Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
April 1, 2009-September 30, 2009

Message from the Inspector General

This Semiannual Report, submitted to Congress pursuant to the *Inspector General Act of 1978,* as amended, summarizes the activities of the Office of Inspector General (OIG) for the reporting period from April 1, 2009, through September 30, 2009.

OIG issued 133 reports on VA programs and operations during this reporting period, for a total of 235 reports issued in fiscal year (FY) 2009. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, financial management, economy in procurement, and information security. OIG audits, investigations, and other reviews identified over $2.3 billion in monetary benefits, for a return of $59 for every dollar expended on OIG oversight. Our criminal investigators have closed 530 investigations and made 286 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work also resulted in 511 administrative sanctions.

At the request of the Secretary and VA's congressional oversight committees, OIG performed an extensive review of the reprocessing of endoscopic equipment at VA Medical Centers (VAMCs). OIG testified on the results of the review before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations in June 2009. The review found that the facilities were noncompliant with existing directives designed to ensure compliance with endoscopic reprocessing procedures, resulting in a risk of infectious disease to Veterans. The Veterans Health Administration's (VHA's) failure to comply on such a large scale suggested fundamental defects in organizational structure. During August 2009, OIG performed unannounced follow-up inspections of VHA facilities that perform colonoscope reprocessing. Among the 129 facilities inspected, all were compliant with requirements for standard operating procedures, and all but one facility had adequate documentation of demonstrated competence for reprocessing staff.

An OIG audit of VHA's Non-VA Outpatient Fee Care Program discovered significant payment errors and weak controls over the justification and authorization process of claims payments. In FY 2008 alone, 37 percent of payments issued by VAMCs were improper, resulting in an estimated $225 million in overpayments and $52 million in underpayments to fee providers. These estimates translate to approximately $1.126 billion in overpayments and $260 million in underpayments over 5 years. VHA lacks reasonable assurance that Fee Program funds were used as intended and in an effective and economical manner for 80 percent of outpatient care payments because VAMCs did not properly justify and authorize fee services as required by VHA policy. OIG made eight recommendations to VHA to ensure outpatient fee care program payments are consistent, reasonable, and proper.

Two OIG administrative investigations substantiated instances of abuse of authority, misuse of position, nepotism, and prohibited personnel practices within the Office of Information and Technology (OI&T). The first investigation substantiated that a senior official within OI&T misused her position, abused her authority, and engaged in prohibited personnel practices when she influenced a VA contractor and later her VA subordinates to employ a friend. It also substantiated that she misused her position when she took advantage of a personal relationship with her supervisor to relocate her duty station outside of the VA Central Office (VACO) commuting area while spending almost 60 percent of her time at VACO on official travel. The report also found that the employee failed to provide proper contract

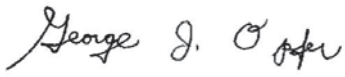
oversight. Further, the investigation substantiated that three other senior officials within OI&T abused their authority and engaged in prohibited personnel practices in the filling of four GS-15 positions.

A second administrative investigation substantiated that a former senior official within OI&T engaged in nepotism when she improperly advocated for the hiring and advancement of her family members and that she abused her authority and engaged in prohibited personnel practices when she improperly hired an acquaintance and friend. It also substantiated that two other OI&T employees misused their positions for the private gain of family members and that one of the employees failed to testify freely and honestly and failed to properly discharge the duties of his position. Additionally, the investigation found that OI&T managers improperly authorized academic degree funding for family and friends; improperly applied hiring authorities to appoint family and friends; and were not fiscally responsible when administering awards. OIG testified on these reports before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations in September 2009.

Two reports issued by the Office of Contract Review this reporting period concluded that VA has not performed adequate oversight of Information Technology (IT) projects. At the request of the Secretary and the Ranking Republican Member, U.S. House of Representatives' Committee on Veterans' Affairs, OIG reviewed the Interagency Agreement (IAA) between OI&T and the Department of Navy, Space and Naval Warfare Systems Center. The review found that all parties entered into the IAA without an adequate analysis to determine whether it was in the best interest of the Government, as required by the Federal acquisition regulations. Moreover, OIG determined that neither party complied with the terms and conditions of the IAA.

The second review, performed at the request of the Ranking Member, U.S. Senate Committee on Veterans' Affairs, made findings consistent with the IAA review. OIG determined that OI&T's program planning and oversight of the Replacement Scheduling Application (RSA) project was ineffective for various reasons. As a result, VA expended over $70 million through January 2009 and does not have a deployable RSA application. The findings from both reports suggest a fundamental inability on the part of OI&T to properly manage IT projects internally.

OIG appreciates the ongoing support we receive from the Secretary, the Deputy Secretary, and senior management. We look forward to working with VA and Congress to transform VA into a 21st Century organization that is people-centric, results-driven, and forward-looking. Most importantly, we will continue to do our part to ensure America's Veterans receive the care, support, and recognition they have earned in service to our country.



GEORGE J. OPFER
Inspector General

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Statistical Highlights

	Reporting Period	FY 2009
DOLLAR IMPACT ($$$ in Millions)		
Better Use of Funds	$43.2	$423.2
Fines, Penalties, Restitutions, and Civil Judgments	$1,212.1	1,220.8
Fugitive Felon Program	$105.9	$216.0
Savings and Cost Avoidance	$16.5	$32.2
Questioned Costs	$865.4	$865.4
OIG Dollar Recoveries	$4.1	$7.6
Contract Review Savings and Dollar Recoveries[1]	$69.2	$165.6
RETURN ON INVESTMENT[2]		
Dollar Impact ($2316.4)/Cost of OIG Operations ($39.2)	$59:1	
Dollar Impact ($2930.8)/Cost of OIG Operations ($78.1)		$38:1
OTHER IMPACT		
Arrests[3]	286	539
Indictments	169	303
Criminal Complaints	107	186
Convictions	209	367
Pretrial Diversions	19	46
Fugitive Felon Apprehensions by Other Agencies Using VA OIG Data	22	48
Administrative Sanctions	511	809
ACTIVITIES		
Reports Issued		
Administrative Investigations	3	4
American Recovery and Reinvestment Act	1	1
Audits and Reviews	20	29
Benefits Inspections	2	2
Combined Assessment Program Reviews	22	47
Community Based Outpatient Clinic Reports (encompassing 31 facilities)	5	5
Counselor to the Inspector General	0	3
Healthcare Inspections	30	48
Joint Review	1	1
Preaward Contract Reviews	26	57
Postaward Contract Reviews	20	35
Contract Review Special Reports	3	3

1. Includes $12.8 million and $43.8 million in questioned costs for this period and FY 2009, respectively.
2. Because oversight work performed by the Office of Healthcare Inspections results in saving lives and not dollars, their operating costs ($7.3 million and $14.6 million for this period and FY 2009, respectively) are not included in calculating return on investment.
3. Includes the apprehension of 34 and 72 fugitive felons by OIG for this period and FY 2009, respectively.

	Reporting Period	FY 2009
Investigative Cases		
Opened	536	1048
Closed	530	1022
Healthcare Inspections Activities		
Clinical Consultations	2	4
Administrative Case Closures	4	11
Hotline Activities		
Cases Opened	538	1012
Cases Closed	567	1015

VA and OIG Mission, Organization & 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) 2009, VA operated under a $93.4 billion budget, with over 278,000 employees serving an estimated 23.4 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, and the Republic of the Philippines.

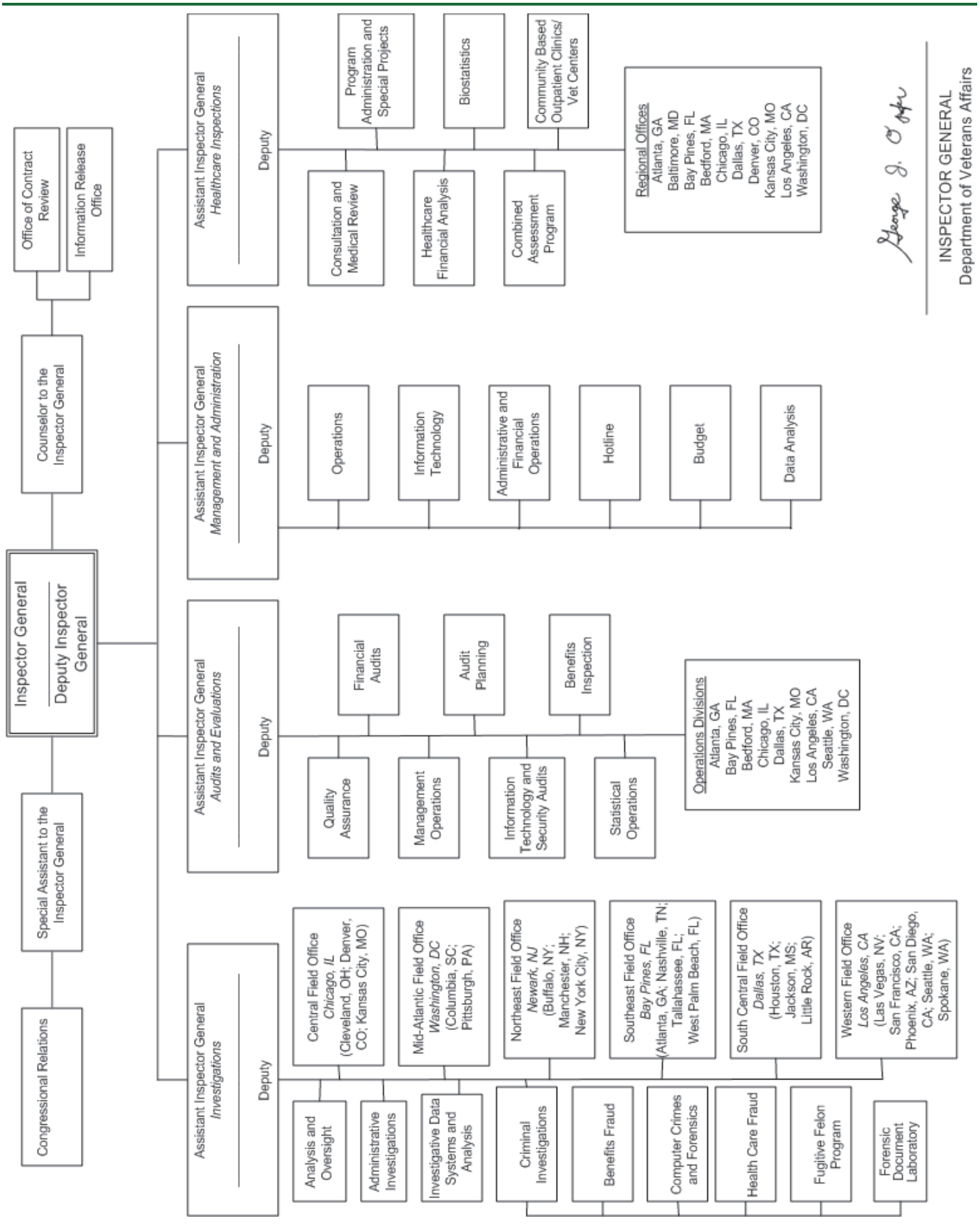
VA has three administrations that serve Veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration provides interment and memorial benefits. For more information,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

VA Office of Inspector General

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

OIG, with 522 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 2009 funding for OIG operations provides $87.8 million from ongoing appropriations. The Office of Contract Review, with 25 employees, receives $3.6 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) contracts. The *American Recovery and Reinvestment Act of 2009* provided OIG an additional $1 million for oversight of the $1.4 billion the Recovery Act provided to VA. 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 strives 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.


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

Office of Healthcare Inspections

The health care that VHA provides Veterans is consistently ranked among the best in the Nation, whether those Veterans are recently returned from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses VHA services. During this reporting period, OHI published 11 national, 1 joint, 22 Combined Assessment Program (CAP), 19 hotline, and 5 Community Based Outpatient Clinic (CBOC) reports to evaluate quality of care issues in many VHA medical facilities.

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 a fraud and integrity awareness program. During this reporting period, OIG issued 22 CAP reports, which are listed in Appendix A. Topics reviewed in a facility CAP may vary based on the facility mission, hotline activity, and VHA Office of Medical Inspector reports. Topics generally run for 6–12 months; the CAP topics in current use since January 2009 are:

- Suicide prevention.
- Contracted/agency registered nurses.
- Quality management.
- Environment of care.
- Coordination of care.
- Medication management.
- Emergency/urgent care operations.
- Survey of health care experiences of patients.
- Physician privileges.

When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use.

First CAP Review at Overseas Facility

OIG conducted the first CAP review of the VA Manila Outpatient Clinic, Manila, Philippines, which is the only VA medical facility located in a foreign country. The clinic complied with selected standards in access to care, patient survey satisfaction scores, and post-deployment screening. OIG made recommendations for improvements in quality management, continuity of care, environment of care, controlled substances inspection program, suicide prevention program, and staff competency assessments. OIG provided fraud and integrity awareness training to 84 employees.

Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany House Resolution 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG recently began a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC

site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review. The objectives of the reviews are to determine (1) whether CBOC quality of care measures are comparable to the parent facility clinics, (2) whether CBOC providers are appropriately credentialed and privileged in accordance with VHA policy, (3) whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of OEF/OIF era Veterans, (4) whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency management planning, (5) the effect of CBOCs on Veterans' perception of care, and (6) whether CBOC contracts were administered in accordance with contract terms and conditions.

During this reporting period, OIG performed 31 CBOC reviews, which were captured in 5 reports. We made recommendations for improvements at the following facilities:

- VISN 1: Bangor and Portland, ME; Conway and Tilton, NH; and Rutland and Colchester, VT.
- VISN 2: Lockport and Olean, NY.
- VISN 4: Berwick, Monaca, Sayre, and Washington, PA.
- VISN 5: Cambridge, Fort Howard, and Greenbelt MD; and Alexandria, VA.
- VISN 6: Wilmington and Jacksonville, NC.
- VISN 9: Somerset, KY.
- VISN 11: Benton Harbor and Grand Rapids, MI; Terre Haute and Bloomington, IN; and Yale and Pontiac, MI.
- VISN 22: Henderson and Pahrump, NV; Palm Desert, Corona, Pasadena, and Santa Maria, CA.

National Reports

Systemic Compliance Failures Found in Endoscopy Reprocessing Practices

OIG received requests from the VA Secretary, the Chairmen and Ranking Members of VA oversight committees, and other Members of Congress, regarding reprocessing errors that placed Veterans at risk of viral infections at VA Medical Centers (VAMCs) in Augusta, GA; Miami, FL; and Murfreesboro, TN. OIG performed a review to assess the extent of related problems throughout VHA. OIG's unannounced inspections conducted at 42 randomly selected medical facilities showed that VA needs to address serious management issues regarding industrial processes. Inspectors found that fewer than half of the selected facilities were in compliance with directives on availability of standard operating procedures at reprocessing sites and documentation of staff training and competency. OIG found that VHA's Clinical Risk Assessment Advisory Board has been effective in providing guidance to VHA leadership on disclosure on adverse events to Veterans. OIG made recommendations to ensure compliance with reprocessing directives, explore possibilities for improving the reliability of reprocessing with experts, and review VHA's organizational structure for needed changes to implement quality controls and ensure compliance with directives.

