Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 72 | April 1–September 30, 2014

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On the Cover

U.S. Soldiers disembark a landing craft at Normandy, France on June 6, 1944. By the end of the day some 150,000 Allied troops had landed on five Normandy beaches and three airborne drop zones. The invasion marked the beginning of the final phase of World War II in Europe, which ended with the surrender of Germany the following May. June 6, 2014, marked the 70th anniversary of the World War II D-Day Normandy landings. Department of Defense photo courtesy of the National Infantry Museum.

Message from the Acting Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our accomplishments during the reporting period April 1–September 30, 2014. Highlighted below are some of the key findings and conclusions that were the result of our work during this reporting period.

The Office of Inspector General (OIG) issued 195 reports and 22 memoranda on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified nearly $1.59 billion in monetary benefits, for a return on investment of $31 for every dollar expended on OIG oversight. OIG investigators closed 462 investigations and made 288 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work and Hotline activity oversight also resulted in 587 administrative sanctions and corrective actions.

In response to allegations of gross mismanagement of VA resources, criminal misconduct by senior leadership, systemic patient safety issues, and possible wrongful deaths, OIG's three line elements conducted a joint review of the Phoenix VA Health Care System (PVAHCS) and found patients experienced access barriers that adversely affected the quality of care provided for them. Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while traveling or temporarily living in Phoenix. OIG examined the electronic health records (EHRs) and other information for 3,409 veteran patients identified from multiple sources, including the 40 patients in PVAHCS's records, and identified 28 instances of clinically significant delays in care associated with access to care or patient scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. During our review of EHRs, we considered the responsibilities and delivery of medical services by primary care providers (PCPs) versus speciality care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the veteran patients we reviewed were on official or unofficial wait lists and experienced delays accessing primary care — in some cases, pressing clinical issues required speciality care, which some patients were already receiving through VA or non-VA providers. For example, a patient may have been seeing a VA cardiologist, but he was on the wait list to see a PCP at the time of his death. While the case reviews in this report document poor quality care, we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.

Since this story first appeared in the national media, OIG received approximately 225 allegations regarding health care at Phoenix and approximately 445 allegations regarding manipulated wait times at other VA medical facilities. Our Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations and is coordinating with the Department of Justice and the Federal Bureau of Investigation. These investigations, while most are still ongoing, have confirmed wait time manipulations are prevalent throughout the Veterans Health Administration (VHA). OIG found VHA did not hold senior headquarters

and facility leadership responsible and accountable for implementing action plans addressing compliance with scheduling procedures. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA's senior leaders and mid-managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible.

Through the efforts of our Office of Investigations, working jointly with the Social Security Administration OIG, Tennessee Bureau of Investigation, and District Attorney's Office, a veteran's widow was arrested for first degree murder and conspiracy to commit first degree murder. The joint investigation revealed the defendant and her current spouse conspired to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on prescription drugs and then staging a crime scene to make it appear he committed suicide. Subsequent to the veteran's death, the defendant applied for Dependency and Indemnity Compensation benefits, claiming her husband's drug overdose stemmed from his service-connected post-traumatic stress disorder. In exchange for a reduced sentence, the defendant's current spouse pled guilty to conspiracy to commit first degree murder and has agreed to cooperate with the prosecution against his spouse. The loss to VA is over $100,000.

OIG's Office of Contract Review (OCR) assessed VHA's use of commercial reverse auctions to procure products and services. OCR's review determined the methodology used to calculate and report savings by using reverse auctions greatly overstated any actual savings and did not comply with VHA's Standard Operating Procedure (SOP). In addition, VHA's mandatory requirement to use reverse auctions violated VA's policy for using priority sources such as Federal Supply Schedule contracts. Over 93 percent of the contract files OCR reviewed did not contain proper documentation to validate the use of reverse auctions in accordance with VHA's SOP. The review also determined contracting officials run the risk of purchasing gray market items by using reverse auctions.

In addition, the Office of Investigations conducted an administrative investigation of VHA's Deputy Chief Procurement Officer and determined she engaged in conduct that was prejudicial to the Government and a conflict of interest, improperly disclosed non-public VA information, misused her position and VA resources, engaged in a prohibited personnel practice, interfered with a VA OIG contract review, acted as an agent of FedBid Inc. in matters before the Government, and did not testify freely and honestly. Additionally, in an attempt to financially benefit FedBid, she, a close personal friend, and FedBid Inc. executives willfully and improperly acted to thwart a VA Official in his oversight duties associated with VA's procurement operations. Collectively, these individuals took significant measures to disrupt and deprive VA's right to conduct official business honestly and impartially.

The Office of Healthcare Inspections (OHI) reviewed opioid presribing practices at VHA facilities. Using a study population of nearly 500,000 patients, OHI assessed the provision of VA outpatient opioids and monitoring of patients on opioid therapy. The concurrent use of benzodiazepines and opioids can be dangerous because opioids and benzodiazepines can depress the central nervous system and thereby affect heart rhythm, slow respiration, and even lead to death. The study revealed take-home benzodiazepines were dispensed to 7.4 percent of the population, with 71 percent dispensed concurrently with opioids. Of the 92.3 percent of patients given take-home acetaminophens, 2 percent were given an average daily dose exceeding the recommended daily dose of 4 grams, placing veterans at risk of liver failure. Opioid patients frequently have complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications. A review of medications by a pharmacist or other health care professional can prevent harmful interactions between these medications. OHI found 38.8 percent of patients in the

population received medication management or pharmacy reconciliation. The Clinical Practice Guideline calls for a urine drug test (UDT) prior to initiating opioid therapy and a follow-up contact at least every 2–4 weeks after any change in medication regimen and requires routine and random UDTs to confirm the appropriate use of opioids by patients and a follow-up contact at least once every 1–6 months for the duration of opioid therapy. Also, OHI determined only 6.4 percent of the new patients received both a UDT before therapy initiation and another UDT within 30 days following therapy initiation, 37 percent of the existing opioid patients received both an annual UDT and a follow-up contact within 6 months of each filled opioid prescription, and 10.5 percent of active substance use patients received both treatment for substance use and a UDT within 90 days of each filled opioid prescription. Even for the subpopulation of 19,724 active substance use patients who were on opioids more than 90 days in fiscal year (FY) 2012, OHI determined only 18.8 percent received a substance use disorder treatment in the FY and a UDT for each 90 days on opioids.

A VA contractor pled guilty to major program fraud. In addition, the defendant's company pled guilty to money laundering in furtherance of a fraudulent pass-through scheme. The guilty pleas follow a Service-Disabled Veteran-Owned Small Business' (SDVOSB) plea to major program fraud and wire fraud, which was entered on behalf of the SDVOSB by the service-disabled veteran owner. An indictment charged the contractor and service-disabled veteran owner in connection with a $23.5 million SDVOSB fraud scheme. The charges included major fraud, wire fraud, money laundering, and conspiracy. Additionally, approximately $3.9 million was seized as part of the investigation. An OIG investigation revealed that from approximately May 2007 to August 2010, the SDVOSB unlawfully received 45 set-aside and/or sole-source SDVOSB contracts from VA and the Department of Defense, to include contracts involving *American Recovery and Reinvestment Act of 2009* (ARRA) funds. The investigation further revealed that the SDVOSB was a pass-through and/or front company for the contractor's other businesses and that the service-disabled veteran was simply a figurehead or "rent-a-vet" who was being used for his service-disabled veteran status.

I want to express my deep gratitude to our OIG employees for their continued commitment to accomplishing OIG's mission to ensure our Nation's veterans and their families receive the best care, benefits, and services possible from VA. Without their dedication, the many accomplishments discussed in this report would not have been possible. Additionally, I am grateful for the continued support of our mission from Members of Congress, the Secretary, the Deputy Secretary, and VA senior management. We look forward to continuing these partnerships as we all continue to work to improve the lives of America's veterans.

RICHARD J. GRIFFIN
Acting Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month	FY
Better Use of Funds	$318.7	$318.7
Fines, Penalties, Restitutions, and Civil Judgments	$37.5	$91.2
Fugitive Felon Program	$123.7	$240.0
Savings and Cost Avoidance	$132.3	$664.9
Questioned Costs	$957.1	$957.1
Dollar Recoveries	$18.6	$28.2
Total Dollar Impact	$1,588.0	$2,300.0
Cost of OIG Operations[1]	$52.0	$104.1
Return on Investment[2]	**31:1**	**22:1**

Investigative Activities	6-Month	FY
Arrests[3]	288	467
Fugitive Felon Arrests	18	47
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	24	25
Indictments	171	299
Criminal Complaints	106	185
Convictions	174	343
Pretrial Diversions and Deferred Prosecutions	18	43
Administrative Investigations Opened	10	19
Administrative Investigations Closed	11	18
Administrative Sanctions and Corrective Actions	288	509
Cases Opened[4]	489	964
Cases Closed[5]	462	880

Hotline Activities	6-Month	FY
Contacts	25,571	39,874
Cases Opened	843	1,330
Cases Closed	584	1,109
Administrative Sanctions and Corrective Actions	299	644
Substantiation Percentage Rate	41	40

Reports and Memoranda	6-Month	FY
Reports Issued		
Audits and Evaluations	19	26
Benefits Inspections	10	10
Joint Reviews	2	2
Peer Reviews of Other OIGs	1	1
National Healthcare Reviews	8	8
Hotline Healthcare Inspections	25	39
Combined Assessment Program Reviews	27	49
Community Based Outpatient Clinic Reviews[6]	34	58
Administrative Investigations	3	4
Preaward Contract Reviews	28	54
Postaward Contract Reviews	32	51
Claim Reviews	5	6
Contract Review Special Reports	1	2
Subtotal	**195**	**310**
Memoranda		
Administrative Investigation Advisories	3	5
Administrative Investigation Closures	6	12
Healthcare Closures	13	23
Subtotal	**22**	**40**
Total Reports and Memoranda	**217**	**350**

Healthcare Inspections Activities	6-Month	FY
Clinical Consultations	5	5

1. The 6-month operating cost for the Office of Healthcare Inspections ($10.8 million), whose oversight mission results in improving the health care provided to Veterans rather than saving dollars, is not included in the return on investment calculation.
2. This figure is calculated by dividing Total Dollar Impact by Cost of OIG Operations.
3. This figure does not include Fugitive Felon arrests by OIG or other agencies.
4 & 5. These figures include administrative investigations opened/closed.
6. Encompassing 171 facilities for the 6-month period.

Glossary

AIG	Assistant Inspector General
ARRA	American Recovery and Reinvestment Act
ADTC	average days to complete
ATF	Bureau of Alcohol, Tobacco, Firearms and Explosives
BME	Biomedical Engineering
CAP	Combined Assessment Program Review
CBOC	Community Based Outpatient Clinic
CCL	cardiac catheterization laboratory
CFO	Chief Financial Officer
CHAMP-VA	Civilian Health and Medical Program of the Department of Veterans Affairs
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CJD	Creutzfeldt-Jakob Disease
CLC	Community Living Center
COS	Chief of Staff
CS	controlled substances
CSB	community service board
CSP	Caregiver Support Program
DCIS	Defense Criminal Investigative Service
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DMO	Designated Management Official
DoD	Department of Defense
DOE	Department of Energy
DOL	Department of Labor
DSS	Decision Support System
EAFH	Eastern Area Fiduciary Hub
ED	emergency department
EHR	electronic health record
EOC	environment of care
EWL	electronic waiting list
FBI	Federal Bureau of Investigation
FCA	Facility Condition Assessment
FFMIA	Federal Financial Management Improvement Act
FISMA	Federal Information Security Management Act
FSS	Federal Supply Schedule
FY	fiscal year
GI	Gastroenterology
GSA	General Services Administration
HCS	Healthcare System
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
ICU	Intensive Care Unit
IG	Inspector General
IPERA	Improper Payments Elimination and Recovery Act
IRS-CI	Internal Revenue Service Criminal Investigation
IT	information technology
LRAC	Local Reasonable Accommodations Coordinator
MH	mental health
MM	medication management
MMU	mobile medical unit
NCA	National Cemetery Administration
NCIS	Naval Criminal Investigative Service
NRM	nonrecurring maintenance
NVCC	Non-VA Care Coordination
OAE	Office of Audits and Evaluations
OALC	Office of Acquisition, Logistics, and Construction
OCR	Office of Contract Review
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHRA	Office of Human Resources and Administration
OIG	Office of Inspector General
OIT	Office of Information and Technology
OM	Office of Management
OMPF	official military personnel file
OOORAM	out-of-operating room airway management
OR	operating room
ORH	Office of Rural Health
OSP	Office of Operations, Security, and Preparedness
PAR	Performance and Accountability Report
PCP	primary care provider
PII	personally identifiable information
P.L.	Public Law
PMC	Pension Management Center
PMI	preventive maintenance inspections

(continued on next page)

PTSD	post-traumatic stress disorder
PVAHCS	Phoenix VA Health Care System
QAR	Qualitative Assessment Review
QM	quality management
RA	reasonable accomodations
RN	registered nurse
RO	Regional Office
RT	respiratory therapy
Rural Initiative	Rural Veterans Burial Initiative
SAO	Systematic Analysis of Operations
SBA	Small Business Administration
SDVOSB	Service-Disabled Veteran-Owned Small Business
SOP	Standard Operating Procedure
SSA	Social Security Administration
SSN	social security number
STR	service treatment records
TBI	traumatic brain injury
U of Utah	University of Utah
UDT	urine drug test
UNM	University of New Mexico
UPS	United Parcel Service
USB	Under Secretary for Benefits
USH	Under Secretary for Health
USPS	United States Postal Service
VAMC	Veterans Affairs Medical Center
VANIHCS	Veterans Affairs Northern Indiana Healthcare System
VARO	Veterans Affairs Regional Office
VASLCHCS	Veterans Affairs Salt Lake City Healthcare System
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSR	Veterans Service Representative
WCP	Workers' Compensation Program

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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) 2014, VA is operating under a $153.9 billion budget, with over 343,000 employees serving an estimated 21.9 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

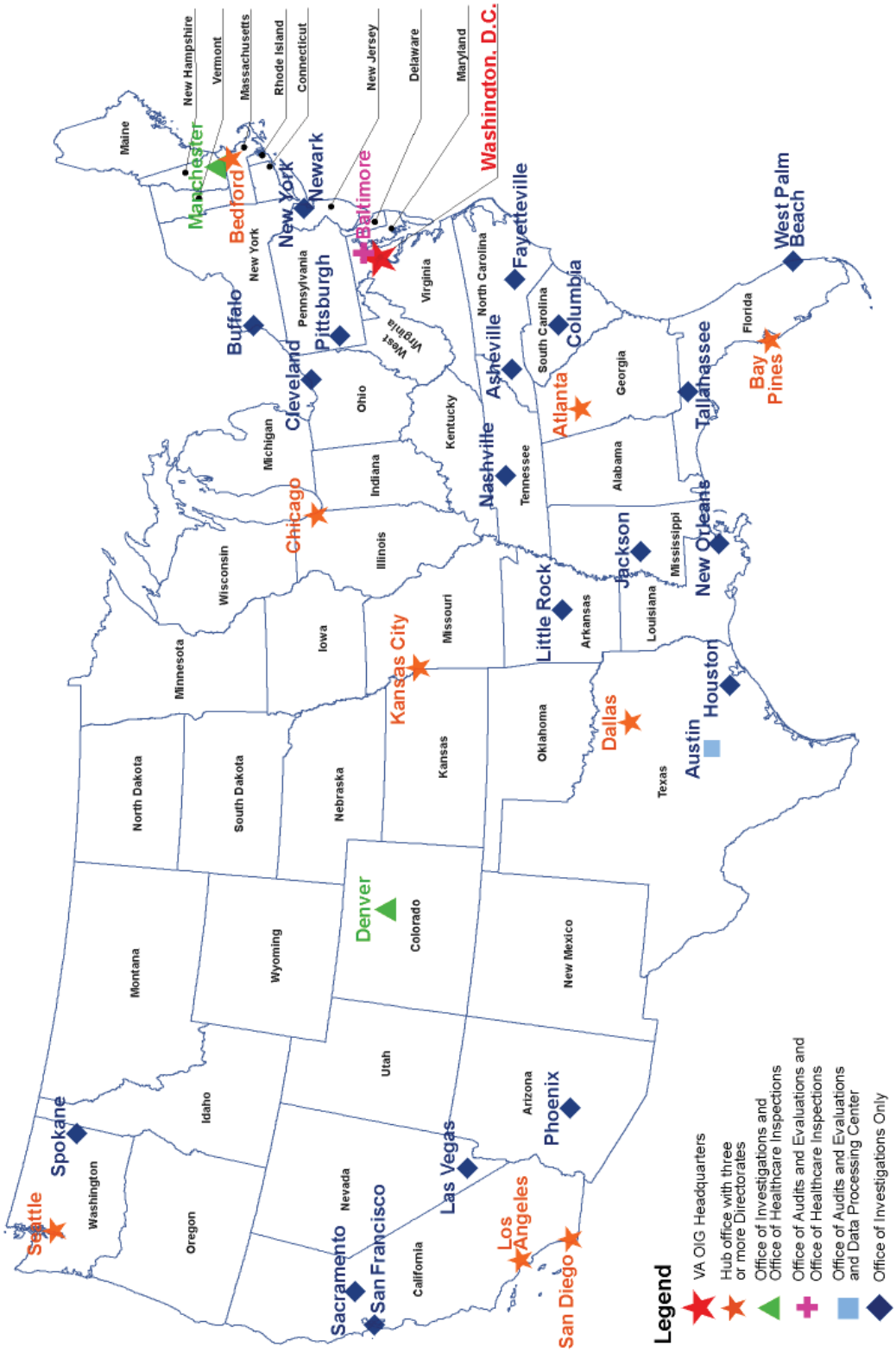
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

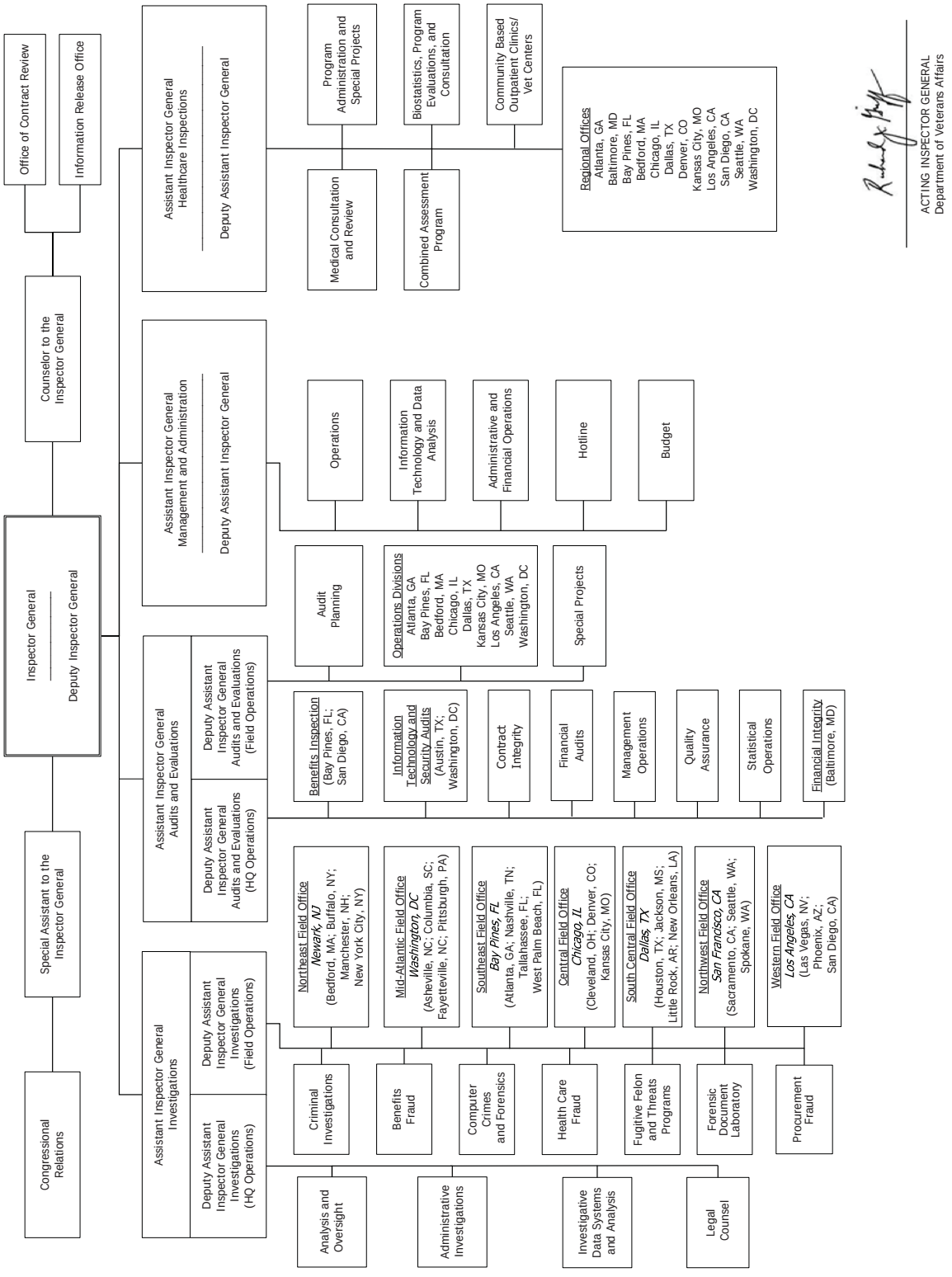
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. In addition, P.L. 100-322, passed on May 20, 1988, charged OIG with the oversight of the quality of VA health care. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 635 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2014 funding for OIG operations provides $121.4 million from ongoing appropriations. The Office of Contract Review, with 26 employees, received $4.2 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS), construction, and health care provider contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country. OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG internet home page at www.va.gov/oig.

OIG Field Offices Map



OIG Organizational Chart



Office of Healthcare Inspections

For many years, VHA has been a national leader in the quality of care provided to patients when compared with our major U.S. health care providers. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 8 national healthcare reviews; 2 joint reviews; 25 Hotline healthcare inspections; 27 Combined Assessment Program (CAP) reviews; and 34 Community Based Outpatient Clinic (CBOC) reviews, covering 171 facilities, to evaluate the quality of veteran care. All reports issued this reporting period are listed in Appendix A.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to veterans. CAP reviews provide cyclical oversight of VHA health care facilities. Their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 27 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 12 months. The topics covered this reporting period include: Quality Management (QM), Environment of Care (EOC), Medication Management (MM), Coordination of Care, Nurse Staffing, Pressure Ulcer Prevention and Management, and Community Living Center (CLC) Resident Independence and Dignity. When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use. During this reporting period, OIG issued six CAP summary reports, which are highlighted in the National Healthcare Reviews section.

Community Based Outpatient Clinic Reviews

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 three primary activities: CBOC information gathering and review, medical record reviews for determining compliance with VHA requirements, and onsite inspections. During this reporting period, OIG performed reviews covering 171 CBOCs reporting to 34 parent facilities and 18 Veterans Integrated Service Networks (VISNs). Site visits were made and physical inspections were performed at 52 of these CBOCs. These reviews are captured in 34 reports. The topics covered this reporting period include: EOC, Alcohol Use Disorder, MM of Fluroquinolones, and Designated Women's Health Provider Proficiencies. During this reporting period, OIG issued one CBOC summary report, which is highlighted in the National Healthcare Reviews section.

National Healthcare Reviews

OIG Makes Six Recommendations on Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy

As requested by the Senate Committee on Veterans' Affairs, OIG assessed the provision of VA outpatient (take-home) opioids and monitoring of patients on opioid therapy. The population consisted of nearly half a million patients who were not receiving hospice/palliative care and who filled at least 1 oral or transdermal opioid prescription from VA for self-administration at home in FY 2012. The average and the median patient age was 59.4 and 61, respectively, and nearly 94 percent of them had been diagnosed with either pain or mental health (MH) issues and 58.4 percent with both. The concurrent use of benzodiazepines and opioids can be dangerous because opioids and benzodiazepines can depress the central nervous system and thereby affect heart rhythm, slow respiration, and even lead to death. OIG determined that take-home benzodiazepines were dispensed to 7.4 percent of the study population, and 71 percent were dispensed concurrently with opioids. Take-home acetaminophens were given to 92.3 percent of the patients, and 2.0 percent of them were given an average daily dose that exceeded the maximum recommended daily dose of 4 grams, placing veterans at risk of liver failure. Opioid patients frequently have complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications. A review of medications by a pharmacist or other health care professional can prevent harmful interactions between these medications. OIG found that 38.8 percent of the patients received MM or pharmacy reconciliation. The Clinical Practice Guideline calls for a urine drug test (UDT) prior to initiating opioid therapy and a follow-up contact at least every 2–4 weeks after any change in medication regimen and requires routine and random UDTs to confirm the appropriate use of opioids by patients and a follow-up contact at least once every 1–6 months for the duration of opioid therapy. OIG determined that only 6.4 percent of the new patients received both a UDT at intake and a follow-up within 30 days of therapy initiation, that 37.0 percent of the existing opioid patients received both an annual UDT and a follow-up contact within 6 months of each filled opioid prescription, and that 10.5 percent of active substance use patients received both treatment for substance use and a UDT within 90 days of each filled opioid prescription. Even for the subpopulation of 19,724 active substance use patients who were on opioids for more than 90 days in FY 2012, OIG determined that only 18.8 percent of them received both a substance use disorder treatment in the FY and a UDT for each 90 days on opioids. OIG made six recommendations.

CAP Summary Report on Construction Safety at VHA Facilities Makes Five Recommendations for Improvement

The purpose of the review was to determine whether VHA facilities had developed effective construction safety programs that provided a safe environment for patients, employees, and visitors during construction and renovation activities in patient care areas. OIG performed this review in conjunction with 27 CAP reviews of VHA medical facilities conducted from October 1, 2012, through September 30, 2013. OIG identified opportunities for improvement in site inspections, contractor tuberculosis risk assessments, committee oversight, training, and documentation and made five recommendations.

CAP Summary on Preventable Pulmonary Embolism Finds Opportunities for Improvement for Patients With One Risk Factor

The purpose of the review was to evaluate the care provided to patients treated at VHA facilities who developed potentially preventable pulmonary embolism. This evaluation was also a follow-up to OIG's report *Healthcare Inspection – Prevention of Venous Thromboembolism in VA Hospitals* (Report No. 06-02459-209, September 26, 2008). OIG conducted this review at 29 VHA medical facilities during CAP reviews performed across the country from October 1, 2012, through March 31, 2013, and encouraged facility management to

expand peer review and to monitor the rate of preventable pulmonary embolism at their facilities. While OIG made several recommendations during facility CAP reviews, OIG made no recommendations in this report.

CAP Summary Report on Nurse Staffing Shows 8 of 28 VHA Facilities Did Not Fully Implement Staffing Methodology

The purpose of the evaluation was to determine the extent to which VHA facilities implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on an acute care unit, a long-term care unit, and an MH unit. OIG conducted this review at 28 VHA medical facilities during CAP reviews performed across the country from April 1 through September 30, 2013. OIG re-emphasized the need for all facilities to fully implement the methodology and accurately address patient needs with safe and adequate staffing. VHA submitted a detailed action plan that was still in progress at the time of this report (see *Combined Assessment Program Summary Report – Evaluation of Nurse Staffing in Veterans Health Administration Facilities*, Report No. 13-01744-187, April 30, 2013.) Therefore, OIG will not make repeat recommendations but will continue to review VHA's corrective actions.

Review of QM Programs at 58 VHA Facilities Shows 47 Require Improvement

The purposes of the review were to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether facility senior managers actively supported QM efforts and appropriately responded to QM results. OIG performed this review at 58 VHA medical facilities during CAP reviews performed across the country from October 1, 2012, through September 30, 2013. All 58 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas. OIG identified opportunities for improvement in the areas of peer review, utilization management, electronic health record (EHR) scanning, review of resuscitation events, and blood usage review.

