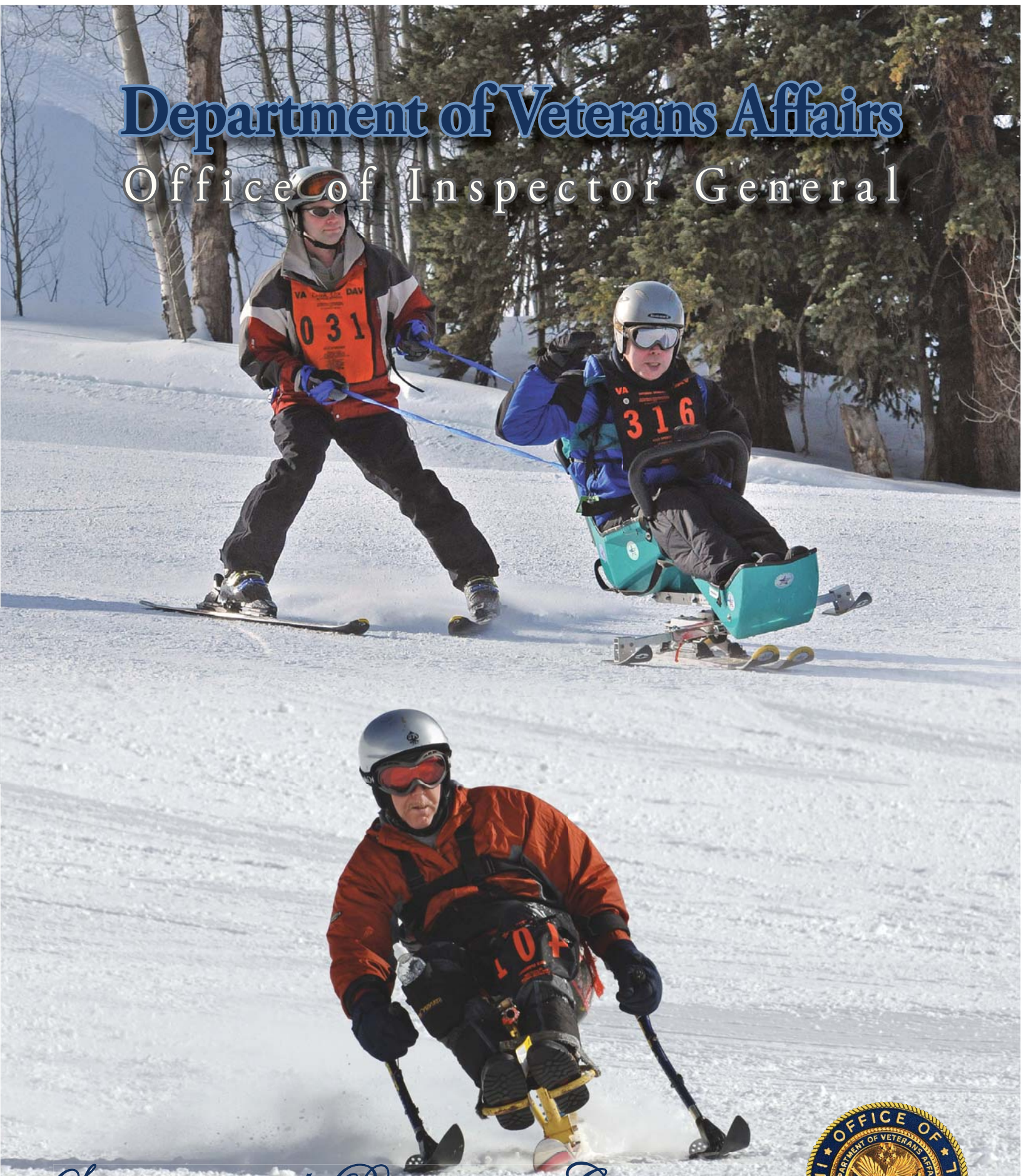
Department of Veterans Affairs

Office of Inspector General



Semiannual Report to Congress

Issue 65 | October 1, 2010—March 31, 2011

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Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress of the United States. Pursuant to the Inspector General Act of 1978, as amended, this report presents the results of our most significant accomplishments during the reporting period October 1, 2010 – March 31, 2011.

During this reporting period, the Office of Inspector General (OIG) issued 140 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $3 billion in monetary benefits, for a return on investment of $65 for every dollar expended on OIG oversight. One of our audits identified that the Veterans Benefits Administration continues to lack adequate procedures to correctly process 100 percent disability evaluations. OIG projects that these weaknesses could cost VA more than $1 billion over the next 5 years.