In August 2009, OIG performed unannounced follow-up inspections of VHA facilities that perform colonoscope reprocessing. Among the 129 facilities inspected, all were in compliance with standard operating procedures. With one exception, all facilities had adequate documentation of demonstrated competence for reprocessing staff. VHA is still in the process of implementing recommendations

made in OIG's initial report, issued June 16, 2009, on the use and reprocessing of flexible fiberoptic endoscopes at VAMCs.

Improved Compliance Needed in Quality Management Programs

OIG completed an evaluation of quality management (QM) programs at 44 VHA medical facilities to determine whether they had comprehensive, effective QM programs and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. Two of the facilities reviewed had significant QM weaknesses. OIG recommended that VHA continue to strengthen QM programs through increased compliance with existing standards and requirements for patient complaints data management, medication reconciliation monitoring, use of the copy and paste functions in the electronic medical record, moderate sedation monitoring, and matching the length of privileges to the length of employment association.

Additional Steps Needed to Screen, Monitor Patients in Residential MH Care Facilities

In accordance with P.L. 110-387, OIG reviewed all residential MH care facilities, including domiciliaries, within VHA. This national review assessed the availability of facilities in each VISN, the supervision and support provided to patients, the ratio of staff to patients, the appropriateness of rules and procedures for the prescription and administration of medications to patients, and protocols for handling missed appointments. Among the findings were that less than half of sites visited had appropriate policies for screening patients for admission; post-discharge monitoring was not evident in 29 percent of patient records; 11 percent of patients allowed to self-medicate narcotics received more than a 7-day supply of medications; and more than half of self-medicating patients had no documentation of an order for self-medication. OIG made recommendations in the five review areas to improve the care provided to Veterans in residential mental health care facilities.

Noncompliance with Informed Consent Requirements in Human Subjects Research Noted

At the request of the Ranking Republican Member, U.S. House of Representatives' Committee on Veterans' Affairs, OIG conducted a review to determine whether VA research involving human subjects had the appropriate informed consent or waiver forms on file and whether the consent forms comply with the Federal and VA regulations and VHA policies. After designing and executing a complex statistical study, OIG estimated that 1.7 percent of consent forms could not be located and that 31 percent on file were noncompliant. Nearly all noncompliant consent forms lacked a witness signature and about 1 percent lacked a signature from the subject or subject's authorized representative. OIG made recommendations to ensure VHA human subjects research programs comply with applicable laws and policies.

Improvements Noted in Access to Orthopedic Services at VA Pacific Islands Health Care System

OIG reviewed challenges impacting the delivery of mental health and orthopedic services at the Pacific Islands Health Care System (HCS) at the request of the Chairman, U.S. Senate Committee on Veterans' Affairs. The review focused on services offered by the main Ambulatory Care Center in Honolulu, HI; and the Maui, HI, CBOC. OIG determined the Ambulatory Care Center in Honolulu meets Veterans' mental health needs on Oahu, although ensuring timely access to mental health services on Maui has been a challenge due to reported shortages of VA and community health providers on the island. Initial orthopedic appointments for Pacific Islands HCS patients were generally timely, and the average wait time for elective orthopedic surgery procedures has improved significantly. OIG found no evidence that the Pacific Islands HCS places unnecessary restrictions on access to orthopedic services and made no recommendations.

VA, Army Personnel Clear on Responsibilities at Tripler Army Medical Center

OIG reviewed and responded to questions raised by the Chairman, Senate Committee on Veterans' Affairs, regarding oversight, equipment, and staffing in the inpatient psychiatric unit (Ward 3B2) operated through a sharing agreement with Tripler Army Medical Center (TAMC). OIG determined that a joint policy defines the responsibilities for Ward 3B2, which generally appear to be clear to managers at both the TAMC and the VA Pacific Islands HCS. Additionally, management had adequately addressed equipment and staffing issues.

OIG Evaluates National Patient Safety Program

OIG evaluated VHA's National Patient Safety (NPS) Program, determining if VHA's NPS Program has been effective in preventing inadvertent harm to patients receiving VHA care and whether it has provided efficient and effective coordination, oversight, and continuous improvement. VHA's 1998 creation of the NPS Program was an important and positive step towards expanding existing patient safety activities. Since 1998, VHA's NPS Program has been the foundation for many national and international patient safety initiatives. However, OIG noted several opportunities to strengthen the NPS Program and made recommendations aimed to achieve programmatic effectiveness and oversight improvement.

OIG Finds VHA Suicide Prevention Programs Generally Compliant

OIG evaluated the extent to which 24 VHA facilities implemented suicide prevention programs in compliance with VHA requirements. All 24 facilities implemented suicide prevention programs that generally met the VHA requirements. To strengthen the programs, OIG recommended that VHA ensure documentation of collaboration between suicide prevention coordinators and mental health providers, development of comprehensive and timely safety plans by mental health providers, and appointment of full-time suicide prevention coordinators at very large CBOCs.

OIG Reviews Vet Centers' Operational Procedures, Recommends Improvements

OIG performed a review of VHA's Vet Centers to gather information about their operational procedures. OIG noted several opportunities to strengthen the Vet Centers' effectiveness, oversight, and continuous improvement and made recommendations to address all of these issues.

VHA Animal Research Generally in Compliance, No Animal Abuse or Neglect Noted

OIG conducted a national review of VHA animal research to assess compliance with requirements in VHA Handbook 1200.7, Use of Animals in Research. The review noted good compliance with documentation requirements for Institutional Animal Care and Use Committee minutes, but lower compliance in performance of semi-annual self-assessments of the animal research program. OIG did not identify any instances of animal abuse or neglect.

Hotline Reports

Flaws Noted in Fee Basis Program at Connecticut HCS

OIG conducted an inspection of the VA Connecticut HCS after a complainant alleged mismanagement of the Fee Basis Program, which allows VA to authorize Veterans' medical care in the community when VA cannot provide all of the necessary care and services. Inspectors substantiated the existence of flaws in the pre-authorization process for fee-based care, but determined that VA physicians were not self-referring or benefiting financially from Fee Basis Program claims. Inspectors acknowledged that managers initiated new procedures to improve oversight prior to the inspection, but also made recommendations to ensure sustained oversight and to eliminate the appearance of self-referrals and conflicts of interest.

Comprehensive Review of Specialty Service Needed at Ft. Harrison, Montana

OIG reviewed actions taken by VHA to address allegations that a physician at the VA Montana HCS in Ft. Harrison, MT, was providing substandard care and engaging in improper medical record documentation practices. OIG found that management officials were initially impeded in addressing these issues due to an insufficient Administrative Board of Investigation product. VHA management officials appropriately obtained external peer reviews of care provided by the subject physician and took necessary personnel actions. OIG recommended VHA perform a comprehensive review of care in the specialty referenced in this report and offer new examinations to Veterans treated by the subject physician.

North Florida/South Georgia Veterans Health System Corrects Pulmonary Staffing

OIG performed a healthcare inspection at the North Florida/South Georgia Veterans Health System in Gainesville, FL, to determine the validity of allegations regarding quality of care issues and the adequacy of pulmonary services. OIG substantiated the allegation that one pulmonology fellow was previously responsible for covering inpatient consultations and the medical intensive care unit (MICU); however, prior to the inspection, there was a realignment of duties that resulted in increased pulmonary coverage. OIG also substantiated that one fellow managed critically ill patients in the MICU while also covering Shands Hospital at the University of Florida, but the medical center had back-up assistance and there was no evidence that this negatively impacted patient care. Lastly, OIG substantiated that fee basis requests for various treatments for lung cancer had declined, but that this decline was the result of improved processes and did not result in treatment delays as alleged.

Discharge Issues for Stroke Patients Found at Salisbury, North Carolina, VAMC

OIG reviewed the validity of allegations regarding the emergency department (ED) at the Salisbury VAMC in Salisbury, NC. OIG did not substantiate that patient treatment was delayed or that the ED staff did not complete a comprehensive assessment. However, OIG substantiated that the patient was improperly discharged to home from the ED and concluded that the implementation of an algorithm for treatment of stroke would be a reasonable step to address discharge issues.

OIG Reviews Allegations Against VA North Texas Health Care System

An OIG review determined that allegations regarding widespread false documentation of resident supervision and unfulfilled contractual obligations by attending physicians from the University of Texas Southwestern Medical Center at Dallas were not valid. The complainant also alleged that an attending physician was not present at the facility during a Code Blue (cardiorespiratory arrest) event. OIG confirmed that although the physician was absent during the Code Blue, there is no requirement to be physically present in the unit to fulfill supervision responsibilities, and the patient was managed appropriately by other physicians. OIG further determined that the system needed to comply with VHA discharge summary documentation requirements and noted that the facility had already implemented corrective actions.

Review of Allegations Finds Issues with Fee Basis Consults at Prescott VAMC

OIG evaluated allegations related to quality of care in several services and a rating change of a peer review at the Bob Stump VAMC in Prescott, AZ. Although the allegations were not substantiated, the inspection revealed that the VAMC lacked a mechanism for tracking their large number of fee basis consults. Additionally, a VAMC provider failed to inform leadership about an unacknowledged abnormal chest x-ray from the Southern Arizona VA Health Care System, Tucson, AZ.

OIG Inspects Allegations Against Hampton, Virginia, VAMC

OIG conducted a review of allegations against the ED at the Hampton VAMC in Hampton, VA. OIG substantiated that the treating physician did not conduct an adequate work-up of a patient's stroke symptoms, the ED physician violated VHA guidelines and erroneously copied and pasted another

patient's laboratory results into the medical record of the complainant, and that staff did not promptly respond to the patient's concerns. OIG could not confirm that the patient's blood pressure was inaccurately recorded or that the physician was discourteous. OIG made four recommendations to address the identified conditions.

Allegations of Denial of Care at VA Central Iowa HCS Unfounded

OIG conducted an inspection in response to allegations that three Veterans were denied access to care after 4:30 p.m. at the VA Central Iowa HCS's Knoxville Division, Knoxville, IA. OIG did not substantiate this allegation, but found that a number of employees did not fully understand the new procedures implemented when the hours of operation changed to Monday through Friday, 7:00 a.m. to 4:30 p.m. OIG recommended that management develop a policy to define how to handle emergencies occurring on VA grounds. Additionally, OIG recommended the facility provide employees and Veterans with the necessary information and guidance on changes to facility hours and procedures.

Allegations Against Tomah, Wisconsin, VAMC Not Validated

OIG conducted an inspection in response to allegations that a registered nurse at the Tomah VAMC in Tomah, WI, provided inappropriate care during an incident involving a terminally ill patient in the Community Living Center. OIG did not substantiate that an intentional unsafe act occurred or that the patient died as a result of the incident; however, managers failed to follow VHA and medical center policy related to allegations of patient abuse. OIG recommended that managers ensure staff immediately report suspected incidents of patient abuse and that further actions are taken in accordance with VHA and medical center policy.

Insufficient Anesthesiology Staffing Allegation Unfounded at San Juan VAMC

An OIG review did not substantiate an allegation of insufficient anesthesiologist staffing at the San Juan VAMC in San Juan, PR, and could neither confirm nor refute the allegation that only one anesthesiologist was on duty one day 2 years ago. OIG also did not substantiate the allegation that anesthesiologists failed to monitor patients during or after surgical procedures. However, the review determined that anesthesia staff failed to properly document the identity of the practitioner who administered each medication during a procedure, and OIG recommended that anesthesia staff be required to properly document medication administration in the anesthesia record.

Quality of Care Allegations Unfounded at Asheville, North Carolina, VAMC

At the request of U.S. Representative Heath Shuler, OIG reviewed multiple allegations concerning poor quality of care, delay in services, and erroneous documentation made by a patient of the Charles George VAMC, Asheville, NC. The complainant alleged that as a result of these issues, he has suffered financial hardship and that staff did not adequately respond to his concerns. OIG did not substantiate the allegations of poor quality of care, delay in services, or inadequate communication, and could not adequately evaluate allegations of financial hardship. OIG did confirm that a provider erroneously documented that the patient suffered "chest pain" during an outpatient visit; however, actions were taken to remedy the condition and OIG made no recommendations.

Claims Made Against VA Hospital in Tampa, Florida, Unfounded

OIG performed a review of the James A. Haley VA Hospital in Tampa, FL, to determine the merit of anonymous allegations concerning perfusionist credentialing and a reorganization of the surgery department. OIG did not substantiate allegations that two perfusionists from a private-sector medical facility worked in the operating room (OR) without appropriate credentials. OIG did not substantiate that a surgery department reorganization favored certain surgeons or that it adversely affected patients. OIG also did not substantiate the allegation that reorganizing the surgical department to control the OR schedule was in violation of recommendations made from a previous report. OIG made no recommendations.

OIG Examines Accusations Surrounding Patient's Death in Little Rock, Arkansas

OIG reviewed allegations of poor care associated with a patient's death at the John L. McClellan Memorial Veterans Hospital in Little Rock, AR. Specifically, the complainant alleged the patient did not have an appropriate medical evaluation prior to colon surgery, that post-operative lack of oxygen nearly caused the patient's death, and that medical treatment in the emergency department was inadequate. Allegations of poor care associated with the patient's death were not substantiated. OIG made no recommendations.

Allegations Not Substantiated Against Nursing Staff at Bay Pines, Florida, VAHCS

OIG did not substantiate allegations made against the nursing staff at the Bay Pines VAHCS in Bay Pines, FL. The allegations purported that registered nurses (RNs) were performing pacemaker checks without proper training, that RNs were given a 1-month deadline to be trained in such checks, and that not allowing pacemaker company representatives to do pacemaker device checks compromised patient safety. OIG's review determined that no untrained personnel were performing pacemaker checks and made no recommendations.

Joint Report

Insufficient Testing of VHA Patient Record Software Found

OIG's Office of Audits and Evaluations and OHI evaluated the testing and deployment of the Computerized Patient Record System (CPRS) version 27 (v27) at the request of the former VA Secretary. The project management team's software development methodology for testing and implementing CPRS v27 did not effectively mitigate risks, associated software functionality defects, and the potential adverse impacts on patient safety. OIG made recommendations to improve the quality and depth of field testing.

Office of Audits and Evaluations

Veterans Health Administration Reports

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.

Audit Estimates Over $1 Billion in Overpayments in VHA's Non-VA Outpatient Fee Care Program

An audit of the VHA's Non-VA Outpatient Fee Care Program discovered significant payment errors and weak controls over the justification and authorization process of claims payments. In FY 2008 alone, 37 percent of payments issued by VAMCs were improper, resulting in an estimated $225 million in overpayments and $52 million in underpayments to fee providers. These estimates translate to approximately $1.126 billion in overpayments and $260 million in underpayments over 5 years. VHA lacks reasonable assurance that Fee Program funds were used as intended and in an effective and economical manner for 80 percent of outpatient care payments because VAMCs did not properly justify and authorize fee services as required by VHA policy. OIG made eight recommendations to VHA to ensure outpatient fee care program payments are consistent, reasonable, and proper.