OIG Makes 10 Recommendations for Improvement After Review of 58 Facilities' Controlled Substance Inspection Program

The purpose of the review was to determine whether VHA facilities complied with requirements related to controlled substances (CS) security and inspections and to follow up on the OIG report *Healthcare Inspection – Review of Selected Pharmacy Operations in Veterans Health Administration Facilities* (Report No. 07-03524-40, December 3, 2009). OIG performed this review in conjunction with 58 CAP reviews of VHA medical facilities conducted from October 1, 2012, through September 30, 2013. OIG identified opportunities for improvement in conducting annual physical security surveys and correcting identified deficiencies; completing quarterly trend reports and providing them to facility Directors; conducting monthly CS inspections of non-pharmacy areas; completing non-pharmacy inspection activities; performing emergency drug cache quarterly physical counts and monthly verification of seals; validating completion of required drug destruction activities, validating accountability of prescription pads stored in the pharmacy, and verifying outpatient pharmacy written prescriptions for schedule II drugs; and providing annual CS inspector training. VHA can strengthen policy by defining acceptable reasons for missed CS area inspections and providing guidance on CS Coordinator performance of monthly inspections. OIG made 10 recommendations.

CAP Summary Report on Palliative Care at VHA Facilities Makes Two Recommendations for Improvement

OIG conducted a review to determine whether VHA facilities performed active hospice and palliative care case finding, provided end-of-life care training to staff, and met selected documentation standards and to assess selected Palliative Care Consult Team processes, documentation, and staffing. OIG performed this review in conjunction with 54 CAP reviews of VHA medical facilities conducted from October 1, 2012, through

September 30, 2013. OIG identified opportunities for improvement in providing required minimum Palliative Care Consult Team staffing and end-of-life care training to staff and made two recommendations.

OIG Recommends the Establishment of Consistent Processes for Notifying Patients and Providers of Cervical Cancer Screening Results

The purpose of OIG's systematic review of VHA's CBOCs was to evaluate compliance with selected VHA requirements regarding cervical cancer screenings and results reporting. The review focused on (1) whether women veterans, ages 23–64, received cervical cancer screening and (2) whether ordering providers and patients received notification of cervical cancer screening results within the timeframes established by VHA policy. OIG recommended that consistent processes be established for notifying (1) ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR and (2) women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR.

Hotline Healthcare Inspections

OIG Finds Questionable Cardiac Interventions, Poor Management of Cardiovascular Care at Hines, Illinois, VA Medical Center

OIG conducted an inspection at the Edward Hines, Jr. VA Hospital in Hines, IL, at the request of Senator Richard Durbin and Congresswoman Tammy Duckworth concerning unnecessary cardiac interventions and poor management of cardiovascular care. OIG substantiated that two patients had questionable indications for coronary bypass surgery and that preoperative planning was inadequate for a patient who underwent coronary artery bypass surgery. OIG found that coronary interventions may have been inappropriate for nine patients who had undergone cardiac catheterizations during 2010–2013. OIG substantiated that there were operating room (OR) environmental and equipment deficiencies, hospital beds were often unavailable, there was poor bed utilization, and the facility did not monitor compliance with two of an affiliated academic institution's contracts. OIG did not substantiate that a patient who died in the OR received inappropriate care, the operation should not have been performed at the facility, and that preoperative planning was inadequate. OIG did not substantiate that there was inadequate staffing or medical support for cardiac surgery, patients had excessively long waits to be admitted from the emergency department (ED), there were delays in or poor quality of echocardiography, non-board certified physicians were assigned to crucial management positions, care was inappropriately provided by trainees and non-physician providers, staff failed to adhere to written policies for the Surgical Intensive Care Unit (ICU), and that Surgical ICU physicians sometimes were at an affiliated academic institution during their VA tours of duty, or that there was a lack of fairness of Administrative Investigation Boards. OIG made four recommendations.

OIG Finds No Relationship Between Length of Patient's ED Wait and Subsequent Clinical Course at Southern Nevada Healthcare System

OIG conducted an inspection at the VA Southern Nevada Healthcare System (HCS), Las Vegas, NV, in response to a request from the House Committee on Veterans' Affairs Chairman Jeff Miller and Congresswoman Dina Titus. OIG evaluated the merit of allegations that a patient experienced an excessive wait for emergency care and that staff repeatedly disrespected the patient. OIG found that in October 2013, an elderly patient spent 5 hours and 6 minutes in the facility's ED, waiting 4 hours and 45 minutes to be evaluated by an ED physician. OIG concluded that a wait of this length was challenging for this patient. However, mitigating this long wait was the fact that numerous other patients who were assessed to be in more urgent need of attention were in the ED at the same time. The facility's target is for less than 10 percent of its ED patients to experience a total ED length of stay of greater than 6 hours. The facility met this target on only 1 day during the week in which the patient

visited the ED. The purpose of triage in the ED is to prioritize incoming patients and to identify those who cannot wait to be seen. The patient's wait time to be triaged by a registered nurse (RN) was 63 minutes. During the patient's multi-hour waiting period, there was no documentation of hourly nursing reassessments as required by local policy. OIG found no relationship between the length of the patient's ED wait and her subsequent clinical course. OIG did not substantiate the allegations of staff disrespect. OIG made two recommendations.

Allegations of Poor Coordination and Care Not Substantiated at the VA Black Hills HCS, Fort Meade, South Dakota

OIG conducted a review in response to allegations received by Senator Tim Johnson's office concerning poor coordination and delivery of care at the VA Black Hills HCS, Fort Meade, SD. OIG was unable to substantiate the allegation that the telephone contact and triage process in place during 2012 was cumbersome, resulted in delayed responses from primary care providers (PCPs) to patients calling for medical care or advice, or was set up to divert calls away from PCPs. OIG did not substantiate the allegation that a veteran's spouse received inaccurate information on obtaining emergency care outside of the system. The staff at the system followed the system policy when providing information on where to take the veteran for care. OIG did not substantiate the allegation of "negligence and medical errors" at the system during the veteran's evaluation and subsequent admission in November 2012. Review of the EHRs showed appropriate care of the veteran's symptoms as they developed. OIG did not substantiate the allegation that VA did not make the veteran aware of all alternatives to care related to podiatry concerns. The veteran was seen by system podiatrists and treated appropriately. Referrals were made for non-VA care when indicated. OIG did not substantiate the allegation that a veteran's spouse was denied care because of difficulty coordinating care under the Civilian Health and Medical Program of the VA (CHAMPVA). The spouse chose to use non-VA care when VA providers were available. VA does not fill prescription medications for CHAMPVA patients who receive care from non-VA providers. OIG made no recommendations.

Dublin, Georgia, VA Medical Center Closed Consult Requests for More than 600 Patients Without Being Seen by Provider

OIG conducted an inspection in response to a complaint, followed by a request from Congressman Jack Kingston, regarding alleged consult mismanagement at the Carl Vinson VA Medical Center (VAMC) in Dublin, GA. OIG found that, in order to meet organizational goals, facility staff improperly "batch closed" more than 1,500 Non-VA Care Coordination (NVCC) consults on April 25, 2014. Batch closure should not have been used to close current requests for care. NVCC staff had generally been following established procedures to individually close older consults in the months preceding the batch closure. By batch closing 1,546 consults, the facility met the consult closure May 1 deadline. More than 600 patients whose consults were batch closed had not been seen by an NVCC provider at the time of consult closure. While OIG substantiated that NVCC staff were instructed to send NVCC consults back to the requesting providers for clinical review, and in some cases, providers had to re-enter consults, this action was appropriate and followed Consult Clean-Up guidance. As a result of the batch-closure, NVCC staff had to re-enter fee authorizations when care was still needed. The facility had difficulty scheduling timely non-VA care appointments. While they did not monitor timeliness of NVCC appointments, a VISN report showed that for the period October 1, 2013, though March 31, 2014, the facility failed to meet VHA's 90-day goal each month. Because some NVCC providers are overwhelmed with referrals, patients requiring certain types of specialty care can wait months for appointments. OIG recommended that the VISN Director review the circumstances surrounding the batch closures and confer with appropriate VA offices to determine the need to take administrative action, if any, and that the Facility Director track the timeliness of NVCC appointment scheduling and promptly respond to potential delays.

Allegations Regarding Mismanagement of Patient Care Assessed at the Carl Vinson VAMC, Dublin, Georgia

OIG conducted an inspection in response to allegations about mismanagement of patient care at the Carl Vinson VAMC (facility), Dublin, GA. OIG did not substantiate that a patient with systemic lupus erythematosus was not promptly treated for a urinary tract infection and that the infection contributed to her premature death. The patient did not have test results consistent with a urinary tract infection. OIG does not know the precise cause of death, but the patient had laboratory evidence consistent with increased lupus activity in the month preceding her death. While facility and contract CBOC providers were aware of the patient's lupus diagnosis, neither acknowledged this significant clinical finding in their progress notes nor consulted a rheumatologist for follow-up. OIG could not substantiate that the patient was told that the facility would not pay for further care with a private-sector rheumatologist. OIG was unable to interview the Albany CBOC providers or their supervisors, but the patient's EHR in the 9 months prior to her death did not reflect discussion of the need for reauthorizing non-VA care. Therefore, OIG could not say specifically what the patient was told about future non-VA care. Based on medical record documentation, it did not appear that either of the Albany CBOC physician assistants who cared for the patient in 2011–2012 ensured that she received appropriate continuity of rheumatology care. Responsible facility clinicians and managers did not comply with guidelines for completing peer reviews, and as a result, the peer review of this case did not address the full scope of quality issues contributing to the patient's outcome. OIG made four recommendations.

Follow-Up Review Shows Overall Improvement in Atlanta, Georgia, VAMC's Oversight of Inpatient & Contracted Mental Healthcare

OIG conducted an inspection at the request of Senator Johnny Isakson to follow up on two prior reports at the Atlanta VAMC, Decatur, GA. OIG evaluated management of care on the VAMC's MH inpatient unit, and assessed administration, management, and coordination of the VAMC's contract MH program through which patients receive outpatient MH services at community service boards (CSBs). OIG noted overall improvements in oversight of the inpatient MH unit and contract MH care program. OIG found that the facility made changes in leadership that enhanced interdisciplinary collaboration and added supervisory processes previously absent from these programs. OIG found that the Under Secretary for Health (USH) had issued a memorandum to the field and published a Handbook to provide guidelines and requirements for inpatient MH units. The facility developed and implemented policies and procedures to address hazardous items on the unit, patient off-unit escorts, urine drug screenings, and patient visitation. The facility also established processes to strengthen documentation of patient monitoring and on-unit observation, interdisciplinary communication, leadership oversight, and rigor of the root cause analysis process. OIG found improvements to the facility's administration and coordination of contract MH care with CSBs, billing, and oversight. However, challenges persist in the absence of a centralized repository for CSB patient data, tracking of patients beyond first appointments, and in the transfer of patient information between the facility and the CSBs. OIG recommended that the Facility Director ensure that a standardized and facility-wide repository be developed and implemented to monitor patients referred to CSBs, patients are tracked for follow-up beyond the first contract MH appointment, and that communication is strengthened to better coordinate patient care.

OIG's Unannounced Inspection at Atlanta VAMC Confirms Ongoing Problems with Medication Carts

OIG conducted an inspection to evaluate allegations of medication cart deficiencies, unsafe medication administration practices, and insufficient leadership response to these problems at the Atlanta VAMC, Decatur, GA. During an unannounced site visit, OIG found that four of the five carts used in the CLC for medication pass had to remain plugged-in due to insufficient battery power and some of the medication drawers on two of the carts did not lock. Of the 14 carts in service on the 7th and 10th medical floors, 5 had to remain

plugged-in due to short battery life and 6 had unsecurable medication drawers. The computers and scanners were functional on all 19 medication carts observed, but OIG noted that some computers were slow to operate or required multiple reboots. OIG found that due to inadequate and/or non-functional medication carts, nurses have had to administer medications late and that nurses did not consistently document the reason for late medication administration. OIG did not substantiate the allegations that due to inadequate and/or non-functional medication carts, nurses had to engage in workarounds; in fact, an approved alternate method was available for nursing staff to follow when administering medications. OIG substantiated that if nurses did not follow medication administration policy, they could be at risk professionally. While OIG confirmed ongoing problems with medication carts, we did not substantiate the allegation that leadership has not responded to complaints about the issue. OIG made three recommendations.

Recruitment Difficulties for Leadership and Clinical Positions Are Delaying Reopening of Fort Wayne, Indiana, Facility's ICU

OIG conducted an oversight review to follow up on the published report, *Healthcare Inspection - Review of Circumstances Leading to a Pause in Providing Inpatient Care at the VA Northern Indiana Healthcare System, Fort Wayne, Indiana*, Report No. 13-00670-265, issued on August 2, 2013. At the time of OIG's follow-up review, 16 medical beds with telemetry capability on the acute medical unit were open; however, the ICU remained closed. As a result, the facility did not accept medically complex patients and offered only limited surgical procedures. Consequently, many area veterans continue to receive non-VA Care. Although VHA approved the facility's proposal to reopen the ICU as a Level 4 ICU, an official date had not been established as of July 2, 2014. OIG found the facility has taken actions to actively recruit qualified clinical and leadership staff, but some clinical staff positions needed to be filled prior to the reopening of the ICU and some leadership positions remained vacant. OIG recommended the VISN Director ensure continued monitoring and implementation of actions for the reopening of the ICU. OIG recommended the VISN Director and the VA Northern Indiana HCS (VANIHCS) Director ensure recruitment efforts continue for vacant leadership and clinical staff positions. OIG recommended the VANIHCS Director ensure that nursing leaders assess the utilization of the nursing staff to systemically plan assignments during times when the acute medical unit's census is low.

OIG Makes Five Recommendations To Improve Caregiver Support Program at Charleston, South Carolina, VAMC

OIG conducted an evaluation in response to allegations that the Caregiver Support Program (CSP) at the Ralph H. Johnson VAMC, Charleston, SC, does not operate in accordance with P.L. 111-163 or VA guidelines. OIG found that: an interdisciplinary team had not appropriately assessed many veterans during the application process; facility leadership did not designate an interdisciplinary CSP team or develop a comprehensive assessment process until February 2014; more than 100 applications were awaiting initial CSP screening, and many of them exceeded the 45-day processing requirement; and CSP staff had not conducted 90-day and annual follow-up visits as required. OIG confirmed that the Chief of Social Work Service and facility leadership did not assure sufficient staffing in a timely manner to conduct CSP follow-up visits. OIG did not substantiate that the Caregiver Support Coordinator, who is an RN, did not possess the knowledge, skills, and abilities to perform the job. OIG found that caregivers received stipend dollars even though the facility had not documented required annual reassessment. OIG made five recommendations.

Healthcare Inspection Results for Resident Supervision in the OR, Ralph H. Johnson VAMC, Charleston, South Carolina

OIG conducted a review in response to a complainant's allegation that inexperienced and first-year residents in the Anesthesiology Service at the Ralph H. Johnson VAMC were improperly supervised while in the OR. OIG conducted an unannounced site visit at the facility and immediately inspected the OR. OIG did not substantiate the allegation that anesthesiology residents were inadequately supervised while in the OR. OIG concluded that

supervisory practices and expectations were clearly understood and adhered to by facility attending physicians, residents, and OR staff. OIG made no recommendations.

OIG Finds Improper Procurement and Billing Practices for Anesthesiology Services at VA Facility in Salt Lake City, Utah

OIG's OHI conducted an inspection in response to allegations about improper procurement of and billing practices for anesthesiology services provided by an affiliated school of medicine, the University of Utah School of Medicine (U of Utah), at the George E. Wahlen VA Salt Lake City HCS (VASLCHCS), Salt Lake City, UT. OIG substantiated the allegation that, until April 2011, there had been no formal negotiated contracts for anesthesiology services between VASLCHCS and U of Utah since 2002 and that VASLCHCS was paying for services performed at the VA facility through the use of purchase orders. OIG substantiated the allegation that U of Utah billed VASLCHCS for work performed by an anesthesiologist employed by VASLCHCS. OIG substantiated the allegation that VASLCHCS was billed at unsupported rates as set forth in VA Directive 1663 for medical services performed by U of Utah anesthesiologists. OIG recommended that the USH develop and implement a plan of action to ensure that procedures described in VA Directive 1663 are followed when purchasing medical services from VA affiliated academic institutions and prohibit the use of purchase orders to obtain contract provider services unless the purchase orders contain required clauses.

OIG Substantiates Inadequate Physician Staffing at CLC at VA HCS in Biloxi, Mississippi

OIG conducted an inspection in response to allegations of inadequate CLC physician staffing, improper supervision of surgical residents, refusal of nursing staff to provide care to CLC patients, a lack of action by the Gulf Coast Veterans HCS, Biloxi, MS, leaders in response to quality of care concerns, and poor quality of care provided in the HCS's ED. OIG substantiated that physician staffing in the CLC, which is part of the Extended Care Service, is inadequate. OIG found that the CLC currently only has one physician, who is also the chief of the service. The Extended Care Service has four physician vacancies and no ongoing active recruitment for these vacancies. OIG did not substantiate that surgical residents were not properly supervised, that nursing staff refused to provide care to CLC patients, that the HCS did not respond appropriately when quality of care concerns were raised or that CLC patients received poor quality of care when transferred to the ED. OIG recommended that the HCS Director actively recruit and fill approved physician vacancies within the Extended Care Service.

Gastroenterology Fellowship Program Complaints Unsubstantiated at VA HCS in Albuquerque, New Mexico

OIG conducted an inspection in response to complaints about the supervision of fellows in the Gastroenterology (GI) Department at the New Mexico VA HCS, Albuquerque, NM. OIG did not substantiate the allegation that the Accreditation Council of Graduate Medical Education requires that patients seen by fellows must also be seen in person within 24 hours by a credentialed attending physician, and that this is not being done in the facility GI Department. Although VHA requires a supervising practitioner to physically meet, examine, and evaluate a patient within 24 hours of an inpatient admission, it is not required for inpatient or outpatient consultations in a specialty service. OIG did not substantiate the allegation that the Chief of GI was co-signing GI Fellow consult notes with "in lieu of" for University of New Mexico (UNM) GI attending physicians who were not seeing patients. OIG found that UNM GI fellows appropriately documented that patients were discussed with their UNM GI supervising practitioner, or alternatively, OIG found an addendum to the original GI consult note was entered by the UNM GI supervising practitioner. OIG also found that the Chief of GI was adding an addendum to the GI consult note and signing for administrative purposes to authenticate and complete the GI consult notes so they would be accessible by other clinical staff. OIG did not substantiate the allegation that UNM GI attending physicians were not credentialed at the facility. OIG found that all four without compensation UNM GI attending physicians who provided coverage at the facility were appropriately

credentialed and privileged. OIG did not substantiate the allegation that senior leadership was unwilling or unable to take corrective action. OIG found that facility leadership was aware of the complaint and had initiated appropriate follow-up prior to our site visit. OIG made no recommendations.

OIG Finds Podiatry Clinic Staffing Issues and Delays in Care Addressed by VA HCS in Montgomery, Alabama

OIG conducted a review at the request of Senator Jeff Sessions to assess allegations concerning Podiatry Clinic staffing issues and delays in care at the Central Alabama Veterans HCS in Montgomery, AL. The complainant alleged that the Podiatry Clinic located at Maxwell Air Force Base had an insufficient number of trained clerical staff and that new referrals and appointment scheduling were delayed due to a lack of trained clerical staff. OIG substantiated the allegation that the clinic lacked a sufficient number of trained clerical staff, which resulted in delays processing new referrals and scheduling appointments. However, these delays appeared to be related to the frequent leave and subsequent retirement of the assigned trained clerk and the lack of access to the Department of Defense's (DoD's) TRICARE® system for the clerks covering the clinic during these absences. The facility addressed this gap by taking actions to ensure that the clinic was staffed with a properly trained clerk on an interim and permanent basis with access to the TRICARE® system. OIG conducted a review of the timeframes for scheduled appointments after the reassignment of a trained clerk and found that VHA and DoD patients were generally scheduled within the required 7 days. OIG made no recommendations.

Poor Management of High Risk Patient's Medications Contributed to Accidental Drug Overdose at Tuscaloosa, Alabama, VAMC

OIG conducted an evaluation in response to allegations that providers at the Tuscaloosa VAMC mismanaged opioid therapy for a high-risk patient and that facility managers did not take appropriate actions after the patient's death. OIG substantiated that facility providers collectively prescribed oxycodone, methadone, and benzodiazepines to a high-risk patient who died of an accidental multi-drug overdose. Three factors contributed to this outcome: (1) the patient's PCP did not consistently complete key elements of the pain assessment, initiate an opioid pain care agreement, ensure adequate patient monitoring and follow-up after prescribing methadone, or document patient education regarding the specific dangers of methadone; (2) the facility did not ensure access to an interdisciplinary pain management team or Pain Clinic to provide needed services to this patient; and (3) the PCP, MH provider, and Suicide Prevention Coordinator did not ensure communication and coordination of care for this high-risk patient. OIG did not substantiate that the facility covered up the patient's subsequent visit to the facility or delayed the autopsy report. However, the facility did not comply with selected aspects of VHA Directives on clinical reviews and patient safety processes. OIG made seven recommendations.

IG Makes Nine Recommendations To Improve Patient Care and Staff Safety at Huntsville, Alabama, Outpatient Clinic

OIG conducted an inspection to assess the merit of allegations concerning the quality of care provided by a PCP and staff safety at the CBOC located in Huntsville, AL. OIG substantiated the PCP did not consistently document opioid medication management, did not consistently document and respond to patients' abnormal test results, and on one occasion, entered a derogatory comment in the EHR. OIG did not substantiate that the PCP had made multiple medication errors, failed to respond to health care concerns appropriately, failed to refer a homicidal/suicidal patient, forced patients to receive vaccinations, and treated patients preferentially causing them to request a transfer of care to another PCP. OIG did not substantiate that the PCP inappropriately instructed staff to shred patients' non-VA medical documents; however, OIG found that staff did not consistently follow facility policy for the management of non-VA medical records. OIG did not substantiate that the PCP yelled and became upset when CBOC staff cautioned the PCP to not perform a procedure that was not approved for the CBOC setting. However, OIG found that the PCP had performed other CBOC-setting approved procedures for which he/she was not privileged to perform. OIG did not substantiate that the facility did not

respond to staff concerns about quality of care or safety. OIG substantiated that the CBOC did not initially have an MH emergency standard operating procedure, and once developed, it did not include all actions staff might take when addressing an MH emergency. OIG substantiated that the CBOC had non-functioning panic alarms. During OIG's inspection, we noted that the facility did not have a pain management policy as required and did not complete mandatory EHR quarterly quality reviews for outpatient programs. OIG made nine recommendations.

Allegations of Patient Neglect Not Substantiated at the Central Alabama Veterans HCS, Tuskegee, Alabama

OIG conducted an inspection to evaluate reporting of suspected patient neglect at the Central Alabama Veterans HCS, Tuskegee, AL. OIG did not substantiate that an RN failed to report a case of suspected neglect to Adult Protective Services or that the RN failed to triage the patient to determine the need for intervention. OIG found that the RN's actions were clinically appropriate. Documentation reflected that the RN attended to the caregiver's concerns and initiated processes to secure respite care and in-home nursing services to support both the patient and caregiver. OIG did not substantiate that a social work supervisor improperly restricted a social worker's ability to report cases of abuse and neglect. Facility practice is for social workers to discuss cases of suspected abuse and neglect with their supervisors before reporting whenever possible. OIG made no recommendations.

Expired Inspection Labels Need Attention but Pose No Immediate Hazard to Patients at Northern Arizona VA HCS, Prescott, Arizona

OIG conducted an inspection in response to a complainant's allegations concerning medical equipment with expired preventive maintenance inspections (PMIs). The confidential complainant alleged that equipment with expired PMIs posed an immediate hazard to the safety of patients at the Northern Arizona VA HCS, Prescott, AZ. OIG did not substantiate the allegation that medical equipment with expired PMIs posed an immediate hazard to the safety of patients. OIG found no evidence of medical equipment failures or malfunctions that contributed to the death, serious injury, or serious illness of any individual. OIG did not substantiate the allegations that all of the respiratory therapy (RT) equipment had expired PMIs, with some exceeding expiration dates by several years, and that several pieces of RT equipment had inspection stickers indicating "routine inspection not applicable." OIG did not substantiate the allegation that the expectation was for RT equipment to remain in use with expired PMIs. OIG substantiated the allegation that other departments had medical equipment with expired PMIs. OIG found medical equipment with expired or missing safety inspection labels and missing equipment entry numbers. OIG substantiated the allegation that the Biomedical Engineering (BME) Department is "short staffed." OIG found that the system was allocated four full-time equivalent BME technician positions but did not fill the vacancies of two technicians who terminated their employment. OIG recommended that the System Director initiate actions to address medical equipment with expired PMIs and assess staffing in the BME Department and take appropriate actions to meet the workload requirements.

OIG Recommends Improvements to Opioid Medication Prescription Processes at VA Western New York HCS, Buffalo, New York

OIG conducted an inspection at the VA Western New York HCS in Buffalo, NY, in response to allegations that staff prematurely referred critically ill ICU patients to the Hospice/Palliative Care Program for hospice care and that providers inappropriately prescribed opioid medications to sedated patients receiving hospice care. Because the HCS predominantly provides hospice care in the CLC, OIG expanded the review to include CLC patients as well as those who received hospice care in the ICU. OIG did not substantiate the allegations that staff prematurely referred ICU patients to palliative care or that sedated ICU patients received opioid medications that were inappropriate. However, OIG found that because providers in the CLC used narrative text orders for

dose increase instructions, pharmacy and on-call physicians were, at times, unaware of opioid medication dose increases made by the CLC nursing staff. In addition, narrative text orders related to opioid infusions placed responsibility for dose increases solely with nursing and lacked recognition of drug pharmacokinetics. Portions of required nursing documentation of patient pain assessments and reassessments were lacking and scanning of paper opioid infusion records was inconsistent in both the CLC and ICU. OIG recommended that the System Director strengthen processes in the CLC to prevent the use of narrative text orders for opioid patient-controlled or nurse-controlled analgesia and that opioid titration orders include titration parameters. OIG also recommended that the System Director strengthen processes to ensure that nursing pain documentation adheres to VHA, VISN, and local policies and copies of paper records are available in EHRs.

Healthcare Inspection Results for Quality of Care and Staffing Concerns, Salem VAMC, Salem, Virginia

OIG conducted an inspection in response to quality of care and staffing concerns at the Salem VAMC, Salem, VA. OIG substantiated that post-operative complications for orthopedic and podiatry surgery cases increased in FY 2013. The VAMC has implemented corrective actions and is monitoring for effectiveness. OIG did not substantiate that bowel perforations occurred during surgery requiring ostomies; that a number of outpatients having lung biopsies required chest tube placements and admissions; that patients were being told that they had a spot on their lung and months later were told they had Stage IV lung cancer; or that a dying patient was inappropriately transferred from the ED to a medical/surgical unit. OIG also did not substantiate that the administrative officer of the day was admitting patients to units that could not properly care for them resulting in those patients being transferred within minutes of arrival. However, OIG did identify inefficiencies in the admission process and inter-unit transfer patterns. OIG substantiated the subject unit had been staffed for 20 patients. In 2013, the unit's bed capacity increased from 20 to 24 patients. Staffing initially remained the same while the facility monitored the average daily census to determine the unit's resource needs. Additional nursing staff has been hired. OIG did not substantiate that the unit routinely received up to 15 admissions during an 8-hour shift. OIG recommended that the Facility Director continue to monitor and address increases in post-operative infection rates and take appropriate corrective actions when indicated and evaluate the admission process in the ED, monitor inter-unit transfer patterns, and take corrective actions as needed.

Emergency Airway Management Policies, Training, and Competency Assessments Need Improvement at Salisbury, North Carolina, VAMC

OIG conducted an inspection in response to allegations regarding out of operating room airway management (OOORAM) at the W. G. (Bill) Hefner VAMC in Salisbury, NC. OIG substantiated that the facility's local policy for OOORAM was not updated as required and, when a new policy was implemented, it did not contain all the components required by VHA Directive 2012-032. OIG also substantiated that the facility's OOORAM training and competency assessments were not consistently completed as required, not enough staff were authorized to perform OOORAM and some staff performed OOORAM without authorization, highly portable video laryngoscopes were not always immediately available, and required analysis after patient care events involving intubation by unauthorized facility staff did not always occur. OIG did not substantiate there was an unacceptable number of "Code Blues" (an emergency situation announced in a hospital to indicate a patient requires immediate resuscitation) and found the facility reviewed events where cardiopulmonary resuscitation was attempted as required. During the course of this review, OIG found the facility had not updated the scope of practice for a non-licensed independent practitioner who was authorized to perform OOORAM. OIG recommended that the Facility Director ensure the facility's OOORAM policy is updated to include all VHA requirements, that processes be strengthened to complete OOORAM training and competency requirements as outlined by VHA and local policies, that processes be strengthened to provide OOORAM coverage as required, that highly portable video laryngoscope equipment is immediately available, that an analysis is performed for

the five identified patient care events in our report, and that the scope of practices are updated for non-licensed independent practitioners who perform OOORAM.