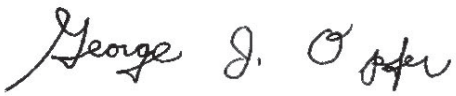
OIG's Offices of Audits and Evaluations and Healthcare Inspections conducted a joint review to assess VA's capacity to address combat stress in women Veterans, as directed by the Conference Report to Accompany the *Consolidated Appropriations Act of 2010.* OIG observed that VA generally diagnosed higher proportions of female Veterans with mental health conditions after separation, but lower proportions were diagnosed with the specific mental health condition of post-traumatic stress disorder and traumatic brain injury. Notwithstanding, OIG did not find any evidence that claims processors applied VBA's current policies and procedures differently when evaluating male and female Veterans' disability claims. OIG recommended regional offices post signs informing Veterans about the services available through the Women Veterans Coordinators, and provide additional sensitivity training to Women Veterans Coordinators and claims processors on military sexual trauma-related disability claims.

The Office of Healthcare Inspections, in its pursuit to help ensure VA provides safe and effective health care, evaluated program oversight and quality assurance processes for diagnostic and therapeutic radiation procedures at Veterans Health Administration facilities. Particularly, the review found an absence of computed tomography (CT) scan oversight to ensure that delivered doses of radiation are not excessive. Care providers are not routinely informing patients prior to imaging procedures that CT scans may cause cancer. Further, OIG identified a need for patients and providers to have information about prior radiation exposure available to them at the time of clinical decision making.

OIG criminal investigators closed 476 investigations, and made 258 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 163 administrative sanctions. In one case, a Veteran was sentenced to 63 months' incarceration and ordered to pay $804,522 in restitution after an OIG and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation proved that for more than 20 years the defendant feigned blindness in order to receive VA monetary benefits.

Throughout our OIG work, the Secretary, Deputy Secretary, and senior management have played critical roles due to their interest and willingness to engage in dialogue about our inspections, audits, evaluations,

and investigations. Together, we are ensuring America's Veterans receive the care, support, and recognition they have earned in service to our country. We will continue to work in partnership with VA and Congress to help transform VA into a 21st Century organization that is people-centric, results-driven, and forward-looking.



GEORGE J. OPFER
Inspector General

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	For the Reporting Period October 1, 2010—March 31, 2011	
DOLLAR IMPACT (in Millions)	Better Use of Funds	$2,313
	Fines, Penalties, Restitutions, and Civil Judgments	$480
	Fugitive Felon Program	$117.2
	Savings and Cost Avoidance	$133.2
	Questioned Costs	$3.8
	Dollar Recoveries	$22.6
	Total Dollar Impact	**$3,069.8**
	Cost of OIG Operations[1]	$47
	Return on Investment (Total Dollar Impact/Cost of OIG Operations)	**65:1**
OTHER IMPACT	Reports Issued	
	Combined Assessment Program Reviews	25
	Community Based Outpatient Clinic Reviews (encompassing 39 facilities)	5
	Healthcare Inspections	31
	Joint Review	1
	Audits and Reviews	10
	Benefits Inspections	6
	Administrative Investigations	3
	Preaward Contract Reviews	44
	Postaward Contract Reviews	15
	Total Reports Issued	**140**
	Investigative Activities	
	Arrests (Not including Fugitive Felons)	228
	Fugitive Felon Arrests	30
	Fugitive Felon Apprehensions by Other Agencies with OIG Assistance	19
	Indictments	172
	Criminal Complaints	67
	Convictions	168
	Pretrial Diversions and Deferred Prosecutions	35
	Administrative Sanctions	163
	Cases Opened	500
	Cases Closed	476
	Healthcare Inspections Activities	
	Clinical Consultations	5
	Administrative Case Closures	14
	Hotline Activities	
	Cases Opened	556
	Cases Closed	381
	Administrative Sanctions	10
	Substantiation Rate	46%
	Contacts	14,936

1. This figure does not include the $9.5 million operating cost for the Office of Healthcare Inspections (OHI). We do not include this figure because oversight work performed by OHI results in saving lives and not dollars.

VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

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

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2011, VA is operating under a $124.2 billion budget, with over 300,000 employees serving an estimated 22.7 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 (NCA) provides interment and memorial benefits. For more information, please visit the VA Internet home page at www.va.gov.