Reducing Unnecessary Open Market Purchases Will Save $41 Million

OIG audited open market purchases made by VHA to determine if medical facilities purchased items on the open market when identical or like items were available for purchase through an existing FSS at a lower price. OIG determined that increased usage of the FSS as well as improved oversight would reduce unnecessary open market medical equipment and supply purchases. These changes will reduce VA's health care item costs by approximately $8.2 million annually or $41 million over 5 years.

Improvements in Major Construction Contract Controls Noted, Additional Oversight Still Needed

OIG conducted a follow-up audit to determine whether VA implemented corrective action plans outlined in a previous audit of VHA's major construction contract award and administration process. The original 2005 OIG report included 12 recommendations that addressed needed improvements in contract award, administration, and project management. The follow-up audit determined that VA has strengthened management controls and oversight with implementation of 10 of the 12 recommendations and a Quality Assurance (QA) Program. VA still needs to improve project management oversight to reduce contract schedule slippage and to close out projects promptly so that unneeded funds can be reprogrammed. The QA Program needs to develop written policies, procedures, and performance measures to guide operations and a formal staffing plan to ensure adequate resources are available to fully implement work requirements.

Pharmacy Contract Management Needs Strengthening

An OIG audit of VA's Consolidated Mail Outpatient Pharmacy (CMOP) determined that VA needs to improve CMOP contract management. The audit revealed that although the National CMOP Office generally complied with Federal and VA acquisition requirements when developing, competing, and monitoring contracts, CMOP managers did not always ensure that the contracts were effective, economical, or that they adequately protected VA's contractual interests. One contract reviewed did not meet Federal and VA acquisition requirements, which if followed could have saved VA $724,426. Three other contracts revealed that CMOPs were susceptible to overpaying for contract services, valued at $40.7 million, due to poor monitoring controls. OIG made recommendations to strengthen contract development controls as well as improve oversight of contract monitoring.

Inventory Controls Inadequate for Non-controlled Pharmaceuticals

OIG audited the CMOP in Charleston and Dallas to determine how well CMOPs inventory and safeguard against the diversion of non-controlled pharmaceuticals. Access controls over specific non-controlled pharmaceuticals stored in the controlled substances vault and cage were adequate, and physical security controls were established to prevent the unauthorized removal of pharmaceuticals from CMOPs. However, OIG determined inventory management controls were inadequate and that inventory system access controls needed strengthening in order to reduce the risk of non-controlled pharmaceuticals being diverted and pilfered.

Accountability Lacking for Non-controlled Drug Inventory

OIG conducted an audit to determine how accurately VHA could account for inventories of non-controlled drugs at increased risk for waste and diversion in its health care facilities. OIG found that VHA cannot accurately account for its non-controlled drug inventories because it has neither implemented nor enforced sufficient controls to ensure pharmacy inventory practices are standardized and pharmacy data is accurate. The accurate and complete data needed to account for these drugs is not available. Furthermore, VHA's Veterans Health Information System and Technology Architecture lacks the capability to capture information on some drugs that are returned to and restocked by a facility when drugs cannot be delivered to the Veteran. VHA needs to improve its ability to account for non-controlled drugs to reduce the risk of waste and diversion.

Mental Health Initiative Funding Adequately Tracked and Used as Intended

OIG's audit of Mental Health Initiative (MHI) funding found that VHA adequately tracks and uses MHI funding as intended. The report also noted that in FY 2009 the Office of Finance established standardized account classification codes for MHI funds that could further enhance transparency and accountability over how MHI funding is spent in the future.

OIG Reviews Recovery Act Funds for State Housing Grants

An OIG review determined that VHA needs to acquire additional staff to accommodate the increased workload within the State Home Construction Grant Program. The *American Recovery and Reinvestment Act* (Recovery Act) provided $150 million for VHA to provide grants for the construction of State extended care facilities.

Veterans Benefits Administration Reports

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.

Benefits Inspection Division Visits Wilmington and Nashville VA Regional Offices

The Benefits Inspection Division conducted an onsite inspection at the Wilmington, DE, VA Regional Office (VARO) to review disability compensation claims processing and Veteran Service Center operations. The Wilmington VARO met the requirements for processing benefit claims involving traumatic brain injury, systematic analysis of operations, correcting Systematic Technical Accuracy Review errors, date stamp accountability, implementation of the Claims Process Improvement model, handling claims-related mail, and responding to electronic inquiries. However, OIG noted several opportunities for improvement and recommended providing refresher training on claims-processing and improving management oversight and controls over operations. The Director concurred with all recommendations, but offered qualifications and commentary on some issues.

The Benefits Inspection Division also reviewed disability compensation claims processing and Veteran Service Center operations during an onsite inspection at the Nashville, TN, VARO. The Nashville VARO met the requirements for processing benefit claims involving diabetes, tracking claims folders, systematic analysis of operations, date stamp accountability, and accurately and timely handling of congressional inquiries. OIG identified several areas for improvement and recommended providing refresher training on claims-processing and improving management oversight and controls over operations in both cases. The Director concurred with all recommendations, except for training Legal Instrument Examiners.

VBA Large Retroactive Payments at Risk for Fraud

The objective of an OIG special review of large retroactive payments at select VAROs was to determine to what extent VBA and VAROs processing large retroactive payments have designed and implemented effective policies, procedures, and mechanisms to prevent and detect fraudulent activity. OIG's review detected no instances where altered or forged medical examination documentation and information improperly supported retroactive payments of $25,000 or above. However, OIG found that VBA lacks sufficient guidance directing VAROs to maintain accountability over its official date stamps. Additionally, medical document reviews focus on the technical sufficiency and completeness of a claim and do not focus on identifying potentially fraudulent medical information. VBA will continue to be vulnerable to these types of fraud-related activities if internal control weaknesses are not improved throughout VAROs.

Audit Recommends Improved Controls over Handling of Veterans' Claims Folders

OIG determined that VBA does not have effective controls in place to manage Veterans' claims folders adequately. At the time of the review, VBA had assigned about 4.2 million claims folders to regional offices for benefit claims processing and safeguarding. Approximately 7 percent of these claims folders were misplaced and an additional 3 percent were lost. Misplaced and lost claims folders ultimately cause unnecessary claim processing delays and place additional burdens on Veterans. OIG made recommendations to ensure that management track the number of lost or rebuilt folders, consistently enforce Control of Veterans Records System policies, and establish effective search procedures for missing claims folders.

VBA Needs to Improve Mailroom Management

OIG conducted an audit to evaluate whether VAROs effectively managed mailroom operations and controlled the timely and accurate processing of claim-related mail. In FY 2008, VBA processed about 33 million pieces of incoming and outgoing mail. Both the significant number of claim-related documents handled by VARO mailrooms and the potential processing effect on Veterans' claims if documents are inappropriately handled or destroyed make this a high-risk area for VBA. OIG determined that VARO mailrooms needed improvements in the handling, processing, and protection of claim-related documents as well as in meeting mailroom security and other operational requirements.

OIG Identifies Opportunities to Improve Rating Claims Processing Timeliness

OIG conducted an audit of VARO rating claims processing in order to identify opportunities to improve timeliness and minimize the number of claims with processing times exceeding 365 days. OIG determined that inefficient VARO workload management and/or claims processing activities performed by entities outside VARO control caused avoidable processing delays for almost all of the claims pending more than 365 days. OIG made 4 recommendations to improve rating claims processing timeliness and minimize the number of rating claims with processing times exceeding 365 days.

Improved Risk Management Could Prevent Funding Fee Increases for Veterans Purchasing Homes

OIG reviewed the effectiveness of risk management within the VBA's Loan Guaranty Service to determine if it adequately identified, analyzed, and reduced risks that could prevent the effective achievement of the program's mission to assist Veterans in purchasing and retaining homes. OIG determined that VBA did not perform a comprehensive risk assessment due to a lack of policies and procedures requiring such action, but instead relied upon external and internal risk analysis reviews that were not coordinated or sufficiently comprehensive to fully identify and manage all potentially significant risks. Because VBA charges Veterans funding fees for most loans to help offset losses incurred in managing and selling foreclosed properties, improved risk management could prevent future increases in funding fees for Veterans.

Compensation and Pension Quality Assurance Program Lacks in Infrastructure

OIG audited VBA's Compensation and Pension (C&P) Site Visit program to determine whether it effectively monitors and evaluates Veterans Service Center (VSC) operations. OIG determined that while the C&P Site Visit program provides centralized oversight and technical assistance to VSC operations, the program lacks the adequate infrastructure and management strategy to meet its mission and goals. OIG concluded that improvement efforts are needed in these areas to ensure the Site Visit program meets its mission and goals and continually provides opportunities to improve VSC operations.

Better Scheduling Practices Could Reduce Incomplete C&P Exams

An OIG audit identified opportunities for VHA and VBA to increase the number of completed C&P exams and determine the causes of some canceled C&P exams. To reduce the number of incomplete C&P exams, VHA needs to improve exam-scheduling procedures, the quality of C&P exam requests, and quality assurance review procedures. Reducing the number of incomplete C&P exam requests, currently around 17 percent, will help ensure that claims decisions are handled more efficiently and Veterans receive timely disability benefit payments.

Incentive Program Results in Delays in Veterans' Payments at Pittsburgh VARO

The OIG reviewed an allegation that VSC managers at the Pittsburgh VARO instructed Veterans Service Representatives (VSR) to intentionally delay the processing of claims from Global War on Terror (GWOT) Veterans in order to receive monetary performance awards. While OIG did not substantiate the allegation against the VSC managers, the review determined that a misunderstanding between management and VSRs about how to meet the incentive award requirements resulted in delayed processing of at least 10 GWOT claims. As a result, five Veterans received payments ranging from $226 to $1,375 a month late. The delays were an unintended consequence of the award program and are contrary to the VBA goals of providing timely decisions on disability compensation claims and reducing the backlog of unprocessed claims. VBA has since suspended the use of incremental incentives at all VAROs nationwide until further notice.

Office of Information and Technology Reports

Improved Oversight of IT Investments Needed in OI&T

An OIG audit found management control deficiencies in OI&T's use of the System Development Life Cycle process, which manages major VA IT investments totaling approximately $3.4 billion. OIG determined that OI&T needs to communicate and enforce guidance to ensure major investments are effectively managed. Moreover, OI&T should take immediate action to implement management controls to ensure centralized oversight of VA's IT investments. These deficiencies prevent OI&T from

ensuring effective and efficient management, leaving VA's IT investment portfolio at risk of cost and schedule overruns, which could ultimately lead to costly, unproductive, or failed programs and projects. OIG made four recommendations to facilitate the implementation of management controls, ensure centralized management of VA's IT investments, improve risk management, and improve the overall governance of VA's IT investments.

VA Needs to Apply Lessons Learned to Technology Program

An OIG audit determined that VA needs to increase management controls over the development of the Financial and Logistics Integrated Technology Enterprise (FLITE) program. The FLITE program is experiencing similar issues that arose during the implementation of the Core Financial and Logistics System: critical program functions were not fully staffed, non-FLITE expenditures were funded through the FLITE program, and contract awards did not comply with competition requirements. VA has already implemented 7 of the 11 recommendations made by OIG to correct these issues.

Improvements Needed in VA's Management of Information Technology Capital Investments

An OIG audit determined that inadequate planning by the OI&T and VA to centralize the management structure over VA's IT resources consequently led to VA's delinquent submission of funding justifications for IT capital investments (Exhibit 300s) to the Office of Management and Budget. OIG further determined that OI&T has not implemented management controls to ensure that it does not miss future Exhibit 300 submission deadlines. In order to manage VA's IT capital investments effectively and efficiently, OI&T needs to develop a comprehensive written plan to achieve more robust and disciplined centralized management processes across VA.

Electronic Contract Management System Report

Audit Shows Electronic Contract Management System Ineffective, Data Incomplete

OIG audited the effectiveness of the Electronic Contract Management System (eCMS) to determine whether it improves the VA procurement process and provides effective procurement oversight. The audit revealed that VA is not using eCMS effectively and that procurement information in the system is incomplete. Incomplete information prohibits VA from benefitting from the full capabilities of the system and from generating reliable reports when making procurement management decisions. OIG determined that integrating eCMS with VA's Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System, commonly known as IFCAP, or the Financial Management System would provide VA with improved acquisition efficiency, reporting, and control over spending.

Office of Investigations

Veterans Health Administration Investigations

The OIG Office of Investigations (OI) 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 164 cases, made 128 arrests, and obtained over $5,263,630 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, the OIG opened 48 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Forty-one defendants were charged with various crimes relating to drug diversion. During this reporting period, OIG also initiated eight investigations regarding fraudulent receipt of health benefits. Eleven defendants were charged with various crimes relating to the fraudulent receipt of health benefits and court ordered payment of fines, restitution, and penalties amounted to $262,264.

Defendants Sentenced for Theft of VA Pharmaceuticals

Two defendants were sentenced to 6 months' incarceration, 36 months' probation, 500 hours' community service, and ordered to pay $670,000 in restitution. The defendants previously pled guilty to the unauthorized sale, purchase, and trade of pharmaceuticals belonging to a public health care entity. A third defendant, a former VA pharmacist, was previously sentenced to 18 months' incarceration, 36 months' probation, 300 hours' community service, and ordered to pay $670,000 in restitution after pleading guilty to conspiracy to steal from a health care benefit program. To date, VA has received $161,000 in restitution from the three defendants. An OIG investigation revealed that for over 3 years the defendants were involved in a scheme to steal and sell stolen VA pharmaceuticals. The former VA pharmacist stole approximately $850,000 worth of non-controlled pharmaceuticals from the Hines, IL, VAMC and then used a small portion of the stolen drugs to stock his personally-owned pharmacy, while selling the remaining drugs to the second defendant who owned a pharmaceutical distributorship. The final defendant was a pharmacy technician who handled the day-to-day operations of the distributorship and assisted with the sale of the stolen pharmaceuticals. The former VA pharmacist's license was placed on probation for 2 years, and he was also fined $7,000 by his State licensing agency. Licensing action is also pending against the other defendants.

Veteran Sentenced for Theft of Health Care Benefits

A Veteran was sentenced to 84 months' incarceration and ordered to pay $90,567 in restitution after pleading guilty to fraud, identity theft, and drug diversion. A joint OIG, Drug Enforcement Agency (DEA), Defense Criminal Investigative Service (DCIS), and local police investigation revealed that the defendant used various alias names and social security numbers in order to fraudulently receive approximately $50,000 in Tricare benefits and approximately $33,000 in VA medical benefits. The defendant also attempted to apply for VA compensation benefits and submitted numerous false documents claiming she had been honorably discharged as a U.S. Army officer having served in the Middle East during OEF. The investigation further determined that the defendant was not eligible for VA or Department of Defense benefits because she was discharged from the Army for not meeting military standards after serving only 37 days. Additionally, the investigation revealed that the defendant was employed as a pharmacist at a national pharmacy chain for 2 years without a pharmacy degree or license.

