Department of Veterans Affairs

Office of Inspector General





Semiannual Report to Congress

Issue 69 | October 1, 2012 – March 31, 2013

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Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our accomplishments during the reporting period October 1, 2012 – March 31, 2013. I would like to take this opportunity to highlight just a few of the chief findings and conclusions that came to fruition during this reporting period.

The Office of Inspector General (OIG) issued 164 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $1.65 billion in monetary benefits, for a return on investment of $33 for every dollar expended on OIG oversight. OIG investigators closed 490 investigations and made 252 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work also resulted in 205 administrative sanctions and corrective actions.

Our Office of Investigations recently prioritized the deterrence of fraud associated with VA's beneficiary travel reimbursement program, which was funded at approximately $861 million in fiscal year (FY) 2012. Typically, this type of fraud involves Veterans grossly inflating the number of miles driven to and from VA facilities in order to obtain higher travel reimbursements by providing a false home address on the claim form. During the last 18 months, we have conducted 225 of these investigations resulting in the arrest of 125 individuals and cumulative terms of imprisonment exceeding 35 years for the 30 individuals already sentenced. In each of these prosecutions, we have encouraged prosecutors to issue press releases to deter this type of fraud. In addition to developing our own data analytic tool to proactively identify possible beneficiary travel fraud, we have worked closely with Veterans Health Administration (VHA) program officials to significantly enhance their own data mining efforts and design new warning posters to be placed where beneficiaries file their claims for travel reimbursements.

The Office of Investigations' efforts also to combat fraud in VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) Program continue to yield judicial and administrative results. During this reporting period, five individuals were arrested after being charged with Federal crimes related to SDVOSB fraud. Convictions resulted in more than $6.8 million in court-ordered payment of fines, forfeitures, restitution, and penalties. One defendant was sentenced to 87 months' imprisonment. Additionally, five individuals and three companies were suspended from receiving Federal contracts. We also have 12 additional actions pending before VA's Suspension and Debarment Committee.

At the request of the Senate Veterans' Affairs Committee, OIG's Office of Healthcare Inspections conducted an inspection to review VHA services available to women Veterans who have experienced military sexual trauma (MST). OIG found that these patients often had more than one mental health (MH) diagnosis and that 90 percent had received VHA MH care within 3 months of admission to a VHA residential or inpatient program.

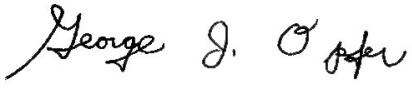
OIG also found that these women were often referred outside their parent facility or Veterans Integrated Service Network (VISN) to one of these programs. However, obtaining authorization for travel funding was frequently cited as a problem for patients and staff because VHA's Beneficiary Travel policy is not aligned with MST policy. If these two policies were better aligned, barriers to access could potentially be reduced. OIG recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for Veterans seeking MST-related MH treatment at specialized residential and inpatient programs outside of the facilities where they are enrolled.

At the request of the Chairman of the House Committee on Veterans' Affairs, OIG's Office of Audits and Evaluations assessed whether the National Cemetery Administration (NCA) adequately identified and addressed issues found during its nationwide internal review of misplaced headstones and unmarked gravesites. We identified several misplaced headstones or unmarked gravesites as well as outdated and illegible gravesite layout maps. The magnitude of this internal review overwhelmed NCA staff and the procedures used led to unidentified errors; however, NCA took timely corrective action to revise their procedures and is committed to correcting all errors.

In addition, the Office of Audits and Evaluations' annual review of VA's compliance with the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) found VA did not to comply with four of the seven IPERA requirements. For FY 2012, VA reported about $2.2 billion in improper payments. We recommended that VA managers implement a statistically valid methodology to estimate improper payments for the Compensation, Pension, and Vocational Rehabilitation and Employment programs, reduce improper payments, and develop achievable reduction targets for the Non-VA Care Fee program. The Office of Management is leading an aggressive VA-wide initiative to ensure compliance with all IPERA requirements.

The Office of Audits and Evaluations also evaluated VHA's community nursing home program to determine if nursing homes met eligibility requirements. We found VA officials did not effectively monitor the nursing home program and did not provide guidance needed to ensure the proper eligibility reviews. We projected VHA annually places about 6,700 patients in ineligible nursing homes at a cost of $59.3 million. We further estimated that over the next 5 years, VHA will place about 33,500 patients at a cost of about $296.5 million in ineligible nursing homes if VHA does not strengthen program oversight and improve its eligibility reviews.

I want to express my sincere appreciation to our OIG employees for their steadfast commitment to accomplishing OIG's mission and identifying opportunities for improvement within VA. I also thank the Secretary, Deputy Secretary, and other senior Department officials and their staffs for their continued support of our work. We look forward to continuing our partnership with the Department and Congress in the months ahead to meet the many challenges facing VA as we work to ensure our Nation's heroes receive the care, support, and recognition they have earned in service to our country. Most of all, we thank our Veterans who have sacrificed generously and selflessly to protect our freedom.



GEORGE J. OPFER
Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total
Better Use of Funds	$296.5
Fines, Penalties, Restitutions, and Civil Judgments	$719.6
Fugitive Felon Program	$93.5
Savings and Cost Avoidance	$525.5
Questioned Costs	$5.1
Dollar Recoveries	$16.3
Total Dollar Impact	$1,656.5
Cost of OIG Operations[1]	$49.5
Return on Investment[2]	**33:1**

1 The 6-month and fiscal year operating costs for the Office of Healthcare Inspections ($10.3 and $20.6 million, respectively), whose oversight mission results in improving the health care provided to Veterans rather than saving dollars, is not included in the return on investment calculation.
2 Calculated by dividing Total Dollar Impact by Cost of OIG Operations.

Reports Issued	6-Month Total
Audits and Evaluations	18
Benefits Inspections	4
National Healthcare Reviews	4
Hotline Healthcare Inspections	23
Combined Assessment Program Reviews	31
Community Based Outpatient Clinic Reviews[3]	14
Administrative Investigations	2
Preaward Contract Reviews	49
Postaward Contract Reviews	17
Claim Reviews	2
Total Reports Issued	**164**

3 Encompassing 65 facilities for the 6-month period.

Investigative Activities	6-Month Total
Arrests[4]	219
Fugitive Felon Arrests	33
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	29
Indictments	152
Criminal Complaints	75
Convictions	204
Pretrial Diversions and Deferred Prosecutions	21
Administrative Investigations Opened	12
Administrative Investigations Closed	11
Advisory Memos Issued	5
Administrative Memos Issued	9
Administrative Sanctions and Corrective Actions	205
Cases Opened[5]	479
Cases Closed[6]	490

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

Healthcare Inspections Activities	6-Month Total
Clinical Consultations	0
Administrative Case Closures	11

Hotline Activities	6-Month Total
Contacts	13,274
Cases Opened	611
Cases Closed	576
Administrative Sanctions and Corrective Actions	358
Substantiation Percentage Rate	43

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Reporting Requirements

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

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

(continued on next page)

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

VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

The Department's mission is to serve America's Veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2013, VA is operating under a $138.5 billion budget, with over 317,000 employees serving an estimated 22.3 million living Veterans. To serve the Nation's Veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

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

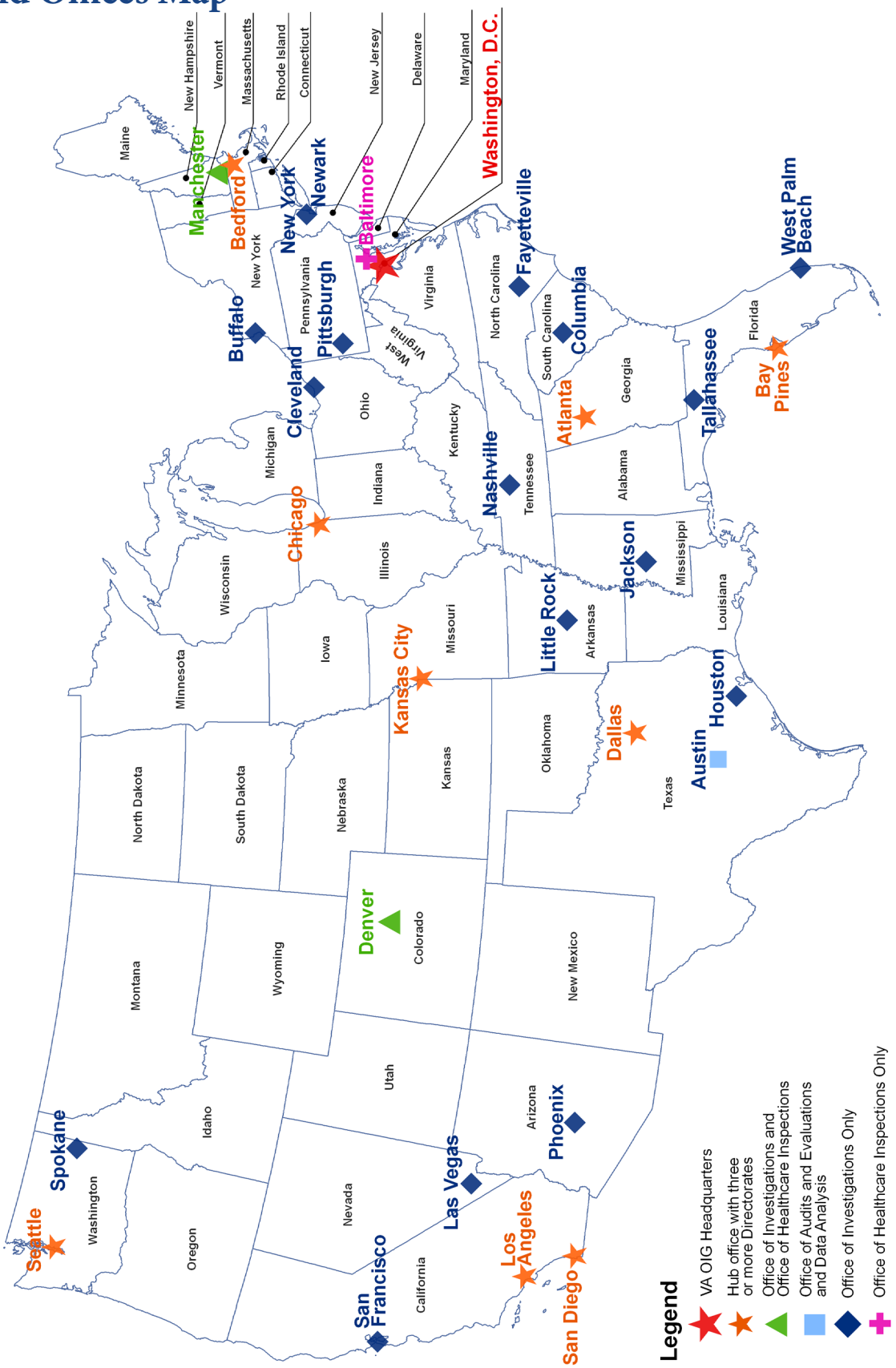
VA Office of Inspector General

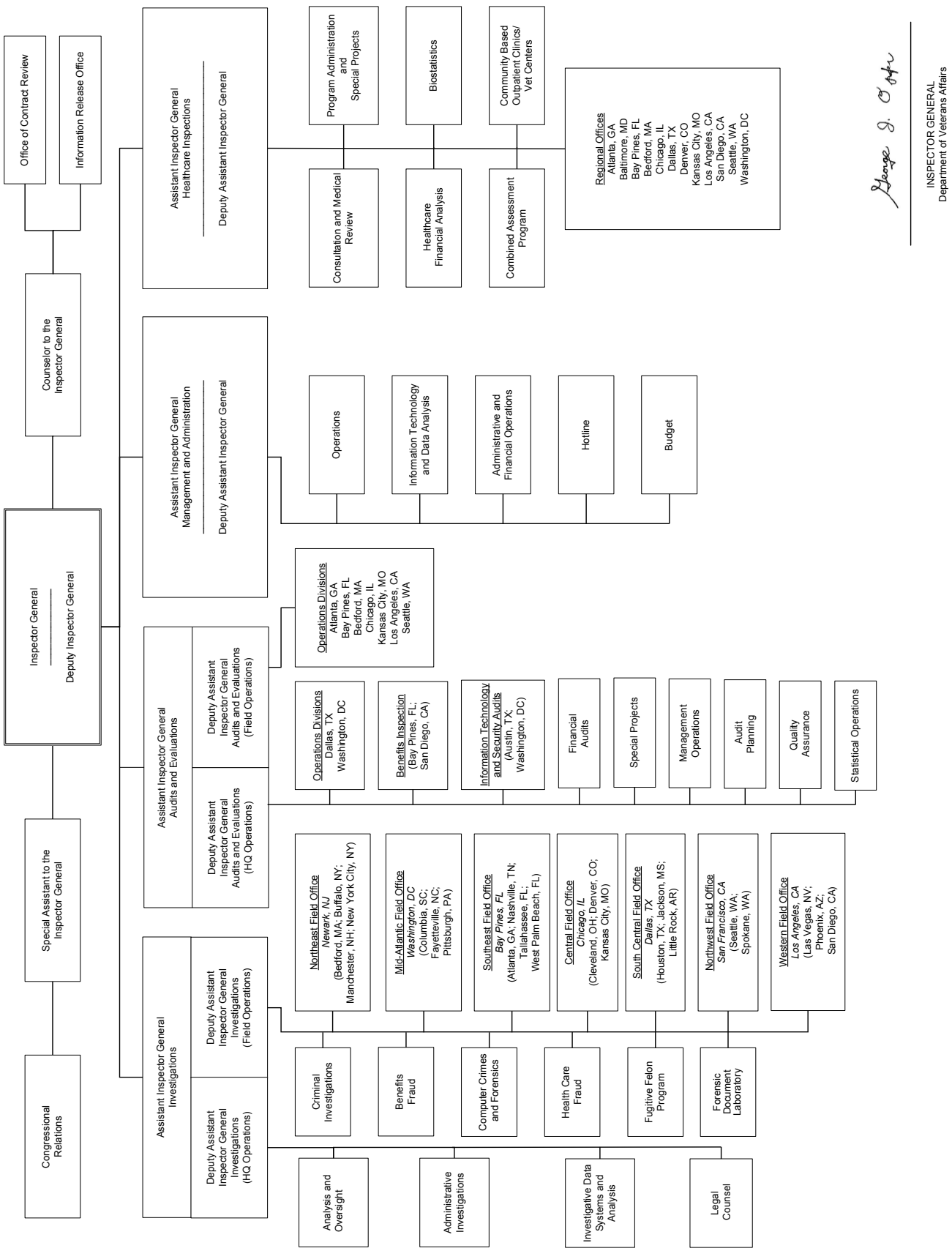
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 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 2013 funding for OIG operations provides $114.8 million from ongoing appropriations. The Office of Contract Review, with 29 employees, receives $4.8 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




Office of Contract Review
Information Release Office
Counselor to the Inspector General
Inspector General
Deputy Inspector General
Special Assistant to the Inspector General
Congressional Relations
Assistant Inspector General Healthcare Inspections
Deputy Assistant Inspector General
Program Administration and Special Projects
Biostatistics
Community Based Outpatient Clinics/ Vet Centers
Consultation and Medical Review
Healthcare Financial Analysis
Combined Assessment Program
Regional Offices
Atlanta, GA
Baltimore, MD
Bay Pines, FL
Bedford, MA
Chicago, IL
Dallas, TX
Denver, CO
Kansas City, MO
Los Angeles, CA
San Diego, CA
Seattle, WA
Washington, DC
Assistant Inspector General Management and Administration
Deputy Assistant Inspector General
Operations
Information Technology and Data Analysis
Administrative and Financial Operations
Hotline
Budget
Assistant Inspector General Audits and Evaluations
Deputy Assistant Inspector General Audits and Evaluations (Field Operations)
Deputy Assistant Inspector General Audits and Evaluations (HQ Operations)
Operations Divisions
Atlanta, GA
Bay Pines, FL
Bedford, MA
Chicago, IL
Kansas City, MO
Los Angeles, CA
Seattle, WA
Operations Divisions
Dallas, TX
Washington, DC
Benefits Inspection
(Bay Pines, FL; San Diego, CA)
Information Technology and Security Audits
(Austin, TX; Washington, DC)
Financial Audits
Special Projects
Management Operations
Audit Planning
Quality Assurance
Statistical Operations
Assistant Inspector General Investigations
Deputy Assistant Inspector General Investigations (Field Operations)
Deputy Assistant Inspector General Investigations (HQ Operations)
Northeast Field Office
Newark, NJ
(Bedford, MA; Buffalo, NY; Manchester, NH; New York City, NY)
Mid-Atlantic Field Office
Washington, DC
(Columbia, SC; Fayetteville, NC; Pittsburgh, PA)
Southeast Field Office
Bay Pines, FL
(Atlanta, GA; Nashville, TN; Tallahassee, FL; West Palm Beach, FL)
Central Field Office
Chicago, IL
(Cleveland, OH; Denver, CO; Kansas City, MO)
South Central Field Office
Dallas, TX
(Houston, TX; Jackson, MS; Little Rock, AR)
Northwest Field Office
San Francisco, CA
(Seattle, WA; Spokane, WA)
Western Field Office
Los Angeles, CA
(Las Vegas, NV; Phoenix, AZ; San Diego, CA)
Criminal Investigations
Benefits Fraud
Computer Crimes and Forensics
Health Care Fraud
Fugitive Felon Program
Forensic Document Laboratory
Analysis and Oversight
Administrative Investigations
Investigative Data Systems and Analysis
Legal Counsel
George J. Opfer
INSPECTOR GENERAL
Department of Veterans Affairs
4/22/2013

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 focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 4 national healthcare reviews; 23 Hotline healthcare inspections; 31 Combined Assessment Program (CAP) reviews; and 14 Community Based Outpatient Clinic (CBOC) reviews, covering 65 facilities, to evaluate the quality of care. All reports issued this reporting period are listed in Appendix A.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities. Their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 31 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 6–12 months. The topics covered this reporting period include: Environment of Care, Construction Safety, Coordination of Care (Hospice and Palliative Care), Long Term Oxygen Therapy, Medication Management (Controlled Substances Inspections), Nurse Staffing, Preventable Pulmonary Embolism, and Quality Management.

Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany House Resolution 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG initiated a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review. During this reporting period, OIG performed 65 CBOC reviews throughout 10 Veterans Integrated Service Networks (VISNs). These reviews were captured in 14 reports, listed in Appendix A. The topics covered this reporting period include: Contracts, Credentialing and Privileging, Emergency Management, Environment of Care, Heart Failure Follow-Up, Management of Diabetes Mellitus (Lower Limb Peripheral Vascular Disease), Vaccinations (Tetanus and Pneumococcal), and Women's Health (Cervical Cancer Screening).

National Healthcare Reviews

Report on Military Sexual Trauma Describes VA Resources Available to Women Veterans, Recommends Review of Travel Policy

At the request of the Senate Veterans' Affairs Committee, OIG reviewed Mental Health (MH) services provided to women with a history of Military Sexual Trauma (MST) treated at VHA residential and inpatient programs. OIG reviewed patient medical records, VHA policy and program self-assessments, and conducted onsite visits at eight programs. OIG found that patients often had more than one MH diagnosis and that 90 percent had received VHA MH care within 3 months of admission. The programs reviewed provided

evidenced-based psychotherapy techniques, gender-specific care, and same gender therapists. Women were often admitted to programs outside their VISN. Obtaining authorization for travel funding was frequently cited as a problem for patients and staff. OIG found that current VHA travel policy is not aligned with MST policy. OIG recommended that the Under Secretary for Health (USH) review existing VHA policy pertaining to authorization of travel for Veterans seeking MST-related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

IG Finds 66 Percent Compliance Rate for Diabetic Patients' Annual Required Foot Care

OIG assessed whether patients with diabetes mellitus and additional risk factors for lower extremity amputation received annual foot care in accordance with VHA requirements. The study population consisted of patients with a diagnosis of diabetes mellitus and one or more of the following risk factors for amputation during July 1, 2009–February 28, 2010: peripheral vascular disease, peripheral neuropathy, and Charcot joint disease with foot deformity. OIG used a two-stage approach to evaluate the annual rate of patient encounters with VA or fee-basis foot care specialists. OIG first examined administrative data for evidence of specialized foot care and then conducted a focused electronic health records (EHRs) review of a randomly selected sample of patients for whom there was no evidence of annual care in administrative data. OIG estimated the VHA compliance rate for annual foot care in this population at increased risk to be 66.2 percent, and OIG is 95 percent confident that the actual compliance rate is between 64.95 and 67.49 percent. OIG recommended and the USH agreed to implement a plan to ensure compliance with VHA's requirement that patients who are at increased risk for amputation be examined by a foot care specialist at least once each year.

Review of Cataract Surgery Care Shows Effective Outcomes and Compliance with VHA Policies

OIG assessed: (1) whether cataract surgery care complied with VHA policies related to informed consent, time-outs, operative report timeliness, and resident supervision; (2) whether cataract surgery patients had improved visual acuity after surgery; (3) selected comorbid conditions and postoperative complications within 30 days of surgery; and (4) whether quality management processes were in place to review care and improve outcomes. OIG found compliance with the documentation of informed consents and resident supervision, timeliness of operative reports, and verification of the patient's correct identity and procedural site during the time-out process. OIG found that patients without diabetes, glaucoma, or macular degeneration had better visual acuity after cataract surgery than patients who had one or more of these three comorbidities. However, VHA should continue to monitor and ensure consistent documentation of intraocular lens implant (IOL) verification in the EHRs for cataract surgeries. OIG noted the completion of the Ophthalmic Surgery Outcomes Database (OSOD) pilot project and suggested that ophthalmology leaders analyze OSOD results and disseminate associated quality improvement methods, if any, to VA cataract surgery facilities. OIG recommended that the USH monitor and ensure consistent verification and documentation of preoperative IOL implant verification in the EHR for all cataract surgeries and ensure analysis of OSOD data and dissemination of associated quality improvement processes to VA cataract surgery facilities.