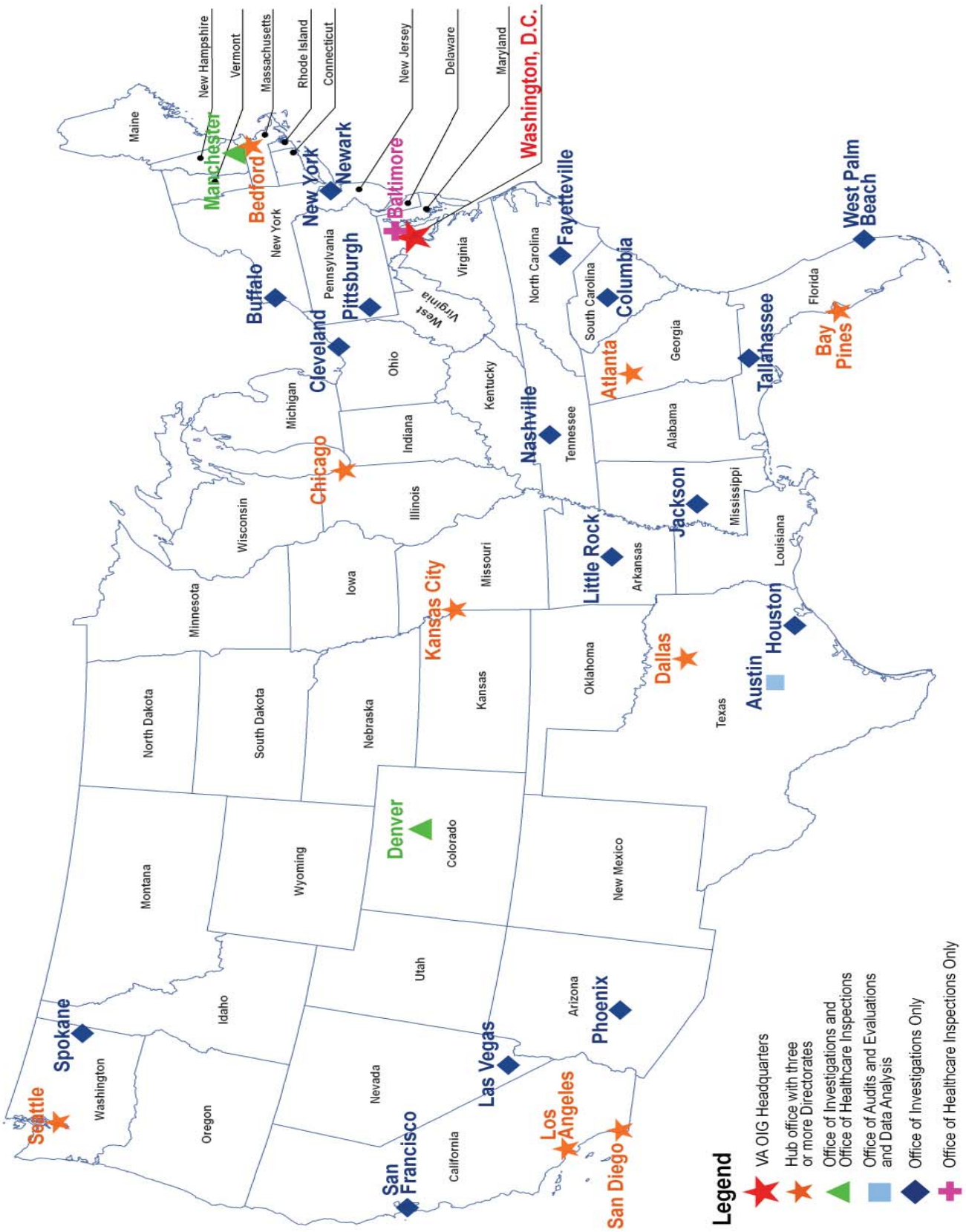
VA Office of Inspector General

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

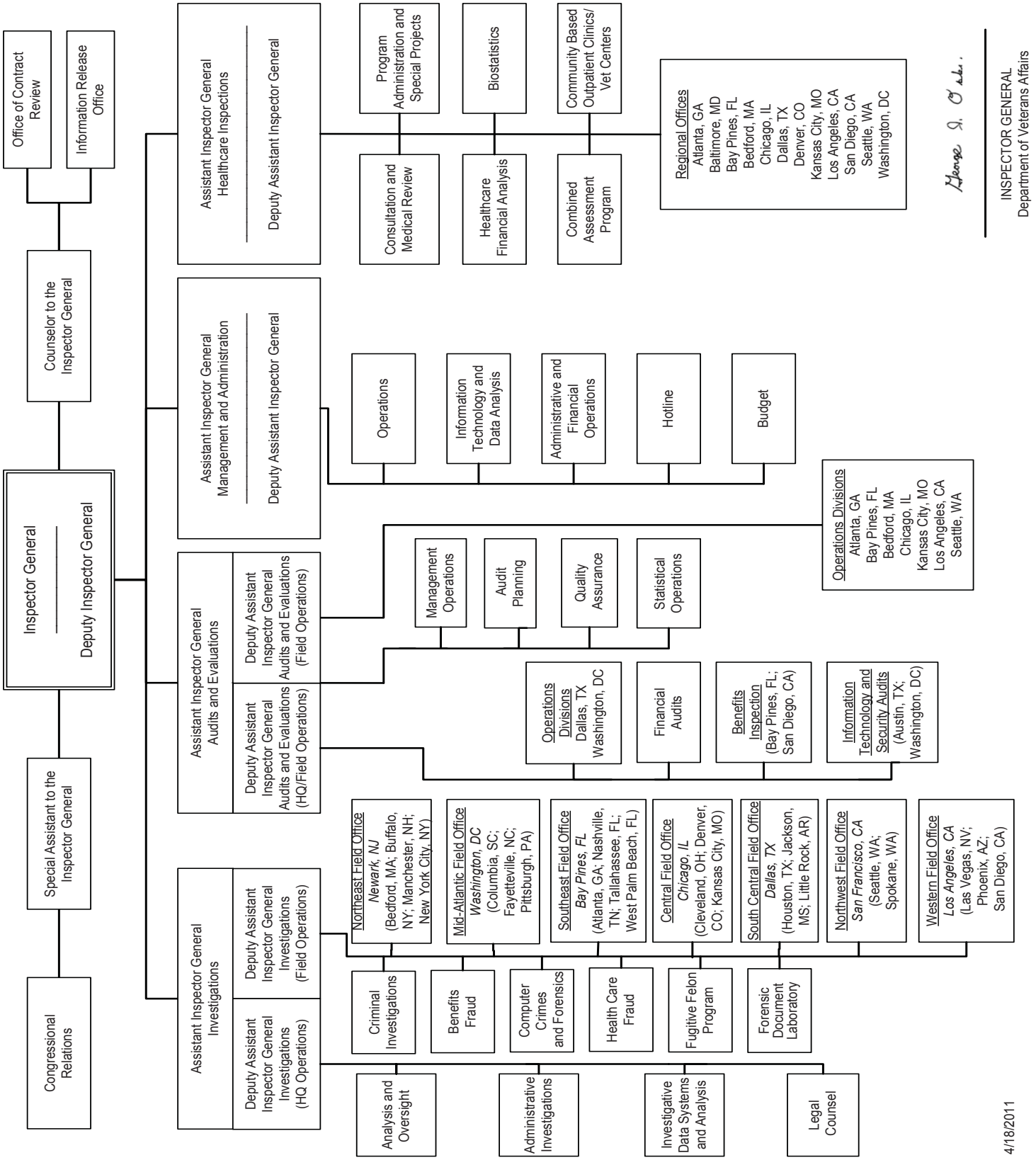
OIG, with 610 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. Anticipated FY 2011 funding for OIG operations provides $109 million from ongoing appropriations. The Office of Contract Review, with 25 employees, receives $4 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) and construction contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country.

OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG Internet home page at www.va.gov/oig.

OIG Field Offices Map



VA and OIG Mission, Organization, and Resources



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/ Operation New Dawn or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 7 national healthcare inspections; 24 Hotline healthcare inspections; 1 joint review; 25 Combined Assessment Program (CAP) reviews; and 5 Community Based Outpatient Clinic (CBOC) reports, covering 39 facilities, to evaluate the quality of care.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities; their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. During this reporting period, OIG issued 25 CAP reports, which are listed in Appendix A. Topics reviewed in a facility CAP may vary based on the facility's mission. Topics generally run for 6–12 months; the CAP topics in current use since October 2010 are:

- Coordination of care.
- Environment of care.
- Management of multidrug-resistant organisms.
- Management of test results.
- Medication management.
- Physician credentialing and privileging (C&P).
- Quality management (QM).

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

Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany House Resolution 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG initiated a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review. The objectives of the reviews are to determine: (1) whether CBOC performance measure scores are comparable to the parent VA Medical Center (VAMC) or Health Care System (HCS) outpatient clinics (OPCs), (2) whether CBOC providers are appropriately credentialed and privileged in accordance with VHA policy, (3) whether appropriate notification and follow-up action are documented in the medical record when critical laboratory test results are generated, (4) the extent patients are notified of normal laboratory test results, (5) whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency planning, (6) whether the CBOC primary care and mental health (MH) contracts were administered in accordance with contract terms and conditions, and (7) whether primary care active panel management and reporting are in compliance with VHA policy.

During this reporting period, OIG performed 39 CBOC reviews throughout 13 Veterans Integrated Service Networks (VISNs). These reviews were captured in five reports. We made recommendations for improvements at the following facilities:

- VISN 1: Stamford and Waterbury, CT; Framingham, MA
- VISN 4: Spring City and Springfield, PA
- VISN 6: Charlottesville, Danville, Fredericksburg, and Lynchburg, VA
- VISN 7: Savannah, GA; Greenville, North Charleston (Goose Creek), and Rock Hill, SC
- VISN 8: Sarasota and Sebring, FL
- VISN 12: Elgin and Oak Lawn, IL; Loyal and Wisconsin Rapids, WI
- VISN 15: Paragould, AR, and Salem, MO
- VISN 16: Jennings and Lafayette, LA
- VISN 17: Bridgeport (Decatur) and Sherman, TX
- VISN 18: Buckeye, Cottonwood, Lake Havasu City, and Show Low, AZ; Espanola and Farmington, NM
- VISN 19: Pocatello, ID, and Nephi, UT
- VISN 20: Caldwell and Twin Falls, ID
- VISN 21: Modesto and Sonora, CA; Kona and Maui, HI