Veteran Sentenced for Stealing Identity of Another Veteran

A Veteran was sentenced to 13½ years' incarceration after pleading guilty to theft and identity theft charges. An OIG investigation determined that the defendant assumed the identity of another Veteran and fraudulently received treatment and medications from VAMCs valued at $161,036. The defendant confessed to the details of the scheme and to diverting, forging, and negotiating four VA benefit checks totaling $3,661, which were intended for the true Veteran and to stealing approximately $35,000 in Social Security benefits issued under the Veteran's name.

Defendant Sentenced for Theft of Veteran's Identity

A non-Veteran was sentenced to 33 months' incarceration, 36 months' probation, and ordered to pay VA restitution of $99,607 after pleading guilty to stealing the identity of a Vietnam Veteran and using that identity to receive health care benefits. The investigation further determined that the defendant was a fugitive, having escaped from prison in Alabama in 1978 after serving less than 1 year of a 44-year prison sentence for robbery and grand larceny.

Veteran's Brother Indicted for Identity Theft and Health Care Fraud

The brother of a Veteran was indicted for health care fraud, theft of public money, identity theft, and, aggravated identity theft. An OIG investigation revealed that the defendant assumed the identity of his brother and fraudulently received VA medical care for over 8 years. The defendant also filed fraudulent applications for medical benefits and documents that contained false income information so he could continue receiving the care at no cost. The loss to VA is $378,542.

Jackson, Mississippi, Personal Care Home Co-owner Sentenced for Exploiting Veterans and Theft of VA Funds

The co-owner of a personal care home in Jackson, MS, was sentenced to 3 years' incarceration and 3 years' probation after being found guilty of exploitation of a vulnerable adult. A joint OIG and State investigation revealed that the owner and co-owner failed to provide adequate living conditions and medical care for Veterans who were residents at the care home. In addition, the defendants negotiated Veterans' VA benefit checks without authorization. Subsequently, the home was closed and all of the residents were relocated to other care homes in the local area.

Investigation Substantiates Improper Expenditures by VHA Officials

An administrative investigation substantiated that a senior official improperly authorized the expenditure of over $86,000 in VA funds to pay for academic degrees for two employees and failed to administer VA policy. It also substantiated that a senior staff assistant misused a Government-issued purchase card, violated and directed another employee to violate Federal acquisition regulations, and misused VA-owned computer systems to access sexually explicit material. The investigation further substantiated that the senior official and senior staff assistant misrepresented facts and displayed a lack of candor. Lastly, it disclosed two purchase card payments that were not applied as intended or properly refunded to VA.

Former Atlanta VAMC Employee Sentenced for Fraud

A former Atlanta VAMC employee was sentenced to 36 months' incarceration, 36 months' probation, and a $5,000 fine after being convicted of mail fraud, criminal conflict of interest, and obstruction. An OIG investigation revealed that the former VAMC employee and a co-conspirator entered into a scheme to house Veterans with mental illness or substance abuse issues in order to receive payments from fiduciaries. The co-conspirators rented a home in the former VA employee's name and housed four Veterans at the property, which subsequently netted monthly profits for the two conspirators.

Waco, Texas, Nursing Assistants Arrested for Patient Abuse

A Waco, TX, VAMC nursing assistant was arrested for assault of a disabled individual after an OIG investigation revealed that the employee repeatedly slapped a cognitively impaired patient. A second

Waco VAMC nursing assistant was arrested on the same charge after an OIG investigation revealed that this employee repeatedly punched a VAMC psychiatric patient causing lacerations to the Veteran's head.

Oklahoma City VAMC Nurse Indicted for Assault

An Oklahoma City VAMC nurse was indicted for assault and concealment of a material fact after an OIG investigation determined that he assaulted an 82 year-old VAMC patient suffering from dementia. When interviewed by OIG agents the defendant initially denied assaulting the patient, who suffered a fractured right humerus bone and severe bruising and swelling in his right arm and hand.

Former Big Spring, Texas, Pharmacy Technician Sentenced for Drug Theft

A former Big Spring, TX, VAMC pharmacy technician was sentenced to 12 months' incarceration and 1 year of probation after pleading guilty to obtaining a controlled substance by fraud. An OIG and VA Police investigation revealed that the defendant accessed pharmacy profiles of unsuspecting Veterans and then created electronic prescriptions for controlled substances using the Veterans' names. More than 2,800 units of Hydrocodone and 450 units of Alprazolam were dispensed and mailed to the defendant's residence.

Former Nashville, Tennessee, Nurse Sentenced for Drug Theft

A former Nashville, TN, VAMC nurse was sentenced to 24 months' incarceration after pleading guilty to obtaining a controlled substance by fraud and theft. An OIG investigation revealed that the defendant stole Hydrocodone from patients to support her ex-husband's drug addiction.

Former West Haven, Connecticut, VAMC Nurse Pleads Guilty to Drug Theft

A former West Haven, CT, VAMC contract nurse pled guilty to theft after a joint OIG and VA Police investigation revealed that during a 4-month period, she diverted 76 controlled narcotics, to include Percocet, Dilaudid, and Fentanyl from a VAMC Pyxis machine. The investigation revealed that the defendant dispensed narcotics to patients not currently in the VAMC and signed for more medication than was actually administered.

Former Martinsburg, West Virginia, Nursing Assistant Pleads Guilty to Theft

A former Martinsburg, WV, VAMC nursing assistant pled guilty to the unauthorized use of an access device. An OIG and VA Police investigation revealed that the defendant used debit cards belonging to two patients to fraudulently obtain money, goods, and services totaling approximately $56,000.

Wife Arrested for Poisoning Veteran

A Veteran's wife was arrested for poisoning her husband while an inpatient at the Temple, TX, VAMC. The Veteran survived the poisoning. A joint OIG, Federal Bureau of Investigation (FBI), and VA Police investigation revealed that the defendant introduced various toxic substances into her husband's beverages over a period of approximately 5 weeks, causing him to repeatedly lose consciousness and require multiple hospital admissions. Video surveillance of the Veteran's hospital room revealed that the defendant continued to poison her husband even after he was admitted to the facility for treatment of previous poisonings committed outside the facility.

Veteran Sentenced for Drug Violations and Identity Theft

A Veteran was sentenced to 4 years' incarceration after pleading guilty to obtaining a controlled substance by fraud and identity theft. An OIG and State police investigation revealed that the Veteran fraudulently obtained controlled substances by using the stolen identities and the DEA numbers of his VA primary care physician and other non-VA physicians.

Syracuse, New York, VAMC Nurse Pleads Guilty to Drug Diversion

A Syracuse, NY, VAMC nurse pled guilty to a criminal information charging him with theft of Government property after an OIG investigation disclosed that he diverted narcotics from a Pyxis machine and failed to follow proper narcotic waste procedures. As part of the plea agreement, the employee agreed to resign from VA employment, surrender his nursing license, and enroll in a drug treatment program.

Former American Lake, Washington, VAMC Employee Pleads Guilty to Drug Diversion

A former American Lake, WA, VAMC receptionist pled guilty to acquiring controlled substances by deception after an OIG investigation revealed that she accessed VA systems and used Veteran information to obtain fictitious prescriptions for Hydrocodone and Alaprazolam. Over 2,000 prescription pills were obtained and distributed by the employee and others. The employee was terminated from her employment because of the investigation.

Little Rock, Arkansas, VA Technician Diverts Pharmaceuticals

A Little Rock, AR, VA pharmacy technician signed a pre-trial diversion agreement relating to charges of possession and distribution of controlled substances. As part of the agreement, the prosecution of the defendant will be deferred for 12 months. The conditions of the deferred prosecution require the defendant to complete 50 hours' community service and submit to drug testing. An OIG investigation determined that from approximately July 2006 to November 2007, the pharmacy technician stole pharmaceuticals, including Hydrocodone, from the VAMC outpatient pharmacy and subsequently sold the stolen drugs.

Former Salt Lake City, Utah, VAMC Employee Sentenced for Drug Diversion

A former Salt Lake City VAMC nurse was sentenced to 365 days' incarceration with the sentence suspended, 18 months' probation, and 100 hours' community service after an OIG investigation revealed that she obtained VA prescriptions under false pretenses. The employee admitted to obtaining the prescriptions of a Veteran by posing as his spouse. The employee resigned her position during the investigation.

Albuquerque VAMC Nurse Indicted for Drug Diversion

An Albuquerque, NM, VAMC nurse was indicted for drug diversion by deception after an OIG investigation disclosed she used the medical center's Acudose system to steal Oxycodone and other controlled substances for personal use. The defendant attempted to conceal the diversion activity by associating the Oxycodone with certain patients, many of them having no order from a physician for the medication.

Former Wilmington, Delaware, VAMC Nurse Sentenced for Drug Diversion

A former Wilmington, DE, VAMC registered nurse was sentenced to 5 years' probation after an OIG investigation revealed that he diverted and tampered with 19 syringes containing the morphine-derivative Hydromorphone from an Omnicell located in the VAMC, replacing the drug with a saline solution. The employee admitted to his wrongdoing and advised that in addition to taking the drugs for personal use, he returned the syringes containing the altered drugs to the Omnicell, which were subsequently administered to various patients. The employee resigned his position with the medical center.

Palo Alto, California, Nursing Instructor Arrested for Drug Diversion

A nurse associated with the Palo Alto, CA, VAMC was arrested after being indicted for possession of a controlled substance by misrepresentation, fraud, and false statements. The nurse, a newly hired clinical instructor at a local community college, provided patient care instruction to students at the VAMC. The defendant failed to disclose that she had previously been fired from employment at two

hospitals for drug diversion. The defendant also misrepresented herself to the VAMC pharmacy manager and obtained Acudose access, which she used on several occasions to divert Hydromorphone. During the investigation, it was also learned that at least six hospitals had made complaints regarding this defendant to a State board alleging drug diversion.

Jackson, Mississippi, VAMC Nurse Indicted for Drug Diversion

A Jackson, MS, VAMC nurse was indicted for diverting Schedule II narcotics for personal use. An OIG investigation revealed that the defendant had been diverting narcotics prescribed to inpatient Veterans for over a year. The employee also falsified VA computerized patient records by inputting fictitious orders to assist him in diverting additional narcotics.

Former Salem, Virginia, VAMC Employees Sentenced for Drug Distribution

A former Salem, VA, VAMC employee was sentenced to 6 months' incarceration after pleading guilty to distributing controlled substances. An OIG and VA Police investigation revealed that the employee was selling prescription pain narcotics on VA property. The employee resigned her position as a result of the investigation. A second former Salem VAMC employee was sentenced to 1 year of incarceration after pleading guilty to distributing controlled substances. An OIG and local police investigation revealed that the subject sold heroin at the VAMC and in the local area. The defendant, who was no longer employed with the VAMC at the onset of the investigation, returned to the VAMC to sell heroin and other narcotics.

Veterans Benefits Administration Investigations

VA administers a number of financial benefits programs for eligible Veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the C&P Service. With respect to VA guaranteed loans, OI conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties.

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program. OI also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. In this reporting period, the death match project recovered $3.6 million, with another $307,000 in anticipated recoveries. Generally, family members of the deceased are responsible for this type of fraud. In the area of benefits processing, OIG opened 313 cases, made 113 arrests, and had $19,818,354 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, the OIG opened 219 investigations regarding deceased payee cases, fiduciary fraud, identity theft, and Veterans/widows fraudulently receiving VA compensation and pension funds. Eighty-two defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to $1,761,789. These investigations include 8 "Stolen Valor" cases resulting in 7 defendants being charged and $314,284 in court ordered payment of fines, restitution, and penalties.

Former Wife of Deceased Veteran Pleads Guilty to Fiduciary Fraud

The ex-wife of a deceased Veteran pled guilty to misappropriation by a fiduciary. A joint OIG, FBI, and DCIS investigation revealed that at the time of the Veteran's death he had named his minor son as the sole beneficiary for his military life insurance. The Veteran's ex-wife obtained court appointed guardianship over the life insurance funds in order for VA to pay the son. Due to a congressionally mandated increase in the maximum life insurance coverage the defendant received approximately $450,000 on her son's behalf. The investigation further determined that in less than 1 year the defendant embezzled almost all of the funds, spending them on extravagant vacations, gambling, cars, and parties.

Former Louisville, Kentucky, VA Employee and DAV Service Officer Plead Guilty

A former Louisville, KY, VARO employee and a former Disabled American Veterans (DAV) service officer pled guilty to conspiracy to defraud the United States, bribery of a public official, and theft of Government funds. In November 2008, the 2 defendants were indicted, along with 12 others, for filing fraudulent claims with VA. These claims were backdated approximately 18 to 24 months by the VARO employee and the DAV service officer causing a large retroactive back payment to be generated to the Veterans. In addition, the two defendants altered or counterfeited medical documents to ensure the fraudulent claims were approved with a 100 percent service-connection disability. Once the retroactive disability payments were received by the Veterans, the two defendants would generally receive two-thirds of the retroactive checks, with the Veterans keeping the monthly VA disability payment. To date, 12 of the indicted defendants have entered guilty pleas. Two additional defendants are pending judicial action. The loss to VA is approximately $2 million.

Veteran Pleads Guilty to $1.5 Million VA Compensation Fraud over 31-Year Period

A Veteran pled guilty to wire fraud and making false statements after an OIG investigation revealed that between April 1976 and October 2007, the Veteran feigned symptoms and exaggerated his injuries to include paraplegia and complete loss of lower bodily functions requiring daily aid and attendance, constant medical care, clothing reimbursement, and adaptive housing and transportation. OIG discovered that during this 31-year period, the Veteran owned an excavation company and operated heavy construction equipment, owned and operated a Federal Aviation Administration repair station as the chief inspector and airframe power plant mechanic, obtained a private pilot's license without physical restrictions, and was a law enforcement officer in a county sheriff's office. During a VA Compensation and Pension examination, the Veteran wheeled himself into the VAMC claiming to be a 30-year paraplegic with complete loss of bodily function below the waist, yet walked unassisted into court the following day on unrelated criminal charges. The loss to VA is approximately $1,551,000.

Veteran Indicted for Fraud

A Veteran was indicted for wire fraud, mail fraud, false statements, and social security fraud after an OIG investigation determined that the Veteran fraudulently received service-connected disability benefits. The Veteran made false statements to VA regarding his claim for Post Traumatic Stress Disorder (PTSD), claiming that he witnessed the death of a fellow sailor. Additionally, the Veteran failed to report to VA that he owns a tavern and is active in the local volunteer fire department and other organizations. The loss to VA is $150,825.

North Carolina Veteran Sentenced in "Stolen Valor" Investigation

A Veteran was sentenced to 6 months' incarceration, 2 years' probation, and ordered to pay $65,956 in restitution after pleading guilty to theft of Government property. An OIG investigation determined that the defendant submitted a fraudulent DD-214 discharge form in order to receive VA benefits. The defendant fraudulently claimed to have received the Purple Heart, Korean Service Medal, Air Force Overseas Ribbon, and a Good Conduct Medal while reportedly serving in Korea during the Korean War. The Veteran never served in Korea during the Korean War.

