for patients with whom they are unfamiliar; however, VHA regulations and local policy do not prohibit such practice. OIG partially substantiated that providers do not routinely document patients' opioid prescription renewal problems in the EHR. The providers did not consistently document an assessment for adherence with appropriate use of opioids and monitor patients for misuse. The primary care providers did not consistently complete the templated Narcotic Instructions Note. OIG partially substantiated that there have been patient hospitalizations and deaths related to opioid misuse. Seven clinic patients were hospitalized for opioid overdose; however, the primary care provider, Psychiatry Service, and/or the facility's Substance Abuse Program appropriately assessed and monitored the patients. There were no deaths related to opioid overdose. OIG recommended that the Facility Director ensure that providers comply with all elements of the management of opioid therapy for chronic pain, as required by VHA and the VA/Department of Defense Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; the Narcotic Instructions Note is reevaluated for appropriate use; and providers comply with established protocol.

Alleged Computed Tomography Scan Delays at Dayton VAMC, Dayton, Ohio, Not Substantiated

OIG conducted an inspection in response to a complainant's allegations that the Dayton, OH, VAMC placed patients with stroke at risk for potential harm because computed tomography (CT) imaging was not staffed 24 hours a day, 7 days a week. The complainant specifically alleged that delays in obtaining CT scans after-hours reduced the patients' chances of getting tissue plasminogen activator (tPA) therapy, often referred to as a "clot buster" drug. Additionally, the complainant alleged that a great deal of overtime money was paid to CT technologists for call coverage after-hours when the CT section was not staffed. OIG did not substantiate the allegation that after-hours on-call staffing resulted in problematic delays in obtaining CT scans or provision of tPA therapy for acute stroke patients. As a supporting stroke facility, the VAMC promptly transfers or diverts

patients acutely presenting stroke symptoms to the community primary stroke center and does not provide CT scans or tPA therapy in these cases. While emergency clinicians were very clear about this process, some imaging staff were not. The VAMC convened a compliance review and, later, an Administrative Investigation Board (AIB) in response to concerns regarding overtime and timekeeping. The AIB found irregularities in the overtime paid for after-hours CT coverage, but did not substantiate that some timekeepers violated policies and procedures related to timekeeping and privacy. OIG concurred with the findings and recommendations of the facility's compliance review and AIB. OIG did not make any recommendations. The VISN and Facility Director concurred with the report. No further action is required.

Review Finds Action Taken To Improve Audiology Services at the Sheridan, Wyoming VA HCS

OIG conducted an inspection to assess allegations regarding audiology services within the Sheridan VA HCS, Sheridan, WY. OIG substantiated that Audiology Service staffing was insufficient; however, the HCS has taken action to improve the provision of audiology services. OIG did not substantiate that requests for audiology consultations, including non-VA purchased care, were inappropriately cancelled or discontinued. OIG substantiated that Veterans' access to audiology services was delayed. The HCS was aware of the situation and had processes and procedures in place to address the demand including the use of non-VA purchased care as a first choice, use of locums tenens, if available, and then the Electronic Wait List. OIG made no recommendations.

OIG Finds Quality of Care Issues, Poor Discharge Planning, and Lapses in Communication at San Juan VAMC

OIG conducted an inspection to review allegations from a confidential complainant about quality of care issues, inadequate discharge planning, and lapses in communication at the San Juan VAMC, San Juan, Puerto Rico. OIG substantiated the allegations that the medical condition leading to the patient's acute delirium was not addressed, and that the patient was not medically stable when he left the facility. OIG substantiated the allegation that the patient lost a significant amount of weight while he was in the hospital, and determined that the patient's nutritional treatment plan was inadequate. OIG substantiated the allegation that the patient fell once, that family members did not receive adequate information regarding the patient's condition, and that no attempts were made by staff to arrange for appropriate follow-up care with providers at the Arizona VA facility. OIG determined that accurate skin assessments were not performed, and that actions taken to prevent and/or treat pressure ulcers were inadequate. OIG recommended that thorough nutritional assessments are completed (including weights), processes be strengthened to ensure nursing staff perform accurate daily skin inspections, and that discharge planning processes are appropriate for the patient's condition. OIG also recommended that the informed consent process complies with VHA requirements, and that the Facility Director consult with Regional Counsel regarding possible disclosure of failure to diagnose a urinary tract infection and prevent and treat pressure ulcers.

Improvements Needed in Length of Stay and Patient Flow Practices at ED of Jesse Brown VAMC, Chicago, Illinois

OIG conducted an inspection in response to a complainant's allegations of a delay in chemotherapy treatment, excessive length of stay (LOS) in the ED, and failure to perform a kidney ultrasound at the Jesse Brown VAMC in Chicago, IL. OIG substantiated a delay in chemotherapy treatment, that the patient experienced excessive LOS in the ED on two occasions while awaiting admission, and that an inpatient kidney ultrasound was ordered but not performed. However, on both ED visits, the patient was promptly triaged and treated. OIG could not substantiate that the patient suffered adverse medical outcomes as a result of these delays. OIG found that there was no clearly defined process for monitoring oncology clinic patients awaiting inpatient beds after hours and that there was inconsistent patient handoff communication between oncology clinic staff and the

ED triage nurses. OIG also identified problems in the Patient Flow Committee structure, membership, and communication of patient flow initiatives to the frontline staff. OIG made three recommendations.

Inadequate Staffing Results in Lengthy Call Center Wait Times at VA Eastern Colorado HCS, Denver, Colorado

OIG conducted an inspection to assess the validity of allegations regarding the ED and the Health Information Call Center (Call Center) at the VA Eastern Colorado HCS, Denver, CO. OIG did not substantiate the allegation that the ED "needs help." While OIG found some ED wait times exceeded 8 hours, OIG determined the facility met VHA's target of less than 10 percent of patients with a LOS over 6 hours. OIG did not substantiate the allegation that ED staff treated two patients discourteously, or that one of the patients was afraid to return to the ED due to alleged discourteous treatment. OIG substantiated the allegations that Call Center understaffing caused long call waiting times and callers to abandon calls. OIG found 40 percent of the Call Center's authorized registered nurse, medical support assistant, and pharmacy technician positions were vacant and determined that inadequate staffing contributed to the Call Center's failure to meet VHA targets for caller response time and call abandonment rates. OIG also found that calls were dropped due to the telephone system's 120-line limitation, and callers who used the automated call return system did not always receive a return call. An upgrade of the telephone system is not planned until FY 2016 when the facility relocates. Additional staff and an upgraded system should eliminate the 120-line limitation and reduce callback system failures. OIG recommended that the VISN and Facility Directors ensure processes are strengthened to improve Call Center practices and staffing levels.

Master Staffing Plan Needed for OR, Weaknesses Identified in the Surgical and OR Improvement Processes at Augusta, Maine, HCS

OIG conducted an inspection to assess the merit of allegations concerning OR staffing, pre-operative anesthesia evaluations of complex patients, and the surgical mortality rate at the VA Maine HCS, Augusta, ME. OIG substantiated that the OR did not have a front desk clerk and/or a nurse scheduled to work in the clean core area. However, due to the absence of a master staffing plan, OIG could not substantiate that the current staff was inadequate to support OR staff. OIG did not substantiate that pre-operative anesthesia evaluations of complex patients are inadequate because providers frequently evaluate patients just prior to surgery. OIG's review of the surgical mortality data did not identify obvious outliers or negative trends that would indicate systemic quality of care issues in the OR and require further review. In addition to the allegations, OIG identified weaknesses in the surgical and OR quality improvement processes. OIG recommended that the VA Maine HCS Director develop and implement a master staffing plan for the OR, ensure that the Surgical Work Group and OR Committee are functioning in accordance with VHA and local policies, and that the recommendations made pursuant to a recent protected VHA Surgical Program review are implemented.

Complaints Unsubstantiated Against Diagnostic Imaging Services at North Florida/South Georgia Veterans Health System, Gainesville and Lake City, Florida

OIG conducted an inspection in response to complaints about diagnostic imaging services at the North Florida/South Georgia Veterans Health System, Gainesville, and Lake City, FL. OIG substantiated that some patients with documented contrast media (contrast) allergies received contrast for CT exams; however, there were processes in place to address potential adverse effects of contrast administration. OIG did not substantiate that patient deaths occurred as a result of contrast administration. OIG substantiated that ureteral stent placements were performed in a cystoscopy clinic without general anesthesia; however, OIG found that other appropriate measures were taken to provide pain control. Further, OIG did not substantiate that the clinic setting was chosen so that urology resident physicians could perform a required number of stent placements for professional education. OIG substantiated that a staff member in the CT department was absent for a protracted period but did not substantiate that the reduced staffing resulted in a backlog of patients. OIG did

not substantiate that a pre-procedure marking was incorrect or that a patient's bowel was perforated. OIG did not substantiate that after-hours radiologist support was lacking for CT technologists at the Lake City campus. OIG did not substantiate that the CT scanner at the Lake City Campus was beyond its useful life and broke down weekly. The scanner had been serviced by the manufacturer with an up-time rate greater than 98 percent. A new scanner has recently been installed in accordance with a routine replacement schedule. 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, reviews, and inspections of VA programs, functions, and facilities. This work addresses 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 and contract 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.

Better Productivity Standards and Staffing Plans Will Improve Tracking, Repairs, and Timely Delivery of Hearing Aids to Veterans

OIG conducted this audit to evaluate the effectiveness of VA's administration of hearing aid order and repair services through VA's audiology services. Tinnitus and hearing loss were the first and second most prevalent service-connected disabilities for Veterans receiving compensation at the end of FY 2012. VA was not timely in issuing new hearing aids to Veterans or in meeting its 5-day timeliness goal to complete repair services. During the 6-month period ending September 2012, VHA issued 30 percent of its hearing aids to Veterans more than 30 days from the estimated receipt date from their vendors. Medical facilities' audiology staff attributed the delays to inadequate staffing to meet an increased workload. In addition, the Denver Acquisition and Logistics Center (DALC) took 17 to 24 days to complete hearing aid repair services, exceeding its 5-day timeliness goal. During this period, 5 of 21 repair technician positions were vacant. These vacancies, and an increased workload, adversely affected DALC's ability to meet its timeliness goal for hearing aid repairs. OIG observed and estimated about 19,500 sealed packages of hearing aids were waiting for repair and staff to record the date received into DALC's production system. According to management, staff did not record the date they received the packages because opening packages had the potential risk of losing small parts. Without a timely recording system, staff cannot adequately respond to Veteran and medical facility inquiries. OIG recommended the Under Secretary for Health (USH) develop a plan to implement productivity standards and staffing plans for audiology clinics. Also, OIG recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (OALC) ensure DALC determines the appropriate staffing levels for its repair lab and establish controls to timely track and monitor hearing aids for repair. The USH and Principal Executive Director, OALC, concurred with OIG's recommendations.

Ineffective Management of Costs and Time Leads to Delays in Leasing of Health Care Centers, None Built by June 2012 Target

Due to House Committee on Veterans' Affairs' interest, OIG conducted this review to determine if VA effectively managed timeliness and costs in the procurement process of seven Health Care Center (HCC) leases. OIG found that VA's management of the HCC lease procurement process has not been effective. As of August 2013, only four of seven leases had been awarded and no HCCs had been built despite VA's target completion date of June 2012. This occurred because the HCCs were a new initiative and guidance was not available for planning leases of this magnitude. VA did not meet the milestones it established for HCC activation and occupancy in spite of

providing Congress with an aggressive project schedule. Given the lack of progress to date and the inadequate planning documentation, it will take far more time than Congress anticipated for VA to award and activate the seven leases. Further, VA could not provide accurate information on HCC spending into April 2013. Officials provided various estimates, from about $4.6 million to $5.1 million, on costs to prepare for HCC lease awards. According to VA officials, central cost tracking was not in place to ensure transparency and accurate reporting on all HCC expenditures. Until effective central cost tracking is instituted, expenditures to acquire the leases will not fully be accounted for. VA also will not have reasonable assurance of accuracy in reporting total HCC costs to Congress. OIG recommended the Principal Executive Director, OALC, and the USH establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities; provide realistic and justifiable timelines for HCC completion; ensure HCC project analyses and key decisions are supported and documented; and establish central cost tracking to ensure transparency and accurate reporting on HCC expenditures. The Principal Executive Director, OALC, and the USH concurred with OIG's recommendations.

Funds for Grants To Help Veteran Families Avoid Homelessness Spent Properly, Eligibility Verification Can Improve

At the request of the House Committee on Veterans' Affairs, Subcommittee on Health, OIG conducted this audit to determine if VHA's Supportive Services for Veteran Families (SSVF) program grantees appropriately expended program funds. In December 2010, VA established the SSVF program to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. For FYs 2012 and 2013, VHA awarded about $60 million and $100 million in SSVF grants, respectively, and has increased awards to nearly $300 million for FY 2014. OIG found that VHA's SSVF program has adequate financial controls in place that are working as intended to provide reasonable assurance that funds are appropriately expended by grantees. OIG determined program staff were reviewing grantee timecards, invoices for temporary financial assistance, subcontractor costs, and conducted annual inspections. However, SSVF program officials can improve controls to ensure only eligible Veterans and their family members participate in the program. OIG found three of five grantees used outdated area median income (AMI) limits to determine eligibility for the program. In addition, four of five grantees did not verify Veterans' discharge status with the required "Certificate of Release or Discharge from Active Duty" (DD 214).

This occurred because some grantees were not aware when new AMI limits were published. To avoid delaying program participation, grantees did not always follow up to ensure receipt of the required DD 214 when an interim eligibility document was used. As a result, VHA risks providing SSVF services to ineligible Veterans or excluding eligible Veterans from the program. OIG recommended the Under Secretary for Health ensure SSVF program management implements a mechanism to inform grantees when the most current AMI limits are published and ensure grantees comply with eligibility documentation requirements. The Under Secretary for Health concurred with OIG's recommendations and provided an appropriate action plan. OIG considers the SSVF program actions sufficient and closed the recommendations as completed.

Other Audits and Evaluations

OIG performs audits of administrative support functions and financial management operations, focusing on adequacy of VA management systems in providing managers information needed to efficiently and effectively manage and safeguard VA assets and resources. OIG oversight work satisfies the *Chief Financial Officers Act of 1990*, P.L. 101-576, audit requirements for Federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

OIG 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.