VHA Lacks Consistent Guidance to Identify and Manage Disruptive Patients, Delays Also Found in Flagging Patient Records

OIG conducted a review to assess how VHA facilities manage patients who display disruptive and violent behaviors. OIG found that VHA facilities vary significantly in how they identify and manage disruptive patient behavior, especially in regards to defining disruptive behavior, documenting incidents and interventions, and employing interventions to prevent and/or minimize the risk of further incidents. OIG also found significant delays in facilities' assignments of Category I Patient Record Flags (PRFs), which are intended to alert VHA employees to patient behavior that may pose an immediate threat to other patients, facility employees, and

visitors. OIG recommended that the USH ensure that VHA program officials provide guidance on what constitutes disruptive behavior and establish common terminology for VHA facilities, develop guidelines for what information facilities should document about disruptive incidents and where this information should be documented, and provide guidance to VHA facilities on collecting and analyzing data on disruptive incidents. OIG also recommended that the USH consider implementing a national reporting system or data collection template for disruptive patient incidents and ensure that VHA facilities implement procedures to improve the timeliness of assigning Category I PRFs to alert VHA employees to patients who may pose an immediate threat. The USH agreed with the findings and recommendations and provided acceptable improvement plans.

Hotline Healthcare Inspections

Allegations of Mismanagement of Government Funds and Quality of Care Issues Not Substantiated at the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan

At the request of Congressman Bill Johnson, former Chairman of the Subcommittee on Oversight and Investigations for the House Veterans' Affairs Committee, OIG conducted an inspection to assess the merits of allegations regarding the mismanagement of Government funds and quality of care issues at the Oscar G. Johnson VA Medical Center (VAMC) in Iron Mountain, MI. OIG reviewed allegations regarding the compensation rates and overtime patterns of nurse administrators and inappropriate patient transfers. Additionally, OIG evaluated the following quality of care allegations: (1) no peer review for physicians and nurses, (2) insufficient number of primary care physicians affected patient care, (3) Intensive Care Unit (ICU) nurses were not appropriately trained, and (4) ICU physicians and nurses did not participate in the ICU Management Committee meetings. OIG did not substantiate any of the allegations, and we made no recommendations.

OIG Finds Emergency Visit at Biloxi VAMC Did Not Meet Standards, Telephone Access at Mobile Clinic Also Faulted

At the request of Congressman Jo Bonner, OIG conducted an inspection to assess allegations concerning a patient's quality of care and problems with services at the VA Gulf Coast Veterans Health Care System (HCS), in Biloxi, MS. OIG substantiated that the patient's overall medical evaluation during one of four emergency department (ED) visits did not meet VHA standards. OIG substantiated that the telephone service at the Mobile CBOC is problematic and that payment for a non-VA hospital stay was originally denied. OIG did not substantiate allegations that the patient's chronic back pain was not addressed at the CBOC or that the patient did not receive timely delivery of durable medical equipment. OIG could neither confirm nor refute that the CBOC provider received any telephone calls from the patient's family during the months of January, February, or March 2012. OIG recommended that leadership ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report, and strengthen processes to address patient complaints regarding the problematic telephone system at the CBOC. The VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan.

Allegations of Patient Care Delays Substantiated at the VA North Texas HCS, Dallas, Texas

OIG conducted an inspection to determine the validity of allegations regarding patient care delays at the VA North Texas HCS, Dallas, TX. A complainant alleged that a dialysis patient waited more than 4 months for permanent vascular access and that ambulatory monitoring for a cardiac patient was delayed 3 months. OIG substantiated that these and other patients experienced excessive wait times. For five recent referrals for vascular access, the time from referral to completion of a procedure was 89–138 days. For 213 patients scheduled for

ambulatory cardiac monitoring, the average wait time was 68 days. OIG also found that clinicians did not review referral requests, consultation reports were not linked to requests in the EHR as required, and that appointment dates requested by patients for vascular and cardiac procedures were incorrectly recorded by scheduling staff. OIG recommended that the Facility Director ensure that patients receive timely vascular and cardiac care, that providers document review of consults in the electronic health record and link results to consult requests, and that staff comply with VHA policy for scheduling outpatient appointments.

IG Follow-Up Review Notes Improvements in Quality of Care and VISN Oversight at Grand Junction, Colorado, Facility

OIG conducted a follow-up review of a report published May 14, 2012, Oversight Review of Quality of Care and Other Issues at the Grand Junction VAMC, Grand Junction, CO. The purpose was to determine whether adverse conditions have been resolved and whether OIG's recommendations were implemented. OIG conducted a site visit to the Grand Junction facility during the week of August 6–9, 2012, interviewed key staff members, and evaluated current processes and documentation. OIG found appropriate oversight by VISN 19. The facility was providing surgical care in accordance with its standard complexity designation and had implemented plans to address deficiencies in peri-operative care. The facility had also taken appropriate action to address the inconsistent availability of surgeons for consultations, deficiencies in quality management procedures, and incomplete medical record documentation. OIG made no recommendations.

Improvements Needed in Scheduling Consults and Patient Contact at the Louis Stokes VAMC, Cleveland, Ohio

OIG conducted an inspection to determine the validity of allegations regarding a patient's care at the Louis Stokes VAMC (the facility). A complainant alleged that biopsy technique and delay in treatment contributed to enlargement of a cutaneous squamous cell carcinoma (CSCC) lesion, affecting the patient's prognosis and necessitating extensive surgical treatment and follow-up. OIG did not substantiate that the biopsy technique used to obtain a tissue sample for diagnosis contributed to a CSCC lesion enlargement. OIG substantiated that a delay in scheduling the patient's Dermatology Clinic appointment occurred but did not substantiate that the delay affected the patient's prognosis. OIG found that the following facility policies and procedures did not ensure adherence to VHA requirements: (1) outlining procedures for contacting patients to schedule an appointment, (2) scheduling consults within the timeframe established by VHA, and (3) defining timeliness of response from Dermatology Service regarding consult requests. OIG recommended that the Facility Director strengthen local policies to include all VHA required elements regarding procedures for contacting patients to schedule appointments. Additionally, OIG recommended that the Facility Director strengthen processes for clinic scheduling and consult tracking and monitor timeliness of outpatient scheduling for adherence with VHA timeliness requirements.

Allegations of Improper Reusable Medical Equipment Practices Substantiated at the VA Northern California Healthcare System, Sacramento, California

OIG reviewed allegations of improper reusable medical equipment practices at the VA Northern California Healthcare System (system), Sacramento, CA. OIG found that the system generally complied with the manufacturer's instructions (MIs) regarding sterilization parameters for selected Olympus and Padgett Dermatome devices. However, sterilization processes for the Phaco Alcon and Midwest dental handpieces were inconsistent with the MIs. OIG concluded that the system's standard operating procedures (SOPs) and sterilization logs were generally inconsistent with the MIs. OIG substantiated the allegations related to bioburden testing, delayed reprocessing, endoscope reprocessing documentation, and staff competencies. OIG

identified improvement opportunities regarding proper use and care of suction canisters and other accessories. The VISN and System Directors agreed with the findings and recommendation and provided acceptable action plans.

Allegations of Inappropriate Respiratory and Clinical Care Evaluated at the VA Northern Indiana HCS, Fort Wayne, Indiana

OIG conducted an inspection to determine the validity of anonymous complainants' allegations regarding inappropriate respiratory and clinical care at the VA Northern Indiana HCS, Fort Wayne, IN. OIG determined that the clinical care provided was appropriate. OIG substantiated the allegation that respiratory care policies were absent or ignored and found that oxygen therapy was being initiated without a provider order. OIG substantiated that an identified physician had a higher readmission rate than other facility physicians and also found that the Peer Review Committee did not ensure specific actions are taken in response to deficiencies identified. OIG did not substantiate the allegations that another physician admitted patients with a diagnosis of pneumonia without obtaining appropriate diagnostic tests, patients were overmedicated due to short staffing, staff were leaving due to inferior patient care, and when patients were designated as "Do Not Resuscitate" they were considered as "Do Not Treat." OIG could not determine if arterial blood gases (ABGs) are performed when not indicated because there was no written criteria for ordering ABGs. OIG recommended that the facility Acting Director ensure that facility respiratory care policies are updated, including specific guidance and expectations for ordering oxygen therapy; that peer review processes comply with VHA policy; and that an assessment of ABG usage is completed.

More Mental Health Workers Needed To Meet Workload Demands at Loma Linda, California, HCS

OIG conducted an evaluation to determine the validity of allegations related to Behavioral Medicine Service (BMS) staffing, workload management, patient evaluations, and supervision at the VA Loma Linda HCS in Loma Linda, CA. OIG substantiated that the facility needed more psychiatrists, psychologists, and social workers to meet the increased MH workload demands. OIG did not substantiate that patient evaluations were inadequate or that the social workers' schedules were not kept full. OIG could not confirm or refute that workload rules were not applied fairly. OIG determined that supervision for the social work staff was adequate and that unlicensed social work staff had appropriate supervision. OIG found that MH patients did not consistently receive timely evaluations. OIG concluded that the Chief, BMS, provided adequate supervision and oversight. However, OIG determined that the facility needs to establish a MH Executive Council (MHEC). OIG recommended that MH patients receive timely care and that a MHEC be established as required by VHA.

Clinical Allegations Involving Surgical Service at Carl Vinson VAMC, Dublin, Georgia, Not Substantiated, But Provider Reprivileging Needs Improvement

OIG conducted an evaluation to determine the validity of allegations related to inadequate communication and delayed interfacility patient transfers between the Carl Vinson VAMC, Dublin, GA, and the Charlie Norwood VAMC, Augusta, GA. OIG did not substantiate the allegation that facility providers gave inaccurate patient information to the Charlie Norwood VAMC prior to a patient's transfer for neurosurgical evaluation. OIG found documentation in the patient's EHR to support that appropriate information was communicated to the Charlie Norwood VAMC. OIG did not substantiate the implication that a patient's colon perforation was the result of the physician's non Board-certified status. OIG could not confirm or refute that delay and transfer issues resulted in a patient's death. During the course of our review, OIG identified opportunities to improve the facility's provider reprivileging processes, as well as the collection and analysis of aggregated surgical complication data. OIG recommended that provider reprivileging processes be conducted in accordance with VHA guidelines. OIG also recommended that the Operative and Other Procedures Review Committee collect

and analyze aggregate surgical complication data to identify trends and patterns, and take appropriate corrective action when indicated.

OIG Finds Alleged Patient Rights Violations Did Not Occur at Carl Vinson VAMC, Dublin, Georgia

OIG conducted an inspection in response to allegations that a patient's rights were violated, that the patient's Durable Power of Attorney for Health Care (DPAHC) may not have been valid, and that facility leaders were not responsive to staff and family concerns about this case. OIG did not substantiate that a patient with dementia, who was deemed to have decision making capacity regarding where he wanted to live, was held against his will for an extended period of time. The Interdisciplinary Treatment Team made efforts to address the complicated medical, ethical, and legal considerations that delayed the patient's discharge to a Florida assisted care facility. OIG could neither confirm nor refute the validity of the patient's DPAHC. Due to a lack of medical record documentation, a Regional Counsel attorney was unable to determine whether the document was legally executed. However, during most of the patient's nearly 3-year stay at the facility, the son was the patient's recognized health care agent by both facility staff and other family members. OIG confirmed that facility leaders did not appear to respond to clinicians' requests for assistance. OIG discussed these issues with facility leadership and were assured that complicated cases will continue to be discussed at the daily executive clinical meeting. OIG made no recommendations.

Allegations of Misdiagnosed Stroke at Atlanta VAMC, Decatur, Georgia, Are Unfounded

OIG conducted an inspection in response to allegations of misdiagnosis and other care issues at the Atlanta, GA, VAMC and CBOCs in VISN 7. The purpose of this inspection was to determine the validity of the allegations. OIG did not substantiate that a facility ED physician misdiagnosed a stroke as vertigo (a feeling of motion while one is stationary) in September 2010. OIG determined that the facility ED physician's evaluation and management of the patient's complaints and hyperglycemia were appropriate. OIG did not substantiate that the patient received deficient care or that facility and CBOC providers failed to appropriately meet the patient's vision, hearing, and stroke rehabilitation needs. Although OIG found VA transportation failed to provide scheduled transportation on two occasions, OIG did not find these failures affected the patient's ability to receive health care or indicated a systemic transportation problem. OIG did not substantiate that patient advocate services were not accessible to the patient. OIG did not substantiate a lapse in civility by a CBOC provider. OIG made no recommendations.

Pancreatic Cancer Misdiagnosis at Hudson Valley HCS, Castle Point, New York, Not Substantiated

OIG evaluated allegations regarding alleged misdiagnosis at the Hudson Valley HCS, Castle Point, NY. Specifically, the complainant alleged a patient initially told by staff he had pancreatic cancer was later advised that he did not due to a mix-up with the laboratory results. In addition, the complainant alleged another patient was never informed of positive pancreatic cancer test results. OIG did not substantiate the allegation that a patient was misdiagnosed with pancreatic cancer or that a patient was diagnosed with pancreatic cancer and not notified. OIG reviewed the EHR of the identified patient and found no mention of pancreatic cancer or reports of emotional distress related to such. The facility had no new cases of pancreatic cancer diagnosed during the relevant timeframe and OIG found no documentation suggestive of a missed or delayed pancreatic cancer diagnosis. It appears unlikely that a laboratory "mix-up" occurred. OIG made no recommendations.

Allegations of Resident Abuse Not Substantiated at Pueblo Community Living Center, Pueblo, Colorado, But Reporting Allegations of Abuse Needs Improvement

OIG conducted an inspection of the Pueblo Community Living Center (CLC), in Pueblo, CO, which is operated by the VA Eastern Colorado HCS, located in Denver, CO. The purpose of the inspection was to determine the

validity of allegations regarding CLC resident abuse and reporting irregularities. OIG did not substantiate the allegation of resident abuse. OIG did not substantiate the allegation that staff attempted to cover up an allegation of abuse or that staff who report potential abuse are retaliated against; however, OIG found staff did not report allegations of abuse as required by VHA and local policies, and did not track or trend incidents such as bruises and skin tears of unknown origin in order to identify potential abuse patterns. OIG recommended that the system Director ensure all Associate Chiefs of Nursing and CLC staff are retrained on the requirements for reporting allegations of abuse and that procedures to report, log, track, trend, and analyze injuries of unknown origin at the CLC are developed.

Deceptive Inventory Management Practices Noted at Castle Point, New York, Pharmacy

OIG conducted a review to determine the validity of several allegations at the Castle Point Campus of the VA Hudson Valley HCS in Castle Point, NY. OIG did not substantiate that patients died in the chemotherapy clinic or during transfer to community hospitals; however, OIG found issues with chemotherapy treatment timeliness. OIG presented findings to the Director about deceptive pharmacy inventory management practices, which resulted in the appointment of an Administrative Investigation Board (AIB). OIG reviewed and concurred with the findings and recommendations of the AIB. OIG confirmed that supplies were moved to the basement to exclude them from the pharmacy inventory count but did not substantiate that they remained there and went unused. OIG determined that there were drug shortages caused by an inadequate inventory management system and national vendor back-orders. OIG did not substantiate allegations related to physician hiring, safety issues for pharmacy staff who worked alone, or a pharmacy manager's conduct. OIG recommended that the Director follow the AIB's recommendations and provide ethics training and a repercussion-free reporting system for pharmacy staff.

IG Recommends Improvements To Reduce Patient Falls at Canandaigua, New York, Community Living Center

OIG conducted a review to assess the merit of an allegation concerning an increased number of patient injuries due to "unnecessary roughness" by staff in the CLC at the Canandaigua VAMC in Canandaigua, NY. OIG did not substantiate the allegation. However, OIG found that since October 2011, the CLC experienced an upward trend in patient falls with a spike in April and May 2012. Facility leaders were aware of the increase in patient falls and had taken steps to identify contributing factors and implement preventive strategies prior to OIG's review. OIG found that the facility's Falls Reduction Program could be strengthened and recommended that the facility Director implement procedures to ensure that CLC unit-level reviews of patient falls are patient-specific, address the specific circumstances surrounding the fall, and that fall prevention interventions are documented in patient care plans. Management agreed with the findings and recommendations and provided an acceptable improvement plan.

OIG Substantiated the VA San Diego HCS, San Diego, California, Patient Call Center Failed to Follow Procedures Resulting in Delays

OIG conducted an inspection to determine the validity of allegations regarding scheduling primary care appointments at the Patient Call Center (PCC), VA San Diego HCS, San Diego, CA. The complainant alleged that a PCC agent refused to schedule a follow-up appointment and an urgent appointment. The complainant also alleged that he was forced to seek medical treatment at a community hospital ED for an infection in his finger, and that he was at risk for amputation of his finger due to lack of medical attention at the HCS. OIG found that the PCC agent did not follow procedures for managing calls and that the PCC agent's failure to follow PCC procedure caused delays. While the HCS failed to provide timely follow-up, OIG determined that the complainant was not denied access to care. OIG recommended that the HCS Director ensure that PCC agents

follow SOPs for scheduling follow-up appointments and managing non-urgent symptomatic calls, and ensure that timeframes for the primary care teams to follow up with patients are established.

Denial of Inpatient Care Allegation, Unsubstantiated at the VA North Texas HCS, Dallas, Texas

OIG conducted an inspection to determine the validity of an allegation related to a patient being denied inpatient MH treatment at the VA North Texas HCS in Dallas, TX. Specifically, the complainant alleged that a patient presented to the ED with suicidal ideation and had to wait in the triage holding area for over 4.5 hours prior to being seen by a psychiatrist. The psychiatrist told the patient that admission was not indicated. The patient had a panic attack, and the police were called to escort the patient out of the facility as the patient was upsetting the staff. OIG did not substantiate that a suicidal patient was denied admission for inpatient treatment. OIG interviewed staff, reviewed the patient's EHR, and reviewed facility policies. Although the patient's EHR documented the patient felt hopeless and depressed, it also documented that the patient denied suicidal ideation. OIG determined that there was no facility policy or SOP written to describe the process for patient evaluations in the ED; therefore, there was no training on such a policy or procedure for anyone working in the ED. This may have contributed to the long ED visit for the patient and influenced the patient's decision to leave against medical advice. OIG also reviewed the patient's ED Integration Software (EDIS) tracking sheet that is used to monitor a patient's real-time movement through the ED. The tracking sheet did not match the patient's EHR. ED administrative and clinical staff do not consistently update EDIS as required. In addition, social workers on call for the ED after hours did not assist homeless patients to find a shelter or direct them to the Healthcare for Homeless Veterans program as required. OIG recommended that the Facility Director ensure that the facility develop a written policy for ED patient evaluation and provide orientation to all ED staff and on-call personnel; EDIS is used as required; and social work services are provided in the ED as required. The VISN and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.

IG Criticizes Washington, DC, VAMC for Delays in Management of Staph Infection and Failure To Conduct Quality Review

OIG conducted a review to determine the validity of allegations regarding a patient's quality of care and communication between professional staff and a patient's family at the Washington, DC, VAMC. The complainant alleged that treatment of the patient's urinary tract infection was delayed; that the facility did not tell the family the patient had a Methicillin-Resistant Staphylococcus Aureus (MRSA) infection; that the patient was released from outpatient care despite the MRSA infection; and that communication with the family about all of the patient's conditions was poor. OIG substantiated that management of the MRSA urinary tract infection was not timely instituted. OIG found that the facility did not conduct a Quality Review for the outpatient MRSA management issue. OIG substantiated that the patient and family were not timely notified of the patient's MRSA infection while he was an outpatient. OIG did not substantiate the allegation that the facility lacked professionalism in relating to the patient's family. OIG recommended that the facility Director, in accordance with VHA Handbook 1004.08, consult with Regional Counsel regarding institutional disclosure to the patient's family; ensure that a quality of care review is conducted with specific attention to deficiencies identified in this report; and monitor providers' documentation to ensure compliance with VHA policies on information management and health records.

Allegations of Issues Regarding Mid-Level Provider Patient Care Substantiated at the George E. Wahlen VAMC, Salt Lake City, Utah

OIG conducted an inspection to assess the merits of allegations concerning the quality of mid-level provider patient care in an ICU and the failure of leadership to take action when complaints were reported at the

George E. Wahlen VAMC, Salt Lake City, UT. OIG substantiated that mid-level providers restarted a patient's home medications without necessary adjustments; inappropriately administered hydralazine to a patient resulting in cardiogenic shock; and failed to timely notify attending physicians when a patient experienced prolonged bradycardia. OIG did not substantiate allegations that facility leadership failed to take any action regarding these complaints. OIG identified issues concerning Physician Assistant (PA) supervision and scope of practice reviews, lack of a process equivalent to credentialing and privileging of physicians for the PAs and nurse practitioners, and confusion regarding the reporting of adverse events. OIG recommended that the Facility Director establish a process for mid-level provider scope of practice reviews that is equivalent to the Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations processes; ensure that mid-level Professional Standards Boards forward their recommendations for the granting of scopes of practice to the Medical Executive Committee for review; provide adverse event reporting training for all ICU staff and attending physicians; and strengthen ICU near miss and adverse event reporting procedures.