Veteran Indicted for Making False Statements to VA

A Veteran was indicted for false statements and false declarations before a court. An OIG and FBI investigation determined that the defendant submitted a fraudulent disability compensation claim to VA for medical conditions caused by Agent Orange exposure during his military service in Vietnam. The defendant also made a similar claim to a U.S. Magistrate Judge during an initial appearance for unrelated Federal charges. The investigation determined that the defendant was never in Vietnam during his military service and was never exposed to Agent Orange.

Veteran Sentenced for Fraudulent Receipt of VA Benefits

A Veteran was sentenced to 30 months' probation and ordered to pay $57,435 in restitution after being convicted of fraudulently receiving VA benefits. An OIG investigation revealed that the Veteran, who was in receipt of Individual Unemployability benefits due to an alleged service-connected back condition, failed to accurately report the level of his disability during a VA C&P examination. Specifically, he denied participating in any sports or hobbies, when in fact he was a member of a bowling association and bowled in multiple leagues.

Veteran Arrested for Education Benefits Fraud

A Veteran was arrested for theft of Government funds and false claims after an OIG investigation determined that he fraudulently received VA education benefits from March 2004 to July 2007. The investigation determined that the defendant submitted VA Monthly Certifications falsely reporting that he was attending school. The loss to VA is $20,920.

Brother of Veteran Arrested for Theft of VA Funds and Services

The brother of a Veteran was arrested after being charged with theft of Government funds and services. An OIG and Social Security Administration (SSA) OIG investigation determined that the defendant used his brother's identity to receive VA medical care and to steal, forge, and negotiate VA pension checks. At the time of the defendant's arrest, he was found to be in possession of identification cards with the name and identifiers of the Veteran, to include a Veteran's Identification Card, a Social Security card, and State driver's license. The loss to VA is $120,063.

Wife of Deceased Veteran Charged with False Claims

A civil complaint was filed charging the wife of a deceased Veteran with violation of the False Claims Act. A civil judgment was granted against the defendant ordering payment of $263,244 to the Government. An OIG investigation revealed that the defendant submitted fraudulent information to VA when she applied for Dependency and Indemnity Compensation (DIC) benefits.

Widow Pleads Guilty to Theft of VA Benefits

The widow of a Veteran pled guilty to theft of Government funds after an OIG investigation disclosed that she fraudulently received VA DIC benefits. The defendant remarried more than 14 years ago and falsely certified to VA that she was unmarried in order to continue to receive VA DIC benefits. The loss to VA is $151,796.

Beneficiary Pleads Guilty to Wire Fraud

The widow of a Veteran pled guilty to wire fraud after an OIG investigation revealed that she failed to report to VA that she had remarried and fraudulently received $125,732 in VA benefits.

Daughter of Deceased Beneficiary Pleads Guilty to Theft

The daughter of a deceased VA DIC beneficiary pled guilty to a criminal information charging her with theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death, pretended to be her mother in her contacts with VA, and stole VA funds that were deposited into her mother's account. The loss to VA is $112,443.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA beneficiary was sentenced to 6 months' home confinement, 3 years' probation, and ordered to pay restitution of $53,580 to VA and $33,784 to SSA. An OIG and SSA OIG investigation revealed that the defendant stole, forged, and negotiated VA and SSA benefit checks that were issued after her mother's death in September 1984. The loss to VA is approximately $239,500.

Daughter of Deceased Beneficiary Charged with Theft

A criminal information was filed charging the daughter of a deceased DIC beneficiary with theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death and subsequently stole, forged, and negotiated VA benefit checks issued after her mother's death in March 1994. The loss to VA is $136,885.

Veteran and Others Indicted for Fraud

A Veteran, his spouse, and a Veterans' Service Organization (VSO) representative were indicted for wire fraud, theft, misprision of a felony, and conspiracy. An OIG investigation determined that the Veteran and his spouse made false statements to VA and SSA concerning the Veteran's inability to ambulate. During the course of the investigation the VSO was found to have "coached" the Veteran and shredded documents that would have exposed the fraud. The loss to VA is $413,509 and the loss to SSA is $165,234.

Fiduciary Pleads Guilty to Embezzlement

A fiduciary pled guilty to making a false statement after an OIG and SSA OIG investigation determined that she embezzled approximately $1.3 million dollars belonging to 33 Veterans for whom she provided fiduciary services.

Defendant Arrested for Theft of Government Funds

A non-Veteran was arrested for theft of Government funds after an OIG investigation revealed he stole the identity of a Veteran and redirected the Veteran's VA compensation benefits and military retirement to his own bank account. The defendant also used the Veteran's personal information to obtain VA health care and to apply for an increase in VA benefits. The defendant attended a C&P examination, posing as the Veteran, and was subsequently granted an increase in compensation benefits. The defendant also fraudulently received several credit cards using the Veteran's personal information. The total loss is approximately $150,000.

Other Investigations

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened 16 cases, made 7 arrests, and had $1,206,624,682 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

OI also investigates theft of IT equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened 4 cases, made 4 arrests, and had $22,158 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Pharmaceutical Manufacturer Settles with Government

A major pharmaceutical manufacturer and its subsidiary have agreed to pay $2.3 billion, the largest health care fraud settlement in the history of the Department of Justice, to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. The subsidiary has

agreed to plead guilty to a felony violation of the Food, Drug, and Cosmetic Act for misbranding a drug with the intent to defraud or mislead. A joint investigation was conducted by OIG, FBI, Department of Health and Human Services (HHS) OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, DCIS, and U.S. Postal Service (USPS) OIG. The investigation determined that the company promoted the sale of the drug for several uses and dosages that the FDA specifically declined to approve due to safety concerns. The company will pay a criminal fine of $1.195 billion, the largest criminal fine ever imposed in the United States. The subsidiary will also forfeit $105 million for a total criminal resolution of $1.3 billion.

In addition, the company has agreed to pay $1 billion to resolve allegations under the civil False Claims Act. The allegations include that the company illegally promoted four drugs and caused false claims to be submitted to Government health care programs for uses that were not medically accepted indications and therefore not covered by those programs. The civil settlement also resolves allegations that the company paid kickbacks to health care providers to induce them to prescribe these and other drugs. The Federal share of the civil settlement is $668,514,830, of which $11.3 million will be returned directly to VA. The State Medicaid share of the civil settlement is $331,485,170.

Previously, as a result of this investigation, a former district manager was found guilty at trial of obstruction of justice and sentenced to 6 months' home confinement and 3 years' probation. A former regional manager was sentenced to 24 months' probation and a $75,000 fine after pleading guilty to distribution of a misbranded drug.

Former CEO Convicted of Fraud

The former Chief Executive Officer of a biopharmaceutical company was convicted of wire fraud after a 7-week jury trial. A 4-year joint investigation conducted by OIG, FBI, FDA Office of Criminal Investigations, and Office of Personnel Management OIG revealed that under the direction of the former CEO, who is also a medical doctor, the company marketed and sold a drug as a treatment for idiopathic pulmonary fibrosis (IPF) despite the fact that it was not approved by FDA as a safe and effective treatment. The majority of the company's sales of this drug were for this off-label use. This investigation further revealed that the former CEO and other senior officials were aware that a clinical trial involving the use of this drug with IPF patients failed. However, when the trial results were publicized, the former CEO caused the issuance and distribution of a false and misleading press release to portray that the trial established that patients lived longer using this drug. The company previously agreed to pay the Government nearly $37 million to resolve criminal charges and civil liability in connection with its illegal marketing and sales. VA's portion of this civil settlement was approximately $3.2 million.

Medical Device Company Executives Plead Guilty

Four executives of a medical device company pled guilty to introducing adulterated medical devices into interstate commerce. An OIG, FDA, HHS OIG, and DCIS investigation revealed that the company marketed the use of a medical device in an unapproved manner and that three deaths resulted, ultimately leading the company to pull the device off the market. None of the deaths occurred at a VA medical facility. The company and a subsidiary recently entered not guilty pleas to related charges. The investigation initiated in 2005 revealed that the company, which was the world's largest maker of bone-related medical devices, promoted an unapproved use for the bone void filler Norian XR. Early in the investigation, OIG coordinated a nationwide, simultaneous mass interview of current sales representatives and their supervisors in the spine division to secure information regarding the company's illegal marketing practices. It was revealed that the company was teaching the sales representatives to promote Norian XR in an off-label manner. Consequently, the sales representatives trained spine surgeons to use the product inappropriately, resulting in the three patient deaths.

Former Pharmaceutical Manager Sentenced for Misbranded Drug Distribution

A former regional manager for a pharmaceutical company was sentenced to 24 months' probation and a $75,000 fine after pleading guilty to a criminal information charging her with distribution of a misbranded drug. A joint OIG, FBI, HHS OIG, FDA, DCIS, and USPS OIG investigation revealed the defendant instructed her sales staff to sell a particular drug for unapproved uses despite FDA safety concerns. The former manager instructed her sales staff to promote the drug for surgical pain in unapproved doses and to make false claims related to the drug's safety.

Company Enters into $262 Million Settlement Agreement with Government

A company that sold laboratory testing kits entered into a settlement agreement with DOJ after an OIG, HHS OIG, FDA OIG, FBI, and U.S. Postal Inspection Service investigation determined that the company manufactured, marketed, and sold specific testing kits that produced inaccurate and unreliable results. Laboratories processing the kits subsequently submitted false claims for reimbursement to Federal health programs, including VA. Although the company did not admit any wrongdoing, they agreed to pay a global settlement of $262 million to the Federal government, with VA receiving $775,175.

Attorney Sentenced for Bribery of West Haven, CT, VAMC Employee

An attorney was sentenced to 2 years' incarceration and 2 years' probation after having previously pled guilty to bribery and tax fraud charges. A joint OIG, FBI, Internal Revenue Service, General Services Administration OIG, and VA Police investigation determined that the defendant bribed a former West Haven, CT, VAMC employee to obtain contracts for work at the medical center. The former VA employee previously pled guilty to bribery charges and is awaiting sentencing.

Veteran Sentenced for Theft of Indianapolis VAMC Computers

A Veteran outpatient at the Indianapolis, IN, VAMC was sentenced to 545 days' incarceration, 40 hours' community service, and was ordered to cooperate fully with search and recovery efforts after pleading guilty to stealing three computers, two monitors, and a printer from unlocked offices during two separate visits at the VAMC. The Veteran stated that he stole this equipment because he had been notified that VBA had created a $17,000 overpayment because of his ineligible receipt of VA pension benefits. One of the stolen computers contained Personally Identifiable Information and Protected Health Information for nearly 12,000 VAMC patients. The defendant claimed that nervousness caused him to discard the equipment stolen during the first visit into a dumpster on VA property. He claimed to discard the remaining stolen property after hearing news reports about a reward offered for information about the theft. OIG has confirmed with the trash service providers for both dumpsters that nothing collected at the time the Veteran stole the equipment would still be retrievable. VA has sent letters offering credit monitoring to the patients affected by this data loss.

Memphis, Tennessee, Researcher Pleads Guilty to Child Pornography Charges

A researcher working at the Memphis, TN, VAMC as a research specialist under a VA grant program pled guilty to a criminal information charging him with the receipt, possession, and transmission of child pornography. An OIG, Immigration and Customs Enforcement, FBI, and VA Police investigation determined that the defendant accessed and used VA computer systems to obtain and transmit child pornography.

Veteran Sentenced for Child Pornography

A Veteran was sentenced to 10 years' incarceration, 20 years' probation, and ordered to register as a sex offender after pleading guilty to possession of child pornography. A joint OIG and county sheriff's office investigation revealed that the Veteran, while living in a VA-owned house and enrolled in a VA work therapy program, had downloaded over 600 images of minors engaged in sexual acts.

Administrative Investigations of Other VA Activities

Two Investigations Substantiate Abuse of Authority, Misuse of Position, Nepotism, and Prohibited Personnel Practices in OI&T

A. An administrative investigation substantiated that a senior official within OI&T misused her position, abused her authority, and engaged in prohibited personnel practices when she influenced a VA contractor and later her VA subordinates to employ a friend. It also substantiated that the senior official misused her position when she took advantage of a personal relationship with her supervisor to relocate her duty station outside of the VACO commuting area while spending almost 60 percent of her time at VACO on official travel. The report also found that the employee failed to provide proper contract oversight. Further, the investigation substantiated that three other senior officials within OI&T abused their authority and engaged in prohibited personnel practices in the filling of four GS-15 positions.

B. The second administrative investigation substantiated that a former senior official within OI&T engaged in nepotism when she improperly advocated for the hiring and advancement of her family members and that she abused her authority and engaged in prohibited personnel practices when she improperly hired an acquaintance and friend. It also substantiated that two other OI&T employees misused their positions for the private gain of family members and that one of the employees failed to testify freely and honestly and failed to properly discharge the duties of his position. Additionally, the investigation found that OI&T managers improperly authorized academic degree funding for family and friends, improperly applied hiring authorities to appoint family and friends, and were not fiscally responsible when administering awards.

Employee-Related Investigations

During this reporting period, the OIG opened 34 investigations regarding criminal activities by VA employees (not including drug diversion). The types of crimes investigated included Workers' Compensation Fraud, theft from Veterans, and theft of VA property or funds. Twenty-four defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to $352,666. Among them were the following:

- A Southeastern Arizona HCS employee was sentenced to 27 months' incarceration and ordered to pay restitution of $365,816 to the Southern Arizona VA HCS after previously pleading guilty to theft of public money, wire fraud, and mail fraud. The defendant was the Clinical Director of Education and Training for two VAMCs and stole VA funds through various schemes.
- A criminal information was filed against a Gainesville, FL, VAMC agent cashier charging her with theft of Government funds. An OIG investigation determined that during a 2-month period, the employee embezzled approximately $12,000 by submitting fraudulent patient travel vouchers.
- A former agent cashier at the Providence, RI, VAMC pled guilty to theft of Government funds. A joint OIG, FBI, and VA Police investigation revealed that the cashier initially reported that an armed individual robbed the agent cashier's office. While being interviewed, the cashier recanted his story and admitted that he had stolen the cash, checks, and other items. A search of the cashier's vehicle and residence resulted in the recovery of the stolen funds and blank checks.