Stronger Accountability over Cost, Schedule, and Scope for Development of VA's Pharmacy Reengineering Project Needed

OIG evaluated the effectiveness of the Office of Information and Technology's (OIT) management of the Pharmacy Reengineering (PRE) project, which was restarted in October 2009 under the Project Management Accountability System (PMAS). Although some progress has been made, OIT has not been effective in keeping the PRE project on target in terms of schedule, cost, and the functionality delivered. Specifically, deployed PRE functionality has improved patient safety; however, project managers have struggled to deploy PRE increments in a timely manner. Project managers were also unable to provide reliable costs at the increment level. OIT restarted PRE at a time when PMAS had not evolved to provide the oversight needed to ensure project success. As such, PRE management was challenged in keeping PRE on track and the project is at an increased risk of not being completed on time and within budget. Moreover, the future of Pharmacy Reengineering is uncertain due to potential plans to transfer funding and remaining development to the Integrated Electronic Health Record (iEHR) project in FY 2014. Stronger accountability over cost, schedule, and scope for the remaining development is needed prior to such a transfer so that iEHR is not compromised by the same challenges. OIG recommended the Executive in Charge and Chief Information Officer (CIO) ensure all of the time used to complete each remaining PRE increment is reported and monitored, including the time on the initial operating capability phase; ensure adequate oversight and controls, including the planning guidance, staffing, and cost and schedule tracking needed to deliver functionality on time and within budget; and establish a plan for future funding of PRE until iEHR is decided. The CIO agreed with OIG's recommendations and provided an acceptable corrective action plan.

Chief Financial Officers Act of 1990 Compliance

The OIG contracted with an independent public accounting firm to audit VA's consolidated financial statements for FY 2013, in accordance with the *Chief Financial Officers Act of 1990*, P.L. 101-576. VA received an unqualified opinion, meaning that its financial statements were materially accurate. With respect to internal control, the contractor identified one material weakness, IT security controls, which was a repeated condition. The contractor also reported that VA did not substantially comply with Federal financial management systems requirements, cited instances of non-compliance with the *Debt Collection Improvement Act of 1996*, P.L. 104-134, and noted that VA was engaged in one active investigation of a possible violation of the *Antideficiency Act*, P.L. 97–258. The contractor also referenced an OIG report issued in FY 2013 citing less than full compliance with the *Improper Payments Elimination and Recovery Act of 2010*, P.L. 111-204.

Federal Information Security Management Act Compliance

In compliance with FISMA, the FY 2013 assessment determined the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. While VA has made progress developing policies and procedures, it still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. OIG 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.

Federal Financial Management Improvement Act of 1996 Compliance

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208 (FFMIA), requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The audit of VA's FY 2013 consolidated financial statements 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. 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. However, not all current systems could be readily accessed and used without extensive manipulation, manual processing, and reconciliation.

Office of Investigations

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 215 cases; made 114 arrests; obtained nearly $2 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $1.77 million in savings, efficiencies, cost avoidance; and recovered more than $813,000.

During this reporting period, OIG opened 97 investigations relating to the diversion of controlled substances by VA employees, Veterans, and private citizens. Fifty-four defendants were charged with various crimes relating to drug diversion. These investigations resulted in $138,617 in court ordered payment of fines, restitution, penalties, and civil judgments as well as $416,922 in savings, efficiencies, cost avoidance, and recoveries.

OIG initiated 13 investigations related to the fraudulent receipt of health benefits, which resulted in 10 defendants being charged with various related crimes. These investigations resulted in $694,629 in fines, restitution, penalties, and civil judgments as well as $539,714 in savings, efficiencies, cost avoidance, and recoveries. OIG also initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, who grossly inflate reported mileage to and from VA facilities in order to increase reimbursement for travel expenses. During this reporting period, OIG opened 16 cases, which resulted in 9 arrests; 16 convictions; 9 imprisonments; $247,565 in court ordered payment of fines, restitution, penalties, and civil judgments; and $100,926 in savings, efficiencies, cost avoidance, and recoveries.

OIG opened 35 investigations regarding criminal activities carried out by VHA employees (excluding crimes related to drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from Veterans, and theft of VA property or funds. As a result of OIG work in this area, 19 defendants were charged with crimes. The investigations resulted in $890,830 in court ordered payments of fines, restitution, and penalties as well as over $1 million in savings, efficiencies, cost avoidance, and recoveries.

The case summaries that follow provide a representative sample of the type of VHA investigations conducted during this reporting period.

Former VAMC Director Pleads Guilty to Corruption

The former Director of the Cleveland and Dayton, OH, VAMCs pled guilty to 64 corruption-related charges. The plea agreement also requires the defendant to pay more than $400,000 in restitution, forfeiture, and fines. A 2-year OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant engaged in money laundering, fraud, and conspiracy to defraud VA by accepting thousands of dollars from contractors in exchange for inside information. As part of the scheme, the defendant conspired with

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Montague, 62, of Brecksville, was the only federal government employee convicted among the more than 60 defendants, and was the last defendant remaining in the seven-year federal investigation into corruption in Cuyahoga County.

During the 1½-hour hearing Thursday afternoon, Assistant U.S. Attorney Antoinette Bacon provided a detailed account of Montague's crimes.

They included money laundering, wire fraud, mail fraud and conspiring to defraud the Department of Veterans Affairs through bribery and kickback schemes in which he accepted tens of thousands of dollars from contractors in exchange for inside information.

Lioi questioned Montague: "Did you engage in the conduct described" in the plea agreement?

"I did, your honor," Montague responded.

Lioi allowed Montague to remain free on bond until he is sentenced.

Under terms of the plea deal, Montague confessed to committing 64 charges contained in the original 65-count indictment. Federal prosecutors agreed to drop one charge involving the bribery of an unidentified public official sometime between 2007 and 2012. The indictment accused Montague of seeking or receiving something of value in return for committing a fraud on the VA on behalf of the unnamed official.

The indictment provided details to a 2010 criminal scheme in which Montague signed a $30,000-a-year consulting contract with an unnamed Buffalo-based design firm, identified only as Business 75.

Montague pleaded guilty to charges that he conspired with employees at the company to defraud the VA through bribery, fraud and kickbacks in exchange for providing confidential information about VA contracts and projects the company was seeking to obtain, causing potential losses to the govern-

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William Montague's crimes included money laundering, wire fraud, mail fraud and conspiring to defraud the Department of Veterans Affairs through bribery and kickback schemes.

"We will continue to protect taxpayers against those who would enrich themselves at the expense of our nation's veterans."

Gavin McClaren, the Cleveland VA's resident agent in charge

new administration building and parking garage at East Boulevard and East 105th Street, adjacent to the VA hospital. A 122-bed dwelling for homeless veterans was privately financed.

Forlani is serving an eight-year prison term for racketeering, bribery and other corruption-related crimes.

"Today's guilty pleas are the result of a two-year investigation conducted by special agents of the Cleveland Veterans Affairs Office of Inspector General and the FBI," said Gavin McClaren, the Cleveland VA's resident agent in charge. "We will continue to protect taxpayers against those who would enrich themselves at the expense of our nation's veter-

employees of a company to defraud VA by providing confidential information about VA contracts and projects the company was seeking to obtain, causing a potential loss to the Government of approximately $20 million.

Former Palo Alto, California, VAMC Employee Pleads Guilty to Bribery

A former Palo Alto, CA, VAMC employee pled guilty to bribery. An OIG and FBI investigation revealed that the defendant, who was a Contracting Officer's Representative, accepted bribes to include cash, airplane tickets for personal travel, and payments for his personal credit card bills in exchange for his influence in getting work for VA contractors. The defendant also provided contractors with confidential pricing information on various construction projects and used his influence to promise continued work to the contractors. The investigation determined that the defendant received $16,527 in bribes and gifts.

Former Lyons, New Jersey, VAMC Patients Are Sentenced for Concealing the Death of Veteran

A Veteran was sentenced to 8 months' incarceration, 3 years' supervised release, and ordered to attend continuous drug and alcohol treatment along with intensive mental health (MH) treatment after pleading guilty to obstruction of justice. A second Veteran was sentenced to 12 months and 1 day of incarceration, 1 year of supervised release, and ordered to attend the same treatment programs after pleading guilty to misprision of a felony. An OIG investigation revealed that the defendants used heroin in another Veteran's room at the Lyons, NJ, VAMC. While using the drug, the Veteran collapsed, and the defendants departed the room and failed to notify staff. The 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. Another aspect of this investigation was its role as the starting point for Operation Red, White, and Blue, a successful undercover drug operation targeting dealers at the same VAMC that resulted in the arrests of seven subjects.

Alexandria, Louisiana, VAMC Nursing Assistant Arrested for Manslaughter

A nursing assistant at the Alexandria, LA, VAMC was arrested on a manslaughter charge related to an altercation with an elderly patient in the VAMC's MH unit.

Former Augusta, Georgia, VAMC Nurse Arrested for Assaulting Patient

A former Augusta, GA, VAMC nurse was indicted and subsequently arrested for assaulting a patient. An OIG investigation revealed that the defendant entered a patient's room, with other staff present, and without provocation punched the patient on his side, resulting in two fractured ribs.

Miami, Florida, VAMC Police Officer Sentenced for Extortion

A Miami, FL, VAMC police officer was sentenced to 2 months' incarceration, 1 year of supervised release, and ordered to pay a $300 special assessment fee. An OIG investigation revealed that the officer used his position to access a State law enforcement database to obtain personal information regarding a U.S. Army service member. The officer then extorted the service member by threatening to post sexually explicit images and provide embarrassing information on social media if the victim failed to pay additional money on a previously satisfied personal loan. The defendant used VA networks and computers to send the extortion emails to the victim. Also, while off-duty and not in any official capacity, the defendant conducted a traffic stop of an off-duty local police officer, using his personally owned vehicle which was equipped with emergency lights, siren, and radio.

Six Years in Prison, $105K Judgment for Former Tampa VAMC Employee Who Stole Identities of Over 100 Inpatients

A former Tampa, FL, VAMC employee was sentenced to 72 months' incarceration, 36 months' supervised release, 50 hours' community service, and ordered to pay $105,271 in restitution after pleading guilty to access

device fraud and aggravated identity theft. An OIG, Internal Revenue Service, Criminal Investigation (IRS CI), and local police investigation revealed that the defendant, a former Tampa VAMC medical support assistant, stole the personally identifiable information (PII) of inpatients and then traded the information for crack cocaine. The PII was subsequently used to file $831,890 in fraudulent tax returns and to obtain lines of credit. The sentence in this case included a vulnerable victim enhancement penalty because the defendant targeted VAMC inpatients.

Former Bronx, New York, VAMC Nursing Assistant Sentenced for Identity Theft

A former Bronx, NY, VAMC nursing assistant was sentenced to 8 months' home confinement, 3 years' probation, and ordered to pay $4,495 in restitution. An OIG and Department of State, Diplomatic Security Service (DSS) investigation revealed that the defendant fraudulently gained employment with VA on two separate occasions and fraudulently obtained a U.S. passport by using the false identity of a person who died in 1988. The defendant, originally from Ghana, resigned from VA in November 2012.

West Palm Beach, Florida Employee Sentenced for Drug Sales

A VA employee, who was also a Veteran, was sentenced to 12 months' incarceration after pleading guilty to the sale of oxycodone. The sentencing stemmed from a 7-month multi-agency drug diversion task force investigation. Operation Tango Vax focused on combating the sale and distribution of illicit and controlled prescription pharmaceuticals at the West Palm Beach, FL, VAMC and the surrounding community by VA employees, Veterans, and their associates. The investigation determined that the majority of all criminal activity occurred at the VAMC and resulted in the seizure of over 3,000 oxycodone pills, 2 vehicles, and $180,920 in cash.

Former VA Contract Health Care Worker Sentenced for Tampering

A former health care worker, who provided contract services to VA in 2008, was sentenced to 39 years' incarceration. The defendant previously 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 disclosed that the defendant stole syringes of fentanyl prepared for patients scheduled to undergo a medical procedure. The defendant then used the stolen syringes to inject himself, causing the syringes to become tainted with his Hepatitis C infected blood, before filling them with saline and then replacing them for use in the medical procedure. As a result, more than 12,000 patients were recommended to be tested for Hepatitis C. Testing identified 45 patients who were infected with the disease, to include 3 Veterans. Two of the Veterans were exposed to the defendant's blood during procedures at a private hospital and one during a procedure at a VAMC.

Former Tucson, Arizona, VAMC Nurse Sentenced for Drug Diversion

A former Tucson, AZ, VAMC nurse was sentenced to 10 months' incarceration and 5 years' probation after pleading guilty to acquisition of a narcotic drug. An OIG investigation revealed that for 6 months the defendant stole over 1,700 controlled substances to include morphine, oxycodone, and hydromorphone.

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

A former Martinsburg, WV, VAMC registered nurse was sentenced to 36 months' probation after pleading guilty to acquiring and obtaining a controlled substance by fraud and deception. An OIG and VA Police Service investigation determined that on five occasions in October 2011 the defendant removed controlled medication from the facility's automated Omnicell medication dispensers using the names of patients whose EHRs indicated that they did not receive the medication.

In an unrelated case, a second former Martinsburg, WV, VAMC registered nurse was sentenced to 24 months' probation after previously pleading guilty to acquiring and obtaining hydromorphone by fraud, deception, and subterfuge. An OIG and VA Police Service investigation determined that on 23 occasions between October

2009 and December 2009 the defendant removed controlled medication from the VAMC's automated Pyxis medication dispensers for patients whose EHRs indicated that they did not receive the medication.

Former Ft. Harrison, Montana, VAMC Contract Employee Sentenced for Drug Diversion

A former Ft. Harrison, MT, VAMC contract employee was sentenced to 5 years' supervised release and barred from employment as a nurse anesthetist. An OIG investigation revealed that the defendant engaged in the diversion and use of sufentanil, hydromorphone, and other injectable narcotics from the VAMC. The defendant was falsely claiming to administer narcotics to patients under anesthesia, when in fact the narcotics were diverted for his personal use.

Former Bath, New York, VAMC Nurse Pleads to Drug Diversion

A former Bath, NY, VAMC nurse pled guilty to a criminal information charging her with possession of oxycodone. An OIG and VA Police Service investigation determined that the defendant diverted controlled substances for her own use. The defendant utilized "as needed" orders to withdraw the medications, documenting the charts as if she had administered the drugs to patients. The defendant usually diverted drugs on the night shift when most of the patients reported being asleep.

Former Togus, Maine, VAMC Pharmacy Technician Sentenced for Drug Theft

A former Togus, ME, VAMC pharmacy technician was sentenced to 2 years' probation and fined $4,000 after pleading guilty to theft of Government property. An OIG investigation revealed that the defendant stole VA non-controlled pills (simvastatin, Fioricet, and Phrenilin) and one controlled narcotic (Vicodin) from the VA pharmacy. A subsequent inventory of the medications disclosed that the pharmacy was missing over 4,700 pills. The defendant admitted to stealing the simvastatin for her husband and the pain medications for her own use.