Allegations of Issues Regarding Dental Patient Care Substantiated at a VISN 9 Dental Clinic

OIG conducted an inspection to assess the merit of allegations regarding dental care provided at a VISN 9 dental clinic. OIG conducted an Employee Assessment Review survey, a short confidential survey that invites all system employees to share general observations about the quality of care and safety provided within the system. The Employee Assessment Review survey results included 15 allegations regarding dental patient care provided at a VISN 9 dental clinic. OIG divided the allegations into four categories: dental vacuum system; dentists' practice issues; eligibility, scheduling, and productivity; and work environment and leadership. Based on OIG's interviews with leadership and staff, VISN Dental Consultant interviews and reports, EHR reviews, patient schedules, dental productivity reports, and onsite physical inspections, OIG substantiated three of the allegations. OIG recommended that leadership ensure that dental clinic staff have adequate knowledge regarding periodontal disease; ensure treatment plans are developed, revised, followed, and documented; and develop and implement a plan to improve communication and professional interaction among dental clinic staff. The VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed.

Allegations of Laboratory Processing Delays and Environmental Safety Concerns Not Substantiated at the VA North Texas HCS, Dallas, Texas

OIG conducted an inspection to determine the validity of allegations regarding laboratory processing delays and environmental safety concerns at the VA North Texas HCS, Dallas, TX. A complainant alleged that specimen containers have unreadable labels that cannot be matched to the paperwork received; a patient went to a private provider for a Papanicolaou (Pap) test because of delays receiving results through the VA, and the test was positive for cancer; service leadership took no action when the Pap test delays were reported; the ventilation system in the Histology laboratory is not adequate; chemicals and explanted pacemakers are not appropriately stored and disposed of; and food and drinks are stored in refrigerators meant for laboratory items. OIG did not substantiate any of the allegations and found proper procedures in place for specimen labeling, processing, and documentation of records. OIG made no recommendations.

IG Finds Excessive Emergency Room Length of Stay a Chronic Problem at Columbia, South Carolina, VAMC

OIG conducted an evaluation in response to allegations of an excessive length of stay (LOS) and lack of treatment for elevated blood pressure in the ED at the William Jennings Bryan Dorn VAMC in Columbia, SC. During OIG's inspection, an anonymous complainant further alleged that acuity levels for various conditions

were triaged lower than indicated by ED guidelines. OIG substantiated the patient's excessive LOS in the ED and determined it to be a chronic problem at the facility. EDIS was not utilized to provide data to assist in improving flow management, and ED providers considered EDIS data entry a low priority. OIG did not substantiate that the facility failed to address a patient's elevated blood pressure in the ED or that urgent or critical conditions were triaged at non-urgent levels. OIG recommended that the Facility Director identify a reporting structure for EDIS data and ensure that mandated quarterly reports containing and utilizing EDIS data are provided, ensure that planned actions to address patient flow are implemented and patient flow outcomes are monitored, and ensure that ED providers and other clinical and administrative staff receive training on the use of EDIS delay reasons and that accuracy is monitored.

IG Finds Conflict of Interest in VA Doctor's Attempts To Influence Committee Reviewing Spouse's Research Proposal

OIG reviewed allegations that a Merit Review Scientific Review Group (SRG) member (Dr. X) violated ethical standards of conduct by approaching other SRG members to seek support for his wife's (Dr. Y's) research proposal. OIG substantiated that Dr. X had a clear conflict of interest in this case, yet he repeatedly attempted to influence other SRG members to score Dr. Y's proposal favorably. Dr. X had a pattern of similar actions in the past. While OIG did not evaluate whether Dr. Y's proposal was inappropriately funded as a result of Dr. X's efforts, Dr. X's actions could have affected the Merit Review proceedings and subsequent funding decisions. As such, a review of Dr. Y's ongoing grant award may be indicated. Further, Dr. X retains a 3-year approval (expiration date in 2014) to submit research proposals to VA Merit Review for possible funding. Because of his pattern of improper conduct, his eligibility for Federal research funding should be reconsidered. The Office of Research and Development (ORD) has revised its guidance on reporting ethical breaches like those discussed in this report; however, SRG members may still be dissuaded from reporting ethical breaches due to concerns about retaliation. OIG recommended that ORD conduct an AIB into this matter and evaluate existing policies and controls related to Merit Review SRG processes. The USH concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed.

The Office of Audits and Evaluations provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, and inspections of VA programs, functions, and facilities. Reviews address the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, Veterans' eligibility for benefits and benefits administration, resource utilization, financial management, forensic auditing, fraud, and information security.

Veterans Health Administration Audits and Evaluations

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

VHA Needs to Strengthen Oversight and Improve Eligibility Review To Avoid Renewing Ineligible Nursing Home Contracts

VHA's Office of Finance reported nursing home program expenditures totaled $614 million in FY 2012 and were estimated to grow to $767 million in FY 2013. OIG found weaknesses and untimely VA health care facility eligibility reviews of 30 nursing homes resulted in the renewal of 5 ineligible nursing homes' contracts. This occurred because VA officials did not effectively monitor the nursing home program and did not provide guidance needed to ensure the proper completion of eligibility reviews. Further, VA review teams did not always obtain and evaluate required operational information about the nursing homes when they performed their initial and subsequent annual reviews. As a result, over the next 5 years, VHA will place about 33,500 patients at a cost of about $296.5 million in ineligible nursing homes if VHA does not strengthen program oversight and improve its eligibility reviews. This amount is not a "cost savings," as Veterans need these vital services, but future payments should be provided to *eligible* nursing homes that provide the quality of care Veterans deserve. OIG recommended the USH update community nursing home policies, conduct a national review to ensure Veterans are not currently in ineligible nursing homes, and strengthen nursing home program oversight and monitoring.

VA Violated Anti-Deficiency Act by Converting Minor Construction Into Major Construction Projects, Better Controls on Medical Center Funding Needed

At the request of the House Committee on Appropriations, and following irregularities identified at the Miami VA HCS, OIG reviewed the VHA Minor Construction Program. VA medical facilities combined design and construction work for 7 of 30 minor construction projects into 3 projects exceeding the $10 million minor construction limit. VHA violated the Anti-Deficiency Act by combining five minor construction projects into two major projects exceeding the $10 million threshold. VHA lacks assurance that construction projects are designed within their approved scopes, medical facility funding is used appropriately, and underperforming projects are identified in a timely manner. OIG recommended the USH publish Minor Construction policy and develop procedures to ensure projects are executed within their approved scopes. VHA should implement funding mechanisms, ensure program reviews are performed, and strengthen project tracking reports. The USH agreed with OIG's recommendations and provided an acceptable corrective action plan.

VHA Needs To Improve Oversight and Controls over Finances and Administration at Providence, Rhode Island, Medical Center

This review determined the validity of 11 allegations relating to financial and administrative matters at the Providence VAMC, Providence, RI. OIG partially or fully substantiated 7 of the 11 allegations made by the complainant and identified opportunities for management to improve oversight and strengthen controls over financial and administrative activities. Providence VAMC officials did not always ensure applicable laws and policies were followed. OIG also questioned costs totaling $4,444 related to misuse of appropriated funds. OIG recommended strengthening the oversight and compliance with policies and procedures, as well as improving controls to ensure employees comply with applicable laws and policies. The VISN 1 Director concurred with OIG's findings and recommendations and provided an appropriate corrective action plan.

VHA Can Improve Specialty Care Services with Staffing Methodology that Implements Productivity Standards

OIG assessed whether VHA has an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services and reported the need for VHA to improve their staffing methodology by implementing productivity standards. Public law mandates VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties, and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. The USH agreed with OIG's finding and recommendations.

VA Heart of Texas Network Will Establish Special Units and Upgrade Training To Improve Non-VA Fee Care Processing

OIG substantiated the allegation the South Texas Veterans HCS (STVHCS) authorized several million dollars in fee care during FYs 2009 and 2010 although it did not have sufficient funds obligated and available to pay for the services the Veterans received. STVHCS did not ensure clinical and fee staff complied with required steps for authorizing fee care and fee staff also did not timely process fee care payments. STVHCS clinical and fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision. Management in the STVHCS and VISN 17 lacked effective oversight mechanisms to ensure sufficient funds were available to pay for the fee care received by Veterans. STVHCS also lacked visibility over these unpaid claims when vendors' invoices were received until fee staff researched, summarized, and processed this information dating back to FY 2009. STVHCS incurred avoidable interest penalties for untimely payments.

VHA Needs To Reconcile Travel Expense Claims with Disbursed Payments To Improve Beneficiary Travel Program and Reduce Risk of Fraud

OIG found VHA lacks assurances that program costs are accurate and paid only to eligible Veterans and that its liabilities, expenditures, and full costs of the Beneficiary Travel Program (BTP) are accurately recorded, monitored, and reported. OIG evaluated VHA's management and oversight of VA's BTP, which has experienced dramatic growth in costs, to ensure reimbursements for Veterans' travel was in compliance with requirements. In 2010, VHA began a series of initiatives to improve program oversight. During this audit, VHA had not fully implemented all changes. VHA has not developed a process to reconcile travel expense claims with disbursed payments. OIG identified differences in mileage reimbursements paid compared with approved mileage

reimbursements. OIG recommended the USH strengthen authorization, payment, and oversight controls for the BTP. The USH concurred with OIG's findings and recommendations and provided an action plan.

Veterans Benefits Administration Audits and Evaluations

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

VA Needs Plan To Resolve Performance Issues with Paperless Claims Processing System To Eliminate Claims Processing Backlog By 2015

In May 2012, the House Appropriations Committee directed OIG to evaluate the Veterans Benefits Management System (VBMS) to determine whether VA has performed sufficient systems testing. OIG's review included assessing whether VBA is positioned to meet its goal of eliminating the claims backlog and increasing the accuracy rate of processing claims to 98 percent by 2015. OIG also evaluated the effectiveness of VBA's efforts to scan and digitize Veterans' claims to support paperless claims processing. OIG found, as of September 2012, in the early stages of VBMS system development, VA had not fully tested VBMS. The system had not been fully developed to the extent that its capabilities could be sufficiently evaluated and the partial deployment to date has experienced system performance issues. VA officials stated they have taken action to improve digitization of Veterans' claims including better organization of electronic claims folders.

VBA Needs To Improve Oversight, Policies, and Risk Management for Foreclosed Property Appraisals

OIG evaluated the effectiveness of VBA's Loan Guaranty Program which paid just over $1.4 billion to acquire about 14,000 foreclosed real estate properties. Specifically, OIG found improvement of liquidation appraisal oversight was needed at the Cleveland and Phoenix Regional Loan Centers. Comparable properties and sales price adjustments were not consistently reviewed to establish appraised value. Policies and procedures lacked sufficient criteria for loan center staff to evaluate every appraisal. The Program did not use an automated appraisal review tool, and VA may not have paid fair and reasonable prices when acquiring some properties. OIG recommended policies and procedures be revised, use of an automated appraisal review tool, implementation of a comprehensive risk management program, and revisions to the Program managers' performance plans.

Better Management Oversight of Vocational Rehabilitation Program Needed To Help Veterans Successfully Operate Own Businesses

OIG evaluated the effectiveness of VBA's Vocational Rehabilitation and Employment (VR&E) program's self-employment services. VBA needs to strengthen management of these services to ensure its area offices effectively plan and provide the self-employment services needed for Veterans to successfully operate their own businesses. VR&E misidentified Veterans participating in self-employment services and did not record all program expenses. Insufficient oversight of data resulted in inadequate resources to accomplish program goals. Program staff was unaware of the correct criteria for rehabilitating Veterans. VBA guidance was not clear when providing services to Veterans with established businesses or when approving plan expenses. OIG recommended improving management and oversight for self-employment services by establishing procedures to ensure approvals for these services are appropriate, data collection on program operations is accurate, performance measures are implemented, and staff training is conducted.

Veterans Benefits Administration Benefits Inspections

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

Key findings included:

- Claims Processing: 50 percent (93/187) of benefit claims reviewed requiring a rating decision were processed in error. These errors involved temporary 100 percent disability evaluations claims related to traumatic brain injuires.
- Systematic Analysis of Operations (SAOs): 67 percent (22/33) of SAOs were not completed timely and/or were incomplete.
- Homeless Veterans Outreach: for 25 percent (1/4) of the VAROs inspected, there was no assurance the VARO was providing adequate outreach to homeless shelters and service providers.

National Cemetery Administration Audit

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

NCA Identifies More Misplaced Headstones After IG Recommended Revisions to Gravesite Review Procedures

The House Committee on Veterans' Affairs requested OIG conduct this audit to determine if NCA adequately addressed issues found during its Phase One review of headstones and markers at VA national cemeteries. OIG found NCA did not have an independent review procedure to identify misplaced headstones and unmarked gravesites, did not provide sufficient resources to conduct a review of this magnitude, and Memorial Service Networks did not provide cemetery directors with updated gravesite layout maps. In July 2012, OIG issued NCA recommendations to revise its procedures for completing gravesite reviews. NCA subsequently conducted its Phase One follow-up and identified 146 additional errors at 4 cemeteries. OIG recommended the Under Secretary for Memorial Affairs ensure an improved process for internal reviews with proper resources and follow-up to correct errors, as well as implementing controls to ensure gravesite maps are accurate. The Under Secretary agreed with the recommendations and provided action plans.

Other Audits and Evaluations

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

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

OIG performs audits of Information Technology (IT) and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and safeguarding Veterans and VA employees, facilities, and information. OIG's audit reports present VA with constructive recommendations needed to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Management Act of 2002*, 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.

Review Questions VA's Methodology for Completing Report on $2.2 Billion in Improper Payments in FY 2012

OIG conducted this annual review to determine whether VA complied with the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) for FY 2012. VA reported about $2.2 billion in improper payments in its FY 2012 Performance and Accountability Report (PAR). In doing so, OIG found VA did not comply with four of seven IPERA requirements in FY 2012. For example, VHA did not report a gross improper payment rate less than 10 percent or meet a reduction target for one program, and VBA did not use statistically valid methodologies to calculate improper payment estimates for some programs or report recapture amounts. VA did meet the requirements to publish a PAR, perform risk assessments, and provide information on its corrective action plans. OIG recommended that action be taken to reduce improper payments and develop achievable reduction targets for the Non-VA Care Fee program, as well as to implement an estimation methodology to achieve statistical precision for VHA programs. Further, a statistically valid estimation methodology needs to be implemented for the Compensation, Pension, and VR&E programs. Lastly, OIG recommended the Executive in Charge for the Office of Management and Chief Financial Officer complete planned actions to improve compliance with IPERA. OIG's recommendations were agreed with and appropriate action plans were provided.

Poor Planning and Project Management Lead to $5.1 Million in Unused Software Encryption Licenses

OIG substantiated the allegation the Office of Information and Technology (OIT) had not installed and activated all of the 300,000 encryption software licenses purchased in 2006 at a cost of about $3.7 million. OIG also found OIT purchased an additional 100,000 licenses in 2011. As of July 2012, OIT had installed and activated

only about 65,000 (16 percent) of the total 400,000 licenses procured. This was due to OIT's poor planning and inadequate management in not allowing time to test the software; ensuring sufficient staff were allocated to the project; adequately monitoring the project; and assuring the remaining licenses were compatible in the current computer environment. As a result, 84 percent of the total 400,000 licenses procured, totaling about $5.1 million in questioned costs, remain unused as of the end of FY 2012.

VA Data Exchanged With Research Partners and University Affiliates at Risk of Unauthorized Access

This audit assessed the effectiveness of VA's management of its systems interconnections and data exchanges with external research and university affiliates. OIG reported VA has not effectively managed its network interconnections and data exchanges with its external research partners. VA could not readily account for various systems linkages and sharing arrangements. VA also could not provide an accurate inventory of research data exchanged, where data was hosted, or the sensitivity levels of the data. OIG identified unsecured electronic and hardcopy research data at VAMCs and in co-located research facilities. VA's data governance approach has been ineffective to ensure that research data exchanged is adequately controlled and protected throughout the data life cycle. OIG recommended OIT and VHA implement a centralized data governance model and ensure formal agreements are established requiring research partners to implement controls commensurate with VA standards for securing and protecting sensitive data.

VA Needs Strategic Plan To Guide Effective Future IT Workforce Development

This audit assessed the effectiveness of OIT's strategic human capital management program. OIG found OIT has not instituted a human capital strategy for its workforce of approximately 7,300 employees and has been managing its human resources in an ad hoc manner. OIT experienced vacancies and excessive turnover in key leadership positions; has not developed succession plans; lacked the human resources needed to move forward with a strategic approach to managing its personnel in line with Federal guidelines; has not fully implemented competency models; and has not identified competency gaps. Additionally, OIT has not assessed its use of contractors to supplement staff nor has OIT established a mechanism to evaluate the success of its human capital initiatives. OIG recommendations included assigning adequate leadership and staff to guide the program, developing a leadership succession plan, and completing a competency gap analysis.

Review Finds Some VAMCs and Clinics Transmitted Sensitive Data Over Unencrypted Network

We evaluated the merits of an allegation that VA was transmitting sensitive data, including personally identifiable information (PII) and internal network routing information, over unencrypted telecommunications carrier networks. OIG substantiated the allegation. OIT personnel disclosed VA typically transferred unencrypted sensitive data, such as EHRs and internal internet protocol addresses, among certain VAMCs and outpatient clinics using an unencrypted telecommunications carrier network. OIT management acknowledged this practice, accepting the security risk of potentially losing or misusing the sensitive information exchanged via a waiver. However, the use of a system security waiver was not appropriate. Without controls to encrypt the sensitive VA data transmitted, Veterans' PII may be vulnerable to interception and misuse by malicious users as it traverses unencrypted telecommunications carrier networks. Further, malicious users could obtain VA router information to identify and disrupt mission-critical systems.

Federal Financial Management Improvement Act of 1996 Compliance

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The audit of VA's FYs 2012 and 2011 consolidated financial statements reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. With respect to internal control, the audit identified one material weakness, IT security controls, which is a repeat condition. The audit also identified one significant deficiency, undelivered orders, as a partial repeat condition and retitled it from "accrued operating expenses." VA took corrective actions sufficient to address the reasonable estimation of the accrued operating expenses portion of unpaid obligations; therefore, accrued operating expenses have been removed from the significant deficiency for this year. VA also took corrective actions sufficient to eliminate one other significant deficiency, loan guaranty reporting, previously cited last year.

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 206 cases; made 143 arrests; obtained over $137.4 million in fines, restitution, penalties, and civil judgments; and achieved over $2.7 million in savings, efficiencies, cost avoidance, and recoveries. The monetary impact includes settlements in an investigative case brought under the *False Claims Act,* P.L. 111-148, which resulted in a fine totaling $136 million.

During this reporting period, OIG opened 61 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Fifty-three defendants were charged with various crimes relating to drug diversion. These investigations resulted in $640,495 in fines, restitution, penalties, and civil judgments as well as $455,447 in savings, efficiencies, cost avoidance, and recoveries. OIG also initiated 22 investigations related to the fraudulent receipt of health benefits, which resulted in 18 defendants being charged with various related crimes. These investigations resulted in $416,582 in fines, restitution, penalties, and civil judgments as well as $572,160 in savings, efficiencies, cost avoidance, and recoveries. OIG opened 31 beneficiary travel fraud investigations involving VA patients who grossly inflated their mileage to and from VA facilities to increase their reimbursement for travel expenses. These investigations resulted in 25 arrests, $419,645 in fines, restitution, penalties, and civil judgments along with $49,952 in savings, efficiencies, cost avoidance, and recoveries. The following entries provide a representative sample of the type of VHA investigations conducted during this reporting period.

Three Former New Orleans, Louisiana, VAMC Employees Plead Guilty to Conspiracy to Commit Health Care Fraud

Three former New Orleans, LA, VAMC employees pled guilty to a criminal information charging them with conspiracy to commit health care fraud. An OIG investigation revealed that between January 2001 and December 2008 the defendants devised a scheme to defraud VA by creating false companies and billing patient files using the identities of Veterans registered with the VAMC. The health care services were never provided to the Veterans. The payments associated with the fraudulently submitted bills were then split among the defendants. The loss to VA is approximately $563,000.

Former Los Angeles, California, VAMC Chief Accountant Sentenced for Embezzlement

A former Los Angeles, CA, VAMC chief accountant was sentenced to 1 year of incarceration, 3 years' supervised release, and ordered to pay VA restitution of $229,191. An OIG investigation revealed that the defendant embezzled $681,087 of VA funds. To date, VA has recovered $451,896 of the embezzled funds. The defendant stole checks sent to VA for various purposes to include prescription rebates, restitution from U.S. District Court, and insurance payments. The defendant then deposited the checks into the VA agent cashier's account at a commercial bank, later withdrawing the funds in a combination of cash and cashier checks. The defendant also embezzled funds from the State of California and non-profits working on the medical center campus. The OIG has provided VHA a Management Implication Notification Report on the details of this crime to allow VHA to determine if stronger controls could be implemented.