Threats Made Against VA Employees

During this reporting period, the OIG initiated 16 criminal investigations resulting from threats made against VA facilities and employees. Fourteen defendants were charged with making threats as a result of the investigations. Among them were the following:

- A Veteran pled guilty to making threats against VA after an OIG investigation revealed that he contacted the Jackson, MS, VAMC by cell phone and stated that he was going to "bomb" VA. The Veteran also told a VA employee that he was a "killing machine," "loved to kill," and "may be the next U.S. bomber."
- A Veteran was sentenced to 4 years' probation and fined $1,000 after being found guilty of communicating threats in interstate commerce. An OIG investigation revealed that the Veteran made threatening phone calls to three VA employees after losing his fee basis benefits. During the calls, the Veteran threatened to injure and kill the employee who revoked his benefits.
- A Veteran was taken into custody by OIG, with assistance from the local sheriff's department and the U.S. Secret Service, and involuntarily committed to a local hospital after making threats against VA and VA employees. The investigation disclosed that the Veteran telephoned a VA office in Muskogee, OK, and made threatening statements to a VA employee. When the defendant was contacted by OIG he made additional threats against VA and its employees, including the OIG. The defendant also stated that in the past he had sent threatening correspondence to the President.
- A Veteran was sentenced to 5 to 15 years' incarceration, all of which was suspended except for 46 months, after pleading no contest to arson charges relating to fires set at two residences, one of which was a VA employee's home that was severely damaged. An OIG and State Police investigation revealed that the Veteran committed arson, vandalized several residences, and vandalized several vehicles at the White River Junction, VT, VAMC. The VA employee, whose home was vandalized and later burned, was the defendant's therapist until the defendant's treatment was terminated due to violent behavior.
- A Veteran was sentenced to 21 days' incarceration for making threats and the assault of a VA police officer at the Togus, ME, VAMC and VARO. An OIG investigation revealed that the Veteran initially made two separate bomb threats to the VAMC. The Veteran subsequently was arrested for threatening to kill the VAMC Director and then assaulting a VA Police Officer. The Veteran confessed to making the threats due to his frustration with his VA appointed fiduciary, who he believed was not providing his VA benefit funds.
- A Veteran was arrested by OIG, assisted by the FBI and local law enforcement, after contacting the VA Suicide Hotline and conveying suicidal and homicidal ideations. The Veteran expressed detailed plans for destroying Government buildings within the New Orleans, LA, area and then expressed a desire to commit suicide by being killed by the police.

Fugitive Felons Arrested with OIG Assistance

Veterans and VA employees continue to be identified and apprehended as a direct result of the OIG Fugitive Felon Program. To date, 31.7 million felon warrants have been received from the National Crime Information Center and participating states resulting in 48,852 investigative leads being referred to law enforcement agencies. Over 2,006 fugitives have been apprehended as a direct result of these leads. Since the inception of the program in 2002, OIG has identified $681.5 million in estimated overpayments with an estimated cost avoidance of $769.2 million. Among the 56 fugitive felon

program arrests made by OIG, VA Police, U.S. Marshals, and local police during this reporting period were the following:

- A U.S. Marshals Service fugitive apprehension strike team, assisted by OIG Special Agents, arrested a Veteran wanted on an outstanding Federal warrant for unlawful flight to avoid prosecution and State charges of aggravated sexual abuse of a child, sodomy, attempted rape of a child, and child abuse. The Veteran had fled the State of Utah and had been a fugitive for approximately 5 months at the time of his arrest in Shreveport, LA.
- A Veteran was arrested at the Houston, TX, VAMC by local police with the assistance of OIG on two separate arrest warrants for aggravated sexual assault of a child.
- A Houston VARO employee was arrested by local law enforcement officers with the assistance of OIG on a warrant from another state for making terrorist threats.
- A Veteran was arrested by a U.S. Marshals Fugitive Apprehension Strike Team with the assistance of OIG for a probation violation stemming from an aggravated assault charge in which the Veteran assaulted a VA Police Officer.

Additionally, six VAMC employees were arrested at various medical centers with the assistance of OIG and VA Police. The employees were wanted on charges to include probation violation, threats, felony DUI, weapon offenses, and drug violations.

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 Division

The Information Technology Division promotes 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 electronic mail by all authorized employees; providing internet document management and control; and providing support to all OIG components.

Administrative and Financial Operations Division

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

Budget Division

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

Data Analysis Division

The Data Analysis Division provides 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.

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 8:30 AM to 4:00 PM Eastern Time. Phone calls, letters, and e-mails are received from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 15,985 contacts, 538 of which became OIG cases. The Hotline also closed 567 cases during this reporting period. Among them were the following:

Process Change in the Handling of Sensitive Documents

A review conducted by the Board of Veterans' Appeals (BVA) determined BVA forwarded documents containing sensitive information on three Veterans to a VSO that did not hold a valid power-of-attorney from those Veterans. As part of an ongoing overhaul of its administrative support operations, BVA has created two new positions to focus on identifying problems related to the quality of the BVA's administrative functions, including the mailing of official materials, and taking corrective actions where necessary.

Veteran's Disability Compensation Reinstated After Mistakenly Declared Deceased

A VBA review determined a Veteran was mistakenly listed as deceased following an action initiated by the VARO and Insurance Center in Philadelphia, PA. As a result of the error, the Veteran's benefits were stopped, and VA Debt Management Center assessed an overpayment of approximately $90,000. Corrective action completed by the St. Petersburg, FL, VARO continued the Veteran's service connected disability compensation and reversed the overpayment.

Veteran Assessed a $90,000 Overpayment

The Louisville, KY, VARO determined a 30 percent service-connected Veteran, awarded a temporary 100 percent service connection for a 1-year convalescence period following surgery, was not reduced back to his 30 percent status for over 2 years. The Veteran has been assessed an overpayment of $90,863.

Violation of Ethical Conduct Results in Fee Basis Employee's Termination

An administrative investigation conducted by the Tennessee Valley HCS, Nashville, TN, confirmed a fee basis nurse practitioner's inappropriate friendship with a patient seen in the mental health clinic. Further, the nurse practitioner exhibited behavior outside the scope of his professional responsibilities with this patient, resulting in the nurse's termination of employment with the facility.

St. Louis VAMC Domiciliary Program Manager Falsifies Medical Documentation

Interviews conducted by facility Risk Management confirmed a physician's assistant assigned as a program manager in the domiciliary at the St. Louis, MO, VAMC falsified the completion of physical examinations for 28 domiciliary residents. Patients interviewed indicated they had not received full physical examinations, as documented by this physician's assistant. Risk management determined no instances of adverse events or unplanned inpatient or outpatient visits related to poor or falsified documentation. The employee was removed and placed on administrative leave by management pending further personnel action. A new program manager was appointed, and management discussed the changes with remaining staff and patients.

Office of Contract Review

The Office of Contract Review (OCR) 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, OCR provides advisory services to OALC contracting activities. OCR completed 49 reviews in this reporting period. The tables that follow provide an overview of OCR 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. Preaward reviews identified $56.4 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included 17 health care provider proposals—accounting for almost $30 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For 22 reports, the sustained savings rate was 65 percent.

	April 1, 2009—September 30, 2009	Summary FY 2009
Preaward Reports Issued	**26**	**57**
Potential Cost Savings	**$56,406,402**	**$121,744,718**

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. OCR reviews resulted in VA recovering contract overcharges totaling over $12.7 million, including $9.8 million related to Veterans Health Care Act compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 20 postaward reviews performed, 13 involved voluntary disclosures. In 9 of the 13 reviews, OCR identified additional funds due.

	April 1, 2009—September 30, 2009	Summary FY 2009
Postaward Reports Issued	**20**	**35**
Potential Cost Savings	**$12,781,460**	**$43,794,446**

Special Reports

VHA Lacks Viable Scheduling System After Spending $70 Million on Replacement Scheduling Application

At the request of the Ranking Member, U.S. Senate Committee on Veterans' Affairs, OIG conducted a review of the award and administration of task orders issued by VA to Southwest Research Institute (SwRI) for the RSA. Work to replace VHA's 20-year-old scheduling system began in February 2001, but in April 2002 the scope of the RSA project was changed from a Commercial Off-the-Shelf solution to an in-house build. From February 2001 through the termination of SwRI's contract in March 2009, OIG found that VA's program planning and oversight of the RSA project was ineffective due to a lack of requirements and program planning, a lack of VA staff with the necessary expertise to execute the RSA project, and multiple changes in OI&T offices with responsibility for the program. As a result, VA expended over $70 million through January 2009 and does not have a deployable RSA application.

Inadequate Analysis, Poor Administration Noted in VA/SPAWAR Agreement for Information Technology Services

At the request of the VA Secretary and the Ranking Republican Member, U.S. House of Representatives' Committee on Veterans' Affairs, OIG reviewed the Interagency Agreement (IAA) between VA's Office of Information and Technology, Office of Enterprise Development, and the Department of Navy, Space and Naval Warfare Systems Center (SPAWAR). Reviewers found that all parties entered into the IAA without an adequate analysis to determine whether it was in the best interest of the Government, as required by the Federal acquisition regulations. Moreover, OIG determined that neither party complied with the terms and conditions of the IAA. OIG suggested that VA re-evaluate the IAA and determine whether it is in the best interest of VA to continue obtaining services through this type of agreement, and if so, issue a new IAA that complies with VA policy.

Contracting Deficiencies Cited in Review of VA, University of Texas Southwest Agreement for Gulf War Research

At the request of the former Secretary of Veterans Affairs, OIG reviewed a contract between VA and The University of Texas Southwestern Medical Center at Dallas (UTSWMC) to conduct Gulf War Illness research. The contract did not include a collaborative pilot study as directed by the Conference Report accompanying the appropriations bill for FY 2006 and did not protect the Government's interests. The review also found that UTSWMC defaulted when it unilaterally, and without notice, changed the informed consent form to prohibit VA access to certain data obtained by UTSWMC in conducting the research. UTSWMC refused to discontinue use of the revised form. OIG concluded that UTSWMC's continued refusal to comply with the terms and conditions set forth in the contract left VA no option but to terminate the contract for default.

Other Significant OIG Activities

Congressional Testimony

OIG Staff Testify on Mental Health Issues Before House Veterans Affairs' Subcommittee on Health

Michael Shepherd, M.D., and Larry Reinkemeyer, Director, Kansas City Office of Audits and Evaluations, testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Health, on two OIG reports, *Healthcare Inspection Implementation of Veterans Health Administration's (VHA) Uniform Mental Health Services Handbook* and *Audit of Veterans Health Administration Mental Health Initiative Funding*. Dr. Shepherd told the Subcommittee that the handbook is an ambitious effort to enhance the availability, provision, and coordination of mental health services to Veterans, and that VHA has made progress in implementation at the medical center level. He also explained OIG's plans in FY 2010 to review implementation at CBOCs where such factors as geographic distance to care and ability to recruit mental health providers may pose greater obstacles to implementation. Mr. Reinkemeyer's testimony addressed VHA's procedures to track and use $371 million allocated to the MHI in FY 2008.

AIG for Healthcare Inspections Testifies on Endoscopy Reprocessing

Assistant Inspector General (AIG) for Healthcare Inspections, John Daigh, M.D., appeared before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations to discuss OIG report, *Healthcare Inspection, Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities.* This review was requested by the VA Secretary, the Chairmen and Ranking Members of VA oversight committees, and other Members of Congress as a result of reprocessing errors that placed Veterans at risk of viral infections at VAMCs in Augusta, GA; Miami, FL; and Murfreesboro, TN. Dr. Daigh told the Subcommittee that OIG's unannounced inspections conducted at 42 randomly selected medical facilities showed that VA needs to address serious management issues regarding industrial processes. Inspectors found that fewer than half of the selected facilities were in compliance with directives on availability of standard operating procedures at reprocessing sites and documentation of staff training and competency. Dr. Daigh was accompanied by OHI's George Wesley, M.D., Jerome Herbers, M.D., and Limin Clegg, Ph.D.

VHA Quality Management Subject of Senate Veterans' Affairs Committee Hearing

Julie Watrous, RN, Director of OHI's Combined Assessment Program, testified before the U.S. Senate Committee on Veterans' Affairs on the above-cited report and two others, *Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008;* and *Healthcare Inspection, Evaluation of the Veterans Health Administration's National Patient Safety Program.* Ms. Watrous described OIG's recommendations to improve quality management through increased compliance with Joint Commission standards and VHA requirements, and to improve the National Patient Safety (NPS) Program's effectiveness and oversight. She discussed the need to standardize processing, strengthen monitoring, and hold staff accountable when internal controls fail as in the case of endoscope reprocessing. Ms. Watrous was accompanied by the AIG for Healthcare Inspections and Victoria Coates, Regional Director of the Atlanta OHI.

Counselor to IG Testifies on VA's Interagency Agreement with Navy's Space and Warfare Systems Center

Counselor to the Inspector General, Maureen Regan, testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Economic Opportunity on an OIG review of the VA's interagency agreement (IAA) with Navy's SPAWAR. This review was requested by

the VA Secretary and the Ranking Republican Member of the U.S. House of Representatives' Committee on Veterans' Affairs. Ms. Regan told the Subcommittee that OIG concluded that neither VA nor SPAWAR has complied with the terms and conditions of the IAA, and that VA had relinquished its oversight role of financial performance and work performed under the IAA to SPAWAR. Ms. Regan also discussed the OIG report on the failure of the Replacement Scheduling Application development program. Ms. Regan was accompanied by Michael Grivnovics, Director, Office of Contract Review.

AIG for Audits and Evaluations Testifies on VA's Inventory of Non-Controlled Drugs

AIG for Audits and Evaluations, Belinda Finn, testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Health on two OIG reports, *Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Accountability* and *Audit of Veterans Health Administration's Management of Non-Controlled Drugs.* She told the Subcommittee that while VA spent $3.7 billion on pharmaceuticals in FY 2008, VHA medical facilities and CMOPs could not accurately account for non-controlled drug inventories because of inadequate inventory management practices, record keeping, and inaccurate pharmacy data. Without improved controls, VHA cannot ensure its non-controlled drug inventories are appropriately safeguarded, nor can VHA accurately account for these expensive inventories. Ms. Finn was accompanied by Irene Barnett, Ph.D., Audit Manager, Bedford Audit Operations Division.

AIG for Investigations Testifies on Administrative Investigations of VA's Office of Information and Technology

AIG for Investigations, James O'Neill, testified before the U.S. House of Representatives' Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations on two recent OIG reports, *Administrative Investigation – Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices Office of Information & Technology, Washington, DC,* and *Administrative Investigation – Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC.* Mr. O'Neill discussed issues related to the hiring practices within OI&T and other administrative matters, including nepotism, misuse of position, prohibited personnel practices, misuse of hiring authorities, improper funding of academic degrees, and improper administration of awards. Mr. O'Neill was accompanied by Joseph Sullivan, Deputy AIG for Investigations, and Michael Bennett, Attorney Advisor.

External Recognition

Dr. Clegg Named a Fellow of the American Statistical Association

Limin Clegg, Ph.D., was elected as a Fellow of the American Statistical Association (ASA) in April 2009 for "bringing statistical science to bear on important public health and policy issues, for scientific leadership in developing and adapting novel statistical approaches to the area of cancer control; and for service to the profession." Dr. Clegg was honored at the ASA annual meeting. ASA is one of the oldest and most prestigious professional societies in the United States. The ASA grants the Fellow honor to no more than 3 out of 1,000 of the Association's full members.