Former Rochester, New York, CBOC Employee Pleads Guilty to Workers' Compensation Fraud

A former VA medical technician at a CBOC in Rochester, NY, pled guilty to a criminal information charging her with workers' compensation fraud. A VA OIG and Department of Labor (DOL) OIG investigation revealed that the defendant claimed to have suffered a back injury while employed by VA and was medically limited to the number of hours she could work. The defendant began receiving Office of Workers' Compensation Program (OWCP) benefits in August 2010 and during the same time period applied for a State license to open a liquor store in which she was listed as president, manager, and sole proprietor. The defendant was observed on multiple occasions working in the liquor store, climbing staircases, reaching for and replacing bottles, carrying large heavy bags, and assisting customers. The defendant continued filing forms with DOL certifying that she was not engaged in any outside employment.

Dallas, Texas, VAMC Nurse Pleads Guilty to Workers' Compensation Fraud

A Dallas, TX, VAMC licensed vocational nurse pled guilty to making a false statement to obtain Federal workers' compensation benefits. A VA OIG and DOL OIG investigation revealed that from November 2007 to June 2011 the defendant received OWCP benefits while she was gainfully employed during all or part of that time period. The defendant admitted to being employed while receiving OWCP benefits and to providing false information in an effort to conceal her employment.

Former Dublin, Georgia, VAMC Nurse Pleads Guilty to Fraud

A former Dublin, GA, VAMC nurse, who was collecting workers' compensation benefits, pled guilty to a criminal information charging her with mail fraud. A VA OIG and DOL OIG investigation revealed that the defendant made more than 200 false claims for mileage and medical cost reimbursements to OWCP. The loss to the Government is approximately $461,000. The defendant was remanded into custody while awaiting sentencing.

Former Lexington, Kentucky, VA Police Lieutenant Sentenced for Theft of Weapons

A former Lexington, KY, VA Police Service lieutenant was sentenced to time served, 36 months' probation, and ordered to pay $765 in restitution. An OIG investigation revealed that the defendant, a police armorer, was allowed unescorted access to the VA Police armory. Subsequently, the defendant stole four Beretta 9mm semi-automatic handguns. The defendant then pawned the handguns for cash throughout the local community. OIG and the VA Police Service were able to recover the stolen weapons.

Former Jackson, Mississippi, VAMC X-Ray Technician Arrested for Theft of Computer

A former Jackson, MS, VAMC x-ray technician was indicted and subsequently arrested for the theft of a VA computer from an examination room at the VAMC. The laptop was recovered at a junior college by OIG and campus police.

Former Hines, Illinois, VA Employee Charged with Theft

A former Hines, IL, VA employee was charged in a criminal information with theft. During an OIG investigation, the defendant admitted to stealing 17 laptop computers between 2008 and 2011 from the Hines Information Technology Center. The defendant then sold the computers to a pawn shop. The loss to VA is $17,000.

Former Union President Sentenced for Embezzlement

A former American Federation of Government Employees union president at the VA NY Harbor HCS was sentenced to 6 months' home confinement, 3 years' probation, and ordered to pay $122,477 in restitution. An OIG and DOL, Office of Labor Management Standards investigation revealed that the defendant embezzled union funds by writing 187 checks to himself from the union's checking account.

VA Contract Employee Pleads Guilty to Theft

A certified nursing assistant providing contract services to the Philadelphia, PA, VAMC pled guilty to theft of Government funds. An OIG investigation revealed that the defendant filed fraudulent time sheets with her employer who then billed VA for payment. The defendant claimed to work an average of 100 hours per week during a period when no actual work was performed. The defendant's employer assisted during the investigation and reimbursed VA $78,819 following the defendant's plea.

Two Former West Palm Beach, Florida, VAMC Employees Indicted for Conspiracy, Theft, and False Statements

Two former West Palm Beach, FL, VAMC employees were indicted for conspiracy, theft, and false statements. An OIG investigation revealed that one of the defendants, who previously worked at the U.S. Attorney's Human Resources (HR) office, conspired with a fellow VA HR employee to alter and forge leave records from the Department of Justice. The altered and forged documents enabled the employee to fraudulently receive approximately $16,608 in leave.

Former Cleveland, Ohio, VAMC Employee Pleads Guilty to Theft of Government Property

A former Cleveland, OH, VAMC employee pled guilty to theft of Government property and false statements. An OIG and VA Police Service investigation revealed that the defendant stole 3,220 pounds of aluminum conduit piping from the VAMC and sold it to a metal recycling center. The stolen aluminum piping and inside wiring were for a backup generator at the VAMC. When the generator was tested after the theft, there were multiple computer network failures, including the computerized patient record system. The piping and wiring had to be replaced in order for the backup generator to function. The defendant agreed to pay VA $12,338 in restitution.

Former Miami, Florida, VAMC Canteen Service Chief Sentenced for Theft

A former chief of the Veterans Canteen Service at the Miami, FL, VAMC was sentenced to 3 years' probation, 50 hours' community service, and ordered to attend drug treatment and to pay $6,716 in restitution after pleading guilty to organized fraud and grand theft. An OIG investigation revealed that the defendant stole VA property, cash, a laptop computer, and a Blackberry; misused his Government issued travel card; and negotiated several bad checks. The loss is $22,450.

Former Brooklyn, New York, VAMC Psychiatrist Sentenced for Health Care Fraud

A former Brooklyn, NY, VAMC psychiatrist was sentenced to 18 months' incarceration, 36 months' supervised release, and ordered to forfeit $1.2 million and pay Medicare restitution after pleading guilty to health care fraud. A VA OIG and Health and Human Services OIG investigation revealed that the defendant submitted false and fraudulent Medicare claims while operating a private practice. The fraud included home visits billed to Medicare while the defendant was on approved sick or bereavement leave from VA.

Long Beach, California, VAMC Employee Arrested for VA Pension Fraud

A Long Beach, CA, VAMC employee, who was also a Veteran, was arrested for pension fraud. An OIG investigation revealed that while employed by the VAMC the defendant applied for and received approximately $60,746 in VA pension benefits without disclosing that between 2007 and 2011 he had earned approximately $155,000 in wages.

Los Angeles, California, VAMC Engineer's Employment Terminated for Conflict of Interest

A Los Angeles, CA, VAMC engineer's employment was terminated for engaging in activities that created a conflict of interest by accepting gifts or gratuities from contractors and for lack of candor. An OIG investigation determined that the employee engaged a contractor to perform work on his personal residence at a significantly discounted price. The employee then failed to disclose this relationship when participating in VA contract negotiations and price determinations involving this contractor.

Former Richmond, Virginia, Housekeeping Aid Sentenced for Travel Benefit Fraud

A former Richmond, VA, housekeeping aid was sentenced to 134 days' incarceration (time served), 3 years' supervised release, and ordered to pay VA $2,334 after pleading guilty to theft of Government benefits. An OIG investigation revealed that the defendant submitted fraudulent travel reimbursement vouchers to the VAMC claiming that he was traveling from a non-existent address in Lynchburg, VA.

Veteran Sentenced for "Stolen Valor" Fraud

A Veteran was sentenced to 5 years' probation, ordered to pay $10,000 in restitution and to participate in a substance abuse treatment program after pleading guilty to false statements related to the delivery of health care. The defendant fraudulently claimed military service during the Vietnam War and that he received military awards and citations to include the Purple Heart, Bronze Star, Silver Star, and Combat Infantry Badge. Over the past 7 years, the defendant received VA health care and VA travel benefits for post-traumatic stress disorder (PTSD) appointments.

Veteran Indicted for Health Care Fraud

A Veteran was indicted for health care fraud and false statements relating to health care matters. An OIG investigation revealed that the defendant misrepresented the extent and severity of his disabilities. Specifically, the Veteran claimed, and was rated for, the loss of use of both of his feet. In actuality, the defendant is capable of walking unassisted. The loss to VA is approximately $260,000.

Non-Veteran Sentenced for Fraud

A non-Veteran was sentenced to 41 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $306,660. An OIG investigation determined that the defendant forged a DD 214, claiming to be an eligible Veteran. Based on the forged DD 214, the defendant received VA health care, including medication, from April 2009 to August 2012 from various VAMCs.

Non-Veterans Indicted for Health Care Fraud

A non-Veteran was indicted for theft of Government funds after fraudulently receiving VA health care and other benefits at the Asheville and Salisbury, NC, VAMCs. The defendant claimed to have served several years in the U. S. Marine Corps, including time in Vietnam. An OIG investigation determined that during much of the time the defendant claimed to have been in military service he was incarcerated. The defendant was the subject of a previous OIG investigation in which he was convicted of the same offense and was sentenced to 2 years' incarceration. The loss to VA is approximately $31,500.

In an unrelated case, a non-Veteran, who falsely claimed to be a Veteran, was indicted for health care fraud. An OIG investigation determined that between April 2003 and April 2012 the defendant fraudulently received VA health care, travel benefits, and Department of Housing and Urban Development–Veterans Affairs Supportive Housing from the Roseburg, OR, VAMC. The loss to VA is approximately $32,000.

In another unrelated case, a non-Veteran was indicted for false, fictitious, or fraudulent claims after an OIG investigation revealed that the defendant, who never served in the U.S. military, fraudulently received $55,458 in VA medical treatment. The defendant also fraudulently filed seven claims for VA pension and disability compensation.

Veteran Pleads Guilty to Interstate Transportation of Stolen Property from Chillicothe, Ohio, VAMC

A Veteran pled guilty to interstate transportation of stolen property. VA construction equipment and VA contractor equipment were stolen from the Chillicothe, OH, VAMC. Some of the stolen VA equipment was subsequently located in West Virginia. The defendant admitted to transporting and selling the stolen property in West Virginia, as well as selling some of the stolen equipment at a local pawn shop. A stolen generator was also recovered during a search of the defendant's residence. The value of the stolen property is approximately $89,200.

Veteran Sentenced for Drug Distribution

A Veteran was sentenced to 38 months' incarceration for selling and delivering oxycodone. An OIG and local law enforcement investigation revealed that the defendant sold his VA prescribed oxycodone to undercover law enforcement officers.

Veteran Arrested for Possession of Heroin with Intent To Distribute

A Veteran was arrested for possession of heroin with intent to distribute. An OIG and VA Police Service investigation revealed that the defendant sold heroin to patients at the Boston, MA, VAMC. The defendant was identified during an undercover operation at the VAMC, and when confronted the defendant admitted to being in possession of heroin that he intended to sell.

Veteran Arrested for Prescription Fraud

A Veteran was arrested after being indicted for obtaining a controlled substance by fraud and aiding and abetting. An OIG investigation revealed that the defendant altered a legitimate VA prescription form issued in 2009 and produced blank copies to obtain narcotics issued under the name of a VA nurse practitioner. As part of the scheme, the defendant used multiple aliases, forged the signature of the nurse practitioner, and used a false

Drug Enforcement Administration number. The defendant is currently on state probation for a similar offense committed in 2011.

Veterans Sentenced for VA Benefit Travel Fraud

The last of 16 defendants was sentenced as a result of an OIG and VA Police Service travel benefits fraud investigation at the Cleveland, OH, VAMC. The defendants received sentences ranging from probation to 18 months' incarceration. In addition, eight additional defendants were charged in state court with filing false travel vouchers. The loss to VA was approximately $353,000.

In a second unrelated case, a Veteran was sentenced to 5 years' probation, 4 months' home confinement, and ordered to pay VA $25,000 in restitution after pleading guilty to making false claims. An OIG investigation revealed that the defendant filed fraudulent travel benefit claims with the White River Junction, VT, VAMC resulting in the payment of inflated travel payments.

In a third unrelated case, a Veteran was sentenced to 10 months' incarceration, 36 months' probation, and ordered to pay VA $21,394 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant submitted 316 fraudulent travel vouchers claiming that he traveled 174 miles round-trip to the Salt Lake City, UT, VAMC, when the defendant lived a few blocks from the facility.

In a fourth unrelated case, a Veteran was sentenced to 4 months' home detention, 5 years' probation, and ordered to pay restitution of $23,795. An OIG investigation revealed that from September 2008 to June 2013 the defendant submitted 740 fraudulent travel benefit vouchers to the Clarksburg, WV, VAMC. The defendant claimed that he resided 40 miles from the facility when he actually lived a few miles from the VAMC.

Veterans Plead Guilty to Theft of Government Travel Benefits

A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that for over 5 years the defendant filed more than 450 fraudulent travel vouchers with the Tuscaloosa, AL, VAMC. The defendant claimed to be traveling from Mississippi when he actually resided in Tuscaloosa. The loss to VA is $42,750.

In a second unrelated case, a Veteran pled guilty to a criminal information charging him with filing a false claim with VA in connection with VA's beneficiary travel program. An OIG investigation determined that from October 2011 to January 2013 the defendant submitted approximately 60 fraudulent travel claims reporting that he traveled 506 miles roundtrip to the Togus, ME, VAMC. The mileage from the defendant's residence to the VAMC was only 96 miles. The loss to VA is $10,448.

In a third unrelated case, a Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he submitted 148 fraudulent travel vouchers to the Salt Lake City, UT, VAMC. The defendant fraudulently claimed that he attended VA-sponsored physical therapy appointments at an affiliate university and provided forged letters from the university to support his claim. The loss to VA is $10,687.

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. During this reporting period, OIG opened 88 investigations, which resulted in 21 arrests and $2.7 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 17,516 possible cases with over 3,337 investigative cases opened. Investigations have resulted in the actual recovery of $73.9 million, with an additional $24.6 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $163.6 million. To date, there have been 661 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 193 cases; made 62 arrests; obtained over $3.75 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $7.4 million in savings, efficiencies, cost avoidance; and recovered more than $3.1 million. One hundred fifty-five 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 41 defendants for these types of investigations. OIG obtained over $3.1 million in court ordered payment of fines, restitution, and penalties and achieved an additional $9.9 million in savings, efficiencies, cost avoidance, and recoveries.

The case summaries that follow provide a representative sample of the type of VBA investigations conducted during this reporting period.

VA Fiduciary Pleads Guilty to Theft of Government Funds

A VA fiduciary pled guilty to theft of Government funds. An OIG and local District Attorney's investigation revealed that the defendant embezzled $202,319 in VA benefits from five Veterans. The defendant used the money to pay personal expenses, issue loans to other people, and other non-authorized expenses.

Veteran's Daughter Pleads Guilty to Misappropriation by a Fiduciary

The daughter of a Veteran, who was his VA-appointed fiduciary, pled guilty to misappropriation by a fiduciary after an OIG investigation revealed that she embezzled approximately $251,500 from her father's funds. From October 2004 to September 2010, the defendant submitted fictitious annual accountings and certificate of deposit forms to VA. An accounting submitted in 2010 reported that $244,857 was held in savings and certificate of deposit accounts when there was less than $100 remaining in these accounts. The defendant admitted to falsifying the financial records to prevent VA from terminating her as her father's fiduciary.

Fiduciary Indicted for Theft

The brother of a VA beneficiary was indicted for theft, money laundering, and theft of entrusted property. An OIG, Social Security Administration (SSA) OIG, and local police investigation revealed that the defendant, who was a VA-appointed fiduciary, submitted an accounting to VA that falsely identified expenses pertaining to his brother for entertainment, clothing, and room and board. During this time period, the Veteran was a bedridden inpatient at a VAMC. The defendant was also found to have used his brother's Social Security benefits for personal gain. When interviewed, the defendant admitted to embezzling both VA and SSA benefits and using those funds to buy a car and for travel. The loss to the VA beneficiary is over $100,000.