Veteran Sentenced for Arson at the Jesse Brown VAMC, Chicago, Illinois

A Veteran was sentenced to 6 years' incarceration after pleading guilty to aggravated arson. An OIG, VA Police Service, and local fire department investigation determined that the defendant set fire to his room at the Jesse Brown VAMC in Chicago, IL. The fire caused damage to the room and extensive smoke and water damage

throughout the ward. Two VA police officers also suffered minor smoke inhalation while evacuating the ward. The investigation further revealed that the defendant tampered with the ceiling-mounted fire suppression sprinkler heads, causing them to malfunction during the fire.

Former Richmond, Virginia, VAMC Housekeeping Aide Sentenced for Homicide

A former Richmond, VA, VAMC housekeeping aide was sentenced to life imprisonment after pleading guilty to the use of a firearm in relation to a crime of violence that caused the death of another. An OIG and Federal Bureau of Investigation (FBI) investigation determined that the defendant, after engaging in a brief verbal confrontation with two individuals in the medical center parking lot, shot one of the individuals in the shoulder with a .38 caliber revolver. Upon seeing the victim fall to the ground, the defendant followed the second individual a short distance and then returned to the victim, shooting him a second time.

Topeka, Kansas, VAMC Neurologist Pleads No Contest to Sexual Battery

A Topeka, KS, VAMC neurologist pled no contest to aggravated sexual battery and sexual battery. An OIG, VA Police Service, and local police investigation revealed that the defendant administered full pelvic examinations without a chaperone and without any medical necessity for such procedures. Five victims were identified in a 1-year period.

Northport, New York, VAMC Employee Found Guilty of Assaulting Co-Worker

A Northport, NY, VAMC employee was found guilty at trial of assaulting a co-worker. An OIG and VA Police Service investigation revealed that the defendant assaulted the co-worker in a private office at the VAMC. The victim was subsequently diagnosed with hand and wrist injuries.

Former Manchester, New Hampshire, VAMC Employee Arrested for Disorderly Conduct

A former Manchester, NH, VAMC employee was arrested for disorderly conduct. An OIG and VA Police Service investigation revealed that the defendant grabbed a VA police officer and shoved him several times before being restrained. The investigation also disclosed that the defendant made threatening comments to a VA physician prior to the altercation with the officer. The defendant was terminated from VA employment.

Phoenix, Arizona, VAMC Nurse Indicted for Elder Abuse

A Phoenix, AZ, VAMC nurse was indicted for vulnerable adult abuse, fraudulent schemes, forgery, theft, identity theft, and negligent homicide. An OIG and local law enforcement investigation determined that the defendant provided inadequate care and treatment to VA-placed Veterans at three assisted living facilities she owned and operated. The State of Arizona subsequently closed the facilities and condemned the buildings. The Veterans were returned to the VAMC or placed in other facilities approved by VA. The defendant also forged cardiopulmonary resuscitation (CPR) certifications for her staff by forging the name of a retired VAMC CPR trainer.

West Palm Beach, Florida, Respiratory Therapist Sentenced for Drug Violation

A VA respiratory therapist was sentenced to 12 years' incarceration, with a 6-year mandatory minimum, and a $157,860 fine after pleading guilty to trafficking in oxycodone. The plea stemmed from a 7-month multiagency 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 Roseburg, Oregon, VAMC Pharmacy Technician Sentenced for Drug Theft

A former Roseburg, OR, VAMC pharmacy technician was sentenced to 24 months' incarceration and ordered to pay $23,475 in restitution. An OIG and Drug Enforcement Administration (DEA) investigation revealed that for approximately 18 months the defendant stole over 6,000 tablets of controlled narcotics from the VAMC pharmacy by posting false drug orders in the VistA database. As part of the scheme, the defendant manipulated VistA by placing disbursement orders to make it appear narcotics were being replenished in narcotic dispensing machines located throughout the VAMC. In particular, the technician selected dispensing machines that did not normally stock a narcotic and so avoided inventory contradictions, automated replenishment orders, and oversight controls. The loss to VA was approximately $23,500.

Former Tucson, Arizona, VAMC Nurse Indicted for Drug Theft

A former Tucson, AZ, VAMC nurse was indicted for fraudulent schemes and acquisition of a narcotic drug. An OIG investigation revealed that for 6 months the defendant stole over 1,700 controlled substance medications to include morphine, oxycodone, and hydromorphone. The defendant tested positive for hydromorphone and morphine use after completing a drug screen.

Former Martinsburg, West Virginia, VAMC Registered Nurse Pleads Guilty to Drug Diversion

A former Martinsburg, WV, VAMC registered nurse pled guilty to acquiring and obtaining a controlled substance by misrepresentation, fraud, forgery, deception, and subterfuge. An OIG and VA Police Service investigation revealed that on approximately 78 occasions, the defendant retrieved controlled medication from the facility's automated Pyxis medication dispensers using the names of VA patients whose electronic medical records indicated that they did not receive the medication.

Former Biloxi, Mississippi, VAMC Nurse Charged with Prescription Forgery

A former Biloxi, Mississippi, VAMC nurse was charged with prescription forgery. An OIG and State investigation revealed that the defendant used the names and personal identifying information of two Veterans from the VAMC to commit the fraud.

Former Boston, Massachusetts, VAMC Employee Sentenced for Possession of Controlled Substances

A former Boston, MA, VAMC employee was sentenced to 12 months' probation after pleading guilty to possession of controlled substances. An OIG and VA Police Service investigation determined that the defendant illegally used controlled substances while on duty at the VAMC. The employee resigned from VA as a result of the investigation.

Former Mountain Home, Tennessee, VAMC Nurse Sentenced for Drug Theft

A former Mountain Home, TN, VAMC nurse previously charged with obtaining controlled substances by fraud, deception, and subterfuge was sentenced to 36 months' probation and 50 hours' community service. An OIG and VA Police Service investigation determined that the defendant removed Dilaudid from a patient's intravenous solution.

Manchester, New Hampshire, VAMC Physician Pleads Guilty to Fraudulently Obtaining Controlled Substances

A Manchester, NH, VAMC physician pled guilty to fraudulently obtaining controlled substances. A VA OIG, DEA, and Office of Personnel Management (OPM) OIG investigation disclosed that from June 2010 to January 2011 the defendant wrote approximately 17 prescriptions totalling 68,760 milligrams (mg) for oxycodone and Oxycontin that were not documented in the medical records of one of his patients. Some of

these prescriptions were written for the patient after the defendant went out on workers' compensation leave. This was in addition to 82,800 mg of oxycodone and Oxycontin that the patient received from VA during the same time period. The patient admitted that he provided some of his narcotics to the defendant. As part of his plea agreement, the defendant agreed to surrender his DEA registration and never apply for another license number.

Alexandria, Louisiana, VAMC Nurse Arrested for Drug Diversion

An Alexandria, LA, VAMC registered nurse was arrested for obtaining prescriptions by fraud, identity theft, computer fraud, and forgery. An OIG and State police investigation revealed that the defendant ordered fraudulent controlled substance prescriptions in the Computerized Patient Record System for Veterans assigned to her care. The defendant then retrieved the controlled medication from the medical center pharmacy by misrepresenting herself as a family member of the Veterans and forged their names on the electronic signature pad. This resulted in the diversion of approximately 780 controlled substance tablets. The defendant was also charged with felony doctor shopping by the State police for an unrelated investigation.

Former Jamestown, New York, CBOC Registered Nurse Arrested for Drug Violations

A former Jamestown, New York, CBOC registered nurse was arrested after being indicted for unlawfully distributing oxycodone, obtaining oxycodone through fraud, forgery and subterfuge, and conspiring. An OIG, VA Police Service, and local police investigation revealed that on eight occasions between May and September 2010, the defendant stole prescription forms from a nurse practitioner at the VA clinic and forged the nurse practitioner's name on prescriptions for oxycodone. The prescriptions were subsequently filled by the defendant or others at a local pharmacy.

Former Temple, Texas, VAMC Mailroom Employee Indicted for Drug Theft

A former Temple, TX, VAMC mailroom employee was indicted for possession of stolen mail (prescription drugs) and theft of Government property. An OIG and VA Police Service investigation determined that the defendant removed the narcotics prior to transferring the packages to the U.S. Postal Service (USPS).

Former Cleveland, Ohio, VAMC Purchasing Agent and Equipment Provider Sentenced for Health Care Fraud

A former Cleveland, OH, VAMC purchasing agent was sentenced to 10 days' incarceration, 6 months' home confinement, 3 years' probation, and ordered to pay $110,581 in restitution after pleading guilty to conspiracy to commit health care fraud. Additionally, the owner of a durable medical equipment provider was sentenced to 3 months' incarceration, 6 months' home confinement, 2 years' supervised release, and ordered to pay $110,581 in restitution. An OIG investigation revealed that the former VA employee used her position to provide competitors' bid information to the medical equipment provider and inflate payments for services. In some instances, the medical equipment was not installed, either because the Veteran refused delivery or died prior to delivery of a ramp or ceiling lift. The company charged as if the equipment had been installed and then kept the unused equipment for a subsequent Veteran.

Former American Federation of Government Employees Union President Pleads Guilty to Theft of Union Funds

A former American Federation of Government Employees union president pled guilty to theft of union funds. An OIG and Department of Labor (DOL), Office of Labor Management Standards investigation revealed that the defendant, while serving as the president of the VA Hospital Workers Union at the New York, NY, VAMC, wrote approximately 187 checks to himself for $112,477 from the union's checking account.

Former Richmond, Virginia, VAMC Social Worker Indicted for Mail Fraud and False Statements

A former Richmond, VA, VAMC social worker was indicted for mail fraud and false statements. A VA OIG and DOL OIG investigation revealed that the defendant, beginning in June 2011, submitted approximately 380 fraudulent travel vouchers claiming reimbursements for taxi rides for physician and rehabilitation appointments. The false travel vouchers were related to two different injury compensation claims filed while the defendant was employed at the West Los Angeles, CA, VAMC. The loss to VA is approximately $44,000.

Former Pittsburgh, Pennsylvania, VAMC Agent Cashier Indicted for Theft

A former Pittsburgh, PA, VAMC agent cashier was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole $4,298 from her agent cashier drawer for personal use.

Former Birmingham, Alabama, VAMC Employee Sentenced for Purchase Card Fraud

A former Birmingham, AL, VAMC employee was sentenced to 1 month of incarceration, 4 months' home detention, 48 months' supervised release, and ordered to pay $6,215 in restitution. An OIG investigation revealed that for over 3 months the defendant misused Government purchase cards, accruing approximately $6,000 in charges for personal expenses, to include vacation and utility bills. The defendant falsely reported that the purchase cards were stolen and fraudulently used and as a result was reissued additional purchase cards.

Miami, Florida, VAMC Employee Sentenced for Credit Card Fraud

A Miami, FL, VAMC employee was sentenced to 24 months' and 1 day of incarceration. An OIG and U.S. Secret Service investigation revealed that the defendant used stolen credit card numbers and identities to make over $9,000 in online purchases from various retailers utilizing VA networks and computers.

Former Togus, Maine, VAMC Canteen Service Cashier Sentenced for Theft

A former Togus, ME, VAMC Canteen Service cashier was sentenced to 12 months' deferred prosecution, 40 hours' community service, a $300 fee, and ordered to pay $344 in restitution. An OIG and VA Police Service investigation, which included the use of a polygraph, determined that the defendant stole cash from the Canteen Service's retail store. The defendant subsequently resigned from VA.

Prescott, Arizona, VAMC Employee Indicted for Fraudulent Schemes

A Prescott, AZ, VAMC employee was indicted for fraudulent schemes and theft by converting services or property. An OIG investigation revealed that the defendant intentionally allowed time sensitive laboratory reagents to expire and then destroyed them because she did not want to complete the work involved in validating newly purchased lab equipment with these reagents. The loss to VA is approximately $50,000.

Lyons, New Jersey, VAMC Employee Arrested for Theft

A Lyons, NJ, VAMC employee was arrested for theft after a VA OIG, General Services Administration (GSA) OIG, and local prosecutor's office investigation determined that he was using the GSA Fleet card to purchase fuel for his personally owned vehicle. The investigation further determined that the defendant fueled his vehicle twice a week from June 2012 to February 2013. The loss to VA is approximately $7,500.

Former Cleveland, Ohio, VAMC Supervisor Sentenced for Trafficking in Counterfeit Goods

A former Cleveland, OH, VAMC supervisor, who was removed from VA employment pursuant to this investigation, was sentenced to 6 months' home detention, 3 years' probation, and ordered to pay $3,020 in restitution to Gucci after pleading guilty to trafficking in counterfeit goods and infringement of copyrighted works. An OIG and VA Police Service investigation revealed that the defendant solicited his employees to purchase counterfeit DVDs and copies of brand name purses on VA property during official duty hours. The

defendant admitted to the criminal activity in a sworn statement and a search of his vehicle resulted in the seizure of counterfeit items totaling $16,061.

Former Bay Pines, Florida, VAMC Employee Sentenced for Theft

A former Bay Pines, FL, VAMC employee was sentenced to time served, 36 months' probation, ordered to participate in a mental health and substance abuse program, reside at a Residential Reentry Center for a period of 6 months, and to pay VA $32,844 in restitution. The defendant had previously pled guilty to theft of Government funds and use and trafficking of unauthorized access devices affecting interstate commerce. An OIG investigation determined that the defendant stole a GSA fuel card and purchased and sold fuel using the card.

Veteran Sentenced for Drug Distribution at a Phoenix, Arizona, VA Clinic

A Veteran was sentenced to 10 years' incarceration after pleading guilty to possession of crystal methamphetamine with intent to sell. An OIG and local law enforcement investigation determined that the defendant sold crystal methamphetamine in the parking lot of a Phoenix, AZ, VA clinic. A subsequent search of the defendant's vehicle resulted in the seizure of crystal methamphetamine, a digital gram scale, and a drug ledger.

Four Defendants Sentenced for Prescription Fraud

Four defendants pled guilty and were sentenced up to 24 months' probation, $600 in fines, and 240 hours' community service for altering and using fraudulent VA oxycodone prescriptions. An OIG investigation revealed that one of the defendants, a Veteran, forged the signature and the DEA number of a VA CBOC contract nurse. The Veteran then conspired with the other defendants to create prescriptions using spurious names and addresses and then submitting them to various retail drug stores.

Veteran Sentenced for Drug Distribution

The last of six Veterans was sentenced to 15 months' incarceration after previously pleading guilty to distributing and conspiring to distribute controlled substances at the Bedford, MA, VAMC. These sentences followed an extensive 6-month OIG, VA Police Service, and DEA investigation into drug distribution at the medical center, a facility that has multiple services for substance abuse and addiction rehabilitation.

Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to theft of Government funds after receiving more than $12,000 in VA health care benefits that he was not entitled to receive. An OIG investigation revealed that the defendant provided VA with a fraudulent DD-214 falsely listing him as the recipient of a Purple Heart and other related decorations. Additionally, the defendant made claims in various Veteran circles about being identified in a book documenting combat experiences in Vietnam and went as far as claiming to be the main figure in a combat pictorial. In actuality, the defendant's true DD-214 revealed that he did not serve in combat and that he was discharged under Other Than Honorable conditions.

Veteran Indicted for Theft of Government Funds and False Statements

A Veteran was indicted for theft of Government funds and false statements. An OIG investigation determined that for approximately 3 years the defendant, who is also homeless, assumed the identity of a deceased Veteran in order to obtain medical treatment at four different VAMCs. In addition to obtaining medical care, the defendant also applied for and received VA pension benefits under the assumed identity. The defendant admitted to assuming the identity of the deceased Veteran and also stated that he would not be eligible to obtain

medical care from VA under his own name because he had an outstanding felony warrant. The loss to VA is in excess of $125,000.

Non-Veteran Arrested for Theft of Government Funds

A non-Veteran was arrested for theft of Government funds after an OIG investigation revealed that he fraudulently received VA health care. The investigation determined that the defendant never served in the U.S. Marine Corps and was previously unenrolled from the Naval Reserve Officer Training Corps. The defendant admitted to lying about being a combat Veteran and receiving injuries from an improvised explosive device while in Afghanistan in order to receive VA medical benefits. The defendant fraudulently received approximately $100,000 in VA medical care.

Veteran Indicted for Theft of Government Services

A Veteran, who was ineligible to receive VA benefits, was indicted for theft of Government services. An OIG investigation revealed that the defendant submitted a fraudulent DD-214 to VA and that from April 2009 to August 2012 he received extensive VA medical care and medication from various VAMCs. The loss to VA is approximately $307,000.

Veteran Sentenced for Health Care Fraud

A Veteran was sentenced to 366 days' incarceration, 36 months' probation, and ordered to pay VA $7,042 in restitution and "Vacations for Veterans" $2,093 in restitution. An OIG investigation revealed that the defendant submitted an altered DD-214 in order to fraudulently receive VA health care benefits from three different VAMCs. The defendant also submitted fraudulent documents to a VARO in an attempt to obtain unauthorized claims for various physical conditions. Further investigation revealed that the defendant received a donated vacation to Hawaii from a Veteran's charity by submitting fraudulent documents and by representing himself as a Purple Heart recipient with terminal cancer.

Grand Jury Indicts Nine Veterans for Filing False Mileage Claims with Dayton, Ohio, Medical Center

Nine Veterans were charged with theft and tampering with records. An OIG and VA Police Service investigation revealed that the defendants filed fraudulent travel vouchers at the Dayton, OH, VAMC in order to obtain travel benefits they were not entitled to receive. The loss to VA is approximately $56,000.

Veteran Pleads Guilty to Travel Benefit Fraud

A Veteran pled guilty to a criminal information charging him with filing false claims to VA for travel benefits. An OIG investigation disclosed that from June 2009 to February 2012, the defendant submitted 156 false travel claims reporting that he was driving to the Togus, ME, VAMC from locations that were over 300 miles roundtrip, when in actuality he resided only 3 miles away. The loss to VA is approximately $17,000.

Veteran Sentenced for Travel Benefit Fraud Against Ann Arbor, Michigan, VAMC

A Veteran, who previously pled guilty to theft of public money, was sentenced to 6 months' incarceration, 2 years' probation and ordered to pay $15,857 in restitution to the Ann Arbor, MI, VAMC. The jail sentence was suspended as long as the defendant maintains certain educational requirements. An OIG investigation revealed that the defendant submitted false claims in order to obtain travel reimbursement benefits that she was not entitled to receive.

Veteran Sentenced to Probation for Travel Benefit Fraud Against Albuquerque, New Mexico, VAMC

A Veteran was sentenced to 3 years' probation and ordered to pay VA $19,136 in restitution after pleading guilty to fraud. An OIG investigation determined that the defendant claimed that he was traveling 450 miles roundtrip to the Albuquerque, NM, VAMC, when in fact he did not possess a driver's license and was living within walking distance of the facility.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 21 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $14,333. An OIG investigation revealed that the defendant, who resided in Gainesville, FL, filed false travel claims for travel from St. Augustine, FL, to the Gainesville, FL, VAMC.

Veteran Indicted for Travel Benefit Fraud

A Veteran was arrested after being indicted for false statements and false claims. An OIG investigation revealed that for 16 months the defendant submitted fraudulent beneficiary travel claims to the White River Junction, VT, VAMC. The loss to VA is approximately $26,000.

Veteran Pleads Guilty to Travel Benefit Fraud

A Veteran pled guilty to theft of Government property after an OIG investigation revealed that from May 2005 to June 2011 he filed 126 fraudulent travel vouchers at the Boise, ID, VAMC. The defendant claimed VA beneficiary travel from multiple states, when in actuality he resided less than 3 miles from the VAMC. The loss to VA is $10,641.

Veteran Sentenced for Travel Benefit Fraud Against Seattle, Washington, VAMC

A Veteran was sentenced to 24 months' incarceration for false claims and conspiracy to defraud VA. The defendant was one of nine Veterans and two VA travel clerks who participated in a conspiracy to defraud VA by submitting hundreds of inflated and fictitious travel benefit vouchers to the Seattle, WA, VAMC. Kickbacks were paid by the Veterans to the VA travel clerks who processed the vouchers. This defendant also participated in the collection of kickback payments from other Veterans involved in the scheme. The estimated loss is in excess of $160,000.

Veterans Benefits Administration Investigations

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

OIG's Information Technology and Data Analysis Division, in coordination with the Office of Investigations, conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. Since the inception of the Death Match project in 2000, OIG has identified 16,660 possible cases with over 3,189 investigative cases opened.

Investigations have resulted in the actual recovery of $68.5 million, with an additional $22.8 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $155 million. To date, there have been 618 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 191 investigations, made 70 arrests, and had a monetary impact of over $8.1 million in fines, restitution, penalties, and civil judgments as well as more than $10.2 million in savings, efficiencies, cost avoidance, and recoveries during this reporting period. These investigations involved the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. One hundred and fifty-nine cases were opened during this period and various criminal charges were filed against 48 defendants for these types of investigations. OIG obtained over $7.3 million in court ordered payment of fines, restitution, and penalties and also achieved an additional $9.3 million in savings, efficiencies, cost avoidance, and recoveries. The following entries provide a representative sample of the type of VBA investigations conducted during this reporting period.

Fiduciary Sentenced for Theft

An attorney was sentenced to 46 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $2,352,107 to VA and $282,112 to the Internal Revenue Service (IRS). An OIG investigation revealed that the attorney, who served as a court-appointed guardian and Federal fiduciary for 54 Veterans, conspired with his wife to steal from the Veterans' bank accounts and failed to report the income on their Federal tax returns. The defendant's wife previously received the same sentence for her involvement in the conspiracy.