Connecticut HCS, West Haven, Connecticut Took Appropriate Steps To Address Patients' Exposure to Creutzfeldt-Jakob Disease

OIG conducted an oversight review regarding potential exposure of two veteran patients to Creutzfeldt-Jakob Disease (CJD) at the VA Connecticut HCS (facility), West Haven, CT. OIG reviewed the facility's procedures for reprocessing of neurosurgical instruments, handling and tracking of loaner instrument trays, and responding to potential exposures and the follow-up actions taken post-exposure. In addition, OIG reviewed VHA reprocessing requirements for neurosurgical instruments. OIG concluded that the facility took appropriate steps to address potential patient exposure to CJD. Managers were proactive in seeking counsel from subject matter experts within the VA and other Government agencies to ensure that proper patient follow-up and notification occurred in a timely manner. Facility providers notified and met with the involved patients and/or their family members to discuss the potential exposure to CJD, the risks of CJD transmission, and answer questions or concerns. Providers documented clinical disclosures in the patients' EHRs. Although the facility met the recommended manufacturer's minimum requirement for sterilization of surgical instruments, the facility amended its process by increasing sterilization time from 4 to 18 minutes for neurosurgical instruments. Additionally, managers implemented a process for tracking all loaner instruments from receipt to return. OIG concluded that VHA had appropriate policies and procedures for reprocessing neurosurgical instruments. OIG made no recommendations.

Allegations Regarding Mismanagement of Catheterization Laboratory Patient Emergencies and Staffing Reviewed at the Baltimore, Maryland, VAMC

OIG conducted an inspection in response to allegations regarding mismanagement of cardiac catheterization laboratory (CCL) patient emergencies and CCL staffing at the Baltimore VAMC, Baltimore, MD. OIG did not substantiate allegations that a patient died because CCL staffing was insufficient to perform an urgent case and leadership delayed transferring the patient to the University of Maryland Medical Center. OIG also did not substantiate allegations that the CCL nurse manager, ICU nurses, and Anesthesia Service ignored CCL staff requests for help during a cardiac emergency. OIG did substantiate that CCL staff were correctly told not to call the rapid response team for help because the CCL is considered an outpatient clinic and the rapid response team is limited to responding to inpatient situations only. OIG did not substantiate that the facility did not follow "standard of care requirements" since there are no definitive national or VHA standards for minimal staffing of the CCL. However, OIG found that the facility did not consistently meet national and local policy requirements for staffing during CCL procedures involving moderate sedation. Changes implemented at the facility in April 2013 required two RNs be present for all CCL procedures. The facility acknowledged ongoing efforts to evaluate the cost-benefit of CCL in-house operations due to low volume of procedures performed in the CCL. Incidental to OIG's inspection, we found that staff were unclear about the roles of the Code Blue and rapid response teams, as well as the process for obtaining anesthesiologist assistance in the event of an emergency in the CCL. OIG made three recommendations.

Allegations Regarding Surgical Service Not Substantiated at the Malcolm Randall VAMC, Gainesville, Florida

OIG conducted an inspection in response to allegations concerning the Surgical Service at the Malcom Randall VAMC (the facility), Gainesville, FL. The facility is part of the North Florida/South Georgia VA HCS in VISN 8. OIG did not substantiate that a cardiopulmonary resuscitation event in the OR was not handled appropriately. OIG did not substantiate that surgeons were not allowed to perform a certain procedure in the OR so that surgical mortality data would be lower. OIG also did not substantiate that patients deemed at high risk of

mortality were sent to a local hospital so that if these patients died, the deaths would not count against the facility's surgical mortality data. OIG noted that a team from VISN 8 completed a site visit to the facility in 2013 and made recommendations to strengthen the facility's surgical program. The facility developed and completed action plans based on these recommendations. OIG made no recommendations.

OIG Identifies Need for ED Staffing Augmentation Plan at VA San Diego HCS, San Diego, California

OIG conducted an inspection in response to allegations concerning critically low RN staffing levels and patient safety issues in the ED at the VA San Diego HCS, San Diego, CA. OIG substantiated that three RNs were on shift after midnight. In June 2013, the ED included an additional full-time RN on the midnight shift to cover for RN call-ins. OIG substantiated the allegation that the HCS did not have an emergency plan or policy that addressed low RN staffing levels in the ED. However, VHA does not require a HCS policy that specifically addresses low RN staffing levels in the ED, but does require that facilities have a plan for additional RNs, providers, and support staff in times of acute overload or disaster. The ED did not have a plan for additional staff in times of acute overload or disaster. OIG did not substantiate that RNs who floated to the ED were not oriented to the floor. However, some RNs reported inadequate orientation at the time of the float. OIG did not substantiate that numerous Patient Event Reports were submitted regarding critically low RN staffing levels on the night shift but no action had been taken. Six Patient Event Reports were submitted and reviewed, and appropriate follow-up actions were taken. OIG partially substantiated the allegation that two patients waited over 9 hours for emergency care. ED staff completed intake assessments within a reasonable time period based on the patients' medical conditions. OIG recommended that the HCS Director implement a policy that includes an ED augmentation plan for additional RNs, providers, and support staff in times of acute overload or disaster and review orientation processes for RNs floating to the ED.

Office of Audits and Evaluations

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

Without Data, VHA Unable To Demonstrate Effectiveness of Mobile Medical Units in Improving Access for Rural Vets

At the request of the House Committee on Appropriations, OIG conducted a review of VA's use of Mobile Medical Units (MMUs) to assess whether VHA is fully utilizing MMUs to provide health care access to veterans in rural areas. OIG found VHA lacked information about the operations of its MMUs and had not collected sufficient data to determine whether MMUs improved rural veterans' health care access. VHA lacked information on the number, locations, purpose, patient workloads, and MMU operating costs. OIG determined VHA operated at least 47 MMUs in FY 2013. Of these, 19 were funded by the Office of Rural Health (ORH) and the remaining 28 were funded by either a VISN or medical facility. Medical facilities captured utilization and cost data in VHA's Decision Support System (DSS) for only 6 of the estimated 47 MMUs. If VHA consistently captured this data, it could compare MMU utilization and costs with other health care delivery approaches to ensure MMUs are providing efficient health care access to veterans in rural areas. These weaknesses occurred because VHA did not designate specific program responsibility for MMU management, define a clear purpose for its MMUs, or establish policies and guidance for effective and efficient MMU operations. As a result of limited MMU data, OIG was unable to fully address the Committee's concerns. However, it is apparent that VHA could not demonstrate whether the almost $29 million ORH spent, as well as unknown medical facility funding for MMUs, increased rural veterans' health care access and the extent to which MMUs could be mobilized to support its emergency preparedness mission. OIG recommended the USH improve the oversight of MMUs by assessing their effect on rural veterans' health care access; establishing specific program responsibilities, policies, and guidance, including requirements to capture MMU data in DSS; and supporting emergency preparedness plans. The USH concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions.

Charleston, South Carolina, VAMC Split Purchases and Made Unauthorized Commitments with Government Purchase Cards

OIG conducted this audit in response to an allegation received through the OIG Hotline that the Engineering Service employees at the Ralph H. Johnson, VAMC, Charleston, SC, were splitting purchases to circumvent the $3,000 micro-purchase limit. OIG expanded its review to determine the extent Engineering Service employees inappropriately used purchase cards from October 2011 through May 2013. OIG substantiated the allegation that Charleston VAMC Engineering Service employees split purchases and identified improper purchase

card payments. OIG sampled 139 purchases Engineering Services made during the period of October 2011 through May 2013, and found 40 were unauthorized commitments totaling $83,100 that avoided competition requirements. The 40 unauthorized commitments included 35 purchases valued at about $69,300 that cardholders split, and 5 purchases valued at about $13,800 that exceeded the micro-purchase limit for services. Engineering Service employees also made 33 purchases where OIG could not determine whether payments were appropriate because of insufficient documentation. The value of these improper payments was about $55,000. This occurred due to ineffective oversight of cardholder transactions and inadequate purchase card training of approving officials and cardholders. As a result, OIG estimated Charleston VAMC's Engineering Service cardholders made about $274,000 in unauthorized commitments and approximately $372,000 of purchases lacked sufficient documentation. OIG recommended the VISN 7 Director review Charleston VAMC Engineering Service's purchase card transactions for unauthorized commitments and purchases lacking sufficient documentation and process necessary ratification and payment recovery actions. Additionally, OIG recommended the VISN 7 Director improve purchase card practices by developing a process to ensure improved oversight and provide sufficient training. The VISN 7 Director concurred with the recommendations and provided an acceptable action plan.

VHA Needs Better Process To Track Funding for Backlogged Maintenance Projects To Ensure Priority Needs Are Met

OIG conducted this audit to assess how effectively VHA's Non-Recurring Maintenance (NRM) Program addressed its most significant maintenance needs. NRM expenditures increased from about $824 million in FY 2008 to $1.8 billion in FY 2013. During this same period, VHA reported their facility maintenance backlog increased from $7.2 billion to $10.7 billion. OIG found VHA needs to increase the effectiveness of its NRM program. VA established an annual goal of reducing its overall maintenance backlog by 9.5 percent and had reasonable assurance the NRM program funds were used for allowable NRM purposes. However, VHA did not have an adequate process to track how much of the over $1.8 billion in NRM funds the medical facilities spent to address its nearly $10.7 billion identified facility maintenance backlog. VHA's Facility Condition Assessment (FCA) inadequately assessed risks to patient safety and underestimated repair costs by $12.3 billion. Lastly, 74 of the 150 NRM construction projects reviewed were not completed within 1 year of their initial planned completion date. This occurred because VHA did not have an adequate process to track their NRM project expenses and adequately monitor expected results. VHA's FCA did not assess patient safety risks or provide reasonable cost estimates for identified maintenance deficiencies. Additionally, VHA did not routinely monitor NRM project schedules. As a result, VHA had not been able to adequately identify how it was using NRM funds to achieve program goals or ensure projects were prioritized to correct significant maintenance deficiencies, including serious patient safety issues. In addition, VHA could not ensure their annual NRM budget requests were accurate or that they were taking timely corrective actions on NRM projects that miss project milestones. OIG recommended the USH; the Executive in Charge, Office of Management (OM) and Chief Financial Officer (CFO); and the Principal Executive Director, Office of Acquisitions, Logistics, and Construction (OALC), standardize NRM accounting procedures, provide program guidance, assign risk levels, estimate more accurate repair costs, and monitor NRM project milestones. VA officials concurred with OIG's recommendations and submitted acceptable corrective action plans.

Opportunities Exist for VHA To Reduce Workers Compensation Program Costs by $95.2 Million with Improved Claims Management

OIG determined whether VHA improved Workers' Compensation Program (WCP) case management to better control costs in chargeback year 2012, which represented the most current audit data available at the time OIG began work on this project. OIG identified issues with claims initiation and monitoring similar to those disclosed in our 2004 and 2011 audit reports. Specifically, WCP case files lacked initial or sufficient medical evidence to support connections between claimed injuries and medical diagnoses. OIG estimated VHA

inaccurately initiated approximately 56 (7 percent) of 793 WCP claims. WCP claims also were not consistently monitored to timely return employees to work. VHA WCP specialists did not make job offers or take actions to detect fraud. OIG projected 489 (61.7 percent) of 793 active claims were inadequately monitored. These issues occurred because VHA still lacked standard guidance and a clear chain of command to ensure compliance with WCP statutory requirements and VA policy. VHA also lacked a fraud detection process. Overall, OIG estimated VHA can reduce WCP costs over the next 5 chargeback years by $11.9 million through improved claims initiation and $83.3 million by increasing efforts to return medically able staff to work. In total, opportunities existed for VHA to reduce WCP costs by roughly $95.2 million with improved claims management. OIG also identified $2.3 million in unrecoverable payments due to VHA's lack of oversight to return medically able employees to work. OIG recommended the Acting USH ensure clear oversight, standard guidance, adequate staffing, and fraud detection procedures to improve VHA's WCP case management. The Acting USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by May 29, 2015.

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.

VBA Could Recover $623 Million in Improper Payments by Offsetting Benefits for Reservists and Guard Members Earning Drill Pay

OIG conducted this audit to determine whether VBA timely processed VA benefit offsets when drill pay was earned concurrently. Federal regulations prohibit reservists and National Guard members from concurrently receiving VA compensation or pension benefits and military reserve pay (referred to in this report as "drill pay") while training on weekends or during full-time training events. The audit focused on VA benefits offsets for beneficiaries who concurrently received drill pay during FYs 2011 and 2012. This data represented the most current audit data available at the time OIG began the audit in August 2013. VBA did not timely offset 601 (86 percent) of 700 cases OIG reviewed for FYs 2011 and 2012. Of the 601 offsets not timely processed, 553 (79 percent) were not processed and the remaining 48 were not processed within VBA's timeliness standard. According to VBA, higher priorities, such as processing compensation claims, took precedence over processing offsets. VBA also lacked an adequate tracking mechanism, a current cost-benefit analysis, and Systematic Analysis of Operations (SAO) reviews of the drill pay offset process. VBA's unprocessed rate for FYs 2011 and 2012 was not significantly different from the 90 percent unprocessed rate reported in OIG's 1997 audit. Therefore, it is likely VBA had not processed hundreds of millions of dollars in offsets since OIG's previous report. OIG projected VBA had not offset payments of approximately $48.9 million for FY 2011 and $95.7 million for FY 2012. If VBA improved controls over drill pay offset processing, OIG projected VBA could recover approximately $478.5 million from FY 2013 through FY 2017 of additional payments. In total, VBA could recover approximately $623.1 million in improper payments. OIG recommended the Under Secretary for Benefits (USB) implement measures to ensure drill pay offsets are timely processed, process all offsets for FYs 2011 and 2012, more effectively track and monitor offsets, update the cost-benefit analysis, and include drill pay offset processing in SAOs. The USB concurred with OIG's recommendations and submitted a corrective action plan.

Greater Attention To Scheduling Exams for Veterans with Temporary 100 Percent Ratings Could Avoid $222 Million in Improper Payments

OIG's objective of this audit was to determine whether VBA took sufficient action to implement recommendation 7 from the 2011 report, *Audit of 100 Percent Disability Evaluations*, which advised VBA to review all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the veterans' electronic records. In January 2011, OIG reported VBA was not correctly evaluating and monitoring 100 percent disability evaluations. OIG projected VA Regional Office (VARO) staff did not correctly process 100 percent disability evaluations for about 27,500 (15 percent) of 181,000 veterans. These disability evaluations included over 9,900 veterans with temporary 100 percent disability evaluations without a future exam date entered in their electronic record. OIG reported that without improved management of these claims, VBA could overpay veterans a projected $1.1 billion in the next 5 years. VBA reviewed all temporary 100 percent disability evaluations but did not take sufficient action to ensure each evaluation had a future exam date. As of January 2014, VBA identified over 8,300 temporary 100 percent disability evaluations for VAROs to review, of which 7,400 (88 percent) had not been reviewed. OIG estimated 3,100 (42 percent) of these veterans received almost $85 million in improper benefit payments since January 2012 because these claims lacked adequate medical evidence. OIG remains concerned about VBA's financial stewardship of these claims and projected VBA, without action, could continue making unsupported payments to veterans totaling about $371 million over the next 5 years. OIG identified a $456 million ($85 million plus $371 million) total impact to the Government. OIG reduced this projection to $222.6 million because the 2011 projection and report included all benefits before December 31, 2015. OIG determined that almost 1,500 claims folders with temporary 100 percent disability evaluations were located at the VA Records Management Center. Previously, VBA told OIG they implemented the recommendation to transfer claims folders with temporary 100 percent disability evaluations back to the VARO of jurisdiction. OIG recommended the USB ensure VARO staff take appropriate action on temporary 100 percent evaluations within 180 days and transfer from the Records Management Center all claims folders with temporary 100 percent evaluations to the VARO of jurisdiction. The USB concurred with OIG's recommendations.

Audit Finds $60 Million in Payment Delays, $41 Million in Inaccurate Payments for Veterans Receiving G.I. Bill Housing and Book Stipends

OIG evaluated VBA's management of Post-9/11 G.I. Bill monthly housing allowance and book stipend payments. OIG performed this audit due to the number of veterans enrolled in the program and the financial risks associated with benefits delivery. During calendar year 2013, VBA paid roughly $5.4 billion in housing allowances and book stipends to approximately 789,000 students. OIG's review of 200 students found that 92 (46 percent) experienced processing delays in the approval of their original claims, and 35 (18 percent) students experienced payment processing delays in their housing allowance and book stipends. Fifteen of the 35 students received approximately $32,000 in payments an average of 73 days after the start of their school terms. In addition, 39 (20 percent) students received 125 improper payments valued at approximately $128,000 and 8 students received roughly $2,400 in book stipends that were not recovered after the students withdrew from courses. Thus, OIG estimated students annually experienced approximately $60.8 million in payment processing delays and received roughly $41 million in improper or inaccurate payments. Over the next 5 years, OIG estimated students could experience roughly $205 million in inaccurate payments if Post-9/11 G.I. Bill claims processing controls were not strengthened. OIG recommended the USB provide veterans additional information on educational benefits and the requirement to relinquish other education benefits before the submission of applications and establish a timeliness standard for the submission of enrollment certifications. OIG also recommended the USB reinforce the need for training and monitoring of school certifying officials, improve monitoring of VBA claims processing staff, address automated claims processing programming issues, reconcile book stipend collection procedures, and collect outstanding improper

payments. The USB concurred with OIG's recommendations and provided plans to complete corrective actions by December 31, 2014.

IG Attributes 131 Days of Disability Claims Processing Time to Delay in Requesting and Receiving DoD Treatment Records

This audit was congressionally required by the *Consolidated Appropriations Act, 2014*. The Act directed VA OIG, in coordination with DoD OIG, to examine the processes and procedures for transmitting service treatment records (STRs) and personnel records from DoD to VA. OIG focused their efforts on VBA processes and timeliness of requesting paper STRs and providing them to VARO staff who needed the records to make decisions on veterans' disability compensation claims. OIG also assessed initial timeliness of receiving electronic STRs from DoD, which was a process that began in January 2014. OIG determined DoD was not timely in providing VBA electronic STRs. From January 1 through June 3, 2014, VBA submitted 7,278 STR requests to DoD for veterans who submitted claims and separated from military service on or after January 1, 2014. Of those, DoD only completed 2,111 requests (29 percent) and 5,167 requests (71 percent) were pending. Of the 2,111 completed STR requests, 377 requests (18 percent) were received by VBA within 45 calendar days of the veterans' separation from military service. This occurred because DoD reported experiencing challenges and delays implementing the process of transmitting electronic STRs to VBA. Based on a review of 400 statistically selected original disability compensation claims completed during calendar year 2013, OIG identified delays within VBA's processes. Delays occurred with VARO staff establishing claims, requesting STRs, and receiving requested STRs. Overall, OIG attributed a total of about 131 days to these processing actions. Delays occurred primarily because of VBA's focus on eliminating the disability claims backlog. As a result of these delays, DoD and VBA need to improve timeliness of their current STR processes in order for VBA to achieve its timeliness goal of processing all claims within 125 days. OIG made recommendations to the USB to improve VBA's processes of requesting and providing STRs to VARO staff. The USB concurred with OIG's recommendations and provided an acceptable action plan.

Delays in Processing Misuse Claims at VBA's Indianapolis Fiduciary Hub Places Well-Being of Beneficiaries at Risk

OIG did this review to determine the merits of three allegations made to the OIG Hotline in May 2013. The complainant alleged the Eastern Area Fiduciary Hub (EAFH) in Indianapolis, IN, was not timely processing allegations of misuse of beneficiary funds, conducting field examinations, and processing some incoming mail. OIG substantiated the three allegations. EAFH had not completed merit reviews for 190 of 214 allegations of misuse of funds and had not completed 17 of 23 investigations of fiduciary misuse of funds within VBA performance standards. In addition, EAFH made 12 determinations concluding fiduciaries misused approximately $944,000 of beneficiary funds. However, EAFH had not timely completed the required actions, such as replacing the fiduciary, requesting repayment from former fiduciaries, or determining if VA was negligent in its oversight of the fiduciaries. As a result, VBA could be responsible for repayment of approximately $944,000 to the affected beneficiaries. OIG also substantiated that EAFH had more than 16,000 pending field examinations, including 11,000 pending field examinations exceededing VBA's timeliness standards. As a result, the general health and well-being of beneficiaries were placed at increased and unnecessary risk. OIG also identified more than 3,200 pieces of mail, some of which was time critical, which had not yet been processed and exceeded EAFH's timeliness standards. Delays in processing the 3,200 pieces of mail ranged from 11 to 486 workdays, with an average delay of 30 workdays. Without effective management of incoming mail, VA's processing of benefits to fiduciaries could be affected. OIG recommended the USB require EAFH implement controls to ensure timely processing of allegations of misuse of beneficiary funds. In addition, OIG recommended the USB ensure EAFH implements a plan to expedite completion of the backlog of field examinations, and to ensure implemented actions continue to reduce the backlog of mail during FY 2014. The USB concurred with OIG recommendations but also included technical comments on OIG's draft report.

While Improvements Noted, VBA's Quick Start Program Claims-Processing Timeliness and Accuracy Need Major Improvement

OIG evaluated VBA's Quick Start Program, comparing results from 2011 to 2013, to determine if VBA's timeliness and accuracy of claims processing improved during this period. The Quick Start Program processed about 30,900 disability claims in FY 2013. This program offers servicemembers a seamless transition from DoD into VA's HCS. In FY 2013, VBA successfully reduced Consolidated Processing Site's Quick Start claims pending inventory by about 8,800 (51 percent), and reduced the average days to complete (ADTC) a claim from 291 days in 2011 to 249 days for the period of April through June 2013. The ADTC remained high because VBA lacked adequate program controls. OIG projected veterans using the Quick Start Program in 2011 experienced an average delay of 196 days in receiving benefits valued at about $88 million. This improved from April through June 2013, when the delays averaged 99 days. OIG also estimated VBA accurately processed 62 percent of Quick Start claims during 2011, improving to about 69 percent during the period April through June 2013. Accuracy rates were still considered low because of insufficient oversight and training as well as conflicting guidance on granting service connection for medical disabilities. OIG recommended the USB increase Veterans Service Network Operation Report capabilities, include pre-discharge processing time in performance results, conduct recurring program evaluations, perform systematic reviews of Quick Start claims processing, and provide training on issues identified. The USB concurred with Recommendations 3 through 7 and 9, and provided plans for corrective actions and requested the OIG close these recommendations. However, the USB non-concurred with Recommendations 1, 2, and 8, stating OIG's findings on timeliness, backlog issues, and rating accuracy were not attributable to VBA's program oversight or management. OIG's audit evidence sufficiently and appropriately provided a reasonable basis for our findings and conclusions. OIG requested VBA provide OIG documentation of actions taken and will follow up on implementation of the corrective actions. Where VBA non-concurred, OIG will continue its scrutiny and reporting.

File Storage and Mail Processing Issues Hamper VARO St. Petersburg's Effectiveness To Process Disability Claims

OIG conducted a site visit and tour at the regional office (RO) in St. Petersburg, FL. OIG identified file storage and mail processing issues requiring attention and action by the USB. RO employees shared information during interviews supporting OIG observations and the issues identified. The RO had a large file room used to store claims folders, as well as STRs and copies of official military personnel files (OMPFs) that have been combined with claims folders. OIG observed that the file room was overfilled with records. This poor file storage and management resulted in RO personnel having difficulties locating files. The volume and weight of the files precluded moving files into permanent shelving units. In addition, OIG determined mailroom personnel did not date stamp STR files and copies of OMPFs files at the time of receipt. Without this information, RO management could not review and assess potential issues and delays with receiving and processing STR and OMPF requests. Claims processors use evidence mail to further develop and make decisions on veterans' disability claims. Intake Processing Center employees reported about a 3-week delay in sorting and processing evidence mail received from the mailroom. In an effort to address these issues immediately, OIG issued this Interim Report-Management Advisory Memo, and made three recommendations to help ensure efficient file storage and mail processing at the RO. Reporting on these issues allowed VBA the opportunity to take timely corrective actions. The USB concurred with OIG's recommendations and provided suitable action plans. Based on actions taken, OIG considered two recommendations closed. OIG will follow up as required on the other recommendation.

VBA's Provisional Ratings for Older Claims Less Effective Than Existing Process, Led To Misrepresentation of Workload

On April 19, 2013, VBA began a Special Initiative to process all claims pending over 2 years. VARO staff were directed to issue provisional ratings for cases awaiting required evidence and complete these claims within 60 days. OIG's review focused on whether (1) provisional ratings resulted in veterans receiving benefits more quickly and helped eliminate the backlog, and (2) older claims were accurately processed under the Special Initiative. OIG found the Special Initiative rating process was less effective than VBA's existing rating process in providing benefits to veterans quickly. Further, VBA removed all provisional claims from its pending inventory, despite more work being needed to complete them. This process misrepresented VBA's actual workload of pending claims and its progress toward eliminating the overall claims backlog. At the end of June 2013, following completion of the Special Initiative, VBA reported 516,922 rating claims pending in its backlog but only 1,258 rating claims pending over 2 years. OIG estimated 7,823 provisionally-rated claims had been removed from the inventory though they still awaited final decisions. These claims represented less than 2 percent of VBA's reported backlog, but about 12 percent of claims completed under the Initiative. VAROs did not prioritize finalization of the provisionally rated claims once they were issued. OIG estimated 6,860 provisional ratings were still awaiting final decisions as of January 2014, 6 months after the Initiative had ended. Because VBA did not ensure existing controls were functioning as needed to effectively identify and manage provisionally rated claims, some veterans may never have received final rating decisions if not for OIG's review. Additionally, VBA did not accurately process 77 (32 percent) of 240 rating decisions OIG reviewed under this Initiative. Generally, these errors occurred because VAROs felt pressured to complete these claims within VBA's 60-day deadline. OIG estimated VARO staff inaccurately processed 17,600 of 56,500 claims, resulting in $40.4 million in improper payments during the Initiative period. OIG recommended the USB establish controls for all provisionally-rated claims, reflect these claims in VBA's pending workload statistics, expedite finalization of provisional ratings, and review for accuracy all claims that received provisional ratings under the Special Initiative. The USB concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required on all actions.

Lapses in Management Controls at Baltimore VARO Result in Mail Mismanagement and Claim Processing Delays

On June 19, 2014, the Acting Director of the Baltimore VARO alerted OIG of approximately 8,000 documents and claims folders for 80 veterans that were inappropriately stored in a supervisor's office. Desk audits of staff office space performed by VARO management revealed approximately 1,500 additional documents containing personally identifiable information (PII) were inappropriately stored in employees' individual workspaces. OIG initiated this review to assess the allegations of a lack of accountability for mail management and benefits claims processing at the VARO. OIG dispatched a team of benefits inspectors to the Baltimore VARO from June 21 to 27, 2014, and substantiated the conditions reported. OIG determined a supervisor had inappropriately stockpiled approximately 8,000 documents in an office. Most of the documents contained PII and consisted of processed and unprocessed claims-related mail. This mail had the potential to affect benefits payments. Some veterans' claims, found in the supervisor's office, required additional processing actions to finalize rating decisions or award benefits payments. Generally, these conditions occurred because the VARO did not use available controls to identify claims folders stored at one location for a lengthy period or adequately monitor cycle-time performance reports for its non-rating related claims inventory. Further, VARO management did not perform quarterly desk audits of staff workspace as required. As a result, more than 9,500 documents and 80 claims folders lacked the oversight necessary to ensure timely claims processing and the protection of veteran and employee PII. A proactive approach to addressing these management issues was needed to rebuild trust with veterans and other VA stakeholders. OIG recommended the USB implement a plan to ensure proper control of documents and claims folders, staff training on mail handling and workload management, quarterly desk audits, and mail mismanagement impact assessments at the Baltimore VARO. The USB concurred with

OIG's recommendations, provided an acceptable corrective action plan, and quickly responded to ensure this mail was processed. Further, the USB directed a 100 percent RO-wide facility and desk audit for mail or documents across the country.