Former VA Fiduciary Pleads Guilty to Misappropriation by a Fiduciary

A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the defendant, who is an attorney and former police officer, embezzled approximately $137,000 of VA benefits from his brother-in-law, a disabled Veteran. The defendant hid the embezzlement by charging it to excessive legal fees.

Former Fiduciary Pleads Guilty to Misappropriation

A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation revealed that from 2005 to 2009, the defendant misappropriated approximately $72,169 in VA benefits from his brother and used the stolen funds to pay for personal expenses.

VA-Appointed Fiduciary Sentenced for Misappropriation

A VA-appointed fiduciary was sentenced to 4 years' probation, ordered to wear a location monitoring device for 180 days, and pay restitution of $28,309 after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed the defendant misappropriated $35,000 in VA benefits intended for the Veteran.

Former VA Fiduciary Sentenced for Harboring Foreign National

A former VA fiduciary was sentenced to 3 years' probation, a $3,000 fine, and 100 hours' community service after pleading guilty to harboring a foreign national. The defendant, an attorney, is also required to disclose his felony conviction to the State Bars of Nevada and California. An OIG investigation revealed that the defendant became romantically involved with a female co-defendant and helped arrange a marriage between the co-defendant and an incompetent Veteran for whom he acted as fiduciary.

Former VA-Appointed Guardian Sentenced for Theft

A former VA-appointed guardian was sentenced to 2 years' probation and ordered to pay the victim $48,000 in restitution. An OIG investigation revealed that the defendant stole funds payable to his sister, the mentally disabled daughter of a deceased Veteran, and used the stolen funds for personal expenses.

VA Fiduciary Indicted for Misappropriation

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 her personal expenses and failed to make 20 mortgage payments toward the Veteran's home. The Veteran's home entered into foreclosure status as a direct result of the defendant's actions.

Veteran's Son Indicted for Misappropriation

The son of a VA beneficiary was indicted for theft from an elderly person and forgery. An OIG investigation revealed that the defendant, who was a VA-appointed fiduciary, misappropriated approximately $30,800 in VA benefits from his father and used the stolen funds to pay for personal expenses. As a result of the misappropriation, the Veteran and his spouse accrued $53,022 in debt to their assisted living facility. The defendant also forged and negotiated a $95,763 life insurance check paid to the Veteran. The loss to the Veteran is approximately $126,583.

Veteran's Brother Arrested for Embezzling Funds

A former VA fiduciary was arrested for dealing in the proceeds of unlawful activity, theft, and theft by deception. An OIG investigation determined that the defendant, a fiduciary for his Veteran brother, embezzled VA funds and used the money for gambling and other personal expenses. The loss to the Veteran is approximately $41,000.

Veterans Sentenced for VA Compensation Fraud

A Veteran was sentenced to 12 months' home detention, 36 months' supervised release, and ordered to pay $75,982 in restitution after pleading guilty to wire fraud. A second Veteran was sentenced to 12 months' home

detention, 36 months' supervised release, ordered to continue substance abuse and MH treatment, and ordered to pay $88,953 in restitution after pleading guilty to wire fraud. From 2003 to 2011, while working at the Maryland Department of Veterans Affairs, a State employee created fraudulent doctor notes and "Correction to DD Form 214, Certificate of Release or Discharge from Active Duty" (DD 215) 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 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.

Veteran Sentenced for Fraud

A Veteran was sentenced to 63 months' incarceration, 36 months' supervised release, fined $5,000, and ordered to pay restitution of $263,937 after pleading guilty to mail fraud and making false material statements. An OIG and U.S. Postal Inspection Service (USPIS) investigation determined that from 2005 to 2011, the Veteran repeatedly certified he had not been employed during the preceding 12 months. During that time the Veteran received royalties and investment income from selling worthless stock to investors pertaining to a drug he marketed as a treatment for cancer and other illnesses.

Veteran Sentenced for False Statements

A Veteran was sentenced to 5 years' probation, to include 12 months' electronic monitoring, and ordered to pay restitution of $144,000 after pleading guilty to making false statements to VA. Since 2000, the Veteran reported to VA that he was not working and had no income. This false claim resulted in the defendant's receipt of VA pension benefits and aid and attendance. An OIG investigation determined that the defendant was serving as a Pastor and had the church pay his bi-weekly salary to his wife, who was also his VA-appointed fiduciary. During this time period, while presumed to be permanently and totally disabled, the defendant also performed miscellaneous maintenance work, towing, welding, and drove a race car, which earned him income above the allowable limits.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 18 months' incarceration and ordered to pay VA $205,402 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant made false claims for benefits for PTSD stemming from trauma received while serving in support of Operation Desert Storm and also claimed to be unemployable and housebound since 1996. The investigation determined that the Veteran earned a Master's Degree in Education and worked full-time as a teacher for over 8 years.

Veteran Arrested for VA and Workers' Compensation Fraud

A Veteran was arrested for fraud and false statements, mail fraud, wire fraud, and false statements to obtain Federal workers' compensation benefits. A VA OIG, U.S. Postal Service (USPS) OIG, and DOL OIG investigation revealed that the defendant, who receives over $9,000 a month in VA and workers' compensation benefits, greatly exaggerated his disabilities and was observed engaging in activities that were inconsistent with his claims. Though allegedly wheelchair bound, the defendant has only been observed using a wheelchair for his appointments with VA and using a cane when attending scheduled DOL and USPS exams. The defendant was also observed playing horseshoes, riding a bicycle, and engaging in a wide variety of physical activities while on a cruise.

Veteran Pleads Guilty to Conspiracy To Defraud the Government

A Veteran pled guilty to conspiracy to defraud the Government. An OIG investigation revealed that the defendant submitted false claims to VA in order to receive VA disability compensation and education benefits for injuries allegedly sustained while in the U.S. Marine Corps. The loss to VA is approximately $90,000.

Veteran Sentenced for Making False Statements to VA

A Veteran was sentenced to 5 months' incarceration, 5 months' home detention, 1 year of supervised probation, and ordered to pay VA restitution of $101,163 after pleading guilty to knowingly making false statements related to a health care matter. An OIG investigation revealed that the defendant made materially false statements concerning his physical abilities and alleged physical limitations. The loss to VA is $119,490.

Veteran Indicted for Fraud and False Statements

A Veteran voluntarily surrendered after being indicted for health care fraud and making false statements pertaining to health care matters. An OIG investigation revealed that the subject misrepresented the extent and severity of his disabilities. The defendant claimed he was unable to walk and was rated for loss of use of both feet. Investigation revealed that the defendant was able to walk without any assistance. The loss to VA is approximately $260,000.

Veteran Arrested for Theft of Government Funds and False Statements

A Veteran was arrested for theft of Government funds and false statements. An OIG investigation revealed that the defendant, in order to receive VA compensation, fraudulently claimed Vietnam service and submitted an altered DD 214 indicating that he received a Purple Heart and Vietnam Gallantry Cross. A review of the Veteran's service record indicated that he never served in Vietnam and did not receive the claimed military awards. The defendant served aboard Navy ships that were not deployed to Vietnam or to any other combat zone. The loss to VA is approximately $102,000.

Veteran Pleads Guilty to Theft and Conspiracy

A Veteran pled guilty to theft of Government funds and conspiracy in making false statements to Federally-licensed firearms dealers. An OIG investigation revealed that the defendant fraudulently obtained VA compensation benefits of approximately $7,500 per month by claiming the loss of the use of both legs. The Veteran was observed ambulating freely, driving a vehicle, rolling hay bales, and operating a riding lawnmower. The Veteran's wife was placed into a pre-trial diversion program and ordered to pay restitution for her part in the scheme to defraud VA. Additionally, the Veteran's mother and stepfather pled guilty to conspiracy in making false statements to Federally-licensed firearms dealers after the investigation revealed that in 2011 and 2012 they purchased over 25 firearms for the defendant, who is a registered sex offender and is prohibited from possessing firearms due to a prior felony conviction for committing a lewd act with a minor. The loss to VA is $159,297.

Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to theft of Government funds. A VA OIG and USPS OIG investigation revealed that the defendant, who was in receipt of VA individual unemployability and other Federal disability benefits, was the owner and operator of an auto sales and laundromat business while reporting that he was unemployed and had no income. The total loss to the Government is approximately $500,000, with VA's loss being approximately $105,000.

Veteran Sentenced for Making False Statements to VA

A Veteran was sentenced to 60 months' probation, 180 days' home detention, and ordered to pay VA $63,562 in restitution after pleading guilty to making false statements. An OIG investigation revealed that between August 2007 and July 2011 the defendant failed to report his earnings in order to fraudulently receive VA pension benefits.

Veteran Indicted for False Claims and Wire Fraud

A Veteran was indicted for false claims and wire fraud after an OIG investigation revealed that he fraudulently claimed PTSD and traumatic brain injury (TBI) as a result of having been injured by an improvised explosive device during combat operations in Iraq. The defendant subsequently received compensation for PTSD due to the fraudulent claims. The investigation further revealed that the defendant was never injured during his service in Iraq. The loss to VA is approximately $45,290.

Veteran Pleads Guilty To Making False Statements to VA

A Veteran pled guilty to making false statements. An OIG investigation revealed that the defendant submitted fraudulent claims to VBA for TBI and PTSD and subsequently made numerous false statements to VHA in support of those claims. The defendant told VA doctors that his service-connected PTSD was due to a traumatic event he experienced while in combat. It was later revealed that the defendant never fell out of a helicopter as he claimed, never deployed, and that he never experienced combat.

Veteran Pleads Guilty To Making False Statements

A Veteran pled guilty to making false statements. An OIG investigation revealed that between August 2007 and July 2011 the defendant, who was receiving VA pension benefits, failed to report his earnings to VA. The loss to VA is $58,440.

Veterans Sentenced for VA Pension Beneficiary Fraud

A Veteran was sentenced to 6 months' incarceration, 8 months' home detention, 3 years' probation, and ordered to pay restitution of $75,246 after pleading guilty to theft of Government funds and making false statements. An OIG investigation revealed that the Veteran fraudulently obtained a VA pension by falsifying his initial application and attempting to hide his assets from VA.

A second Veteran was sentenced to 9 months' home confinement, 3 years' probation, and ordered to pay restitution of $61,129 after pleading guilty to theft of Government funds and identity theft. An OIG investigation revealed that the defendant fraudulently reported no income and his inability to work in order to receive VA pension benefits. The defendant also opened numerous bank accounts, using fraudulent identities, in order to hide almost $1 million in unreported funds while receiving the VA pension benefits.

Veteran Indicted for Theft of VA Education Benefits

A Veteran was indicted for theft of Government funds after an OIG investigation revealed that he falsely claimed to be attending school at a community college. The defendant made these fraudulent claims in order to obtain Post 9/11 GI Bill benefits and carried out his scheme by obtaining and submitting VBA documentation used by schools to certify enrollment. The loss to VA is approximately $70,000.

Veteran Sentenced for Theft of VA Benefits from Deceased Beneficiary

A Veteran was sentenced to 13 months' incarceration, 2 years' supervised release, and ordered to pay $124,944 in restitution after an OIG investigation revealed that the defendant received and negotiated VA benefit checks issued after the death of the beneficiary.

Non-Veteran Pleads Guilty to Fraud

A non-Veteran pled guilty to conspiracy to commit mail, wire, and bank fraud. An OIG and FBI investigation determined that the defendant provided down payments to multiple buyers during real estate closings that were reported to the lenders as originating from a family member of the buyer. The funds were fraudulently reported on the Uniform Residential Loan Application to increase the buyer's credit scores, allowing them to qualify for mortgages they were not otherwise qualified to receive. Thirteen loans were identified in the scheme, to

include a VA-guaranteed home loan. The potential loss to VA should this guaranteed VA home loan default is approximately $152,203.

Defendant Pleads Guilty in Deceased Beneficiary Investigation

A subject pled guilty to misuse of a Social Security Number (SSN) after a VA OIG and SSA OIG investigation revealed that the defendant assisted the daughter of a deceased beneficiary with forging and negotiating VA and SSA benefit checks that were issued after the beneficiary's death in July 2002. The defendant used false identifiers to open bank accounts through which the checks were negotiated. The daughter of the deceased beneficiary was previously sentenced in this case. The loss to VA is approximately $120,500.

Niece of Deceased Beneficiary Pleads Guilty to Theft of Public Money

The niece of a deceased beneficiary pled guilty to theft of public money. After her aunt's death in April 2005, the defendant transferred VA funds from her deceased aunt's account into another account in her aunt's name. The defendant then withdrew the funds and used them to pay her expenses. The loss to VA is $105,765.

Widow of Deceased Veteran Sentenced for Theft

The widow of a deceased Veteran was sentenced to 5 months' incarceration, 36 months' probation, and ordered to pay VA $76,998 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited and issued by a Department of the Treasury check after her husband's death in December 2007.

Defendant Sentenced for Theft of VA Benefit Check

A defendant was sentenced to 4 months' home detention and 1 year of probation after pleading guilty to theft of Government funds. An OIG and local police investigation revealed that the defendant sold a stolen $32,000 retroactive VA benefit check, issued to the daughter of a deceased Veteran, to an undercover officer.

Son of Deceased Veteran Sentenced for Fraud

The son of a deceased Veteran was sentenced to 4 months' home detention, 2 years' probation, and ordered to pay VA restitution of $16,995 and the SSA restitution of $62,110 after pleading guilty to program fraud. A VA OIG and SSA OIG investigation revealed that the defendant failed to report his father's January 2007 death to VA and the SSA. The defendant subsequently stole SSA benefits and VA benefits that were direct deposited to his father's account.

Defendant Sentenced for Misuse of SSN

A defendant was sentenced to 33 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $177,694 ($58,052 to SSA and $119,642 to VA) jointly and severally with another defendant after pleading guilty to misuse of an SSN. A VA OIG and SSA OIG investigation revealed that the defendant conspired with the daughter of a deceased beneficiary to receive, forge, and negotiate VA and SSA benefit checks that were issued after the beneficiary's death in July 2002.

Daughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 10 months' confinement in a halfway house, 60 months' probation, 12 months' home detention, and ordered to pay VA $103,557 in restitution. An OIG investigation revealed that the defendant failed to report her mother's May 2005 death to VA and subsequently stole VA benefits that were direct deposited to the beneficiary's account. The loss to VA is $103,557.

Friend of Deceased VA Widow Beneficiary Sentenced for Theft of Government Funds

The friend of a deceased VA widow beneficiary was sentenced to 2 years' probation and ordered to pay restitution of $130,071 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the beneficiary's death in April 2003.

