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Message from the Deputy Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to the Inspector General Act of 1978, as amended, this report presents the results of our accomplishments during the reporting period October 1, 2014–March 31, 2015. 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 174 reports and 9 memoranda on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified nearly $1.17 billion in monetary benefits, for a return on investment of $21 for every dollar expended on OIG oversight. OIG investigators closed 511 investigations and made 188 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 605 administrative sanctions and corrective actions.

Special agents within our Office of Investigations successfully secured prosecution of a number of corrupt VA employees. Among them were the Chief of Prosthetics at the West Palm Beach, FL, VA Medical Center (VAMC), who pled guilty to conspiracy to commit health care fraud related to VA prosthetics procurement; the director of the North Charleston, SC, VA Consolidated Mail Outpatient Pharmacy, who was charged with stealing prescription medications from VA; and a Palo Alto, CA, VAMC engineer, who was indicted for receiving an illegal gratuity. In addition, the extensive investigative work of our special agents on the conduct of corrupt VA employees led to the sentencing of a Palo Alto, CA, VAMC Contracting Officer's Representative on bribery charges and a former Dublin, GA, VAMC nurse, who was sentenced to 5 years' incarceration and ordered to pay restitution of $454,740 for mail fraud.

The Office of Investigations has continued its efforts to combat and deter eligibility fraud in VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) Program. During this reporting period, two individuals were indicted, one was convicted at trial, and five were sentenced to terms of imprisonment ranging from 27 to 56 months' for their involvement in this type of fraud. One other individual agreed to a civil settlement requiring payment of $1.3 million to the Government.

Our Office of Investigations has maintained its determination in preventing drug diversion, especially in VAMCs. During this reporting period, 7 individuals were arrested and 11 individuals were sentenced to terms of imprisonment. In one drug diversion case, five individuals, which included employees at the Long Beach, CA, VAMC pharmacy, were sentenced after their involvment in diverting over 16,000 prescription medication tablets from pharmacy robots as well as stealing an unknown amount of medication from pharmacy shelves or medication parcels. Subsequent to the investigation, nine pharmacy employees retired, resigned, or were terminated.

OIG's Office of Healthcare Inspections (OHI) evaluated allegations at the Northern Indiana Health Care System (HCS) in Fort Wayne, IN, relating to access and quality issues that may have affected a patient who ultimately

died by suicide after a self-inflicted gunshot wound. Though OHI determined the outcome may have been the same for this patient, there were several missed opportunities where the patient's care and effectiveness of VA's system processes could have been improved. Specifically, lapses in communication and provider failures to review information available in the patient's electronic health record (EHR) during care transitions compromised the patient's mental health and primary care and diminished the benefits associated with VA's EHR system. In addition, OHI found an absence of oversight in the continuum of the patient's care and no indication that HCS providers analyzed the patient's multiple suicide risk factors.

OHI also evaluated the clinical management of a veteran who reported a recent suicide attempt at the Hampton, VA, VAMC but died several weeks after the reported attempt. The medical examiner who performed an autopsy of the veteran stated that "The manner of death is accident" and recorded the cause of death as the combined toxic effects of two medications, a narcotic pain reliever and an anti-anxiety medication, with severe disease of one coronary artery contributing to the death. OHI found that staff did not identify the veteran's suicide risk factors and did not report the veteran's recent suicidal behavior as required by Veterans Health Administration policy. OHI also substantiated the allegation that the veteran suffered from undiagnosed heart disease even though his complaints of chest pain and shortness of breath had been evaluated on several occasions.

OHI assessed the merit of allegations that physicians at the Chillicothe, OH, VAMC prescribed opioid medications for patients they had never evaluated. OHI substantiated that physicians prescribed opioids for patients with whom they had no direct interaction or did not thoroughly assess. Additionally, OHI substantiated that physicians did not consistently document medication effectiveness prior to renewing prescriptions for patients at increased risk for adverse medication effects or diversion and were not consistently documenting use of the Ohio Automated Rx Reporting System, a state prescription drug monitoring program.

Our Office of Audits and Evaluations (OAE) received numerous allegations regarding poor management of the VA Regional Offices (VAROs) and how this mismanagement impedes VA's ability to process veterans' claims accurately and in a timely manner. OAE substantiated an allegation that Little Rock VARO staff adjusted dates of claims for unadjudicated claims discovered in the files; however, staff did so in compliance with Veterans Benefits Administration (VBA) guidance (FAST Letter 13-10) in effect at that time. Based on their review, OAE concluded that adjusting the dates of aging claims to more recent "discovered" dates resulted in a lack of assurance that staff would expedite processing of the discovered unadjudicated claims, further delaying benefits decisions for veterans. Adjusting the dates of claims also misrepresented the time required for VARO staff to process the claims, potentially making performance look better than it actually was. In order to minimize confusion or misinterpretation of guidance for future claims processing, OAE recommended that VBA maintain a standard, universal policy for establishing dates of claims.

At the Oakland Veterans Service Center, management had created a special project team to process 2,155 informal claims which had been found. VARO management believed staff processed the 2,155 informal claims but eventually determined staff did not process 537 of them. OAE reviewed a sample of 34 informal claims and found 7 (21 percent) remained unprocessed, some as old as July 2002. OAE also found that the Oakland VARO staff had repeatedly reviewed these seven informal claims from December 2012 through June 2014 without taking additional action or maintaining adequate records. As a result, veterans did not receive consideration for benefits to which they may have been entitled. OAE recommended the VARO Director complete and certify the review of the 537 informal claims, take appropriate action, and provide documentation to certify these actions are complete as well as implement a plan to train staff on the proper procedures for

processing informal claims and overseeing staff.

OAE found that VA needs to improve the management of its Drug-Free Workplace Program. VA only selected roughly 3 of every 10 applicants for pre-employment drug testing before hiring these individuals into Testing Designated Positions (TDPs) in fiscal year (FY) 2013. OAE estimated that of the nearly 22,600 individuals VA reported hiring into TDPs in FY 2013, approximately 15,800 were hired without a pre-employment drug test. OAE found VA facilities tested only 68 percent of the 3,420 employees selected for random drug testing in FY 2013 and identified at least 19,100 employees in TDPs who were not subject to the possibility of monthly random drug testing. Additionally, OAE discovered VA erroneously designated as many as 13,200 employees in non-TDPs for drug testing in FY 2014. Furthermore, only 17 (33 percent) of the 51 employees who tested positive for drugs as a result of reasonable suspicion of on-the-job drug use or after a workplace accident or injury were referred to VA's Employee Assistance Program. As a result, there is little assurance that VA's program is performing as intended to identify and eliminate illegal drug use in its workforce. Since VA's workforce is expected to grow significantly with the passage of the *Veterans Access, Choice, and Accountability Act of 2014*, VA needs to take actions to address weaknesses in its Drug-Free Workplace Program immediately.

The accomplishments above and the many others discussed in this report would not have been possible without the unwavering dedication and sustained commitment of our employees to identify opportunities for improvement within VA and accomplish OIG's mission of ensuring our Nation's veterans and their families receive the best care, benefits, and services possible from VA. In addition, 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 work together to improve the lives of America's veterans.

RICHARD J. GRIFFIN
Deputy Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total
Better Use of Funds	$820.7
Fines, Penalties, Restitutions, and Civil Judgments	$16.8
Fugitive Felon Program	$97.2
Savings and Cost Avoidance	$89.3
Questioned Costs	$135.3
Dollar Recoveries	$7.8
Total Dollar Impact	$1,167.1
Cost of OIG Operations[1]	$55.5
Return on Investment[2]	**21:1**

Investigative Activities	6-Month Total
Arrests[3]	188
Fugitive Felon Arrests	22
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	7
Indictments	163
Criminal Complaints	47
Convictions	168
Pretrial Diversions and Deferred Prosecutions	43
Administrative Investigations Opened	14
Administrative Investigations Closed	5
Administrative Sanctions and Corrective Actions	282
Cases Opened[4]	562
Cases Closed[5]	511

Hotline Activities	6-Month Total
Contacts	22,442
Cases Opened	1,094
Cases Closed	544
Administrative Sanctions and Corrective Actions	323
Substantiation Percentage Rate	41

Reports and Memoranda	6-Month Total
Reports Issued	
Audits and Evaluations	15
Benefits Inspections	8
Joint Reviews	1
National Healthcare Reviews	4
Hotline Healthcare Inspections	24
Combined Assessment Program Reviews	31
Community Based Outpatient Clinic Reviews[6]	20
Administrative Investigations	2
Preaward Contract Reviews	47
Postaward Contract Reviews	20
Claim Reviews	2
Subtotal	**174**
Memoranda	
Administrative Investigation Advisories	0
Administrative Investigation Closures	3
Audit Closures	4
Healthcare Closures[7]	2
Subtotal	**9**
Total Reports and Memoranda	**183**

Healthcare Inspections Activities	6-Month Total
Clinical Consultations	**8**

1. The 6-month operating cost for the Office of Healthcare Inspections ($10.6 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. Does not include Fugitive Felon arrests by OIG or other agencies.
4 & 5. Includes administrative investigations opened/closed.
6. Encompassing 117 facilities for the 6-month period.
7. In addition to the 2 Healthcare administrative closure memorandums issued this reporting period, OIG published 23 Healthcare administrative closure memorandums that had been issued prior to FY 2015. These are listed in Appendix A.

Glossary

AFGE	American Federation of Government Employees
AIG	Assistant Inspector General
BHS	Boston Healthcare System
CAP	Combined Assessment Program
CBO	Chief Business Office
CBOC	Community Based Outpatient Clinic
CIGIE	Council of the Inspectors General for Integrity and Efficiency
the Circular	Accounting of Drug Control Funding and Performance Summary
CLC	community living center
CNA	certified nursing assistant
COR	Contracting Officer Representative
COS	Chief of Staff
CRC	colorectal cancer
DCBO	Deputy Chief Business Officer
DCIS	Defense Criminal Investigative Service
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DIG	Deputy Inspector General
DME	Durable Medical Equipment
DoD	Department of Defense
DOE	Department of Energy
DOL	Department of Labor
ED	emergency department
EHR	electronic health record
EOC	environment of care
EPVAHCS	El Paso VA Health Care System
Fact Sheet	National Consult Delay Review Fact Sheet
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFMIA	Federal Financial Management Improvement Act
FISMA	Federal Information Security Management Act of 2002
FSC	Financial Services Center
FSS	Federal Supply Schedule
FY	fiscal year
GI	gastroenterology
GPD	Grant and Per Diem
GSA	General Services Administration
HCPS	Health Care Claims Processing System
HCS	Health Care System
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion/Disease Prevention
HUD	Department of Housing and Urban Development
HVAC	House Veterans' Affairs Committee
IG	Inspector General
IOP	Integrated Oversight Process
IT	Information Technology
MAVERIC	Massachusetts Veterans Epidemiology Research and Information Center
MH	mental health
MICU	medical intensive care unit
MPA	methylprednisolone acetate
MRI	magnetic resonance imaging
MS&C	medical support and compliance
NA	nursing assistant
NCA	National Cemetery Administration
NECC	New England Compounding Center
NIC	Non-Institutional Care
NVCC	Non-VA Care Coordination
OAE	Office of Audits and Evaluations
OALC	Office of Acquisition, Logistics, and Construction
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHRA	Office of Human Resources and Administration
OIG	Office of Inspector General
OIT	Office of Information Technology
OM	Office of Management
ONDCP	Office of National Drug Control Policy
OPIA	Office of Public and Intergovernmental Affairs
ORO	Office of Research Oversight
OSP	Office of Operations, Security, and Preparedness
P.L.	Public Law
PBO	PMAS Business Office
PII	personally identifiable information
PMAS	Project Management Accountability System

(continued on next page)

PMC	Pension Management Center
PSM	patient safety manager
PTSD	post-traumatic stress disorder
PVAHCS	Phoenix VA Health Care System
QAR	Qualitative Assessment Review
QM	quality management
RN	registered nurse
SBA	Small Business Administration
SDVOSB	Service-Disabled Veteran-Owned Small Business
SMC	special monthly compensation
SSA	Social Security Administration
TBI	traumatic brain injury
TDP	Testing Designated Position
the Call Center	VA's National Call Center for Homeless Veterans
Tridec	Tridec Technologies
UCLA	University of California, Los Angeles
USB	Under Secretary for Benefits
USH	Under Secretary for Health
USO	United Service Organizations
USPIS	United States Postal Inspection Service
USPS	United States Postal Service
VAC	vacuum assisted closure
VAMC	VA Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VOA	Virtual Office of Acquisition
VSC	Veterans Service Center

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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 Joint Reviews and Settlements Office of Investigations Office of Management and Administration Office of Contract Review Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period	Office of Healthcare Inspections Office of Audits and Evaluations Joint Reviews and Settlements Office of Investigations
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed	Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted	Office of Investigations
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided	Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use	Appendix A
§ 5 (a) (7) a summary of each particularly significant report	Office of Healthcare Inspections Office of Audits and Evaluations Joint Reviews and Settlements Office of Investigations
§ 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) 2015, VA is operating under a $163.5 billion budget, with over 351,000 employees serving an estimated 22 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

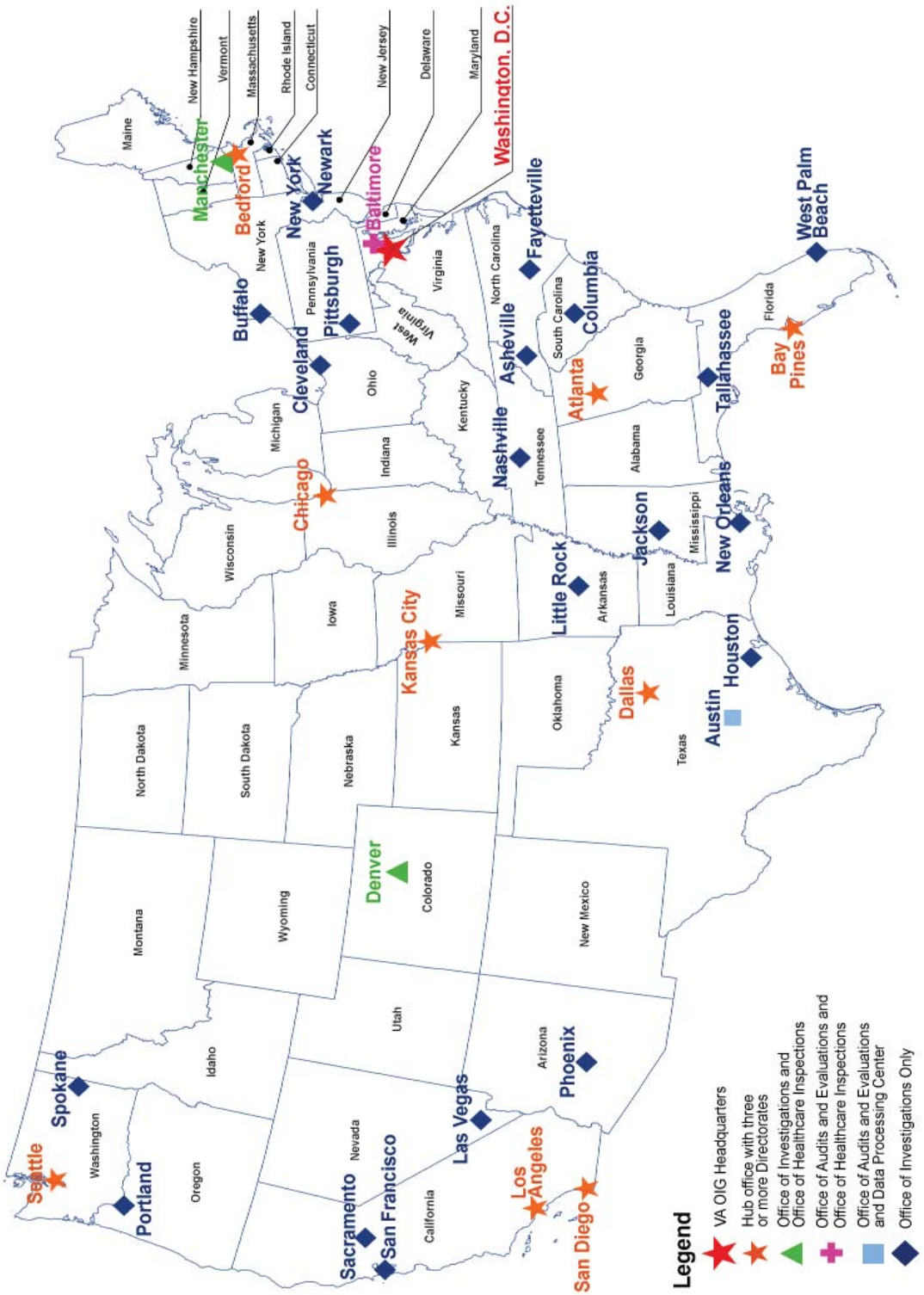
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

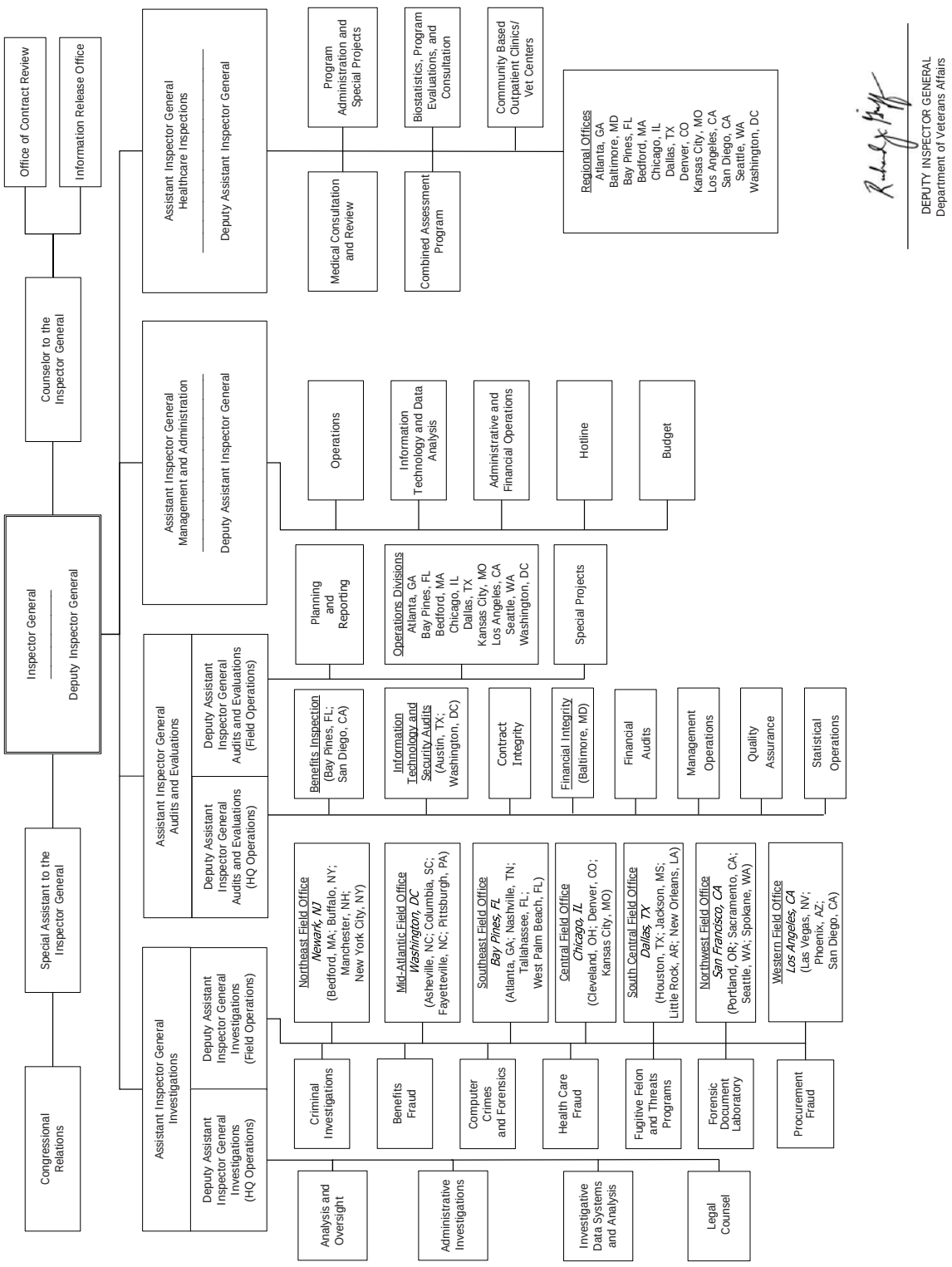
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General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

OIG, with 660 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 2015 funding for OIG operations provides $126.4 million from ongoing appropriations. The Office of Contract Review, with 31 employees, received $5.7 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 4 national healthcare reviews; 24 Hotline healthcare inspections; 31 Combined Assessment Program (CAP) reviews; and 20 Community Based Outpatient Clinic (CBOC) reviews, covering 117 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 31 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, Coordination of Care, Magnetic Resonance Imaging (MRI) Safety, Acute Ischemic Stroke Care, Surgical Complexity, and Emergency Airway Management. 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 two CAP summary reports, which are highlighted in the National Healthcare Reviews section.

Community Based Outpatient Clinic Reviews

The purpose of these 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 117 CBOCs reporting to 20 parent facilities and 16 Veterans Integrated Service Networks (VISNs). Site visits were made and physical inspections were performed at 25 of these CBOCs. These reviews are captured in 20 reports. The topics covered this reporting period include: EOC, Alcohol Use Disorder, Human Immunodeficiency Virus (HIV) screening, and Outpatient Documentation.

National Healthcare Reviews

VHA Lacks Assurance That National Consult Reviews Were Properly Resolved, Key Statements in Fact Sheet Were Misleading

OIG evaluated VHA's review of "unresolved" consults and the accuracy of VA's summary, the National Consult Delay Review Fact Sheet (Fact Sheet), as requested by the Chairman of the House Veterans' Affairs Committee (HVAC). Unresolved consults are requests for consultations that are open or active in patients' electronic health records (EHR). In September 2012, VHA initiated a multi-phased review of consults that were unresolved for more than 90 days. By May 2014, the number of unresolved consults had decreased considerably. However, because VHA did not implement appropriate controls, OIG found it lacks reasonable assurance that facilities appropriately reviewed and resolved consults; closed consults only after ensuring veterans had received the requested services, when appropriate; and, where consult delays contributed to patient harm, notified patients as required by VHA policy. OIG's review of the Fact Sheet found several key statements related to the scope and results of VHA's review of unresolved consults were misleading or incorrect. These statements were repeated by VHA leaders at meetings with congressional staff and during media events. In July 2014, VHA issued a letter to the Chairman of the HVAC that included information intended to clarify statements in the Fact Sheet. OIG recommended that the Interim Under Secretary for Health (USH): (1) conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review; (2) ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm that patients have received appropriate care; and (3) after reviewing the circumstances of any inappropriate resolution of consults, confer with the Office of Human Resources and Administration (OHRA) and the Office of General Counsel (OGC) or other relevant agency to determine the appropriate administrative action to take, if any.