Inappropriate Actions Misstated Houston, Texas, VARO's Inventory, Timeliness, and Placed Some Claims at Risk of No Decision

On July 10, 2014, the OIG received an allegation from VBA senior leadership in VA Central Office that a Houston VARO employee inappropriately changed or removed system controls for benefits claims without taking proper actions on the claims. VBA uses electronic system controls to identify types of claims, and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. OIG substantiated the allegation that the employee inappropriately cleared, changed, and cancelled controls in the electronic record used to track and identify benefits claims without taking proper actions to complete the claims. The VARO's independent review team determined the employee incorrectly cleared system controls in 136 (44 percent) of 308 claims, making these unfinished claims appear to be completed. OIG sampled 60 of the 308 cases and determined the independent review team accurately identified whether corrective actions were needed and established new controls where required. Further, OIG found the employee incorrectly changed or cancelled system controls in 38 of 51 additional claims OIG sampled. The employee believed the actions were appropriate and would improve production, but conceded making mistakes during what he said was a period of immense stress. To address the issue, VBA leadership initiated administrative action, to include removal of the employee's system access. These inappropriate actions misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may never have received decisions on their claims if the VARO's independent review team had not discovered the improper actions by the employee. OIG's review did not identify any fraud resulting in personal financial gain; however, the inappropriate actions described in this report undermine program effectiveness. Therefore, OIG recommended the Houston VARO Director take immediate action to fully review and correct, as appropriate, all actions the employee took to clear, change, or cancel controls for claims. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee.

Anonymous Allegations That Los Angeles, California, VARO Management Manipulated Data Not Substantiated

On June 24, 2014, OIG received an anonymous allegation that Los Angeles, CA, VARO management instructed staff to manipulate data to meet a VBA claims processing timeliness goal. The complainant alleged that management told staff to update VBA's electronic system to make it appear that VARO staff properly requested documentation to support veterans' claims, although no actions were actually taken to obtain the required evidence. OIG did not substantiate the allegation that management instructed staff to input incorrect data in VBA's electronic system. OIG determined VARO management provided written instructions to the assigned veterans service representatives (VSRs) on initiating development of evidence to process 183 claims. However, OIG found that one of the seven VSRs assigned this workload had made entries in VBA's electronic system to reflect documentation had been requested to support veterans' claims, although the employee took no actions to obtain the required evidence. This VSR acknowledged manipulating data for claims, stating this was done to comply with verbal instructions from management. Based on the review, OIG concluded one employee misunderstood management's instructions and made improper entries in VBA's electronic system. Since the errors were the result of one individual, OIG did not consider this a systemic issue. However, given the nature and seriousness of the employee's claims processing errors, OIG recommended that the VARO Director take action to correct the fourteen errors the employee introduced in the electronic records on the claims processed.

OIG also recommended the Director ensure monitoring of all employees' work to ensure that all future work is performed in accordance with VBA policy.

Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VAROs, focusing on disability compensation claims processing and performance of Veterans Service Center operations. 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 10 reports during this reporting period, which are listed in Appendix A.

Key findings from the benefits inspections issued this reporting period are listed below.

- OIG reported 45 percent of the temporary 100 percent disability evaluations reviewed were not processed accurately. The majority of these errors occurred when VARO staff did not input reminder notifications in VBA's electronic system to request reexaminations of these veterans as required by VBA policy.
- OIG inspections have reported a slight improvement in processing traumatic brain injury (TBI) claims. During OIG's first 3-year cycle of benefits inspections, staff incorrectly processed 31 percent of TBI claims, compared to an error rate of 24 percent for all reports published in the past 2 years. For the current 10 inspections published during this reporting period, VARO staff incorrectly processed 20 percent of the TBI claims OIG reviewed.
- VARO staff incorrectly processed 32 percent of claims involving Special Monthly Compensation and ancillary benefits.
- OIG found that 35 percent of SAOs were either incomplete or untimely. SAOs provide an organized means of reviewing Veteran Service Center claims processing operations to identify existing or potential problems and propose corrective actions.
- We found processing delays occurred in 45 percent of the claims that required rating decisions to reduce or discontinue benefits. Proposed reductions were not processed timely. When VARO staff obtains evidence that a lower disability evaluation would result in a reduction or discontinuance of current compensation payments, staff must inform the beneficiary of the proposed reduction in benefits.

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.

To Improve Access to Burial Options, NCA Needs Better Methodology To Identify Unserved Rural Veterans

In accordance with P.L. 113-6, *Consolidated and Further Continuing Appropriations Act of 2013*, which requires NCA to address congressional concerns that NCA does not adequately serve the Nation's rural veterans, OIG conducted this audit to evaluate whether NCA's Rural Veterans Burial Initiative (Rural Initiative) identified the number and percentage of unserved veterans in rural areas. NCA's Rural Initiative did not adequately identify the number and percentage of veterans residing in rural areas who do not have reasonable access to a burial option. OIG determined that prior to the planned Rural Initiative National Veterans Burial Grounds, NCA was not providing reasonable access to a burial option for approximately 302,000 (34 percent) of roughly 888,000 rural veterans in the initiative's 8 targeted states. When completed, NCA's Rural Initiative is expected to decrease the total number of unserved rural veterans by nearly 120,000 (40 percent) to roughly 182,000 in these 8 states. NCA could not adequately identify the number and percentage of unserved veterans who reside in rural areas because it used a methodology that identified veterans residing within a 75-mile radius of a National, VA-funded State, or tribal organization veterans' cemetery and did not classify veterans as rural, urban, or any other designation. In addition, NCA lacked a specific performance measure that evaluated NCA's progress towards increasing service to rural veterans. As a result, NCA could not evaluate the level of service provided to veterans and their families residing in rural areas throughout the eight targeted states or the entire Nation. Without this veteran population information, NCA cannot adequately report to Congress, and other stakeholders, its performance on serving rural veterans. OIG recommended the Under Secretary for Memorial Affairs establish a methodology to identify the number and percentage of served and unserved rural veterans, publish a national map showing the areas and number of served and unserved rural veterans, and establish performance goals for the percentage of rural and urban veterans served. The Under Secretary concurred with the recommendations and submitted acceptable corrective action plans.

Other Audits and Evaluations

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

OIG performs audits of information technology (IT) and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and safeguarding veterans and VA employees, facilities, and information. OIG's audit reports present VA with constructive recommendations needed to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Management Act of 2002* (FISMA), P.L. 107-347, as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit. These evaluations have led OIG to report information security and security of data and data systems as a major management challenge for VA.

VA Improved Compliance with Improper Payment Reporting, More Work Needed by VBA and VHA To Reduce Improper Payments

VA reported $1.1 billion in improper payments in its FY 2013 Performance and Accountability Report (PAR). OIG's assessment of VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA) for FY 2013 was based on FY 2012 data as reported by VA. OIG conducted this FY 2013 review to determine whether VA complied with IPERA. OIG found VA implemented a new risk assessment process in FY 2013 across all of its programs, and met five IPERA requirements for FY 2013 by publishing a PAR, performing risk

assessments, publishing improper payment estimates, providing information on corrective action plans, and reporting on its payment recapture efforts. However, VA did not comply with two of seven IPERA requirements for FY 2013. This represents an improvement over FY 2012, when VA was not in compliance with four of the seven IPERA requirements. This year, OIG identified areas for improvement in both VBA and VHA's IPERA reporting. VBA underreported improper payments for its Compensation program. Test procedures for the Compensation program and one Education program also had not included steps needed to identify all types of improper payments. VHA reported a gross improper payment rate of greater than 10 percent for one program and did not meet reduction targets for two programs. OIG recommended the USB ensure thorough procedures for testing sample items used to estimate improper payment for the Compensation and Post 9/11 G.I. Bill programs. OIG also recommended the USH implement the corrective action plan included in the PAR to reduce improper payments for the State Home Per Diem program, and develop achievable reduction targets for that and the Beneficiary Travel program. OIG will follow up on implementation of the proposed action plans during OIG's next annual IPERA review.

Unauthorized Commitments Requiring Ratification Actions Estimated at $85.6 Million for FYs 2012 and 2013

OIG initiated this review in response to allegations made to the OIG Hotline. The complainant alleged VA purchase cardholders made unauthorized commitments and VA had not performed mandatory ratification actions on identified unauthorized commitments. These unauthorized commitments circumvented Federal acquisition laws and increased the risks of VA misusing taxpayer funds. OIG substantiated the allegations. Specifically, OIG estimated during FYs 2012 and 2013 VA made about 15,600 potential unauthorized commitments which require ratification actions; they are valued at approximately $85.6 million. Unauthorized commitments occurred because of inadequate warrant information, insufficient verification of cardholder warrant limitations, and insufficient training. Cardholders could be held financially responsible for these actions. VA lacked adequate controls to prevent cardholders from making a high volume of unauthorized commitments, which made it resource intensive to perform ratification actions for each unauthorized commitment. In December 2012, VA institutionally ratified thousands of unauthorized commitments made with the Pharmaceutical Prime Vendor, instead of performing individual ratification actions for each unauthorized commitment. By deviating from ratification requirements, VA lacked reasonable assurance cardholders protected the Government's interests when goods and services were acquired. For example, these unauthorized commitment actions did not provide assurance of obtaining fair and reasonable prices or that competition requirements were met. Further, the practice of institutional ratification does not hold individuals accountable for this serious offense and repeat offenses could still occur. OIG recommended the Executive in Charge, OM and CFO, review FYs 2012 and 2013 purchase card transactions and submit identified unauthorized commitments for ratification. OIG also recommended the Principal Executive Director, OALC, maintain an accurate database of warranted contracting officers and limit institutional ratifications. The Executive in Charge, OM and CFO, and the Principal Executive Director, OALC, concurred with the findings and recommendations. OIG considers the corrective action plans they submitted acceptable and will follow up on their implementation.

Chief Financial Officers Act of 1990 Compliance

OIG contracted with an independent public accounting firm to audit VA's consolidated financial statements for FY 2013, in accordance with the *Chief Financial Officers Act of 1990*, P.L. 101-576. VA received an unqualified opinion, meaning that its financial statements were materially accurate. With respect to internal control, the contractor identified one material weakness, IT security controls, which was a repeated condition. The contractor also reported VA did not substantially comply with Federal financial management systems

requirements, cited instances of non-compliance with the *Debt Collection Improvement Act of 1996*, P.L. 104-134, and noted that VA was engaged in one active investigation of a possible violation of the *Antideficiency Act*, P.L. 97–258. The contractor also referenced an OIG report issued in FY 2013 citing less than full compliance with the *Improper Payments Elimination and Recovery Act of 2010*, P.L. 111-204.

Federal Information Security Management Act Compliance

In compliance with FISMA, the FY 2013 assessment determined the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. While VA has made progress developing policies and procedures, it still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. OIG continued to identify significant deficiencies related to controls in system access, configuration management, continuous monitoring, as well as service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction.

Federal Financial Management Improvement Act of 1996 Compliance

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208 (FFMIA), requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The audit of VA's FY 2013 consolidated financial statements reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. This condition was due to one material weakness concerning IT security controls. Also, the audit reported that VA's complex and disjointed financial system architecture resulted in a lack of common system security controls and inconsistent maintenance of critical systems. Consequently, VA continued to be challenged with consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and newly implemented systems. As a result, certain financial statement line items may not be readily recreated and supported by audit trails of detailed financial transactions. However, not all current systems could be readily accessed and used without extensive manipulation, manual processing, and reconciliation.

Joint Reviews and Settlements

OIG Issues Interim Report on Phoenix Wait List, Makes Four Recommendations to VA Secretary for Immediate Action

OIG provided an interim report of the ongoing review at the Phoenix HCS. The report identified the allegations substantiated to date, and provided recommendations that VA should implement immediately. Allegations at the Phoenix HCS included gross mismanagement of VA resources and criminal misconduct by VA senior hospital leadership, creating systemic patient safety issues and possible wrongful deaths. OIG substantiated that significant delays in access to care negatively impacted the quality care at this medical facility. OIG initiated this review in response to allegations first reported to the OIG Hotline and expanded it at the request of the VA Secretary and the Chairman of the House Veterans' Affairs Committee. Due to the multitude and broad range of issues, OIG conducted a comprehensive review requiring an in-depth examination of many sources of information necessitating access to records and personnel, both within and external to VA. OIG used its combined expertise in audit, healthcare inspections, and criminal investigations, along with our institutional knowledge of VA programs and operations and legal authority to conduct a review of this nature and scope. Our review has identified multiple types of scheduling practices that are not in compliance with VHA policy. Since the multiple lists OIG found were something other than the official Electronic Wait List (EWL), these additional lists may be the basis for allegations of creating "secret" wait lists. OIG did not report the results of its clinical reviews in this interim report on whether any delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment, particularly for those veterans who died while on a waiting list. Lastly, while conducting our work at the Phoenix HCS, our onsite OIG staff and OIG Hotline received numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. OIG is assessing the validity of these complaints and if true, the impact to the facility's senior leadership's ability to make effective improvements to patients' access to care. OIG recommended the VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans OIG identified as not being on any existing wait list. Also, OIG recommended a review of all existing wait lists at the Phoenix HCS to identify veterans who may be at greatest risk because of a delay in the delivery of health care. OIG recommended initiation of a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition. Finally, OIG recommended the VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's EWL.

IG Issues Final Report on Phoenix HCS Waiting List, Makes 24 Recommendations to VA Secretary for Corrective Action

This is the final report addressing allegations of gross mismanagement of VA resources, criminal misconduct by senior leadership, systemic patient safety issues, and possible wrongful deaths at the Phoenix VA HCS (PVAHCS). OIG found patients at the PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or ED visits, and when seeking care while traveling or temporarily living in Phoenix. In February 2014, a whistleblower alleged that 40 veterans died waiting for an appointment but the whistleblower did not provide OIG with a list of 40 patient names. OIG examined the EHRs and other information for 3,409 veteran patients identified from multiple sources, including the 40 patients in PVAHCS's records, and identified 28 instances of clinically significant delays in care associated with access to care or patient scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 care deficiencies that were unrelated to access or scheduling.

Of these 17 patients, 14 were deceased. During our review of EHRs, we considered the responsibilities and delivery of medical services by PCPs versus speciality care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the veteran patients we reviewed were on official or unofficial wait lists and experienced delays accessing primary care — in some cases, pressing clinical issues required speciality care, which some patients were already receiving through VA or non-VA providers. For example, a patient may have been seeing a VA cardiologist, but he was on the wait list to see a PCP at the time of his death. While the case reviews in this report document poor quality care, we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.

Since the PVAHCS story first appeared in the national media, OIG received approximately 225 allegations regarding health care at Phoenix and approximately 445 allegations regarding manipulated wait times at other VA medical facilities. OIG's Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. OIG is coordinating investigations with the Department of Justice and the Federal Bureau of Investigation (FBI). These investigations, while most are still ongoing, have confirmed that wait time manipulations are prevalent throughout VHA. VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures. In May 2013, the then Deputy USH for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA's senior leaders and mid-managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible. Where OIG confirmed potential criminal violations, OIG presented findings to the appropriate Federal prosecutors. If prosecution was declined, OIG provided documented results of investigation to VA's senior management for appropriate administrative action. OIG will do the same when investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, OIG kept the U.S. Office of Special Counsel apprised of active criminal investigations as they relate to referrals of whistleblower disclosures of allegations relating to wait times and scheduling issues.

This report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a HCS that often could not timely respond to their mental and physical health needs. Immediate and substantive changes are needed. If headquarters and facility leadership are held accountable for fully implementing VA's action plans for this report's 24 recommendations, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide accelerated, timely access to the high quality health care veterans have earned—when and where they need it. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. OIG will establish a rigorous follow-up to ensure full implementation of all corrective actions. The VA Secretary acknowledged that VA is in the midst of a very serious crisis and will use OIG's recommendations to hone the focus of VA's actions moving forward. The VA Secretary also apologized to all veterans and stated VA will continue to listen to veterans, their families, Veterans Service Organizations, and VA employees to improve access to the care and benefits veterans earned and deserve.

Office of Investigations

Veterans Health Administration Investigations

The Office of Investigations conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 177 cases; made 202 arrests; obtained nearly $3.2 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $2.4 million in savings, efficiencies, and cost avoidance; and recovered more than $26,000.

During this reporting period, OIG opened 41 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 103 defendants were charged with various crimes relating to drug diversion. These investigations resulted in over $187,000 in court ordered payment of fines, restitution, penalties, and civil judgments as well as nearly $1.1 million in savings, efficiencies, cost avoidance, and recoveries.

OIG initiated 4 investigations related to the fraudulent receipt of health benefits, which resulted in 14 defendants being charged with various related crimes. These investigations resulted in nearly $2 million in fines, restitution, penalties, and civil judgments. OIG also initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, who grossly inflate reported mileage to and from VA facilities in order to increase reimbursement for travel expenses. During this reporting period, OIG opened five cases, which resulted in three arrests; six convictions; six imprisonments; over $134,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and $18,000 in savings, efficiencies, cost avoidance, and recoveries.

OIG opened 53 investigations regarding criminal activities carried out by VHA employees (excluding crimes related to drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from veterans, and theft of VA property or funds. As a result of OIG work in this area, 24 defendants were charged with crimes. The investigations resulted in over $726,000 in court ordered payments of fines, restitution, and penalties as well as over $1.2 million in savings, efficiencies, cost avoidance, and recoveries.

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

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

A former Palo Alto, CA, VAMC employee pled guilty to bribery. An OIG and FBI investigation revealed that the former employee, a contracting officer representative, accepted bribes, including cash and car payments, in exchange for ensuring that VA contractors received continuous work. The defendant received approximately $32,400 in bribes and gifts. As a result of the same investigation, a former VA contractor pled guilty to providing a gratuity to a public official. The investigation revealed that the contractor gave gifts and cash valued at $143,068. The gifts included vehicles, paying for personal travel expenses, and working on the home of a VA employee.

Cleveland, Ohio, VAMC Employee Sentenced for Sexual Assault

A Cleveland, OH, VAMC employee was sentenced to 60 days' incarceration and 2 years' community control under the supervision of the probation department's sex offender unit after pleading guilty to sexual imposition and unlawful restraint. An OIG and VA Police Service investigation revealed that for approximately 6 months

and on numerous occasions the defendant physically restrained another VA employee against her will while groping and kissing her. The defendant would follow the victim into various rooms at the medical center, close the door, and prevent her from escaping while he assaulted her.

Tuskegee, Alabama, VAMC Compensated Work Therapy Participant Arrested for Sexual Abuse at the Tuskegee, Alabama, VAMC

A Tuskegee, AL, VAMC Compensated Work Therapy participant was indicted and arrested for sexual abuse. An OIG, VA Police Service, and FBI investigation determined that the defendant assaulted a handicapped VA Volunteer Services worker at the VAMC. The defendant was ordered held without bond pending trial.

Former Salisbury, North Carolina, VAMC Police Officer Sentenced for Attempted Robbery

A former VA police officer was sentenced to 44 months' incarceration and 3 years' supervised release. An OIG investigation revealed that while working on duty at the Salisbury, NC, VAMC the officer attempted to rob the credit union, located on the campus of the VAMC, by forcing an employee into the credit union as she was opening for the day. The officer concealed his identify by wearing coveralls over his uniform, a ski mask, and gloves. Two construction workers witnessed the incident and chased the defendant as he fled from the scene. The officer evaded the workers by hiding in a heating, ventilating, and air conditioning room; exiting in his uniform; and assisting in the search for the "suspect." Later that day, a duffel bag containing the items worn during the attempted robbery was located in the locked heating, ventilating, and air conditioning room, and the officer was subsequently identified when he returned a few days later to retrieve the bag.

Veteran Who Was Employed by the U.S. DoD in Germany Admits to Fraudulently Receiving $1.2M in VA Health Coverage

A veteran living in Germany pled guilty to health care fraud after being extradited to the United States. The defendant agreed to a forfeiture judgment of $2,205,032 with VA receiving $1,261,512. A VA OIG, Office of Personnel Management OIG, U.S. Army Criminal Investigation Command, and Defense Criminal Investigative Service (DCIS) investigation revealed that the veteran falsified claims paid by the VA Foreign Medical Program and the Federal Employee's Health Benefit Program. The defendant was a civilian employee of the DoD.

Former Gainesville, Florida, VAMC Employee Sentenced for Identity Theft

A former Gainesville, FL, VAMC medical support assistant was sentenced to 2 years' probation after pleading guilty to attempting to use the identity of another person. An OIG, Internal Revenue Service Criminal Investigation (IRS-CI), and local police investigation revealed that the defendant unlawfully obtained veterans' PII with the intent of filing false tax returns.

Former Tampa, Florida, VAMC Volunteer Sentenced for Identity Theft

A former Tampa, FL, VAMC volunteer was sentenced to 48 months' incarceration and 36 months' supervised release. A non-veteran was sentenced to 42 months' incarceration, 36 months' supervised release, and ordered to pay $149,864 in restitution. An OIG and IRS-CI investigation revealed that the former volunteer stole VAMC patients' PII and sold or traded it to his co-defendant for crack cocaine, knowing that the PII would be used to file fraudulent tax returns. The stolen PII was subsequently used to file $552,981 in fraudulent returns.

Oakland, California, CBOC Employee Charged With Battery

An Oakland, CA, CBOC employee was charged with battery. An OIG and VA Police Service investigation revealed that the defendant slapped a patient after the patient greeted the employee as "buddy." The employee believed that the term "buddy" was a racial slur. When interviewed, the employee stated that if he had thought about it more he would have used a closed fist and knocked the patient out.

Former Salisbury, North Carolina, VAMC Nursing Assistants Charged With Assault

A former Salisbury, NC, VAMC nursing assistant was charged in a criminal information with the assault of an elderly dementia patient at the VAMC. An OIG investigation revealed the defendant struck the patient under his eye and attempted to conceal her actions by leaving the scene. The defendant subsequently confessed to striking the patient. A second former Salisbury, NC, VAMC nursing assistant was charged in a criminal information with assault of an elderly dementia patient at the VAMC. An OIG investigation revealed that after being struck by the patient, the defendant became angry, wrapped the patient's arm around his neck, and pulled him down the hallway to his room and then forced him into his bed. Prosecution was declined on the nursing assistant, who admitted to restraining the same patient to his wheelchair by stretching the patient's sleeves of his t-shirt over the handles of the wheelchair. Both employees resigned from their positions as a result of this investigation.

Augusta, Georgia, VAMC Nurse Pleads Guilty to Assault

An Augusta, GA, VAMC nurse pled guilty to assault and agreed to surrender his nursing license. An OIG and VA Police Service investigation revealed that the defendant entered a patient's room, while two other staff members attempted to treat the patient, and punched the patient causing serious bodily injury.

Fresno, California, VAMC CLC Nurse Charged with Elder Abuse

A Fresno, CA, VAMC CLC nurse was charged with elder abuse. An OIG investigation revealed that the nurse entered the veteran's CLC room and requested the veteran get out of bed. When the veteran ignored the request the defendant grabbed the veteran by his ear, pulled him out of bed, and forced him into a wheelchair. This action resulted in a serious laceration to the veteran's left ear.

Former Seattle, Washington, VAMC Employee Sentenced for Making Threat

A former Seattle, WA, VAMC employee was sentenced to 364 days' incarceration (suspended), 30 days in a community work program, 12 months' probation, and ordered to pay $2,722 in restitution and to have no contact with VA after pleading guilty to threatening to bomb the VAMC. An OIG and VA Police Service investigation determined that the defendant wrote two letters indicating that multiple bombs would detonate somewhere in the hospital within 2 weeks. No bombs or improvised explosive devices were found. The defendant later admitted that he wrote the letters as a diversionary tactic in an attempt to delay an investigation regarding his misuse of a Government fuel credit card.

San Francisco, California, VAMC Food Service Worker Sentenced for Making Threats

A San Francisco, CA, VAMC Food Service worker was sentenced to 50 hours' community service after pleading guilty to impeding or disrupting the performance of official duties of Government employees. An OIG and VA Police Service investigation revealed that the defendant placed a suspicious package wrapped in a black trash bag in the food service area of the medical center. A note was attached to the package that warned of "severe eye damage and possible blindness for the rest of your natural life," if the package was opened.

VA Employee Arrested for Making Threats at the North Little Rock, Arkansas, VAMC

A VA employee, who is also a veteran, was arrested for making threats. An OIG investigation revealed that the defendant contacted the North Little Rock, AR, VAMC and threatened to kill other VA employees. OIG agents, assisted by the U.S. Marshals Service, executed an arrest and search warrant at the defendant's residence and seized a handgun, drugs, and numerous stolen industrial cleaning supplies from the VAMC. The defendant is currently being held without bond and additional charges are pending.

Former Long Beach, California, VAMC Housekeeping Aide Sentenced for Threats

A former Long Beach, CA, VAMC housekeeping aide was sentenced to 585 days' incarceration and 3 years' probation after pleading nolo contendere to criminal threats. An OIG, VA Police Service, and FBI Joint

Terrorism Task Force investigation revealed that the defendant made threatening statements toward the VAMC and a VA police officer.

Gainesville, Florida, VAMC Nursing Assistant Sentenced for Theft

A Gainesville, FL, VAMC nursing assistant was sentenced to 18 months' incarceration after pleading guilty to elder abuse, larceny, grand theft, and fraud. An OIG investigation revealed that the defendant stole funds from an elderly VA patient's bank account.

West Haven, Connecticut, VAMC Supervisor Pleads Guilty to Theft of Government Property

A West Haven, CT, VAMC facilities maintenance supervisor pled guilty to theft of Government property. A VA OIG, VA Police Service, and General Services Administration (GSA) OIG investigation revealed that for over 3 years the defendant used VA employees, materials, vehicles, and equipment to make renovations to her basement, kitchen, bathrooms, and deck. The loss to VA is between $15,000 and $20,000. Additionally, the defendant and 11 other VA employees are facing administrative sanctions.

Former Compensated Work Therapy Employee Sentenced for Theft from Togus, Maine, VAMC

A former Compensated Work Therapy employee was sentenced to time served (6 months), 6 months' community confinement, 3 years' supervised release, and ordered to pay $2,590 in restitution. The defendant previously pled guilty to theft of copper wire and pipe fittings from the Togus, ME, VAMC. An OIG investigation disclosed that the defendant sold over 400 pounds of wire and pipe fittings to a local recycling company and used the money to support his drug addiction. The loss to VA is approximately $4,000.

Former Philadelphia, Pennsylvania, VA Contract Employee Sentenced for Fraud

A former contracted certified nursing assistant working at the Philadelphia, PA, VAMC was sentenced to 5 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $75,819. An OIG investigation revealed that the defendant submitted false time sheets to her employer, fraudulently claiming that she was working an average of 100 hours per week and causing VA to overpay her $75,819 in unearned wages. The defendant submitted over $108,000 in false time sheet hours.

Northport, New York, VAMC IT Specialist Arrested for Illicit Salary Supplementation

A Northport, NY, VAMC IT specialist was arrested for illicit salary supplementation. An OIG investigation revealed that the defendant unlawfully accepted over $40,000 in gifts, to include expense paid vacations, dinners, golf outings, and concert tickets, from sales representatives working for a telecommunications firm contracted by the VAMC. The gifts were paid to the defendant because of a longstanding relationship he developed with the contractor and not for any specific act.

Orlando, Florida, VAMC Work-Study Employee Sentenced for Theft of Government Property

An Orlando, FL, VAMC work-study employee was sentenced to 12 months' probation after pleading guilty to theft of Government property. An OIG and VA Police Service investigation revealed that the defendant stole Continuous Positive Airway Pressure equipment from the VAMC and then sold and shipped the equipment from the VA mailing facility. The loss to VA is $29,902.