Former Fiduciary Pleads Guilty to Theft of Government Funds

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

Former Fiduciary Pleads Guilty to Theft

A former fiduciary pled guilty to theft of public funds. An OIG investigation revealed that the defendant embezzled funds from the accounts of various Veterans. The defendant withheld the Veterans' funds from deposits or wrote checks to himself from the Veterans' accounts. The loss in VA funds is $236,204.

Former Fiduciary Sentenced for Misappropriation

A former VA fiduciary was sentenced to 24 months' incarceration and ordered to pay $121,424 in restitution after pleading guilty to misappropriation by a fiduciary. An OIG investigation determined that the defendant began embezzling VA funds from a Veteran within a few months of becoming a fiduciary, during a time when the Veteran was undergoing dialysis treatments. The defendant failed to pay or provide for the Veteran's living expenses in a timely manner and used the funds for his own personal use. Unfortunately the Veteran died during the course of the investigation.

Fiduciary Pleads Guilty to Theft of Veteran's Benefits

A VA-appointed fiduciary pled guilty to the misapplication of fiduciary property of the elderly. An OIG investigation revealed that the defendant misappropriated $23,930 in VA benefits intended for the Veteran.

The defendant's failure to pay for the Veteran's medical expenses also resulted in the Veteran's being refused admission to a nursing home and denial of medical care.

Fiduciary Indicted for Misappropriation

A VA-appointed fiduciary was indicted for misappropriation by a fiduciary. An OIG investigation revealed the defendant misappropriated $35,000 in VA benefits intended for the Veteran and used the funds for personal expenses.

Former Legal Assistant Sentenced for Embezzlement

A former legal assistant working at a law firm was sentenced to 4 months' incarceration, 8 months' home confinement, 60 months' probation, and ordered to pay $20,377 in restitution. An OIG investigation revealed that the defendant embezzled funds from 19 Veteran fiduciary accounts. In an effort to conceal the embezzlement from VA, the defendant submitted falsified accountings to her fiduciary firm. The loss to VA is $25,377.

Former Fiduciary Sentenced for Theft of Government Benefits

A former VA fiduciary was sentenced to a minimum 6 months' court supervised sobriety program and ordered to pay $83,652 in restitution after pleading guilty to theft of Government funds. A VA OIG and SSA OIG investigation determined that from April 2005 to September 2009 the defendant, who was acting as his brother's fiduciary, embezzled VA and SSA benefits for his personal use.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 5 years' probation and ordered to pay VA $68,358 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant continued to receive and negotiate VA benefit checks as the VA-appointed fiduciary for a Veteran who died in October 2009.

New Hampshire Fiduciary Sentenced to Prison and Fined $55K for Embezzling Funds from Disabled Veterans

The former estate manager of a nonprofit corporation, who was also a VA fiduciary, was sentenced to 13 months' incarceration, 3 years' supervised release, and ordered to pay approximately $55,000 in restitution. A VA OIG, SSA OIG, and local law enforcement investigation revealed that the defendant embezzled funds from 23 victims, including 3 disabled Veterans, by creating a payee code that issued checks to the defendant and by purchasing gift cards at retail stores. After discovering discrepancies in the victims' accounts, the nonprofit corporation took prompt action to terminate the employee, notify authorities, and reimburse the victims.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 1 year of incarceration, 9 years' probation, and ordered to pay $26,083 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant embezzled benefits from a VA beneficiary and used the funds for his personal use.

Nine Veterans Indicted for VA Compensation Fraud

A retired Maryland Department of Veterans Affairs State employee and eight other Veterans, to include a retired Baltimore VARO employee, were indicted for wire fraud and Hobbs Act violations. From 2003 to 2011, while working at the Maryland Department of Veterans Affairs, the State employee created fraudulent doctor's notes and amendment forms, commonly referred to as DD-215s, as part of claims for service-connected disability. 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 the Veterans had been diagnosed with

diabetes and were insulin dependent. The fraudulent DD-215s were used as proof of service in Vietnam. The State employee also filed a fraudulent DD-215 form to increase his own rating for post-traumatic stress disorder (PTSD). Seventeen 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 Theft of Government Funds

A Veteran was sentenced to 60 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $893,739 after pleading guilty to the theft of Government funds. The defendant, who was treated by VA for numerous ailments, claimed to be wheelchair bound and required the need of an aide. The defendant gave various fabricated accounts to neighbors, the media, and VA staff on how his injury occurred, including being a U.S. Navy SEAL wounded during Operation Desert Storm, being injured during hand-to-hand combat training, falling down steps, and being shot by friendly fire while at Ft. Bragg. The investigation also revealed that while the defendant reported to VA that he was not ambulatory, he completed the North Carolina Basic Law Enforcement Training program and later held jobs as a police officer and a child protective services officer.

Veteran Pleads Guilty to VA Compensation Fraud

A Veteran pled guilty to aggravated misappropriation, misrepresentation, fraud, and possession and transfer of false documents and was sentenced to time served, ordered to pay $652,652 in restitution, and to serve probation until he repays the full restitution amount, including a provision that the defendant is to spend 1 day in jail for each instance of non-payment to VA. An OIG Benefits Inspection and subsequent investigation revealed that the defendant fraudulently received both VA compensation and pension benefits based upon multiple fraudulent enlistments in the U.S. Army and a fraudulent Social Security card. This case is the OIG's first prosecution and conviction in the Commonwealth of Puerto Rico after securing legal standing from Puerto Rico's Attorney General. The OIG became the first Federal Law Enforcement Agency to be authorized to present criminal cases directly to the Commonwealth Attorney for prosecution.

Veteran Pleads Guilty to Making False Statements

A Veteran pled guilty to a criminal information for willfully making false statements relating to his VA benefits. The defendant, who received more than $7,000 per month in VA compensation benefits, reported to VA that he had no use of his upper or lower extremities, required assistance with daily activities, and required prosthetic aids. An OIG investigation determined that the defendant could walk and drive a vehicle without any assistance and only used his VA-issued electric scooter while attending VA medical appointments. The loss to VA is approximately $510,000.

Veteran Convicted of Fraud

A Veteran was found guilty at trial of mail fraud, wire fraud, false statements, and workers' compensation fraud against VA and the U.S. Navy. An OIG and Naval Criminal Investigative Service investigation revealed that since 2005 the Veteran received over $400,000 in fraudulent VA individual unemployability benefits and DOL workers' compensation benefits by claiming dual compensation for an on-the-job injury and by failing to disclose to VA that he was in receipt of Office of Workers' Compensation Program benefits. Additionally, while receiving both benefits the Veteran was managing a successful landscaping business. The loss to VA is over $143,000.

Judge Gives New York Man 2 Years' Probation for Altering DD-214 and Falsely Claiming Purple Heart in Attempt To Get VA Benefits

A former Canandaigua, NY, VAMC employee was sentenced to 24 months' probation. An OIG investigation revealed that the defendant submitted a fraudulent Purple Heart certificate and altered medical notes, military documents, and a discharge certificate in order to fraudulently increase his VA compensation benefits.

Veteran Indicted for VA Compensation Fraud

A Veteran receiving VA disability compensation was indicted for theft after an investigation by OIG and FBI revealed that he received a special monthly compensation by fraudulently claiming the loss of the use of his feet. The loss to VA is $61,686.

Veteran Indicted for Theft of Government Funds and False Statements

A Veteran was indicted for theft of Government funds and false statements. An OIG investigation revealed that for several years the defendant concealed his income from VA. Due to his alleged severe disabilities, the defendant received aid and attendance and his wife was appointed as his VA fiduciary. The defendant was rated as permanently and totally disabled and having no income. In actuality, the defendant was employed as a pastor at different churches, worked as a handyman, and drove a race car in a stock car race. The loss to VA is approximately $254,000.

Veteran Indicted for Theft of Government Funds

A Veteran was indicted and arrested for theft of Government funds, workers' compensation fraud, and false statements. The VA rated the defendant as 100 percent service-disabled for PTSD, fibromyalgia, and back issues after reporting that he was socially isolated, could not tolerate crowded areas, lift heavy objects, and was unable to function in society. A VA OIG, U.S. Postal Service OIG, and DOL OIG investigation revealed that during this time the defendant coached youth sports, participated in events, bred and sold dogs for profit, and lifted heavy objects. The loss to VA is approximately $51,000 and the loss to the U.S. Postal Service is in excess of $288,000.

Veteran Indicted on Multiple Charges

A Veteran was indicted and arrested for interstate threats against VA employees, theft of Government funds, false impersonation of an officer or employee of the United States, and smuggling night vision goggles from the United States. The defendant was rated 100 percent service-disabled for PTSD, back and neck issues, and chronic obstructive pulmonary disease (COPD). An OIG, Defense Criminal Investigative Service, and Immigration and Customs Enforcement (ICE) investigation revealed that the defendant submitted a fraudulent DD-214 to VA, misrepresented his true level of functioning, impersonated military personnel, participated in civilian-contracted military exercises, taught martial arts, and illegally bought and sold military-grade lasers overseas. The loss to VA is approximately $120,000.

Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to theft of Government funds after an OIG investigation disclosed that he made false statements in order to fraudulently obtain VA disability benefits. From 2000 to 2012 the defendant received VA compensation payments for panic disorder with agoraphobia, a back injury, and aid and attendance. The defendant admitted that he defrauded VA by exaggerating his disabilities and lying about his ability to work. The loss to VA is approximately $329,000.

Veteran and Spouse Plead Guilty to Theft of Government Funds

A Veteran and his spouse pled guilty to conspiracy, false statements, theft of Government funds, and SSA fraud and were subsequently sentenced to 30 months' and 20 months' incarceration, respectively. The defendants were also ordered to pay $326,390 in restitution to VA and SSA and were required to forfeit $78,804 in funds that were previously seized from their bank account. A VA OIG, SSA OIG, FBI, and U.S. Air Force investigation revealed that the defendants conspired to fraudulently obtain benefits from VA and SSA by providing numerous false statements and forged documents which reflected that the Veteran had participated in Special Operations combat duty in Vietnam and Iran while he was a member of the U.S. Air Force.

Veteran Sentenced for Making False Statements

A Veteran was sentenced to 60 months' probation, 90 days' home detention, 100 hours' community service, a $2,000 fine, and ordered to pay $51,237 in restitution after pleading guilty to making false statements. A VA OIG and Department of Transportation OIG investigation revealed that while the defendant was receiving COPD benefits from VA, he was reporting to the Federal Aviation Administration (FAA) that he was not diagnosed with a lung disease. During several VA medical exams, the defendant failed to fully cooperate during his Pulmonary Function Tests in order to continue to fraudulently receive VA COPD benefits. The defendant subsequently cooperated fully during an FAA Pulmonary Function Test to provide proof that he did not have COPD. The defendant's VA COPD benefits were terminated.

Veteran Sentenced for VA Pension Beneficiary Fraud

A Veteran was sentenced to 5 years' probation and ordered to pay VA $177,108 in restitution. An OIG investigation revealed that the defendant and his live-in girlfriend structured their business in the girlfriend's name to hide the defendant's income in order to qualify for VA pension benefits. Accordingly, the Veteran and his girlfriend operated the business for over 8 years while the Veteran received VA pension benefits and co-pay exempt VA health care. The defendant is also being charged in a separate case with delivery of a controlled substance for selling his VA-prescribed morphine tablets.

Veteran's Widow Sentenced for Theft of VA Benefits

A widow receiving Dependency and Indemnity Compensation (DIC) was sentenced to 4 years' probation, with the first 10 months to be served in home confinement, and ordered to pay $188,546 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA that she remarried 19 years ago.

Wife of Deceased Veteran Arrested for Failure to Report Remarriage

The wife of a deceased Veteran was indicted and subsequently arrested for falsifying VA documentation. An OIG investigation determined that the defendant failed to report her remarriage in 1978 to VA in order to continue to receive benefits she was no longer entitled to receive. The loss to VA is approximately $308,000.

Nephew of DIC Beneficiary Forges and Negotiates Erroneously Issued VA Benefit Check

The nephew of a deceased DIC beneficiary was indicted for theft of Government funds. An OIG and U.S. Secret Service investigation revealed that the defendant received, forged, and negotiated three VA benefit checks that were issued after the beneficiary's death in January 2010 and converted the funds for his own personal use. The largest of the checks was for $122,636 and was issued in error by VA. The total loss to VA is $124,994.

Daughter of a Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation determined the defendant withdrew the VA benefits from a joint bank account after her mother's death in May 2007. The loss to VA is $63,300.

Granddaughter of Deceased Beneficiary Sentenced for Theft of VA Funds

The granddaughter of a deceased beneficiary was sentenced to 33 months' incarceration, 36 months' supervised release, and ordered to pay $222,641 in restitution after pleading guilty to theft of Government funds, wire fraud, and Social Security fraud. A VA OIG, OPM OIG, Housing and Urban Development (HUD) OIG, U.S. Secret Service, and SSA OIG investigation revealed that the defendant stole VA benefits and OPM retirement payments after her grandmother's death in April 1986. Also, the defendant failed to notify Social Security and a public housing authority of her illicit income in order to receive additional benefits.

Son of Deceased Beneficiary Sentenced for Theft of VA Benefits

The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG and FBI investigation revealed that the defendant stole VA benefits that were direct deposited to a joint bank account after his father's death in March 2006. The defendant used the stolen funds for personal use. The loss to VA is $202,662.

Daughter of Deceased Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased beneficiary was arrested after being indicted for theft of Government funds. A VA OIG and SSA OIG investigation determined that the defendant stole $68,086 in VA benefits and $120,332 in SSA benefits that were direct deposited into her mother's account after her mother's death in April 2003. The defendant admitted to using the stolen funds for personal use.

Son of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The son of a deceased VA beneficiary pled guilty to a criminal information charging him with theft of Government funds. The defendant admitted to disguising his voice in an attempt to sound like his mother when he was contacted by phone by a Veterans Service Representative regarding an address change he fraudulently submitted to VA. The defendant also admitted to stealing the VA benefits that were direct deposited to his mother's account after her death in November 2003. The loss to VA is $107,848.

Daughter of Deceased Beneficiary Sentenced for Theft

The daughter of a deceased VA and SSA beneficiary was sentenced to 366 days' incarceration, 2 years' supervised release, and ordered to pay $177,694 in restitution after pleading guilty to conspiracy, theft, and false statements. A VA OIG and SSA OIG investigation revealed that the defendant provided false statements to VA and SSA after her mother's death in July 2002 and then continued to receive, forge, and negotiate her deceased mother's benefit checks. The loss to VA is $119,642.

Other Investigations

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened 25 cases, made 5 arrests, and obtained over $563.5 million in fines, restitution, penalties, and civil judgments. The monetary impact includes $500 million in a fine resulting from an investigative case brought against Abbott Laboratories under the qui tam provisions of the *False Claims Act*, P.L. 111-148.

OIG also investigates theft of IT equipment or data, network intrusions, and child pornography. In the area of information management crimes, OIG opened two cases, made one arrest, and achieved $1,400 in savings, efficiencies, cost avoidance, and recoveries.

Phony War Hero Gets 7 Years in Prison for Scheme To Get Government Contracts Meant for Veterans

A Veteran was sentenced to 87 months' incarceration and a personal forfeiture of $6,836,278 after pleading guilty to conspiracy to commit fraud against the United States, major program fraud, wire fraud, money laundering, conspiracy, and false statements. The Veteran, who owns a construction company, falsely claimed to be a service-disabled and highly decorated war Veteran in order to qualify for contracts set aside for businesses owned by service-disabled Veterans. A VA OIG, GSA OIG, Small Business Administration (SBA) OIG, and Department of Defense (DoD) investigation revealed that the defendant received over $6.7 million in contracts from VA and over $748,000 in contracts from DoD awarded under the Service-Disabled Veteran-Owned Small Business (SDVOSB) program. The defendant claimed service in Vietnam and that he was awarded three Silver Stars, three Purple Heart Medals, and numerous other citations. Federal and State records report that the defendant served in the National Guard from 1963 to 1968, with 6 months' service on active duty, and that he never left the State of Missouri. Three co-defendants are awaiting trial.

Non-Veteran Indicted for SDVOSB Fraud

A non-Veteran owner of an SDVOSB was indicted for conspiracy to defraud the United States and wire fraud. A VA OIG, SBA OIG, GSA OIG, and U.S. Army Criminal Investigations Division (CID) investigation revealed that from late 2005 to November 2010 the defendant fraudulently represented that a company he owned was an SDVOSB in order to qualify for and obtain Government contracts from VA, GSA, the U.S. Army, and the U.S. Navy. The defendant utilized disabled Veterans to serve nominally as president and majority owners of the SDVOSB. However, the defendant actually operated the company since 2006. As a result of this scheme, the SDVOSB received over $100 million in payments from VA.

VA Contractor Pleads Guilty in SDVOSB Fraud

A VA contractor was arrested and subsequently pled guilty to conspiracy to commit wire fraud. A VA OIG, GSA OIG, SBA OIG, DOL OIG, and U.S. Army CID investigation revealed that the defendant submitted statements to VA, SBA, and other Government agencies falsely representing that he, a minority and service-disabled Veteran, owned and managed the daily operations of the business in order to get Federal government contract awards that were set aside for, or preferentially awarded to, disadvantaged minority and service-disabled Veteran-owned and operated small businesses. A co-conspirator was previously convicted for his involvement in the scheme.

Veteran Sentenced for SDVOSB Fraud

A Veteran was sentenced to 100 hours' community service at a Veterans' service organization, 5 years' probation, and fined $206,844 after pleading guilty to making false statements for representing his company as an SDVOSB. An OIG investigation revealed that the defendant submitted claims to VBA for a service-connected disability in 1969 and 2009 and was denied service connection for each of his claims. The defendant fraudulently certified his company as an SDVOSB, and VA awarded approximately $5,849,000 in SDVOSB set-aside contracts to the company between August 2009 and March 2011. Approximately $3,571,000 of the contract awards were funded with *American Reinvestment and Recovery Act of 2009* (ARRA) funds.

New York Men Face 10 Years in Prison if Convicted for Pretending To Be Disabled Veterans To Receive Set-Aside VA Contracts

Two contractors were arrested for committing major fraud against the United States. An OIG and FBI investigation revealed that the two defendants, who owned and operated a separate non SDVOSB construction company, used the service-disabled Veteran status of a relative to bid on and be awarded Government contracts through a second company. Because of the scheme, the defendants were awarded contracts valued at over $13 million.

Veteran Indicted for SDVOSB Fraud

A Veteran was indicted for wire fraud and aggravated identity theft after a VA OIG and SBA OIG investigation revealed that, in order to obtain VA contracts for architectural and engineering services, he fraudulently claimed to be the owner of an SDVOSB. The defendant had been discharged from the Navy with a pre-existing condition, after which he filed for and was denied VA benefits. When his company was scheduled for an onsite review to verify his company as an SDVOSB, the defendant again filed for and was denied VA benefits. Because of his fraudulent actions, the company was paid over $1.4 million, approximately $156,500 of which was funded with ARRA funds.

Former USPS Supervisor and Employee Plead Guilty to Theft of $2.8 Million in U.S. Treasury Checks from Atlanta Mail Facility

A former USPS supervisor and employee pled guilty to theft of Government money and possession of stolen U.S. Treasury checks. A joint VA OIG, U.S. Secret Service, SSA OIG, USPS OIG, USPS Inspection Service (USPIS), and Georgia Department of Revenue investigation revealed the defendants stole 1,300 U.S. Treasury checks worth $2.8 million while employed at an Atlanta mail distribution facility. The defendants subsequently provided them to a network of brokers and check cashers (other co-defendants) who negotiated the checks and split the proceeds with the defendants. A search of one defendant's residence resulted in the recovery of 661 recently stolen U.S. Treasury checks, which included 9 VA benefit checks, totaling over $590,000. The 2 defendants are believed to be the source of all the stolen checks, which has led to the subsequent arrest of 11 additional defendants.

Physician's Assistant Pleads Guilty to Health Care Fraud

A physician's assistant pled guilty to health care fraud. An OIG investigation revealed that a physician's assistant, his wife, and a physician serving as the medical director were contracted to conduct disability rating examinations of Veterans. The contract with VA stipulated that the physician was to perform all disability rating examinations conducted at the clinic. The investigation disclosed that the physician's assistant conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008. The physician's assistant forged the doctor's signature on all of the reports and then submitted the reports and false claims to VA for payment. This investigation originated under the qui tam provisions of the *False Claims Act*, and civil action is still pending. The loss to VA is $154,872.

Mortgage Broker Sentenced for Loan Guaranty Fraud

A mortgage broker was sentenced to 10 years' incarceration after pleading guilty to engaging in organized criminal activity. An OIG and local investigation revealed that the defendant conspired with a loan officer and a realtor to defraud the VA Home Loan Guaranty Program on the purchase of a residential property valued at $416,772. The realtor, who is also a Veteran, previously pled guilty to a charge of false statements and received a 10-year suspended sentence in return for his cooperation and testimony against the mortgage broker. The loan officer involved in this investigation was indicted on other unrelated charges.