National Reports

First Year of OIG CBOC Reviews Find VAMCs Need to Improve Oversight

OIG began a systematic review of VHA CBOCs, reviewing 58 facilities between April 2009 and February 2010. Overall, the CBOCs generally met VHA directives and guidelines and appear to be providing a quality of care that is not substantially different from parent VAMCs. No statistically significant differences were found between VA-staffed and contract CBOCs overall. However, OIG noted several opportunities to improve the parent facilities' oversight of CBOCs and made seven recommendations to the Under Secretary for Health.

CAP Reviews Show Need for More Improvements Cleaning Reusable Medical Equipment

OIG evaluated reusable medical equipment (RME) processes at 45 facilities during CAP reviews conducted January 1–September 30, 2010, to determine whether facilities complied with VHA standards for RME sterilization and high-level disinfection, provided and documented annual training for employees performing RME reprocessing activities, and assessed and documented annual competencies for employees performing RME reprocessing activities. VHA facilities recognized the importance of safe and consistent RME practices and had taken steps to improve compliance; however, problems in RME practices continue to occur. OIG found that compliance with applicable RME requirements needs to improve in the following areas: standard operating procedures, training and competency assessment, flash sterilization, environment, and reporting to the Executive Committee of the Medical Staff. OIG issued six recommendations to correct the findings.

Radiation Safety Evaluated in VHA Facilities

At the request of the House Committee on Veterans' Affairs, OIG evaluated program oversight and quality assurance processes for diagnostic and therapeutic radiation procedures at VHA facilities. The review focused on four areas associated with the greatest potential for harm to Veterans: radiation therapy (RT), computed tomography (CT), fluoroscopy, and nuclear medicine. VHA has disseminated information in an

effort to reduce CT dose variability, but OIG found no oversight of actual doses being delivered. OIG's review of patients with the highest cumulative radiation doses from CT scans showed that neither patients nor providers had data about cumulative radiation exposure available to them at the time of clinical decision making. OIG also discovered that patients were not informed that CT scans may cause cancer. No issues were found in the use of fluoroscopy or nuclear medicine. OIG made five recommendations to improve operations.

VHA Medical License Tracking Needs Improvement

OIG evaluated the systems and processes designed to ensure that physicians' medical licenses were current and in good standing in VHA medical facilities. OIG determined that the processes used to capture and monitor medical license expiration dates were inconsistent and fragmented across VHA medical facilities. OIG made two recommendations for improvement.

VHA Magnetic Resonance Imaging Safety Program Needs Improvement

OIG evaluated VHA facilities' magnetic resonance imaging (MRI) safety programs by determining whether facilities implemented and maintained MRI safety and infection control policies and procedures, provided adequate employee training, completed appropriate patient screening and informed consents, and conducted risk assessments of MRI suites. Inspectors evaluated 50 MRI suites at 43 facilities during CAP reviews conducted from July 1, 2009, through September 30, 2010. VHA facilities had recognized the importance of safety in the MRI suites and had implemented adequate policies and procedures. OIG identified four areas where compliance with MRI safety requirements and guidelines needs to improve, including training. The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates.

Nationwide Review of VAMC QM Finds Significant Weaknesses in Four Facilities

OIG completed an evaluation of 55 VAMCs to determine whether they had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. OIG conducted this review during CAP reviews performed across the country from October 1, 2009, through September 30, 2010. Although all 55 facilities had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, four facilities had significant weaknesses including the Memphis, TN, VAMC; the El Paso, TX, HCS; the Carl Vinson VAMC, Dublin, GA; and the Providence, RI, VAMC. To improve operations, OIG recommended that VHA reinforce requirements for comprehensive utilization management programs; thorough review of individual resuscitation episodes and trending of aggregate data; and life support training policies, monitoring, and actions. OIG also recommended that facility senior managers review the mortality data provided to them in Inpatient Evaluation Center reports and take actions as appropriate when negative trends are identified.

Improvements Noted in Suicide Prevention Safety Plans in VHA Facilities

At the request of VHA, OIG conducted a review to re-evaluate the extent to which VHA MH providers consistently developed suicide prevention safety plans (SPSPs) for patients assessed to be at high risk for suicide. OIG evaluated SPSP practices at 45 facilities during CAP reviews conducted January 1–September 30, 2010. VHA facilities recognized the importance of developing comprehensive, timely SPSPs for high-risk patients. Additionally, VHA issued appropriate timeframes for initiating SPSPs. However, despite VHA's efforts to comply with suicide prevention program requirements, problems with SPSP development continue to occur. OIG recommended that the Under Secretary for Health,

in conjunction with VISN and facility senior managers, ensure that MH providers develop and timely document SPSPs that meet all applicable criteria.