OIG Identifies Top Five VHA Shortage Occupations To Meet Veterans Access, Choice, and Accountability Act Reporting Mandate

OIG conducted a determination of VHA occupations with the largest staffing shortages as required by Section 301 of the *Veterans Access, Choice, and Accountability Act of 2014*. OIG interpreted "largest staffing shortage" to encompass broader deliberation than simply the number needed to replace or backfill vacant positions. OIG performed a rules-based analysis on VHA data to identify these occupations. OIG determined that the five occupations with the "largest staffing shortages" were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist. This determination is the first of several OIG determinations on VHA occupational staffing shortages. OIG plans to incorporate additional data in future determinations to provide more detailed recommendations. OIG recommended that the Interim USH continue to develop and implement staffing models for critical need occupations.

Review of 47 VHA Facilities Shows High Compliance with Pressure Ulcer Requirements, But Some Improvements Needed

OIG conducted a review to determine whether VHA clinicians complied with selected requirements related to pressure ulcer prevention and management. OIG performed this evaluation in conjunction with 47 CAP reviews of VHA medical facilities conducted from April 1, 2013, through March 31, 2014. OIG noted high compliance with VHA policy in many areas, including facilities' local pressure ulcer policies, requirements for comprehensive skin assessments, and use of a standardized risk assessment tool. OIG identified opportunities for improvement in administrative requirements and employee training, risk assessment and prevention, documentation, and medication storage and made nine recommendations.

OIG Inspections of 50 VHA Medical Facilities Results in Four Recommendations To Improve Discharge Planning

The purpose of the review was to evaluate discharge planning for VHA inpatients with the following selected post-discharge needs: (1) special diet, (2) weight monitoring, (3) wound care, and (4) prosthetics (supplies and/or equipment). OIG conducted this review at 50 VHA medical facilities during CAP reviews performed across the country from October 1, 2013, through September 30, 2014. Although OIG observed many positive practices, we identified four opportunities for VHA facilities to improve. OIG recommended that the Interim USH, in conjunction with VISN and facility leaders, ensure that: clinicians provide and document discharge instructions for all identified needs; clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions; clinicians reconcile conflicting needs and instructions before discharging patients; and patients receive ordered post-discharge referrals.

Hotline Healthcare Inspections

In recent years, Hotline inspections have become an increasingly significant part of OHI's workload. The purpose of Hotline inspections is to investigate the validity of allegations presented by complainants (patients, families, staff, Members of Congress, and others) about VHA facilities or programs. Hotline inspections range from relatively simple, single allegation, single patient or facility issues to complex, multi-allegation, multi-patient or facility issues regarding patient care, such as patient safety and/or care quality, coordination, and access. During this reporting period, OHI received 1,142 Hotline referrals regarding patient care issues from OIG's Hotline Division. Of these referrals, OHI opened 47 Hotline inspections. In addition, OIG published 24 Hotline inspection reports addressing a variety of topics including opioid prescribing practices, suicide risk management, follow-up on critical test results, telemetry monitoring, delays in care, consult management, and staff training and competency.

It should also be noted that up until February 2015, OHI administratively closed, but did not publish, some Hotline inspections when allegations were not substantiated, were substantiated but were appropriately acted upon by VHA officials, and/or were the subject of tort claims. However, in January 2015, we discontinued this practice. During this reporting period, OIG published 23 Hotline inspections that were previously administratively closed prior to FY 2015. These administrative closures are listed in Appendix A. OIG is in the process of publishing the remainder of the administrative closures, which we will report in future Semiannual Reports.

OIG Review Finds Quality and Coordination of Care Issues at Three VISN 11 Facilities Prior to Veteran's Suicide

At the request of Congresswoman Jackie Walorski, OIG conducted an evaluation in response to allegations relating to access and quality issues at the Northern Indiana Health Care System (HCS), Fort Wayne, IN, affecting a patient who ultimately died by suicide after a self-inflicted gunshot wound. OIG determined that, although the outcome may have been the same for this patient, there were several missed opportunities where the patient's care and the effectiveness of VA's system processes could have been improved. Communication breakdowns and providers' failures to review information available in the patient's EHR during care transitions compromised the patient's mental health (MH) and primary care and diminished the benefits associated with the VA's EHR system. The advantages of comprehensive access to health records and exchange of health information, which are key features of the EHR system, were not consistently and effectively utilized. OIG found an absence of oversight in facilitating the continuum of this patient's care. OIG found no indication that VA providers analyzed the patient's multiple suicide risk factors. Further, although VHA has extensive policy

specifications to help ensure a patient's MH course is comprehensively and continuously monitored, in the totality of this case, the policy was more abstract than applied. OIG made 14 recommendations.

Review Finds Delay Obtaining MRI at Goshen, Indiana, CBOC

OIG conducted an inspection at the request of Congresswoman Jackie Walorski to assess care provided to a patient at the Goshen CBOC Goshen, IN, who died of complications related to metastatic lung cancer. OIG determined that, although this patient's metastatic disease presentation was not typical, there was a delay in obtaining an MRI after computed tomography results showed left rib involvement, and his quality of life could have been improved through an earlier diagnosis. OIG could not, however, determine that an earlier diagnosis would have changed his outcome. OIG also determined the patient and his wife were not aware of VA's Patient Advocacy Program. OIG made two recommendations.

Veteran's Suicide Risk Not Properly Managed by Hampton VA Medical Center, Better Training for Staff and Contract Providers Needed

OIG conducted an inspection at the request of Senator Richard Burr to assess the merit of allegations received from a complainant concerning the clinical management of a veteran who reported a recent suicide attempt and failure to diagnose a cardiac condition at the Hampton VA Medical Center (VAMC), Hampton, VA. The veteran died several weeks after the reported suicide attempt. The medical examiner who performed an autopsy stated that "The manner of death is accident" and recorded the cause of death as the combined toxic effects of two medications, a narcotic pain reliever and an anti-anxiety medication, with severe disease of one coronary artery (a blood vessel that supplies the heart muscle) contributing to the death. OIG substantiated that the veteran's reported attempt to commit suicide was not managed as required by VHA policy. OIG found that although all but one of the clinical staff members in the VAMC's Emergency Department (ED) and MH clinics had completed suicide risk management training, they did not identify his suicide risk factors and did not report the veteran's recent suicidal behavior as required by VHA. OIG substantiated the allegation that the veteran suffered from undiagnosed heart disease. However, his complaints of chest pain and shortness of breath had been evaluated on several occasions. OIG found that his physical exam, laboratory studies, and four electrocardiograms were within normal limits and did not support a need for a further, more invasive evaluation. OIG found that contracted providers were not required to undergo suicide risk management training. OIG made two recommendations. The VISN and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan.

Review Finds Gaps in Patient Rounds and Documentation at Spinal Cord Unit, Hampton VAMC, Hampton, Virginia

OIG conducted an inspection to assess the validity of allegations that improper nursing care resulted in a patient's death at the Hampton VAMC, Hampton, VA. The complainant alleged that nursing staff did not conduct required rounds and failed to properly respond when staff received reports that the patient's condition was deteriorating. The complainant also alleged that the patient's health record was incomplete. OIG substantiated that the nursing staff did not perform patient rounds in accordance with VAMC policy, which requires a patient to be checked every 30 minutes. In addition, OIG found no documentation of actions taken when non-nursing staff notified Spinal Cord Injury staff of a change in the patient's condition. OIG could not determine whether a failure to immediately assess the patient for possible problems led to this patient's death. OIG recommended that the Hampton VAMC Director initiate a review to evaluate patient rounds and EHR documentation policies, train and educate appropriate staff to ensure consistent adherence to patient assessment and documentation procedures, and consult with Regional Counsel regarding institutional disclosure.

Delays Identified in Reporting Incidents to Patient Safety Manager at West Palm Beach VAMC, QM Understaffing Noted

OIG conducted an inspection in response to a letter forwarded by Florida Governor Rick Scott. The letter contained multiple allegations about the quality of care at the West Palm Beach VAMC, West Palm Beach, FL. OIG did not substantiate that events related to patient falls resulting in injury and the deaths of two patients were not reported or investigated. However, OIG found that the investigation of one of the seven patient falls that OIG reviewed was not timely. OIG did not substantiate the allegation that a patient missed a scheduled chemotherapy treatment; however, completion of the patient's chemotherapy was delayed, and the incident was not reported to the Patient Safety Manager (PSM) as required. OIG did not substantiate the allegation that a patient was inappropriately given medication during a cardiac arrest or that the patient's death was not properly reported or investigated; however, OIG found that the correct progress note was not used, resulting in the Risk Manager not initiating the required review. OIG substantiated the allegation that a patient had the wrong lens implant placed in his eye during cataract surgery because the operative team failed to properly perform the time-out process. The PSM was not notified of the incident immediately, as required, using the Critical Incident Tracking Notification system. OIG did not substantiate the allegation that facility staff "covered up" or failed to disclose adverse events. OIG found that local policy for reporting patient incidents and/or safety concerns was not being followed, causing unnecessary delays and missed opportunities for early intervention. Although not an allegation, OIG found that QM Service has been chronically understaffed. OIG made four recommendations.

OIG Makes Four Recommendations To Improve Staffing and Reduce Falls in the Medical Intensive Care Unit, West Palm Beach, Florida, VAMC

OIG conducted an inspection in response to complaints about staffing and patient care issues in the medical intensive care unit (MICU) at the West Palm Beach VAMC (facility), in West Palm Beach, FL. OIG substantiated the allegation that nursing management had an inappropriate understanding of the staffing methodology in the MICU. OIG did not substantiate that insufficient staffing in the MICU caused orders to be missed or delays in blood transfusions. OIG substantiated that understaffing in the MICU contributed to an increase in patient falls. OIG did not substantiate that two falls resulted in patient injury. OIG substantiated that frequent floating of the MICU staff contributed to the departure of several experienced registered nurses (RNs) and that frequent floating and assignment changes of MICU staff occurred. OIG substantiated the allegation that nursing staff were sent to areas where they did not feel competent. OIG did not substantiate the allegation that, to prevent the use of overtime, a staff member who was still being oriented was required to sit with suicidal patients. OIG did not substantiate that insufficient staffing caused difficulty in covering additional duties of MICU RN staff. OIG did not substantiate that the step down unit was frequently closed. OIG substantiated that one RN was left alone in the step down unit on four occasions. OIG did not substantiate that the RN had to leave the patients unattended. OIG found that the facility's process for reporting incidents was not set up to ensure that incidents were reported as required. OIG also found that the facility policy for prevention of falls was not being followed. OIG made four recommendations.

OIG's Follow-Up Review of Columbia, South Carolina, VAMC Shows More Improvement Needed, New Issues Also Noted

At the request of Members of the House and Senate Committees on Veterans' Affairs, OIG conducted an evaluation of conditions identified in its initial report *Quality of Care, Management Controls, and Administrative Operations* (Report No. 13-00872-71, issued February 6, 2014), at the William Jennings Bryan Dorn VAMC, Columbia, SC. The purpose of this follow-up review was to determine whether identified conditions have abated, continued unchanged, or worsened and whether OIG's recommendations were implemented. In the initial report, OIG noted that critical leadership positions were filled by a series of "acting" and temporary managers over a period of several years which contributed to past delays in correcting identified deficiencies.

A permanent Chief of Staff and Medical Center Director were installed in January and April 2014 respectively, which has accelerated the VAMC's progress in addressing deficient conditions. However, many of the problems outlined in OIG's initial Hotline report still existed, in whole or in part, at the time of OIG's follow-up visit (July 2014). OIG found that the VAMC had implemented corrective actions in response to the 12 recommendations in OIG's initial report, yet improvements were still needed. OIG agreed with closure of 2 recommendations and will continue to follow up on the remaining 10 recommendations from the initial report. In addition, during the July 2014 visit, OIG found improper storage of patient information, medical and surgical supplies, medications, grafts, and patches. OIG made one additional recommendation related to proper storage.

Allegations Not Substantiated That Radiology Procedures Were Performed by Poorly Trained Staff at Salem, Virginia, VAMC

OIG conducted an inspection at the request of Senator Tim Kaine in response to allegations that interventional radiology procedures at the Salem VAMC (facility), in Salem, VA, were being performed by a radiologist with inadequate training, that the facility lacked adequate medical and surgical support for patients who might develop complications after certain interventional radiology procedures, and that the facility has no formal training and competency program for interventional radiology nurses and technicians. The purpose of the review was to determine whether the allegations had merit. OIG did not substantiate the allegation that radiology procedures at the facility were being performed by a radiologist with inadequate training. OIG found that facility credentialing staff properly verified all educational, training, and licensure credentials for the subject radiologist who was then granted initial privileges to perform procedures, including the two procedures named in the allegation. OIG did not substantiate the allegation that the facility lacked adequate medical and surgical support for patients who might develop complications after certain interventional radiology procedures. The facility has a vascular surgeon and gastroenterologists who are onsite during interventional procedures and available should a patient undergoing an interventional radiology procedure need further care. In addition, the facility has a fully equipped Post Anesthesia Care Unit and Intensive Care Unit. OIG did not substantiate that the facility has no formal training and competency program for interventional radiology nurses and technicians. The facility requires all interventional radiology nurse and technician staff to undergo an annual competency assessment, which is completed by direct observation of the technician while performing his or her duties. OIG made no recommendations.

OIG Finds High Quality Medical Care at Iowa City, Iowa, VA HCS, More Work Needed To Sustain Progress in Workplace Culture

OIG conducted an inspection at the request of Senator Charles E. Grassley to follow up on a prior inspection at the Iowa City VA HCS, Iowa City, IA. OIG previously evaluated the overall quality of care, management, and operations, as well as an allegation that concerns expressed by staff "have been largely ignored," and published *Review of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa* (Report No. 12-02263-269, issued August 29, 2012). For the current inspection, OIG assessed the implementation and progress of the action plans developed in response to OHI recommendations from the 2012 report and evaluated a new allegation that "nothing had changed in Iowa City." OIG noted overall improvements and did not substantiate the allegation that "nothing had changed." OIG found that high quality medical care had been maintained. While some concerns remain in limited areas regarding blame, fear of retaliation, and reactionary leadership, system leadership is working to create a culture and environment that feels safe and non-retaliatory and acknowledges the need for continued progress in these areas. OIG made no recommendations.

Ten Percent of Patients Seeking Emergency Care at Leavenworth, Kansas, VAMC Did Not Receive Required Medical Screening

OIG conducted an inspection to assess the validity of an allegation concerning the Dwight D. Eisenhower VAMC ED, Leavenworth, KS, part of the Eastern Kansas HCS, Topeka, KS. OIG substantiated the allegation that 10 percent of patients who sought care at the Leavenworth VAMC ED did not receive a required medical screening examination to determine whether an emergency medical condition existed. OIG also determined Leavenworth VAMC ED RN triage staff did not always use required ED documentation templates, and ED and Primary Care Clinic nursing staff did not consistently document required assessments. OIG recommended that the Eastern Kansas HCS Director ensure all patients who present to the Leavenworth VAMC ED requesting an examination or treatment receive a medical screening examination, that Leavenworth VAMC ED and Primary Care Clinic nursing staff document required assessments, and that compliance be monitored.

OIG Recommends Strengthening Radiology Scheduling Processes at VA Loma Linda HCS, Loma Linda, California

OIG conducted a review to assess the merit of allegations concerning radiology scheduling and other administrative issues at the VA Loma Linda HCS. OIG substantiated that blind scheduling occurred; however, OIG found no evidence of treatment delays. OIG could not substantiate the allegation that patients did not consistently receive appointment reminder letters. OIG concluded that scheduling clerks needed to consistently document patients' actions or dispositions in the Appointment Management and the Radiology Package programs. Program managers needed to monitor exam cancellations to ensure the appropriate reason is documented between these two programs. OIG substantiated that non-VA imaging exams were not uploaded into the EHRs for three subject patients. However, OIG concluded that uploading these images would not have influenced treatment courses for the patients because clinicians were aware of the exam results. OIG did not substantiate the allegation of staff mismanagement in the ultrasound walk-in clinic. OIG concluded that the number of staff on duty as well as the volume and complexity of ultrasound orders influenced the clinic's early closure. OIG also did not substantiate that staff were not timely in notifying patients with Breast Imaging Reporting and Database System category zero results. OIG made five recommendations.

Review Finds Inadequate Follow-Up of MRI Results at Charlotte, North Carolina, CBOC

OIG reviewed an allegation of improper notification of test results and delayed care at the Charlotte CBOC, Charlotte, NC. OIG did not substantiate the allegation that the patient was not properly notified of his MRI results. However, OIG found that the clinical process of discussing the test results, negotiating a treatment plan, and educating the patient about his condition did not comply with VHA guidelines. OIG substantiated the allegation that the patient's treatment was delayed. The primary care provider did not adequately follow up after receiving the patient's abnormal MRI results or follow through on the patient's plan of care. Failure to take clinical action may have contributed to a more complex clinical course for this patient. OIG made three recommendations.

Review Finds No Clinically Significant Delay in Gastroenterology Care at Durham VAMC, Durham, North Carolina

OIG conducted an inspection to determine whether a patient, who is now deceased, received appropriate and timely diagnostic testing for colorectal cancer (CRC) at the Durham VAMC in Durham, NC. OIG confirmed that almost 8 months elapsed between the patient's initial gastrointestinal-related complaints in January 2011 until his colonoscopy in August. OIG did not find that this 8-month timeframe represented a clinically significant delay in care. The patient's clinical presentation was unusual for a patient with CRC for both the early age of onset, as well as the short time period from initial symptoms to the discovery of advanced cancer. None of the providers were suspicious for CRC given the patient's age at presentation and no known family history, and they reasonably considered inflammatory bowel disease as the more likely diagnosis. OIG could not say

with certainty that the patient's outcome would have been different had he received the diagnostic colonoscopy sooner. The colonoscopy and subsequent computerized tomography scan revealed the patient had a large mass and advanced CRC with metastasis to the liver. As CRC is typically a slow-growing cancer, the patient likely had advanced CRC at the time of his initial presentation with symptoms. OIG made no recommendations.

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VAMC, Salisbury, North Carolina

OIG conducted an inspection in response to allegations that a physician improperly closed Non-VA Care Coordination (NVCC) consults and inappropriate comments were made about a patient at the W.G. (Bill) Hefner VAMC in Salisbury, NC. OIG did not substantiate the allegation that a physician improperly cancelled or discontinued NVCC consults, thus denying patients needed care. Record reviews of 214 consults revealed that the reasons for cancellation or discontinuation were logical, met VHA and/or local guidelines, and were appropriately documented. While OIG substantiated the allegation that a physician made an inappropriate comment about a patient, OIG found that the facility took appropriate action, and the physician apologized for the statement. OIG made no recommendations.

Review Finds Physicians Did Not Thoroughly Assess Patients Before Renewing Opioid Prescriptions at Chillicothe, Ohio VAMC

OIG conducted an inspection in response to allegations that physicians at the Chillicothe, OH, VAMC prescribed opioid medications for patients they had never evaluated. In addition, patients were alleged to be at risk because no prescriber was monitoring them for adverse reactions, pain relief, or opioid abuse. OIG did not substantiate that physicians improperly prescribed opioid medications for patients whom they had not seen or examined. OIG did substantiate that physicians prescribed opioids for patients with whom they had no direct interaction, but this is not a violation of law or VA policy. OIG substantiated that physicians did not consistently document medication effectiveness prior to renewing prescriptions for patients at increased risk for adverse medication effects or diversion. OIG also found that physicians were not consistently documenting use of the Ohio Automated Rx Reporting System, a state prescription drug monitoring program. OIG did find that urine drug screens were routinely performed. According to VHA policy, patients on chronic opioid therapy are to be evaluated every 1 to 6 months. Although renewing opioid prescriptions without examining patients is not a violation of law or VA policy, a minimum review of patient information is required. OIG's review of 88 patients for whom opioids were prescribed in 2013 and 2014, and who were at increased risk for complications or abuse of opioids, revealed that physicians did not thoroughly assess patients before renewing opioid prescriptions. OIG recommended that the Facility Director ensure that patients receiving recurrent prescriptions for high potency and/or large quantities of opioid medications are routinely identified and provided appropriate follow-up care, and prescribing physicians review the prescription history reports contained in the Ohio Automated Rx Reporting System for patients who are prescribed opioids.

Veterans Referred for Outside Urologic Care by Phoenix HCS Potentially at Risk for Being Lost to Follow-Up

During OIG's 2014 review of scheduling practices and wait times at the Phoenix VA Health Care System (PVAHCS), OIG found that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays in either obtaining an appointment, scheduling follow-up, and/or receiving authorizations for non-VA urology care. This prompted OIG to open an expanded review, specifically focusing on access to care within PVAHCS' Urology Department. While the OIG review is ongoing, some concerning preliminary findings requiring the Interim USH's immediate attention were identified. These findings suggest that delays associated with the processing of referrals through the Office of NVCC could potentially be putting patients at risk for being lost to follow-up. As PVAHCS continues to recruit and hire

physicians and mid-level providers to staff its Urology Department, it is critical that staffing and administrative processes related to non-VA authorized care be properly administered.

OIG Makes Five Recommendations To Improve Scheduling Procedures at PVAHCS Radiology Department

OIG conducted an inspection in response to allegations regarding appointment scheduling, staffing, and other administrative issues in the Radiology Department of the PVAHCS (facility), in Phoenix, AZ. OIG substantiated the allegations that a Microsoft Outlook software calendar was used to supplement radiology scheduling, that radiology appointments were not reflected on the patients' clinic appointment reminder lists, and that radiology clerks had no access to the facility-wide scheduling system. OIG also substantiated that films and files had been stored in the basement and were not easily accessible to staff for a limited time and that the Radiology Department had insufficient clerical staff. OIG recommended that the Interim Facility Director ensure that the Radiology Department uses software that is consistent with VA policy to schedule appointments. OIG also recommended that Radiology Department managers explore the use of the scheduling system by radiology clerks, develop and implement a scheduling policy and a formal training program for clerks, monitor clerical needs to ensure all radiology areas are staffed, and implement the facility's plan for centralized radiology scheduling and procedures to ensure a timely response to phone calls or messages.