Other Investigations

OIG investigates a wide array of criminal offenses in addition to those listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. OIG also investigates information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. During this reporting period, OIG opened 22 cases; made 3 arrests; obtained more than $400,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and achieved over $123,400 in savings, efficiencies, and cost avoidance.

Widow Indicted for Murder of Veteran Husband

The widow of 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 District Attorney's Office investigation revealed that the defendant and her current spouse conspired to murder her previous husband, a combat Veteran and VA beneficiary, by forcing him to overdose on prescription drugs and then staging the scene to make it appear that he committed suicide. The defendant later applied for Dependency and Indemnity Compensation (DIC) benefits and falsely claimed that her husband's drug overdose was related to his PTSD disability. The defendant's current spouse previously pled guilty to conspiracy to commit first degree murder and agreed to fully cooperate with the prosecution against his wife in exchange for a reduced sentence. The loss to VA is over $104,865.

Former VA Contracting Officer Pleads Guilty To Accepting Bribes

A former VA contracting officer pled guilty to receipt of a bribe by a public official. An OIG and FBI investigation revealed that for approximately 4 years the defendant, responsible for administering VA contracts worth millions of dollars, accepted bribes including cash, two vehicles, airplane tickets, hotel stays, and professional football tickets all worth $105,742 in exchange for her influence in awarding contracts. In return for the bribes, the defendant was able to ensure continuous work for the contractors at various VA campuses.

VA Contractor Arrested for Fraud

A VA contractor was arrested for conspiracy, mail fraud, wire fraud, and bank fraud relating to a large-scale Ponzi scheme. An OIG and FBI investigation revealed that the defendant accepted more than $125 million from investors who believed they were financing company contracts to supply latex gloves to VA. In reality, company sales totaled only about $25,000 per year. As part of the scheme, the defendant falsified VA invoices and letters and also requested one of his employees to impersonate a VA contracting official.

Construction Company Owner and Son-in-Law Plead Guilty to Fraud

The owner of a New Mexico construction company and his son-in-law pled guilty to conspiracy and to committing a major fraud against the United States. The plea agreements require 57 months' incarceration for the owner and 37 months' incarceration for his son-in-law. An OIG investigation determined that the owner of the company paid his step-brother approximately $50,000 to use his service-disabled Veteran status in order to qualify for and obtain $10.9 million in VA Service-Disabled Veteran-Owned Small Business (SDVOSB) contracts. The owner's step-brother previously pled guilty to conspiracy, major fraud, and wire fraud.

Small Business Owner Arrested for SDVOSB Fraud

The owner of a small business that contracted with VA to provide goods and services was arrested for fraudulently representing her company as an SDVOSB in order to obtain more than $1.2 million in Government contracts set aside for disabled Veterans. An OIG, General Services Administration (GSA) OIG, and IRS CI investigation revealed that the defendant fraudulently certified that her father-in-law, who was a Veteran, was the service-disabled owner of the company. The father-in-law was not service-disabled and also had very little involvement with the company. In actuality, the company was managed by the defendant and her husband as they controlled all revenues and the company's daily operations.

Veteran Pleads Guilty to Wire Fraud

A Veteran pled guilty to wire fraud after a VA OIG and Small Business Administration (SBA) OIG investigation revealed that he fraudulently claimed to be the owner of an SDVOSB in order to qualify for and obtain $1.4 million in VA contracts for architectural and engineering services. The Veteran did not have a service-connected disability and had previously been denied VA benefits.

Company Owner Sentenced After Pleading Guilty to Obstruction of a Grand Jury Investigation

The owner of a large construction company was sentenced to 12 months' probation and a $5,000 fine after pleading guilty to obstructing a grand jury investigation by altering and deleting documents from his computer. A VA OIG, GSA OIG, Army Criminal Investigations Division, SBA OIG, and DOL OIG 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 deleted the documents on his computer that were required by the subpoena and relevant to the pending investigation.

Husband and Wife Indicted for Fraudulent Claims and Other Charges

A husband and wife were indicted for conspiracy, fraudulent claims, mail fraud, and embezzlement. An OIG investigation revealed that from 2008 to 2009 the defendants, co-founders of a non-profit film school that taught cinematography to wounded Veterans, billed the VA Vocational Rehabilitation & Employment program for equipment that was never provided to the students and for a class that was never taught. In addition to the fraudulent claims to VA, the defendants used foundation money to pay for their personal medical expenses, alcohol, groceries, and a vacation while claiming to never receive a salary or any benefits.

Palo Alto, California, VAMC Employee and Three Other Subjects Indicted on Multiple Charges

A Palo Alto, CA, VAMC employee and three other subjects were indicted for conspiracy, bank fraud, access device fraud, fraud in connection with identification information, and aggravated identity theft. An OIG and VA Police Service investigation revealed that the defendants conspired to access a protected VA computer system at the Palo Alto VAMC. The VAMC employee subsequently stole a VA employee's PII and used the identifiers to create unauthorized credit card accounts and counterfeit checks. All of the defendants subsequently used the credit card accounts and checks to make purchases at various stores. The purchased items were then sold for cash or traded for illegal narcotics.

Company Employee Arrested for False Statements

A company employee was arrested for false statements after a VA OIG, Housing and Urban Development (HUD) OIG, and USPIS investigation revealed that he participated in an interstate fraudulent construction bond scheme involving multiple Federal agencies. The defendant was an employee of an "assignment of claims company" identified as one of four straw companies that had been working together to provide fictitious bonding documents to construction companies that were unable to obtain traditional bonding. The company entered into an agreement with the VISN 6 contracting office to disburse all funds from the U.S. Government to sub-contractors and suppliers of a North Carolina-based SDVOSB construction company. The defendant received payment from one of the straw company's owners to sign the bonds for the multimillion-dollar project even though funds were not available to support the project. As a result of the scheme, VA and HUD projects fell into default.

Veteran Pleads Guilty to Fraud and Theft

A Veteran pled guilty to wire fraud, aggravated identity theft, and filing a false tax return. A multi-agency investigation revealed that from 2007 to 2013 the Veteran created a series of fraudulent charter schools in order to receive approximately $25,000,000 in surplus Government computer equipment under GSA's Computers

for Learning Program. The defendant subsequently obtained computers from VA facilities located in multiple states. The computers fraudulently obtained from VA were valued at approximately $1.9 million.

VA Contractor Sentenced for Bribery

A contractor doing business with the East Orange, NJ, VAMC was sentenced to 6 months' home confinement, 2 years' probation, and a $2,000 fine after previously pleading guilty to bribery. An investigation by OIG and the FBI revealed that between October 2012 and February 2013, the defendant offered to pay a $5,000 bribe to a VA employee for assistance in having his two companies placed on a multimillion-dollar multiple award task order contract. The defendant subsequently made two cash payments totaling $1,000 to the VA employee for his assistance.

Major Teaching Hospital Reimburses VA for Overbilling

A major teaching hospital, which provided VA fee basis radiation proton therapy treatments, reimbursed VA $557,661 as the result of an agreement negotiated with the assistance of the U.S. Attorney's Office, Civil Division. An OIG investigation revealed that the hospital overbilled VA for radiation treatments.

Former Bedford, Massachusetts, VAMC Police Chief Pleads Guilty to Conspiracy To Kidnap

A former Bedford, MA, VAMC Police Chief pled guilty to conspiracy to kidnap. An OIG and FBI investigation revealed that from the spring of 2011 to January 2013, the former police chief and two co-conspirators engaged in a series of e-mail and instant message communications during which they discussed and planned the kidnapping, torture, and murder of the spouse and other family members of one of the co-conspirators. This planning included the co-conspirator providing the former police chief with photographs of these family members and the approximate location of their residence. The co-conspirators ceased active planning of the kidnapping when the FBI arrested a New York City police officer for a related kidnapping conspiracy and began investigating one of the co-conspirators. In addition, beginning in approximately January 2013, the former police chief, one of the co-conspirators, and an undercover agent began discussions about kidnapping a woman. The former police chief participated in multiple conversations with both the undercover agent and the other co-conspirator about the conspiracy's objective to kidnap and commit acts of violence against the intended victim (an undercover FBI agent) and other women. The co-conspirator purchased a high-voltage Taser gun, based on the police chief's recommendation, which they intended to use in the commission of the kidnapping. VA computers were examined by the OIG Computer Crimes and Forensics Lab, resulting in the discovery of incriminating evidence. Charges against the two co-conspirators are pending further judicial action.

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

A former Northport, NY, VAMC environmental engineer was sentenced to 51 months' incarceration and 7 years' supervised release after having previously pled guilty to accessing child pornography with intent to view. As part of his supervised release, the defendant must submit to periodic polygraph examinations and avoid unsupervised contact with minors. An OIG and local police investigation revealed that while employed by VA, the defendant searched for and accessed child pornography sites using VA systems. The defendant was arrested without incident following an appointment with his probation officer relating to a previous conviction for molesting a family member who was a minor.

Service Officer Sentenced for Possession of Child Pornography

A former Vietnam Veterans of America service officer was sentenced to 48 months' incarceration, lifetime probation, and ordered to register as a sex offender after pleading guilty to possession of child pornography. An OIG investigation revealed that the defendant possessed child pornography on his personal laptop that was located in an office at the St. Petersburg, FL, VA Regional Office (VARO).

Veteran Sentenced for Grand Larceny

A Veteran and former USPS employee was sentenced to 1 to 3 years' incarceration and ordered to pay restitution of $400,000 after pleading guilty to grand larceny. A VA OIG, USPS OIG, and local police investigation revealed that the defendant befriended an elderly disabled Veteran while working as his postal carrier. From January 2006 to February 2013, the defendant stole over $400,000 from the victim's accounts, which included VA benefits, using ATM withdrawals and balance transfers while the victim was residing in a VAMC nursing home.

Hines, Illinois, VA Employee Charged With Theft

A VA Hines Information Technology Center (Center) employee was charged with theft. During an OIG investigation, the defendant admitted that he stole 17 newly purchased laptop computers from the Center. Some of the computers were then pawned at a local shop by the defendant's wife.

Former Employee of Non-Profit Research Institute Pleads Guilty to Theft and Misuse of a Passport

A former employee of a VA affiliated non-profit research institute pled guilty to theft from programs receiving Federal funds and misuse of a passport. A VA OIG, U.S. Department of Homeland Security, Immigration and Customs Enforcement, Department of State DSS, and SSA OIG investigation revealed that the defendant used a false SSN, date of birth, and passport to conceal his criminal history and obtain employment with the research institute. After gaining employment, 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 his initial location and had obtained employment and housing using another fictitious name, SSN, date of birth, and passport. The other investigative agencies joined the case after it was determined that the defendant committed additional criminal offenses in an effort to elude capture and gain new employment.

Two Non-Veterans Arrested for Theft of Government Property

Two non-Veterans were arrested for theft of Government property. An OIG, IRS CI, and local police investigation revealed that the defendants used Veterans' PII, obtained from stolen VA medical records and other individuals' information, to file $469,391 in fraudulent tax returns.

Veteran's Brother Pleads Guilty to Identity Theft

A Veteran's brother pled guilty to possession of a fraudulent Florida driver's license, making a false application for a Florida driver's license, and fraudulent use of identification. An OIG and Florida Highway Patrol investigation revealed that the defendant, who was not a Veteran, obtained a Florida driver's license and received treatment at the Miami, FL, VAMC while using his brother's identity. The defendant received approximately $59,403 in VA medical care to which he was not entitled.

Former Tampa, Florida, VAMC Volunteer Pleads Guilty to Identity Theft

A former volunteer at the Tampa, FL, VAMC pled guilty to conspiracy to defraud the Government, access device fraud, and aggravated identity theft. An OIG, IRS CI, and local police investigation revealed that the defendant stole VA patients' PII, traded it for crack cocaine, and used the PII to file $522,981 in fraudulent tax returns.

Veteran Sentenced for Identity Theft

A Veteran was sentenced to 30 months' incarceration, 36 months' supervised release, and ordered to pay VA $178,607 in restitution. An OIG investigation revealed that for over 7 years the defendant, a wanted fugitive felon, used the identity of his brother and fraudulently received approximately $178,000 in VA health care benefits and pension benefits. The defendant's brother resides in the Netherlands and never applied for or received any VA benefits. During the investigation, evidence was secured by the State Department through the Dutch National Police that was critical to the defendant's conviction.

Veteran Pleads Guilty to Identity Theft and Fraud

A Veteran pled guilty to aggravated identity theft, wire fraud, and bank fraud. A VA OIG, SSA OIG, Department of the Treasury OIG, and Washington State Social and Health Services investigation revealed that the defendant stole the personal identification of two Veterans to establish fraudulent VA e-Benefit accounts and re-route compensation payments to prepaid debit cards. The defendant obtained information on over 100 individuals and caused a combined loss of over $85,000 to VA, SSA, private individuals, and corporations.

Non-Veterans Convicted of Using Veterans' Identity for Tax Refund Fraud

A non-Veteran was found guilty at trial of wire fraud, theft of Government funds, and aggravated identity theft. An OIG, IRS CI, and Florida Highway Patrol investigation revealed that the defendant used Veterans' PII from stolen VA medical records and other information to file $630,783 in fraudulent tax returns.

In a separate case, two other non-Veterans pled guilty to access device fraud and aggravated identity theft. An OIG, IRS CI, and local police investigation revealed that the defendants used Veterans' PII obtained from stolen Tampa, FL, VAMC medical records to file $469,391 in fraudulent tax returns.

Defendant Sentenced for Theft of Government Funds and Identity Theft

A defendant was sentenced to 61 months' incarceration, 3 months' probation, and ordered to pay VA $122,134 in restitution after pleading guilty to theft of Government funds and aggravated identity theft. An OIG and Department of State DSS investigation determined that beginning in approximately 1986 the defendant assumed the identities of at least five different individuals. On four occasions, the defendant entered the military under fraudulent identities and obtained VA education benefits using one of these fraudulent identities. This investigation also determined that the defendant obtained U.S. passports under two fraudulent identities and had applied for passports under other identities.

Federal Grand Jury in Puerto Rico Returns Seven-Count Indictment Against Man Who Received VA Benefits Using Assumed Identity

A Veteran was indicted and subsequently arrested for wire fraud, theft, identity theft, aggravated identity theft, false statements, and false statements in application and use of a passport. An OIG and Department of State DSS investigation revealed that the defendant fraudulently enlisted in the U.S. Army by using his cousin's identity after being discharged and barred from re-enlistment under his own identity. The defendant admitted to using his cousin's identity in order to fraudulently re-enlist and obtain VA compensation, education, and medical benefits. The loss to VA is approximately $904,000.

Former USPS Maintenance Manager Sentenced for Drug Theft

A former USPS maintenance manager was sentenced to 5 years' probation and ordered to pay an $8,000 fine and $558 in restitution. A VA OIG and USPS OIG investigation revealed that between April and October 2012 the defendant stole more than 17 mail packages containing the Schedule II narcotic Vicodin that was shipped from a VA Consolidated Mail Outpatient Pharmacy. The defendant confessed to stealing all of the VA's missing medications and was in possession of two of the packages when caught by postal supervisors.