Dr. Clegg is the Director of the Biostatistics Division in the Office of Healthcare Inspections. She also holds an adjunct appointment at the full professor rank in the Department of Biostatistics, Bioinformatics, and Biomathematics in the School of Medicine at Georgetown University. Dr. Clegg received many awards from Federal government agencies in recognition of her professional accomplishments. She was also recognized as the Distinguished Alumni by the Department of Biostatistics at the University of North Carolina at Chapel Hill in 2004 and received the Delta Omega (the honor society for public health) Alumni Award for her "work in the practice of public health that

would serve as a model for future graduates" in 2008. She was elected to the International Statistical Institute in 2006. In addition to numerous Federal government reports and publications, she has published over 50 research manuscripts in highly regarded peer-reviewed professional journals, including the flagship journals: *Journal of the American Statistical Association, Biometrics, American Journal of Epidemiology, Journal of National Cancer Institute,* and *New England Journal of Medicine.*

2009 Council of the Inspectors General on Integrity and Efficiency Awards

The Council of the Inspectors General on Integrity and Efficiency (CIGIE) selected five OIG projects, one of which was a joint project with the Department of Defense Inspector General, for "Awards for Excellence."

- Paul Lore, Office of Investigations, San Francisco, CA – This investigation led to the successful prosecution of a VA employee and two contractors in a bribery and kickback scheme involving contracts at the Fresno, CA, VAMC valued at $3.5 million.
- Carl Scott, Office of Investigations, Atlanta, GA – This investigation led to the conviction of an Atlanta, GA, VAMC social worker and accomplice who defrauded VA for care of mentally ill and disabled Veterans at an assisted living facility.
- VHA Noncompetitive Clinical Sharing Agreements Audit Team – This audit identified $60 million in savings over 5 years by strengthening controls in contracts between VA and affiliated medical schools and university hospitals. Team members include: Randall Alley, Kevin Day, Maria Foisey, Lee Giesbrecht, Barry Johnson, Claire McDonald, Matthew Rutter, Walter Stucky, Orlando Velasquez, and Sherry Ware.
- Access to VA Mental Health Care for Montana Veterans Review Team – This review continued OHI's pioneering work in the use of a VA/DOD population data base to review travel times for all Montana Veterans to different levels of mental health care services provided by VA. Team members include: Patricia Christ, Limin Clegg, Stephen Foley, Jerry Goss, Jerome Herbers, Nathan McClafferty, Dana Moore, Michael Shepherd, Patrick Smith, Yurong Tan, and Richard Wright.
- DoD/VA Care Transition Process for OEF/OIF Service Members Review Team – This review identified proposals to improve the transition process for wounded OEF/OIF service members, including one that resulted in the enactment of legislation authorizing VA to pay for home improvements for disabled members of the Armed Forces before their discharge. Team members from the OIG include: Patricia Christ, Limin Clegg, Donna Giroux, Jerome Herbers, Nelson Miranda, and Randall Snow.

Appendix A: List of OIG Reports Issued

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
Office of Audits and Evaluations				
Audits and Reviews (Total Monetary Value = $908,585,654)				
09-00091-103 04/06/2009	Audit of Veterans Health Administration Mental Health Initiative Funding			
08-01987-118 04/28/2009	Audit of Veterans Benefits Administration's Loan Guaranty Program Risk Management			
08-01084-112 04/29/2009	Follow-Up Audit of VA's Major Construction Contract Award and Administration Process	$69,379	$69,379	
09-00213-125 05/12/2009	Review of Alleged Claim Processing Delays to Receive Monetary Performance Awards at VA Regional Office Pittsburgh, PA			
08-02436-126 05/13/2009	Audit of Veterans Benefits Administration Compensation and Pension Site Visit Program			
08-02730-133 05/28/2009	Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Accountability			
08-02679-134 05/29/2009	Audit of VA's Management of Information Technology Capital Investments			
09-00026-143 06/10/2009	Audit of Consolidated Mail Outpatient Pharmacy Contract Management	$724,476	$724,476	
08-01322-114 06/23/2009	Audit of Veterans Health Administration's Management of Non-Controlled Drugs			
08-01392-144 06/25/2009	Audit of VA Incomplete Compensation and Pension Medical Examinations			
08-01136-156 06/30/2009	Review of Veterans Benefits Administration Large Retroactive Payments			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
08-01519-172 07/21/2009	Audit of Veterans Health Administration Open Market Medical Equipment and Supply Purchases	$41,172,031	$41,172,031	
08-00921-181 07/30/2009	Audit of VA Electronic Contract Management System			
08-02901-185 08/03/2009	Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program			$865,419,768
09-02088-201 08/21/2009	Informational Report Review of Availability of Mental Health and Orthopedic Services at the VA Pacific Islands Health Care System			
09-01467-216 09/16/2009	Audit of FLITE Program Management's Implementation of Lessons Learned	$1,200,000	$1,200,000	
08-03156-227 09/23/2009	VA Regional Office Rating Claims Processing Exceeding 365 Days			
09-01193-228 09/28/2009	Audit of Veterans Benefits Administration's Control of Veterans' Claims Folders			
09-01239-232 09/30/2009	Audit of VA's System Development Life Cycle Process			
08-01759-234 09/30/2009	VA Regional Office Claim-Related Mail Processing			
Benefits Inspections				
09-01994-230 09/29/2009	Inspection of VA Regional Office Wilmington, DE			
09-01664-231 09/29/2009	Inspection of VA Regional Office Nashville, TN			
American Recovery and Reinvestment Act				
09-01814-210 09/01/2009	Flash Report American Recovery and Reinvestment Act Oversight Advisory, Staffing Challenges Facing Veterans Health Administration's State Home Construction Grant Program			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
Office of Healthcare Inspections				
Combined Assessment Program Reviews				
09-00858-113 04/21/2009	VA Manila Outpatient Clinic Manila, Philippines			
08-03089-116 04/27/2009	Atlanta VA Medical Center Decatur, Georgia			
09-00732-124 05/12/2009	Jack C. Montgomery VA Medical Center Muskogee, Oklahoma			
09-01001-130 05/20/2009	Spokane VA Medical Center Spokane, Washington			
08-02601-131 05/20/2009	North Chicago VA Medical Center North Chicago, Illinois			
08-03075-137 06/02/2009	Charles George VA Medical Center Asheville, North Carolina			
08-03088-138 06/02/2009	G. V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi			
08-02562-139 06/03/2009	Samuel S. Stratton VA Medical Center Albany, New York			
08-02602-140 06/03/2009	VA Illiana Health Care System Danville, Illinois			
08-02415-151 06/25/2009	Grand Junction VA Medical Center Grand Junction, Colorado			
09-01685-154 06/30/2009	Louis A. Johnson VA Medical Center Clarksburg, West Virginia			
08-03090-160 07/01/2009	James A. Haley Veterans' Hospital Tampa, Florida			
08-03076-161 07/10/2009	James H. Quillen VA Medical Center Mountain Home, Tennessee			
08-02564-163 07/13/2009	Syracuse VA Medical Center Syracuse, New York			
09-01643-170 07/23/2009	VA Pacific Islands Health Care System Honolulu, Hawaii			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
08-03086-192 08/11/2009	Central Alabama Veterans Health Care System Montgomery, Alabama			
08-02417-200 08/21/2009	VA Black Hills Health Care System Fort Meade and Hot Springs, South Dakota			
08-02418-202 08/25/2009	Sheridan VA Medical Center Sheridan, Wyoming			
08-02565-204 08/31/2009	VA Western New York Healthcare System, Buffalo, New York			
08-02604-214 09/16/2009	Iowa City VA Medical Center Iowa City, IA			
09-02287-215 09/17/2009	VA Loma Linda Healthcare System Loma Linda, California			
09-02264-225 09/22/2009	Amarillo VA Health Care System Amarillo, TX			
Community Based Outpatient Clinics Reviews				
09-01446-167 07/16/2009	Community Based Outpatient Clinic Reviews Bangor and Portland, ME; Conway and Tilton, NH; and Rutland and Colchester, VT			
09-01446-199 08/20/2009	Community Based Outpatient Clinic Reviews Benton Harbor and Grand Rapids, MI; Terre Haute and Bloomington, IN; and Yale and Pontiac, MI			
09-01446-203 08/26/2009	Community Based Outpatient Clinic Reviews Henderson and Pahrump, NV; Palm Desert and Corona, CA; and Pasadena and Santa Maria, CA			
09-01446-226 09/23/2009	Community Based Outpatient Clinic Reviews Lockport and Olean, NY; Monaca and Washington, PA; Berwick and Sayre, PA; and Somerset, KY			
09-01446-233 09/30/2009	Community Based Outpatient Clinic Reviews Cambridge and Fort Howard, MD; Alexandria, VA and Greenbelt, MD; and Wilmington and Jacksonville, NC			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
Healthcare Inspections				
08-02917-105 04/06/2009	Implementation of VHA's Uniform Mental Health Services Handbook			
09-01108-106 04/07/2009	Administrative Issues VA Pacific Islands Health Care System, Honolulu, Hawaii			
07-01148-109 04/15/2009	Review of VA Use of Animals in Research Activities			
09-00497-110 04/16/2009	Alleged Anesthesia Staffing and Quality of Care Issues VA Caribbean Healthcare System, San Juan, Puerto Rico			
08-02725-127 05/15/2009	Review of Informed Consent in the Department of Veterans Affairs Human Subjects Research			
08-00026-129 05/19/2009	Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2008			
09-01219-141 06/03/2009	Alleged Mismanagement of the Fee Basis Program VA Connecticut Healthcare System, West Haven, Connecticut			
09-01784-146 06/16/2009	Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities			
08-02075-148 06/18/2009	Evaluation of the Veterans Health Administration's National Patient Safety Program			
08-00038-152 06/25/2009	Review of Veterans Health Administration Residential Mental Health Care Facilities			
08-02992-162 07/08/2009	Oversight Review of Specialty Service Issues at the VA Montana Health Care System, Fort Harrison, Montana			
08-00623-169 07/16/2009	Informational Report Community Based Outpatient Clinic Cyclical Reports			
08-02589-171 07/20/2009	Readjustment Counseling Service Vet Center Report			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-00275-173 07/22/2009	Alleged Substandard Patient Care Atlanta VA Medical Center, Decatur, Georgia			
09-00410-174 07/23/2009	Alleged Inappropriate Care in the Community Living Center Tomah VA Medical Center, Tomah, Wisconsin			
09-00524-177 07/28/2009	Alleged Denial of After-Hours Care at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, Iowa			
08-02516-178 07/29/2009	Quality of Care Issues and Staffing Deficiencies John J. Pershing VA Medical Center, Poplar Bluff, Missouri			
09-00315-182 07/30/2009	Pulmonary Services and Quality of Care Issues, North Florida/South Georgia Veterans Health System, Gainesville, Florida			
09-01699-184 08/03/2009	Alleged Cardiology Quality of Care Issues Bay Pines VA Healthcare System, Bay Pines, Florida			
09-01657-187 08/05/2009	Alleged Quality of Care Issues Charles George VA Medical Center Asheville, North Carolina			
09-00356-198 08/17/2009	Alleged Surgical Service Issues James A. Haley VA Hospital, Tampa, Florida			
09-01104-205 08/27/2009	Quality of Care Issues W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina			
09-01468-208 08/31/2009	Surgical Care Case Review John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas			
09-02848-218 09/17/2009	Follow-Up Colonoscope Reprocessing at VA Medical Facilities			
09-00835-217 09/18/2009	Quality of Care, Documentation, and Courtesy Issues Hampton VA Medical Center, Hampton, VA			
09-01255-219 09/18/2009	Quality of Care Review Bob Stump VA Medical Center, Prescott, Arizona			
09-02307-220 09/18/2009	Surgical Quality of Care Review Southern Arizona VA Health Care System, Tuscon, Arizona			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-00400-221 09/21/2009	Alleged Substandard Quality of Care in the Cardiothoracic Surgery Program Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin			
09-02024-222 09/21/2009	Alleged Resident Supervision Issues VA North Texas Health Care System, Dallas, Texas			
09-00326-223 09/22/2009	Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January-June, 2009			
Office of Investigations				
Administrative Investigations				
07-00429-115 04/22/2009	Improper Funding of College Degrees, Failure to Administer and Follow Policy, and Misuse of Government Resources VHA Office of Finance			
09-01123-195 08/18/2009	Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices Office of Information & Technology Washington, DC			
09-01123-196 08/18/2009	Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC			
Office of Contract Review				
Preaward Reviews (Total Monetary Value = $56,406,402)				
09-01157-105 04/02/2009	Review of Proposal Submitted by University of Texas Medicine - San Antonio for Orthopedic Services at the Audie L. Murphy Division of the South Texas Veterans Health Care System	$1,537,300		
09-01363-107 04/10/2009	Review of Proposal Submitted by the University of Nevada, School of Medicine under Solicitation Number VA 261-08-RP-0076, for Infectious Diseases Services at the VA Sierra Nevada Health Care System	$179,496		

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-01364-108 04/09/2009	Review of Proposal Submitted by the University of Nevada, School of Medicine under Solicitation Number VA-261-09-RP-0037, for Medical Officer of the Day Services at the VA Sierra Nevada Health Care System	$718,992		
09-01693-117 04/24/2009	Review of Proposal Submitted by the University Medical Center Corporation, under Solicitation Number VA-258-08-RP-0080, for Radiation Oncology Services for the Southern Arizona Veterans Affairs Health Care System	$135,823		
09-001004-122 05/12/2009	Review of Proposal Submitted by University of Alabama Health Services Foundation, under Solicitation Number VA 247-08-RP-0275, for Neurosurgery Services to VA Medical Center, Birmingham, Alabama	$1,124,532		
09-01675-123 05/14/2009	Review of Proposal Submitted by Ohio State University under Solicitation Number VA-250-08-RP-0068, for Ophthalmology Services to the Chalmers P. Wylie VA Ambulatory Care Center	$1,387,876		
09-01737-132 05/27/2009	Review of Federal Supply Schedule Proposal Submitted by ScriptPro USA Inc. Under Solicitation Number RFP-797-FSS-99-0025-R6	$947,374		
09-02052-136 05/28/2009	Review of Proposal Submitted by the University of Colorado, Denver, Department of Neurosurgery, under Solicitation Number VA-259-09-RP-0199 for Neurosurgery Professional Services for the Eastern Colorado VA Health Care System, Denver Division	$3,985,687		
09-02196-145 06/11/2009	Review of Proposal Submitted by Meharry Medical College, under Solicitation Number VA-249-08-RP-0255, for GYN Services to the New York Campus of the Tennessee Valley Healthcare System	$265,493		