Review Finds Need for Triage Guidelines and Training at Alamosa, Colorado, CBOC

OIG conducted an inspection to determine the validity of allegations of poor quality care and lack of courtesy provided to a patient at the VA Eastern Colorado HCS's Alamosa CBOC. The complainant alleged that a nurse did not adequately assess and triage a patient because the patient presented late on a Friday afternoon and that the nurse treated the patient with disrespect, sarcasm, and a lack of compassion. It was also alleged that CBOC staff attempted to contact the patient through his brother instead of the emergency contact on file for the patient. OIG did not substantiate that a nurse did not adequately assess the patient; however, OIG substantiated that the nurse did not appropriately triage the patient to a higher level provider based on that assessment. A physician later determined that the patient had not been appropriately triaged and took action to advise the patient to seek additional medical care; however, managers did not address the nurse's failure to appropriately triage the patient. CBOC staff reported that they were unaware of formal policies or procedures for the triage of walk-in patients. OIG could not substantiate that the CBOC nurse was disrespectful, sarcastic, or uncompassionate to the patient. OIG could not substantiate that a CBOC staff member contacted the patient's brother instead of the emergency contact listed in the patient's EHR. OIG made two recommendations to the Director of the VA Eastern Colorado HCS.

Allegations Regarding Ophthalmology Service at VA Illiana HCS, Danville, Illinois, Not Substantiated

OIG conducted an inspection to assess the merit of allegations made by an anonymous complainant about the Ophthalmology Service at the VA Illiana HCS (facility), Danville, IL. OIG did not substantiate that surgery was performed on the wrong eye of a patient, or that the ophthalmologist ordered an antibiotic late. OIG did not substantiate that the patient's death was due to two eye infections or that the facility Mortality and Morbidity Committee "covered up" issues related to the patient. OIG did not substantiate that an ophthalmologist was using unsterile instruments. OIG did not substantiate that the ophthalmologist did not perform retinal exams or treat glaucoma due to an inability to read optical coherence tomography tests. OIG substantiated that the ophthalmologist saw a patient in her private practice but the patient was sent back to the VA appropriately. OIG did not substantiate that patients were referred inappropriately to private practices. OIG substantiated that patients were not referred back to the facility's Optometry Service after surgery, but this was appropriate for workflow reasons. OIG substantiated that the ophthalmologist was taking VA patient records to her private practice; however, the facility was aware, and personally identifiable information (PII) was protected. OIG noted

that three investigations showed serious interpersonal problems amongst the staff and providers of the service, but recommended actions had not been taken. OIG recommended that all recommendations for interpersonal training for the staff and providers in the Ophthalmology and Optometry Services be implemented.

Review of Gastroenterology Service at Lovell North Chicago, Illinois, Facility Finds Inconsistent Documentation of Non-VA Care in VA Records

OIG conducted an inspection in response to allegations of mismanagement of gastroenterology (GI) services and other quality of care deficiencies at the Captain James A. Lovell Federal Health Care Center (facility), North Chicago, IL. OIG received multiple allegations of "turmoil and chaos" related to a recent reorganization of senior leadership. OIG focused on prioritization of GI services, alleged quality of care deficiencies, requests for unnecessary GI procedures, and the lack of coordination of non-VA GI care. OIG substantiated allegations that facility gastroenterologists had been directed by facility leaders to prioritize care in favor of active duty service members and that scheduled GI procedures were limited to four per day. However, OIG found that the facility leaders' decision to prioritize care in favor of service members was made in accordance with a 2010 Department of Defense (DoD)/VA Executive Agreement that outlines terms of operation for the facility and that veterans were receiving care when necessary through the Non-VA Medical Care Program. OIG substantiated a significant lapse in the management of a patient's low blood sugar. However, OIG found the facility had appropriately addressed the issue. OIG did not substantiate the allegations that an increase in falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures occurred as a result of senior leaders' mismanagement after a reorganization in spring 2014 or that facility leaders requested that GI staff perform unnecessary procedures. OIG also did not substantiate that the facility lacked a process for coordinating non-VA GI care. However, OIG did find inconsistencies in the posting of non-VA GI procedure results into the VA EHR. OIG recommended that the Facility Director ensure that documentation of procedure results from non-VA GI care providers is obtained and available in the EHR for review in a timely and consistent manner.

OIG Recommends Training in Wound Care Device at the Community Living Center, Charlie Norwood VAMC, Augusta, Georgia

OIG conducted an inspection in response to allegations concerning staffing and quality of care issues resulting in patient harm and death in the community living center (CLC) at the Charlie Norwood VAMC, Augusta, GA. OIG substantiated that the VAMC was without one of three RN Certified Wound Care Specialists for over a year. OIG did not substantiate that several patients' wounds were neglected as a result of the vacancy. While OIG found that one patient had several pressure wounds, OIG determined that the care for this patient's wounds was acceptable. OIG substantiated the allegation that a patient had a wound vacuum assisted closure (VAC) device that nurses and physicians failed to maintain. OIG found that the sponge from the wound VAC adhered to the wound and required removal. OIG concluded that the lack of training may have contributed to a delay in care. OIG did not substantiate that the primary care provider failed to send a patient to the inpatient medical unit earlier during the day, which resulted in a code being announced later that evening. OIG also did not find that the patient provided a written statement regarding the incident and that the VAMC failed to address it. OIG substantiated that a patient developed several wounds that needed debridement. However, OIG did not determine that it was due to the lack of an RN wound care specialist onsite. OIG recommended that the Facility Director require that all nursing staff in the CLC receive the required training on the wound VAC device.

OIG Review Refutes Allegations of Insufficient Staffing and Consult Management Issues at Carl Vinson VAMC, Dublin, Georgia

OIG conducted an inspection in response to allegations of insufficient staffing and consult management issues at the Carl Vinson VAMC, Dublin, GA. OIG substantiated that telemetry technicians monitor telemetry patients without RN supervision; however, we did not find this practice to be improper. OIG did not substantiate the

allegation that when nursing assistants (NAs) provided close observation (visual monitoring of a patient every 10–15 minutes), it increased the nursing assistant's likelihood of being injured. OIG substantiated the allegation that, at times, unit 8A East staff scheduled for the midnight tour worked shifts other than their regularly scheduled tours of duty. However, the facility's standard operating procedures for nurses state that tour changes, compensatory time, and overtime are to be used to assure adequate staffing when reassignment of staff from another area is not feasible. OIG did not substantiate the allegation that the 8A East midnight tour had a staffing mix of 1 RN and 2 NAs to care for 28 patients. The usual 8A East staffing assignment for the midnight tour included one RN, one licensed practical nurse, and two NAs. OIG did not substantiate the allegation that NVCC staff members assigned to a consult clean-up project were not properly trained to process backlogged NVCC consults. OIG made no recommendations.

OIG Makes Two Recommendations To Improve Patient Telemetry Monitoring at Michael E. DeBakey VAMC, Houston, Texas

OIG conducted an inspection in response to allegations that untrained employees monitor inpatients on telemetry (portable device that allows continuous observation of a patient's heart rate and rhythm); that since January 2014, several inpatients on telemetry monitoring have died who potentially could have been saved if nursing staff were alerted rapidly to observed cardiac arrhythmias; and that the new telemetry monitoring equipment installed in February 2013 does not allow patient monitoring in a safe and effective way at the Michael E. DeBakey VAMC, Houston, TX. OIG did not substantiate the allegation that untrained employees were monitoring inpatients who were on telemetry. OIG did not substantiate the allegation that patients on telemetry, during the period January 1, 2014, through July 18, 2014, died who potentially could have been saved if telemetry staff had notified nursing staff of observed cardiac arrhythmias. However, of the 40 telemetry patients with facility-conducted mortality reviews, OIG found documentation of 18 (45 percent) patients with a "hospice" or "comfort care" status. OIG did not substantiate the allegation that the new telemetry monitoring equipment installed in February 2013 prevents patients on telemetry from being monitored in a safe and effective way. OIG did not find staff sleeping; however, OIG did find that some unit staff were not carrying the facility-required telephones used for direct communication between telemetry and unit staff. OIG revisited the same areas during the day shift and found staff on two of the same units not carrying the required telephones. OIG recommended that the Facility Director ensure that the appropriateness of assigning patients to telemetry is reviewed. OIG also recommended that the Facility Director ensure dedicated wireless telephones are continuously carried by unit charge nurses or designees for effective communication between unit and telemetry monitoring technicians as required by local policy.

OIG Makes 11 Recommendations To Improve Access to Care at El Paso Health Care System

OIG's OHI conducted a review in response to concerns raised by Congressman Beto O'Rourke regarding access to care and productivity at the El Paso VA Health Care System (EPVAHCS). The purpose of this review was to determine the extent to which those concerns had merit. OIG substantiated the concerns expressed. OIG found the many veterans seeking care at the EPVAHCS faced challenges accessing care timely, particularly patients who were new to EPVAHCS. The timeliness of veterans' access to care exceeded the 30-day benchmark established by the VA Secretary for three of four specialties included in OIG's review—orthopedics, urology, and cardiology. In contrast, three EPVAHCS clinics met the 30-day access benchmark—primary care, MH care, and GI. OIG also found that numerous factors affected the timeliness of veterans' access to care at the EPVAHCS, including staffing, productivity, and clinic cancellations and no shows. OIG explored these factors, as well as other key issues and management challenges described by officials OIG interviewed, and their impact on access. Efforts to improve access at the EPVAHCS should consider the factors OIG described in this report, both individually and in combination. OIG made 11 recommendations.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) 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. During the reporting period, OAE published 15 audits and evaluations of VA programs and operations, conducted 8 benefits inspections of VA Regional Office (VARO) operations, and administratively closed 4 reviews.

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 Corrective Action VHA Could Inappropriately Award and Manage $795 Million in Support Service Contracts Over Next 5 Years

In FY 2012, the Office of Management and Budget stated Government spending for support service functions quadrupled over the past decade. Previous OIG audits identified recurring systemic deficiencies in virtually all phases of VHA's contracting processes. VHA's support service contract costs increased 60 percent from approximately $503 million for approximately 5,100 contracts in FY 2012 to just over $805 million for approximately 4,700 support service contracts in FY 2013. OIG determined whether staff adequately developed, awarded, and monitored VHA support service contracts. OIG found VHA did not have effective internal controls or follow existing controls to ensure adequate development, award, monitoring, and documentation of support service contracts. Within OIG's statistical sample of 95 support service contracts, OIG found 1 or more contract deficiencies in each. The contract deficiencies included insufficient documentation of key contract development and award decisions, assurance that paid invoice amounts were correct and funds were de-obligated following the contract completion, and a complete history of contract actions in VA's mandatory Electronic Contract Management System. These deficiencies occurred because VHA management did not have an effective quality assurance program, Integrated Oversight Process (IOP) reviews were not completed, and contracting officers did not delegate and meet with contracting officers' representatives as required. If VHA does not take timely action to improve its support service contracting processes, OIG estimated it will inappropriately compete, award, and manage contract funds totaling $159 million annually or $795 million over the next 5 years through FY 2019. OIG recommended VHA improve their quality assurance and training programs, revise and complete IOP reviews, objectively evaluate contracting officer's performance, and ensure contracting officers' representatives are delegated and met with quarterly. The USH concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions.

Homeless and At-Risk Veterans Experience Problems Accessing VA's National Call Center for Homeless Veterans

VHA's National Call Center for Homeless Veterans (the Call Center) is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. OIG has assessed the effectiveness of the Call Center in helping veterans obtain needed homeless services. OIG determined that

homeless and at-risk veterans (homeless veterans) who contacted the Call Center often experienced problems either accessing a counselor and/or receiving a referral after completing the Call Center's intake process. Of the estimated 79,500 homeless veterans who contacted the Call Center in FY 2013: just under 21,200 (27 percent) could only leave messages on an answering machine—counselors were unavailable to take calls; almost 13,000 (16 percent) could not be referred to VA medical facilities—their messages were inaudible or lacked contact information; and approximately 3,300 (4 percent) were not referred to VA medical facilities, despite having provided all the necessary information. Referred homeless veterans did not always receive the services needed because the Call Center did not follow up on referrals to medical facilities. Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or improvements to ensure the quality of the homeless services. Finally, the Call Center closed just under 24,200 (47 percent) referrals even though the VA medical facilities had not provided the homeless veterans any support services. In total, OIG identified 40,500 missed opportunities where the Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services from VA medical facilities. OIG recommended the Interim USH stop the use of the answering machine, implement effective Call Center performance metrics to ensure homeless veterans receive needed services, and establish controls to ensure the proper use of Call Center special purpose funds. The Interim USH concurred with OIG's recommendations and provided responsive action plans. OIG will follow up on these actions.

Security Control Weaknesses at Massachusetts VA Research Center Put Veterans' Personal Information at Risk

In August 2013, the Senate Committee on Veterans' Affairs asked OIG to review allegations that the Massachusetts Veterans Epidemiology Research and Information Center's (MAVERIC) security control weaknesses put veterans' personal information and other sensitive information at risk. It was also alleged that the Boston Healthcare System (BHS) leased off-site commercial office space for MAVERIC staff that the complainant considered wasteful. OIG substantiated the allegation that MAVERIC security control weaknesses put veterans' personal information and other sensitive information at unnecessary risk. In December 2013, OIG found hard copy veterans' personal information and unencrypted portable data storage devices unsecured in MAVERIC office space. VHA's Office of Research Oversight (ORO) found similar issues in August 2013 when it conducted a review of BHS research groups. In light of the issues identified during OIG's review and by ORO, OIG concluded that BHS had not taken sufficient action to safeguard the confidentiality of veteran's personal information. This occurred because BHS did not establish sufficient oversight of MAVERIC physical security controls, such as ensuring secure storage of veterans' personal information and encryption of portable storage media. OIG also substantiated the allegation that BHS leased off-site commercial office space, which OIG determined was underutilized. BHS entered into a 5-year lease totaling about $938,000 without determining how much office space it needed and whether there was available VA space. As a result, OIG estimates BHS could spend approximately $593,000 over the 5-year lease period for underutilized office space. OIG recommended the Director of VISN 1, in conjunction with the Office of Information and Technology (OIT), improve oversight of MAVERIC physical security controls and implement a plan to maximize use of the off-site commercial space if continued need for the office space is justified. The Director of VISN 1 concurred with OIG's recommendations and provided acceptable action plans.

VHA Violated Appropriations Law by Improperly Obligating $92.5 Million Meant for Medical Support on Information Technology Development

OIG conducted a review in response to allegations received by OIG Hotline Division. OIG evaluated the merits of an allegation that VHA's Chief Business Office (CBO) violated appropriations law by improperly obligating over $96 million in medical support and compliance (MS&C) funds to pay for the development of the Health Care Claims Processing System (HCPS). OIG substantiated that CBO violated appropriations law by improperly

obligating a total of $92.5 million of MS&C appropriations to finance the development of HCPS. The difference between the alleged and substantiated amounts is due to an estimate cited by the complainant. Of the $92.5 million, the Financial Services Center spent approximately $73.8 million. However, $18.7 million still remains obligated. MS&C appropriations are only authorized for administering medical, construction, supply, and research activities. CBO's misuse of MS&C appropriations occurred because the Deputy Chief Business Officer (DCBO) did not seek the required Information Technology (IT) Systems appropriations to fund the development of HCPS. Though initiated by the former DCBO for Purchased Care, MS&C appropriations were used instead of requesting funding from OIT in hopes of achieving a faster delivery of this new information system. The current DCBO allowed the expenditures to proceed unchecked. As a result, CBO violated appropriations law when it improperly obligated approximately $92.5 million of MS&C appropriations to develop HCPS. OIG recommended the Interim USH establish oversight mechanisms, seek the return of all MS&C appropriations, de-obligate all current MS&C funds, and obtain appropriate funding for HCPS development. OIG also recommended that the Interim USH determine if appropriate administrative action should be taken against DCBO senior officials in the Purchased Care's chain of command. The Interim USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by September 30, 2015. OIG considered these planned actions acceptable and will follow up on their implementation.

VHA Risks Improper Payments of $56.2 million if Controls for Emergency Transportation Claims Are Not Strengthened

OIG conducted an audit to determine the accuracy of payments for VHA's non-VA medical care emergency transportation claims. The Non-VA Medical Care Program assists veterans who cannot feasibly receive care at a VA medical facility. Inaccurate payments affect VA's commitment to delivering timely and high-quality health care to veterans while controlling costs. VHA's Non-VA Medical Care Program improperly paid 129 of 353 emergency transportation claims (37 percent) from April 1, 2013, through September 30, 2013. Of the total 353 payments valued at $585,800, the 129 improper payments amounted to $167,600. Non-VA medical care staff made the following improper payments: (1) $19,300 for 27 of 353 claims (8 percent) to vendors that submitted a claim or required documentation untimely, (2) $25,000 for 7 of 353 claims (2 percent) for care provided to ineligible veterans, and (3) $123,300 for 95 of 353 claims (27 percent) for the incorrect amount. These claims were improperly paid because staff did not conduct an adequate review to ensure that all documentation was received prior to processing the claim and did not correctly determine veterans' eligibility for emergency transportation. Staff also misunderstood the criteria for processing non-service- and service-connected emergency transportation claims. As a result, OIG projected an annual improper payment amount of approximately $11.2 million. Over the next 5 years, OIG projected improper payments of approximately $56.2 million if claims processing controls are not strengthened. OIG recommended the Interim USH implement periodic training and systematic reviews of emergency transportation claims, and instruct the sampled VA medical facilities to initiate recovery of overpayments and reimbursement of underpayments identified in this audit. The Interim USH concurred with OIG's recommendations and provided responsive action plans. OIG will follow up on these actions.

VHA Missed Telehealth Opportunities That Could Have Delayed Veterans' Need for Long-Term Care, More Specific Metrics Needed

The goal of the Home Telehealth Program is to improve veterans' access to care while reducing patient treatment costs. The program does this by remotely monitoring patients' vital signs in the home and intervening early when adverse trends are detected. OIG determined how effectively VHA is managing its Home Telehealth Program. VHA missed opportunities to expand enrollment for Non-Institutional Care (NIC) patients in the Home Telehealth Program. NIC telehealth patients showed the best outcomes, in terms of reduced inpatient admissions and bed days of care. In FY 2013, the number of NIC patients-served declined by 4 percent, while the number of Chronic Care Management and Health Promotion/Disease Prevention (HPDP) patients-served

grew 51 and 37 percent, respectively. The significant change in the mix of patients receiving care in this program occurred due to a change in the performance methodology. VHA began to measure program performance by the total number of patients-enrolled, rather than focusing on the increase in enrollment for NIC patients. This change in performance metrics encouraged VHA to enroll more HPDP participants. These participants would likely need less intervention from Primary Care physicians, because their health care needs would be less complex. VHA was successful in reaching its new performance metric. However, obtaining this goal did not result in more patients with the greatest medical needs receiving care under the program. As a result, VA missed opportunities to serve additional NIC patients who could have benefited from the Home Telehealth Program. VA could have potentially delayed the need for long-term institutional care for approximately 59,000 additional veterans in FY 2013. OIG recommended the Interim USH implement mechanisms to identify demand for NIC patients and develop specific performance measures to promote enrollment of NIC patients. The Interim USH concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions.

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.

Informal Claims Not Properly Controlled at Oakland, California, VARO, 21 Percent of Claims Reviewed Not Processed, Some as Old as 2002

On July 10, 2014, OIG received a request for assistance from the Under Secretary for Benefits (USB) to review allegations that the VARO in Oakland, CA, had not processed nearly 14,000 informal requests. The allegation indicated some claims dated back to the mid-1990s. The same allegation was forwarded to OIG by Representative Doug LaMalfa, who also requested an OIG review. In addition, another complainant alleged that "informal claims" were being improperly stored. OIG immediately initiated an unannounced, onsite review at VARO Oakland and its Sacramento satellite office. OIG substantiated the allegations that VARO staff had not processed informal claims. OIG confirmed that staff had not properly controlled these claims documents, which were accidently found in a filing cabinet during a construction project. OIG did not identify any current storage or control issues during our site visit. VARO management advised that a team assisting the Oakland Veterans Service Center (VSC) had located approximately 14,000 informal claims, some of which dated back to the mid-1990s. VA considers an informal claim as any type of communication or action indicating the intent to apply for one or more benefits, in accordance with existing laws. Management stated it counted the documents and actually identified 13,184 informal claims. Of these 13,184 informal claims, 2,155 required review or action by VARO staff. VARO management told OIG they had created a "special project team" to process the 2,155 informal claims and thought the task had been completed. However, between April through May 2014, VARO staff again "discovered" additional claims, some of which the VARO's "special project team" had annotated as reviewed. After 2 months, VARO management created a tracking spreadsheet to determine which claims needed to be processed. VARO management determined staff (assigned to the special project team) had not processed 537 informal claims. At the time of their onsite review, OIG could not confirm the existence of the 13,184 informal claims, or which of them were the 2,155 claims needing review or action. OIG reviewed 34 of these newly "discovered" claims and found 7 (21 percent) remained unprocessed. While no claims in their sample dated back to the mid-1990s, some were as old as July 2002. OIG also found VARO staff had repeatedly reviewed these seven informal claims from December 2012 through June 2014 for various reasons, but took no additional action on them as required. VARO staff did not maintain adequate records or provide proper supervision to ensure informal claims received timely processing. As a result, veterans

did not receive consideration for benefits to which they may have been entitled. During their inspection, no current issues related to the lack of control and improper storage of informal claims documents came to their attention. OIG recommended the VARO Director complete and certify the review of the 537 informal claims, take appropriate action, and provide documentation to certify these actions are complete. Also, the Director should better enforce compliance with existing VBA and VARO policies pertaining to the processing of informal claims.

VBA Guidance on Date of Claim Made Claims Difficult To Track and Misrepresented Processing Time at Little Rock VARO

On July 11, 2014, OIG received an anonymous allegation that staff at the Little Rock VARO inappropriately applied the VBA's Fast Letter 13-10, "Guidance on Date of Claim Issues," dated May 20, 2013. The complainant alleged that adjusting the dates of claims was done to give the appearance that VBA was making more progress than it actually had in eliminating its backlog of disability claims. On June 27, 2014, the USB suspended use of Fast Letter 13-10 after OIG determined staff were misapplying the guidance at another VARO. OIG had previously reported to the USB that the guidance was used inappropriately to adjust dates of claims for unadjudicated claims discovered in the files. Changes to veterans' claims were made to process old mail instead of unadjudicated claims information found in the files. OIG substantiated the allegation that Little Rock VARO staff adjusted dates of claims for unadjudicated claims discovered in the files; however, staff did so in compliance with VBA Fast Letter guidance in effect at that time. OIG reviewed documentation on 48 unadjudicated claims that VARO staff located in claims folders from May 22, 2013, through June 20, 2014. Staff adjusted the dates of claim for all 48 cases OIG reviewed, resulting in the claims having more current dates than the dates they were initially received within VA. OIG interviewed staff who raised concerns that the use of this guidance led to providing veterans with incorrect information on claims processing timeliness. The application of this guidance was also considered inconsistent with VBA standard policy requiring use of the earliest date that a document is stamped as received at a VA facility as the date of claim. Staff typically process claims in their workloads by claim type and age, generally working the oldest claims first. This VARO maintained records of the changes made to veterans' claims per the requirements in the guidance. To mitigate the potentially adverse effect the date adjustments would have on veterans' benefits, Little Rock VARO staff took the initiative to develop a spreadsheet to track all unadjudicated claims found in the claims folders where dates of claims were changed. This action provided VARO managers with assurance that staff could easily identify the claims and initiate required development actions. Based on OIG's review, OIG concluded that adjusting the dates of aging claims to more recent "discovered" dates resulted in a lack of assurance that staff would expedite processing of the discovered unadjudicated claims, further delaying benefits decisions for veterans. Adjusting the dates of claims also misrepresented the time required for VARO staff to process the claims, potentially making performance look better than it actually was. In order to minimize confusion or misinterpretation of guidance for future claims processing, OIG recommended that VBA maintain a standard, universal policy for establishing dates of claims. In a memo received January 8, 2015, the USB concurred with OIG's recommendation and reported VBA terminated the use of Fast Letter 13-10, effective June 27, 2014. The memo also indicated all VARO staff had been instructed to immediately follow the permanent procedural guidance found in VBA's governing directives for all claims, to include "found" claims. However, as outlined in this report, OIG concluded that VBA did not take action to terminate Fast Letter 13-10 until January 22, 2015. Further, OIG remains concerned that VBA's permanent guidance related to dates of claims continues to provide for an exception that allows VARO staff to use a later date of claim, despite having evidence that an earlier date of claim exists.