Former Rochester, New York, Medical Assistant Sentenced for Workers' Compensation Fraud

A former VA medical assistant at the Rochester, NY, CBOC was sentenced to 6 months' home confinement, 5 years' probation, and ordered to pay $14,524 in restitution after pleading guilty to Workers' Compensation fraud. A VA OIG and Department of Labor (DOL) OIG investigation revealed that the defendant claimed to have suffered a back injury while employed by VA and was medically limited to the number of hours she could work. The defendant began receiving workers' compensation in August 2010 and during the same time period applied for a State license to open a liquor store in which she was listed as president, manager, and sole

proprietor. The defendant was observed on multiple occasions working in the liquor store, climbing staircases, reaching for and replacing bottles, carrying large heavy bags, and assisting customers. The defendant continued filing forms with DOL certifying that she was not engaged in any outside employment.

Tallahassee, Florida, VA Outpatient Clinic Dental Technician Sentenced for Practicing Dentistry Without a License

A Tallahassee, FL, VA outpatient clinic dental technician was sentenced to 24 months' incarceration, 156 months' probation, and 650 hours' community service after being convicted at trial of practicing dentistry without a license. An OIG and local sheriff's office investigation determined that the defendant identified victims through her employment as a VA dental technician and then used stolen VA equipment to perform dental surgery.

Former Jackson, Mississippi, VAMC X-Ray Technician Sentenced for Theft

A former Jackson, MS, VAMC x-ray technician was sentenced to 3 years' supervised probation, $750 in fines and fees, and ordered to complete a drug and alcohol treatment program after pleading guilty to grand larceny. An OIG investigation revealed that the defendant stole a VA laptop from the medical center and kept it for personal use. The laptop was recovered and contained no PII.

Long Beach, California, VAMC Employees Arrested for Fraud and Receiving Stolen Property

A pharmacist, three pharmacy technicians, and a distribution supervisor at the Long Beach, CA, VAMC were arrested for committing computer access fraud and receiving stolen property. An OIG investigation revealed that the defendants diverted non-controlled VA medications or received stolen VA medications. Since 2011, over 16,000 tablets of prescription medications were diverted.

VA OIG, U.S. Postal Inspections Arrest Two Bronx, New York, VA Workers for Allegedly Distributing Five Kilograms of Cocaine

Two Bronx, NY, VAMC employees were arrested for possession with intent to distribute a controlled substance based on a complaint alleging that they engaged in a conspiracy to distribute more than five kilograms of cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Administration (DEA) Organized Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service (USPS) Priority Mail parcels containing one to two kilograms of cocaine were mailed from Puerto Rico to the VAMC warehouse. The defendants subsequently took possession of these packages and ultimately transferred the drugs off station. On the day of the arrest, agents observed the defendants take the package into a private office in the warehouse and exchange money for the package.

West Palm Beach, Florida, VAMC Employee and Husband Sentenced for Drug Trafficking

A West Palm Beach, FL, VAMC employee and her husband were sentenced to a combined 71 months' incarceration and assessed $160,292 in fines and court fees after pleading guilty to trafficking oxycodone and the sale of marijuana. These sentences stemmed from a 7-month OIG and local drug diversion task force investigation. The investigation focused on combating the sale and distribution of illicit and controlled prescription pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation identified that the majority of all criminal activity occurred at the medical center and resulted in the seizure of over 3,000 oxycodone pills, two vehicles, and $180,920 in cash.

VAMC Employees Arrested for Drug Diversion

A Mountain Home, TN, VAMC nurse was indicted and arrested for theft of a controlled substance. An OIG and VA Police Service investigation revealed that on numerous occasions the defendant diverted oxycodone tablets from a psychiatric patient. The defendant subsequently confessed to stealing the veteran's narcotics. Administrative action is also pending against the defendant. In addition, a Gainesville, FL, VAMC RN was

arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant removed hydromorphone from medical center Pyxis machines for her own use. Finally, an Atlanta, GA, VAMC pharmacist was charged with theft by taking after an OIG investigation revealed that the defendant stole pills from the VA pharmacy and attempted to conceal them in her personal bag. The defendant subsequently admitted to the theft of the drugs.

A Gainesville, FL, VAMC medical support assistant was arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that the defendant intentionally removed and ingested wasted controlled substances from sharps containers.

Former Palo Alto, California, VAMC Nurse Pleads Guilty to Drug Diversion

A former Palo Alto, CA, VAMC RN pled guilty to obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant diverted approximately 1,200 syringes of hydromorphone, totaling more than 3,850 milligrams, by taking the doses that she claimed to have given to patients, logging in under the profiles of other nurses, or initiating false wasting entries under both her profile and those of the other nurses.

VAMC Nurses Sentenced for Drug Diversion

A former Fort Harrison, MT, VAMC nurse anesthetist was sentenced to 5 years' supervised release and barred from employment as a nurse after pleading guilty to acquiring controlled substances by fraud and deception. An OIG investigation revealed that the defendant was diverting and using sufentanyl and other controlled substances while performing his duties as a VA nurse.

A former Bath, NY, VAMC licensed practical nurse was sentenced to 5 years' probation after pleading guilty to possession of oxycodone. An OIG and VA Police Service investigation revealed that the defendant diverted medications intended for patients for personal use.

St. Louis, Missouri, VAMC Nurse Indicted for Drug Diversion

A St. Louis, MO, VAMC RN was indicted for health care fraud and aggravated identity theft. An OIG investigation revealed that the defendant diverted Dilaudid from patients in the emergency room for personal use.

Former Dayton, Ohio, VAMC Physician Pleads Guilty to Drug Violation

A former Dayton, OH, VAMC physician pled guilty to aiding and abetting another in the possession of a controlled substance absent a valid prescription. An OIG, State medical board, and DEA Tactical Diversion Squad investigation revealed that the defendant, who was the supervisor of the VAMC's pain management clinic, wrote VA prescriptions for oxycodone to a veteran and his non-veteran spouse which were then filled at outside pharmacies. The extra oxycodone was intended for the veteran with whom the defendant admitted to having a sexual relationship. As part of her plea, the defendant agreed to permanently surrender her medical license and DEA number after having previously been removed from her position at the VAMC.

San Francisco, CA, VAMC Anesthesiologist Arrested for Possession of a Controlled Substance

A San Francisco, CA, VAMC anesthesiologist was arrested for possession of a controlled substance. An OIG, DEA, and local police investigation revealed that the defendant surrendered her DEA registration after emergency personnel treated her for an apparent overdose of ketamine and fentanyl. A day prior to the emergency call, the defendant logged into the VAMC AcuDose-Rx dispensing cabinet and recorded that she had wasted injectable ketamine and fentanyl. The defendant subsequently confessed to possessing narcotics at her residence without a prescription and overdosing on the drugs. The defendant was subsequently terminated by VA for failure to maintain a current certification.

Former Nashville, Tennessee, VAMC Supervisory Pharmacist Sentenced for Drug Theft

A former Nashville, TN, VAMC supervisory pharmacist was sentenced to 1 year of supervised probation after pleading guilty to theft over $500 and official misconduct. An OIG investigation revealed that the defendant diverted large amounts of drugs from the VAMC when she was employed as the night shift supervisor.

Former Philadelphia, Pennsylvania, VAMC Cooperative Student Arrested for Prescription Fraud

A former Philadelphia, PA, VAMC cooperative student, who is a veteran and a former VA employee, was arrested for the theft and use of a VA employee's prescription pad. An OIG and State investigation revealed that the defendant stole a VA employee's prescription pad, forged the signature of the VA employee, and used the prescriptions to obtain various controlled medications at retail pharmacies.

Veterans Sentenced for Drug Distribution at VAMCs

A veteran was sentenced to 1 year of probation after pleading guilty to possession of heroin with intent to distribute. An OIG and VA Police Service investigation revealed that the defendant sold heroin to patients at the Boston, MA, VAMC. The defendant was identified during an undercover operation at the VAMC. When confronted, the defendant admitted to being in possession of heroin that he intended to sell.

A second veteran was sentenced to 6 months' home confinement and 5 years' probation after pleading guilty to possession of a controlled substance. An OIG investigation determined that the defendant, who resided in transitional housing for homeless veterans, sold heroin on numerous occasions to veterans receiving treatment at the Lyons, NJ, VAMC where the transitional facility is co-located. This case was a result of a long-term drug investigation, which resulted in several defendants being arrested for drug distribution.

A third veteran was sentenced to 66 months' incarceration and 36 months' supervised release after pleading guilty to selling his VA prescribed narcotics to a co-conspirator. The defendant was also ordered to be released to immigration officials following his incarceration for potential deportation.

Veterans and Non-Veteran Arrested for Drug Distribution at Long Beach, California, VAMC

Five veterans were arrested for illegally selling a controlled substance. An OIG and VA Police Service investigation revealed that veterans were selling controlled prescription pharmaceuticals and illegal narcotics at the Long Beach, CA, VAMC. During the investigation, two of the defendants also sold a handgun and an automatic rifle to an undercover officer. In addition, one veteran and one non-veteran were arrested for obtaining controlled substances by fraud, possessing controlled substances, and selling controlled substances to an undercover officer. Another veteran, who is a registered sex offender, was arrested for possessing, transporting, and selling controlled substances to an undercover officer. If convicted, this would be the veteran's third felony conviction, which may result in a life sentence. This veteran's bail was set at $1,050,000.

Veterans Indicted for Doctor Shopping for Controlled Medication

A total of 25 veterans were indicted for obtaining prescription medication by fraud, deceit, or subterfuge and theft of Government property. To date, 23 of the defendants have been located and arraigned on these charges after an OIG, State, and local investigation revealed numerous veterans were simultaneously obtaining controlled medication from VA and outside sources. Each veteran and their respective VA physicians were interviewed and provided information in furtherance of the cases. The U.S. Attorney for the District of South Carolina worked in conjunction with the local coordinator of the VA's Veterans Justice Outreach Program to pursue appropriate judicial avenues.

Veteran Sentenced for "Doctor Shopping" for Controlled Substances

A veteran was sentenced to 11 months and 29 days' incarceration (suspended) and 11 months and 29 days' probation after pleading guilty to failing to disclose to a healthcare practitioner the receipt of a controlled

substance of similar therapeutic use within the previous 30 days. An OIG investigation revealed that the defendant obtained controlled substances from both VA and non-VA providers during the same time period. The defendant's ability to receive controlled substances from VA has been terminated.

Veterans Plead Guilty to Drug Possession at New Jersey VAMCs

Two veterans previously arrested for their roles in distributing heroin, crack cocaine, and pharmaceutical controlled substances at the Lyons and East Orange, NJ, VAMCs pled guilty to possession of controlled and dangerous drugs. The defendants were arrested following a joint undercover and consensual monitoring operation with OIG, FBI, and VA Police Service targeting drug distribution that was interfering with drug treatment being provided to veterans at the VA facilities.

Non-Veteran Arrested for Theft and False Statements

A non-veteran was arrested after being indicted for theft of Government funds and false statements. A VA OIG and Department of Housing and Urban Development (HUD) OIG investigation determined that the defendant, who never served in the U.S. armed forces, received medical treatment at the Topeka, KS, VAMC and HUD-Veterans Affairs Supportive Housing benefits. The defendant also filed for VA disability compensation and pension benefits on multiple occasions, all of which were denied. The loss to VA is $223,664 and the loss to HUD is $5,131.

Non-Veteran Pleads Guilty to False Statements

A non-veteran, who claimed to have served in Vietnam with the U.S. Marine Corps, pled guilty to false statements. An OIG investigation revealed that the defendant received VA health care and other benefits that he was not entitled to receive. The defendant was previously convicted in 2008 for defrauding VA of more than $75,000 and was sentenced to 2 years' incarceration. The current loss to VA is $31,696.

Non-Veteran Arrested for Making False Claims to the Government

A non-veteran was arrested after being indicted for making false claims to the Government. An OIG and DCIS investigation determined that the defendant, who never served in the U.S. armed forces, received medical treatment at the Miami, FL, VAMC. The defendant unsuccessfully filed for disability compensation and pension benefits numerous times. The loss to VA is $55,458.

Eight Veterans Indicted for Travel Benefit Fraud

Eight veterans were indicted for theft of public money. An OIG and VA Police Service investigation revealed that each of the defendants submitted fraudulent travel voucher claims to the Mountain Home, TN, VAMC. Each defendant claimed a false address which increased their distance of travel to and from the VAMC. The total loss to VA is $40,188.

Seven Veterans Arrested for False Statements at West Palm Beach, Florida, VAMC

Seven veterans were arrested for false statements related to the VA beneficiary travel program. An OIG investigation revealed that the defendants submitted false travel vouchers to the West Palm Beach, FL, VAMC in order to receive increased reimbursement for travel to and from their VA appointments. The loss to VA is approximately $157,753.

Veterans Sentenced for Travel Benefit Fraud

A veteran was sentenced to 6 months' home confinement, 3 years' probation, and ordered to pay VA $10,448 in restitution for filing false claims with VA. An OIG investigation revealed that from October 2011 to January 2013 the defendant submitted 64 fraudulent travel claims to VA reporting that he traveled 260 miles each way to appointments at the Togus, ME, VAMC. In actuality, the mileage from the defendant's residence to the medical center was only 40 miles each way.

Another veteran was sentenced to 5 years' probation, 6 months' home confinement, 20 hours' community service, attend counseling, and ordered to pay $42,749 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant filed over 600 fraudulent travel vouchers with the Tuscaloosa, AL, VAMC.

Veteran Arrested for Travel Benefit Fraud at Montrose, New York, VAMC

A veteran was arrested for grand larceny relating to beneficiary travel fraud. A VA OIG, NY State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 513 occasions the defendant claimed and received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also being reimbursed for travel by VA. The loss to VA is $19,733.

Veterans Charged with Travel Benefit Fraud at the Asheville, North Carolina, VAMC

A proactive investigation into the beneficiary travel program at the Asheville, NC, VAMC resulted in charges being filed against eight veterans for false, fictitious or fraudulent claims. A total of 12 veterans were the subjects of this investigation; the remaining four are currently in plea negations with the U.S. Attorney's Office. The approximate aggregate loss to VA is $100,000.

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 IT and Data Analysis Division, in coordination with the Office of Investigations, conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. During this reporting period, OIG opened 171 investigations, which resulted in 21 arrests and $4.3 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,114 possible cases with over 3,508 investigative cases opened. Investigations have resulted in the actual recovery of $78.2 million, with an additional $26.4 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $171.3 million. To date, there have been 682 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 264 cases; made 72 arrests; obtained over $3.4 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $12.2 million in savings, efficiencies, and cost avoidance; and recovered more than $4.7 million. Two hundred thirty-nine (91 percent) of these investigations involved the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. Various criminal charges were filed against 66 defendants for these types of investigations. OIG obtained over $3.3 million in court ordered payment of fines, restitution, and penalties and achieved an additional $16.5 million in savings, efficiencies, cost avoidance, and recoveries.

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

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 30 months' incarceration and 3 years' supervised release after pleading guilty to theft of Government funds. A VA OIG, Social Security Administration (SSA) OIG, Railroad Retirement Board OIG, and the Montana Attorney General investigation revealed that the defendant embezzled $369,585 of SSA, VA, and Railroad Retirement funds while operating a for profit fiduciary business.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary and city prosecutor was sentenced to 24 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $198,669 after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant, appointed fiduciary for five incompetent veterans, embezzled VA benefits from the veterans and used the funds for personal expenses. The defendant is also facing additional State charges.

Fiduciary Pleads Guilty to Misappropriation

The fiduciary of a 100 percent service-connected incompetent veteran pled guilty to theft, misappropriation by fiduciaries, and Social Security representative fraud. A VA OIG and SSA OIG investigation revealed that the fiduciary failed to provide fiduciary accountings as required and misappropriated $321,512 in VA and Social Security funds.

Former VA Fiduciary Pleads Guilty to Misappropriation

A former VA fiduciary pled guilty to misappropriation by a fiduciary and theft of Government funds. VA OIG, SSA OIG, and a State financial crimes task force investigation substantiated that the fiduciary embezzled $206,368 in VA funds from multiple veterans and collected another $62,781 in fees from VA that she was not entitled to receive. The fiduciary also embezzled $23,092 in SSA benefits. The total loss is $292,242.

Former Fiduciary Sentenced for Misappropriation

A former fiduciary, who was also the daughter of an incompetent veteran, was sentenced to 366 days' incarceration and 2 years' supervised release after pleading guilty to misappropriation by a fiduciary. No restitution was ordered because the defendant had already repaid the veteran's estate in full. An OIG investigation revealed that the defendant embezzled approximately $251,534 from her father's account.

VA Fiduciary Pleads Guilty to Misappropriation

A VA fiduciary pled guilty to misappropriation by a fiduciary. During an OIG investigation, the defendant admitted to stealing at least $120,000 from veterans and non-Federal state conservatorship accounts that had been placed under his control.

Fiduciary Sentenced for Theft

The brother of a VA beneficiary, who was also his fiduciary, was sentenced to 3 years' probation, 25 hours' community service, and ordered to pay VA restitution of $102,726 after pleading guilty to theft by unlawful taking. An OIG and local police investigation revealed that the defendant submitted an accounting to VA that falsely identified expenses pertaining to his brother for entertainment, clothing, and room and board. During this time period, the veteran was a bedridden inpatient at a VAMC. When interviewed, the defendant admitted to embezzling his brother's VA benefits and using the funds to buy a car and for travel expenses.

Fiduciary Sentenced for Grand Theft

A veteran's son, acting as his fiduciary, was sentenced to 150 days' incarceration, 3 years' probation, and ordered to pay restitution of $75,000 after pleading guilty to grand theft. An OIG investigation revealed that the

defendant used the VA funds, as well as other assets of his father, for his personal use while neglecting to pay his father's assisted living facility bills.

Fiduciary Arrested for Theft

The son of a VA beneficiary, who was also his fiduciary, was arrested for theft by unlawful taking and wire fraud. A VA OIG, SSA OIG, and Health and Human Services (HHS) OIG investigation revealed that the defendant had been embezzling his father's VA, SSA, and personal funds since 2010. The loss is approximately $70,000.

Former Fiduciary Pleads Guilty to Misappropriation

A former VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation determined that the fiduciary stole $28,305 in VA funds that should have been used to pay the veteran's nursing home expenses. The defendant embezzled the funds for use in a failed construction business.

VA-Appointed Fiduciary Sentenced for Theft

A VA-appointed fiduciary was sentenced to 5 years' probation and ordered to pay restitution of $45,060 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds intended for his disabled brother.

Long Beach, California, VAMC Employee Charged with Theft of Government Funds

A criminal information was filed against a veteran, who was also a full-time Long Beach, CA, VAMC employee, for theft of Government funds. An OIG investigation revealed that while employed at the VAMC the defendant applied for and received approximately $60,746 in VA pension benefits without disclosing that between 2007 and 2011 he earned approximately $155,097 in wages.

Veterans Plead Guilty to Theft of Government Funds

A veteran pled guilty to theft of Government funds. An OIG and Department of State Diplomatic Security Service investigation revealed that the defendant fraudulently enlisted in the U.S. Army by using his cousin's identity after being discharged and barred from re-enlistment under his true identity. The defendant's fraud was identified during a Diplomatic Security Service passport investigation. The defendant admitted to using his cousin's identity in order to fraudulently re-enlist and obtain VA compensation, education, and medical benefits. The loss to VA is $1,441,470.

Another veteran pled guilty to theft of Government funds. As part of the plea agreement, the defendant agreed to a forfeiture money judgment of $503,298. An OIG investigation revealed that the defendant submitted altered Certificates of Release or Discharge From Active Duty (DD-214s), a fraudulent Purple Heart certificate, and a forged "buddy statement" to VA in order to support his claim for post-traumatic stress disorder (PTSD). The investigation also revealed that the defendant was "doctor shopping" from approximately January 2010 to August 2012.

Veteran Arrested for VA Compensation Fraud

A veteran was arrested for theft of Government funds and false statements. An OIG investigation revealed that the defendant misrepresented the extent and severity of his disabilities in order to obtain a fraudulent disability rating. Specifically, the veteran claimed and was rated for blindness with best corrected vision making him capable of counting fingers at a distance of 1 foot. The defendant was observed driving a vehicle on a daily basis, as well as performing other daily activities that required better vision than claimed. The loss to VA is approximately $344,700.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 24 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $108,489 after pleading guilty to theft of Government funds and conspiracy to make false statements to Federally-licensed firearms dealers. An OIG investigation revealed that the defendant obtained VA compensation benefits by claiming the loss of the use of both legs. The veteran was observed ambulating freely, driving a vehicle, mowing grass, and feeding horses. The veteran's wife was placed into a pre-trial diversion program and ordered to pay restitution of $18,000 for her part of the scheme. Additionally, the veteran's mother was sentenced to 1 year of probation and the veteran's stepfather was sentenced to 3 years' probation, to include 6 months' home detention, after pleading guilty to conspiracy in making false statements to Federally-licensed firearms dealers. The mother and stepfather purchased over 25 firearms for the defendant, who is a registered sex offender and is prohibited from possessing firearms due to a prior felony conviction for committing a lewd act with a minor. The loss to VA is $159,297.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 60 months' probation and ordered to pay VA $26,989 in restitution. An OIG investigation revealed that between February 2006 and October 2007 the defendant concealed his employment from VA in order to continue to receive individual unemployability benefits.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced to 24 months' probation, 6 months' home detention, 100 hours' community service, and ordered to pay VA $116,233 (constituting the remaining balance of the original $122,993 loss to the Government) in restitution after pleading guilty to theft of Government funds. A VA OIG, IRS-CI, and DOL OIG investigation revealed that the defendant was employed as a building contractor while fraudulently receiving Individual Unemployability benefits.

Veteran Sentenced for Wire Fraud

A former U.S. Marine Corps Captain was sentenced to 4 months' incarceration, 1 year of home confinement, and ordered to pay $90,602 in restitution after pleading guilty to wire fraud. An OIG and Naval Criminal Investigative Service (NCIS) investigation revealed that the defendant failed to inform VA that he returned to active duty and continued to receive VA disability benefits that he was not entitled to receive. The defendant also falsely claimed military housing reimbursement for rent he never paid. Also, while on active duty the defendant tried to increase the amount of his improper disability payments. The loss to VA is $41,862 and the loss to DoD is $48,740.

Veteran Sentenced for VA Compensation and Education Benefits Fraud

A veteran was sentenced to 18 months' incarceration, 36 months' supervised release, and ordered to pay $89,277 in restitution after pleading guilty to conspiracy to defraud VA. An OIG investigation revealed that the defendant received VA disability compensation and education benefits for injuries not sustained while in the U.S. Marine Corps.

Veteran Sentenced for Theft and False Statements

A veteran was sentenced to 60 months' probation and ordered to pay VA $53,270 in restitution after pleading guilty to theft of Government funds and false statements. An OIG investigation revealed that in an effort to support his claims for compensation benefits the defendant feigned a greater degree of hearing loss to VA physicians, made false statements to VA MH providers, and altered a DD-214 to fraudulently reflect service in Vietnam and to having received a Bronze Star and a Purple Heart.

Veteran Sentenced for VA Pension Fraud

A veteran was sentenced to 3 years' incarceration after pleading guilty to theft. An OIG investigation revealed that the defendant falsified his income in order to qualify for VA pension benefits.

Veteran Pleads Guilty to Theft of VA Pension Benefits

A veteran pled guilty to theft of Government funds after an OIG investigation revealed he fraudulently obtained VA pension benefits while operating a construction company. The loss to VA is $33,470.

Veteran Pleads Guilty to Defrauding a Government Program

A veteran pled guilty to defrauding a Government program. A VA OIG and SSA OIG investigation revealed that the defendant fraudulently applied for and received VA and SSA benefits. The defendant failed to report his employment income to VA and SSA. The loss to VA and SSA is approximately $50,000.

Home Care Owner Indicted for Wire Fraud Involving Deceased Veteran

A defendant was indicted for wire fraud after a VA OIG and SSA OIG investigation revealed that the defendant owned and operated a personal care home where a veteran beneficiary resided. After the veteran's death in November 1997, the defendant stole VA and SSA benefits that were direct deposited to a joint account. The approximate loss to VA is $258,000.

Business Owner Indicted for Theft

A business owner was indicted for mail fraud, bank fraud, passing a forged endorsement on a U.S. Treasury check, theft of Government property, and aggravated identity theft. An OIG investigation revealed that before her death, a widow beneficiary had her VA benefits mailed to a private mailbox business operated by the defendant. The defendant then stole, forged, and negotiated VA benefit checks that were issued after the beneficiary's death in February 2001. The loss to VA is $116,598.

Deceased Veteran's Daughter Charged with Theft of Government Funds

The daughter of a deceased veteran was charged in a criminal information with theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA benefits that were direct deposited into a joint checking account after her father's death in January 1991. The defendant also stole SSA benefits that were direct deposited into a savings account of the veteran and his deceased spouse. Additionally, in July 2004 the defendant sent VA a letter and a Declaration of Status of Dependents, both of which were purported to have been signed by the deceased veteran. The loss to VA is $572,717, and the loss to the SSA is $58,633.

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

The daughter of a deceased widow beneficiary pled guilty to theft of Government funds. An OIG investigation disclosed that the defendant fraudulently stole VA benefits that were direct deposited after her mother's death in March 1993. The loss to VA is $271,402.

Daughter of Deceased Dependency and Indemnity Compensation Beneficiary Ordered to Repay VA

The daughter of a deceased Dependency and Indemnity Compensation (DIC) beneficiary, who was previously charged in a civil complaint, agreed to the stipulation of a civil judgment in favor of VA that ordered the defendant to pay $162,954. An OIG investigation revealed that the defendant, a joint account holder on her deceased mother's bank account, failed to report her mother's May 2006 death to VA and then used the VA funds deposited after her mother's death for personal expenses and to repair her deceased mother's residence.

Son of a Deceased VA Beneficiary Sentenced for Theft
The son of a deceased beneficiary was sentenced to 3 years' probation and ordered to pay VA $92,152 in restitution. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited to his mother's account after her death in August 2005.

Son of Deceased Beneficiary Sentenced for Theft of VA Benefits
The son of a deceased beneficiary was sentenced to 30 days' incarceration, 60 months' probation, and ordered to pay restitution of $86,802. An OIG and FBI investigation determined that the defendant stole VA benefits that were direct deposited after the veteran's death in December 2010.

Son of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into a joint account after his mother's death in May 2007. The loss to VA is $83,472.

Husband of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The husband of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA funds that were direct deposited to a joint account after his wife's death in April 2004. The loss to VA is $75,815.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The daughter of a deceased VA beneficiary was sentenced to 60 months' probation, 200 hours' community service, and ordered to pay VA $56,744 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited to a joint account after her mother's death in December 2005. The defendant admitted to using the stolen funds to pay for personal expenses.

Daughter and Son of Deceased Beneficiary Arrested for Theft
The daughter and son of a deceased VA beneficiary were arrested for theft of VA benefits that were direct deposited after their mother's death in May 2008. The loss to VA is $65,951.

VA Funds Recovered
An OIG investigation revealed that VA direct deposited compensation benefits into the bank account of a veteran who died in March 1981. The bank eventually abandoned the funds to the Commonwealth of Virginia in October 2011. Working in conjunction with VA's Debt Management Center, OIG was able to recover $684,384 from the Commonwealth of Virginia.

Other Investigations
OIG investigates a wide array of criminal offenses in addition to those listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. OIG also investigates information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. During this reporting period, in the area of procurement practices, OIG opened 15 cases that resulted in 12 arrests; 6 convictions; 2 imprisonments; more than $1.7 million in court ordered payment of fines, restitution, penalties, and civil judgments; and over $115,000 in savings, efficiencies, and cost avoidance. OIG investigative work in this area resulted in five debarments and one contractor suspension.

Veteran's Widow Arrested for Murder

A veteran's widow was arrested for first degree murder and conspiracy to commit first degree murder. A VA OIG, SSA OIG, Tennessee Bureau of Investigation, and District Attorney's Office investigation revealed that the defendant and her current spouse conspired to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on prescription drugs and then staging a crime scene to make it appear that he committed suicide. The defendant later applied for DIC benefits and falsely claimed that her husband's drug overdose was related to his service-connected PTSD. The defendant's current spouse has pled guilty to conspiracy to commit first degree murder and has agreed to fully cooperate with the prosecution against his wife in exchange for a reduced sentence. The loss to VA is over $100,000.