Non-Veteran Arrested for Loan Fraud

A non-Veteran was indicted and arrested for conspiracy, mail fraud, wire fraud, and bank fraud. An OIG and FBI investigation determined that the defendant provided down payments to multiple buyers during real estate closings in the form of gift funds 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 buyers' credit score and allowed them to qualify for mortgages. Thirteen loans were identified in the scheme, including a VA-guaranteed home loan. The potential loss to VA should this guaranteed VA home loan default is about $152,203.

Veteran Charged with VA Home Loan Fraud

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

Subject Sentenced for Making False Statements

A defendant was sentenced to 27 months' incarceration, 5 years' supervised release, and ordered to pay $544,602 in restitution ($48,754 to VA) after pleading guilty to false statements relating to a credit application. A VA OIG and HUD OIG investigation revealed that the defendant purported to buy over 50 properties from distressed homeowners "subject to" the underlying mortgage. The defendant then "sold" the homes to individuals with poor credit, little or no assets, and weak work histories. To obtain down payments, the defendant filed Federal income tax returns for buyers to receive first time homebuyer refunds and later demanded kickbacks from the buyers.

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

A former West Los Angeles, CA, VAMC employee was found guilty at trial of possession of child pornography and was sentenced to 9 years' incarceration, followed by a lifetime of supervised release. The defendant previously pled guilty to the sexual abuse of his daughter in his apartment, which was located at the Hines, IL, VAMC.

Veteran Sentenced for Possession of Child Pornography

A Veteran was sentenced to 204 months' incarceration, 10 years' supervised release, and a $1,200 fine after pleading guilty to possession of child pornography. An OIG and ICE investigation revealed that the Veteran was storing and sending child pornography through the Internet using VA computers.

Veteran Sentenced for Possession of Child Pornography at Phoenix, Arizona, VAMC

A Veteran was sentenced to 57 months' incarceration and lifetime probation after pleading guilty to possession of child pornography. An OIG investigation revealed that the defendant was viewing child pornography on his personal laptop computer in his hospital room at the Phoenix, AZ, VAMC. A search warrant and subsequent forensic examination of the defendant's laptop and related memory card devices identified approximately 110 digital images and 77 digital videos depicting child pornography.

Former New Mexico Clinic Contract Employee Pleads Guilty to Possession of Child Pornography

A former VA contract employee pled guilty to possession of child pornography. An OIG investigation determined that the defendant accessed internet websites containing images of child pornography and then saved the images to his VA-issued computers while working at two VA clinics in New Mexico. The defendant remains in custody pending sentencing.

Veteran Indicted for Possession of Child Pornography at Dayton, Ohio, VAMC

A Veteran was arrested after being indicted for possession of child pornography. An OIG investigation determined that the defendant viewed sexually explicit images of minor children while a patient at the Dayton, OH, VAMC. The defendant had the material on a removable computer storage device and viewed the images in a computer room available to patients at the VAMC. The defendant was previously convicted of possessing child pornography in 2003.

Non-Veteran Arrested for Identity Theft

A non-Veteran was indicted and subsequently arrested for aggravated identity theft, wire fraud, filing false claims, and theft of Government funds. An OIG, IRS Criminal Investigation Division, and local police investigation revealed that the defendant used Veterans' personal identifying information obtained from stolen VA medical records and other individuals' information to file fraudulent tax returns. The defendant received approximately $160,000 in fraudulent refunds and attempted to file approximately $350,000 in additional fraudulent returns. The defendant in this investigation is also the subject of an unrelated statewide shoplifting ring. During a consent search, a significant amount of stolen property was recovered. Racketeering charges are now being considered.

Former Home Health Aide Indicted for Identity Theft

The former home health aide of a disabled Veteran was indicted for identity theft, exploitation of the elderly and disabled, theft by taking, and theft by deception. An OIG investigation revealed that the defendant stole the Veteran's personal and financial information while acting as a caregiver. Using the Veteran's information, the defendant subsequently contacted VA and redirected the Veteran's VA compensation benefits. To further the scheme, the defendant applied for and received several prepaid debit cards in the Veteran's name and used the prepaid debit cards for his personal use. The loss to VA is approximately $17,900.

Veteran Indicted for Identity Theft

A superseding indictment was filed charging a Veteran with possession of child pornography, failure to register as a sex offender, false statements in order to acquire a firearm, health care fraud, and aggravated identity theft, in addition to the original charges of fraudulently obtaining a U.S. passport and possessing firearms as a convicted felon. An OIG investigation revealed that the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity for the past 7 years and used the false identity to obtain a U.S. passport, purchase firearms, vote, obtain employment, and obtain VA-funded medical care through the VA fee basis program. A computer analysis conducted by OIG's Computer Forensics Laboratory identified child pornography linked to the defendant. The defendant continues to be detained.

Non-Veteran Arrested for Identity Theft

A non–Veteran was arrested for the criminal use of a personal identification, fraudulently obtaining goods or services from a health care provider, and organized scheme to defraud. An OIG, VA Police Service, and local police investigation revealed that the defendant stole a Veteran's identity in order to fraudulently receive approximately $19,000 in VA medical care and services.

Veteran Charged with Defrauding the VA Grant and Per Diem Program

A Veteran, purporting to be an advocate for homeless Veterans, was charged in a criminal information with theft of public funds and making false statements. An OIG investigation revealed that the defendant founded a company with a stated purpose of providing training, transportation, and housing for homeless Veterans in the Nashville, TN, area. The defendant provided false information in her applications submitted to the VA Grant and Per Diem Program; subsequently obtained the grants; and then diverted the majority of the VA funds to her own personal use, to include vacation trips to gambling establishments. The defendant improperly obtained $360,600 as part of the grant fraud scheme.

Veteran Pleads Guilty to Mail Fraud

A Veteran pled guilty to mail fraud after fraudulently receiving advanced VA education payments under the Post 9/11 GI Bill. An OIG investigation revealed that the defendant, while on active duty, obtained a personnel roster that contained personally identifiable information of other service members. After being discharged from the service, the defendant used the identities of six Veterans to request advanced VA education payments. The Veteran had the checks, in the names of other Veterans, mailed to her address and created false powers of attorney in order to negotiate the checks. The loss to VA is $18,000.

Veteran Caretakers Arrested for Theft of Government Funds

Three former Veteran caretakers were indicted and subsequently arrested for conspiracy and theft of Government funds. An OIG and USPIS investigation revealed that the defendants applied and received VA pension benefits without the knowledge of a Veteran while he resided in their personal care home. From August 2003 to October 2010, the defendants used a post office box to receive and negotiate all of the Veteran's VA benefit checks. The approximate loss to VA is $123,000.

Former Health Care Worker Indicted for Diverting Drugs

A former health care worker, who provided contract services to VA in 2008, was indicted for possession of a controlled substance by fraud and tampering with consumer products with reckless disregard. A multi-agency investigation revealed that the defendant stole syringes filled with the narcotic painkiller fentanyl, which were prepared and intended for patients scheduled to undergo medical procedures, and replaced them with syringes he had previously stolen and filled with saline. The defendant, who was infected with Hepatitis C, used the stolen syringes to inject himself, causing them to become tainted. As a result, over 30 patients became infected with Hepatitis C, including three Veterans. Two of the Veterans were exposed to the defendant during procedures at a private hospital and one during a procedure at a VAMC.

Former VA Community Residential Care Home Employee Arrested for Drug Diversion

A former VA community residential care home employee was arrested for diversion of a controlled substance. An OIG investigation revealed that the defendant illicitly obtained clonazepam from several Veterans living at the home and that she attempted to conceal the theft by replacing the stolen clonazepam with over-the-counter pills. This case was initiated when it was discovered that several Veterans were going to be short on their monthly VA prescription medication supply.

USPS Employee Pleads Guilty to Theft of VA Drugs

A USPS employee pled guilty to theft of Government mail by an employee. An OIG and USPS OIG investigation revealed that between June 2011 and April 2012 the defendant stole approximately 18 VA shipments of controlled narcotics.

USPS Carrier Arrested for Drug Possession

A USPS carrier was arrested for drug possession charges after she confessed to stealing numerous packages of controlled VA medications. A VA OIG, USPS OIG, and local law enforcement investigation revealed that for approximately 1 year the defendant stole packages intended for five different Veterans in a rural section of North Carolina. A search of the defendant's residence resulted in the discovery of VA parcel packaging, pill bottles, and controlled medication.

Physical Therapist Pleads Guilty to Obstruction of a Health Care Audit

A physical therapist providing fee basis service to VA and other Government beneficiaries pled guilty to a criminal information charging him with obstruction of a health care audit. A VA OIG, Health and Human Services OIG, and FBI investigation revealed that the defendant deliberately obstructed a Medicare/Medicaid audit in order to hide the fact that he was billing for services not provided by licensed physical therapists and that he was not documenting treatment provided to his patients.

Defendant Sentenced for Burglary at the Cleveland, Ohio, VAMC

A defendant was sentenced to 7 years' incarceration after pleading guilty to burglary. An OIG and VA Police Service investigation revealed that the defendant, who had a long history of violent criminal activity, committed the burglary in the room of a paraplegic Veteran at the Cleveland, OH, VAMC Spinal Cord Injury Unit. The burglary occurred during the night while the Veteran was sleeping in the room.

Contract Employee Sentenced for Theft of Firearm at San Joaquin Valley National Cemetery, Santa Nella, California

An employee, working for a VA contractor at the San Joaquin Valley National Cemetery in Santa Nella, CA, was sentenced to 180 days' incarceration and 36 months' probation after pleading guilty to theft of a firearm. An OIG and local sheriff's office investigation revealed that the defendant stole an M-14 rifle that had been left at the cemetery by a California National Guard soldier after a burial service. The weapon was recovered.

Cousin of Disabled Veteran Arrested for Theft

The cousin of a disabled Veteran was arrested for elder abuse, grand theft, forgery, and burglary. An OIG investigation revealed that the defendant stole his cousin's checkbook from his room at the Livermore VAMC CLC in Livermore, CA, and then forged and negotiated several checks. The loss to the Veteran is over $20,000.

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 12 and closed 11 administrative investigations. The Division investigated 32 allegations, 13 of which were substantiated. This work resulted in the issuance of two final reports containing six recommendations for administrative or corrective action.

The Administrative Investigations Division issues advisory memoranda when an allegation has been substantiated and VA needs to take some action, but where the violation does not rise to the level of a formal recommendation. The Division also issues administrative memoranda in cases where one or more of the allegations were not substantiated. During this reporting period, the Administrative Investigations Division issued five advisory memorandums and nine administrative memorandums. OIG also obtained $1,816 in dollar recoveries.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 48 criminal investigations resulting from assaults and threats made against VA facilities and employees. Thirty-five defendants were charged with related charges as a result of the investigations. OIG investigative work resulted in the following:

- A Veteran was arrested for sexual battery of a Topeka, KS, VAMC contract employee. An OIG and local police investigation revealed that the defendant sexually assaulted the female employee during a medical appointment. The defendant confessed to touching the employee without her consent.
- A Veteran was arrested for sexually assaulting a VA employee at the Manchester, NH, VAMC. An OIG, VA Police Service, and local police investigation revealed that the defendant grabbed the employee in the groin area while at the employee's desk. The victim was subsequently absent from work because she felt frightened by the incident.
- An inpatient at the Northampton, MA, VAMC was arrested for assaulting a VA employee. An OIG and VA Police Service investigation revealed that the defendant punched the victim in the head several times and bit the employee on the side of the neck. The employee required medical treatment.
- A Veteran pled guilty to the assault of a Lyons, NJ, VAMC police officer. An OIG investigation revealed that the Veteran, while an inpatient at the VAMC, assaulted VA police officers on multiple occasions while officers were responding to several different medical assistance calls. The defendant was held without bail since his arrest in July 2012 due to his assaultive behavior towards the judge, prosecutor, and U.S. Marshals during his initial appearance. The defendant was remanded to the custody of State officials for parole violations while he awaits sentencing.
- A Veteran was arrested by OIG and the FBI after threatening to kill a Major General of the U.S. Army National Guard. During a compensation and pension appointment with a VAMC psychologist, the defendant discussed a detailed plan to assassinate the Major General at a retirement ceremony. The Veteran is currently being held without bond pending trial.
- A Veteran was arrested for making threats after an OIG, Federal Protective Service (FPS), and local police investigation revealed that he threatened to shoot a vocational rehabilitation counselor at the Montgomery, AL, VARO. The defendant made the threat after being told that the counselor needed to review his file and that he needed a "Plan of Service" before the counselor could authorize a computer software purchase.
- A Veteran was arrested and subsequently indicted for intimidating a Federal employee engaged in his official duties. An OIG and local sheriff's office investigation revealed that the defendant threatened to return to the Montgomery, AL, VAMC and kill a VA physician and everyone else who entered the medical center. During a search incident, OIG agents and the local officers seized a rifle, shotgun, and two handguns.
- A Veteran was arrested after an OIG and local police investigation determined that during a telephone conversation with a Dothan, AL, CBOC employee, the Veteran threatened to use his handgun to kill the employee along with 42 other people. The initial law enforcement contact with the Veteran resulted in a 2-hour standoff as the Veteran barricaded himself in his residence with a firearm. The defendant was subsequently subdued and arrested without incident after he attempted to flee from officers. He is currently being held without bond pending judicial action.

- A Veteran was arrested for aggravated harassment after an OIG, FPS, and local police investigation determined that she threatened to cause bodily harm to a New York, NY, vocational rehabilitation counselor. On a voicemail recording to the victim and during a subsequent conversation with a service organization officer, the defendant stated that she was going to harm the counselor at the VARO or outside of the facility.
- A Veteran was sentenced to 4 months' home confinement, 5 years' probation, and a $2,000 fine. The Veteran was convicted at trial of making terroristic threats to a call taker at the Phoenix, AZ, VA Call Center. An OIG and local police investigation revealed that the defendant told the call taker that he was going to the Atlanta VARO and shoot the first 3,000 people he saw if he did not receive a permanent rating decision within 5 business days.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive Veterans and VA employees as a direct result of the OIG Fugitive Felon Program. To date, 49.5 million felony warrants have been received from the National Crime Information Center and participating states resulting in 62,848 investigative leads being referred to law enforcement agencies. Over 2,334 fugitives have been apprehended as a direct result of these leads. Since the inception of the OIG Fugitive Felon Program in 2002, OIG has identified $977.6 million in estimated overpayments with an estimated cost avoidance of $1.14 billion. During this reporting period, OIG opened 43 and closed 41 fugitive felon investigations. OIG investigative work resulted in the arrest of 33 fugitive felons, including 6 VA employees. Apprehension of VA employees includes the following charges: rape, negligent homicide, assault with a weapon, probation violations, and drug violations. Based on the information provided to OIG, at least 29 additional arrests were made by other law enforcement agencies.

- An Orlando, FL, VAMC employee wanted for felony distribution of cocaine was arrested by local law enforcement with the assistance of OIG and VA Police Service.
- A Veteran wanted for felony theft and drug possession was arrested by local law enforcement and U.S. Marshals with the assistance of OIG agents.
- A Veteran wanted for felony theft was arrested by local police with the assistance of OIG agents. An OIG investigation revealed that the Veteran also had prior incidents with the VA Police Service.
- A Veteran wanted for a violation of probation warrant stemming from an original felony theft charge was arrested by the local sheriff's office with the assistance of OIG.

Office of Management and Administration

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

Operations Division

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

Information Technology and Data Analysis Division

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

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

Administrative and Financial Operations Division

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

Budget Division

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

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 9:00 AM to 4:00 PM Eastern Time. OIG receives phone calls, letters, and e-mails from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 13,274 contacts, 611 of which became OIG cases. An additional 435 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 576 cases during this reporting period, substantiating allegations 43 percent of the time. During the first half of FY 2013, external Hotline cases resulted in 358 administrative sanctions and corrective actions and over $8.8 million in monetary benefits. The following cases were initiated as a direct result of Hotline contacts.

OIT Officials Waste Millions on Unneeded Computers

A review conducted by OIT revealed that it spent $7.2 million in FY 2010 for the advance purchase of 90 unneeded computer servers. OIT decided against using the equipment in March 2011 due to a shift in its data storage strategy. Additionally, the servers did not conform to new OIT standards, and OIT had no contractual arrangement for returning them. In response to the Hotline review, OIT reported that 16 of the 90 servers were put in service for different purposes in January 2013. OIG concluded that purchasing advance supplies without a definitive need or a return method was a waste of funds.

Contractor Breaches Security at Houston, Texas, VAMC

A Houston, TX, VAMC review substantiated that it permitted four contractor employees to enter the VAMC and work on a project for 90 days without required VA identification badges, contracting officer approval, or background checks. The VAMC determined that a contractor's failure to inform VA of their subcontracting plans contributed to the breach of security. As a result of the Hotline referral, contractor work was suspended until the contractor employees received required VA approvals and identification badges.

Review Identifies VA Compensation Paid to Soldiers During Drill Duty

A review conducted by the White River Junction, VT, VARO determined that since 2009 it improperly paid VA compensation to 44 Veterans who were simultaneously receiving payment for performing drill or training assignments from the military Reserves or National Guard. In response to the Hotline referral, the VARO initiated collection for $189,608 in overpayments and tightened its internal controls.

Hotline Tip Stops Improper Payments to No-Show Florida Physician

An administrative investigation conducted by the Gainesville, FL, VAMC substantiated that a part-time physician accepted Government pay over a 4-year period even though he neither performed the required work nor was present at the VAMC. As a result, the VAMC issued a bill of collection in the amount of $116,184.

VA Pension Scheme Based on Hidden Disability Income Exposed

A review conducted by the Milwaukee, WI, VARO found that VA paid non service-connected pension benefits to a Veteran who was ineligible because he exceeded annual income thresholds. The overpayment occurred because the Veteran withheld that he was also receiving social security disability benefits. As a result of the review, the VARO stopped his VA pension and began collection. The case resulted in an estimated savings of $104,011 that would have been paid over a 5-year period if the overpayment had not been reported and stopped.

Hotline Complaint Ends Improper Payments Based on Concealed Marriage

A review by the Philadelphia, PA, VARO confirmed that a spouse receiving DIC failed to notify the VARO of her remarriage in June 2011. The case resulted in an estimated 5-year savings of $96,594.

VARO Reduces Compensation for Incarcerated Veteran Following Hotline Tip

A review by the Salt Lake City, UT, VARO found that a Veteran failed to inform VBA of his incarceration, resulting in improper payment of unreduced benefits for 12 months ending December 2012. The case resulted in an estimated 5-year savings of $96,506.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's Office of Acquisition, Logistics and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 68 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. Forty-nine preaward reviews identified approximately $505 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule (FSS) proposals, preaward reviews during this reporting period included 11 health care provider proposals, accounting for approximately $48 million of the identified potential savings.

October 1, 2012 – March 31, 2013	
Preaward Reports Issued	49
Potential Cost Savings	$505,143,202

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 $12.7 million, including approximately $7.3 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 17 postaward reviews performed, 8 involved voluntary disclosures. In five reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

October 1, 2012 – March 31, 2013	
Postaward Reports Issued	17
Dollar Recoveries	$12,720,968

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period OIG reviewed two claims and determined that approximately $1.9 million of claimed costs were unsupported and should be disallowed.

October 1, 2012 – March 31, 2013	
Claim Reports Issued	2
Potential Cost Savings	$1,860,602

Congressional Testimony

Assistant Inspector General for Audits and Evaluations Tells Congress VA's Efforts to Fix Errors in Temporary 100 Percent Disability Ratings Are Not Aggressive Enough

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on issues related to VBA's effectiveness in processing temporary 100 percent disability ratings. She discussed the results of a January 2011 audit on the issue as well as recent results from OIG's inspections of VAROs where OIG continues to find a consistently high error rate for processing temporary 100 percent disability ratings. VBA has not been aggressive, timely, or thorough in completing its national review of the issue and they have continued to rely on electronic fixes but done little to address the issue of staff error. The long delay in taking action places VA at risk of underpaying some Veterans and repeatedly overpaying others without proper support, thereby diverting millions of dollars from other important programs for America's Veterans today and into the future. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of OIG's Kansas City Office of Audits and Evaluations, and Mr. Brent Arronte, Director of OIG's San Diego Benefits Inspections Division.

AIG Tells House Panel That Indecision Measuring Physician Productivity Is Hampering Maximum Utilization of Resources

Linda A. Halliday testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, that VHA did not have an effective staffing methodology to ensure appropriate staffing levels for physician specialty care services. Moreover, VHA could not agree on how to develop a methodology although required to do so by Public Law 107-135, *Department of Veterans Affairs Health Care Programs Enhancement Act of 2001*. This indecision resulted in insufficient guidance to VA medical facilities as well as potentially insufficient services to Veterans. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer.

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, 2013, OIG has expended $2.5 million (the entire $1.0 million OIG received under ARRA and $1.5 million from regular appropriations) in conducting its comprehensive program of ARRA oversight. OIG's ARRA-related accomplishments and activities completed to date include:

- Issued seven final audit and evaluation reports and one interim advisory report on VA management of ARRA program activities.
- Conducted 616 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 506 and closed 366 criminal investigations, including 96 convictions, 174 referrals for monetary reclamation, and $82,250 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. DOL OIG conducted a peer review of VA OIG and issued the final report on March 21, 2013, which provided a rating of PASS.