Honolulu, Hawaii, VARO Supervisor's Removal of Electronic Controls Undermined Effectiveness and Misrepresented Inventory

On October 29, 2014, OIG received a request from the Director of the Honolulu, HI, VARO asking that OIG assess alleged data manipulation involving a supervisory employee from that office. Specifically, a Honolulu

VARO fact-finding initiative revealed a supervisor improperly removed controls from an electronic record used to identify and process claims without taking the appropriate actions. Additionally, results from their fact-finding indicated this supervisor directed staff to disregard VBA policy when processing some claims. OIG substantiated the allegation that the supervisor inappropriately removed controls in the electronic record used to track and identify claims related to verifying the status of veterans' dependents without taking proper actions to complete the claims. OIG reviewed 139 cases and determined the supervisor inappropriately removed system controls for 100 benefits claims. The supervisor admitted to removing controls from the electronic record but stated it was not his intention to misrepresent data. Further, in one instance, OIG determined the supervisor instructed VARO staff to disregard VBA policy related to a claim involving recoupment of separation pay. The actions to remove claims from the electronic record misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may have continued to receive additional compensation for dependents that they were not entitled to receive. The inappropriate actions described in this report undermine program effectiveness. Therefore, OIG recommended the Honolulu VARO Director take immediate action to correct, as appropriate, all improper actions taken by the supervisor. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee. The VARO Director concurred with OIG's recommendations and management's planned actions are responsive. OIG will follow up as required. The VARO Director informed OIG the supervisor who took the improper actions related to dependency claims resigned his position.

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

Overall, 28 percent of benefit claims we reviewed requiring a rating decision were processed in error. These errors involved claims related to temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, and special monthly compensation (SMC) and ancillary benefits. Further, VAROs did not timely process benefit reductions, causing improper payments to veterans.

Key findings included:

- Temporary 100 Percent Disability Evaluations: 33 percent of these claims were processed in error. We identified processing errors resulting in 379 improper payments to 36 veterans totaling approximately $489,000.
- TBI claims: 16 percent of these claims were processed in error. We identified processing errors resulting in 80 improper payments to 5 veterans totaling approximately $30,500.
- SMC and Ancillary Benefits: 34 percent of these claims were processed in error. We identified processing errors resulting in 1,133 improper payments to 34 veterans totaling approximately $1,065,000.

- Benefit Reductions: 26 percent of benefits reductions were delayed or incorrectly processed. We identified processing errors resulting in 359 improper payments to 49 veterans totaling approximately $565,000.

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 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.

OIG Questions $5 Million in Public Affairs Outreach Contracts, Finds Inadequate Oversight and Lack of Performance Metrics

OIG evaluated the merits of Hotline complaints that VA's Office of Public and Intergovernmental Affairs (OPIA) awarded an outreach contract to Woodpile Studios, Inc., alleging that it yielded no apparent increase in the use of VA health care, benefits, or services by veterans. Furthermore, the complaint alleged that OPIA then planned to solicit new outreach contracts without evaluating the effectiveness of the prior contract. OIG substantiated the allegations regarding OPIA mismanagement of its outreach contracts. OIG confirmed that in July 2010, OPIA awarded a contract to Woodpile Studios, Inc., to provide support for outreach campaigns at an initial cost of $5.2 million. However, OPIA could not demonstrate that contract activities resulted in increased awareness of and access to VA health care, benefits, and services for veterans. OIG also confirmed that OPIA solicited significant new outreach service contracts without evaluating the effectiveness of the previous contract. OPIA management stated that leadership turnover contributed to ineffective oversight of the outreach contract management and solicitations. Consequently, Woodpile contractors performed functions that were inherently Governmental. Questionable use of a labor-hour order instead of a performance-based contract contributed to invoices for activities that did not clearly link to accomplishment of VA outreach goals. By awarding new contracts without first evaluating the performance of the prior Woodpile contract, OPIA continued to expend funds on questionable outreach activities. OPIA also lacked performance metrics to fully assess improvements in access to VA benefits and services for veterans. OIG recommended that the Assistant Secretary for OPIA ensure effective oversight of outreach contract management and prevent contractors from performing inherently Governmental tasks. The Assistant Secretary should also implement metrics to ensure the outreach campaigns improve veteran awareness and access to VA services. The Acting Assistant Secretary for OPIA concurred with OIG's report recommendations and summarized corrective actions for OIG consideration. OIG will monitor implementation of the corrective action plans.

Follow-Up Audit Shows More Discipline, Accountability Needed for Effective Oversight of VA IT Development Projects

In June 2009, VA launched the Project Management Accountability System (PMAS). This follow-up audit assessed whether the OIT took effective actions to address recommendations OIG made to strengthen PMAS in two prior audit reports. OIT has taken steps to improve PMAS. Although steps were taken to improve PMAS,

more than 5 years after its launch, OIT still has not fully infused PMAS with the discipline and accountability necessary for effective oversight of IT development projects. Two OIT offices did not adequately perform planning and compliance reviews. The PMAS Business Office (PBO) still had Federal employee vacancies and the PMAS Dashboard lacked a complete audit trail of baseline data. Project managers continued to struggle with capturing increment costs and project teams were not reporting costs related to enhancements on the PMAS Dashboard. These conditions occurred because OIT did not provide adequate oversight to ensure that prior OIG recommendations were sufficiently addressed and that controls were operating as intended. OIT also did not adequately define enhancements in the PMAS Guide. As a result, VA's portfolio of IT development projects was potentially being managed at an unnecessarily high risk. OIG also identified approximately $6.4 million in cost savings OIT could achieve by hiring Federal employees to replace contract employees currently augmenting PBO staff. OIG recommended the Executive in Charge ensure compliance and planning reviews are performed, replace PBO contract workers with Federal employees, modify the PMAS Dashboard so that it retains a complete audit trail of baseline data, establish stronger cost reporting controls, and ensure OIT reports enhancement costs on the dashboard. The Executive in Charge concurred with all but one OIG recommendation and provided acceptable planned corrective actions. OIT did not concur with Recommendation 4, stating that contractors are needed due to increases in workload. OIG's audit evidence provides a sufficient and reasonable basis for its findings and conclusions. Thus, where OIT disagreed, OIG will continue its scrutiny and reporting and will follow up on OIT's implementation of corrective actions. The Executive in Charge also provided technical comments that were considered but not included in this report. OIG continues to retain our position that it would be more economical to perform the PMAS Business Office workload by replacing contract employees with Government employees.

OIG Finds No Evidence To Question Accuracy of Information Presented in the Deputy Secretary's Official Biography

On December 3, 2014, OIG received an allegation that the official biography of Mr. Sloan Gibson, Deputy Secretary for the U.S. Department of Veterans Affairs, does not present accurate and transparent information. The allegation focused on the information available on VA's Web site relating to Mr. Gibson's accomplishments during the period 2008–2013, when he held a leadership role at the United Service Organizations, Inc. (USO). Specifically, the complainant questioned the methodology used to calculate net fundraising, which in turn questioned the source of funds enabling dramatic growth in USO programs and facilities. Using USO's publically available audited financial statements and program lists from 2008 through 2013, OIG did not substantiate the allegation. OIG does not have oversight authority over the USO. Although congressionally chartered, the USO is a nonprofit, private organization, and not a Government agency. Without access to USO internal financial documents, OIG could not test the reliability, accuracy, or completeness of the documents received from the complainant. OIG focused their review specifically on the accuracy of the statement, in the Deputy Secretary's official biography that "During his five years at the USO, net fundraising grew 90 percent, enabling dramatic growth in programs and facilities supporting their forward-deployed men and women, military families, as well as their wounded, ill, and injured Servicemembers, their families, and the families of the fallen." Based on OIG's review of the publicly available financial statements, OIG calculated reasonable, comparable percentages as contained within the official biography. Additionally, OIG identified a dramatic increase in programs from 2008–2013. In conclusion, OIG found no physical or testimonial evidence to question the accuracy of the statements made in the VA Deputy Secretary's official biography. Thus, OIG did not make a recommendation to change the information in the Deputy Secretary's official biography.

Audit Finds Immediate Action Needed To Address Weaknesses in VA Drug-Free Workplace Program

OIG conducted an audit to assess how effectively VA's Drug-Free Workplace Program identifies and addresses illegal drug use among VA employees. VA needs to improve management of its Drug-Free Workplace Program.

VA selected about 3 of every 10 applicants for pre-employment drug testing before hiring these individuals into Testing Designated Positions (TDPs) in FY 2013. OIG estimates that of the nearly 22,600 individuals VA reported hiring into TDPs in FY 2013, approximately 15,800 were hired without a pre-employment drug test. VA facilities tested approximately 68 percent of the 3,420 employees selected for random drug testing in FY 2013. OIG identified at least 19,100 employees in TDPs who were not subject to the possibility of monthly random drug testing. In addition, VA erroneously designated as many as 13,200 employees in non-TDPs for drug testing in FY 2014. Further, only 17 of the 51 employees who tested positive for drugs (33 percent) as a result of reasonable suspicion of on-the-job drug use or after a workplace accident or injury were referred to VA's Employee Assistance Program. These issues occurred because VA does not support that all tentative selectees for TDPs need to be drug tested before being hired. VA also does not effectively monitor local facility compliance with random employee drug testing requirements. Furthermore, VA lacks adequate oversight to ensure the accuracy of drug testing data and that consistent personnel actions are taken when employees test positive for drugs. As a result, VA has little assurance that this program is performing as intended to identify and eliminate illegal drug use in its workforce. Since VA's workforce is expected to grow significantly with the passage of the *Veterans Access, Choice, and Accountability Act of 2014*, VA needs to take actions to address weaknesses in its Drug-Free Workplace Program immediately. OIG recommended the Deputy Assistant Secretary for Human Resources Management implement processes to ensure full compliance with VA's pre-employment applicant drug testing and random employee drug testing requirements, and improve program integrity by ensuring the accurate coding of employees in TDPs. The Acting Deputy Assistant Secretary for Human Resources Management concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions.

Independent Review of VA's FY 2014 Detailed Accounting Submission to the Office of National Drug Control Policy

OIG reviewed VA's FY 2014 Detailed Accounting Submission to the Director, Office of National Drug Control Policy (ONDCP), pursuant to *ONDCP Circular: Accounting of Drug Control Funding and Performance Summary* (the Circular), concerning its drug methodology, reprogrammings, and transfers, as well as its fund control notices. OIG conducted the review in accordance with attestation standards established by the American Institute of Certified Public Accountants and the applicable standards contained in Government Auditing Standards. An attestation review is substantially less in scope than an examination. The objective of an examination is the expression of an opinion on the assertions in the Submission. Accordingly, OIG does not express such an opinion. Based upon our review, except for the effects, if any, of the material weakness discussed in *Audit of VA's Financial Statements for FYs 2014 and 2013* (Report No. 14-01504-32, November 12, 2014), nothing came to our attention that caused us to believe that management's assertions were not fairly stated in all material respects based on the criteria set forth in the ONDCP circular. VA concurred with OIG's report without further comments.

Independent Review of VA's FY 2014 Performance Summary Report to ONDCP

OIG is required to review VA's FY 2014 Performance Summary Report to the Director, ONDCP, pursuant to the Circular, dated January 18, 2013, and as authorized by 21 U.S.C. § 1703(d)(7). The Performance Summary Report is the responsibility of VA's management and is included in the report as Attachment A (Patient Reported Abstinence) and Attachment B (Research and Development). OIG reviewed, according to the Circular's criteria and requirements, whether VA has a system to capture performance information accurately and whether that system was properly applied to generate the performance data reported in the Performance Summary Report. OIG also reviewed whether VA offered a reasonable explanation for failing to meet a performance target, for any recommendations concerning plans and schedules for meeting future targets, or for revising or eliminating performance targets. Furthermore, OIG reviewed whether the methodology described in the Performance Summary Report and used to establish performance targets for the current year is reasonable, given past

performance and available resources; and whether VA established at least one acceptable performance measure for each Drug Control Decision Unit, as defined by the Circular, for which a significant amount of obligations were incurred. Based upon OIG's review and the Circular's criteria, nothing came to our attention that caused us to believe VA does not have a system to capture performance information accurately or the system was not properly applied to generate the performance data reported in the Performance Summary Report. VA concurred with OIG's report.

Chief Financial Officers Act of 1990 Compliance

OIG contracted with an independent public accounting firm to audit VA's consolidated financial statements for FY 2014, 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. VA restated its FY 2013 financial statements for Cumulative Results of Operation and Unexpended Appropriations, although this had no effect on Total Net Position. As a result, the contractor replaced its FY 2013 auditor's report with its FY 2014 report on the restated financial statements. With respect to internal control, the contractor identified one material weakness, "IT Security Controls," which was a repeated condition. They also identified two significant deficiencies, "Financial Reporting" and "Accrued Operating Expenses." Additionally, the contractor reported that VA did not substantially comply with Federal financial management systems requirements and cited instances of noncompliance with Title 38 U.S. Code § 5315 and Title 31 U.S. Code § 3715, pertaining to the charging of interest and recovery of administrative costs. The contractor noted that VA was investigating two possible violations of the *Antideficiency Act*, P.L. 97–258, and is in the process of reporting two others. Three of these instances involved the combination of minor construction projects above the $10 million ceiling, beyond which congressional approval for use of funds is required. The contractor also referenced an OIG report issued in FY 2014 citing less than full compliance by VA 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 2014 assessment determines the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. The report and any findings will be reported in the SAR for the period ending September 30, 2015.

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 2014 consolidated financial statements reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. This condition was due to VA's complex, disjointed, and legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continued to be challenged in its efforts to apply consistent enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems. These difficulties contributed to the material weakness of "IT Security Controls" and the significant deficiency of "Financial Reporting" noted in the audit report for VA's FY 2014 consolidated financial statements.

Joint Reviews and Settlements

Sole-Source Contracts Inappropriately Awarded to Company Owned by Friends of Management at VA Technology Acquisition Center

OIG's investigation and review substantiated allegations relating to the award and administration of contracts to Tridec Technologies (Tridec) for the Virtual Office of Acquisition (VOA) software development project. The contracts, valued at more than $15 million, were awarded sole-source to Tridec by VA's Technology Acquisition Center utilizing the provisions of Title 38 U.S. Code § 8127. The review substantiated that VA management officials, one of whom had a personal relationship with one of Tridec's owners, split the requirements to ensure that Tridec was awarded the contracts without competition. Two former VA management officials, one of whom was a personal friend of one of Tridec's owners, engaged in lack of candor when interviewed by OIG Special Agents. A previous OIG audit substantiated allegations that VOA was not managed under the control and oversight of VA's Project Management Accountability System and was, in part, unnecessary.

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 155 cases; made 92 arrests; obtained over $500,000 in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $2.5 million in savings, efficiencies, and cost avoidance; and recovered more than $151,300.

During this reporting period, OIG opened 34 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 39 defendants were charged with various crimes relating to drug diversion. These investigations resulted in over $31,700 in court ordered payment of fines, restitution, penalties, and civil judgments; and over $548,000 in savings, efficiencies, cost avoidance, and recoveries.

OIG initiated seven investigations related to the fraudulent receipt of health benefits, which resulted in six defendants being charged with various related crimes. These investigations resulted in nearly $42,000 in fines, restitution, penalties, and civil judgments; and over $242,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OIG also initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, who grossly inflate reported mileage to and from VA facilities in order to increase reimbursement for travel expenses. During this reporting period, OIG opened four investigations. Also during this time, 12 defendants were charged, 13 others were convicted, and 7 defendants were incarcerated. The investigations resulted in over $73,000 in court ordered payment of fines, restitution, penalties, and civil judgments and $255,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OIG opened 41 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, 16 defendants were charged with crimes. The investigations resulted in over $130,000 in court ordered payments of fines, restitution, and penalties as well as nearly $1 million in savings, efficiencies, cost avoidance, and recoveries.

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

Former VISN 20 Northwest Network Employee Sentenced for Attempted Murder

A former VISN 20 employee was sentenced to 22 years' incarceration after pleading guilty to attempted murder, stalking, and assault. An OIG, VA Police Service, Federal Bureau of Investigation (FBI), and local sheriff's office investigation determined that the defendant shot her former supervisor, the VISN 20 Chief Financial Officer, twice in the abdomen with a handgun after entering VA office space.

Durable Medical Equipment Vendor Sentenced for Kickbacks

A Durable Medical Equipment (DME) vendor, who cooperated with the Government, was sentenced to 120 days' home confinement and 2 years' probation. An OIG investigation revealed that the defendant paid more than $71,000 in kickbacks to the former West Palm Beach, FL, VAMC Chief of Prosthetics and conspired with that employee to create fraudulent DME orders, which were never provided to veterans. For over 4 years, the defendant cultivated relationships within the Prosthetics Service to obtain over $2.2 million in DME orders. Additionally, the defendant conspired with the VA employee to create an orthotic shoe fitting business, in which

they agreed to split the profits. The loss to VA is approximately $143,019 for the fraudulent DME orders and $671,730 in overcharges for DME.

Former Director of the North Charleston, South Carolina, VA Consolidated Mail Outpatient Pharmacy Charged with Theft of Government Property

The former director of the North Charleston, SC, VA Consolidated Mail Outpatient Pharmacy was charged by the U.S. Attorney for the District of South Carolina with stealing prescription medications from VA.

Gainesville, Florida, VAMC RN Arrested for Fraudulently Acquiring Controlled Substances

A Gainesville, FL, VAMC RN was arrested for fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant removed meperidine and fentanyl from VA Pyxis machines and then used the diverted narcotics.

Former Palo Alto, California, VAMC Nurse Sentenced for Drug Diversion

A former Palo Alto, CA, VAMC RN was sentenced to 3 years' probation after pleading 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. The defendant diverted these syringes by using the doses that she claimed to have given to patients, logging into the automated dispensing system under the profiles of other nurses and withdrawing doses, or initiating false wasting entries under both her profile and those of the other nurses.

Gainesville, Florida, VAMC RN Enters into Pre-Trial Agreement

A Gainesville, FL, VAMC RN entered into a pre-trial intervention agreement after fraudulently acquiring controlled substances. The agreement included 18 months' probation and 50 hours' community service. An OIG investigation revealed that on multiple occasions the defendant removed hydromorphone from the medical center's Pyxis machines and diverted the narcotics for personal use.

Former VA Physician and a Veteran Arrested for Obtaining a Controlled Substance by Fraud

A former VA physician and a veteran were arrested for obtaining a controlled substance by fraud. An OIG and local police investigation revealed that the VA doctor treated the veteran for a period of time while a legitimate provider/patient relationship existed. However, the provider/patient relationship became personal, and after leaving VA employment, the doctor continued to prescribe controlled medications to the veteran using VA prescriptions. Both the doctor and the veteran received pills from the prescriptions that were filled at outside pharmacies. The doctor surrendered her medical license as a result of this investigation.

Long Beach, California, VAMC Pharmacist, Three Pharmacy Technicians, and a Distribution Supervisor Sentenced for Drug Theft

A Long Beach, CA, VAMC pharmacist, three pharmacy technicians, and a distribution supervisor were sentenced to 2 days' incarceration, 3 years' probation, 30 to 60 days' community service, and ordered to pay $150 in restitution after pleading guilty to computer access and fraud or receiving stolen property. An OIG investigation revealed that the defendants diverted non-controlled VA medications or knowingly received stolen VA medications. Since 2011, over 16,000 tablets of prescription medications were diverted from the pharmacy robots, and an unknown amount of medication was stolen from the pharmacy shelves or from the medication parcels that were returned to the VAMC in the mail. Subsequent to the investigation, nine pharmacy employees retired, resigned, or were terminated.

Former VA Contractor Sentenced for Drug Theft at Palo Alto, California, VAMC

A former VA contractor was sentenced to 30 days' incarceration and 2 years' probation after pleading guilty to burglary and possession of controlled substance paraphernalia. An OIG and VA Police Service investigation

revealed that the defendant stole sharps containers full of used syringes and mostly empty narcotic vials from the Palo Alto, CA, VAMC. The defendant used his position as an exterminator to convince VA employees to allow him access to a biohazard holding cage that contained sharps containers ready for disposal. A search of the defendant's work vehicle revealed approximately 20 gallons of used syringes and empty narcotic vials. The defendant admitted that he used syringes from the stolen sharps containers to inject himself with morphine and dilaudid.

University of California, Los Angeles, Anesthesiologist Charged with Theft of Government Property and Simple Possession

A University of California, Los Angeles (UCLA), anesthesiologist was charged with theft of Government property and simple possession of a controlled substance. A multi-agency investigation revealed that while completing a rotation at the West Los Angeles, CA, VAMC and providing anesthesia care to a veteran in surgery, the defendant collapsed due to sublingual ingestion of clonazepam and injection of multiple controlled substances.

Defendants Arrested for Possession with Intent to Distribute a Controlled Substance at the Bronx, New York, VAMC

A defendant was arrested for possession with intent to distribute a controlled substance for engaging in a conspiracy to distribute more than 5 kilograms of cocaine at the Bronx, NY, VAMC. The defendant was arrested at his residence, and a search of the defendant's vehicle revealed several hidden compartments utilized to transport contraband. A second subject was arrested in Puerto Rico for the same charge. Following the arrest, a search warrant was executed at a storage unit rented by the defendant, and approximately 1.2 kilograms of cocaine and approximately $30,000 in cash were seized. An OIG, U.S. Postal Inspection Service (USPIS), and Drug Enforcement Administration's (DEA's) New York Organized Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service (USPS) Priority Mail parcels containing 1 to 2 kilograms of cocaine each were mailed from Puerto Rico to the medical center warehouse. The first defendant would take possession of these packages from a VA employee and subsequently drive off station. Previously, two VAMC employees were arrested for their participation in this conspiracy.