VA Contractor Indicted for Bribery and Providing Gratuities

An OIG and FBI investigation revealed that from July 2009 to March 2011, a VA contractor paid bribes and gratuities to a Sacramento, CA, VA contracting officer. The contractor provided the contracting officer with cash payments, Disneyland tickets, and hotel accommodations that were worth approximately $43,400. In exchange for the payments, the contractor received 27 VA contracts and task orders worth approximately $7.4 million.

Medical Equipment Company Reaches Civil Settlement with Federal Government

A medical equipment company reached a civil settlement of $6 million with the Federal Government. The agreement resulted from a joint VA OIG, HHS OIG, DOL OIG, and DoD OIG investigation into allegations that the medical equipment company entered into a kickback scheme by creating personal service agreements with staff members of physician offices to promote the use of the company's bone growth stimulators. The bone growth stimulators are medical devices used to repair bone fractures that are slow to heal. The company also refurbished used bone growth stimulators and billed the Government for the price of new bone growth stimulators. VA will receive $66,488 of the settlement.

Home Health Aid Agency Owner Indicted on Fraud Charges

The owner of a home health aid agency was indicted for health care claims fraud, forgery, Medicaid fraud, and falsifying or tampering with records after billing Medicaid and VA over $100,000 for services that were never provided. An OIG and state investigation revealed that between May 2011 and April 2013 the defendant made false certification and representations regarding licensing and training to Medicaid and fraudulently received over $44,000 from VA by billing for services that were not provided.

VA Contractor Pleads Guilty to Wire Fraud

A VA contractor pled guilty to wire fraud. An OIG investigation revealed that the defendant had a contract to supply latex gloves to VA and, based on this contract, he accepted more than $150 million from investors who believed they were supplying financing for performance on the contract. The defendant did not reveal to his investors that his sales to VA totaled only about $25,000 per year. The defendant admitted to operating a large-scale Ponzi scheme, falsifying VA documents, and instructing his employees to impersonate VA officials. The defendant is awaiting sentencing and has agreed to pay restitution in the amount of $50 million.

Program Manager Indicted for Conspiracy To Defraud the Government

A defendant was indicted for conspiracy to defraud the Government with respect to claims and false, fictitious, and fraudulent claims. A VA OIG, DCIS, Small Business Administration (SBA) OIG, DOL OIG, and FBI investigation revealed that the defendant, who was a program manager for a small, disadvantaged 8(a) company, was involved in the alteration of two subcontractors' proposals. One of the altered proposals was submitted by a Service-Disabled Veteran-Owned Small Business (SDVOSB) company to the Clarksburg, WV, VAMC. The loss to VA is $73,793. The other proposal was submitted by another 8(a) company to a Navy facility. The loss to the Navy is $297,022.

VA Construction Contractor Pleads Guilty to Bribery, Conspiracy, and Tax Fraud

A VA construction contractor pled guilty to bribery, conspiracy to defraud the U.S. Government, and tax fraud. An OIG, FBI, and IRS CI investigation revealed that between 2007 and 2012 the defendant paid over $671,975 in bribes to a former supervisory engineer at the East Orange, NJ, VAMC in connection with VA contracts. Additionally, the investigation disclosed the defendant and the VA engineer, who was also criminally charged, conspired to set up three companies (one being a fraudulent SDVOSB company) to obtain VA contracts. The VA engineer then directed more than $6 million worth of VA construction projects to those companies with more than $3 million being paid to the falsely claimed SDVOSB.

Omaha Contractor Faces Prison for Pass-Through Scheme That Took 45 Contracts Away From Veteran-Owned Businesses

A VA contractor pled guilty to major program fraud. In addition, the defendant's company pled guilty to money laundering in furtherance of a fraudulent pass-through scheme. The guilty pleas follow an SDVOSB's plea to major program fraud and wire fraud, which was entered on behalf of the SDVOSB by the service-disabled veteran owner. An indictment charged the contractor and service-disabled veteran owner in connection with a $23.5 million SDVOSB fraud scheme. The charges included major fraud, wire fraud, money laundering, and conspiracy. Additionally, approximately $3.9 million was seized as part of the investigation. An OIG investigation revealed that from approximately May 2007 to August 2010, the SDVOSB unlawfully received 45 set-aside and/or sole-source SDVOSB contracts from VA and DoD, to include contracts involving *American Recovery and Reinvestment Act of 2009* (ARRA) funds. The investigation further revealed that the SDVOSB was a pass-through and/or front company for the contractor's other businesses and that the service-disabled veteran was simply a figurehead or "rent-a-vet" who was being used for his service-disabled veteran status.

Company Owner Pleads Guilty to SDVOSB Fraud

The president and owner of a company that contracted with VA as an SDVOSB pled guilty to false claims. A VA OIG, GSA OIG, and IRS-CI investigation revealed that the defendant and her company had been doing business with VA under a GSA Schedule as a Woman-Owned business since 2008. In 2009, the defendant self-certified her company to be an SDVOSB claiming her father-in-law was the service-disabled owner and operator of the business. In reality, her father-in-law had been denied service connection by VA and never owned or operated the business. After the creation of the Center for Verification and Evaluation and the subsequent certification process in order to be included in the Vet Biz registry, the defendant went to great lengths to change and submit corporate, banking, and IRS tax records to provide proof to VA that the company was an SDVOSB, while also maintaining her Woman-Owned status with New York State. During her plea, the defendant admitted that she knew her claims were false and that they led to dozens of contracts to provide furniture and interior space planning at VA facilities. The loss to the Government is approximately $1.2 million.

Construction Company Owner Sentenced for SDVOSB Fraud

The owner of a New Mexico construction company was sentenced to 57 months' incarceration and ordered to forfeit $1.1 million. The owner's son-in-law was sentenced to 37 months' incarceration and ordered to forfeit $250,000. Both defendants previously pled guilty to conspiracy and to committing a major fraud against the United States. An OIG investigation determined that the owner of the company paid his stepbrother approximately $50,000 to use his service-disabled veteran status in order to qualify for and obtain $10.9 million in VA SDVOSB contracts. The owner's stepbrother previously pled guilty to conspiracy, major fraud, and wire fraud.

Veteran Indicted for SDVOSB Fraud

A veteran was indicted for wire fraud after obtaining payment through a fraudulently obtained SDVOSB contract. The veteran, along with other unindicted co-conspirators, obtained a contract from VA to transport

veterans who use wheelchairs and claimed that a service-disabled veteran owned 51 percent of the business. It was further alleged that his company met all criteria to obtain the set aside contract. As a result, the subjects were paid in excess of $3.2 million. Civil forfeiture provisions were also included as part of the indictment. Also, the purported service-disabled veteran is the subject of further investigation as he had been declared blind and was observed operating a motor vehicle. As a result of the alleged disability, the veteran was paid approximately $600,000 in VA benefits.

Construction Company Owners Enter into Pretrial Diversion Agreements

Two brothers, the current owners of an established construction company, entered into separate pretrial diversion agreements with a U.S. Attorney's Office relating to their role in establishing a sham SDVOSB. As part of the agreement, the defendants are required to pay VA restitution of $195,000 and have agreed to a 3-year debarment, both individually and as a company, from any Government contracts. The defendants are also to be supervised by U.S. Probation and Pretrial Services for 12 months. An OIG and FBI investigation determined that the defendants served as officers of the SDVOSB, provided start-up capital, and secured bonding for the stepson of one of the brothers. The stepson served as the majority owner of the SDVOSB, although the two defendants maintained control of the business. The defendants then used the sham company as a pass through for the established company to secure SDVOSB set-aside contracts. The SDVOSB obtained almost $13.5 million in set-aside contracts.

Tennessee Grand Jury Returns Fraud Indictment in Scheme to Get Set-Aside Contracts Meant for Veterans and Small Business

A veteran and three other defendants were indicted for major fraud against the U.S. Government, wire fraud, and conspiracy to commit wire fraud. A VA OIG, SBA OIG, and Department of Interior OIG investigation revealed that from August 2008 to April 2013, multiple set-aside and sole source contracts were awarded by VA and other Federal agencies, to include contracts involving ARRA funds, to various front companies controlled and financed by two of the defendants. These two defendants, who are husband and wife, submitted fraudulent documentation in order to obtain and maintain eligibility for the set-aside programs. The veteran defendant was determined to be a figurehead of the company, used only to qualify for the SDVOSB sole-source and set aside contracts. The loss to the Government is approximately $14.8 million, with an approximate loss to VA of $3.8 million.

Pennsylvania Contractor Admits Hiring Veteran as "Straw" Partner To Obtain $8M in Government Contracts Meant for Disabled Veterans

A contractor pled guilty to participating in a conspiracy to defraud the United States as part of a scheme to receive an $8.7 million SDVOSB set-aside contract. The defendant also agreed to the criminal forfeiture of more than $2.4 million. The defendant admitted that the veteran with whom she partnered was merely a "straw person" and, contrary to her representations to the Government, had no duties with the contract and accepted only a small annual payment so that his name and status could be used. The defendant also admitted that the contract company's project manager at a Federal building and another contractor participated in the scheme.

Missouri Man Pleads Guilty To Making False Claims Enabling Company To Win $6.7M in Contracts Intended for Veterans

The co-owner of a company pled guilty to conspiracy to commit fraud against the United States, major program fraud, and wire fraud. The contractor admitted that he and his father, a co-defendant, made false claims in order for their company to fraudulently obtain SDVOSB set aside contracts of $6.7 million from VA and $748,000 from DoD. Two other defendants have pled guilty in the case.

Former State of Maryland Department of Veterans Affairs, Employee Pleads Guilty to Extortion

A former Maryland VA employee pled guilty to extortion. An OIG investigation revealed that from 2003 to 2011, while working at the Maryland VA, the defendant created fraudulent doctor notes and amendment forms commonly referred to as DD-215s as part of claims for service-connected disabilities. The defendant solicited and received cash payments from veterans in exchange for assistance with their claims. The doctor's notes claimed that the veterans had been diagnosed with diabetes and were insulin dependent. The fraudulent DD-215s were used as proof of service in Vietnam. The defendant also filed a fraudulent DD-215 form to increase his own rating for PTSD. A total of 17 veterans received compensation benefits using the fraudulent forms. The loss to VA is $1,151,219. The State employee also assisted the veterans in receiving $255,555 in property tax waivers from the State that they were not entitled to receive.

Chief Executive Officer Sentenced for Wire Fraud

A chief executive officer of a VA-approved direct lender was sentenced to 51 months' incarceration, 5 years' supervised release, and ordered to pay restitution of $3,242,888 after pleading guilty to wire fraud. An OIG, FBI, and Special Inspector General for the Troubled Asset Relief Program investigation revealed that the defendant defrauded a major bank, which resulted in losses of approximately $5.3 million. The defendant secured funds from the bank by making false representations relating to a line of credit he allegedly maintained with a separate title company where he held an undisclosed affiliation and failed to pay off certain loans the second company was responsible to pay. The defendant used the money to pay off other loans not disclosed to the lending bank and for personal enrichment.

Former New England Compounding Center Supervisory Pharmacist Indicted for Mail Fraud

A former New England Compounding Center supervisory pharmacist was indicted for mail fraud. A multi-agency investigation revealed that the defendant allegedly caused a shipment of contaminated methylprednisolone acetate vials to be labeled as injectable and fit for human use. The vials were ultimately shipped to pain clinics and used on patients. The contaminated vials resulted in the death or severe illness of numerous patients who received the injections. VA received several products from New England Compounding Center, including the methylprednisolone acetate. Two veterans were identified as having died as a result; however, they had received the contaminated medicine from non-VA providers.

Former Service Company Employee Sentenced for Theft of VA Equipment

A former field service engineer for a private company was sentenced to 1 day of time served, 2 years' supervised release with 1 year of home detention, and ordered to pay restitution of $197,770. An OIG and Food and Drug Administration investigation determined that the defendant stole four endoscopy and colonoscopy scopes, valued at $114,210, from the Fort Wayne, IN, VAMC. The defendant subsequently admitted to the theft of additional scopes, bringing the total value of stolen VA medical equipment to $220,000.

Training Center Owners Arrested for Theft

Two owners of a training center were arrested for grand theft, organized scheme to defraud, and conspiracy. An OIG investigation revealed that the defendants owned and operated a school that billed VA between $5,750 and $7,750 for courses taken by veterans as part of their Post-9/11 G.I. Bill benefits, while charging non-veterans between $249 and $645 for the same courses. The loss to VA is $635,465.

Mortgage Broker Sentenced for Fraud

A mortgage broker was sentenced to 4 months' incarceration, 6 months' home detention, 3 years' probation, and ordered to forfeit $327,039 after pleading guilty to conspiracy to commit mail, wire, and bank fraud. An OIG and FBI investigation determined that the defendant provided funds to multiple buyers that were used as the down payment during real estate closings. The funds were fraudulently reported on the Uniform Residential

Loan Application form as gifts from a family member and were used to increase the buyers' credit scores allowing them to qualify for larger mortgages. Thirteen loans were identified in the scheme, including a VA-guaranteed home loan. The potential loss to the VA if the guaranteed VA home loan defaults is approximately $152,203.

Kerrville, Texas, VAMC Employee Arrested for Receipt of Child Pornography

A Kerrville, TX, VAMC employee was arrested for receipt of child pornography. An OIG investigation revealed that while the defendant was working a midnight shift he regularly searched for and downloaded child pornography using the VA computer in his work area. The defendant admitted to routinely engaging in similar conduct while at home and gave consent for FBI agents to conduct a search of his residence and personal computer.

VA-Affiliated Employee Sentenced for Theft

A former temporary employee of a VA-affiliated non-profit research institute was sentenced to 21 months' incarceration, 36 months' supervised release, and ordered to pay VA restitution of $59,979 after pleading guilty to theft from programs receiving Federal funds and misuse of a passport. A VA OIG, Homeland Security Investigations, Defense Security Service, and SSA OIG investigation revealed that the defendant used a false Social Security Number (SSN), date of birth, and passport to conceal his criminal history and obtain employment with the research institute. After gaining employment, the defendant fraudulently opened two corporate accounts in the name of the VA research group and deposited 20 checks totaling approximately $68,000, withdrawing almost $60,000 for personal use. When arrested, the defendant was living approximately 100 miles away from his initial location and had obtained employment and housing using another fictitious name, SSN, date of birth, and passport. The other investigative agencies joined the investigation after it was determined that the defendant committed additional criminal offenses in an effort to elude capture and gain new employment.

Former VA Cemetery Mechanic Sentenced for Workers' Compensation Fraud

A former VA cemetery mechanic was ordered at sentencing to pay VA restitution of $15,281 and was also fined $25,000. An OIG investigation revealed that the defendant, who filed a worker's compensation claim for an on-the-job injury in 2006, was working as a mechanic at a local auto body shop. The defendant failed to report his employment to the DOL Office of Workers' Compensation and also claimed he could not return to work because of his injuries.

Las Vegas, Nevada, VAMC Employee Convicted of Seeking Sexual Relationship with Young Girl

A Las Vegas, NV, VAMC employee was convicted at trial of coercion and enticement. An OIG and local police investigation revealed that the defendant used VA computers to post ads on Craig's List stating that he was seeking a sexual relationship with a young girl. The employee corresponded with an undercover officer, who he believed was a 14-year-old girl, and was subsequently arrested when he arrived at a meeting location.

Veteran Pleads Guilty to Drug and Weapon Violations

A veteran pled guilty to a variety of drug charges and knowingly possessing and transferring a machine gun. As part of the plea, the defendant agreed to forfeit a number of long guns, handguns, and ammunition confiscated during the arrest and execution of a search warrant at his residence. An OIG, Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), DCIS, and local police investigation revealed that the defendant participated in a plan with at least two other veterans in the theft and transport of at least two machine guns allegedly supplied from Fort Bragg. Controlled buys of the guns were conducted, and the other veterans were arrested based on those purchases. This defendant continued his illicit activity to include selling a shotgun, ammunition, a bullet proof vest, and his VA prescription medications to one of the previously arrested veterans.

Two Non-Veterans Arrested for Robbery

Two non-veterans were arrested for the armed robbery of a VA employee at the Memphis, TN, VAMC. An OIG, VA Police Service, and local police investigation revealed that the defendants stole the employee's backpack at gunpoint in the VAMC parking lot.

Federal Judge Gives 7.5 Year Sentence to Florida Man for Identity Theft that Victimized Veterans at Haley VAMC

A non-veteran was sentenced to 90 months' incarceration, 48 months' supervised release, and ordered to pay $418,723 in restitution after pleading guilty to aggravated identity theft and theft of Government funds. An OIG, IRS-CI, and local police investigation revealed that the defendant, a convicted murderer, used veterans' PII from stolen Tampa, FL, VAMC medical records to file $418,723 in fraudulent tax returns.

Non-Veteran Sentenced for Identity Theft

A non-veteran was sentenced to 87 months' incarceration, 36 months' supervised release, and ordered to pay $630,753 in restitution. A VA OIG, IRS-CI, and Florida Highway Patrol investigation revealed that the defendant used veterans' PII from stolen Tampa, FL, VAMC medical records and other non-veterans' PII to file $819,659 in fraudulent tax returns.

Veteran Sentenced for Credit Card Fraud

A veteran was sentenced to 366 days' incarceration after pleading guilty to a variety of credit card fraud charges after an OIG and VA Police Service investigation revealed that the defendant stole a VA physician's purse while receiving treatment at the West Palm Beach, FL, VAMC and used the physician's credit cards to make fraudulent transactions.

Non-Veteran Sentenced for Identity Theft at the Cleveland, Ohio, VAMC

A non-veteran was sentenced to 18 months' incarceration after pleading guilty to identity theft. An OIG investigation revealed that the defendant assumed the identity of a veteran and then from September 2010 to March 2013 fraudulently used the veteran's PII to obtain medical care at the Cleveland, OH, VAMC. The loss to VA is $13,800.

Former Contract Employee Arrested for Identity Theft

A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents was indicted and arrested for unlawful disclosure of protected health information, access device fraud, and aggravated identity theft. An OIG, IRS-CI, Florida Department of Law Enforcement, Florida Highway Patrol, local Sheriff's office, and local police department investigation revealed that the defendant stole medical records containing veterans' PII that were intended to be destroyed. The defendant then sold the records to multiple defendants who subsequently used the PII to file $1.4 million in fraudulent tax returns. One of these defendants, who bought the PII, was sentenced to 54 months' incarceration, 36 months' supervised release, and ordered to pay $295,000 in restitution. This defendant subsequently used the stolen PII to file $418,723 in fraudulent tax returns.

Veteran Sentenced for Identity Theft and Fraud

A veteran was sentenced to 48 months' incarceration, 60 months' probation, and ordered to pay $86,273 in restitution after pleading guilty to aggravated identity theft, wire fraud, and bank fraud. A VA OIG, SSA OIG, Department of the Treasury OIG, and State social and health services investigation revealed that the defendant stole and utilized the PII of two veterans to establish fraudulent VA e-Benefits accounts and re-route service compensation payments to prepaid debit cards. The veteran also utilized Direct Express to set up fraudulent accounts through prepaid debit card-issuing banks in order to launder VA and SSA payments. The defendant

obtained PII for over 100 individuals from various sources and caused a combined fraud loss of over $86,000 to VA, SSA, private individuals, and corporations.

Non-Veteran Pleads Guilty to Identity Theft and Conspiracy

A non-veteran pled guilty to identity theft and conspiracy to obtain property by false pretenses. The defendant failed to appear for sentencing, and the presiding judge issued orders for arrest and set a $1,000,000 secured bond. An OIG and local law enforcement investigation revealed that the defendant used 26 victims' identities, to include 13 veterans, to fraudulently open more than 150 cable accounts and then sold those accounts to other people.

Non-Veteran Arrested for Identity Theft

A non-veteran pled guilty to access device fraud and aggravated identity theft. An OIG, IRS-CI, and local sheriff's office investigation revealed that during an undercover operation the defendant purchased what he believed to be a Tampa, FL, VAMC patient's PII. The defendant subsequently used the "controlled" PII, in conjunction with a deceased individual's PII, to file $307,721 in fraudulent tax returns.

Defendant Pleads Guilty to Fraud

An individual pled guilty to a variety of identity theft fraud charges after an OIG and VA Police Service investigation revealed that the defendant, along with a Palo Alto, CA, VAMC employee and two other defendants, conspired to steal the PII of a VAMC employee and used the information to create unauthorized credit card accounts and counterfeit checks. Criminal charges have also been filed against the VA employee and the other two subjects. The defendants used the credit card accounts and counterfeit checks to make purchases at various retail stores. The purchased items were then either sold or traded for narcotics.

Non-Veteran Indicted on Multiple Fraud Charges

A non-veteran was indicted for conspiracy to commit mail and wire fraud, aggravated identity theft, and firearm charges. An OIG, IRS-CI, ATF, and local police investigation revealed that the defendant used Veterans' PII obtained from stolen VAMC medical records and other sources to file approximately $3.1 million in fraudulent tax returns. Also, the defendant, who is a convicted felon, was in possession of multiple firearms.

Former Bank Manager Arrested for Theft by a Bank Officer

A former bank manager was arrested for theft by a bank officer. An OIG investigation determined that while the defendant was employed by a bank he became aware that a veteran had died in the Dominican Republic. VA was unaware of the veteran's death and continued depositing VA compensation benefits into the veteran's account. The defendant then embezzled the VA funds and funds from another bank customer to support a gambling habit. The loss to VA is $37,830.

Veteran's Son Arrested for Exploitation

The son of a veteran was indicted and arrested for exploitation of an aged adult and theft from a person 65 years of age or older. An OIG and local sheriff's office investigation revealed that the defendant abandoned the veteran at a residence, stole the veteran's debit card, and continued to use VA benefits intended for the veteran. The loss is $31,353.

OIG Investigation Results in 2 Years in Prison for Woman Who Squandered $364K in Grants Meant for Homeless Veterans

A veteran was sentenced to 24 months' incarceration, 2 years' supervised release, and ordered to pay $364,000 in restitution after pleading guilty to making false material statements and theft of Government funds. An OIG investigation revealed that the defendant fraudulently obtained three separate grants from the VA Grant and Per Diem Program. The grants were intended to provide housing and assistance to homeless veterans.

However, the defendant used the grant funds for personal gain. During the execution of a search warrant at the defendant's residence, large amounts of lottery tickets, gambling slips, and other gambling paraphernalia were found.

Veteran Sentenced for Interstate Transportation of Stolen Property From Chillicothe, Ohio, VAMC

A veteran was sentenced to 24 months' incarceration and 3 years' supervised release after pleading guilty to interstate transportation of stolen property. An OIG investigation revealed that the defendant stole VA construction equipment and VA contractor equipment from the Chillicothe, OH, VAMC. Some of the stolen VA construction equipment was subsequently transported and sold by the defendant in West Virginia. The defendant admitted to transporting and selling the stolen property, as well as selling some of the stolen equipment at a local pawn shop. A stolen generator was also recovered during a search of the defendant's residence. The value of the stolen property transported to West Virginia is approximately $89,200.

Former USPS Employee Pleads Guilty to Theft

A former USPS employee pled guilty to delay of mail, theft of mail by a postal employee, and conspiracy to distribute a controlled substance. A VA OIG and USPS OIG investigation determined that from 2010 to 2013 the defendant stole VA packages containing narcotic drugs from a USPS distribution facility. The defendant admitted to selling the stolen narcotics. A Federal search warrant executed at the defendant's residence revealed large quantities of stolen narcotics as well as stolen mail matter.

Former UPS Employee Sentenced Possession of a Controlled Substance

A former United Parcel Service (UPS) employee was sentenced to 3 years' supervised probation, ordered to complete a drug and alcohol abuse assessment, and to pay a $2,000 fine and restitution of $195 after pleading guilty to possession of a controlled substance with intent to sell or deliver. An OIG investigation revealed that during a 2-week period the defendant stole 1,520 tablets of VA controlled substances from 8 UPS packages. The investigation also revealed that the defendant used and sold the stolen tablets.

USPS Postmaster Arrested for Theft of VA Drugs

A USPS Postmaster, who is also a service-connected veteran, was indicted and arrested for mail theft. A VA OIG and USPS OIG investigation revealed that the defendant stole 50–60 VA narcotic parcels from a U.S. mail sorting facility.

Veterans Indicted for Drug Distribution

Two veterans were indicted for drug distribution charges. An OIG and State Police investigation resulted in five controlled buys with one defendant during which the defendant sold a total of 196 Percocet pills, and two controlled buys with the second defendant during which that defendant sold morphine and oxycodone pills. Both defendants obtained these pills from VA.

Former Home Health Aide Charged With Theft

A former home health aide, employed by a company contracted by VA to provide home health care services to a blind veteran, was charged with theft of $7,300 from the veteran's account using multiple wire transfers. An OIG and local police investigation disclosed that the defendant gained access to the veteran's account and hid this fact from her employer because she knew it was against company policy. The defendant confessed that she embezzled the money without the veteran's knowledge.

Defendant Pleads Guilty to Possession of a Controlled Substance

A defendant pled guilty to possession of a controlled substance. An OIG investigation determined that the defendant, who resided in transitional housing for homeless veterans, sold heroin to veterans receiving treatment at the Lyons, NJ, VAMC where the transitional facility is co-located.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 40 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 48 defendants. OIG obtained nearly $116,000 in savings, efficiencies, cost avoidance, and recoveries. OIG investigative work resulted in the following:

- A veteran was indicted for assault after an OIG investigation revealed that he struck a Waco, TX, VAMC police officer in the mouth, resulting in injuries.
- A veteran was arrested for assault, vandalism, and battery after an OIG and VA Police Service investigation revealed that while he was a patient at the Long Beach, CA, VAMC he assaulted a nurse, punched and kicked another patient, and ripped a water fountain off the wall.
- A veteran was arrested for assaulting a VA physician during a medical appointment at the San Jose, CA, CBOC. An OIG and VA Police Service investigation revealed that while at the CBOC the defendant repeatedly requested the physician refill his prescription for Xanax. The physician believed the veteran was drug seeking and refused to refill his prescription. The defendant became disruptive, verbally abusive, and attacked the physician from behind. The veteran fled the CBOC and was subsequently arrested by the local sheriff's office.
- A veteran was convicted at trial of assault on a VA physician. An OIG investigation revealed that the defendant became angry at how long he had to wait for his appointment for pain medication and subsequently assaulted his Miami, FL, VAMC physician.
- A veteran was arrested for assault on a Federal officer. An OIG, VA Police Service, and FBI investigation revealed that Wilmington, DE, VAMC police officers, responding to a complaint of a man with a gun, confronted the suspect on VA property and ordered him to drop his weapon. The suspect failed to comply and raised his weapon in an apparent threatening manner. VA Police fired twice and struck the suspect in the hand. The suspect was taken into custody, treated for his injuries, and transported to a local psychiatric facility for evaluation.
- The son of a VA physician was arrested for aggravated assault after stabbing his father multiple times at the Memphis, TN, VAMC. An OIG, VA Police Service, FBI, and Memphis Police Department investigation determined that the defendant traveled from Virginia to Tennessee and attacked his estranged father with a knife.
- A veteran was sentenced to 20 months' incarceration and 3 years' probation after pleading guilty to threatening to murder a Government employee. An OIG and VA Police Service investigation determined that the defendant threatened to kill Seattle, WA, VAMC police officers while they were engaged in the performance of their official duties.
- A veteran was arrested for stalking after OIG, VA Police Service, and a local District Attorney's Office investigation revealed that he was regularly sending letters and leaving sexually explicit telephone messages for a VA social worker, formerly assigned to the defendant's care. The defendant had been warned several times by both VA police officers and OIG agents not to have any contact with the victim.

The defendant disregarded the warnings and attempted to meet with the victim near her residence. In conjunction with the arrest, a temporary order of protection was issued.