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-01965-149 06/17/2009	Review of Proposal Submitted by New York University School of Medicine under Solicitation Number RFP VA-243-08-RP-0160 for Radiation Safety Services at New York Harbor Healthcare System	$41,623		
09-02169-157 06/29/2009	Review of Proposal Submitted by Anesthesia Services, PC under Solication Number VA-251-09-RP-0048 for Anesthesia Services at the John D. Dingell Medical Center, Detroit	$723,287		
09-01957-175 07/22/2009	Review of Proposal Submitted by the Medical College of Wisconsin, under Solicitation Number VA-69D-08-RQ-0451 for Perfusionist Services at Clement J. Zablocki VA Medical Center	$4,484,161		
09-01943-176 07/28/2009	Review of Federal Supply Schedule Proposal Submitted by ConMed Linvatec Under Solicitation Number RFP-797-FSS-99-0025-R5	$547,515		
09-02392-180 07/30/2009	Review of Proposal Submitted by University of Alabama at Birmingham under Solicitation Number VA-247-08-RP-0302, for Pathology Services to Birmingham VA Medical Center	$1,071,349		
09-02598-183 07/31/2009	Review of Proposal Submitted by West Virginia University, Robert C. Byrd Health Science Center, under Solicitation Number VA-244-09-RP-0042 for Radiology Services for the Louis A. Johnson VA Medical Center, Clarksburg, WV	$5,136,795		
09-01794-186 08/03/2009	Review of Federal Supply Schedule Proposal Submitted by Valeant Pharmaceuticals International Under Solicitation Number M5-Q50A-03-R2	$3,037,200		
09-01680-189 08/11/2009	Review of Federal Supply Schedule Proposal Submitted by Cardinal Health 211 Inc., Under Solicitation Number RFP 797-FSS-99-0025-R5	$8,935,007		

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-02478-193 08/12/2009	Review of Proposal for Primary Care Services and Tele-mental Health Services Submitted by Utah Navajo Health Systems, Inc.	$619,440		
09-02582-194 08/12/2009	Review of Proposal Submitted by University of Nebraska Medical Center Physicians under Solicitation Number VA-263-09-RP-0211 for Cardiology Services at the VA Nebraska Western-Iowa Health Care System	$277,634		
09-02148-190 08/13/2009	Review of Proposal Submitted by University of Maryland School of Medicine under Solicitation Number RFP VA-245-09-RP-0110 for Radiology Imaging Services at VA Maryland Health Care System	$6,672,615		
09-00708-191 08/18/2009	Review of Federal Supply Schedule Proposal Submitted by Ranbaxy Pharmaceuticals, Inc. under Solicitation Number M5-Q50A-03-R2	$1,908,920		
09-02732-209 08/27/2009	Review of Proposal Submitted by University of Miami, School of Medicine, under Solicitation Number VA-248-09-RP-0346 for Cardio-Thoracic Physician Surgical Services at Miami VA Healthcare System	$1,297,936		
09-03322-224 09/17/2009	Review of Proposal Submitted by Louisiana State University Health Sciences Center-Shreveport under Solicitation Number VA-256-09-RP-0189, for Orthopaedic Services to Overton Brooks VA Medical Center	$787,574		
09-02977-212 09/21/2009	Review of Federal Supply Schedule Proposal Submitted by Roxane Laboratories under Solicitation Number M5-Q50A-03-R2	$2,409,559		
09-03025-213 09/22/2009	Review of Federal Supply Schedule Proposal Submitted by Boehringer Ingelheim Pharmaceuticals, Inc. under Solicitation Number M5-Q50A-03-R2			

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-01518-229 09/29/2009	Review of Federal Supply Schedule Extension Proposal Submitted by Karl Storz Endoscopy America under Contract Number V797P-4512a	$8,173,214		
Postaward Reviews (Total Monetary Value = $12,781,638)				
09-00673-111 04/14/2009	Review of Azur Pharma's Federal Supply Schedule Billings under Contract Number V797P-5905x			
08-02007-18 04/30/2009	Review of Ortho Biotech Products, L.P.'s Voluntary Disclosure and Refund Offer under Federal Supply Schedule Contract Number V797P-5372x			$357,267
09-00945-120 04/30/2009	Review of Watson Pharma's Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contract Number V797P-5913x			$633,135
07-02027-119 05/06/2009	Review of Staff Care Inc.'s Federal Supply Schedule Contract V797P-4209a			
09-01898-121 05/07/2009	Review of Veteran Sales LLC dba QuickMedical GS's Voluntary Disclosure and Refund Offer under Contract Number V797P-4995a			$16,248
09-01581-128 05/13/2009	Review of Mylan Pharmaceuticals Inc.'s Voluntary Disclosure under Federal Supply Schedule Contract Number V797P-5891x			$202,272
07-01108-135 06/11/2009	Review of the BrainLab Inc. Federal Supply Schedule Contract V797P-4802a			
08-02996-147 06/15/2009	Review of Voluntary Disclosure and Refund Offer Submitted By Ethex Corporation, Federal Supply Schedule Contract Number V797P-5164x			$155,500
08-00658-150 06/18/2009	Review of Venosan North America Incorporated's Voluntary Disclosure and Refund Offer, under Federal Supply Schedule Contract Number V797P-4042a			$23,530

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
09-01920-159 06/30/2009	Review of Ranbaxy Pharmaceuticals Contract Modification Number 0030, under Federal Supply Schedule Contract Number V797P-5769X			
09-00657-158 07/07/2009	Review of Modification 14 of Contract Number V101(93)P-2224, and Contract Number VA101(049A3) P-0336 awarded to The Joint Commission for Accreditation of Healthcare Service			
08-01050-153 07/13/2009	Review of GE Healthcare's Voluntary Disclosure and Refund Offer of Public Law 102-585, 603 Errors under Contract Numbers V797P-5317x, 5013E, 5461x and 5854s			$9,806,078
08-02727-168 07/14/2009	Review of Kimberly-Clark Corporation's Self-Audit under Federal Supply Schedule Contract Number V797P-3767k			
09-01809-165 07/14/2009	Review of Shire's Voluntary Disclosure and Refund Offer of Public Law 102-585 Errors under Contract Number V797P-5898x			$1,364
09-02382-166 07/15/2009	Review of GlaxoSmithKline Consumer's Proposed Refund under Federal Supply Schedule Contract Number V797P-5560x			$14,437
07-00262-179 07/29/2009	Review of Federal Supply Schedule Contract V797P-5775x with Wyeth Pharmaceuticals			
09-00367-188 08/07/2009	Review of Schering–Plough's Voluntary Disclosure and Refund Offer for Public Law 102–585 § 603 Pricing Errors under Federal Supply Schedule Contract Number V797P–5777x			$12,976
07-03293-206 08/25/2009	Review of Animas Corporation's Voluntary Disclosure and Refund Offer under Federal Supply Schedule Contract Number V797P-4592a			$1,158,090
08-00133-197 09/10/2009	Review of Alcon Laboratories Inc. Voluntary Disclosures under Federal Supply Schedule Contract Number V797P-5352x			$190,701

Report Number/Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
08-02761-211 09/10/2009	Review of Alcon Laboratories Inc. Voluntary Disclosures under Federal Supply Schedule Contract Number V797P-5825x			$210,040
Special Reports				
09-01213-142 06/04/2009	Review of Interagency Agreement between the Department of Veterans Affairs and Department of Navy, Space and Naval Warfare Systems Center (SPAWAR)			
09-01075-164 07/15/2009	Review of Contract No. VA549-P-0027 Between the Department of Veterans Affairs and The University of Texas Southwestern Medical Center at Dallas (UTSWMC) for Gulf War Illness Research			
09-01926-207 08/26/2009	Review of the Award and Administration of Task Orders Issued by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program (RSA)			
Joint Reviews				
09-01033-155 06/29/2009	Review of Defects in VA's Computerized Patient Record System Version 27 and Associated Quality of Care Issues			

Totals

Reports Issued	Funds Recommended for Better Use		Questioned Costs
	by OIG	and Agreed to by Management	
133	**$99,572,288**	**$99,572,288**	**$878,201,406**

Appendix B: Status of OIG Reports Unimplemented for Over 1 Year

The *Federal Acquisition Streamlining Act of 1994*, P.L. 103-355, requires Federal agencies to complete final action on each OIG report recommendation within 12 months after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (September 30, 2008, and earlier). The FY 2008 FISMA audit, which contains unimplemented OIG recommendations from previous years' FISMA audits, is included in the total of unimplemented reports and recommendations, but because it was issued after September 30, 2008, it is not included in the reports that are over 1 year old on the right side of the table. Some reports and recommendations are counted more than once because they have actions at more than one office. Of the reports open less than 1 year, seven reports and eight recommendations have actions at two or more offices.

Unimplemented OIG Reports and Recommendations				
VA Office	Total Issued as of 09/30/2009		Issued 09/30/2008 and Earlier	
	Reports	Recommendations	Reports	Recommendations
VHA	83	446	13	47
VBA	10	39	2	3
OI&T[1]	8	102	1	1
OALC[2]	5	16	0	0
OM[3]	2	3	0	0
OSP[4]	1	1	0	0

[1] Office of Information and Technology (OI&T)
[2] Office of Acquisitions, Logistics, and Construction (OALC)
[3] Office of Management (OM)
[4] Office of Operations, Security & Preparedness (OSP)

Reports Unimplemented for Over 1 Year

Report Number/Issue Date	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
04-02887-169 07/08/2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	VHA	5 of 8	
04-02330-212 09/30/2005	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	VHA	1 of 3	
05-03028-145 05/17/2006	Review of Access to Care in the Veterans Health Administration	VHA	2 of 9	
06-02238-163 07/11/2006	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OI&T	1 of 6	
07-00616-199 09/10/2007	Audit of the Veterans Health Administration's Outpatient Waiting Times	VHA	4 of 5	
06-03677-221 09/28/2007	Audit of the Acquisition and Management of Selected Surgical Device Implants	VHA	2 of 7	$21,948,162
07-00564-121 05/05/2008	Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations	VHA	4 of 5	
07-01202-124 05/07/2008	Healthcare Inspection, Scopes of Practice for Unlicensed Physicians Engaged in Veterans Health Administration Research Activities	VHA	2 of 2	
07-03505-129 05/19/2008	Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3	VHA	9 of 9	

Report Number/Issue Date	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
06-03552-169 07/17/2008	Audit of Veterans Benefits Administration Transition Assistance for Operations Enduring and Iraqi Freedom Service Members and Veterans	VBA	2 of 8	
07-03042-182 08/06/2008	Healthcare Inspection, Human Subjects Protections Violations at the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas	VHA	1 of 2	
08-01559-193 09/05/2008	Audit of the Impact of the Veterans Benefits Administration's Special Hiring Initiative	VBA	1 of 2	
07-02796-203 09/11/2008	Audit of Veterans Health Administration's Government Purchase Card Practices	VHA	1 of 4	$799,997
08-01383-205 09/23/2008	Administrative Investigation Preferential Treatment, Improper Travel Vouchers, Misuse of Resources, and Interference with an OIG Investigation Central Alabama Veterans Health Care System	VHA	4 of 11	
08-00477-211 09/29/2008	Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreement	VHA	7 of 7	$59,895,666
08-00244-213 09/30/2008	Audit of Procurements Using Prior-Year Funds to Maintain VA Healthcare Facilities	VHA	5 of 7	$10,104,678
TOTALS			**51**	**$92,748,503**

Appendix C: *Inspector General Act* Reporting Requirements

The table below cross-references the specific pages in this Semiannual Report to the reporting requirements where they are prescribed by the *Inspector General Act*, as amended by the *Inspector General Act Amendments of 1988,* P.L. 100-504, and the *Omnibus Consolidated Appropriations Act of 1997*, P.L. 104-208.

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 the Act. The audit of VA's consolidated financial statements for FY 2008 and 2007 reported three material weaknesses, all of which are repeat conditions from the prior year's audit. The audit also indicated that VA is not in substantial compliance with FFMIA because VA did not substantially comply with Federal financial management systems requirements. VA is in the process of revising and expanding existing remediation plans for the three repeat material weaknesses identified in the FY 2008 and 2007 audit.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	Commented on 405 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 9-41
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 9-41
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 55-57
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 9-41
Section 5 (a) (5)	Summary of instances where information was refused	None
Section 5 (a) (6)	List of reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 42-54
Section 5 (a) (7)	Summary of each particularly significant report	See pages 9-41
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 59
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	See page 59

IG Act References	Reporting Requirements	Status
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See Table 1 and Table 2 below
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 5(b) of FFMIA	See page 58

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2008	0	$0
Issued during reporting period	1	$865.4
Total inventory this period	1	$865.4
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	1	$865.4
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	1	$865.4
Total carried over to next period	0	$0

Table 2: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2008	0	$0
Issued during reporting period	4	$43.2
Total inventory this period	4	$43.2
Management decisions during the reporting period		
Agreed to by management	4	$43.2
Not agreed to by management	0	$0
Total management decisions this reporting period	4	$43.2
Total carried over to next period	0	$0

Appendix D: Government Contractor Audit Findings

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

Appendix E: *American Recovery and Reinvestment Act* Oversight Activities

In February 2009, OIG received $1 million in Recovery Act funds to conduct a comprehensive program of oversight for the VA projects, programs, grants, and initiatives funded under the Act. OIG's program of oversight includes audit, evaluation, investigation, fraud prevention, and other monitoring activities covering the major VA programs that received a total of $1.4 billion in Recovery Act funding. VA programs receiving Recovery Act funding included:

- $1.0 billion for VHA medical facility nonrecurring maintenance (NRM) and energy projects.
- $150.0 million for VHA Grants to States for extended care facilities.
- $50.0 million for National Cemetery Administration headstone, marker, gravesite, and monument repairs; NRM, energy, and road repair projects; and equipment upgrades.
- $157.1 million for VBA claims processing hiring initiative and support of Veterans economic recovery payments.
- $50.1 million for OI&T support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

In addition to other OIG work, OIG conducts oversight of Recovery Act-related activities and accomplishments to date include the following:

- Began six audits and evaluations of the VA programs and activities receiving Recovery Act funding. An additional audit will start in the first quarter of FY 2010. OIG reports will be issued at the end of each review and on an interim advisory basis as needed.
- Issued a Recovery Act advisory report, *Staffing Challenges Facing Veterans Health Administration's State Home Construction Grant Program*.
- Conducted 100 fraud awareness training and outreach sessions attended by 6,997 VA and other officials responsible for managing or overseeing Recovery Act programs and projects.
- Opened one investigative case of alleged criminal wrongdoing pertaining to a Recovery Act-funded project.
- Established an OIG Recovery Act Web site linked to both the VA Recovery Act Web site and the OIG Hotline. OIG also developed and posted Recovery Act fraud prevention training materials on the OIG Recovery Act Web site.
- Expended the $1 million in Recovery Act funding conducting oversight and outreach activities. In FY 2010, OIG will continue Recovery Act oversight utilizing regular appropriations.

Copies of this report are available to the public. Written requests should be sent to:

Office of the Inspector General (53A)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

The report is also available on our website:

http://www.va.gov/oig/publications/semiann/reports.asp

For further information regarding VA OIG, you may call 202-461-4720.

On the Cover: The National World War II Memorial in Washington, DC, illuminated after dark. Cover photo courtesy of Department of Defense.

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Department of Veterans Affairs
Office of Inspector General
Semiannual Report to Congress

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