Defendant Sentenced for Drug Distribution at Bedford, Massachusetts, VAMC

A defendant was sentenced to probation for 1 year and ordered to stay away from all VAMCs after pleading guilty to distribution of contraband narcotics. An OIG, DEA, and VA Police Service investigation determined that the defendant sold heroin to a confidential informant on five occasions, with four of those sales occurring at the Bedford, MA, VAMC. The defendant was arrested in the act of selling approximately 7.5 grams of heroin to the informant.

Veteran Arrested for Drug Distribution at Bedford, Massachusetts, VAMC

A veteran, who resided at the Bedford, MA, VAMC, was arrested for distribution of heroin after an OIG, Drug Enforcement Agency, and VA Police Service investigation determined that the defendant was selling illicit drugs to veterans receiving treatment for substance abuse. The investigation was initiated based on a history of illicit drugs being used at the VAMC, a history of drug overdoses, and concerns voiced by medical center staff.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 9 to 18 months' incarceration and 2 years' probation after pleading guilty to the delivery of heroin on VA property. The defendant was identified as the seller of heroin to another veteran on VA property during an OIG, VA Police Service, and county police investigation.

Veteran Sentenced for "Doctor Shopping"

A veteran was sentenced to between 6 and 23½ months' incarceration, 10 years' probation, and ordered to undergo substance abuse and mental health evaluations after pleading guilty to obtaining a controlled substance by misrepresentation, fraud, forgery or deception. An OIG and Pennsylvania Office of Attorney General investigation revealed that for 5 months the veteran received over 1,000 tablets of Schedule II Controlled Substances from both VA and non-VA sources.

Veteran Charged with "Doctor Shopping"

A veteran was charged with obtaining controlled substances by misrepresentation or fraud. A VA OIG and Health and Human Services (HHS) OIG investigation revealed that the defendant used one name as a veteran to obtain controlled substances from VA and another name to obtain controlled substances from a State of Florida Medicaid program. For approximately 2 years the defendant obtained 10,792 pills of Schedule II Controlled Substances from both VA and non-VA providers.

Veteran Arrested for "Doctor Shopping"

A veteran was arrested for obtaining a controlled substance by the concealment of a material fact. An OIG investigation revealed that for over 2 years the defendant obtained 16,335 methadone tablets from both VA and outside sources.

Bribery Charges Involving Palo Alto, California, VAMC Employees and Contractors Result in Judicial Actions

A former Palo Alto, CA, VAMC Contracting Officer Representative (COR) was sentenced to 16 months' incarceration, 3 years' probation, and a $25,000 fine after pleading guilty to bribery. An OIG and FBI investigation revealed that the defendant accepted approximately $16,500 in bribes that included cash, airline tickets, and having his credit card bill paid in exchange for ensuring that a VA contractor received continuous work. Another former Palo Alto, CA, VAMC COR was sentenced to 60 days' incarceration, 3 years' probation, and a $7,500 fine after pleading guilty to bribery. An OIG and FBI investigation revealed that the defendant accepted approximately $32,400 in bribes and gifts in exchange for ensuring that certain VA contractors received continuous work. Both of these defendants, a former VA contracting officer, and a former VA contractor were all charged with multiple offenses to include receipt of a bribe by a public official, bribery of a public official, false statements to a Government agency, conspiracy to commit money laundering, money laundering, and aiding and abetting. In a separate investigation, a VA contractor pled guilty to providing a gratuity to a VA contracting officer. An OIG and FBI investigation revealed that between 2008 and 2011 the contractor paid bribes and gratuities worth approximately $91,000 to a contracting officer and a COR. The gifts included cash, professional football tickets, Disneyland vacation packages, and a new F-150 truck. In exchange for the gifts, the contractor received VA contracts and task orders worth approximately $7.5 million.

Former Palo Alto, California, VAMC Engineer Indicted for Receiving Bribes

A former Palo Alto, CA, VAMC engineer was indicted for receiving an illegal gratuity by a public official. An OIG and FBI joint investigation revealed that while acting as a COR on a $1,488,802 MRI installation project, the defendant received $7,000 in cash from a VA sub-contractor. Additionally, the defendant received $9,230 of roofing work on his residence that was paid for by another VA contractor. After providing the illegal gratuities, the contractors received favorable treatment by VA.

Former Atlanta, Georgia, VAMC Physician's Assistant Indicted on Multiple Charges

A former Atlanta, GA, VAMC physician's assistant was indicted for conflict of interest, receipt of a gratuity by a public official, and conspiracy. An OIG investigation revealed that from July 2009 to January 2010 the defendant, while employed with VA, accepted $500 per month from a medical supply distributor to promote a

wound care product to fellow medical providers. The defendant placed a large number of orders for the same product, which were paid for by the medical center. The defendant did not disclose to anyone at the VAMC that she received compensation based on the sales of the medical product. Further investigation revealed that the defendant, on her personal computer, also compiled protected health information and PII from veteran patients she treated to compare the effectiveness of wound care treatment options while using the wound care product. The defendant subsequently resigned from VA and accepted a position with the manufacturer of the wound care product.

Houston, Texas, VAMC Contract Specialist Indicted for Misapplication of Fiduciary Property

A Houston, TX, VAMC contract specialist was indicted for misapplication of fiduciary property. A VA OIG and Small Business Administration (SBA) OIG investigation revealed that the defendant awarded an overpriced sole-source contract to her common-law husband's business. The contract is worth approximately $150,000.

Former Hampton, Virginia, VAMC RN Arrested for Abusive Sexual Contact

A former Hampton, VA, VAMC RN was arrested for abusive sexual contact. An OIG investigation revealed that while working in the ED the defendant sexually assaulted a patient.

Former Augusta, Georgia, Nurse Sentenced for Assault

A former Augusta, GA, VAMC nurse was sentenced to 12 months' probation and a $1,000 fine. The defendant also 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.

Husband of Portland, Oregon, VAMC Employee Arrested for Assault

The husband of a Portland, OR, VAMC employee was arrested for assault. An OIG and VA Police Service investigation revealed that the defendant assaulted his wife in the VAMC parking lot. The employee was hospitalized as a result of her injuries.

Las Vegas, Nevada, VAMC Employee Sentenced for Coercion and Enticement

A Las Vegas, NV, VAMC employee was sentenced to 120 months' incarceration and lifetime supervised release after being convicted at trial of coercion and enticement. An OIG and local police investigation revealed that the defendant used VA computers to post advertisements on Craigslist seeking a sexual relationship with a young girl. The employee corresponded with an undercover officer whom he believed was a 14-year-old girl and was subsequently arrested when he arrived at a prearranged location for a meeting with the girl.

Washington, DC, VAMC Employee Arrested for Threats of Bodily Harm

A Washington, DC, VAMC employee was arrested for threatening to bring weapons into the medical center and "become an emerging threat."

North Little Rock, Arkansas, VAMC Employees Prosecuted for Threats to Federal Officials

A VA employee was indicted for making threats against a Federal official. An OIG investigation disclosed that the defendant threatened to kill VA employees and also referenced going on a mass shooting spree at the Central Arkansas Veterans HCS facility in North Little Rock, AR. The defendant is currently being held without bond. A second North Little Rock, AR, VAMC employee, who is also a veteran, was convicted at trial of making threats against a Federal official and threats by interstate communications. An OIG investigation disclosed that the defendant contacted the VAMC and threatened to kill his supervisor. The defendant initially stated that he had a gun and that he had waited for his supervisor to come outside the VAMC. The defendant left and then made the threat to return and kill his supervisor. The defendant is currently being held pending a sentencing hearing.

Veteran Indicted for Abusive Sexual Contact of Portland, Oregon, VAMC Nursing Assistant

A veteran was indicted for abusive sexual contact. An OIG investigation determined that while the veteran was an inpatient at the Portland, OR, VAMC, he groped a VA certified nursing assistant (CNA) while she was performing her duties. The defendant, a registered sex offender, admitted that he had previously assaulted other nurses in a similar manner.

Veteran Sentenced for Firing a Weapon at the VA Lubbock, Texas, Outpatient Clinic

A veteran was sentenced to 18 months' incarceration (suspended), 5 years' probation, 120 hours' community service, and ordered to pay VA restitution of $3,352 after pleading guilty to criminal mischief. Also, the veteran is now classified as a convicted felon and is prohibited from possessing firearms. An OIG and local police investigation revealed that the defendant discharged a firearm into the VA Lubbock, TX, Outpatient Clinic and then fired again once inside the clinic causing additional damage to the property.

Philadelphia, Pennsylvania, CNA Charged with Theft of Government Funds

A CNA, who had worked for a contractor providing services to the Philadelphia, PA, VAMC, was charged with theft of Government funds. An OIG investigation revealed that the defendant billed the contractor for hours in which services were not performed. The loss to VA is $64,377.

Former Northport, New York, VAMC IT Specialist Sentenced for Illicit Salary Supplementation

A former Northport, NY, VAMC IT Specialist was sentenced to 1 year of probation and ordered to pay a $250 fine after pleading guilty to 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 medical center. The gifts were paid to the defendant because of a long standing relationship he developed with the contractor and not for any specific act.

Long Beach, California, VAMC Employee Sentenced for VA Pension Benefit Fraud

A veteran and former full-time Long Beach, CA, VAMC employee was sentenced to 12 months' home confinement, 3 years' probation, and ordered to pay $60,746 in restitution. An OIG investigation revealed that while employed by VA the defendant applied for and received VA pension benefits which are limited to low income veterans. The defendant failed to disclose that between 2007 and 2011 he had earned approximately $155,000 in wages from VA. The employee resigned in lieu of termination.

Former Dublin, Georgia, VAMC Nurse Sentenced for Fraud

A former Dublin, GA, VAMC nurse was sentenced to 60 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $454,740 after pleading guilty to mail fraud. A VA OIG and Department of Labor (DOL) OIG investigation revealed that the defendant made over 200 false claims for mileage and medical cost reimbursements associated with a workers' compensation claim.

Birmingham, Alabama, VAMC Union President Arrested for Embezzlement

A Birmingham, AL, VAMC employee, who served as president of the American Federation of Government Employees (AFGE) union, was indicted and arrested for bank fraud and other charges. A VA OIG, DOL OIG, and DOL Office of Labor-Management Standards investigation revealed that the defendant embezzled more than $132,000 from the local AFGE chapter.

Former Palo Alto, California, VAMC Employee Sentenced for Conspiracy and Fraud

A defendant was sentenced to 24 months' incarceration, 5 years' probation, and ordered to pay over $3,000 in restitution after pleading guilty to conspiracy and fraud in connection with identification information. An OIG

and VA Police Service investigation revealed that a Palo Alto, CA, VAMC employee and three other defendants conspired to steal personal identification of another VAMC employee and use that information to create unauthorized credit card accounts and counterfeit checks. The defendants then used the credit card accounts and checks to make purchases at various retail stores. The items purchased at the stores were either sold or traded for narcotics.

Veteran and Sister Indicted for Fraud and False Statements

A veteran and his sister were indicted for wire fraud, mail fraud, and making false statements. A multi-agency investigation revealed that the defendants provided false statements to VA regarding the veteran's eligibility for the VA Care Giver Support Program. The loss to VA is approximately $85,000.

Non-Veteran Arrested for Health Care Fraud

A non-veteran was indicted and subsequently arrested for health care fraud. The defendant falsely claimed to have served in the Army National Guard from 1996 to 2010, to have suffered from post-traumatic stress disorder (PTSD), and to have served in combat during two tours in Afghanistan. An OIG investigation revealed that the defendant never served in the military and was incarcerated during the same time period that she claimed to have been in the military. For over 2 years, the defendant received over $20,000 in VA health care benefits in addition to non-VA care paid by VA. The defendant also received more than 10,000 milligrams of oxycodone from VA. During the investigation, the defendant fled to New Mexico, where she was apprehended by the U.S. Marshals Service.

Non-Veteran Sentenced for Health Care Fraud

A Roseburg, OR, VAMC outpatient was sentenced to 60 months' probation after pleading guilty to health care fraud. An OIG investigation determined that the defendant fraudulently received travel benefits, Department of Housing and Urban Development (HUD) and VA's Supportive Housing, and health care from the medical center. The defendant initially falsified his application for VA health care benefits in 2002 and continued to apply for and receive additional VA benefits until 2012. The loss to VA is approximately $32,000.

Non-Veteran Sentenced for "Stolen Valor" Fraud

A non-veteran was sentenced to 18 months' incarceration and ordered to pay VA $31,696 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant fraudulently claimed to be a Marine Corps veteran with service in Vietnam in order to receive VA health care benefits.

Former Seattle, Washington, VAMC Employee Pleads Guilty to VA Travel Benefit Fraud

A former Seattle, WA, VAMC employee, who is also a veteran, pled guilty to submitting false statements to the Government. An OIG investigation determined that the defendant submitted false travel benefit claims for himself and his wife while he was working as a VA travel clerk.

Seven Veterans Indicted for VA Beneficiary Travel Fraud at the West Palm Beach, Florida, VAMC

Seven veterans were indicted 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.

Five Veterans Sentenced for Travel Benefit Fraud at Mountain Home, Tennessee, VAMC

Five veterans were sentenced to various periods of incarceration, supervised release, and ordered to pay VA restitution of between $1,187 and $7,594 after pleading guilty to theft of public money. An OIG and VA Police

Service investigation revealed that the defendants submitted fraudulent travel vouchers to the Mountain Home, TN, VAMC claiming an inflated distance of travel.

Veteran Indicted for Travel Benefit Fraud at Detroit, Michigan, VAMC

A veteran was indicted for false statements and theft. An OIG investigation determined that the defendant submitted false travel reimbursement claims indicating that he traveled in excess of 4 hours to the Detroit, MI, VAMC for appointments. The loss to VA is $33,000.

Veteran Sentenced for Travel Benefit Fraud at Marion, Illinois, VAMC

A veteran was sentenced to 60 days' incarceration, 3 years' supervised release, and ordered to pay restitution of $20,147. An OIG investigation revealed that the defendant received beneficiary travel pay based on travel from a fraudulent address in Kentucky to the Marion, IL, VAMC. The investigation further determined that the defendant resided in Marion, IL. The loss to VA is $20,147.

Veteran Arrested for Travel Benefit Fraud Submitted to Asheville, North Carolina, VAMC

A veteran was arrested for false, fictitious, or fraudulent claims. This defendant is one of 13 veterans charged with submitting fraudulent travel claims to the Asheville, NC, VAMC for travel benefits to which they were not entitled by exaggerating the distance they traveled to receive care. The loss to VA in these cases is approximately $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 237 investigations, which resulted in 19 arrests and $4.25 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,106 possible cases with over 3,745 investigative cases opened. Investigations have resulted in the actual recovery of $82.45 million, with an additional $27.7 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $177.7 million. To date, there have been 701 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 343 cases; made 76 arrests; obtained over $4.9 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $9.7 million in savings, efficiencies, and cost avoidance; and recovered more than $5.6 million. Three hundred ten 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 55 defendants for these types of investigations. OIG obtained over $4.4 million in court ordered payment of fines, restitution, and penalties and achieved an additional $15 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 State of Maryland VA Employee Sentenced for Extortion

A former State of Maryland VA employee was sentenced to 366 days' incarceration and ordered to pay $1,284,399 after pleading guilty to extortion under the "*Hobbs Act*." From 2003 to 2011, while working at the State of 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. An OIG investigation revealed that the defendant 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, were insulin dependent, and the fraudulent DD-215s were used as proof of service in Vietnam. The State employee also filed a fraudulent DD-215 form to increase his own disability rating. A total of 17 veterans received compensation benefits using the fraudulent forms. The loss to VA is $1,151,219. The defendant also assisted the veterans in receiving $255,555 in property tax waivers from the State that they were not entitled to receive.

VA-Appointed Fiduciary Pleads Guilty to Theft of Government Funds

A VA-appointed fiduciary for an incompetent veteran pled guilty to theft of Government funds. An OIG investigation determined that the fiduciary misappropriated over $89,636 in VA funds.

Former VA Fiduciary Arrested for Theft and Misappropriation

A former VA fiduciary was arrested for theft of Government funds and misappropriation by a Federal fiduciary. An OIG investigation revealed that for over 5 years the defendant stole approximately $141,000 from 22 veterans, using excessive "fiduciary fees" and her sham company to justify the excessive expenses.

Former VA-Appointed Fiduciary Sentenced for Embezzlement

A former VA-appointed fiduciary was sentenced to 5 years' supervised probation and ordered to pay VA restitution of $30,240 after pleading guilty to embezzlement. An OIG investigation revealed that the defendant, as the fiduciary, failed to notify VA that a widow beneficiary had died. The defendant subsequently received and negotiated VA benefit checks issued after the beneficiary's death in April 2009 and used the funds for personal expenses.

Former VA-Appointed Fiduciary Arrested for Theft

A former VA-appointed fiduciary was arrested for aggravated theft and criminal mistreatment. An OIG and local sheriff's office investigation revealed that the fiduciary misused the accounts of two veterans as well as numerous other non-veterans for personal gain. The loss to VA is $36,378.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 5 years' probation, 48 hours' community service, and ordered to pay restitution of $41,086 after pleading guilty to theft by deception. An OIG investigation determined that the defendant, a fiduciary for his veteran brother, embezzled VA funds and used the money for gambling and other personal expenses.

Veteran Sentenced for "Stolen Valor" Fraud

A veteran was sentenced to 24 months' incarceration, 3 years' supervised probation, and ordered to pay VA restitution of $503,298 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant, a retired state trooper, 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 PTSD. The investigation also revealed that the defendant was "doctor shopping" from approximately January 2010 to August 2012.

Veteran and Spouse Arrested for Compensation Fraud

A veteran and his spouse were arrested for wire fraud, mail fraud, and conspiracy for fraudulently receiving VA and Workers' Compensation benefits. A VA OIG, USPS OIG, and DOL OIG investigation revealed that, although the veteran claimed to be paralyzed, he was observed walking, riding a bike, and cutting trees with a chain saw. The defendant only utilized a wheelchair when attending his VA medical appointments and a cane when attending his USPS and DOL exams. The veteran's wife is accused of assisting her husband with his deception. The loss to VA is approximately $700,000, and the loss to the USPS is approximately $300,000.

Widow of Deceased Veteran Sentenced for VA Compensation Fraud

The widow of a deceased veteran was sentenced to 14 months' probation, 8 months' home detention, ordered to pay $62,142 in restitution, and undergo MH treatment. An OIG investigation determined that the defendant failed to notify VA of her February 2007 remarriage and continued to receive Dependency and Indemnity Compensation (DIC) she was no longer entitled to receive.

Veteran Convicted of VA Compensation Fraud

A veteran was found guilty at trial of wire fraud and theft of Government funds. An OIG investigation revealed that the veteran submitted an additional claim to VA for disability benefits, falsely claiming exposure to Agent Orange while serving in Vietnam for 2 months in 1965. The veteran was subsequently awarded 100 percent disability with individual unemployability. The investigation further determined that the veteran's only overseas duty was in Germany. The loss to VA is $456,649.

Veteran Pleads Guilty to VA Compensation Fraud

A veteran pled guilty to theft of public money after an OIG investigation revealed that he fraudulently received VA compensation benefits based on an altered DD-214 that he falsified in 1970 by claiming multiple combat awards, including two Purple Hearts and a Silver Star. Approximately 30 years later, the defendant submitted a fraudulent application to VA seeking compensation for PTSD and shell fragment wounds. The defendant claimed to have participated in hand-to-hand combat and sustained bayonet wounds, a gunshot wound, and shrapnel wounds. The defendant claimed on VA forms and in discussions with VA physicians that he had survived these battle wounds and that he had killed numerous enemy combatants. Through a review of records, witness interviews, and the defendant's own admissions, OIG's investigation determined that the defendant did not receive any combat awards and did not suffer any combat injuries while in Vietnam. Also, the investigation determined that his scars were not related to injuries suffered in combat. From approximately October 1999 through July 2014, the defendant received $174,656 in VA funds to which he was not entitled.

Veteran Pleads Guilty to VA Compensation Fraud

A veteran pled guilty to forging military discharge certificates after an OIG investigation revealed that he received VA disability compensation by using an altered DD-214 that falsely claimed he had incurred injuries stemming from his service in Vietnam and that he had received a Purple Heart as well as a Vietnam Gallantry Cross. Although the defendant was enlisted in the Navy during that era, he was never injured, never served in a combat role, and never deployed to Vietnam. The loss to VA is $101,367.

Veteran's Compensation Reduced After OIG Investigation

An OIG investigation revealed that a veteran was receiving VA disability compensation for multiple sclerosis based on false documents he submitted beginning in 1989 that exaggerated the nature and extent of his disability. The investigation further revealed that the veteran was incarcerated prior to and after conviction for state charges of kidnapping and armed robbery. The veteran never complained about nor had any symptoms related to his alleged disability while incarcerated. Due to the lengthy state sentence of 12 years, the U.S. Attorney's Office declined prosecution of the VA fraud. VBA reviewed the veteran's claims based on this investigation, and, as a result, the veteran was re-rated and an overpayment of $1,248,251 was established.

Veteran Pleads Guilty To Making False Statements

A veteran pled guilty to making false statements in connection with VA compensation claims that he submitted to a VARO. An OIG investigation revealed that the defendant submitted more than 90 fraudulent forms for 21 different veterans without their knowledge or consent. The defendant forged each veteran's signature and falsely stated that each veteran suffered from various medical conditions.

Veteran Sentenced for Fraudulent Acceptance of Payments

A veteran was sentenced to 5 years' probation and ordered to pay VA restitution of $61,000 after pleading guilty to the fraudulent acceptance of payments. An OIG investigation revealed that since 2003 the defendant had been collecting individual unemployability benefits while he was employed as a full-time security officer.

Niece of Deceased VA Beneficiary Sentenced for Theft

The niece of a deceased DIC beneficiary was sentenced to 6 months' incarceration, 60 months' probation, 100 hours' community service, and ordered to pay VA $112,064 in restitution. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant withdrew VA funds from a joint account after her aunt's death in October 2005.

Son of a Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The son of a deceased VA beneficiary pled guilty to theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA DIC and SSA benefits that were direct deposited after his mother's death in December 2009. The loss to VA is $61,548, and the loss to SSA is approximately $36,000.

Daughters of Deceased VA Beneficiaries Arrested for Theft of VA Benefits

The daughter of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in July 2005. The loss to VA is $133,924. Another daughter of a deceased beneficiary was arrested for theft of Government funds. An OIG investigation determined that the defendant stole VA funds that were direct deposited into a joint bank account after her mother's death in September 2005. The defendant admitted to stealing the funds and using them for personal expenses. The loss to VA is $63,197.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased VA beneficiary was indicted and arrested for theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in December 2008. The loss to VA is $84,029.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased DIC beneficiary was sentenced to 5 months' incarceration, 2 years' supervised release, and ordered to pay VA $90,600 in restitution after pleading guilty to theft of Government funds. The defendant was also ordered to participate in a substance abuse treatment program. An OIG investigation revealed that the defendant failed to notify VA of her mother's death in December 2007 and then stole VA benefits that were direct deposited to a joint account.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated 41 VA benefit checks and stole VA funds from 14 direct deposits that were issued after her mother's death in October 2009. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA to make it appear her mother was still alive in order to continue to receive the VA benefits. The loss to VA is $78,939.