Hotline Reports

Marion, Illinois, VAMC Shows Substantial Improvement in Certain Areas

An OIG re-evaluation of the Marion VAMC QM program found that current senior leaders have implemented and supported a comprehensive QM program and that the selected C&P processes reviewed were in current compliance. The results of this re-evaluation indicated substantial improvement in the QM and selected C&P areas cited for noncompliance in evaluations conducted by OIG in 2008 and 2009. The VISN Director concurred with the conclusions and OIG made no recommendations.

Review Conducted of a Deceased Veteran's Quality of Care at a VAMC

At a Congressman's request, OIG conducted an inspection to assess the quality of a Veteran's care at a VAMC and to determine if the events leading to the Veteran's death were connected to any issues with the quality of care. OIG's review identified three areas for improvement. Specifically, the VAMC needs to ensure smooth transitions when there are changes in Veterans' providers and/or care settings, improve internal communications between providers and external communications with Veterans and other parts of the VA system, and review the procedures of the Disruptive Behavior Committee. OIG issued four recommendations to the VAMC leadership to correct the findings.

Improvements Recommended for Prescription and Staffing Practices at Hampton, Virginia, VAMC

At the request of Senator Jim Webb, OIG conducted a healthcare inspection of quality of care issues including prescribing practices, pain management, and staffing in primary care (PC) at the Hampton, VA, VAMC. OIG did not substantiate that PC providers were forced to write prescriptions for patients not under their care; however, inspectors did confirm that patients could request a new provider if the original provider refused to write narcotic prescriptions. OIG also substantiated that the Physical Therapy (PT) department was understaffed, but did not substantiate that there was a 6-month backlog of appointments or that PT staff were not trained in pain management. Lastly, OIG determined that managers took appropriate steps to protect staff against threats made against the VAMC. OIG recommended that all prescribing providers be trained in the process for prescribing medications for temporary or newly assigned patients, and that managers evaluate all options for recruitment and retention of physical therapists. Management agreed with the findings and recommendations, and provided acceptable implementation plans.

Better Documentation of Resident Bathing Needed at Hampton VAMC Community Living Center

Also at the request of Senator Webb, OIG conducted a separate inspection of the Hampton VAMC to determine the validity of anonymous allegations regarding quality of care, personnel, and other issues in the community living center (CLC). OIG substantiated the allegation that weekly showers do not occur for all residents; however, residents who do not receive weekly showers receive alternate types of weekly bathing. OIG also substantiated that some staff members were habitually tardy without disciplinary action; however, CLC managers had addressed this issue prior to OIG's review. OIG did not substantiate the other allegations, and recommended that the VAMC Director require that CLC Nurse Managers monitor accurate documentation of resident bathing.

OIG Substantiated Inadequate Communication of Discharge Planning at Hampton VAMC

At the request of Senator Jim Webb, OIG reviewed the validity of allegations regarding quality of care and communication at the Hampton VAMC. OIG substantiated that VAMC managers and the hospitalist did not adequately communicate with the complainant. However, OIG determined that efforts to improve communications between management, clinical staff, and the complainant were effective; therefore, OIG made no recommendations. OIG did not substantiate allegations that Emergency Department (ED) or inpatient staff provided poor patient care; however, OIG did determine that staff did not involve the complainant, who was the caregiver and held Power of Attorney for the patient, in the discharge planning process or provide complete and timely discharge instructions and medications to the patient and his son. OIG made one recommendation to address this finding.

Hospice and Palliative Care Training Needed for Emergency Room Staff at Hampton, Virginia, VAMC

Evaluating the validity of four allegations made against the Hampton, VAMC, OIG substantiated the allegation that an emergency room (ER) provider did not perform a complete evaluation. OIG also substantiated the allegation that staff did not provide the Veteran with hospice care when requested. The complainant alleged that there were hospice beds available at the facility, but OIG did not substantiate the allegation. Furthermore, OIG could not confirm or refute the allegation that staff treated the Veteran and spouse poorly. OIG recommended that all ER staff receive training in hospice and palliative care, active case finding for Veterans in need of hospice and palliative care occurs, and the facility conducts hospice and palliative care education activities for all clinical staff.

Northport, New York, VAMC Nuclear Medicine Residency Training Program Discontinued Due to OIG Findings

OIG conducted an inspection to determine the validity of five allegations regarding Nuclear Medicine Service at the Northport, NY, VAMC. As a result of the inspection, the VAMC Director discontinued the nuclear medicine residency training program in June 2010 and removed the two unlicensed trainee physicians. In addition, the VHA Office of Academic Affiliations discontinued the funding for nuclear medicine resident positions at the VAMC.