- A veteran was sentenced to 3 years' probation and ordered to attend special counseling pertaining to education, employment, and self-help after pleading guilty to aggravated harassment. An OIG investigation revealed that the defendant made bomb threats against a VAMC because of a reduction in benefits and a wage garnishment letter he received in the mail.
- A veteran who threatened to blow up VA, put his guns to use, and also threatened the USPS was arrested after fleeing for 10 days from his residence in Delaware. The veteran was located and arrested in another state and is awaiting extradition.
- A veteran was indicted for terroristic threats. An OIG investigation revealed that the defendant called a VA Telephone Care Service Hotline and threatened to kill a physician's assistant at the Beaumont, TX, CBOC. The phone call was recorded, and the defendant subsequently confessed to making the threats.
- A defendant was sentenced to 81 days' incarceration and ordered to stay away from the victim, a VA employee, after pleading guilty to harassment. A VA OIG, U.S. Secret Service, Federal Protection Service, VA Police Service, and local law enforcement investigation disclosed that the defendant placed a letter on the Government vehicle of an OIG agent that was addressed "To All Americans," and identified the author as a VA supervisor. The letter reported that the author had an arsenal of ammunition, guns, and dangerous chemicals. The letter also warned of a big threat coming soon and made threats to kill the President within 1 month. The defendant previously made unfounded allegations against the VA supervisor after the defendant learned that he would not be interviewed for a full-time VA position.
- A veteran was arrested for making threats to do bodily harm. An OIG investigation revealed that the defendant told a VA Call Center that he was going to get a gun and shoot employees at the Roanoke, VA, VARO.
- A veteran was arrested for making terroristic threats after an OIG investigation revealed that he threatened to get a weapon and shoot his VA doctor and other employees at the Long Beach, CA, VAMC. The defendant claimed that he was frustrated because he could not get his medications.
- A veteran was indicted and arrested for making threats towards VA staff, VA facilities, and a VA-assigned fiduciary. An OIG and Federal Protective Service investigation revealed that in June 2013 the defendant made threats to use an explosive device and a firearm to kill VA employees and his VA fiduciary in order to get his VA benefits.
- A veteran was arrested for making terroristic threats after an OIG and VA Police Service investigation revealed that he threatened to kill a Long Beach, CA, VAMC physician, the physician's family, and three VA police officers. The defendant made the threats because he wanted more narcotics. Also, an assault rifle was seized from the veteran's residence.
- A veteran was placed on a 72 hour involuntary psychiatric hold after making multiple telephonic bomb threats against the Sacramento, CA, VAMC. An OIG investigation revealed that in addition to the recent threat made by the veteran he had made similar threats in the past that resulted in bomb searches and evacuations of the medical center.
- A veteran was arrested for assault and criminal threats. An OIG and VA Police Service investigation revealed that the defendant arrived at the Long Beach, CA, VAMC and threatened to kill himself, his girlfriend, and three VAMC police officers. The defendant also assaulted two of the officers while attempting to leave the VAMC. During the investigation, a handgun and two rifles were subsequently recovered, weapons that the defendant was not authorized to possess. The veteran was later charged with possession of firearms by a prohibited person.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 57 million felony warrants have been received from the National Crime Information Center and participating states resulting in 69,879 investigative leads being referred to law enforcement agencies. Over 2,442 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.11 billion in estimated overpayments with an estimated cost avoidance of $1.33 billion. During this reporting period, OIG opened 23 and closed 27 fugitive felon investigations, identifying $123.1 million in estimated overpayments. OIG investigative work resulted in the arrest of 18 fugitive felons, including 4 VA employees. VA employees were apprehended on charges related to assault, drug violations, and probation violations. Based on the information provided to OIG, at least 24 additional arrests were made by other law enforcement agencies.

- A veteran was arrested by the local sheriff's office with the assistance of OIG and the U.S. Marshals Service at the West Palm Beach, FL, VAMC. The defendant was wanted for violation of probation stemming from aggravated assault with a deadly weapon.
- An Atlanta, GA, VARO employee was arrested by the local police with the assistance of OIG and VA Police Service. The employee was wanted for aggravated sodomy, aggravated assault, battery (family violence), cruelty to children, and aggravated assault-family violence.

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 10 and closed 11 administrative investigations. The Division investigated 22 allegations, 15 of which were substantiated. This work resulted in the issuance of 3 reports containing 10 recommendations for administrative or corrective action. These reports are listed in Appendix A.

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

Senior VA Procurement Official Pressured Contracting Staff To Give Preference in Reverse Auction Services Task Order

The VHA Deputy Chief Procurement Officer engaged in conduct prejudicial to the Government, a conflict of interest, improperly disclosed non-public VA information, misused her position and VA resources, engaged in a prohibited personnel practice, interfered with a VA OIG contract review, acted as an agent of FedBid, Inc. in matters before the Government, and did not testify freely and honestly. Additionally, in order to financially benefit FedBid, Inc., the employee, along with a close personal friend and FedBid, Inc. executives, willfully and improperly acted to thwart a VA official in his oversight duties associated with VA's procurement operations. Together they took significant measures to disrupt and deprive VA's right to transact official business honestly and impartially, free from improper and undue influence.

Former Under Secretary for Memorial Affairs Promoted Friend and Gave Preferential Treatment to NCA Contractor

The former Under Secretary for Memorial Affairs engaged in a prohibited personnel practice when he created a position and preselected an employee for that position. He also engaged in preferential treatment of an NCA contractor when he developed a less-than-arm's-length relationship with the contractor. Further, NCA improperly gave the contractor sole-source contracts to provide one-to-one employee development services to select NCA employees.

VAMC Director and Equal Employment Opportunity Program Manager Failed To Comply with Americans with Disabilities Act and VA Policy

A VAMC Director failed to meet reasonable accommodations (RA) confidentiality requirements by disclosing an employee's confidential medical information to unauthorized VA managers, medical staff, and other employees. In addition, the Director improperly appointed herself the Designated Management Official (DMO); substituted her medical judgment for that of an employee's physicians; delayed accommodating the employee while gathering additional, unnecessary medical information; and neglected to provide the employee avenues of redress when she denied the employee's RA request. Further, the VAMC Equal Employment Opportunity Program Manager and Local Reasonable Accommodations Coordinator (LRAC) failed to implement the *Americans with Disabilities Act Amendments Act of 2008* and subsequent Equal Employment Opportunity Commission guidance after receiving directions from VA's Office of Diversity and Inclusion. The LRAC violated confidentiality requirements when she consulted VHA physicians and revealed the nature of the employee's condition to the DMO and others and failed to follow VA policy when she composed an RA denial letter without providing avenues of redress for the VA employee. Further, a Regional Counsel Staff Attorney failed to provide proper advice to the LRAC concerning the employee's prospective RA, as she told the LRAC that RA guidelines did not recognize the employee's medical condition as a disability.

Office of Management and Administration

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

Operations Division

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

Information Technology and Data Analysis Division

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

Data Analysis staff provide automated data processing technical support of OIG and other Federal and governmental agencies requiring information from VA files. Data Analysis Division products facilitate the identification of fraud-related activities and support OIG comprehensive initiatives that result in solutions beneficial to VA. The following summary provides an example of the type of Data Analysis Division projects initiated this semiannual period.

Review Finds Improper Payments Made to Incarcerated Veteran

A proactive review by the IT and Data Analysis Division found that VA incorrectly calculated benefits for a veteran who has been incarcerated in a Federal prison since 2012. The review identified improper payments to the veteran exceeding $68,000. These findings have been referred to VBA for action.

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, purchase card coordination, and property management.

Budget Division

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

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 9:00 AM to 4:00 PM Eastern Time. OIG receives phone calls, web submissions, e-mails, and letters from employees, veterans, the general public, Congress, the U.S. Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. The Hotline also houses the Whistleblower Protection Ombudsman, who provides education about protections for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation.

During this reporting period, the Hotline received 25,571 contacts, 843 of which became OIG cases. An additional 427 of the Hotline contacts became OIG non-case referrals. The Hotline makes non-case referrals to the appropriate VA organization if the allegation does not rise to the level of a case but appears to warrant VA action. The Hotline also closed 584 cases, substantiating allegations 41 percent of the time. External Hotline cases resulted in 299 administrative sanctions and corrective actions and $2.8 million in monetary benefits. In addition, the Hotline responded to more than 727 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Employee Benefits Fraud Detected in the VA Sunshine Healthcare Network, Tampa, Florida

A VISN review found that a VAMC employee in Florida knowingly provided false dependency information on a Health Benefits Election Form, allowing multiple ineligible individuals to receive health care under the Federal Employees Health Benefits Program. As a result of the review, the facility is pursuing multiple corrective actions, including administrative action against the employee.

Review Substantiates Misuse of Official Time at the VA Caribbean HCS, San Juan, Puerto Rico

An HCS review in San Juan, PR, substantiated that a health care provider improperly used VA time to work at his private medical practice. The review also found another provider frequently accepted full VA compensation without completing his tour of duty. As a result, appropriate administrative action has been proposed against the two employees.

Unused Medical Equipment at Boston VA HCS, Boston, Massachusetts

A review conducted by the Boston, MA, HCS identified multiple pieces of unused ophthalmology and optometry equipment that was purchased but stored in a warehouse without a targeted location for service. The value of the unused equipment was $1.2 million. As a result, the HCS turned in excess equipment and instituted multiple corrective actions to improve controls over inventory management and equipment purchasing.

Philadelphia, Pennsylvania, VARO Terminates Improper DIC Benefits

Two Hotline reviews conducted by the Philadelphia, PA, VARO substantiated that two surviving spouses improperly continued to accept DIC benefits without informing the VARO of their remarriages, as required. One surviving spouse improperly collected $185,008 over a period of 15–20 years, and the other improperly collected $160,172 over a 14-year period. As a result, the VARO terminated their DIC benefits and initiated collection for overpayments totaling $345,180.

Improper Death Pensions Found by VA Pension Management Center, St. Paul, Minnesota

Reviews conducted by the St. Paul, MN, Pension Management Center (PMC) found that two surviving spouses, one in Texas and another in Oregon, improperly continued to receive a death pension by failing to inform VA of additional income. In both cases, the additional unreported income disqualified their pensions. As a result of the review, the PMC terminated their pensions and initiated collection of $108,996 in overpayments.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's OALC to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 66 reviews in this reporting period. The tables that follow provide an overview of OIG performance during this reporting period.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Twenty-eight preaward reviews identified approximately $103 million in potential cost savings during this reporting period. In addition to FSS and Architecture/Engineering Services proposals, preaward reviews during this reporting period included 11 health care provider proposals, accounting for approximately $26 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2013–March 31, 2014	26	$506,120,095
April 1–September 30, 2014	28	$103,422,432
Fiscal Year	54	$609,542,527

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 $13.9 million, including approximately $3.9 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 32 postaward reviews performed, 18 involved voluntary disclosures. In four reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2013–March 31, 2014	19	$5,525,077
April 1–September 30, 2014	32	$13,869,819
Fiscal Year	51	$19,394,896

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 five claims and determined that approximately $11.3 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2013–March 31, 2014	1	$3,163,380
April 1–September 30, 2014	5	$11,349,794
Fiscal Year	6	$14,513,174

Special Reviews

Period	Special Reports Issued	Potential Cost Savings
October 1, 2013–March 31, 2014	1	$0
April 1–September 30, 2014	1	$0
Fiscal Year	2	$0

Review of Fed Bid Contract Finds Reported Savings Overrated and Negative Impact on FSS Contractors

OIG conducted a review of VHA's use of commercial reverse auctions to procure products and services. The review determined that the methodology used to calculate and report savings by using reverse auctions greatly overstated any actual savings and did not comply with VHA's standard operating procedure. VHA's mandatory requirement to use reverse auctions violated VA's policy for using priority sources such as FSS contracts. Over 93 percent of the contract files reviewed did not contain proper documentation to validate the use of reverse auctions in accordance with VHA's standard operating procedure. The review also determined that contracting officials run the risk of purchasing gray market items by using reverse auctions.

Other Significant OIG Activities

Congressional Testimony

OIG Tells Congress Unexpected Deaths Could Be Avoided if VHA Focused First on Core Health Care Mission

Dr. John D. Daigh, Jr., Assistant Inspector General (AIG) for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States House of Representatives, on recent reports by OIG that point to issues related to the quality of care provided at some VA facilities that may have resulted in unexpected deaths. Dr. Daigh focused on reports related to delays in scheduling consult exams, introduction of new technology without adequate regard to patient safety, and disregard for routine VA policies and procedures. While recognizing that no two facilities are the same, Dr. Daigh stressed that it would be beneficial to VA to review the organizational structure and business rules of VHA to determine if changes would make the delivery of quality health care the priority and reduce the potential for errors.

Acting IG Testifies Before Senate Committee on State of VA Health Care, Lays Out Work to Date on Phoenix Wait List Review

Richard J. Griffin, Acting IG, testified before the Committee on Veterans' Affairs, United States Senate, on the state of VA health care. His written statement focused on recent reports by OIG that point to issues related to the quality of care provided at specific VA facilities that led to adverse outcomes. In his opening statement, Mr. Griffin gave an overview of OIG's ongoing review at the Phoenix HCS and outlined the components of an exhaustive review underway at Phoenix HCS and at other sites in the VHA system. Mr. Griffin was accompanied by Dr. John D. Daigh, Jr., AIG for Healthcare Inspections.

AIG for Audits and Evaluations Tells Congress That VA Not Processing Quick Start Claims Timely

Linda A. Halliday, 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 the results of a recent audit of VBA's Quick Start program. Her testimony focused on the OIG report, *Audit of the Quick Start Program*. Ms. Halliday discussed accuracy and timeliness issues related to this VBA initiative, and while there was an improvement in the processing times and accuracy between FY 2011 and FY 2013, it was not significant enough to aid in achieving VA's goals regarding timeliness and accuracy. Ms. Halliday was accompanied by Mr. Kent Wrathall, Director, OIG's Atlanta Office of Audits and Evaluations; Ms. Nora Stokes, Director, OIG's Bay Pines Benefits Inspections Division; and Mr. Ray Figueroa, Project Manager, OIG's Bay Pines Benefits Inspections Division.

Acting IG Testifies Before House Committee on Interim Report on Delays at the Phoenix HCS

Richard J. Griffin, Acting IG, testified before the Committee on Veterans' Affairs, United States House of Representatives, on OIG's *Interim Report – Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*. He discussed the interim report as well as the work OIG has remaining in the review and repeated OIG's commitment to working with Department of Justice officials in this review. He stressed the importance of holding leadership accountable for inappropriate scheduling practices and remarked that it will "no longer be a game" once someone loses his or her job or faces criminal charges. Mr. Griffin was accompanied by Ms. Linda Halliday, AIG for Audits and Evaluations.

AIG for Audits and Evaluations Testifies That Decrease in VBA Backlog Adversely Affected Accuracy and Other Workloads

Linda A. Halliday, AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on OIG's work on the progress of VBA efforts to address the claims backlog. Ms. Halliday discussed the results of recent OIG reports, including *Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years*, which estimated that VBA removed over 7,000 provisionally rated claims from the inventory even though they still awaited final decisions. This process misrepresented VBA's actual workload of pending claims and its progress toward eliminating the overall claims backlog. Because VBA did not ensure existing controls were functioning as needed to effectively identify and manage provisionally rated claims, some veterans may never have received final rating decisions if not for OIG's review. She also discussed concerns about other VBA workload areas that have experienced delays and/or an increase in volume due to the focus on claims processing. These areas include: appeals, benefit reductions, education benefits, other eligibility determinations, and dependency changes. Ms. Halliday was accompanied by Mr. Brent Arronte, Director, OIG's San Diego Benefits Inspections Division.

Acting IG Testifies Before Senate Panel on OIG Findings and Recommendations on Patient Deaths and Scheduling Delays at Phoenix HCS

Richard J. Griffin, Acting IG, testified before the Committee on Veterans' Affairs, United States Senate, on the "State of VA Healthcare." He discussed the OIG recent report, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA HCS. Mr. Griffin discussed the findings and the 24 recommendations in the report as well as the scope and methodology used by OIG to determine if veterans died while waiting for appointments at the Phoenix VA HCS. He was accompanied by Dr. John D. Daigh, Jr., AIG for Healthcare Inspections; Ms. Linda A. Halliday, AIG for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General, and Mr. Larry Reinkemeyer, Director, OIG Kansas City Office of Audits and Evaluations (OAE).

Acting IG Vigorously Rejects Speculation That VA Influenced Phoenix Report Findings at U.S. House Committee on Veterans' Affairs

Richard J. Griffin, Acting IG, testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing on "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report." Mr. Griffin refuted allegations that the OIG's report findings were changed by VA during the draft report review and comment process, in particular, the insertion of a sentence that the OIG could not conclusively assert that the absence of timely care caused the deaths of these veterans. He explained that this sentence was inserted for clarity to summarize the results of the OIG's clinical case reviews that were performed by our board-certified physicians, and that the change was made strictly on the OIG's own initiative; neither the language nor the concept was suggested by anyone at VA. He was accompanied by Dr. John D. Daigh, Jr., AIG for Healthcare Inspections; Ms. Linda A. Halliday, AIG for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General, and Mr. Larry Reinkemeyer, Director, OIG Kansas City OAE.

False Claims Act Settlements

This reporting period, VA received over $29 million in funds from settlements in cases filed under the *qui tam* provisions of the *False Claims Act*. The amount represents VA's damages in four cases: two involved off–label marketing, another involved false underwriting for VA guaranteed loans, and the last involved *Trade Agreements Act* violations.

American Recovery and Reinvestment Act of 2009 Oversight Activities

Enacted in February 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 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 Office of Information Technology (OIT) support of VBA implementation of the new Post-9/11 GI Bill education assistance programs for veterans.

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

As of September 30, 2014, OIG has expended $2.5 million (the entire $1.0 million OIG received under ARRA and $1.5 million from regular appropriations) in conducting its comprehensive program of ARRA oversight. OIG's ARRA-related accomplishments and activities completed to date include:

- Issued seven final audit and evaluation reports and one interim advisory report on VA management of ARRA program activities.
- Conducted 622 fraud awareness training and outreach sessions across the country attended by over 17,250 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 547 and closed 478 criminal investigations, including 143 convictions, 202 referrals for monetary reclamation, and $101,250 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. On March 21, 2013, DOL OIG completed their quality control peer review of VA OIG's system of quality control, and provided a peer review rating of 'pass.' There was one finding not considered of sufficient significance to affect the opinion expressed in their report. The next peer review is scheduled for November 2015 and will be conducted by the U.S. Agency for International Development OIG.

The Act also requires VA OIG to report the results of any peer review it conducted of another OIG's audit operation during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period. VA OIG did not complete any peer reviews on fellow OIGs for the period ending September 30, 2014. VA OIG completed a peer review of the SSA OIG and issued the final report on August 16, 2012, which contained no recommendations.

Additionally, OIG reports that no Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review (QAR) was conducted by another OIG during this reporting period. The last CIGIE QAR conducted on VA OIG's investigative operations was completed by the Environmental Protection Agency OIG in March 2013. The final report was issued on August 23, 2013, and contained no recommendations. VA OIG conducted a CIGIE QAR of the Department of Energy (DOE) OIG's Investigative Operations in April 2014 and issued the final report in July 2014. The report indicated the system of internal safeguards and management procedures for the investigative function of DOE OIG in effect for the year ending 2013 is in compliance with the quality standards established by the CIGIE and the applicable Attorney General Guidelines. These safeguards and procedures provide reasonable assurance of conforming with professional standards in the conduct of its investigations.

Government Contractor Audit Findings

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each IG appointed under the *Inspector General Act of 1978* to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued no reports meeting this requirement.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 271 proposals and made 30 comments.

Refusals to Provide Information or Assistance

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

duties and responsibilities prescribed to OIG in the Act. OIG is required to provide a summary of instances when such information or assistance is refused. OIG reports no such instances occurring during this reporting period.

Employee Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

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

- John Moore, a Hotline Analyst at OIG Headquarters, was activated by the Army National Guard in March 2013.
- Kenneth Sardegna, an Auditor at OIG Headquarters, was activated by the U.S. Army in June 2007.
- Charles Cook, a Health Systems Specialist in the Bay Pines, FL, Office of Healthcare Inspections, was activated by the U.S. Army in March 2014.

Appendix A: Reports Issued During Reporting Period

Table 1: List of Reports Issued by Type

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

Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
4/15/2014 13-02926-112	FY 2013 Review of VA's Compliance With the Improper Payments Elimination and Recovery Act			
4/17/2014 13-02267-124	Audit of VHA's Engineering Service Purchase Card Practices at the Ralph H. Johnson VAMC, Charleston, SC			$660,000
5/7/2014 13-00589-137	Audit of the Non-Recurring Maintenance Program			
5/14/2014 13-03213-152	Audit of VHA's Mobile Medical Units			
5/15/2014 14-00657-144	Interim Report - VBA's Efforts to Effectively Obtain Service Treatment Records and Official Military Personnel Files			
5/20/2014 12-00177-138	Audit of the Quick Start Program			
5/21/2014 13-00991-154	Review of Alleged Unauthorized Commitments Within VA			$85,600,000
5/28/2014 13-03018-159	Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub	$944,000	$944,000	
5/29/2014 13-01391-72	VA's *Federal Information Security Management Act* Audit for Fiscal Year 2013			
6/3/2014 13-02129-177	Audit of VBA's Management of Concurrent VA and Military Drill Pay Compensation			$623,100,000
6/6/2014 14-01686-185	Follow-up Audit of VBA's 100 Percent Disability Evaluations	$222,600,000	$222,600,000	
7/7/2014 11-00323-169	Follow-Up Audit of VHA's Workers' Compensation Case Management	$95,200,000	$95,200,000	$2,300,000
7/11/2014 13-01452-214	Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments			$205,000,000
7/14/2014 13-03468-203	Audit of NCA's Rural Veterans Burial Initiative			

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	
7/14/2014 13-03699-209	Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years			$40,400,000
7/14/2014 14-03644-225	Review of Alleged Mail Mismanagement at VBA's Baltimore VA Regional Office			
8/28/2014 14-00657-261	Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records			
9/18/2014 14-03736-273	Review of Alleged Data Manipulation at the Los Angeles VA Regional Office			
9/30/2014 14-04003-298	Review of Alleged Data Manipulation at the VA Regional Office Houston, TX			
		$318,744,000	**$318,744,000**	**$957,060,000**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
6/10/2014	13-04324-170	VA Regional Office, Reno, Nevada
6/24/2014	14-00383-171	VA Regional Office New York, New York
7/10/2014	14-01053-172	VA Regional Office New Orleans, Louisiana
7/24/2014	14-01497-188	VA Regional Office St. Louis, Missouri
8/5/2014	14-00902-207	VA Regional Office Atlanta, Georgia
8/7/2014	14-01253-208	VA Regional Office Columbia, South Carolina
8/7/2014	14-01501-229	VA Regional Office Des Moines, Iowa
9/24/2014	14-01502-259	VA Regional Office Seattle, Washington
9/25/2014	14-02357-270	VA Regional Office Chicago, Illinois
9/30/2014	14-02889-310	VA Regional Office White River Junction, Vermont

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
4/7/2014	14-00659-111	VA Caribbean Healthcare System, San Juan, Puerto Rico
4/9/2014	14-00309-118	Portland VA Medical Center, Portland, Oregon
4/10/2014	14-00658-121	VA Loma Linda Healthcare System, Loma Linda, California
4/14/2014	14-00305-123	Southern Arizona VA Health Care System, Tucson, Arizona
4/17/2014	14-00307-126	Birmingham VA Medical Center, Birmingham, Alabama
4/24/2014	14-00683-130	Lebanon VA Medical Center, Lebanon, Pennsylvania

Office of Healthcare Inspections | Combined Assessment Program Reviews

Issue Date	Number	Facility
4/28/2014	14-00684-132	VA Northern Indiana Health Care System, Fort Wayne, Indiana
5/6/2014	14-00689-142	Orlando VA Medical Center, Orlando, Florida
5/14/2014	14-00688-162	Canandaigua VA Medical Center, Canandaigua, New York
5/19/2014	14-00685-156	VA Montana Health Care System, Fort Harrison, Montana
5/20/2014	13-04243-151	Wilmington VA Medical Center, Wilmington, Delaware
5/20/2014	14-00687-155	W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
5/27/2014	14-00686-166	Aleda E. Lutz VA Medical Center, Saginaw, Michigan
7/24/2014	14-01290-222	South Texas Veterans Health Care System, San Antonio, Texas
7/25/2014	14-01294-224	VA Black Hills Health Care System, Fort Meade, South Dakota
7/31/2014	14-02063-231	New Mexico VA Health Care System, Albuquerque, New Mexico
8/1/2014	14-02065-230	Washington DC VA Medical Center, Washington, DC
8/5/2014	14-01289-227	James J. Peters VA Medical Center, Bronx, New York
8/12/2014	14-01291-241	Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
8/14/2014	14-01293-243	VA New York Harbor Healthcare System, New York, New York
8/19/2014	14-02067-253	Fayetteville VA Medical Center, Fayetteville, North Carolina
8/28/2014	14-01292-258	Bay Pines VA Healthcare System, Bay Pines, Florida
9/2/2014	14-02068-264	Grand Junction VA Medical Center, Grand Junction, Colorado
9/2/2014	14-02066-266	Providence VA Medical Center, Providence, Rhode Island
9/4/2014	14-02069-268	John D. Dingell VA Medical Center, Detroit, Michigan
9/11/2014	14-02072-283	VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
9/29/2014	14-02075-292	Bath VA Medical Center, Bath, New York

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews

Issue Date	Number	Parent Facility
4/14/2014	14-00234-125	Lebanon VA Medical Center, Lebanon, Pennsylvania
4/18/2014	14-00239-127	VA Northern Indiana Health Care System, Fort Wayne, Indiana
4/24/2014	14-00241-128	El Paso VA Health Care System, El Paso, Texas
4/28/2014	14-00240-129	Southern Arizona VA Health Care System, Tucson, Arizona
4/28/2014	14-00227-131	Birmingham VA Medical Center, Birmingham, Alabama
5/13/2014	14-00236-153	James E. Van Zandt VA Medical Center, Altoona, Pennsylvania
5/22/2014	14-00244-147	Canandaigua VA Medical Center, Canandaigua, New York
5/22/2014	14-00231-158	Aleda E. Lutz VA Medical Center, Saginaw, Michigan
5/27/2014	14-00242-160	W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
6/10/2014	14-00905-182	Huntington VA Medical Center, Huntington, West Virginia
6/25/2014	14-00912-192	South Texas Veterans Health Care System, San Antonio, Texas
6/26/2014	14-00914-190	VA Eastern Kansas Health Care System, Topeka, Kansas

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews

Issue Date	Number	Parent Facility
6/26/2014	14-00911-193	VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
6/26/2014	14-00235-195	Wilmington VA Medical Center, Wilmington, Delaware
6/30/2014	14-00908-194	Hampton VA Medical Center, Hampton, Virginia
7/2/2014	14-00909-191	VA Black Hills Health Care System, Fort Meade, South Dakota
7/2/2014	14-00932-200	James J. Peters VA Medical Center, Bronx, New York
7/7/2014	14-00910-205	Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington
7/8/2014	14-00915-206	Robert J. Dole VA Medical Center, Wichita, Kansas
7/16/2014	14-00918-204	Grand Junction VA Medical Center, Grand Junction, Colorado
7/22/2014	14-00931-213	John D. Dingell VA Medical Center, Detroit, Michigan
7/23/2014	14-00916-218	West Texas VA Health Care System, Big Spring, Texas
7/28/2014	14-00921-223	Washington DC VA Medical Center, Washington, DC
8/1/2014	14-00934-221	VA New York Harbor Healthcare System, New York, New York
8/1/2014	14-00919-228	New Mexico VA Health Care System, Albuquerque, New Mexico
8/8/2014	14-00904-226	Bay Pines VA Healthcare System, Bay Pines, Florida
8/12/2014	14-00923-237	Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
8/13/2014	14-00922-240	Providence VA Medical Center, Providence, Rhode Island
8/18/2014	14-00924-247	Fayetteville VA Medical Center, Fayetteville, North Carolina
9/8/2014	14-00938-272	Minneapolis VA Health Care System, Minneapolis, Minnesota
9/16/2014	14-00926-281	Alexandria VA Health Care System, Pineville, Louisiana
9/25/2014	14-00929-287	Tennessee Valley Healthcare System, Nashville, Tennessee
9/29/2014	14-00928-291	Bath VA Medical Center, Bath, New York
9/30/2014	14-00927-293	VA Long Beach Healthcare System, Long Beach, California