Former United Parcel Service Employee Sentenced for Drug Theft

A former United Parcel Service (UPS) employee was sentenced to 70 to 84 months' incarceration and a $50,000 fine after pleading guilty to larceny and possession of controlled substances. A VA OIG, local police, and UPS Corporate Security investigation revealed that the defendant stole four UPS packages containing VA-prescribed narcotics shipped or intended for shipment to Veterans residing in North Carolina.

Non-Veteran Arrested for Theft and Burglary at Tampa, Florida, VAMC

A non-Veteran was arrested for theft and burglary. An OIG and VA Police Service investigation revealed that on at least two occasions the defendant stole computers from the Tampa, FL, VAMC. The defendant is also a suspect in the theft of additional computers from the same VAMC. The defendant was apprehended while attempting to leave the facility with a computer and later told investigators that he intended to sell the computer for crack cocaine. The stolen computers were properly encrypted. The loss to VA is approximately $7,800.

Three Defendants Sentenced for Wire Fraud

Three defendants were sentenced after pleading guilty to wire fraud. The first defendant was sentenced to 2 years' incarceration and 3 years' supervised release. The second defendant was sentenced to 5 years' probation, and the third defendant was sentenced to 2 years' incarceration and 3 years' supervised release. All three defendants were ordered to pay VA a total of $147,285 in restitution. An OIG investigation revealed that these defendants and three others were involved in rigging bids to refurbish VA-acquired properties. The other defendants were previously sentenced.

Defendant Charged with Theft of VA Property

A defendant was charged in a criminal information with theft of Government property and with introducing into interstate commerce a stolen device that was misbranded. An OIG and Food and Drug Administration investigation revealed that the defendant stole eight Olympus endoscopy and colonoscopy scopes from VAMCs in Dayton, OH, and Fort Wayne, IN. The defendant also admitted to the theft of scopes from other public and private hospitals. The loss to VA is approximately $220,000.

Beauty School Owner Sentenced for Making False Statements

The owner of a beauty school in Richmond, VA, who was approved to teach cosmetology to students eligible to receive VA education benefits, was sentenced to 20 months' incarceration, 3 years' supervised release, and ordered to pay VA $85,610 in restitution after pleading guilty to false statements. An OIG investigation determined that after a second defendant's cosmetology school in Chesapeake, VA, was destroyed by fire and she lost her teaching accreditation with the State of Virginia, the two defendants conspired to recruit and train students eligible to receive benefits in the Chesapeake area while submitting paperwork to VA fraudulently certifying that the students were enrolled and receiving training at the Richmond beauty school. The second defendant also pled guilty to false statements and is pending sentencing.

Non-Veteran Sentenced for Drug Possession

A non-Veteran was sentenced to 2 years' incarceration and ordered to pay a $7,500 fine after being found guilty at trial of multiple drug possession charges. An OIG investigation revealed that a Veteran obtained over 2,200 doses of a controlled substance from VA and his private physician, which the Veteran then provided to the defendant. A felony warrant for the Veteran remains outstanding.

Four Defendants Arrested on Multiple Fraud Charges

Four defendants were arrested after being indicted for conspiracy, mail fraud, check forgery, aggravated identity theft, and access device fraud. An OIG and U.S. Secret Service investigation revealed that the defendants were involved in a conspiracy to steal and negotiate Department of the Treasury checks from VA and IRS. One of the co-conspirators was a former VISN employee. After indictment, two defendants fled and were captured 2 months later by the U.S. Marshals Service. Both subjects were ordered held pending trial.

Former Dell Contractor Indicted for Theft of Government Property

A former Dell contractor assigned to the Jackson, MS, VAMC was indicted for theft of Government property. An OIG investigation revealed that the defendant stole desktop and laptop computers from the VAMC and sold them on Craigslist. Two stolen VA computers were recovered during the investigation.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 36 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 24 defendants and 4 imprisonments. OIG obtained nearly $4,000 in court ordered payment of fines, restitution, and penalties as well as over $87,000 in savings, efficiencies, cost avoidance, and recoveries. OIG investigative work resulted in the following:

- A Veteran was sentenced to 2 years' incarceration and 4 years' probation after pleading guilty to making terroristic threats. An OIG investigation revealed that the defendant threatened to kill Atlanta, GA, VAMC medical staff by going to his residence to get a weapon, return, and shoot them in the head if he was not granted a 100 percent disability pension rating. The Veteran left the VAMC and before he could return got into a shootout with local police at his residence after the officers responded to a domestic disturbance call. The Veteran was charged separately for this offense.
- A Veteran was sentenced to 194 days' incarceration, 12 months' probation, and ordered to have no contact with the victim after pleading guilty to battery. An OIG and VA Police Service investigation revealed that the Veteran made sexual comments and then assaulted a VA nurse practitioner at the West Palm Beach, FL, VAMC.
- A Veteran was arrested for assaulting a VA psychiatrist at the Waco, TX, VAMC. The defendant choked the psychiatrist while being admitted as a psychiatric inpatient.
- A Veteran was sentenced to 6 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $1,850 (payment of victim's medical bill) after pleading guilty to the assault of a Federal employee. An OIG and VA Police Service investigation revealed that the defendant, who was an inpatient at the Portland, OR, VAMC, assaulted a nurse causing a fractured jaw.
- A Veteran was indicted for assault after an OIG and VA Police Service investigation revealed that he assaulted two VA police officers while at the Bath, NY, VAMC. At the time of the assault, the defendant was being processed for possible admission. The Veteran is being held pending further judicial action.
- A Veteran was arrested for assaulting an East Orange, NJ, VAMC employee. An OIG investigation revealed that the defendant attacked a social worker by spitting in her face and fracturing her elbow. The defendant was held pending a bail hearing.
- A Veteran was sentenced to a $1,000 fine and a $25 special assessment after pleading guilty to assault on a Federal officer. An OIG investigation revealed that the Veteran struck a Reno, NV, VAMC police officer in the face and chest while the officer was in the performance of his official duties.
- A Veteran was indicted for threats by telephone to unlawfully damage and destroy a building, unlawful possession of a firearm, and unlawful possession of ammunition. An OIG and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation revealed that the defendant made a telephonic threat to destroy the Buffalo, NY, VAMC by means of an explosive. The Veteran was also discovered to be in possession of a firearm and ammunition and was charged for these offenses based on previous commitments to a psychiatric facility.
- A Veteran was arrested for communicating an interstate threat. An OIG, FBI, VA Police Service, and local police investigation revealed that the defendant threatened to kill his ex-wife, a Roseburg, OR, VAMC employee. The defendant made threatening statements to his wife by text messages and voicemails while she was on duty at the VAMC.
- A Veteran was arrested after he told a VA social worker that he was going to start killing people at the San Diego, CA, VAMC. An OIG investigation revealed that the defendant left voicemail messages after he was discharged from the VAMC due to his disruptive behavior.

- A Veteran pled guilty to threatening to murder a Government employee. An OIG and VA Police Service investigation revealed that in August 2013 the defendant made several threats to kill Seattle, WA, VAMC employees and police officers. The defendant remains in custody pending trial.
- A Veteran was charged with making harassing telephone calls. An OIG investigation revealed that the defendant made numerous threatening calls to the Pembroke Pines, FL, VA CBOC threatening the staff. The Veteran repeatedly called the clinic and threatened to commit mass murder if he did not receive additional narcotics. The threats resulted in the clinic's closure and patients' appointment cancellations.
- A Veteran and former Compensated Work Therapy employee was arrested for harassment. An OIG, U.S. Secret Service, Federal Protective Service, and VA Police Service investigation identified the Veteran as the suspect who authored and placed a threatening letter on an OIG agent's vehicle. The defendant previously made unfounded allegations against his VA supervisor.
- A Veteran was arrested and subsequently indicted for threatening to murder a Government employee and failing to register as a sex offender. An OIG and VA Police Service investigation revealed that in August 2013 the defendant made several threats to kill VA employees and police officers. The defendant also failed to register as a sex offender when he moved to Washington State. The defendant remains in custody pending trial.
- A Veteran was sentenced to 8 months' incarceration and 2 years' probation after pleading guilty to making a false bomb threat. An OIG and sheriff's office investigation revealed that the Veteran called the VA Crisis Hotline and said he had 4 pounds of C4 explosives and ball bearings and that he was going to the Detroit, MI, VARO for payback after being denied benefits.
- A former Seattle, WA, VAMC employee was charged in a criminal information with making a threat to bomb the VAMC. An OIG and VA Police Service investigation determined that the defendant wrote two separate letters indicating that multiple bombs would detonate somewhere in the VAMC within 2 weeks. No bombs or improvised explosive devices were found. The defendant later admitted that he wrote the letters as a diversionary tactic in order to delay an investigation that was being conducted by VA Police Service and GSA OIG over his suspected misuse of a Government fuel credit card.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive Veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 54.6 million felony warrants have been received from the National Crime Information Center and participating states resulting in 67,502 investigative leads being referred to law enforcement agencies. Over 2,401 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.06 billion in estimated overpayments with an estimated cost avoidance of $1.26 billion. During this reporting period, OIG opened 36 and closed 34 fugitive felon investigations, identifying $116.3 million in estimated overpayments. OIG investigative work resulted in the arrest of 29 fugitive felons, including 3 VA employees. VA employees were apprehended on charges related to health care violations, sexual assault, and probation violations. Based on the information provided to OIG, at least one additional arrest was made by other law enforcement agencies.

- A Phoenix, AZ, VAMC employee was arrested by the local police with the assistance of OIG and VA Police Service. The employee was wanted for the rape of a 9-year-old girl.
- A Veteran wanted for aggravated sexual assault on a child was arrested by a U.S. Marshals Regional Fugitive Task Force with the assistance of OIG and VA Police Service.

- A Veteran wanted in Arizona for a felony probation violation related to aggravated assault of a police officer was arrested in San Jose, CA, by the local police department with the assistance of OIG and the VA Police Service. The Veteran is pending extradition.
- A Veteran was arrested by the local police with the assistance of OIG and the VA Police Service at the Phoenix, AZ, VAMC. The Veteran had been shot by local police and was wanted for unlawful flight from law enforcement and aggravated assault with a weapon against an officer. A second Veteran wanted for sexual battery, burglary with assault, and false imprisonment was arrested by the U.S. Marshals Service with the assistance of OIG agents.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG opened nine and closed seven administrative investigations. The Division investigated 15 allegations, 8 of which were substantiated. This work resulted in the issuance of 1 report containing 17 recommendations for administrative or corrective action. This investigation concerned allegations related to failure to properly supervise, misuse of official time and resources, and a prohibited personnel practice in the VA Center for Innovation.

The Administrative Investigations Division issues advisory memoranda when an allegation has been substantiated and OIG suggests VA take some action based on the investigation, but where the violation does not rise to the level of a formal recommendation. The Division also prepares closure memoranda for allegations that are not substantiated and not otherwise included in a report or advisory memorandum. During this reporting period, the Administrative Investigations Division issued two advisory memoranda and six closure memoranda. OIG also obtained $30,990 in dollar recoveries.

Lax Supervision by VA Officials Leads to Misuse of Position, Travel, & Resources; Prohibited Personnel Practice Also Committed

The former (resigned) Director of VA's Center for Innovation did not properly detail and supervise a GS-12 VBA Rating Veterans Service Representative (RVSR), which led to the RVSR misusing official time, taking unauthorized travel, misusing about $31,000 in travel funds, misusing a VA position and resources, and installing unapproved software to a VA laptop for sexting. The former Director also engaged in a prohibited personnel practice when he pressured VBA officials to create a non-competitive GS-13/14 position to give preference to and promote the RVSR; however, he intentionally did not tell the VBA officials of an ongoing OIG investigation of the RVSR for misconduct so that they could make fully informed decisions. Further, VBA officials engaged in a prohibited personnel practice when they failed to make proper considerations in their personnel decisions and created a position to promote the RVSR without question and solely due to the former Director's request.

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. The following summaries provide an overview of the types of Data Analysis Division projects initiated this semiannual period.

Review Discovers $170K in Improper Payments Made to Deceased Beneficiary

A proactive review by the Information Technology and Data Analysis Division found that VA continued to pay benefits to a Veteran who had died in 2006. The improper payments went undetected, in part, because the Veteran's name was incorrectly listed in VA records. The review identified improper payments to the deceased Veteran exceeding $170,000. This case was referred to the Office of Investigations.

Review Determines Veteran Lied To Collect $82K in Individual Unemployability Benefits

The Individual Unemployability (IU) program allows VA to pay certain Veterans disability compensation at the 100 percent rate, even though VA has not rated their service-connected disabilities at the total level. In order to qualify, the Veteran must certify that he or she is unable to maintain substantial employment as a result of service-connected disabilities. A proactive review by the Information Technology and Data Analysis Division revealed that a Veteran received IU benefits exceeding $82,000 despite being actively employed. This case was referred to the Office of Investigations.

Veteran Indicted and Facing Extradition for Forging Invoices for $2.2M in Foreign Medical Care

A group led by the Information Technology and Data Analysis Division to proactively review VA's Foreign Medical Program found that a Veteran's claims and reimbursements substantially exceeded expected levels. Subsequent review by the Office of Investigations found that the Veteran submitted $2.2 million in forged

invoices for alleged medical care in a foreign country. The loss to VA is believed to be $1.2 million. The Veteran was indicted and extradition is pending.

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, web submissions, e-mails, and letters from employees, Veterans, the general public, Congress, the U.S. Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. The Hotline also houses the Whistleblower Protection Ombudsman, who provides education about protections for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation.

During this reporting period, the Hotline received 14,303 contacts, 487 of which became OIG cases. An additional 427 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 525 cases, substantiating allegations 40 percent of the time. External Hotline cases resulted in 345 administrative sanctions and corrective actions and $13.9 million in monetary benefits. In addition, the Hotline responded to more than 1,000 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Non-OIG Audit Identifies Significant Improper Payments in the FY 2009 State Veteran Home Program

Auditors hired by the VHA Chief Business Office (CBO) substantiated that VA made $11.7 million in overpayments to state Veterans homes in FY 2009. Specifically, auditors identified 360 improper payments totaling $9,631,661 based on erroneous patient days and $2,110,498 in disbursements not supported by invoices or obligations. However, due to inadequate records, auditors were not able to resolve an allegation that collections for prior year overpayments were not credited to the correct appropriations. Auditors made numerous recommendations to address pervasive problems in the internal controls over this program. VHA transferred oversight of this program to CBO in May 2010, and the scope of the audit did not include program changes since 2009.