Problems Cleaning Dental Equipment Persist at the St. Louis, Missouri, VAMC

At the request of the House Committee on Veterans' Affairs, OIG conducted a review to determine the sequence of events involving alleged improperly cleaned and sterilized dental RME, errors in reprocessing or sterilization, actions taken to correct deficiencies, and decisions related to patient notification of breaches in dental equipment reprocessing or sterilization at the John Cochran Division (JCD) of the St. Louis, MO, VAMC. Responsible managers did not verify the adequacy of RME reprocessing practices, nor did they assure that corrective actions were consistently implemented in response to VHA guidance and the Infectious Disease Program Office report. However, OIG concluded that the occurrence of a patient-to-patient transmission of a blood-borne infectious disease at the JCD was unlikely. OIG also concluded that the VAMC promptly set-up and staffed its Dental Review Clinic, made appropriate efforts to contact identified patients, and provided adequate support and follow-up to patients. Three recommendations were made to improve operations.

Allegation That Bladder Removed without Consent Unfounded at St. Louis VAMC

OIG reviewed a patient's allegations that the JCD of the St. Louis, VAMC surgically removed his bladder and created a neobladder (a bladder using a portion of intestine) in 2007 without his consent. He also alleged that the VAMC did not provide pain medication after the surgery. OIG did not substantiate the allegations; however, it was determined that a Minneapolis, MN, VAHCS radiologist incorrectly documented that the patient's bladder, seen on a September 2009 ultrasound, was a neobladder. Additionally, staff at the VAMC did not consistently document pain assessments as required by local policy. OIG recommended that the HCS Director of Radiology and Chief of Staff correct the medical record and disclose to the patient the facts surrounding an incorrect 2009 ultrasound report. OIG also recommended that VAMC staff document patient pain assessments as required.

Allegations of Telemetry Unit Issues Not Substantiated at St. Louis VAMC

An evaluation was performed by OIG to determine the validity of allegations related to the availability of personal protective equipment (PPE) and blood pressure machines, staff compliance with isolation precautions, and functionality of equipment on the telemetry unit at the JCD of the St. Louis VAMC. OIG substantiated that PPE was not always available on the telemetry unit and some equipment needed for patient care on the telemetry unit was non-functional at the time of the complaint; however, actions to resolve the issues were ongoing or were addressed prior to OIG's visit. OIG also substantiated that blood pressure machines may not have always been available on the telemetry unit; however, OIG determined that staff could secure additional machines through Logistics Service as needed for patient care. Allegations that staff failed to follow proper isolation precautions when caring for infectious patients were not substantiated. OIG also noted that managers established an executive office action line for staff to report their concerns to leadership. No recommendations were made.

CLC Students in Need of Additional Safety Training at Palo Alto, California, HCS

An OIG review evaluated the merit of an allegation regarding the quality of care a Veteran received at the Palo Alto, CA, HCS CLC. OIG substantiated that the Veteran was left unattended on a patio, but did not substantiate that he was sunburned. An occupational therapy student left him on the patio without informing nursing staff. The Veteran was in the sun for approximately 2 hours and experienced a heat reaction before staff discovered him. Clinical staff responded appropriately, and he sustained no long-term effects. After the incident occurred, the CLC Manager took appropriate actions, initiated additional safety measures, and educated staff on heat exposure. However, OIG determined that students of other disciplines did not receive the same training; therefore, OIG recommended that all students who interact with CLC residents receive safety training.

Delays in Test Results, Diagnoses Found at VA Northern Indiana HCS, Ft. Wayne, Indiana

A review was conducted by OIG to determine the validity of allegations regarding quality of care and delay in treatment of a patient at the VA Northern Indiana HCS, Fort Wayne, IN. OIG substantiated that there were delays in notification of the patient's test results and diagnosis of Myasthenia Gravis (MG), with missed opportunities for follow-up care. Allegations that a delay in diagnosis and treatment may have led to multiple ER visits and a subsequent hospital admission were also substantiated. Finally, OIG substantiated that a provider prescribed an antibiotic that exacerbated the patient's MG. OIG did not substantiate that the patient's complaints of infection were ignored and could neither confirm nor refute that nurses did not use aseptic technique when connecting intravenous tubing or that there were significant delays in access to primary care. OIG recommended that the facility complete an external peer review for the appropriateness of care.

Questioned Accuracy of Chemotherapy Dosage Software Not Substantiated at Fargo, North Dakota, VAMC

OIG reviewed the validity of allegations made to the OIG Hotline Division regarding unresolved software problems with the electronic ordering of chemotherapy at the Fargo, ND, VAMC. The complainant specifically alleged that a patient received an increased dose of chemotherapy because of software problems with a recently installed electronic ordering program (IntelliDose®), and that the dosage side effects required the patient to be admitted to the intensive care unit. OIG did not substantiate the specific allegations; however, inspectors did determine that staff pharmacists were uncomfortable verifying IntelliDose® chemotherapy orders and voiced concerns to managers. The Chief of Staff responded to concerns and instructed staff that oncologists would assume all responsibility for verifying dosages of chemotherapy. OIG made no recommendations.