Office of Healthcare Inspections | National Healthcare Reviews

Issue Date	Number	Title
5/8/2014	14-01288-145	Combined Assessment Program Summary Report – Construction Safety at Veterans Health Administration Facilities
5/12/2014	14-01073-139	Combined Assessment Program Summary Report – Preventable Pulmonary Embolism at Veterans Health Administration Facilities
5/12/2014	14-01072-140	Combined Assessment Program Summary Report – Evaluation of Nurse Staffing in Veterans Health Administration Facilities April–September 2013
5/12/2014	13-00054-148	Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2013
5/14/2014	14-00895-163	Healthcare Inspection – VA Patterns of Dispensing Take – Home Opioids and Monitoring Patients on Opioid Therapy

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Title**
6/10/2014	14-01785-184	Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities
8/11/2014	14-00727-239	Combined Assessment Program Summary Report – Evaluation of Hospice and Palliative Care in Veterans Health Administration Facilities
9/23/2014	14-02198-284	Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
4/8/2014	13-02053-119	Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois
4/30/2014	14-01104-134	Alleged Excessive Wait for Emergency Care and Staff Disrespect, VA Southern Nevada Healthcare System, Las Vegas, Nevada
5/6/2014	13-01819-133	Improper Procurement and Billing Practices for Anesthesiology Services, George E. Wahlen VA Healthcare System, Salt Lake City, Utah
5/19/2014	13-04474-157	Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama
5/23/2014	14-00612-167	GI Fellowship Program Issues, New Mexico VA Health Care System, Albuquerque, New Mexico
5/28/2014	14-01119-168	Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi
6/9/2014	13-04592-179	Alleged Preventive Maintenance Inspection Deficiencies, Northern Arizona VA Health Care System, Prescott, Arizona
6/9/2014	13-04195-180	Quality of Care Concerns, Hospice/Palliative Care Program, VA Western New York Healthcare System, Buffalo, New York
6/19/2014	12-03869-187	Follow-Up of Mental Health Inpatient Unit and Outpatient Contract Programs, Atlanta VA Medical Center, Decatur, Georgia
6/23/2014	13-03604-198	Quality of Care and Staffing Concerns, Salem VA Medical Center, Salem, Virginia
6/23/2014	14-00637-199	Resident Supervision in the Operating Room, Ralph H. Johnson VA Medical Center, Charleston, South Carolina
6/25/2014	13-02665-197	Medication Management Issues in a High Risk Patient, Tuscaloosa VAMC, Tuscaloosa, Alabama
7/1/2014	13-04520-201	Potential Exposure to Creutzfeldt-Jakob Disease, VA Connecticut Healthcare System, West Haven, Connecticut
7/1/2014	14-00467-202	Substandard Care of a Lupus Patient at the Albany CBOC and Carl Vinson VA Medical Center, Dublin, Georgia

Office of Healthcare Inspections | Hotline Healthcare Inspections

Issue Date	Number	Report Title
7/14/2014	14-00992-210	Alleged Surgical Care Issues, Malcom Randall VA Medical Center, Gainesville, Florida
7/15/2014	13-02892-217	Alleged Mismanagement in the Cardiac Catheterization Laboratory, VA Maryland Health Care System, Baltimore, Maryland
7/16/2014	14-02903-211	Reporting of Suspected Patient Neglect, Central Alabama Veterans Health Care System, Tuskegee, Alabama
7/16/2014	14-02396-212	Alleged Medication Cart Deficiencies and Unsafe Medication Administration Practices, Atlanta VA Medical Center, Decatur, Georgia
7/17/2014	14-01322-215	Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama
8/12/2014	14-03010-251	Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA
8/20/2014	14-01467-256	Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota
8/21/2014	14-00991-255	Deficiencies in the Caregiver Support Program, Ralph H. Johnson VA Medical Center, Charleston, South Carolina
8/28/2014	13-00670-262	Follow-Up Review of the Pause in Providing Inpatient Care VA Northern Indiana Healthcare System, Fort Wayne, Indiana
9/3/2014	14-00271-265	Emergency Department Staffing and Patient Safety Issues, VA San Diego Healthcare System, San Diego, California
9/30/2014	13-04005-296	Out of Operating Room Airway Management Concerns, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

Joint Reviews

Issue Date	Number	Title
5/28/2014	14-02603-178	Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System
8/26/2014	14-02603-267	Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

Office of Investigations | Administrative Investigations

Issue Date	Number	Report Title
4/14/2014	13-02649-120	Administrative Investigation, Failure to Comply with Americans with Disabilities Act and VA Policy, Veterans Health Administration
7/17/2014	13-03899-216	Administrative Investigation, Prohibited Personnel Practice and Preferential Treatment, National Cemetery Administration, VA Central Office

Office of Investigations | Administrative Investigations

Issue Date	Number	Report Title
9/26/2014	13-03065-304	Administrative Investigation, Conduct Prejudicial to the Government and Interference of a VA Official for the Financial Benefit of a Contractor, Veterans Health Administration, Procurement & Logistics Office, Washington, DC

Office of Contract Review | Preaward Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
4/4/2014	14-01143-122	Review of FSS Proposal Submitted Under a Solicitation	$67,202,237
4/22/2014	14-01174-135	Review of FSS Proposal Submitted Under a Solicitation	$5,978,353
4/30/2014	14-01087-141	Review of Proposal Submitted Under a Solicitation	$4,450,360
5/7/2014	14-01392-161	Review of FSS Proposal Submitted Under a Solicitation	$125,694
5/8/2014	14-02411-165	Review of Proposal Submitted Under a Solicitation	$4,289,531
5/12/2014	13-04437-164	Review of Proposal Submitted Under a Solicitation	$543,295
5/21/2014	14-02098-175	Review of Proposal Submitted Under a Solicitation	$2,331,034
5/22/2014	14-02210-176	Review of FSS Proposal Submitted Under a Solicitation	
5/29/2014	14-01878-181	Review of FSS Proposal Submitted Under a Solicitation	$1,299,222
6/2/2014	14-02435-183	Review of FSS Proposal Submitted Under a Solicitation	$42,614
6/4/2014	14-02493-186	Review of Proposal Submitted Under a Solicitation	$5,992,943
6/11/2014	14-02451-189	Review of FSS Proposal Submitted Under a Solicitation	
7/10/2014	14-03166-219	Review of FSS Proposal Submitted Under a Solicitation	
7/10/2014	14-03117-220	Review of FSS Proposal Submitted Under a Solicitation	
7/30/2014	14-02680-238	Review of FSS Proposal Submitted Under a Solicitation	
8/1/2014	14-03423-244	Review of FSS Proposal Submitted Under a Solicitation	
8/12/2014	14-02565-248	Review of Proposal Submitted Under a Solicitation	$1,058,760
8/14/2014	14-03961-257	Review of Proposal Submitted Under a Solicitation	$446,495
9/2/2014	14-04239-277	Review of FSS Proposal Submitted Under a Solicitation	
9/3/2014	14-03308-278	Review of Product Additions Submitted Under an FSS Contract	
9/9/2014	14-04448-275	Review of Proposal Submitted Under a Solicitation	$2,390,483
9/10/2014	14-04253-282	Review of Proposal Submitted Under a Solicitation	$1,912,916
9/10/2014	14-04870-285	Review of Request to Add Products to an FSS Contract	
9/25/2014	14-04403-300	Review of Proposal Submitted Under a Solicitation	$2,146,340
9/29/2014	14-02706-307	Review of FSS Proposal Submitted Under a Solicitation	$922,140
9/29/2014	14-04886-312	Review of Request to Add Products to an FSS Contract	
9/30/2014	14-04735-301	Review of Proposal Submitted Under a Solicitation	$487,715
9/30/2014	14-02866-308	Review of FSS Proposal Submitted Under a Solicitation	$1,802,300
			$103,422,432

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
4/23/2014	14-01539-136	Review of Compliance with Public Law Under an FSS Contract	$1,762,359
4/30/2014	12-03498-143	Review of Price Reduction and Public Law Damages under an FSS Contract	$168,303
5/5/2014	13-02210-150	Review of Voluntary Disclosure of Price Reduction Clause Errors Under a Contract	$436,411
5/8/2014	10-00666-146	Review of Self-Audit Performed Under an FSS Contract	$726,545
5/21/2014	14-00008-174	Review of Public Law Overcharges for Late Addition of a Covered Drug Under a FSS Interim Agreement	$6,657
6/16/2014	14-00014-196	Review of FSS Contract	
7/28/2014	11-01656-234	Review of Voluntary Disclosure Under an FSS Contract	$105,285
7/28/2014	11-04247-235	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$214,243
7/29/2014	12-03762-233	Review of FSS Contract	
7/30/2014	12-00441-232	Review of FSS Contract	$137,569
8/4/2014	08-00816-245	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$3,374,170
8/4/2014	14-01706-246	Review of Voluntary Disclosure of Overcharges Resulting From an Acquisition	$3,385,932
8/5/2014	14-04153-242	Special Review Regarding Termination	
8/7/2014	13-02271-250	Review of Voluntary Disclosure and Refund Submitted Under an FSS Contract	$679,656
8/8/2014	14-00536-249	Review of Voluntary Disclosure of Late Additions Under an Interim Agreement Contract	$39,090
8/12/2014	14-04371-254	Review of Voluntary Disclosure of Overcharges Resulting from Federal Ceiling Price Recalculations Under an FSS Contract	$23,794
8/19/2014	12-00645-260	Review of Voluntary Disclosure Submitted for Pricing Errors Under an FSS Contract	$498,701
8/20/2014	12-03760-263	Review of Voluntary Disclosure and Refund Offer Submitted Under an FSS Contract	$86,986
8/27/2014	08-00847-269	Review of FSS Contract	$515,880
9/2/2014	14-03868-236	Review of Voluntary Disclosure Submitted Under an FSS Contract	$14
9/2/2014	14-00006-274	Review of Public Law Compliance for a Covered Drug Under an FSS Contract	$3,354
9/2/2014	14-04495-276	Review of Request to Add Products to an FSS Contract	

Office of Contract Review | Postaward Reviews

Issue Date	Number	Report Title	Dollar Recoveries
9/3/2014	14-00179-279	Review of Compliance with Public Law Under an FSS Contract	$16,277
9/15/2014	14-03169-286	Review of Voluntary Disclosure for Public Law Damages Under an FSS Contract	$9,951
9/16/2014	14-01442-288	Review of Non-Delivery of Purchased Goods by FSS Customers Under an FSS Contract	$12,204
9/16/2014	14-02856-290	Review of Voluntary Disclosures and Refund Offer Under an FSS Contract	$387,329
9/23/2014	12-03759-297	Review of FSS Contract	$15,000
9/25/2014	14-05013-302	Review of Disclosure of Pricing Errors Under Interim Agreement Contract	$191
9/29/2014	10-03285-311	Review of Voluntary Disclosure Under an FSS Contract	
9/30/2014	14-02237-289	Review of Public Law Overcharges for the Late Submission of Permanent Federal Ceiling Prices Under an FSS Contract	$1,263,176
9/30/2014	14-04050-306	Review of Letter Requesting Pricing Relief under an FSS Contract	
9/30/2014	14-00013-309	Review of Public Law Compliance for a Covered Drug Under an FSS Contract	$742
			$13,869,819

Office of Contract Review | Claim Review

Issue Date	Number	Report Title	Savings and Cost Avoidance
4/10/2014	14-00802-114	Review of Costs Incurred During VA's Delay of Lease	
4/10/2014	13-02858-116	Review of Payment Claim on the Termination of a Contract	$878,730
4/10/2014	13-02859-117	Review of Payment Claim on the Termination of a Contract	$1,388,972
5/2/2014	13-00949-149	Review of Claim Submitted Under a Contract	$7,448,087
5/13/2014	13-01371-173	Review of Certified Claim Submitted Under a Contract	$1,634,005
			$11,349,794

Office of Contract Review | Special Review

Issue Date	Number	Report Title
9/26/2014	13-01408-294	Review of VHA's Use of Reverse Auction Acquisitions

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$318,744,000	$957,060,000		
Preaward Reviews			$103,422,432	
Postaward Reviews				$13,869,819
Claim Review			$11,349,794	
	$318,744,000	**$957,060,000**	**$114,772,226**	**$13,869,819**

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	6	$957,060,000
Total inventory this period	**6**	**$957,060,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	6	$957,060,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**6**	**$957,060,000**
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	3	$318,744,000
Total inventory this period	**3**	**$318,744,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	3	$318,744,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**3**	**$318,744,000**
Total carried over to next period	**0**	**$0**

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

Appendix B: Unimplemented Reports and Recommendations

The F*ederal Acquisition Streamlining Act of 1994*, P.L. 103-355, as amended by the *National Defense Authorization Act of 1996*, P.L. 104-106, requires agencies to complete final action on each management decision required with regard to a recommendation in an OIG's report within 12 months after the date of the OIG's report. If the agency fails to complete final action within the 12-month period, OIG is required to identify the matter in each semiannual report until final action on the management decision is completed.

Table 1 identifies the number of open OIG reports and recommendations with results sorted by action office. As of September 30, 2014, there are 197 total open reports and 1120 total open recommendations. However, 9 reports and 9 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 41 reports and 83 recommendations that, as of September 30, 2014, remain open for more than 1 year. The total monetary benefit attached to these reports is $1,529,080,001.

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	23	131	154	34	865	899
Veterans Benefits Administration	5	20	25	15	110	125
National Cemetery Administration	0	2	2	0	5	5
Office of Acquisitions, Logistics, and Construction	4	4	8	11	16	27
Office of Management	2	2	4	6	4	10
Office of Information and Technology	5	2	7	13	37	50
Office of Human Resources and Administration (OHRA)	3	0	3	4	0	4
Office of Operations, Security, and Preparedness (OSP)	2	0	2	2	0	2
Office of General Counsel (OGC)	2	0	2	5	0	5
Chief of Staff (COS)	1	0	1	2	0	2
Total	**47**	**161**	**208**	**92**	**1037**	**1129**

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 [Human Resources] to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such action. *Recommendation 10: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s improper VA appointment, and take such action.* *Recommendation 13: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s improper VA appointment, to include her appointment at a rate above the minimum, and take such action.* *Recommendation 26: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper FCIP [Federal Career Intern Program] appointments, failure to provide 2-year formal training programs, and subsequent conversions to career-conditional status of _____, and take such action.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 27: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine whether OI&T managers made additional improper FCIP appointments, failed to provide a 2-year formal training program, and subsequently converted employees to career-conditional status, and take appropriate corrective action. *Recommendation 29: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper DHA [Direct Hire Authority] appointments of _____ and take such action.* *Recommendation 30: We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to identify any additional improper VA appointments made using DHA, and take appropriate corrective action.* *Recommendation 33: We recommend that the Assistant Secretary for Information and Technology ensure that a review of OI&T retention incentives is conducted to ensure that they are necessary and support the mission and program needs and that they fully comply with law, OPM [Office of Personnel Management] regulations, and VA policy.* ** OIG disagrees with OGC's legal opinions finding that a violation of the nepotism statute did not occur and no legal basis exists for collecting funds from individual employees, but closed recommendations 1, 3, and 18-24 because OIT is planning no further action in light of OGC's legal opinions. OIG stands by the recommendations, but will not waste any more resources in pursuit of corrective action.*			
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 to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC [most favored customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).* *Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.*			

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 4: We recommend 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.*				
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.				
07/21/11	**09-00981-227**	**Review of VHA Sole-Source Contracts with Affiliated Institutions**	**VHA**	**None**
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.				
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.*				
03/30/12	**11-00312-127**	**Audit of VHA's Prosthetics Supply Inventory Management**	**VHA**	**$35,500,000**
Recommendation 5: We recommended the Under Secretary for Health revise the Veterans Health Administration's Inventory Management Handbook to require at least one prosthetic supply inventory manager from each VA medical center to attend VA's Acquisition Academy's Supply Chain Management School and become Certified VA Supply Chain Managers.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
05/30/12	**10-03166-75**	**Audit of VA Regional Offices' Appeals Management Processes**	**VBA**	**None**
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals. *Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.* *Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.* *Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.*				
08/16/12	**11-01406-247**	**Healthcare Inspection – Evaluation of Community Based Outpatient Clinics, Fiscal Year 2011**	**VHA**	**None**
Recommendation 10: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, implement measures to minimize IT network space vulnerabilities in accordance with VA policy.				
09/28/12	**12-00375-290**	**Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC**	**OM/OGC**	**None**
Recommendation 4: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville EUL [Enhanced Use Lease] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 5: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem. *Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer immediately determine what services VOA is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA [Volunteers of America]. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.*				
09/28/12	**12-01012-298**	**Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation**	**VHA/OALC**	**None**
Recommendation 7: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices. *Recommendation 8: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts.* *Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.*				
09/30/12	**12-00165-277**	**Review of Alleged Delays in VA Contractor Background Investigations**	**OSP**	**None**
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/30/12	**12-02525-291**	**Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida**	**OM/OIT**	**$762,198**
Recommendation 25: We recommended the VA Secretary establish budgetary controls to ensure centralized accounting for individual conference expenditures. *Recommendation 26: We recommended the VA Secretary ensure conference budgets are authorized and monitored to ensure appropriate expenditures.* *Recommendation 30: We recommended the VA Secretary require travelers and approving officials to comply with the requirement to include a cost comparison when choosing to use a privately owned vehicle instead of a government contracted mode of transportation.* *Recommendation 43: We recommended the VA Secretary establish an effective cost system for credit card purchases that appropriately assigns costs to individual major VA events.*				
10/23/12	**11-01823-294**	**Audit of VA's Systems Interconnections with Research and University Affiliates**	**VHA/OIT**	**None**
Recommendation 4: We recommend the Under Secretary for Health develop and implement a centralized data governance and storage model that ensures accurate inventory of all research data collected, data collection compliance with research protocols, and secure management of research information over the data life cycle.				
12/11/12	**11-00317-37**	**Audit of Vocational Rehabilitation and Employment Program's Self-Employment Services at Eastern and Central Area Offices**	**VBA**	**None**
Recommendation 3: We recommended the Under Secretary for Benefits develop and implement performance measures that evaluate the success of self-employment services.				
01/07/13	**12-03744-84**	**Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas**	**VHA**	**None**
Recommendation 12:We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/06/13	**12-02802-111**	**Review of Alleged Transmission of Sensitive VA Data Over Internet Connections**	**OIT**	**None**
Recommendation 1: We recommend the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements.				
03/07/13	**11-02585-129**	**Healthcare Inspection – Management of Disruptive Patient Behavior at VA Medical Facilities**	**VHA**	**None**
Recommendation 2: We recommended that the Under Secretary for Health ensure that VHA program officials develop guidelines for what information VHA facilities should document regarding disruptive incidents and where this information should be documented.				
03/28/13	**12-02503-151**	**Administrative Investigation, Misuse of Official Time and Resources and Failure to Properly Supervise, Office of Human Resources and Administration, Washington, DC**	**OHRA**	**None**
Recommendation 2: We recommend that the Acting Assistant Secretary for Human Resources and Administration determine the total salary paid to [redacted] for the 39 days that [redacted] was AWOL [absent without leave] from VA or worked for [redacted] while on sick leave and ensure that a bill of collection is issued to [redacted] for that amount, since [redacted] cannot receive pay for the period of time that [redacted] was absent without authorization.				
04/11/13	**12-04179-167**	**Inspection of VA Regional Office Baltimore, Maryland**	**VBA**	**None**
Recommendation 1: We recommended the Baltimore VA Regional Office Director develop and implement a plan to ensure staff review all existing reminder notifications and schedule medical reexaminations as required.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
04/11/13	**12-03939-175**	**Healthcare Inspection – Alleged Inappropriate Surveillance, James A. Haley Veterans' Hospital Tampa, Florida**	**VHA**	**None**
Recommendation 1: We recommended that the Under Secretary for Health ensures that VHA policy addresses the clinical uses of covert and overt VSCs [video surveillance cameras] in a clinical setting, including public notification, informed consent, approval, and responsibility for use of these devices, as well as detail procedures for staff to follow in obtaining video recordings for teaching, patient care and treatment, patient safety, healthcare operations, general security, and law enforcement purposes. Restrictions on the use of personal electronic devices within a VA facility to photograph and video should also be considered.				
04/23/13	**13-00994-180**	**Healthcare Inspection – Legionnaires' Disease at the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania**	**VHA**	**None**
Recommendation 2: We recommended that the VA Pittsburgh Healthcare System Director ensure routine flushing of hot-water faucets and showerheads.				
05/02/13	**13-01743-192**	**Combined Assessment Program Summary Report – Evaluation of Moderate Sedation 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 clinicians consistently document all required elements of comprehensive pre-sedation assessments and that facilities monitor compliance. *Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that when there is a provider change, clinicians consistently document that the patient was informed of and agreed to the change and that facilities monitor compliance.* *Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that clinicians consistently discharge MS [moderate sedation] patients appropriately and safely and that facilities monitor 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
06/12/13	**13-01741-215**	**Combined Assessment Program Summary Report – Colorectal Cancer Screening and Follow-Up in Veterans Health Administration Facilities**	**VHA**	**None**
Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that clinicians document follow-up plans or document that no follow-up is warranted within 14 days of positive CRC [colorectal cancer] screening results. *Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that clinicians discuss diagnostic testing options with patients and that desired testing is performed within 60 days of the positive CRC screening results.*				
06/13/13	**13-00026-213**	**Community Based Outpatient Clinic Reviews at Central Texas Veterans Health Care System, Temple, TX, and VA Texas Valley Coastal Bend Health Care System, Harlingen, TX**	**VHA**	**None**
Recommendation 3: We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.				
06/25/13	**13-00026-223**	**Community Based Outpatient Clinic Reviews at VA Pacific Islands Health Care System, Honolulu, HI**	**VHA**	**None**
Recommendation 2: We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.				
06/25/13	**13-00235-225**	**Administrative Investigation, Conduct Prejudicial to the Government, Veteran Employment Services Office, Office of Human Resources and Administration, Washington, DC**	**OALC/OHRA/ OGC/COS**	**None**
Recommendation 1: We recommend that the Interim Chief of Staff confer with the Offices of Acquisition and Logistics (OAL) and General Counsel (OGC) to seek reimbursement of the $509,884 paid to Serco due to their failure to perform in accordance with the terms of the contract to provide a system to capture and report accurate data to support VA's needs.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 2: We recommend that the Interim Chief of Staff confer with OGC and HR Officials outside of VESO [Veteran Employment Services Office] to ensure that VESO positions are evaluated to ensure that VESO has an effective, efficient, and fully engaged workforce.				
06/25/13	**13-00644-231**	**Review of VA's Acquisitions Supporting the Veteran Employment Services Office**	**OHRA**	**$4,400,000**
Recommendation 1: We recommended the Acting Assistant Secretary for Human Resources and Administration improve the development and management ofADVANCE-funded acquisitions by strengthening the Strategic Management Group's process to fully assess program offices' procurement requests against VA's existing internal capacities. *Recommendation 5: We recommended the Acting Assistant Secretary for Human Resources and Administration develop policy that prohibits the approval of modifications to interagency agreement terms that combine the costs and terms of distinct deliverables into one deliverable.*				
07/11/13	**13-00896-234**	**Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland**	**VHA**	**None**
Recommendation 2: We recommended that the local observation bed policy be revised to include all required elements. *Recommendation 11: We recommended that processes be strengthened to ensure that soiled utility rooms are secured at all times.*				
08/01/13	**13-01189-267**	**Prevention of Legionnaires' Disease in VHA Facilities**	**VHA**	**None**
Recommendation 2: We recommended that the Under Secretary for Health provide a plan that simplifies implementation of the directive, and that provides guidance, education, and monitoring of the implementation of the revised Prevention of Legionella Disease directive when issued.				
08/05/13	**13-00899-261**	**Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia**	**VHA**	**None**
Recommendation 11: We recommended that processes be strengthened to ensure that acute care staff accurately document PU [pressure ulcer] location, stage, risk scale score, and data acquired and that compliance be monitored.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 12: We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and risk scales for patients at risk for or with PUs and that compliance be monitored.				
08/16/13	**12-00040-268**	**Vet Center Contracted Care Program Review**	**VHA**	**None**
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with the RCS [Readjustment Counseling Service] Chief Officer, ensure that Team Leaders receive, review, and approve psychosocial assessments and counseling plans prior to authorizing contracted counseling services. *Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with the RCS Chief Officer, ensure that Readjustment Counseling Service uses a standard template that includes terms and conditions that are consistent with those in the Readjustment Counseling Service policy.* *Recommendation 6: We recommended that the Under Secretary for Health, in conjunction with the RCS Chief Officer, ensure that Team Leaders authorize contracted counseling services in accordance with Readjustment Counseling Service and Veterans Health Administration policy.*				
08/27/13	**13-01975-292**	**Combined Assessment Program Review of the VA Central California Health Care System, Fresno, California**	**VHA**	**None**
Recommendation 1: We recommended that processes be strengthened to ensure that continued stay reviews are consistently performed on at least 75 percent of patients in acute beds. *Recommendation 11: We recommended that processes be strengthened to ensure that acute care staff consistently document location, stage, risk scale score, and/or date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.* *Recommendation 12: We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.*				
09/04/13	**12-00181-299**	**Audit of VBA's Pension Payments**	**VBA**	**$502,000,000**
Recommendation 1: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements procedures that ensure continued veteran and beneficiary eligibility.				

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 Benefits implement the use of the enhanced interagency exchange agreements with the Internal Revenue Service and Social Security Administration to reduce delays in verifying veteran and beneficiary reported income. *Recommendation 4: We recommend the Under Secretary for Benefits establish a matching program with Medicaid to automatically identify veterans and beneficiaries that require nursing home adjustments.* *Recommendation 5: We recommend the Under Secretary for Benefits ensure the Pension Management Centers clearly outline processing priorities in their workload management plans.* *Recommendation 6: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements its plan to revise triage procedures and establish processing lanes to ensure prompt screening and routing of claims.* *Recommendation 7: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service corrects the duplicate records identified in this audit.*				
09/12/13	**13-01976-312**	**Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut**	**VHA**	**None**
Recommendation 6: We recommended that processes be strengthened to ensure that restrooms and showers on inpatient units are clean. *Recommendation 7: We recommended that processes be strengthened to ensure that public restrooms and elevators are clean, that public restrooms are free from environmental safety hazards, and that automatic door opening switches in all public restrooms are operational.*				
09/13/13	**13-02313-310**	**Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas**	**VHA**	**None**
Recommendation 12: We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/27/13	**13-01974-337**	**Combined Assessment Program Review of the Philadelphia VA Medical Center, Philadelphia, Pennsylvania**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.				
09/27/13	**12-02387-343**	**Audit of VA's Technology Acquisition Center Contract Operations**	**OALC**	**$57,900,000**
Recommendation 1: We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction ensure that contracting activities can adequately justify the use of exceptions to competition requirements in the Federal Acquisition Regulation when awarding Indefinite/Delivery Indefinite Quantity task orders. *Recommendation 3: We recommended the Principal Executive Director for the Office of Acquisition, Logistics, and Construction build work steps into the Integrated Oversight Process to hold contracting officers accountable for preventing violations of Federal Acquisition Regulation competition requirements.*				
09/30/13	**11-01653-300**	**Review of VHA's Management of Travel, Duty Stations, Salaries and Funds in the Procurement and Logistics Office**	**VHA**	**$17,803**
Recommendation 3: We recommend the Chief Procurement and Logistics Officer take action to recoup salary overpayments or pay underpayments for incorrect duty station assignments, as appropriate, in accordance with VA guidance.				
09/30/13	**11-00330-338**	**Audit of Selected VHA Non-Institutional Purchased Home Care Services**	**VHA**	**$893,500,000**
Recommendation 4: We recommended the Under Secretary for Health strengthen non-institutional care program oversight to monitor budgeted and expended funding for purchased home care services and ensure average daily census performance monitoring data is accurate, reliable, and transparent. *Recommendation 6: We recommended the Under Secretary for Health implement management controls to ensure VA medical facilities adhere to the Veterans Health Administration's requirements related to the identification and management of ineligible and high-risk purchased home care agencies.*				
Total				**$1,529,080,001**

Department of Veterans Affairs
Office of Inspector General

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