Hotline Exposes Systemic Issues at VA Maryland Research Center

A review by the VA Maryland HCS uncovered systemic research center problems, including unapproved collection of patient data, inadequate documentation of screening to protect human subjects, questionable privileging decisions, performance of procedures outside of authorized scopes of practice, and a lack of written procedures for interpreting test results. Reviewers also confirmed a patient experienced pain and complications following a study procedure. In response to the review, the system suspended eight research protocols and initiated numerous corrective actions, including removal of a responsible senior official.

Review Identifies Improper Research on Human Subjects at the VA Minneapolis HCS

The VA Office of Research Oversight (ORO) found that the Minneapolis. MN, HCS improperly permitted a VA contractor to conduct VA research without providing adequate oversight or authorization. The review found that individuals lacking appropriate VA appointments or research scopes of practice were permitted to conduct VA research and informed consent disclosures and *Health Insurance Portability and Accountability Act of 1996* authorizations for this research were deficient. In addition, the review found research subjects' personal information was improperly disclosed to outside parties. ORO also found noncompliance related to human research and identified additional concerns outside of ORO's purview. ORO recommended VHA take numerous actions to address their findings and reviewed their corrective action plans.

Contract Specialist Commits VHA to Improper Verbal Procurements

VHA's Procurement and Logistics Office (PLO) substantiated an allegation that a contract specialist in the Western Service Area Office improperly committed VA to multiple-year procurements without ensuring that required documentation, including pricing and scope of work, was created, approved, and obligated. VHA identified 28 contracts since June 2012 valued at $3.6 million that lacked required documentation. As a result of the review, PLO reassigned the contract specialist's workload and initiated administrative action.

Loma Linda HCS Employee Violates Federal Standards of Ethical Conduct

A review by the Loma Linda, CA, HCS found that a supervisor failed to adhere to employee standards of conduct. The supervisor did not maintain impartiality in performing official duties by supervising an employee with whom the supervisor was living. In addition, the supervisor misused VA resources by performing medical exams on non-Veteran employee family members. The HCS took actions to address the violations.

Hotline Tips Reveal Three Surviving Spouses Improperly Received Compensation

Three Hotline referrals resulted in approximately $408,000 in DIC overpayment recoveries or avoidances. In the first, the Philadelphia, PA, VARO substantiated that for 19 years a surviving spouse from Levittown, PA, improperly collected $160,172 in DIC benefits because she did not inform VA of her remarriage in 1979. In a second case, the Philadelphia VARO substantiated that a claimant residing in Rolesville, NC, improperly received DIC payments by declaring in 2011 that she was the surviving spouse of a recently deceased Veteran, whom she divorced in the 1980s. VA would have paid $137,649 to the claimant over a 5-year period if the fraud had gone undetected. Finally, a review conducted by the St. Paul, MN, VARO found that a surviving spouse in Cameron Park, CA, improperly received $110,111 in DIC benefits by concealing her remarriage since April 2003. In all three cases, VA terminated the improper DIC payments and initiated collection actions.

Review Ends Fifteen-Year-Old Scheme To Collect Undue Benefits

A review conducted by the St. Paul, MN, VARO substantiated that a Veteran from Bursen, CA, improperly received $258,080 in VA benefits by concealing his divorce that occurred in February 1999. As a result of the Hotline referral, the VARO reduced the Veteran's benefits and began collecting the improper payments.

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 47 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. Twenty-six preaward reviews identified approximately $506 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 five health care provider proposals, accounting for approximately $9.1 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2013 – March 31, 2014	26	$506,120,095

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 $5.5 million, including approximately $2.5 million related to *Veterans Health Care Act* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 19 postaward reviews performed, 12 involved voluntary disclosures. In nine 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, 2013 – March 31, 2014	19	$5,525,077

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 one claim and determined that approximately $3.2 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2013 – March 31, 2014	1	$3,163,380

Special Review

Poor Internal Controls Gave Advantage to Vendor Whose Lease Proposal for Butler HCC Had Numerous False Statements

In June 2013, OIG issued a Management Advisory Memorandum advising VA of the findings of its review of the lease awarded to Westar Development Company, LLC (Westar) for the Butler, PA, HCC. OIG found that Westar principals made false and misleading statements regarding its Veteran ownership status, past performance and experience, and teaming arrangements. A follow-on review found that VA's change to a one-step lease acquisition process created an advantage for Westar and that VA officials did little to verify material facts disclosed by Westar such as Veteran ownership, past experience, and teaming arrangements. OIG's review also determined that VA did not have support for its decision to dismiss a protest of the lease awarded to Westar and that VA's financial analysis of the lease cost was not accurate. VA Management did not agree with OIG's findings relating to the identified deficiencies, but largely agreed with the recommendations.

Other Significant OIG Activities

Congressional Testimony

Deputy Inspector General Tells Congress VA Needs To Fully Implement Handbook on Conferences to Prevent Excessive Spending (Testimony provided 10/30/2013)

Mr. Richard J. Griffin, Deputy Inspector General, testified before the Committee on Oversight and Government Reform, United States House of Representatives, on a 2012 OIG report dealing with VA's planning for two Human Resources Conferences held in 2011 in Orlando, Florida. His testimony outlined the findings of the report as well as the status of the 49 recommendations contained in the report. At the time of the hearing, 15 of 18 recommendations dealing with personnel actions had been closed while only 8 of 31 recommendations dealing with conference management were closed over a year after the report was issued. Many of the conference management recommendations could be addressed by a handbook on conference planning, execution, and reporting. However, at the time of the hearing, VA had not finalized a handbook on this matter. Mr. Griffin was accompanied by Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations.

OIG Staff Testifies Before Congress That VA is Ineffective in Managing Capital Planning and Asset Management (Testimony provided 11/20/2013)

Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on several OIG reports dealing with VA's planning for, and management of, minor construction projects and health care centers. She focused on findings from OIG reports that show the consequences of VA's poor planning and management of its capital improvements. Ms. Halliday was accompanied by Ms. Maureen Regan, Counselor to the Inspector General.

OIG Tells Congress VA Continues To Face Challenges in Improving Accuracy and Timeliness of Disability Claims (Testimony provided 12/4/2013)

Ms. Sondra McCauley, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on the results of OIG inspections of VAROs. OIG conducts cyclical reviews which include how well the VAROs process high-risk claims. OIG continues to find error rates of about 30 percent in the VARO processing of claims for TBI and temporary 100 percent disability ratings. Ms. McCauley also discussed OIG's ongoing work reviewing the Veterans Benefits Administration's initiative dealing with claims over 2 years old and the accuracy of claims processed in the Veterans Benefits Management System. Ms. McCauley was accompanied by Mr. Brent Arronte, Director, San Diego Benefits Inspections Division.

False Claims Act Settlements

This reporting period, VA received over $47.6 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, three of which included anti-kickback violations. Another involved the misrepresentations made during negotiations for an FSS contract.

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 March 31, 2014, 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 535 and closed 448 criminal investigations, including 132 convictions, 196 referrals for monetary reclamation, and $97,750 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 no reports meeting this requirement.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 217 proposals and made 32 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 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.
- Charles Cook, a Health Systems Specialist in the Bay Pines, FL, Office of Healthcare Inspections, was activated by the U.S. Army in March 2014.

Appendix A: Reports Issued During Reporting Period

Table 1: List of Reports Issued by Type		
Office of Audits and Evaluations | Audits, Evaluations, and Reviews		
Issue Date	**Number**	**Report Title**
10/22/2013	12-04046-307	Review of VA's Management of Health Care Center Leases
11/27/2013	13-01316-22	Audit of VA's Consolidated Financial Statements for FY's 2013 and 2012
12/23/2013	12-04536-308	Audit of VA's Pharmacy Reengineering Software Development Project
2/10/2014	14-00258-66	Independent Review of VA's FY 2013 Detailed Accounting Submission to the Office of National Drug Control Policy
2/11/2014	14-00257-67	Independent Review of VA's FY 2013 Performance Summary Report to the Office of National Drug Control Policy
2/20/2014	12-02910-80	Audit of VA's Hearing Aid Services
3/31/2014	13-01959-109	Audit of VHA's Supportive Services for Veteran Families Program

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	**Facility**
10/28/2013	13-02638-01	Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio
10/30/2013	13-02640-06	VA Greater Los Angeles Healthcare System, Los Angeles, California
11/22/2013	13-02643-20	James H. Quillen VA Medical Center, Mountain Home, Tennessee
12/3/2013	13-02642-21	Northern Arizona VA Health Care System, Prescott, Arizona
1/7/2014	13-02314-39	Carl Vinson VA Medical Center, Dublin, Georgia
1/15/2014	13-03651-42	El Paso VA Health Care System, El Paso, Texas
1/24/2014	13-03649-52	Michael E. DeBakey VA Medical Center, Houston, Texas
1/27/2014	13-02641-50	Coatesville VA Medical Center, Coatesville, Pennsylvania
1/29/2014	13-03650-53	Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
2/3/2014	13-03621-57	VA Central Iowa Health Care System, Des Moines, Iowa
2/3/2014	13-03652-59	Lexington VA Medical Center, Lexington, Kentucky
2/6/2014	13-04240-60	White River Junction VA Medical Center, White River Junction, Vermont
2/11/2014	13-04242-61	Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana
2/14/2014	13-03626-73	James E. Van Zandt VA Medical Center, Altoona, Pennsylvania
2/19/2014	13-03648-75	Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio
2/25/2014	13-04241-78	Boise VA Medical Center, Boise, Idaho
2/25/2014	13-03655-84	VA Salt Lake City Health Care System, Salt Lake City, Utah
3/5/2014	13-03623-89	Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan
3/12/2014	13-03653-91	Atlanta VA Medical Center, Decatur, Georgia
3/19/2014	14-00306-95	VA Eastern Colorado Health Care System, Denver, Colorado
3/26/2014	13-03620-102	Syracuse VA Medical Center, Syracuse, New York

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
3/31/2014	14-00308-105	Overton Brooks VA Medical Center, Shreveport, Louisiana

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	**Number**	**Parent Facility**
10/25/2013	13-00026-352	VA Western New York Healthcare System, Buffalo, New York
11/6/2013	13-00026-07	VA Greater Los Angeles Healthcare System, Los Angeles, California
11/7/2013	13-00026-08	Richard L. Roudebush VA Medical Center, Indianapolis, Indiana
11/13/2013	13-00026-10	Kansas City VA Medical Center, Kansas City, Missouri
12/5/2013	13-00026-24	James H. Quillen VA Medical Center, Mountain Home, Tennessee
1/8/2014	13-03415-31	Michael E. DeBakey VA Medical Center, Houston, Texas
1/13/2014	13-03413-40	Syracuse VA Medical Center, Syracuse, New York
1/16/2014	13-03418-44	Lexington VA Medical Center, Lexington, Kentucky
1/17/2014	13-03417-34	Portland VA Medical Center, Portland, Oregon
1/21/2014	13-03414-46	VA Central Iowa Health Care System, Des Moines, Iowa
1/22/2014	13-03421-49	White River Junction VA Medical Center, White River Junction, Vermont
2/4/2014	13-03423-55	Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana
2/5/2014	13-03416-56	VA Montana Health Care System, Fort Harrison, Montana
2/13/2014	13-04331-63	Boise VA Medical Center, Boise, Idaho
2/27/2014	13-03424-74	Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
2/27/2014	14-00224-83	Orlando VA Medical Center, Orlando, Florida
2/28/2014	13-03420-85	VA Salt Lake City Health Care System, Salt Lake City, Utah
3/13/2014	13-03549-92	Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan
3/13/2014	14-00233-96	VA Caribbean Health Care System, San Juan, Puerto Rico
3/14/2014	14-00228-94	Overton Brooks VA Medical Center, Shreveport, Louisiana
3/17/2014	13-03419-90	Atlanta VA Medical Center, Decatur, Georgia
3/18/2014	14-00223-93	VA Eastern Colorado Health Care System, Denver, Colorado
3/24/2014	13-03422-99	Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio
3/31/2014	14-00232-110	VA Loma Linda Healthcare System, Loma Linda, California

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
10/23/2013	13-00505-348	Emergency Department Patient Deaths' Memphis VA Medical Center, Memphis, Tennessee
11/5/2013	13-03670-13	Audiology Staffing, Consult Management, and Access to Care, Sheridan VA Healthcare System, Sheridan, Wyoming

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
11/7/2013	13-00133-12	Alleged Improper Opioid Prescription Renewal Practices, San Francisco VA Medical Center, San Francisco, California
11/20/2013	12-04061-18	Alleged Computed Tomography Scan Delays and Timekeeping Abuses, Dayton VA Medical Center, Dayton, Ohio
12/9/2013	13-00488-26	Alleged Chemotherapy Delay and Excessive Emergency Department Length of Stay, Jesse Brown VA Medical Center, Chicago, Illinois
12/23/2013	13-03862-35	Emergency Department Length of Stay and Call Center Wait Times, VA Eastern Colorado Health Care System, Denver, Colorado
12/30/2013	13-01956-37	Quality of Care Issues, San Juan VA Medical Center, San Juan, Puerto Rico
2/6/2014	13-00872-71	Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
2/12/2014	13-03624-58	Alleged Patient Safety Concerns in the Operating Room, VA Maine Healthcare System, Augusta, Maine
2/12/2014	13-03178-70	Alleged Lapses in Communication and Poor Quality of Care, Charlie Norwood VA Medical Center, Augusta, Georgia
2/18/2014	13-03747-76	Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, Connecticut
3/20/2014	13-00853-100	Alleged Adverse Outcomes and Access Issues in Diagnostic Imaging Services, North Florida/South Georgia Veterans Health System, Gainesville, Florida
3/27/2014	13-03089-104	Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida
3/31/2014	13-02073-106	Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns, VA Central Iowa Health Care System, Des Moines, Iowa

Office of Investigations | Administrative Investigation		
Issue Date	**Number**	**Report Title**
2/24/2014	13-01488-86	Administrative Investigation, Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice, VA Center for Innovation, VA Central Office

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/16/2013	13-04347-04	Review of Proposal Submitted Under a Solicitation	$1,464,253
10/18/2013	13-04346-05	Review of Proposal Submitted Under a Solicitation	$2,220,381
10/28/2013	13-02270-09	Review of Contract Extension Proposal Submitted Under an FSS Contract	$5,848,820
10/28/2013	13-04392-11	Review of FSS Proposal Submitted Under a Solicitation	