Widower of a Deceased VA Beneficiary Sentenced for Theft

The widower of a deceased VA beneficiary was sentenced to 5 months' incarceration, 5 months' home confinement, 36 months' probation, and ordered to pay VA restitution of $75,815 after pleading guilty to theft of public funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to a joint account after his wife's death in July 2004 and used the money for personal expenses.

Veteran Arrested for Theft of Government Funds

A veteran was arrested for theft of Government funds. An OIG and SSA investigation revealed that the defendant filed fraudulent VA and SSA documents reporting that his 103-year-old mother was still alive. Following the execution of multiple search warrants, agents learned that the defendant likely disposed of his mother's body in an unmarked grave in the 1980's; however, her remains have not yet been located. The loss to VA is approximately $370,000, and the loss to SSA is approximately $114,000.

Business Owner Arrested for Theft of VA Funds

A business owner was sentenced to 5 months' incarceration, 3 years' probation, and ordered to pay VA $116,000 in restitution. 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.

Widow Arrested for Theft and False Statements

A widow was arrested for theft of Government funds and false statements after an OIG investigation determined that the defendant, while receiving widow's pension benefits, failed to report her re-marriage and provided false statements to VA in order to continue to fraudulently receive the benefits. The loss to VA is $55,894.

Veteran Pleads Guilty to Theft and Identity Fraud

A veteran pled guilty to theft of Government funds and aggravated identity fraud after obtaining fraudulent benefits from VA and SSA. A VA OIG and SSA OIG investigation revealed that the defendant had been collecting Individual Unemployment benefits since 1997 because of his fraudulent reporting of severe disabilities to VA and SSA. During this time, the defendant was working as a golf professional, pastor, and car salesman in multiple states. The aggravated identity charge was a result of the defendant working and purchasing vehicles using other individuals' personal information in an attempt to hide his employment history from VA. The loss to VA is approximately $365,000, and the loss to SSA is approximately $407,000.

Veteran Sentenced for Making False Statements

A veteran was sentenced to 180 days' home confinement, 2 years' probation (including MH treatment), and ordered to pay restitution of $63,041 to VA and $83,188 to SSA after pleading guilty to making a false statement. A VA OIG and SSA OIG investigation revealed that the defendant falsely claimed to VA and SSA that he was not employed when in actuality he was working full-time earning substantial income.

Veteran and Non-Veteran Co-Conspirator Arrested for VA Education Fraud

A veteran and non-veteran co-conspirator were indicted and arrested for conspiracy to defraud the Government, theft of Government funds, and mail fraud. An OIG investigation revealed the defendants fraudulently received Chapter 33 VA education benefits and also assisted other veterans in receiving VA educational benefits that they were not entitled to receive. The loss to VA is approximately $108,000.

Veteran Pleads Guilty to Theft of VA Education Benefits

A veteran pled guilty to theft of Government funds after an OIG investigation revealed that he falsely claimed to be attending school at a local community college. In fact, the defendant was overseas for much of the time that he was supposed to be attending classes. The defendant made these fraudulent claims in order to obtain

Post 9/11 GI Bill benefits and carried out his scheme by obtaining and submitting VBA documentation used by schools to certify enrollment. The loss to VA is $75,955.

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. During this reporting period, in the area of procurement practices, OIG opened 19 cases and made 19 arrests. These investigations resulted in $5.7 million in court ordered payment of fines, restitution, penalties, and civil judgments; and $255,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

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 information management crimes, OIG made one arrest and involving more than $1,600 in fines, restitution, penalties, and civil judgments; and over $39,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Convicted of Service-Disabled Veteran-Owned Small Business Fraud

A veteran, who is not service-disabled, was convicted at trial of wire fraud for circumventing the procurement set-aside rules used to award a patient transportation contract as a Service-Disabled Veteran-Owned Small Business (SDVOSB). As a result, the company fraudulently received more than $3.2 million from VA. An OIG investigation determined that the defendant obtained the contract by falsely claiming that another veteran, who is service-disabled, was the majority owner/operator of the company instead of the defendant. Additionally, due to the poor execution of the contract, patients were endangered; in fact, one was seriously injured.

OIG SDVOSB Fraud Investigation Leads to Prison Time for San Antonio, Texas, Businessman

A veteran was sentenced to 366 days' incarceration, 3 years' supervised release, and ordered to pay restitution of $1,494,000 after pleading guilty to wire fraud. A VA OIG and SBA OIG investigation revealed that the defendant fraudulently claimed to be the owner of an SDVOSB in order to qualify for and obtain VA SDVOSB set-aside contracts for architectural and engineering services. The defendant did not have a service-connected disability and had previously been denied VA benefits. Additionally, the defendant submitted documents containing false information regarding employees and past projects. The defendant, his wife, and 20 of their affiliated companies have been suspended and debarment has been proposed.

Defendant and Contractor Sentenced for SDVOSB Fraud

A VA contractor was sentenced to 2 years' probation, with up to 180 days in a residential reentry program, and a contracting firm was sentenced to 2 years' probation. Both contractors were also ordered to forfeit $3,352,510 (jointly) after pleading guilty to major program fraud. A VA OIG, General Services Administration (GSA) OIG, SBA OIG, Defense Criminal Investigative Service (DCIS), and Federal Deposit Insurance Corporation OIG investigation revealed that the defendant and another contractor secured approximately $23.5 million in SDVOSB set-aside and sole-source contracts under the guise of a legitimate SDVOSB business when the business was actually a pass-through company.

$1.3 Million Civil Settlement Between U.S. Department of Justice and Construction Company That Claimed SDVOSB Status

A civil settlement was reached between a U.S. Attorney's Office and Veteran Construction Associates concerning allegations of SDVOSB fraud. The $1.3 million settlement represented fraudulently obtained profits and additional civil-imposed penalties. An OIG investigation revealed a "rent-a-vet" scheme in which the veteran

was a full-time state employee during much of the time he and his co-conspirators claimed the veteran to be the full-time owner of the SDVOSB.

Five Defendants Sentenced for SDVOSB Fraud

Five defendants involved in an SDVOSB scheme were sentenced to terms of between 27 to 56 months' incarceration, home confinement, fines, assessments, and joint restitution of $267,697. Debarment of the defendants and the company involved in this case is pending. A VA OIG, DOL OIG, DCIS, Department of Homeland Security OIG, and HUD OIG investigation determined that the company's owner was not a service-disabled veteran and had obtained various Federal contracts under a set-aside SDVOSB solicitation. The VA contract involved was valued at $50,000.

Son of Disabled Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft Relating to SDVOSB Fraud

The son of a disabled veteran was indicted for theft of Government funds and aggravated identity theft. A VA OIG, Army Criminal Investigation Command, DCIS, GSA OIG, SSA OIG, and SBA OIG investigation revealed that the defendant, using two separate businesses, obtained 15 SDVOSB contracts by using his father's identity and military records without his father's knowledge or consent. As a result, the defendant was awarded 5 VA contracts and 10 U.S. Army and Air Force contracts totaling $2.7 million.

Contractor Sentenced for SDVOSB Fraud

The president and owner of a company providing office supplies and furniture to VA was sentenced to 8 months' home confinement, 2 years' supervised release, and ordered to pay VA restitution of $100,000 after pleading guilty to making false claims. An OIG investigation revealed that for a number of years the defendant represented to VA that her company was an SDVOSB by claiming her father-in-law was the service-disabled owner and operator of the business. In fact, her father-in-law was not service-disabled and never owned or operated the business.

VA Contractor Ordered To Pay Restitution

A VA contractor was ordered to pay $108,199,452 in restitution. The defendant was previously sentenced to 20 years' incarceration and 3 years' supervised release after pleading guilty to wire fraud. An OIG investigation revealed that the defendant, who had a contract to supply latex gloves to VA, accepted more than $150 million from investors who believed they were financing his VA contracts. In reality, sales to VA were 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 Government is also pursuing forfeiture of 11 real properties in which the defendant has a partial ownership interest; 2 apartment buildings; 2 vehicles; and the cash value and proceeds from 20 bank accounts, 3 insurance policies, numerous seized checks, and money orders. The Government is also pursuing any tax liabilities that may be owed by the defendant.

Daiichi Sankyo, Inc. Agrees To Pay $39 Million To Resolve Civil Allegations

Daiichi Sankyo, Inc., a global pharmaceutical company, has agreed to pay the United States and state Medicaid programs $39 million to resolve civil allegations under the *False Claims Act*. A VA OIG, FBI, DCIS, and HHS OIG investigation revealed that the company was paying kickbacks in the form of honoraria payments, meals, and other remuneration to physicians who participated in speaker programs from January 2004 to March 2011. The VA's portion of the total damages is $547,206.

Company Reaches Civil Settlement of $44.5 Million with Federal Government

A records and data management company reached a civil settlement of $44.5 million with the Federal government for violation of the *False Claims Act*. The agreement resulted from a multiple agency investigation into allegations that the company overcharged Federal agencies for record storage services under several GSA

contracts. The company overcharges included mischarging for shelf space, failing to provide GSA with accurate information about the company's commercial sales practices, and failing to comply with the price reduction clause of the GSA contracts. The VA contracts were for approximately $12 million.

Former Dell Contractor Sentenced for Theft of Government Property

A former Dell contractor assigned to the Jackson, MS, VAMC was sentenced to 4 months' incarceration, 3 years' supervised probation, 3 months' community confinement, and ordered to pay $3,886 in restitution after pleading guilty to theft of Government property. An OIG investigation revealed that the defendant used his position to steal and then sell VA computers. As a result of the investigation, stolen VA computer workstations and stolen VA laptop computers were recovered.

Fourteen Defendants Indicted for Involvement with Nationwide Fungal Meningitis Outbreak

Fourteen defendants were arrested after being indicted for their involvement in the 2012 nationwide fungal meningitis outbreak. An OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, FBI, DCIS, and USPIS investigation revealed that the outbreak was caused by contaminated vials of methylprednisolone acetate (MPA) manufactured by the New England Compounding Center (NECC). Sixty-four patients who received the contaminated doses died and almost 700 others were diagnosed with a fungal infection. VA purchased several products from NECC, including MPA, but no VA patients were affected. It is alleged that all NECC products were falsely represented to NECC customers, including VA. The owner and head pharmacist were each charged with second-degree murder, and the 12 other defendants, all associated with NECC, were indicted on charges to include racketeering, mail fraud, conspiracy, contempt, structuring, and violations of the *Food, Drug, and Cosmetic Act*. In addition to the contaminated vials of MPA, the indictment alleges that NECC's employees knowingly made and sold numerous drugs in a similar unsafe manner and in unsanitary conditions. Also, the investigation determined that NECC repeatedly took steps to shield its operations from regulatory FDA oversight by claiming to be a pharmacy dispensing drugs pursuant to valid, patient-specific prescriptions when, in fact, NECC routinely dispensed drugs in bulk without valid prescriptions.

Veteran's Spouse Arrested for Attempted First Degree Murder

The spouse of a veteran was arrested for attempted first degree murder. An OIG and local sheriff's office investigation revealed that for several years the defendant attempted to murder the veteran by poisoning him. The poisoning resulted in the veteran receiving treatment on several occasions at the Mountain Home, TN, VAMC for life-threatening issues. The defendant subsequently shot the veteran in the back leaving him paralyzed. Due to the OIG poisoning investigation, premeditation was able to be shown which enhanced the charge from attempted second degree murder to attempted first degree murder.

Veteran Sentenced for Fraud

A veteran was sentenced to 10 years' incarceration, 3 years' supervised release, and ordered to pay $7,280,253 in restitution after pleading guilty to wire fraud, aggravated identity theft, and filing a false tax return. A multi-agency investigation revealed that from 2007 to 2013 the defendant created a series of fraudulent charter schools in order to receive approximately $30 million in surplus government computer equipment under a GSA program, which included computers from VA facilities located in multiple states. The loss to VA is $1,932,070.

Personal Care Home Owner Pleads Guilty to Theft

The owner of a personal care home pled guilty to theft. 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 into a joint account. The approximate loss to VA is $258,000.

Co-Conspirator Sentenced for Conspiracy, Forgery, and Identity Theft

A fourth and final co-conspirator was sentenced to 46 months' incarceration, 3 years' probation, and ordered to pay $128,320 in restitution after pleading guilty to conspiracy to pass forged U.S. Treasury checks, forged securities, and identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant and co-conspirators stole the identities of numerous individuals, filed fraudulent tax returns, and forged and negotiated VA benefit checks.

Contract Employee Pleads Guilty to Identity Theft Involving Tampa, Florida, VAMC Medical Records

A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents pled guilty to access device fraud and aggravated identity theft. A multi-agency 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.

Non-Veteran Sentenced for Identity Theft and Conspiracy To Obtain Property by False Pretenses

A non-veteran was sentenced to 15 to 18 months' incarceration after pleading guilty to identity theft and conspiracy to obtain property by false pretenses. An OIG and local law enforcement investigation revealed that the defendant used 26 victims' identities, 13 of whom were veterans, to fraudulently open more than 150 cable accounts and then sell those accounts.

Kaplan University Employee Arrested for Possession of Unauthorized Access Devices and Aggravated Identity Theft

A Kaplan University employee was arrested for possession of unauthorized access devices and aggravated identity theft. An OIG, FBI, and Internal Revenue Service Task Force investigation revealed that the defendant stole veterans' and military service members' identities that he obtained while overseeing VA education benefits at Kaplan University. During the investigation, undercover law enforcement personnel purchased VA and Kaplan documents containing identity information for 195 veterans who either attended or applied to Kaplan University and later seized similar documents for another 147 veterans during the execution of a search warrant. Also, a second defendant was sentenced to 51 months' incarceration and 3 years' supervised release for using a veteran's identity that she obtained from the Kaplan University employee.

Non-Veteran Pleads Guilty to Identity Theft

A non-veteran pled guilty to identity theft. An OIG and state police investigation revealed that the defendant used his veteran brother's identity to obtain controlled substances, health care, and beneficiary travel payments from the Louisville, KY, VAMC. The loss to VA is $20,567.

Veteran Sentenced for Identity Fraud

A veteran was sentenced to 18 months' incarceration, 36 months' supervised release, 100 hours' community service, and ordered to pay VA $550,849 in restitution. An OIG and Bureau of Diplomatic Security Service investigation revealed that the defendant fraudulently enlisted in the U.S. Army using his cousin's identity after being discharged and barred from re-enlistment under his true identity. The defendant admitted to using his cousin's identity in order to fraudulently re-enlist and obtain VA compensation, education, and medical benefits. The loss to VA is $1,441,470.

Two Non-Veterans Plead Guilty to Fraud and Identity Theft

Two non-veterans pled guilty to various fraud and identity theft charges. An OIG, Internal Revenue Service Criminal Investigations Division, and local sheriff's office investigation revealed that the defendants used veteran's stolen PII to commit tax fraud in excess of $610,000.

Non-Veteran Indicted for Identity Theft

A non-veteran was indicted for possession of 15 or more access devices and aggravated identity theft. An OIG and local police investigation revealed that the defendant had involvement in an extensive identity theft fraud scheme, obtained a Florida driver's license using a veteran's identity, and received medical treatment at the Miami, FL, VAMC while using the same identity. The defendant also used the veteran's identity to obtain VA medical treatment in Ohio. The loss to VA is approximately $2,000.

Non-Veteran Arrested for Forgery and Identity Theft

A non-veteran was arrested for forgery and identity theft. An OIG and local police investigation revealed that the defendant provided false local court documents to VA that named the defendant as a court-appointed guardian for a veteran. The documents included false court orders, as well as forged medical reports from doctors.

Former Chief Executive Officer of a Non-Profit Company Indicted for Obstruction of an Audit

A former Chief Executive Officer of a non-profit company was indicted for obstruction of an audit. An OIG investigation revealed that the defendant made false representations by inflating the value of property when applying for a grant to provide funds for the purchase of property to be used to house indigent veterans. Six days after the purchase of the property the non-profit company received a $50,000 kickback from the seller.

Ex-Husband of Personal Care Home Owner Sentenced for Theft of Government Funds

The ex-husband of a personal care home owner was sentenced to 27 months' incarceration, 3 years' supervised release, and ordered to pay $400,417 in restitution ($258,045 to VA and $142,372 to SSA). A VA OIG and SSA OIG investigation revealed that the defendant's ex-wife owned and operated a personal care home where a veteran beneficiary resided. Prior to the veteran's death, the defendant opened a joint account with the veteran and arranged for the VA and SSA benefits to be deposited into the joint account. The defendant then stole VA and SSA funds that were deposited after the veteran's death in November 1997. In 2007, the defendant opened a second joint account in the deceased veteran's name in an effort to profit from the interest earned from the stolen VA and SSA funds.

Former Home Health Aide Sentenced for Theft

A former home health aide, employed by a company contracted by VA to provide home health care services to a blind veteran, was sentenced to 6 months' incarceration, 3 years' probation, and ordered to pay $7,330 to the contractor after pleading guilty to the theft of funds from the veteran's account. The contractor had previously reimbursed the veteran. During an OIG investigation, the defendant confessed that she accessed the veteran's bank account and embezzled money without the veteran's knowledge.

Veteran's Daughter and Her Boyfriend Sentenced for Theft

The daughter of a veteran was sentenced to 9 months' incarceration, and her boyfriend was sentenced to 20 days' incarceration after pleading guilty to theft. The defendants were also ordered to pay VA $25,423 in restitution. An OIG investigation revealed that the defendants contacted a VA Call Center and posed as the veteran in order to change the mailing address of the veteran's VA benefits checks. The defendants then received, forged, and deposited the checks into a bank account they had opened in the veteran's name.

Former Bank Manager Sentenced for Theft

A former bank manager was sentenced to 5 months' incarceration, 36 months' supervised release, 200 hours' community service, and ordered to pay restitution of $37,830 after pleading guilty to Theft by a Bank Officer. An OIG investigation determined that while the defendant was employed by a bank, he embezzled VA funds that were deposited into the account of a deceased veteran beneficiary. The defendant also embezzled funds from another bank customer and used the stolen money from both accounts to support a gambling habit.

USPS Carrier Pleads Guilty to Mail Theft

A USPS carrier pled guilty to mail theft. A VA OIG and USPS OIG investigation revealed that for over a year the defendant stole at least 20 VA-issued narcotic parcels from a mail sorting facility.

Postal Service Manager Pleads Guilty to Theft of Mail

A Postal Service manager pled guilty to theft of mail by an officer or employee. A VA OIG, USPIS, and USPS OIG investigation revealed that the defendant stole a large number of controlled VA pharmaceuticals intended for veterans in both Kentucky and Indiana. A search warrant was executed during the investigation resulting in the recovery of approximately 2,000 pills and numerous VA pill bottles. The loss to VA exceeds $2,000.

Veteran Sentenced for Drug and Weapons Violations

A veteran was sentenced to 20 months' incarceration after pleading guilty to knowingly, intentionally, and unlawfully possessing with intent to distribute a substance containing oxycodone and knowingly possessing and transferring a machine gun. Also, the veteran forfeited 15 assorted rifles, handguns, and 16,000 rounds of ammunition, which had been confiscated during a search of his residence. An OIG, Bureau of Alcohol, Tobacco, and Firearms, DCIS, and local police investigation revealed that the defendant participated in a conspiracy with at least two other veterans in the theft and transport of at least two machine guns stolen from Fort Bragg. Undercover purchases of the guns were conducted, and two separate arrests were made regarding those purchases. The defendant also sold a shotgun, ammunition, bulletproof vest, and his VA prescription medications to one of the previously arrested veterans.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 28 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 24 defendants. Investigations resulted in almost $210,000 in fines, restitution, penalties, and civil judgments; and OIG obtained nearly $287,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OIG investigative work resulted in the following:

- A veteran was sentenced to 24 months' incarceration, 3 years' supervised release, and ordered to pay a $1,000 fine after pleading guilty to assault. An OIG investigation revealed that the defendant struck and injured a Waco, TX, VAMC police officer. In another case, a second veteran was sentenced to 3 years' probation and 100 hours' community service after pleading guilty to assaulting two VA police officers at the Bath, NY, VAMC.
- A defendant was convicted at trial of assaulting a Federal police officer with a deadly or dangerous weapon. An OIG and VA Police Service investigation revealed that the defendant and her sister, neither of whom are veterans, were soliciting money at the Central Arkansas Veterans HCS in Little Rock, AR, when a VA police officer approached them. The defendant ignored an order to stop and subsequently injured the police officer with her vehicle as she fled the medical center.

- A veteran was indicted for assaulting an East Orange, NJ, VAMC social worker. An OIG and VA Police Service investigation revealed that the defendant verbally abused the social worker, to include making sexually explicit comments. The defendant also spit in the social worker's face and beat her with a metal cane resulting in the employee suffering a fractured elbow. Due to the assault resulting in bodily injury, the defendant is subject to a penalty enhancement that could include up to 20 years' incarceration.
- A veteran was sentenced to time served (7 months) and 12 months' supervised release, 4 months of which is to be in a residential re-entry center. An OIG and FBI investigation revealed that the defendant made an emergency phone call warning of a man with a gun at the Wilmington, DE, VAMC. When VA police officers responded, the veteran pointed a handgun at the officers. The gun was later identified as a BB gun. After the veteran failed to respond to repeated commands to drop his weapon, an officer fired two shots; one shot grazed the veteran's hand. During a subsequent interview, the defendant admitted that he was depressed, wanted to end his life, and was attempting to commit 'suicide by cop.'
- A veteran was involuntarily committed after making threats against a St. Petersburg, FL, VARO employee and President Obama. An OIG, U.S. Secret Service, and VA Police Service investigation revealed that the veteran threatened the VARO employee and demanded $90,000 from VA so that he could buy guns and ammunition to blow up the world in order to achieve world peace. During an interview, the veteran also threatened President Obama and Members of Congress.
- A veteran was arrested for communicating threats. After the initial threat, the veteran was banned from receiving treatment at a CBOC and was required to receive treatment at the Asheville, NC, VAMC. During the following 3 weeks, the veteran threatened to kill herself and VA staff, including her doctor, on two additional occasions. The defendant visited the VAMC without checking in with VA Police Service as required and refused a consent search of her belongings. It was also confirmed that the defendant had obtained a handgun permit.
- A veteran was sentenced to time served (19 months), 2 years' supervised release, and additional psychiatric treatment after pleading guilty to possession of a firearm by someone adjudicated as mentally ill or who has been committed to a mental institution. An OIG investigation was initiated after the defendant made threats toward a Buffalo, NY, VAMC employee and was then found to be in possession of weapons and ammunition even though he was a convicted felon.
- A veteran was sentenced to 2 years' probation after pleading guilty to making a terroristic threat. An OIG investigation revealed that during a recorded call to a VISN Telephone Care Service, the defendant threatened to kill both a VA physician assistant and a Federal Administrative Law Judge.
- A veteran was arrested for threatening several Reno, NV, VAMC employees. An OIG and VA Police Service investigation revealed that the defendant, while receiving care at the VAMC, threatened to shoot three VA staffers with an M-16 rifle if he did not receive proper medical care. The defendant was criminally charged based on the severity of the threats and his prior criminal history.
- A veteran was convicted for making criminal threats and resisting arrest. The court also ordered that the veteran undergo a 90-day diagnostic test before sentencing. 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 VA police officers. The defendant also assaulted two of the officers while attempting to leave the medical center. During the investigation, a handgun and two rifles were recovered. The defendant was not authorized to possess these weapons.
- A veteran was arrested for aggravated harassment after an OIG, state police, and VA Police Service investigation revealed that the veteran, during treatment at a VA Community Day Program Center, touched a female VA employee and then continually harassed her by telephone. The employee was granted an order of protection by a judge who also ordered the defendant be psychologically evaluated.