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

Additionally, OIG reports that one Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review (QAR) was conducted by another OIG during this reporting period. This CIGIE QAR was conducted on VA OIG's investigative operations and was completed by the Environmental Protection Agency OIG in March 2013. The oral report 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 contract review reports under this requirement.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 279 proposals and made 22 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 Recognized for Achievements

- Nate Landkammer, Special Agent, Southeast Field Office, Nashville, Tennessee, received the U.S. Attorney's Award for Excellence in February 2013. The U.S. Attorney's Office recognized Nate for his outstanding work on the Robert Neener case involving the production of counterfeit military certificates. This investigation held accountable a subject who sold counterfeit military and law enforcement awards and training certificates to over 600 victims through an Internet printing business. As a result of Nate's efforts leading a multiagency investigation, Mr. Neener pled guilty to possessing and selling documents with counterfeit seals and pretending to be a Federal employee. A Federal judge sentenced him to 3 years' incarceration, 3 years' supervised release, and ordered him to pay restitution of over $43,000 to his victims.
- Dr. Alan Mallinger, Senior Physician, Office of Healthcare Inspections, was inducted into the American College of Psychiatrists at a ceremony in February 2013 at the College's annual meeting. The American College of Psychiatrists comprises more than 800 psychiatrists who have demonstrated excellence in the field of psychiatry, and achieved national recognition in clinical practice, research, academic leadership, or teaching.
- Dennis Wokeck, Director of Management Operations, Office of Audits and Evaluations, received the Silver Beaver Award on April 4, 2013, from the National Capital Area Council of the Boy Scouts of America for distinguished service to youth.

OIG Employees Currently Serving on or Returning From Active Military Duty

We extend our thanks to OIG employees listed below who are on military duty.

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

Appendix A
List of Reports Issued

Table 1: List of Reports Issued by Type

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

Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
10/4/2012 10-04045-124	Audit of VBA's Liquidation Appraisal Oversight in the Cleveland and Phoenix Regional Loan Centers			
10/11/2012 12-01903-04	Review of VA's Alleged Incomplete Installation of Encryption Software Licenses			$5,100,000
10/23/2012 11-01823-294	Audit of VA's Systems Interconnections with Research and University Affiliates			
10/29/2012 11-00324-20	Audit of VA's Office of Information Technology Strategic Human Capital Management			
12/11/2012 11-00317-37	Audit of Vocational Rehabilitation and Employment Program's Self-Employment Services at Eastern and Central Area Offices			
12/17/2012 10-01937-63	Review of Allegations at VA Medical Center, Providence, Rhode Island	$4,444	$4,444	
12/17/2012 12-03346-69	Review of VHA's Minor Construction Program			
12/27/2012 11-01827-36	Audit of VHA's Physician Staffing Levels for Specialty Care Services			
1/10/2013 11-04359-80	Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds			
1/18/2013 12-01284-13	Audit of VA's Consolidated Financial Statements for Fiscal Years 2012 and 2011			
2/4/2013 11-04376-81	Review of VBA's Transition to a Paperless Claims Processing Environment			
2/6/2013 11-00336-292	Audit of VHA's Beneficiary Travel Program			
2/7/2013 12-02223-98	Audit of NCA's Internal Gravesite Review of Headstone and Marker Placement			
3/6/2013 12-02802-111	Review of Alleged Transmission of Sensitive VA Data Over Internet Connections			
3/15/2013 12-04241-138	Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012			
3/29/2013 11-00331-160	Audit of the Community Nursing Home Program	$296,500,000	$296,500,000	

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
3/31/2013 13-00680-142	Independent Review of VA's FY 2012 Performance Summary Report to the Office of National Drug Control Policy			
3/31/2013 13-00682-143	Independent Review of VA's FY 2012 Detailed Accounting Submission to the Office of National Drug Control Policy			
		$296,504,444	**$296,504,444**	**$5,100,000**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
1/3/2013	12-02089-60	VA Regional Office, Anchorage, Alaska
1/11/2013	12-03355-88	VA Regional Office, Detroit, Michigan
2/21/2013	12-03477-118	Veterans Service Center, Cheyenne, Wyoming
3/28/2013	12-03629-139	VA Regional Office, Nashville, Tennessee

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
10/10/2012	12-02599-03	Minneapolis VA Health Care System, Minneapolis, Minnesota
10/17/2012	12-02601-07	VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
10/17/2012	12-02189-14	VA Long Beach Healthcare System, Long Beach, California
10/29/2012	12-02188-15	VA St. Louis Health Care System, St. Louis, Missouri
11/7/2012	12-01877-25	Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania
11/8/2012	12-02600-28	John D. Dingell VA Medical Center, Detroit, Michigan
11/9/2012	12-03074-29	VA Northern California Health Care System, Sacramento, California
12/4/2012	12-03072-48	VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts
12/7/2012	12-03075-52	Miami VA Healthcare System, Miami, Florida
12/7/2012	12-03073-57	Robert J. Dole VA Medical Center, Wichita, Kansas
12/10/2012	12-03071-53	Fayetteville VA Medical Center, Fayetteville, North Carolina
12/12/2012	12-03741-61	VA Maine Healthcare System, Augusta, Maine
12/20/2012	12-03076-65	West Texas VA Health Care System, Big Spring, Texas
1/3/2013	12-03740-75	Durham VA Medical Center, Durham, North Carolina
1/7/2013	12-02602-79	Huntington VA Medical Center, Huntington, West Virginia
1/7/2013	12-03744-84	Central Texas Veterans Health Care System, Temple, Texas

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
1/17/2013	12-00710-85	VA New York Harbor Healthcare System, New York, New York
1/17/2013	12-04190-89	North Florida/South Georgia Veterans Health System, Gainesville, Florida
1/28/2013	12-04189-95	Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
1/29/2013	12-04192-97	San Francisco VA Medical Center, San Francisco, California
2/4/2013	12-03745-93	Iowa City VA Health Care System, Iowa City, Iowa
2/7/2013	12-04605-107	G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi
3/4/2013	12-03077-122	Hampton VA Medical Center, Hampton, Virginia
3/4/2013	12-04191-123	Northport VA Medical Center, Northport, New York
3/6/2013	12-04604-127	Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
3/15/2013	13-00277-134	Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
3/18/2013	13-00276-135	Charles George VA Medical Center, Asheville, North Carolina
3/21/2013	12-04188-140	Battle Creek VA Medical Center, Battle Creek, Michigan
3/26/2013	13-00273-147	John J. Pershing VA Medical Center, Poplar Bluff, Missouri
3/27/2013	13-00275-149	Chillicothe VA Medical Center, Chillicothe, Ohio
3/28/2013	13-00279-156	VA Palo Alto Health Care System, Palo Alto, California

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	Number	Reports
11/14/2012	11-03655-30	Brooklyn (Chapel Street) and Sunnyside (Queens), New York; Franklin (Venango), Pennsylvania
11/27/2012	12-00581-27	Minden (Carson Valley), Nevada; Auburn (Sierra Foothills), Chula Vista, and Escondido, California
11/30/2012	12-00580-50	Franklin, West Virginia; Stephens City, Virginia; Greenbelt, Maryland; Southeast Washington, DC
2/6/2013	12-03850-105	Durham VA Medical Center, Durham, North Carolina
2/12/2013	12-03850-106	Salem VA Medical Center, Salem, Virginia
2/14/2013	12-03852-110	Alaska VA Healthcare System, Anchorage, Alaska
2/14/2013	12-03850-112	Charles George VA Medical Center, Asheville, North Carolina
2/15/2013	12-03852-109	Spokane VA Medical Center, Spokane, Washington
2/19/2013	12-03854-114	Iowa City VA Health Care System, Iowa City, Iowa
2/20/2013	12-03851-102	John J. Pershing VA Medical Center, Poplar Bluff, Missouri
2/26/2013	12-03851-117	Marion VA Medical Center, Marion, Illinois
2/28/2013	12-03854-115	William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
3/22/2013	13-00026-137	San Francisco VA Medical Center, San Francisco, California
3/29/2013	13-00026-157	VA Palo Alto Health Care System, Palo Alto, California

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	Number	Title
12/5/2012	12-03399-54	Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma
1/17/2013	11-00711-74	Foot Care for Patients with Diabetes and Additional Risk Factors for Amputation
3/7/2013	11-02585-129	Management of Disruptive Patient Behavior at VA Medical Facilities
3/28/2013	11-02487-158	Evaluation of Cataract Surgeries and Outcomes in VHA Facilities

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	Number	Title
10/12/2012	12-01487-08	Delay in Treatment, Louis Stokes VA Medical Center, Cleveland, Ohio
10/16/2012	12-02098-11	Reusable Medical Equipment Issues, VA Northern California Health Care System, Sacramento, California
10/18/2012	12-03146-12	Alleged Mismanagement of Resources and Quality of Care Issues, Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan
10/23/2012	12-03594-10	Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas
10/24/2012	11-03462-17	Respiratory Care and Other Clinical Concerns, VA Northern Indiana Health Care System, Fort Wayne, Indiana
10/26/2012	12-00206-23	Follow-Up Review of Quality of Care and Other Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
11/13/2012	12-03041-32	Alleged Misdiagnosis, Hudson Valley Health Care System, Castle Point, New York
11/15/2012	12-03660-31	Alleged Misdiagnosis and Other Care Issues, Atlanta VA Medical Center, Atlanta, Georgia
11/19/2012	12-01758-40	Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California
11/27/2012	12-02508-45	Alleged Violation of Patient Rights, Carl Vinson VA Medical Center, Dublin, Georgia
11/28/2012	12-02277-49	Clinical and Administrative Allegations Involving Surgical Service, Carl Vinson VA Medical Center, Dublin, Georgia
11/29/2012	12-03858-46	Alleged Resident Abuse and Abuse Reporting Irregularities at the Pueblo Community Living Center, VA Eastern Colorado Healthcare System, Denver, Colorado
12/21/2012	12-02352-72	Pharmacy and Quality of Care Issues, VA Hudson Valley Health Care System, Castle Point, New York
12/21/2012	12-03543-73	Alleged Patient Safety Deficiencies in the Community Living Center, Canandaigua VA Medical Center, Canandaigua, New York

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	Number	Title
1/7/2013	12-04214-83	Emergency Department Evaluation of a Homeless Veteran, VA North Texas Health Care System, Dallas, Texas
1/28/2013	12-04108-96	Appointment Scheduling and Access, Patient Call Center, VA San Diego Healthcare System, San Diego, California
2/1/2013	12-02476-103	Mid-Level Provider Oversight, George E. Wahlen VA Medical Center, Salt Lake City, Utah
2/5/2013	13-00636-104	Laboratory Processing Delays and Environmental Safety Concerns, VA North Texas Health Care System, Dallas, Texas
2/7/2013	12-01556-108	Alleged Quality of Care Issues and Communication Lapses, Washington, DC, VA Medical Center, Washington, DC
2/27/2013	12-03753-121	Issues at a VA Mid South Healthcare Network Dental Clinic
3/19/2013	12-02612-141	Alleged Quality of Care and Problems with Services, VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi
3/26/2013	12-02317-144	Improper Conduct During Merit Review Proceedings
3/26/2013	12-03038-145	Excessive Length of Stay and Quality of Care Issues in the Emergency Department, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

Office of Investigations | Administrative Investigations		
Issue Date	Number	Title
3/28/2013	12-02503-151	Misuse of Official Time and Resources and Failure to Properly Supervise, Office of Human Resources and Administration, Washington, DC
3/28/2013	12-01841-152	Improper Locality Pay, Service Area Office West and Desert Pacific Healthcare Network, Long Beach, California

Office of Contract Review | Preaward Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
10/10/2012	12-03996-62	Review of Proposal Submitted Under a Solicitation	$549,869
10/15/2012	12-02803-16	Review of FSS Proposal Submitted Under a Solicitation	$16,693,680
10/16/2012	12-03611-19	Review of FSS Proposal Submitted Under a Solicitation	$28,800
10/17/2012	12-04056-09	Review of Proposal Submitted Under a Solicitation	$129,990
10/18/2012	12-03134-02	Review of Proposal Submitted Under a Solicitation	$4,573,220
10/25/2012	12-03836-24	Review of FSS Proposal Submitted Under a Solicitation	$249,771
11/7/2012	12-01888-33	Review of FSS Proposal Submitted Under a FSS Contract	$1,947,729
11/13/2012	12-01600-38	Review of Proposal Submitted Under a Solicitation	
11/13/2012	12-03978-39	Review of FSS Proposal Submitted Under a Solicitation	$6,963,814

Office of Contract Review | Preaward Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
11/15/2012	12-04383-42	Review of FSS Proposal Submitted Under a Solicitation	$36,810,779
11/15/2012	12-03156-43	Review of Subcontractor Proposal Submitted Under a Solicitation	$89,541
11/15/2012	12-01891-44	Review of Subcontractor Proposal Submitted Under a Solicitation	
11/19/2012	12-04275-47	Review of Contract Extension Proposal Submitted Under a FSS Contract	
11/26/2012	12-03158-51	Review of Subcontractor Proposal Submitted Under a Solicitation	$40,678
11/29/2012	12-03151-56	Review of Proposal Submitted Under a Request for Proposal	$4,916
11/29/2012	12-02261-58	Supplement to Review of Proposal for a Change Order Submitted Under a Contract	-$435,583
11/29/2012	12-04485-59	Review of FSS Proposal Submitted Under a Solicitation	
12/5/2012	12-03154-64	Review of Proposal Submitted Under a Request for Proposal	$774,341
12/6/2012	12-01716-66	Review of Proposal Submitted Under a Solicitation	$150,825
12/6/2012	12-03612-67	Review of FSS Proposal Submitted Under a Solicitation	$856,870
12/6/2012	12-01895-68	Review of Subcontractor Proposal Submitted Under a Solicitation	
12/12/2012	12-04559-70	Review of FSS Proposal Submitted Under a Solicitation	$2,041,857
12/19/2012	13-00286-76	Review of FSS Proposal Submitted Under a Solicitation	$2,978,900
12/19/2012	13-00841-77	Review of Request for Product Additions to a FSS Contract	
12/21/2012	12-03623-78	Review of Contract Extension Proposal Submitted Under a FSS Contract	$2,223,044
12/28/2012	13-00231-82	Review of FSS Proposal Submitted Under a Solicitation	
1/3/2013	13-00055-86	Review of FSS Proposal Submitted Under a Solicitation	$1,648,170
1/16/2013	13-00282-94	Review of FSS Proposal Submitted Under a Solicitation	
1/20/2013	12-01719-90	Review of Proposal Submitted Under a Solicitation	
1/22/2013	13-00915-91	Review of Proposal Submitted Under a Solicitation	$2,667,447
1/23/2013	12-04560-99	Review of FSS Proposal Submitted Under a Solicitation	$31,395,100
1/24/2013	12-03757-101	Review of FSS Proposal Submitted Under a Solicitation	$70,605,600
1/25/2013	13-00622-92	Review of Proposal Submitted Under a Solicitation	$1,237,710
2/11/2013	13-00547-113	Review of Proposal Submitted Under a Solicitation	$3,346,796
2/12/2013	12-01721-119	Review of Subcontractor Proposal Submitted Under a Solicitation	
2/13/2013	13-00001-120	Review of FSS Proposal Submitted Under a Solicitation	
2/15/2013	13-00590-124	Review of FSS Proposal Submitted Under a Solicitation	$1,903,540
2/20/2013	13-00134-125	Review of FSS Proposal Submitted Under a Solicitation	$2,836,833

Office of Contract Review | Preaward Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
2/26/2013	12-01718-128	Review of Proposal Submitted Under a Solicitation	
2/26/2013	13-00801-131	Review of FSS Proposal Submitted Under a Solicitation	
3/11/2013	13-00933-136	Review of FSS Proposal Submitted Under a Solicitation	$632,935
3/14/2013	13-00697-132	Review of Proposal Submitted Under a Solicitation	$457,986
3/15/2013	13-00213-148	Review of FSS Proposal Submitted Under a Solicitation	$17,716,079
3/20/2013	13-00561-153	Review of FSS Proposal Submitted Under a Solicitation	$259,059,680
3/26/2013	13-00548-150	Review of Proposal Submitted Under a Solicitation	$776,251
3/26/2013	13-01471-163	Review of Contract Extension Proposal Submitted Under a FSS Contract	
3/27/2013	13-00588-154	Review of Proposal Submitted Under a Solicitation	$2,222,540
3/27/2013	12-03995-159	Review of Proposal Submitted Under a Solicitation	$2,781,669
3/28/2013	13-00914-162	Review of Proposal Submitted Under a Solicitation	$29,181,825
			$505,143,202

Office of Contract Review | Postaward Reviews			
Issue Date	Number	Title	Dollar Recoveries
10/2/2012	12-01417-01	Review of Late Addition and Overbilling of a Covered Drug Under a FSS Contract	$3,611
10/3/2012	12-01412-06	Review of Late Addition of a Covered Drug Under a FSS Contract	$635
10/16/2012	07-02359-18	Review of Voluntary Disclosure and Refund Offer Under a FSS Contract	$1,401,306
10/22/2012	12-02663-21	Review of Cost Reimbursable Vouchers Submitted Under a Contract	$210,038
10/22/2012	12-01423-22	Review of Public Law Errors Under a FSS Interim Agreement	
11/13/2012	13-00453-35	Review of Late Implementation of Permanent Federal Ceiling Prices Under Contracts	$490
11/14/2012	11-02765-41	Review of Voluntary Disclosure and Refund Offer Under a FSS Contract	$1,155,637
11/27/2012	13-00131-55	Review of Voluntary Disclosure and Refund Offer Under a FSS Contract	$403,694
12/17/2012	12-03225-71	Review of Public Law and Price Reduction Damages Under FSS Contracts	$1,866
1/7/2013	12-02219-87	Review of Voluntary Disclosure and Refund Offer Under a FSS Contract	$579,442

Office of Contract Review | Postaward Reviews			
Issue Date	Number	Title	Dollar Recoveries
1/23/2013	10-02201-100	Review of Covered Drug Items Added to a FSS Contract	$69,948
2/7/2013	12-03001-116	Review of Public Law and Price Reduction Damages Under a FSS Contract	$360,410
2/20/2013	12-02015-126	Review of Voluntary Disclosure Under a Contract	$1,691,478
3/4/2013	11-01310-133	Review of Voluntary Disclosure and Refund Offer Under a FSS Contract	$4
3/14/2013	10-02208-146	Review of Voluntary Disclosure of Overcharges Resulting from Acquisition of Companies	$6,839,320
3/20/2013	13-02049-585	Review of Commercial Sales Practices Disclosures Regarding a FSS Contract	
3/27/2013	12-01418-165	Review of Late Implementation of Federal Ceiling Prices Under a Contract	$3,090
			$12,720,968

Office of Contract Review | Claim Reviews			
Issue Date	Number	Title	Savings and Cost Avoidance
10/4/2012	12-02776-05	Review of Settlement Proposal Submitted Under a VA Contract	$897,548
2/26/2013	12-02071-130	Review of Termination Settlement Proposal Submitted Under a Contract	$963,054
			$1,860,602

Total Potential Monetary Benefits of Reports Issued				
Report Type	Better Use of Funds	Questioned Costs	Savings and Cost Avoidance	Dollar Recoveries
Audits, Evaluations, and Reviews	$296,504,444	$5,100,000		
Preaward Reviews			$505,143,202	
Postaward Reviews				$12,720,968
Claims Reviews			$1,860,602	
	$296,504,444	**$5,100,000**	**$507,003,804**	**$12,720,968**

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	1	$5,100,000
Total inventory this period	**1**	**$5,100,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	1	$5,100,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**1**	**$5,100,000**
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	2	$296,504,444
Total inventory this period	**2**	**$296,504,444**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$296,504,444
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**2**	**$296,504,444**
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, 2013, there are 187 total open reports and 1,018 total open recommendations. However, 5 reports and 12 recommendations are double or triple counted in Table 1 because they have actions at more than one office. Table 2 identifies the 42 reports and 139 recommendations that, as of March 31, 2013, remain open for more than 1 year. The total monetary benefit attached to these reports is $4,011,861,000.