Office of Contract Review | Preaward Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
10/30/2013	13-04189-14	Review of Product Additions Submitted Under an FSS Contract	
11/13/2013	13-03480-17	Review of Contract Extension Proposal Submitted Under an FSS Contract	
12/5/2013	13-03676-27	Review of FSS Proposal Submitted Under a Solicitation	$159,278,904
12/5/2013	13-04550-28	Review of Contract Extension Proposal Submitted Under an FSS Contract	
12/11/2013	14-00176-29	Review of FSS Proposal Submitted Under a Solicitation	
12/18/2013	13-04166-36	Review of FSS Proposal Submitted Under a Solicitation	$12,924,210
12/19/2013	13-04642-38	Review of FSS Proposal Submitted Under a Solicitation	$7,004,740
12/30/2013	13-04321-41	Review of FSS Proposal Submitted Under a Solicitation	$35,449,657
1/8/2014	13-04402-45	Review of Proposal Submitted Under a Solicitation	$2,896,319
1/14/2014	13-03795-47	Review of FSS Proposal Submitted Under a Solicitation	$8,485,668
1/30/2014	12-01380-65	Review of Proposal Submitted Under a Contract	$991,452
2/4/2014	14-01041-69	Review of Contract Extension Proposal Submitted Under an FSS Contract	
2/12/2014	14-01158-77	Review of Proposal Submitted Under a Solicitation	$1,433,918
2/12/2014	14-00728-81	Review of FSS Proposal Submitted Under a Solicitation	
2/12/2014	14-01075-82	Review of Request for Modification - Product Additions Submitted Under an FSS Contract	$33,456
2/14/2014	13-04430-64	Review of Proposal Submitted Under a Solicitation	$1,080,950
3/10/2014	14-01173-97	Review of Request for Product Additions to an FSS Contract	
3/11/2014	14-00804-98	Review of Request for Modification - Product Additions to an FSS Contract	$222,834,697
3/18/2014	13-04273-101	Review of FSS Proposal Under a Solicitation	$38,265,840
3/19/2014	14-01423-103	Review of Request for Product Additions to an FSS Contract	
3/26/2014	14-00165-107	Review of Request for Modification - Product Additions Submitted Under an FSS Contract	$2,094,875
3/26/2014	13-03211-108	Review of Contract Extension Proposal Submitted Under an FSS Contract	$3,811,955
			$506,120,095

Office of Contract Review | Postaward Reviews

Issue Date	Number	Report Title	Dollar Recoveries
10/17/2013	10-00517-03	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$5,958

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
10/30/2013	10-01771-15	Public Law Review of Contract Numbers	$833,483
11/21/2013	13-01209-19	Review of Voluntary Disclosure of Public Law Damages for Covered Drugs Under an FSS Contract	$22,010
11/26/2013	13-03772-23	Review of Voluntary Disclosure Submitted Under an FSS Contract	$141,399
11/26/2013	14-00115-25	Review of Voluntary Disclosure of Public Law Damages for Covered Drugs Under an FSS Contract	$2,245
12/11/2013	14-00001-30	Review of Compliance with Public Law for Covered Drugs	
12/17/2013	14-00137-32	Review of Compliance with Public Law Under an FSS Contract	$14,196
12/18/2013	10-02727-33	Review of Voluntary Disclosure Under an FSS Contract	$76,063
12/31/2013	09-00344-02	Settlement Agreement	$1,150,000
1/7/2014	13-02793-43	Review of Public Law Damages Under an FSS Contract	$52,670
1/22/2014	12-01926-51	Review of Voluntary Disclosure of Public Law Pricing Errors Under Four FSS Contracts	$258,745
1/22/2014	13-03712-54	Review of Voluntary Disclosure Submitted Under FSS Contracts	$54,124
1/23/2014	13-02952-48	Review of Public Law Compliance for Covered Drugs Under an FSS Contract	$10,844
1/31/2014	13-03877-68	Review of Voluntary Disclosure and Refund Offer Under Contracts	$316,319
2/6/2014	11-03837-62	Review of Compliance with Public Law Under an FSS Interim Agreement	$578,106
2/18/2014	14-00003-79	Review of Voluntary Disclosure Regarding Public Law Compliance Under Four FSS Contracts	$3,851
3/13/2014	14-00010-87	Review of Voluntary Disclosure of Drug Pricing Violations Under an FSS Contract	$34,433
3/13/2014	12-02426-88	Review of Compliance with Public Law Under an FSS Contract	$1,749,830
3/27/2014	13-03041-115	Review of Voluntary Disclosure of Pricing Errors Under Contracts	$220,801
			$5,525,077

Office of Contract Review | Claim Review			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/31/2013	13-04234-16	Review of Termination Settlement Proposal Submitted under a Contract	$3,163,380
			$3,163,380

Office of Contract Review | Special Review		
Issue Date	**Number**	**Report Title**
3/31/2014	13-02697-113	Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center

Total Potential Monetary Benefits of Reports Issued		
Report Type	**Savings and Cost Avoidance**	**Dollar Recoveries**
Preaward Reviews	$506,120,095	
Postaward Reviews		$5,525,077
Claim Review	$3,163,380	
	$509,283,475	**$5,525,077**

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	0	$0
Total inventory this period	**0**	**$0**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	0	$0
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**0**	**$0**
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	0	$0
Total inventory this period	**0**	**$0**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	0	$0
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**0**	**$0**
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 March 31 2014, there are 163 total open reports and 769 total open recommendations. However, 8 reports and 7 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 43 reports and 84 recommendations that, as of March 31, 2014, remain open for more than 1 year. The total monetary benefit attached to these reports is $1,609,517,553.

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	25	108	133	37	593	630
Veterans Benefits Administration	4	3	7	9	12	21
National Cemetery Administration	0	1	1	0	5	5
Office of Acquisitions, Logistics, and Construction	3	6	9	10	16	26
Office of Management (OM)	2	0	2	6	0	6
Office of Information and Technology	7	2	9	16	37	53
Office of Human Resources and Administration (OHRA)	3	3	6	5	6	11
Office of Operations, Security, and Preparedness (OSP)	3	0	3	3	0	3
Office of General Counsel (OGC)	2	1	3	3	2	5
Chief of Staff	0	2	2	0	18	18
Total	**49**	**126**	**175**	**89**	**689**	**778**

<table>
<tr><th colspan="5">Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old</th></tr>
<tr><th>Issue Date</th><th>Number</th><th>Title</th><th>Responsible Organization(s)</th><th>Monetary Impact of Open Recommendations</th></tr>
<tr><td>07/11/06</td><td>06-02238-163</td><td>Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans</td><td>OSP</td><td>None</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td>08/18/09</td><td>09-01123-195</td><td>Administrative Investigation, Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC</td><td>OIT</td><td>None</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td>08/18/09</td><td>09-01123-196</td><td>Administrative Investigation, Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC</td><td>OIT</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 6: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR [Human Resources] to determine the appropriate corrective action concerning _______’s appointment, to include her appointment at a rate above the minimum, and take such action.

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

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

Recommendation 26: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper FCIP [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.</td></tr>
</table>

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. *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.* *Recommendation 30: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to identify any additional improper VA appointments made using DHA, and take appropriate corrective action.* *Recommendation 33: We recommend that the Assistant Secretary for Information and Technology ensure that a review of OI&T retention incentives is conducted to ensure that they are necessary and support the mission and program needs and that they fully comply with law, OPM [Office of Personnel Management] regulations, and VA policy.* ** OIG disagrees with 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 [most favored customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government). Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2. Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised. Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.				
09/30/10	**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. *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.*				
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).				
11/02/11	**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. *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.* *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.*				
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.				

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 recommend the Under Secretary for Benefits develop controls to electronically capture information contained on completed disability benefits questionnaires. *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.*				
02/29/12	**11-03668-107**	**Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi**	**VHA**	**None**
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.				
03/08/12	**11-02254-102**	**Audit of the Management and Acquisition of Prosthetic Limbs**	**VHA**	**None**
Recommendation 6: We recommend the Under Secretary for Health identify and assess the adequacy of VA's in-house fabrication capabilities for prosthetic limbs. *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.*				
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.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/30/12	**11-00312-127**	**Audit of VHA's Prosthetics Supply Inventory Management**	**VHA**	**$35,500,000**
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. *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.*				
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. *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.* *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.*				
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 [computerized patient record 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
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. *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.* *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.* *Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.*				
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. *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.* *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.*				
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.				

<table>
<tr><th colspan="5">Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old</th></tr>
<tr><th>Issue Date</th><th>Number</th><th>Title</th><th>Responsible Organization(s)</th><th>Monetary Impact of Open Recommendations</th></tr>
<tr><td>08/16/12</td><td>11-01406-247</td><td>Healthcare Inspection – Evaluation of Community Based Outpatient Clinics, Fiscal Year 2011</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td>08/27/12</td><td>12-00575-255</td><td>Community Based Outpatient Clinic Reviews: Payson and Show Low, AZ; Long Beach (Cabrillo) and Laguna Hills, CA</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">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.

Recommendation 14: We recommended that the VAMC Director ensures that access to MH services at the Payson CBOC complies with VHA directives.</td></tr>
<tr><td>09/07/12</td><td>12-00577-273</td><td>Community Based Outpatient Clinic Reviews: Wilmington, NC; Columbus, GA; Goose Creek, SC; and Savannah, GA</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 1: We recommended that Columbus CBOC clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.</td></tr>
<tr><td>09/26/12</td><td>12-00828-287</td><td>Healthcare Inspection – Consultant Responses, Nurse Staffing, Deep Dives, and Communication, VA Illiana Health Care System, Danville, Illinois</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">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.</td></tr>
</table>

<table>
<tr><th colspan="5">Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old</th></tr>
<tr><th>Issue Date</th><th>Number</th><th>Title</th><th>Responsible Organization(s)</th><th>Monetary Impact of Open Recommendations</th></tr>
<tr><td>09/28/12</td><td>12-00375-290</td><td>Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC</td><td>OM/OGC</td><td>None</td></tr>
<tr><td colspan="5">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.

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.

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.</td></tr>
<tr><td>09/28/12</td><td>12-01012-298</td><td>Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation</td><td>VHA/OALC</td><td>None</td></tr>
<tr><td colspan="5">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.

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.

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.</td></tr>
</table>

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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**	**$762,198**
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 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 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.* *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.* *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.*				
10/11/12	**12-01903-04**	**Review of VA's Alleged Incomplete Installation of Encryption Software Licenses**	**OIT**	**$5,100,000**
Recommendation 2: We recommended the Assistant Secretary for Information Technology, if it is determined to continue the project, develop a plan that includes sufficient human resources and monitoring to install and activate all of the purchased encryption software licenses.				

<table>
<tr><th colspan="5">Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old</th></tr>
<tr><th>Issue Date</th><th>Number</th><th>Title</th><th>Responsible Organization(s)</th><th>Monetary Impact of Open Recommendations</th></tr>
<tr><td>10/23/12</td><td>11-01823-294</td><td>Audit of VA's Systems Interconnections with Research and University Affiliates</td><td>VHA/OIT</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 2: We recommend the Assistant Secretary for Information and Technology support the Under Secretary for Health by providing the information technology infrastructure needed to implement a centralized data governance and storage model to securely manage research information over the data life cycle.

Recommendation 3: We recommend the Assistant Secretary for Information and Technology direct Information Security Officers to partner with the Veterans Health Administration's Institutional Review Boards, research personnel, and research partners to routinely conduct joint oversight and monitoring of research labs to ensure security of sensitive veterans' data, compliance of data collections with research protocols, and fulfillment of the Department's information security requirements.

Recommendation 4: We recommend the Under Secretary for Health develop and implement a centralized data governance and storage model that ensures accurate inventory of all research data collected, data collection compliance with research protocols, and secure management of research information over the data life cycle.</td></tr>
<tr><td>12/10/12</td><td>12-03071-53</td><td>Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 16: We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation within the required timeframe.

Recommendation 22: We recommended that processes be strengthened to ensure that staff complete all actions required in response to critical test results.</td></tr>
<tr><td>12/11/12</td><td>11-00317-37</td><td>Audit of Vocational Rehabilitation and Employment Program's Self-Employment Services at Eastern and Central Area Offices</td><td>VBA</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 3: We recommended the Under Secretary for Benefits develop and implement performance measures that evaluate the success of self-employment services.</td></tr>
<tr><td>12/17/12</td><td>12-03346-69</td><td>Review of the Minor Construction Program</td><td>VHA</td><td>None</td></tr>
<tr><td colspan="5">Recommendation 3: We recommended the Under Secretary for Health review the seven minor construction projects that were integrated into three combined projects which exceeded the $10 million construction appropriation limit to determine if major construction projects were created, and take appropriate administrative action.</td></tr>
</table>

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
01/07/13	**12-03744-84**	**Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that conversions from observation bed status to acute admissions are consistently 30 percent or less. *Recommendation 5: We recommended that processes be strengthened to ensure that damaged furniture in patient care areas is repaired or removed from service and that the facility be well maintained.* *Recommendation 12:We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.*				
02/06/13	**11-00336-292**	**Audit of VHA's Beneficiary Travel Program**	**VHA**	**None**
Recommendation 2: We recommend the Under Secretary for Health implement training necessary to ensure the Veterans Health Administration staff properly code Beneficiary Travel Program expenses entered into the Financial Management System.				
03/06/13	**12-02802-111**	**Review of Alleged Transmission of Sensitive VA Data Over Internet Connections**	**OIT**	**None**
Recommendation 1: We recommend the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements.				
03/06/13	**12-04604-127**	**Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts**	**VHA**	**None**
Recommendation 5: We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened and discarded when expired. *Recommendation 6: We recommended that managers initiate actions to address the identified physical security deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/07/13	**11-02585-129**	**Healthcare Inspection - Management of Disruptive Patient Behavior at VA Medical Facilities**	**VHA**	**None**
Recommendation 2: We recommended that the Under Secretary for Health ensure that VHA program officials develop guidelines for what information VHA facilities should document regarding disruptive incidents and where this information should be documented.				
03/21/13	**12-04188-140**	**Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan**	**VHA**	**None**
Recommendation 16: We recommended that facility implement the mandated staffing methodology for nursing personnel.				
03/28/13	**12-02503-151**	**Administrative Investigation, Misuse of Official Time and Resources and Failure to Properly Supervise, Office of Human Resources and Administration, Washington, DC**	**OHRA**	**None**
Recommendation 2: We recommend that the Acting Assistant Secretary for Human Resources and Administration determine the total salary paid to [redacted] for the 39 days that [redacted] was AWOL [absent without leave] from VA or worked for [redacted] while on sick leave and ensure that a bill of collection is issued to [redacted] for that amount, since [redacted] cannot receive pay for the period of time that [redacted] was absent without authorization.				
03/29/13	**11-00331-160**	**Audit of the Community Nursing Home Program**	**VHA**	**$296,500,000**
Recommendation 3: We recommend the Under Secretary for Health implement a formal oversight and communication process to ensure healthcare facilities comply with Veterans Health Administration nursing home policy and perform proper eligibility reviews.				
Total				**$1,609,517,553**

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On the Cover

On Saturday, December 7, 2013, a commemorative wreath laying ceremony was held on the U.S. Navy Memorial's outdoor plaza in Washington, DC, to honor Pearl Harbor Remembrance Day. 2013 marked the 72nd anniversary of the attack on Pearl Harbor. Cover photo courtesy of the Department of Veterans Affairs photographer Robert Turtil.

Department of Veterans Affairs
Office of Inspector General

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