- A veteran was arrested for making threats to the staff at the Fayetteville, NC, VAMC and staff at Fort Bragg, NC. An OIG, FBI, VA Police Service, and local law enforcement investigation revealed that the defendant made threats to come to the facilities and use a firearm to kill VA and Fort Bragg employees.
- A veteran was arrested for threatening to kill a Hampton, VA, VAMC physician whom he blamed for "horrible" care following an accident in 1987, despite the fact the physician was not employed by VA or providing care to the patient at that time. During interviews with OIG agents, the defendant repeated the threatening statements that he had previously communicated to a VA staff member.

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, 59.8 million felony warrants have been received from the National Crime Information Center and participating states resulting in 72,545 investigative leads being referred to law enforcement agencies. Over 2,472 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.14 billion in estimated overpayments with an estimated cost avoidance of $1.39 billion. During this reporting period, OIG opened 31 and closed 26 fugitive felon investigations, identifying $97.2 million in estimated overpayments. OIG investigative work resulted in the arrest of 22 fugitive felons, including 5 VA employees. VA employees were apprehended on charges related to assault, drug violation, and probation violations. Based on the information provided to OIG, at least seven additional arrests were made by other law enforcement agencies.

- An Atlanta, GA, VAMC employee was arrested at the medical center by local police with the assistance of OIG and the VA Police Service. The fugitive was wanted for battery (family violence).
- A West Los Angeles, CA, VAMC employee was arrested by the local sheriff's office with the assistance of OIG and the VA Police Service. The fugitive was wanted for possession of dangerous drugs.
- OIG and VA Police Service assisted a local police department with arresting a fugitive VA employee at the Mountain Home, TN, VAMC. The fugitive was wanted on an outstanding warrant for accessory after the fact to murder.
- A veteran was arrested at the Manhattan, NY, VAMC by a U.S. Marshals Service Regional Task Force with the assistance of OIG. The fugitive was wanted for charges to include indecent and aggravated assault. The fugitive is alleged to have lured a female minor to a hotel room in Pennsylvania where he tied her to a bed, sexually assaulted her, and then struck her in the head several times with a mallet.

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 14 and closed 5 administrative investigations. The Division investigated 12 allegations, 4 of which were substantiated. This work resulted in the issuance of two reports containing nine 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 administrative closures for allegations that are not substantiated and not otherwise included in a report or advisory memorandum. During this

reporting period, the Administrative Investigations Division did not issue any advisory memorandums but issued three administrative closures.

Fayetteville HCS Employee's Involvement in Evaluation of Family's Property Created Appearance of Conflict of Interest

A VHA Project Manager improperly participated as a member of a survey team, creating an appearance of a conflict of interest, when she did not recuse herself from the site selection process for a new health care center after realizing that properties to be reviewed were owned by her extended family members. As a VA employee and Professional Engineer she knew that her participation may be a conflict of interest, or perceived as one, and that she should have recused herself from the site selection process as soon as she realized a family connection to the properties. This process ultimately resulted in VA purchasing about 35 acres of land from her extended family member for about $4.25 million. Further, VHA senior officials failed to properly discharge the duties of their positions when they individually learned of the possible conflict of interest and took insufficient action, and there were many discrepancies found within the records associated with the solicitation and purchase of this particular property.

Former VHA DCBO for Purchased Care Committed Prohibited Personnel Practice, Others Misused Official Time

The former (retired) DCBO for Purchased Care engaged in a prohibited personnel practice when she gave preference in hiring to a former VA coworker and VA contractor employee. To reach her favored candidate, she created a program manager position, defined the scope and manner of competition through misuse of a non-competitive reinstatement authority for Federal employees, and defined the requirements of the position by writing the position description while she possessed the favored candidate's resume. In addition, an Office of Compliance and Business Integrity employee misused official time and resources, improperly exchanged information with two subordinates who did the same, when they engaged in investigative research on their supervisors outside the scope of their official duties, because the employee was not selected for a promotion to the Director of Program Oversight and Informatics position.

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 the VA incorrectly calculated benefits for a veteran who has been incarcerated in a Federal prison since 2012. This matter was referred to VBA, which confirmed the findings and has planned corrective actions. The monetary impact of this proactive review totals $66,460.

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, 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 22,442 contacts, 1,094 of which became OIG cases. An additional 395 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 544 cases, substantiating allegations 41 percent of the time. External Hotline cases resulted in 323 administrative sanctions and corrective actions and $2.6 million in monetary benefits. In addition, the Hotline responded to more than 1,000 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Lack of Quality Care for Female Veterans at the Atlanta, Georgia, VAMC

A review by the Atlanta VAMC revealed that care for female veterans was not seamless due to lack of availability of proficient staff for gender specific complaints as well as a lack of comfort by some clinicians in providing gender specific care to women. As a result of the review, the facility identified and is pursuing eight specific corrective actions.

Mismanagement of Grantee Funds by Non-Profit Organization

On behalf of the Grant and Per Diem (GPD) office, the VA Financial Services Center (FSC) conducted a review of Veterans First and concluded that the non-profit organization failed to provide adequate documentation to support its program expenditures. Further, since Veterans First maintained its Service Center and Per Diem revenues and expenses in the same account, the FSC was unable to determine their actual operating costs. GPD issued an intent-to-terminate letter to Veterans First and took action to recover questioned costs identified in the review. OIG estimates that over a 5-year period, VA could have paid more than $900,000 in overpayments to Veterans First.

Pension Benefits Fraud in Florida

A review conducted by the St. Petersburg, FL, VARO found that a veteran was receiving benefits as a home-bound pension recipient but owned and operated a business. The Pension Management Center (PMC) contacted the veteran and provided the opportunity to count his unreported business income. The veteran failed to respond, and as a result, the VARO terminated his benefits effective to the start date in 2008. A bill of collection totaling $14,616 was issued to the veteran.

DIC Fraud by a Veteran's Widow

The St. Paul, MN, VARO conducted a review of a widow's benefits to determine if she was receiving DIC payments even though she was remarried. The VARO concluded that at the time she applied for benefits, she was already remarried. Subsequently, the VARO terminated her benefits effective to the 2001 start date and issued a bill of collection totaling $160,783.

Benefits Fraud by an Incarcerated Veteran

The Regional Office in Houston conducted a Social Security Prison Match and confirmed that an incarcerated veteran was still receiving full benefits as well as benefits for a spouse despite the fact that he was divorced. As a result, the veteran's benefits were reduced to 10 percent because he was currently in prison, the former spouse was removed from the veteran's award, and an overpayment against the veteran's account was established.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's Office of Acquisition, Logistics, and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 69 reviews in this reporting period. The tables that follow provide an overview of OIG performance during this reporting period.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Forty-seven preaward reviews identified more than $73 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 14 health care provider proposals, accounting for approximately $38 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2014 – March 31, 2015	47	$73,679,191

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 $1.9 million, including approximately $690,000 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 20 postaward reviews performed, 10 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, 2014 – March 31, 2015	20	$1,971,852

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, OIG reviewed two claims and determined that approximately $249,000 of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2014 – March 31, 2015	2	$249,306

Other Significant OIG Activities

Congressional Testimony

Deputy Inspector General Testifies Before House Appropriations Subcommittee on Military Construction and VA on How VA Can Improve Service to Veterans

Richard J. Griffin, Deputy Inspector General (DIG), testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, on OIG's oversight of VA programs and operations. He focused on OIG's recent work involving veterans' access to care, including the review of scheduling practices and poor care at the PVAHCS, which was a watershed event for VA and OIG. As a result, OIG launched investigations at 98 VA medical care facilities into allegations that scheduling was manipulated to make wait times for outpatient appointments appear to be shorter than the actual wait times experienced by veterans. He explained the dramatic increase in the number of contacts to the OIG Hotline as well as the number of inquiries sent to OIG by Members of Congress and by veterans and their families since reporting on PVAHCS began last year. He also discussed VBA's delivery of benefits and the need to improve financial stewardship of taxpayer funds, data integrity, and overall claims management and focus more efforts on addressing the timeliness and accuracy associated with processing veterans' claims. Mr. Griffin was accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General (AIG) for Healthcare Inspections.

AIG for Audits and Evaluations Testifies at House Committee on Veterans' Affairs Subcommittee Field Hearing on the Operations of the Philadelphia, Pennsylvania, VARO

Linda A. Halliday, AIG for Audits and Evaluations, testified at a field hearing of the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on October 3, 2014. The hearing was held at the Pemberton, NJ, campus of Burlington County College and focused on the operations of the Philadelphia, PA, VARO. Ms. Halliday discussed the initial results of OIG's unannounced visit to the VARO in June 2014 and advised that OIG's work continues on the issues raised during the visit. These issues include allegations that mail was not scanned timely into Virtual VA—the electronic claims repository; staff were hiding mail or shredding mail; staff were cherry-picking claims to process; and the VARO improperly implemented Fast Letter 13-10, which was rescinded based on OIG's June 2014 management advisory memorandum to the USB. OIG will issue a final report when our work is completed. Ms. Halliday was accompanied by Ms. Nora Stokes, Director, Bay Pines Benefits Inspection Division; Mr. Al Tate, Audit Manager, Atlanta Office of Audits and Evaluations; and Mr. Jeffrey Myers, Benefits Inspector, San Diego Benefits Inspection Division.

Deputy AIG for Audits and Evaluations Testifies Before House Committee on Veterans' Affairs on VA's Longstanding Information Security Weaknesses

Sondra F. McCauley, Deputy AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the security of VA's IT systems. Ms. McCauley discussed the results of the annual audit of VA's consolidated financial statement that for the 15th year in a row found IT security was a material weakness. She did acknowledge some improvements in VA's IT security management but noted that these improvements require time to be fully implemented and show evidence of their effectiveness. Ms. McCauley was accompanied by Mr. Michael Bowman, Director, IT and Security Audits Division.

AIG for Healthcare Inspections Testifies Before the Senate Veterans' Affairs Committee on OIG's May 2014 National Opioid Report and Recommendations To Reduce Risk to Veterans

John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States Senate, on OIG's May 2014 national report, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*. He discussed results that indicate that VA is not following its own procedures for managing patients that are being treated with opioids. He noted that VA has taken action on four of the six recommendations in the report. Dr. Daigh also discussed overarching findings from OIG's reporting on opioid prescription practices since 2011, where we found that the use of high dose opioids in patients with a substance use disorder and mental illness is a common clinical situation; compliance with clinical guidelines is not routine; primary care providers bear the responsibility for managing these complex patients, often with limited support from pain management experts and related specialists; the use of high dose opioids causes friction within provider groups, where opinions on the proper use of these medications varies; and non-traditional therapies that may offer the benefit of less narcotic use are not fully utilized.

AIG for Healthcare Inspections Testifies at Joint Congressional Field Hearing on Prescription Practices at the Tomah, Wisconsin, VAMC, and VHA-Wide Opioid Review

John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified at a field hearing of the Committee on Homeland Security and Governmental Affairs, United States Senate, and the Committee on Veterans' Affairs, United States House of Representatives, on March 30, 2015. The hearing was held in Tomah, WI, and focused on the prescription of opioids at the Tomah VAMC. Dr. Daigh focused on the issues raised in OIG's *Healthcare Inspection – Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin*, and the results of OIG's May 2014 national report, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*, which mirrors the time frame of our work in Tomah. OIG inspections found that in 2012, VA providers were in general non-compliance with VA and DoD clinical practice guideline requirements including the use of urine drug screens and follow up visits; the practice of refilling prescriptions at least 7 days early; the concomitant use of benzodiazepines and narcotic medications; or ensuring that veterans with substance use disorder and chronic pain receive concurrent treatment for their substance use disorder and urinary drug testing. The data as reported for FY 2012, makes clear that the VA system of care was managing patients being treated with opioids very poorly. Dr. Daigh was accompanied by Alan Mallinger, M.D., Senior Physician, OHI.

Counselor to the Inspector General Outlines Legal Requirements OIG Must Follow When Releasing Information to Congress

Maureen T. Regan, Counselor to the Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing on "The Power of Legislative Inquiry – Improving the VA by Improving Transparency." Ms. Regan provided information on the laws and requirements that OIG must follow when releasing information to Congress and the public. Ms. Regan explained that OIG is transparent in reporting the findings and conclusions of OIG work as permitted under existing laws and regulations, and that OIG has complied with applicable legal requirements for reporting and responding to Congress. She also addressed issues regarding OIG's December 8, 2014, report on contracts awarded by VA's Technical Acquisition Center to Tridec for the VOA, and the factual errors in a letter sent by the Department of Treasury Inspector General to the Committee Chairman and Ranking Member questioning the integrity of this report. Ms. Regan announced at the hearing that the DIG had referred the Treasury Inspector General's involvement in a VA matter to the Integrity Committee for the Council of the Inspectors General for Integrity and Efficiency (CIGIE) for a full investigation, including the conduct of all individuals involved.

False Claims Act Settlements

For this reporting period, VA received payments totaling $5,664,038 from settlement agreements in complaints filed under the *qui tam* provisions of the *False Claims Act*. This amount represents VA's single damages in these cases; the total collected by the Department of Justice on behalf of VA exceeded $11 million. The amount represents settlements in three cases, one of which was based on violations of the *Trade Agreements Act*. The remaining two settlements were based on violations of regulations relating to off-label marketing.

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. There were no peer reviews done on VA OIG during this reporting period. 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 March 31, 2015.

Additionally, OIG reports that no 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 215 proposals and made 26 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, OHI, 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	
11/19/2014 12-02576-30	Audit of VHA's Support Service Contracts	$795,000,000	$795,000,000	
11/20/2014 13-01545-11	Review of Alleged Mismanagement of VA's Office of Public and Intergovernmental Affairs Outreach Contracts			$5,000,000
12/3/2014 13-01859-42	Audit of VHA's National Call Center for Homeless Veterans			$267,000
12/17/2014 14-00517-54	Review of Alleged Mismanagement at VHA's Massachusetts Veterans Epidemiology Research and Information Center	$593,000	$593,000	
1/22/2015 13-03324-85	Follow-up Audit of the Information Technology Project Management Accountability System	$6,400,000	$6,400,000	
2/18/2015 14-03981-119	Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California			
2/19/2015 15-02101-143	Review of the Allegation Concerning Information Presented in the Deputy Secretary's Official Biography			
2/26/2015 14-03963-139	Review of Alleged Data Manipulation at the VA Regional Office Little Rock, Arkansas			
3/2/2015 14-00730-126	Review of Alleged Misuse of VA Funds to Develop the Health Care Claims Processing System	$18,700,000	$18,700,000	$73,800,000
3/2/2015 13-01530-137	Audit of Non-VA Medical Care Claims for Emergency Transportation			$56,200,000
3/5/2015 15-00875-129	Independent Review of VA's FY 2014 Performance Summary Report to the Office of National Drug Control Policy			
3/5/2015 15-00874-131	Independent Review of VA's FY 2014 Detailed Accounting Submission to the Office of National Drug Control Policy			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
3/9/2015 13-00716-101	Audit of VHA's Home Telehealth Program			
3/26/2015 15-00880-157	Review of Alleged Data Manipulation at the VA Regional Office Honolulu, HI			
3/30/2015 14-02383-175	Audit of VA's Drug Free Workplace Program			
		$820,693,000	**$820,693,000**	**$135,267,000**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	**Number**	**Facility**
10/8/2014	14-02100-271	VA Regional Office Portland, Oregon
10/8/2014	14-01688-303	VA Regional Office Salt Lake City, Utah
11/10/2014	14-02577-07	VA Regional Office Buffalo, New York
11/13/2014	13-03221-08	VA Regional Office Providence, Rhode Island
11/17/2014	14-02101-09	VA Regional Office Huntington, West Virginia
2/24/2015	14-02689-122	VA Regional Office Boston, Massachusetts
3/26/2015	14-04623-120	VA Regional Office Manchester, New Hampshire
3/26/2015	14-04622-150	VA Regional Office Fargo, North Dakota

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	**Facility**
10/2/2014	14-02064-252	VA Eastern Kansas Health Care System, Topeka, Kansas
10/14/2014	14-02071-02	VA Long Beach Healthcare System, Long Beach, California
10/16/2014	14-02077-01	Tennessee Valley Healthcare System, Nashville, Tennessee
10/16/2014	14-02070-305	Alexandria VA Health Care System, Pineville, Louisiana
10/27/2014	14-02074-06	Huntington VA Medical Center, Huntington, West Virginia
11/3/2014	14-02076-13	Robert J. Dole VA Medical Center, Wichita, Kansas
11/12/2014	14-02084-16	Miami VA Healthcare System, Miami, Florida
11/18/2014	14-02083-24	Minneapolis VA Health Care System, Minneapolis, Minnesota
11/24/2014	14-02078-38	Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington
11/25/2014	14-02079-10	Central Alabama Veterans Health Care System, Montgomery, Alabama
11/25/2014	14-02080-29	West Texas VA Health Care System, Big Spring, Texas
12/1/2014	14-02081-41	VA Northern California Health Care System, Mather, California

Office of Healthcare Inspections | Combined Assessment Program Reviews

Issue Date	Number	Facility
1/6/2015	14-02073-57	Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania
1/14/2015	14-04210-63	Samuel S. Stratton VA Medical Center, Albany, New York
1/20/2015	14-04214-70	Gulf Coast Veterans Health Care System, Biloxi, Mississippi
1/20/2015	14-02082-82	Hampton VA Medical Center, Hampton, Virginia
1/26/2015	14-04218-92	St. Cloud VA Health Care System, St. Cloud, Minnesota
1/27/2015	14-04221-91	Memphis VA Medical Center, Memphis, Tennessee
2/2/2015	14-04219-98	VA Illiana Health Care System, Danville, Illinois
2/4/2015	14-04211-94	VA Hudson Valley Health Care System, Montrose, New York
2/4/2015	14-04215-99	Cincinnati VA Medical Center, Cincinnati, Ohio
2/5/2015	14-04223-100	VA North Texas Health Care System, Dallas, Texas
2/10/2015	14-04224-107	Erie VA Medical Center, Erie, Pennsylvania
2/12/2015	14-04213-115	Tomah VA Medical Center, Tomah, Wisconsin
2/25/2015	14-04226-125	VA Ann Arbor Healthcare System, Ann Arbor, Michigan
2/25/2015	14-04229-130	Beckley VA Medical Center, Beckley, West Virginia
3/4/2015	14-04222-141	VA Roseburg Healthcare System, Roseburg, Oregon
3/4/2015	14-04228-144	VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts
3/10/2015	14-04227-147	VA San Diego Healthcare System, San Diego, California
3/31/2015	15-00071-158	West Palm Beach VA Medical Center, West Palm Beach, Florida
3/31/2015	15-00072-160	Ralph H. Johnson VA Medical Center, Charleston, South Carolina

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews

Issue Date	Number	Parent Facility
10/7/2014	14-00925-299	Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania
11/10/2014	14-00939-27	Miami VA Healthcare System, Miami, Florida
11/12/2014	14-00937-31	VA Northern California Health Care System, Mather, California
12/4/2014	14-00930-14	Central Alabama Veterans Health Care System, Montgomery, Alabama
1/6/2015	14-04368-56	Samuel S. Stratton VA Medical Center, Albany, New York
1/12/2015	14-04380-79	Gulf Coast Veterans Health Care System, Biloxi, Mississippi
1/15/2015	14-04385-65	Tomah VA Medical Center, Tomah, Wisconsin
1/15/2015	14-04383-78	Memphis VA Medical Center, Memphis, Tennessee
1/21/2015	14-04382-86	St. Cloud VA Health Care System, St. Cloud, Minnesota
1/22/2015	14-04451-88	VA Illiana Health Care System, Danville, Illinois
2/5/2015	14-04378-97	VA Hudson Valley Health Care System, Montrose, New York
2/11/2015	14-04389-106	Erie VA Medical Center, Erie, Pennsylvania
2/17/2015	14-04386-124	VA North Texas Health Care System, Dallas, Texas
2/19/2015	14-04476-116	Cincinnati VA Medical Center, Cincinnati, Ohio

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews

Issue Date	Number	Parent Facility
3/4/2015	14-04396-142	VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts
3/10/2015	14-04394-145	VA San Diego Healthcare System, San Diego, California
3/30/2015	15-00116-191	Dayton VA Medical Center, Dayton, Ohio
3/31/2015	15-00113-161	West Palm Beach VA Medical Center, West Palm Beach, Florida
3/31/2015	14-04391-162	VA Ann Arbor Healthcare System, Ann Arbor, Michigan
3/31/2015	15-00108-194	Martinsburg VA Medical Center, Martinsburg, West Virginia

Office of Healthcare Inspections | National Healthcare Reviews

Issue Date	Number	Title
12/15/2014	14-04705-62	Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet
1/30/2015	15-00430-103	OIG Determination of Veterans Health Administration's Occupational Staffing Shortages
2/3/2015	14-05132-90	Combined Assessment Program Summary Report - Evaluation of Pressure Ulcer Prevention and Management at Veterans Health Administration Facilities
3/31/2015	15-01809-163	Combined Assessment Program - Evaluation of Coordination of Care in Veterans Health Administration Facilities

Office of Healthcare Inspections | Hotline Healthcare Inspections

Issue Date	Number	Report Title
10/2/2014	14-03212-295	Emergency Department Concerns, Dwight D. Eisenhower VAMC, Leavenworth, Kansas
10/21/2014	14-01261-03	Follow-Up of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa
11/5/2014	13-02527-23	Alleged Nursing Deficiencies Led to Patient's Death, Hampton VA Medical Center, Hampton, Virginia
11/6/2014	14-03298-20	Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, North Carolina
11/14/2014	14-01519-40	Quality and Coordination of Care Concerns at Three Veterans Integrated Service Network 11 Facilities
11/24/2014	14-00661-43	Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California
12/2/2014	14-05128-51	An Analysis of Mental Health, Primary Care, and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso, Texas
12/9/2014	14-00351-53	Alleged Inappropriate Opioid Prescribing Practices, Chillicothe VA Medical Center, Chillicothe, Ohio