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	124	**149**	105	718	**823**
Veterans Benefits Administration	3	11	**14**	6	42	**48**
National Cemetery Administration	0	1	**1**	0	4	**4**
Office of Management	0	2	**2**	0	6	**6**
Office of Information and Technology	6	5	**11**	14	46	**60**
Office of Human Resources and Administration	1	4	**5**	2	13	**15**
Office of Operations, Security, and Preparedness	3	1	**4**	4	2	**6**
Office of Acquisitions, Logistics, and Construction	3	1	**4**	7	10	**17**
Office of Small and Disadvantaged Business Utilization	1	0	**1**	1	0	**1**
Office of General Counsel	0	3	**3**	0	50	**50**
Total	**42**	**152**	**194**	**139**	**891**	**1,030**

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/11/06	06-02238-163	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OSP	None
Recommendation d: We recommend that the Secretary ensure that all position descriptions are evaluated and have proper sensitivity level designations, that there is consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.				
08/18/09	09-01123-195	Administrative Investigation, Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC	OIT	None
Recommendation 5: We recommend that the Assistant Secretary for Information and Technology confer with the Office of Human Resources to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such corrective action.				
08/18/09	09-01123-196	Administrative Investigation, Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC	OIT	None
Recommendation 6: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such action. *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.*				

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 regulations, and VA policy.* ** OIG disagrees with the Office of General Counsel's (OGC's) legal opinions finding that a violation of the nepotism statute did not occur and no legal basis exists for collecting funds from individual employees, but closed recommendations 1, 3, and 18-24 because OIT is planning no further action in light of OGC's legal opinions. OIG stands by the recommendations, but will not waste any more resources in pursuit of corrective action.*				
12/03/09	09-01849-39	Healthcare Inspection, VistA Outages Affecting Patient Care, Office of Risk Management and Incident Response, Falling Waters, WV	OIT	None
Recommendation 3: We recommend that the Assistant Secretary for Information and Technology ensure that the Office for Information Protection and Risk Management performs and reports on risk management for essential medical IT systems.				
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.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
06/07/10	08-02969-165	Review of Federal Supply Schedule 621 I--Professional and Allied Healthcare Staffing Services	OALC	None
Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable. *Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).* *Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.* *Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.* *Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.*			
09/17/10	10-00969-248	ARRA Oversight Advisory Report: Review of Efforts to Meet Competition Requirements and Monitor Recovery Act Awards	OALC	None
Recommendation 2: We recommended the Executive Director of the OALC develop and issue a comprehensive policy that clearly defines the appropriate procedures for the proper completion of adequate contractor responsibility determinations and related justifications.				
09/30/10	10-01575-262	VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12	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.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
01/24/11	09-03359-71	Veterans Benefits Administration Audit of 100 Percent Disability Evaluations	VBA	$1,130,000,000
Recommendation 7: We recommended the Acting Under Secretary for Benefits conduct a review of all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the Veterans' electronic records.				
02/18/11	09-03850-99	Veterans Benefits Administration Audit of the Veterans Service Network	OIT	$35,000,000
Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.				
03/30/11	10-00639-135	Veterans Benefits Administration Review of Pension Management Centers	VBA	$205,000,000
Recommendation 1: We recommend the Acting Under Secretary for Benefits establish an operational plan to ensure Pension Management Centers efficiently and effectively manage the workload to achieve timeliness standards. *Recommendation 3: We recommend the Acting Under Secretary for Benefits establish specific performance goals for Income Verification Matches and implement controls to ensure timely processing to reduce overpayments, including exploring alternative measures such as assigning a dedicated claims processor or team to process Income Verification Matches.*				
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 5: We recommend the Under Secretary for Health ensure VHA contracting staff adhere to all policy requirements contained in VA Directive 1663. *Recommendation 6: We recommend the Under Secretary for Health develop a standard that accurately defines the expected hours and workload from one FTE [full-time equivalent] for each specialty that can be applied by the contracting staff to determine the number of FTE and hours to be procured under the contract.* *Recommendation 7: We recommend the Under Secretary for Health develop clear and well defined national standard SOWs [statements of work] for each specialty that can be tailored as needed to address specific procurement requirements if needed.*				

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 8: We recommend the Under Secretary for Health develop and require the use of a standard pricing schedule for procedure based contracts that require the listing of all CPT [Current Procedure Terminology] codes with estimated quantities and proposed prices for each code. *Recommendation 9: We recommend the Under Secretary for Health conduct an evaluation to determine the feasibility of using an administrator or intermediary to process billings for procedure based contracts performed at the affiliate similar to those used by Medicare administrators.* *Recommendation 10: We recommend the Under Secretary for Health develop a more robust process to ensure compliance with conflict of interest laws and regulations and their applicability to all Title 38 employees who have a relationship with affiliates.* *Recommendation 11: We recommend the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.*				
07/25/11	10-02436-234	Audit of the Veteran-Owned and Service-Disabled Veteran-Owned Small Business Programs	OSDBU	$2,500,000,000
Recommendation 3: We recommended the Executive Director of the Office of Acquisition, Logistics, and Construction coordinate with the Deputy Under Secretary for Health and the Executive Director of the Office of Small and Disadvantaged Business Utilization to develop and mandate training for contracting officers on VOSB [Veteran-Owned Small Business] and SDVOSB ownership and control requirements and the assessment of subcontracts and joint venture agreements for compliance with FAR [Federal Acquisition Regulation], VAAR [Veterans Affairs Acquisition Regulation], and Federal regulations.				
07/27/11	10-03516-229	Review of Alleged Unauthorized Access to VA Systems	OIT	None
Recommendation 5: We recommend the Assistant Secretary for Information and Technology review contractor system security controls and practices to ensure compliance with VA's information security requirements.				
08/29/11	10-03162-262	Audit of the Project Management Accountability System Implementation	OIT	None
Recommendation 4: We recommended the Assistant Secretary for Information and Technology modify the Project Management Accountability System Dashboard to maintain original baseline data and issue guidance to ensure project performance is measured against both the original and current baselines.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 5: We recommended the Assistant Secretary for Information and Technology designate personnel and provide them with detailed written procedures to perform periodic independent reviews of the Project Management Accountability System Dashboard to ensure data reliability and completeness.				
09/02/11	10-01744-265	Audit of National Contract Awards at VA's National Acquisition Center	OALC	None
Recommendation 3: We recommend the Executive Director for the Office of Acquisition, Logistics, and Construction establishes controls to monitor and ensure the timely completion of the Electronic Contract Management System upgrade, including the National Acquisition Center's Contract Management system functions to eliminate the duplication of effort in data entry.				
09/07/11	11-02869-272	Combined Assessment Program Summary Report, Management of Test Results in Veterans Health Administration Facilities	VHA	None
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities' written policies are comprehensive and define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients. *Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that practitioners notify patients of normal results and that managers monitor compliance.*				
09/21/11	11-01997-289	Management of Patient Abuse Cases, Charlie Norwood VA Medical Center, Augusta, GA	VHA	None
Recommendation 4: We recommended that the Medical Director ensure that the appropriate process is followed when SLB [State Licensing Board] reporting is indicated.				
09/30/11	11-00308-294	Follow-Up Audit of VHA's Part-Time Physician Time and Attendance	VHA	None
Recommendation 1: We recommend the Under Secretary for Health reinstitute the requirement that all part-time physicians (including those on fixed schedules) who have duties other than clinical activities complete a written agreement detailing the approximate amount of time that will be spent on VHA clinical, research, education, and administrative activities. *Recommendation 2: We recommend the Under Secretary for Health require VA medical center management to establish procedures to periodically monitor the activities of all part-time physicians to ensure consistency with written employment agreements.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 3: We recommend the Under Secretary for Health clarify procedures requiring staff to establish and use baseline levels to monitor part-time physicians' activities for an entire pay period during the month. *Recommendation 4: We recommend the Under Secretary for Health clarify procedures including documentation requirements to ensure semi-annual physical reviews are random and reviewers make visual verification when the part-time physician is at VA.* *Recommendation 5: We recommend the Under Secretary for Health require VA medical center management to establish oversight procedures to ensure staff follow the requirements in VA Handbook 5011/12 to maintain accurate schedules for part-time physicians.* *Recommendation 6: We recommend the Under Secretary for Health require VA medical center management to establish oversight procedures to ensure staff follow the requirements in VA Handbook 5011/12 to promptly record actual hours worked and leave taken by part-time physicians.*				
09/30/11	10-03850-298	Audit of VHA's Workers' Compensation Case Management	VHA	$105,300,000
Recommendation 3: We recommended the Under Secretary for Health establish clear reporting lines with delegated authority for overseeing and enforcing Workers' Compensation Program policy (repeat recommendation from the 2004 VA OIG audit report). *Recommendation 4: We recommended the Under Secretary for Health establish a plan outlining the roles, responsibilities, procedures, and training needed for the Director of Safety, Health, and Environmental Compliance to accomplish Workers' Compensation Program oversight and enforcement control.* *Recommendation 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).*				
09/30/11	10-04037-295	Audit of VA's Enrollment Centers' Implementation of Personal Identity Verification Requirements	OSP	None
Recommendation 2: We recommended the Assistant Secretary for Operations, Security, and Preparedness direct VA Enrollment Centers to evaluate information supporting the eligibility of Personal Identity Verification credential holders and take action to deactivate Personal Identity Verification credentials of individuals who did not satisfy processing requirements.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 4: We recommended the Assistant Secretary for Operations, Security, and Preparedness develop and issue guidance to ensure Registrars screen all Personal Identity Verification credential applicants against the Terrorist Screening Database prior to issuing Personal Identity Verification credentials.				
10/27/11	11-02081-09	Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, NC	VHA	None
Recommendation 4: We recommended that processes be strengthened to ensure that all services provide the required medical record reviews and that the reviews include all required components.				
11/01/11	11-01406-14	Community Based Outpatient Clinic Reviews: Bennington, VT and Littleton, NH; Jamestown and Lackawanna, NY; Hagerstown, MD and Petersburg, WV	VHA	None
Recommendation 7: We recommended that the copies of Short-Term Fee Basis reports of the Bennington CBOC patients are filed or scanned into the medical record. *Recommendation 11: We recommended that managers establish a process to ensure that patients at the Bennington and Littleton CBOCs are notified of mammogram results within the allotted timeframe and that notification is documented in the medical record.* *Recommendation 12: We recommended that managers ensure fee basis mammography results are received and scanned into CPRS [Computerized Patient Record System] at the Bennington and Littleton CBOCs.* *Recommendation 54: We recommended that the Chief of OIT evaluates the use of the IT closet at the Petersburg CBOC and implements appropriate measures according to VA policy.*				
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 23: We recommended that the ordering practitioners, or surrogate practitioners, communicate the Short-Term Fee Basis results to the patient within 14 days from the date made available to the ordering practitioner at the Escondido CBOC. *Recommendation 29: We recommended that access is improved for disabled Veterans at the Lancaster CBOC.*				

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 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.*				
11/14/11	10-02887-30	Audit of Retention Incentives for Veterans Health Administration and VA Central Office Employees	OHRA	$1,061,000
Recommendation 1: We recommend the Assistant Secretary for Human Resources and Administration, in coordination with the Under Secretary for Health and the Deputy Assistant Secretary for the Corporate Senior Executive Management Office, issue revised national guidance clarifying the retention incentive process and what is needed to adequately justify, approve, and support an incentive award. *Recommendation 8: We recommend the Assistant Secretary for Human Resources and Administration provide the oversight and training needed to ensure responsible officials properly justify, approve, and maintain supporting documentation for retention incentives as required by policy.*				
12/01/11	11-02051-39	Healthcare Inspection – Emergency Department Quality of Care, Safety, and Management Issues, Dallas VA Medical Center, Dallas, Texas	VHA	None
Recommendation 1: We recommended that the Facility Director ensures that RN triage practices are consistently performed and training is completed. *Recommendation 2: We recommended that the Facility Director ensures that communication and referral processes between the ED [Emergency Department] and PCCs [Primary Care Clinics] include more effective data sharing and joint efforts to improve patient flow.* *Recommendation 3: We recommended that the Facility Director ensures that ED managers monitor orthopedic surgery consultation timeliness of response to ED consultation requests.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
12/09/11	11-01406-38	Community Based Outpatient Clinic Reviews: Ft. Pierce and Okeechobee, FL; Charleston and Williamson, WV; Mansfield and Philadelphia, OH; Agana Heights, GU, and Hilo, HI	VHA	None
Recommendation 8: We recommended that the Short-Term Fee Basis consults at the Charleston CBOC are approved by appropriate leadership or designee in accordance with VHA and local policy. *Recommendation 10: We recommended that the ordering practitioners, or surrogate practitioners, at the Charleston CBOC document in the medical record that they reviewed the Short-Term Fee Basis report.* *Recommendation 12: We recommended that the Charleston CBOC manager ensures that their providers notify patients with abnormal mammography results within 14 calendar days and that notification is documented in the medical record.* *Recommendation 13: We recommended that the Charleston CBOC manager establishes a process to ensure patients with normal mammograms are provided written notification of results within the allotted timeframe and that notification is documented in the medical record.*				
01/06/12	11-03941-61	Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Temple, Texas	VHA	None
Recommendation 2: We recommended that the Medical Center Director ensure that patients receive timely colorectal cancer screening follow-up as required by VHA Directive.				
01/11/12	11-02718-50	Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia	VHA	None
Recommendation 7: We recommended that processes in the CLC [Community Living Center] be strengthened to ensure that EN [enteral nutrition] documentation includes all required elements.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
01/19/12	11-03654-66	Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee	VHA	None
Recommendation 3: 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. *Recommendation 5: We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.* *Recommendation 7: We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.*				
02/03/12	10-03822-80	Improper Time and Attendance and Preferential Treatment, Center of Excellence, VISN 17, Waco, Texas	VHA	None
Recommendation 2: We recommend that the Network 17 Director ensure that either bills of collection in the appropriate amounts are issued to Drs. Gulliver, _____ , _____ , and _____ for the hours they received an improper salary supplementation for performing tasks on the TAMU [Texas A&M University] grant during their official VA hours or ensure that the appropriate amount of annual leave is deducted from their leave balances. *Recommendation 3: We recommend that the Network 17 Director ensure that Dr. Gulliver and her subordinates, as required by VA policy, are placed on appropriate work schedules and that they accurately record their time and attendance, to include the accumulation and use of any credit hours.*				
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. *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.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
02/29/12	11-03668-107	Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi	VHA	None

Recommendation 1: We recommended that processes be strengthened to ensure that FPPEs [Focused Professional Practice Evaluations] are consistently initiated and completed and that results are reported to the Clinical Executive Board.

Recommendation 4: We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of the medical record quality review process and that all services and programs are included.

Recommendation 6: We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Recommendation 7: We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Recommendation 8: We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Recommendation 9: We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Recommendation 10: We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Recommendation 15: We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Recommendation 16: We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

Recommendation 22: We recommended that processes be strengthened to ensure that EOC [environment of care] rounds include participation by all required team members or their representatives.

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/08/12	11-02254-102	Audit of the Management and Acquisition of Prosthetic Limbs	VHA	None
Recommendation 2: We recommend the Under Secretary for Health improve the guidance issued to Certified Prosthetists for their review of vendor quotes. *Recommendation 5: We recommend the Under Secretary for Health establish reasonable pricing standards for prosthetic limb items that Medicare has yet to classify.* *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.				
03/12/12	11-00334-115	Audit of the Homeless Providers Grant and Per Diem Program	VHA	None
Recommendation 1: We recommended the Under Secretary for Health publish standards to ensure the safety, security, and privacy of Veterans in Grant and Per Diem Program facilities. *Recommendation 2: We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state the gender of the proposed homeless populations the provider intends to serve.* *Recommendation 3: We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to manage Veteran safety, security, and privacy issues.* *Recommendation 4: We recommended the Under Secretary for Health publish standards on medication management to ensure the safe storage of medications in Grant and Per Diem Program facilities.* *Recommendation 5: We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address storage of medications.*				

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 6: We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address Veterans' nutritional and dietary issues. *Recommendation 7: We recommended the Under Secretary for Health establish policies to perform periodic unannounced visits to observe the storage and preparation of food, serving of meals, and to ensure changing conditions are identified timely during the grant award.* *Recommendation 8: We recommended the Under Secretary for Health update the Grant and Per Diem Program inspection checklist to ensure safe transitional housing and effective support services are provided to homeless Veterans.* *Recommendation 9: We recommended the Under Secretary for Health implement procedures to ensure providers have the capability and mechanisms to deliver proposed services to Veterans, prior to funds being awarded.* *Recommendation 13: We recommended the Under Secretary for Health implement monitoring procedures to ensure that quality and reliable information is provided to the Northeast Program Evaluation Center.*				
03/14/12	11-03663-111	Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama	VHA	None
Recommendation 1: We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe. *Recommendation 6: We recommended that processes be strengthened to ensure that providers include follow-up appointment recommendations in discharge instructions and that appointments are scheduled within the requested timeframes.* *Recommendation 7: We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon CLC admission and at clinic visits.*				
03/15/12	11-03660-114	Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan	VHA	None
Recommendation 9: We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
03/16/12	11-03653-106	Community Based Outpatient Clinic Reviews: Durango, CO; Raton and Silver City, NM; Odessa, TX	VHA	None

Recommendation 1: We recommended that the New Mexico VA HCS establish a Preservation-Amputation Care and Treatment Team program in accordance with VHA policy.

Recommendation 3: We recommended that the clinicians at the Durango, Raton, and Silver City CBOCs provide education of foot care to all diabetic patients and document the education in CPRS.

Recommendation 6: We recommended that providers at the Silver City CBOC document a justification for using STFB [Short-Term Fee Basis] care in the medical record.

Recommendation 7: We recommended that patients are sent written notification when a STFB consult is approved.

Recommendation 8: We recommended that the ordering practitioners, or surrogate practitioners, communicate the STFB results to the patient within 14 calendar days from the date made available to the provider.

Recommendation 12: We recommended that radiology mammogram orders are entered into CPRS for all fee basis and contract mammograms and that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order at the Odessa CBOC.

Recommendation 13: We recommended that the Women's Health Liaison at the Odessa CBOC collaborates with the Women Veterans Program Manager.

Recommendation 15: We recommended that results of FPPEs for performance monitoring are reported to the MEC [Medical Executive Committee].

Recommendation 16: We recommended that aggregate data is collected, compared, and utilized during the re-privileging process at the Raton and Silver City CBOCs.

Recommendation 17: We recommended that OPPE data is reviewed and discussions of the MEC are documented prior to re-privileging providers at the Odessa CBOC.

Recommendation 18: We recommended that access for disabled Veterans be re-evaluated and appropriate action taken at the Raton and Silver City CBOCs.

Recommendation 19: We recommended that accessibility issues related to the modular building at the Raton CBOC are re-evaluated and appropriate action taken.

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 20: We recommended that the environmental conditions are corrected at the Raton CBOC. *Recommendation 21: We recommended that medications are secured from unauthorized access at the Durango CBOC.* *Recommendation 23: We recommended that the Odessa CBOC comply with ADA [Americans with Disabilities Act] requirements for door hardware.* *Recommendation 24: We recommended that the Contracting Officer ensures the contract clearly states the requirements for payment and specifically defines a qualifying visit.*				
03/19/12	11-03653-112	Community Based Outpatient Clinic Reviews: Pensacola (Joint Ambulatory Care Center), FL; New Braunfels, San Antonio (North Central Federal Clinic), and Victoria, TX	VHA	None
Recommendation 2: We recommended that the JACC [Joint Ambulatory Care Center] CBOC ordering providers document in the medical record that they reviewed the STFB imaging report within 14 days from the date made available to the provider. *Recommendation 6: We recommended that providers at the JACC CBOC document a justification for the use of STFB care in the medical record.* *Recommendation 10: We recommended that the JACC CBOC ordering providers document in the medical record that they reviewed the STFB imaging report within 14 days from the date made available to the provider.* *Recommendation 11: We recommended that the ordering providers, or surrogate providers, at the JACC CBOC communicate the STFB results of the imaging report to the patient within 14 days from the date made available to the provider.* *Recommendation 12: We recommended that the JACC CBOC establish a process to ensure that patients with normal mammogram results are notified of results within the allotted timeframe and that notification is documented in the medical record.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/27/12	10-02888-129	Audit of Management Control Structures for VISN Offices	VHA	None

Recommendation 1: We recommended the Under Secretary for Health review FY 2012 Veterans Integrated Service Network Director performance appraisals and appraisal input to ensure that the revised performance measures and "Fully Successful" performance threshold facilitate the identification of problem areas and improved performance outcomes.

Recommendation 2: We recommended the Under Secretary for Health implement a control mechanism to ensure the uniform and consistent implementation of performance measures across and within Veterans Integrated Service Network offices and the linkage of the performance measures with the achievement of VHA organizational goals.

Recommendation 3: We recommended the Under Secretary for Health develop a clear definition of who is a Veterans Integrated Service Network office employee; ensure Veterans Integrated Service Network offices consistently apply this definition; and maintain accurate, reliable, and complete Veteran Integrated Service Network office staffing data in VA's automated information systems and other appropriate management information systems.

Recommendation 5: We recommended the Under Secretary for Health review current Veterans Integrated Service Network office positions filled by Title 38 staff to ensure that the positions require clinical knowledge and skills, and if not, require Veterans Integrated Service Network Directors to take action at the earliest feasible point possible to reclassify the positions as administrative positions.

03/30/12	11-00312-127	Audit of VHA's Prosthetics Supply Inventory Management	VHA	$35,500,000

Recommendation 2: We recommended the Under Secretary for Health collaborate with the VA Office of Information and Technology to develop a detailed plan of the steps needed to replace Prosthetics Inventory Package and Generic Inventory Package with a comprehensive modern inventory system, including milestones for deliverables and a methodology for tracking progress.

Recommendation 3: We recommended the Under Secretary for Health establish a mechanism to ensure VA medical center prosthetic supply inventory managers receive the training required by the Veterans Health Administration's Inventory Management Handbook.

Recommendation 4: We recommended the Under Secretary for Health collaborate with the Executive Director, Office of Acquisition, Logistics, and Construction, to develop a VA Acquisition Academy curriculum and certification program for prosthetic supply inventory managers that includes training on the inventory management practices and techniques discussed in this report.

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 5: We 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.* *Recommendation 7: We recommended the Under Secretary for Health discontinue using the metric of comparing prosthetic excess supply inventory and budgets and establish a mechanism to ensure VA medical centers submit the prosthetic inventory performance metrics required by the Veterans Health Administration's Inventory Management Handbook.* *Recommendation 9: We recommended the Under Secretary for Health establish policies and procedures requiring Veterans Integrated Service Network Prosthetic Representatives to conduct cyclical reviews at VA medical centers within their jurisdiction to evaluate prosthetic supply inventory management practices and provide a comprehensive written report detailing the evaluation results to the Prosthetic and Sensory Aids Service Central Office and Veterans Integrated Service Network and VA medical center directors.*				
Total				**$4,011,861,000**

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