Office of Healthcare Inspections | Hotline Healthcare Inspections

Issue Date	Number	Report Title
12/15/2014	13-00872-52	Follow-Up Evaluation of Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn, VA Medical Center, Columbia, South Carolina
12/18/2014	14-02887-64	Quality of Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
1/7/2015	14-04702-60	Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, Georgia
1/8/2015	14-02412-69	Ophthalmology Service Concerns, VA Illiana Health Care System, Danville, Illinois
1/13/2015	14-00615-61	Alleged Quality of Care and Courtesy Issues at the Alamosa Community Based Outpatient Clinic, Alamosa, Colorado
1/28/2015	14-00875-112	Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona
2/12/2015	14-01708-123	Staffing and Patient Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
2/18/2015	14-04194-118	Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015	14-02022-134	Alleged Lack of Training and Support for Interventional Radiology Procedures, Salem VAMC, Salem, Virginia
2/26/2015	14-00875-133	Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona
3/3/2015	14-04473-132	Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
3/9/2015	15-00190-146	Inadequate Follow-Up of an Abnormal Imaging Result, Charlotte Community Based Outpatient Clinic, Charlotte, North Carolina
3/19/2015	14-02437-117	Staffing and Quality of Care Issues in the Community Living Center, Charlie Norwood VA Medical Center, Augusta, Georgia
3/24/2015	15-00794-151	Delay of Care, Goshen Community Based Outpatient Clinic, Goshen, Indiana
3/30/2015	14-02139-156	Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia
3/31/2015	14-03927-197	Patient Telemetry Monitoring Concerns, Michael E. DeBakey VA Medical Center, Houston, Texas

Office of Healthcare Inspections | Hotline Administrative Closures

Issue Date	Number	Report Title
5/1/2015	13-00244-348	Alleged Violation of Patient Rights, Sheridan VA Health Care System, Sheridan, Wyoming

Office of Healthcare Inspections | Hotline Administrative Closures

Issue Date	Number	Report Title
5/1/2015	14-04496-349	Consult Management Concerns, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

Office of Healthcare Inspections | Hotline Administrative Closures Prior to FY 2015

Issue Date	Number	Title
2/6/2015	11-04212-127	Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin
3/17/2015	14-01088-165	Review of Surgical Care for Select Patients With Gastrointestinal Surgery, Gulf Coast Veterans Health Care System, Biloxi, Mississippi
3/17/2015	14-01311-166	Oversight Review of Facility Response to an Internal Investigation's Findings and Recommendations, VA Northern Indiana Health Care System, Marion, Indiana
3/17/2015	13-03411-167	Alleged Denial of Treatment of an Actively Suicidal Veteran, Tennessee Valley Healthcare System – Nashville, Nashville, Tennessee
3/17/2015	13-03176-168	Alleged Delayed Diagnosis and Treatment, Poor Communication, and Staff Insensitivity, VA Palo Alto Health Care System, Palo Alto, California
3/17/2015	13-03948-169	Patient Safety Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
3/18/2015	14-01308-171	Alleged Jeopardized Resident Care in the Long Term Care Spinal Cord Injury Unit, Louis Stokes VA Medical Center, Cleveland, Ohio
3/18/2015	14-00463-172	Urology Section Evaluation Delays in Patients with a History of Cancer, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
3/18/2015	13-01877-173	Alleged Nepotism and Preferential Treatment, North Florida/South Georgia Veterans Health System, Gainesville, Florida
3/18/2015	12-03487-174	Alleged Mismanagement of Care and Lack of Administrative Action, Robert J. Dole VA Medical Center, Wichita, Kansas
3/18/2015	14-01698-176	Follow-Up of Facility Response to Administrative Board of Investigation Findings and Recommendations, Harry S. Truman Memorial Veterans Hospital, Columbia, Missouri
3/18/2015	14-02141-177	Alleged Environment of Care Deficiencies in the Post-Traumatic Stress Disorder Unit VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts
3/18/2015	14-04437-178	Primary Care Provider Concerns at the Robert J. Dole VA Medical Center, Wichita, Kansas
3/19/2015	14-01960-179	Alleged Non-Compliance with VHA Policy, Lexington VA Medical Center, Lexington, Kentucky
3/19/2015	14-01422-180	Emergency Department Falsification of Performance Measure Data, Michael E. DeBakey VA Medical Center, Houston, Texas

Office of Healthcare Inspections | Hotline Administrative Closures Prior to FY 2015

Issue Date	Number	Title
3/19/2015	14-03180-181	Colorectal Cancer Screening in 2010, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas
3/19/2015	13-03862-182	Alleged Dental Provider Issues at the Pueblo Community Based Outpatient Clinic, VA Eastern Colorado Health Care System, Denver, Colorado
3/19/2015	14-01740-183	Physician Assistant Credentialing, Grand Junction VA Medical Center, Grand Junction, Colorado
3/20/2015	14-00299-184	Alleged Quality of Care Issues, North Florida/South Georgia Veterans Health System, Gainesville, Florida
3/20/2015	14-00703-185	Alleged Inappropriate Opiates Prescribing Practices, Lexington VA Medical Center, Lexington, Kentucky
3/20/2015	14-04480-186	Temporary Closure of the Cardiothoracic Surgery Program, Oklahoma VA Medical Center, Oklahoma City, Oklahoma
3/20/2015	13-03662-187	Suspicious Death, Alleged Premature Discharge, and Quality of Care Issues, VA Southern Nevada Healthcare System, Las Vegas, Nevada
3/20/2015	13-04594-188	Mental Health Provider Concerns at the VA Central Iowa Health Care System, Des Moines Division, Des Moines, Iowa

Joint Review

Issue Date	Number	Report Title
12/8/2014	12-02387-59	Review of Allegations Regarding the Technical Acquisition Center's Award of Sole-Source Contracts to Tridec for the Virtual Office of Acquisition

Office of Investigations | Administrative Investigations

Issue Date	Number	Report Title
3/10/2015	12-03002-102	Appearance of a Conflict of Interest, Fayetteville VA Medical Center, Fayetteville, North Carolina
3/26/2015	14-00730-170	Prohibited Personnel Practice and Misuse of VA Time and Resources, Veterans Health Administration, Chief Business Office Purchased Care, Denver, Colorado

Office of Contract Review | Preaward Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
10/8/2014	14-04245-04	Review of FSS Proposal Submitted Under a Solicitation	$2,071,460
10/21/2014	14-04682-05	Review of Proposal Submitted Under a Solicitation	$729,211
10/22/2014	14-04359-12	Review of Proposal Submitted Under a Solicitation	$5,145,510

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/23/2014	14-04563-15	Review of Proposal Submitted Under a Solicitation	$3,008,895
10/23/2014	14-04312-19	Review of Request to Add Products to an FSS Contract	
10/23/2014	14-03254-22	Review of Subcontract Proposal	$34,454
10/24/2014	14-04856-21	Review of Proposal Submitted Under a Solicitation	$2,787,020
10/27/2014	14-04577-25	Review of FSS Proposal Submitted Under a Solicitation	$1,971,487
10/29/2014	14-04684-28	Review of FSS Proposal Submitted Under a Solicitation	
11/5/2014	14-05034-34	Review of FSS Proposal Submitted Under a Solicitation	
11/5/2014	14-03930-35	Review of Request for Price Increases Submitted Under an FSS Contract	$753,697
11/6/2014	14-03928-37	Review of Request to Add Products to an FSS Contract	$2,358,965
11/10/2014	14-05071-36	Review of Proposal Submitted Under a Solicitation	$3,971,652
11/13/2014	15-00104-33	Review of Proposal Submitted Under a Solicitation	$1,064,729
11/24/2014	15-00309-46	Review of FSS Proposal Submitted Under a Solicitation	
11/24/2014	14-03255-48	Review of Subcontract Proposal Submitted under a Contract	$17,877
11/24/2014	14-04320-49	Review of Request to Add Products to an FSS Contract	
11/24/2014	14-03253-50	Review of Proposal Submitted Under a Contract	-$79,908
12/3/2014	14-04508-55	Review of FSS Proposal Submitted Under a Solicitation	
12/9/2014	15-00568-47	Review of Proposal Submitted Under a Solicitation	$178,107
12/15/2014	14-04975-68	Review of FSS Proposal Submitted Under a Solicitation	
12/16/2014	15-00345-71	Review of FSS Proposal Submitted Under a Solicitation	
12/16/2014	14-05133-72	Review of Product Additions Submitted Under an FSS Contract	
12/17/2014	14-05036-74	Review of FSS Proposal Submitted Under a Solicitation	
12/18/2014	15-00202-80	Review of Proposal Submitted Under a Solicitation	$1,534,930
12/19/2014	15-00984-77	Review of Proposal Submitted Under a Solicitation	$174,845
12/22/2014	14-04700-81	Review of Product Additions Submitted Under an FSS Contract	$2,230,160
12/23/2014	14-04780-84	Review of Product Additions Submitted Under an FSS Contract	$180,785
1/6/2015	15-01154-87	Review of Request for Price Increases Submitted Under an FSS Contract	
1/9/2015	14-04343-83	Review of Proposal Submitted Under a Solicitation	$7,356,516
1/9/2015	14-04071-89	Review of Contract Extension Proposal Submitted Under an FSS Contract	$768,790
1/12/2015	15-01153-93	Review of Request for Modification to Add Products and Request Price Increases Submitted Under an FSS Contract	
1/16/2015	15-00446-96	Review of FSS Proposal Submitted Under a Solicitation	

Office of Contract Review | Preaward Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
1/26/2015	15-00762-104	Review of Proposal Submitted Under a Solicitation	$30,697
1/27/2015	15-01650-108	Review of Request for Price Increases Submitted Under an FSS Contract	
1/27/2015	15-00307-109	Review of Request for Modification and Product Additions Submitted Under an FSS Contract	
1/28/2015	14-04871-111	Review of Request for Modification and Product Additions Submitted Under an FSS Contract	$825,858
1/29/2015	15-00203-105	Review of Proposal Submitted Under a Solicitation	$3,273,270
2/2/2015	15-00308-113	Review of FSS Proposal Submitted Under a Solicitation	$2,133,920
2/27/2015	14-04741-149	Review of FSS Proposal Submitted Under a Solicitation	$21,036,786
3/4/2015	15-00860-152	Review of Product Additions Submitted Under an FSS Contract	$548,352
3/12/2015	15-01999-153	Review of Proposal Submitted Under a Solicitation	$2,100,109
3/16/2015	15-01006-164	Review of Proposal Submitted Under a Solicitation	$6,561,693
3/23/2015	15-02471-189	Review of FSS Proposal Submitted Under a Solicitation	
3/24/2015	15-01690-192	Review of Product Additions Submitted Under an FSS Contract	
3/26/2015	15-01691-193	Review of FSS Proposal Submitted Under a Solicitation	
3/30/2015	15-01647-196	Review of FSS Proposal Submitted Under a Solicitation	$909,324
			$73,679,191

Office of Contract Review | Postaward Reviews

Issue Date	Number	Report Title	Dollar Recoveries
10/23/2014	14-00185-18	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$41,634
10/29/2014	14-01441-17	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$773,369
10/31/2014	14-02695-26	Review of Voluntary Disclosure Under an FSS Contract	$7,024
11/18/2014	15-00002-44	Review of Public Law Compliance for a Covered Drug Under an FSS Contract	$4,420
11/24/2014	10-03950-45	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$25,976
12/5/2014	14-04487-58	Review of Self-Audit Performed Under an FSS Contract	$19,389
12/15/2014	14-00007-67	Review of Disclosure of Public Law Pricing Errors Under Contracts	$2,533
12/16/2014	15-00017-66	Follow-Up Review of Pricing Errors under a Contract	$65,330

Office of Contract Review | Postaward Reviews

Issue Date	Number	Report Title	Dollar Recoveries
12/17/2014	14-01707-73	Review of Voluntary Disclosure and Refund Offer Under an FSS Contract	$416,831
12/18/2014	13-00948-75	Review of Public Law Compliance for a Covered Drug Under an FSS Contract	$410,171
12/18/2014	14-03805-76	Review of Voluntary Disclosure Under an FSS Contract	$66,758
1/21/2015	15-00019-95	Review of Disclosure of Pricing Errors Under a Contract	$15,567
1/29/2015	15-00016-110	Review of Public Law Compliance for a Covered Drug Under an FSS Contract	
1/29/2015	14-03866-114	Review of Voluntary Disclosure for Publix Law Damages Under an FSS Contract	$249
2/9/2015	15-00011-128	Review of Voluntary Disclosure Under an FSS Contract	$114,854
2/11/2015	14-00469-136	Review of Voluntary Disclosure Under an FSS Contract	$4,942
2/12/2015	14-03998-135	Review of Self-Audit Performed Under an FSS Contract	
2/12/2015	15-00012-138	Review of Voluntary Disclosure Under an FSS Contract	$1,286
3/25/2015	13-03905-148	Review of Public Law Drug Pricing Provisions Under an Interim Agreement and Contract	$1,425
3/27/2015	15-00015-195	Review of Compliance with Public Law Under a Contract	$94
			$1,971,852

Office of Contract Review | Claim Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
11/18/2014	14-03986-39	Review of Certified Claim Submitted Under a Contract	$212,929
2/20/2015	15-01184-140	Review of Claim Submitted on a Purchase Agreement	$36,377
			$249,306

Total Potential Monetary Benefits of Reports Issued

Report Type	BUOF	Questioned Costs	Savings and Cost Avoidance	Dollar Recoveries
Audits, Evaluations, and Reviews	**$820,693,000**	**$135,267,000**		
Preaward Reviews			**$73,679,191**	
Postaward Reviews				**$1,971,852**
Claim Review			**$249,306**	
	$820,693,000	**$135,267,000**	**$73,928,497**	**$1,971,852**

Table 2: Resolution Status of Reports with Questioned Costs

Resolution Status	Number	Dollar Value
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	4	$135,267,000
Total inventory this period	**4**	**$135,267,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	4	$135,267,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**4**	**$135,267,000**
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	4	$820,693,000
Total inventory this period	**4**	**$820,693,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	4	$820,693,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**4**	**$820,693,000**
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 OIG 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 March 31, 2015, there are 205 total open reports and 1,150 total open recommendations. However, 8 reports and 10 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 35 reports and 67 recommendations that, as of March 31, 2015, remain open for more than 1 year. The total monetary benefit attached to these reports is $681,962,198.

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	19	149	168	27	979	1006
Veterans Benefits Administration	5	17	22	14	52	66
National Cemetery Administration	0	1	1	0	3	3
Office of Public and Intergovernmental Affairs	0	1	1	0	3	3
Office of Acquisitions, Logistics, and Construction	6	0	6	13	0	13
Office of Management (OM)	3	0	3	8	0	8
Office of Information and Technology	4	2	6	5	42	47
Office of Human Resources and Administration	2	1	3	2	5	7
Office of Operations, Security, and Preparedness (OSP)	2	0	2	2	0	2
Office of General Counsel	2	0	2	5	0	5
Chief of Staff (COS)	1	0	1	2	0	2
Total	**44**	**171**	**215**	**78**	**1084**	**1162**

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.				
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 [Office of Acquisition and Logistics] 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.* *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**	**Audit of the Veterans Service Network**	**OIT**	**$35,000,000**
Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 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.				
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.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.				
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. *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 [Volunteers of America] is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. 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.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.				
09/30/12	**12-00165-277**	**Review of Alleged Delays in VA Contractor Background Investigations**	**OIT/OSP**	**None**
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.				
09/30/12	**12-02525-291**	**Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida**	**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 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**	**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.				

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.				
03/28/13	**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 _____ for the 39 days that _____ was AWOL [absent without leave] from VA or worked for _____ while on sick leave and ensure that a bill of collection is issued to _____ for that amount, since _____ cannot receive pay for the period of time that _____ was absent without authorization.				
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 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 colorectal cancer screening results.				
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 and General Counsel 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 [Office of General Counsel] and HR [human resources] 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.				
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. *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.*				
09/27/13	**12-02387-343**	**Audit of VA's Technology Acquisition Center Contract Operations**	**OALC**	**$108,700,000**
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.*				
10/22/13	**12-04046-307**	**Review of VA's Management of Health Care Center Leases**	**VHA/OALC**	**None**
Recommendation 1: We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction, in coordination with the Under Secretary for Health, establish adequate guidance for the procurement of large-scale build-to-lease facilities.				
01/27/14	**13-02641-50**	**Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, Pennsylvania**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that contractors receive OSHA [Occupational Safety and Health Administration] Construction Safety training prior to project initiation.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
02/03/14	**13-03621-57**	**Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa**	**VHA**	**None**
Recommendation 4: 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.				
02/04/14	**13-03423-55**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana**	**VHA**	**None**
Recommendation 4: We recommended that staff document that medication reconciliation be completed at each episode of care where the newly prescribed fluoroquinolone is administered, prescribed, or modified. *Recommendation 5: We recommended that staff document the evaluation of each patient's level of understanding for the medication education provided.*				
02/05/14	**13-03416-56**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Montana Health Care System, Fort Harrison, Montana**	**VHA**	**None**
Recommendation 13: We recommended that CBOC/PCC [Primary Care Clinic] staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.				
02/06/14	**13-00872-71**	**Healthcare Inspection – Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina**	**VHA**	**None**
Recommendation 2: We recommended that the Facility Director ensure that morbidity outliers are discussed and analyzed, and that corrective actions are taken as indicated. *Recommendation 5: We recommended that the Facility Director ensure that infection control surveillance data is analyzed and trended, and that Infection Control Sub-Council minutes include required elements and reflect preventive and corrective measures.* *Recommendation 8: We recommended that the Facility Director ensure that Quality Management oversight and reporting structures are fully integrated, comprehensive, and functional.*				

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 9: We recommended that the Facility Director ensure oversight and subordinate committee minutes include required elements; and reflect data analysis, conclusions, action tracking and follow-up, and outcome measurement. *Recommendation 11: We recommended that the Facility Director ensure compliance with Veterans Health Administration policies on identification and reporting of cases for peer review, including use of the Occurrence Screening package.*				
02/06/14	**13-04240-60**	**Combined Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont**	**VHA**	**None**
Recommendation 11: We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.				
02/12/14	**13-03624-58**	**Healthcare Inspection – Alleged Patient Safety Concerns in the Operating Room, VA Maine Healthcare System, Augusta, Maine**	**VHA**	**None**
Recommendation 3: We recommended that the Facility Director implement the recommendations made during a protected Veterans Health Administration Surgical Program review.				
02/24/14	**13-01488-86**	**Administrative Investigation, Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice, VA Center for Innovation, VA Central Office**	**VBA**	**None**
Recommendation 7: We recommend that the VA Chief of Staff ensure that _____ is issued a bill of collection for $30,990.29 to reimburse VA for a misuse of travel funds. *Recommendation 8: We recommend that the VA Chief of Staff ensure that _____'s time and attendance between March and October 2012 is corrected and that he is charged the appropriate annual and sick leave for that time.* *Recommendation 9: We recommend that the VA Chief of Staff ensure that the total amount paid to _____ for the 20 instances that he was absent without authorization be determined and that _____ is issued a bill of collection for that amount, since he cannot receive pay for the time that he was absent without authorization.*				

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 recommend that the VA Chief of Staff confer with OHRA and OGC to determine the appropriate administrative action, if any, to take concerning the prohibited personnel practice and _____'s promotion.				
02/25/14	**13-03655-84**	**Combined Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah**	**VHA**	**None**
Recommendation 4: We recommended that processes be strengthened to ensure that members from Surgery and Anesthesia Services attend Blood Transfusion Committee meetings.				
02/25/14	**13-04241-78**	**Combined Assessment Program Review of the Boise VA Medical Center, Boise, Idaho**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that the review of electronic health record quality includes most services.				
03/12/14	**13-03653-91**	**Combined Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia**	**VHA**	**None**
Recommendation 17: 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. *Recommendation 18: We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education to patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.*				
03/18/14	**14-00223-93**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Colorado Health Care System, Denver, Colorado**	**VHA**	**None**
Recommendation 2: We recommended that all staff document that medication reconciliation was completed at each episode of care when the newly prescribed fluoroquinolone was administered, prescribed, or modified.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/31/14	**13-02073-106**	**Healthcare Inspection – Administrative Irregularities, Leadership Lapses, and Quality of Care Concerns VA Central Iowa Health Care System, Des Moines, Iowa**	**VHA**	**None**
Recommendation 2: We recommended that the Facility Director ensure that selection of physicians who will be participating in medical educational activities is conducted within the standards of the Accreditation Council of Graduate Medical Education's Residency Review Committee and that compliance be monitored. *Recommendation 4: We recommended that the Facility Director ensure processes be strengthened so that Focused Professional Practice Evaluations for licensed independent practitioners are consistently conducted as required, and that compliance is monitored.* *Recommendation 5: We recommended that the Facility Director ensure that the Chief of Staff maintain a comprehensive list of staff that is authorized to perform out of Operating Room airway management in compliance with facility policy.*				
03/31/14	**13-02697-113**	**Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center**	**OALC/OM**	**None**
Recommendation 3: We recommended that the Principal Executive Director, OALC ensure the Contracting Officer takes an active role in decisions and does not abdicate responsibility to the project manager or broker. *Recommendation 4: We recommended that the Principal Executive Director, OALC determine ownership of each LLC [limited liability company] involved for future projects, including the SPE [Special Purpose Entity] LLC if used by the developer.* *Recommendation 7: We recommended that the Principal Executive Director, OALC establish requirements that Past Performance Survey Forms be verified. Searches should be conducted online in FPDS [Federal Procurement Data System] for Government-wide contracts. Searches should be conducted online in the Electronic Contract Management System for VA contracts. Contact should be made with the project owner to discuss vendor's role as disclosed on the Past Performance Survey Forms. Focus should be on the entity, not only the individuals.* *Recommendation 8: We recommended that the Principal Executive Director, OALC require vendors to submit documentation, such as teaming arrangements, that key team members such as architects, engineers, and GCs [general contractor] are committed and able to do the project*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/31/14	14-00232-110	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Loma Linda Healthcare System, Loma Linda, California	VHA	None
Recommendation 6: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				
Total				**$681,962,198**

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On the Cover

Wreath laid at the Pacific Arch of the Memorial in honor of the 70,000 Americans who served during this historic battle of WWII. On Thursday, February 19 at 12 p.m., World War II veterans and members of the Friends of the National World War II Memorial (Friends) Board of Directors gathered at the World War II Memorial in Washington, DC to commemorate the 70th anniversary of Iwo Jima, a five-week battle that comprised some of the fiercest and bloodiest fighting of the Pacific Theater of Operations of World War II. Cover photo courtesy of the Department of Veterans Affairs photographer Robert Turtil.

Department of Veterans Affairs

Office of Inspector General

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