Allegations Not Substantiated Against Boise, Idaho, VAMC Wound Care Management

OIG evaluated the validity of allegations that VA physicians at the Boise, ID, VAMC self-referred patients for wound care to private practices and skilled nursing facilities in violation of conflict of interest rules. The complainant's allegations were not substantiated. The inspection revealed that there is only one community facility capable of providing hyperbaric oxygen therapy (HBOT) to Veterans within 160 miles. VA physicians employed by the community facility providing HBOT and wound care were salaried employees. The facility staff had previously reviewed conflict of interest concerns and involved Regional Counsel in the decision to utilize this community facility. OIG made no recommendations.

Review Finds Opportunities to Improve Communication and Suicide Risk Training at Dayton, Ohio, VAMC

At the request of Congressman Steven Buyer, OIG evaluated the care of a patient who committed suicide on the grounds of the Dayton, OH, VAMC after leaving the ED. OIG found that the ED staff made reasonable efforts to provide treatment to the patient in the hours preceding his suicide, and providers made appropriate efforts to manage the patient's pain and treat his MH conditions from August 2008 to April 2010. However, OIG found opportunities to improve communication and suicide risk management training. OIG recommended that the VISN Director and VAMC Director require providers to optimize appropriate "hand-off" and intra-staff communication and require clinical staff to complete VHA mandatory suicide risk management training.

Alleged Issues in Fee Basis Care at the Martinsburg, West Virginia, VAMC

The purpose of OIG's review was to determine the validity of an allegation that the Interim Chief of Staff denied Fee Basis Service (FB) consults because of cost at the Martinsburg, WV, VAMC. OIG did not substantiate the allegation. However, OIG did identify a process during the review that required improvement and recommended that staff receive education on the VAMC's process for FB approval.

Allegations Against Clinical and Administrative Staff Not Substantiated at Alexandria VAMC, Pineville, Louisiana

OIG conducted an evaluation to determine the validity of allegations regarding quality of care, altered medical records, intimidation, and management responsiveness at the Alexandria VAMC, Pineville, LA. OIG did not substantiate the allegations made by the seven complainants, but rather determined that the treatment provided to all patients included in the review was appropriate. OIG found no evidence that the treatment provided by the physician in question was improper or harmful. Additionally, VA Police acted properly to protect the patients and VAMC staff, and management took acceptable actions to address patient and family concerns. OIG made no recommendations.

Allegations of Imminent Danger Not Substantiated at Southern Arizona VA HCS, Tucson, Arizona

In response to a Hotline allegation, OIG investigated allegations of unsafe care and imminent danger to patients at the Southern Arizona VA HCS in Tucson, AZ. OIG substantiated that there was unsafe triage of patients in the ED, because staff did not always evaluate every patient before discharge as required by policy. OIG did not substantiate the other allegations, but did note opportunities for improvement in the areas of clinic operations, organizational improvement, and care of patients with chronic pain. OIG made two recommendations to correct the findings.

Allegations of Poor Quality of Care in RT Substantiated at Long Beach, California, VAHCS

OIG inspected the Long Beach, CA, VAHCS to determine the validity of allegations regarding RT. Allegations included inappropriate care, lack of competence of radiation oncologists, lack of communication with facility leadership, and a hostile work environment. OIG substantiated the allegation of poor care for 1 of the 10 patients reported and identified medical record documentation deficiencies for 9 of the 10 patients. Allegations that facility leaders were not aware of adverse patient outcomes in RT were also substantiated, and OIG found that action was not taken to correct deficiencies identified in peer reviews. OIG did not substantiate the allegation that radiation oncologists lacked competence and did not address the allegation of a hostile work environment in this report. Four recommendations were made to correct the findings.

Temporary Lodging Program Policies Needed at Martinez, California, OPC and Center for Rehabilitation and Extended Care

OIG conducted an inspection to determine the validity of allegations regarding quality of care issues for six patients at the Martinez, CA, OPC and Center for Rehabilitation and Extended Care. OIG substantiated the allegations regarding inadequate care for two of the six patients reviewed, and also substantiated the allegation that the center lacked the infrastructure in which to provide quality care for observation patients. However, OIG determined that system managers took appropriate actions; therefore, OIG did not make any recommendations regarding these allegations. OIG did not substantiate the allegation that surgical outpatients were inappropriately placed in a contracted community setting without adequate care after their procedures. One recommendation was made to the facility for the development and implementation of local temporary lodging or Hoptel Program policies and procedures.

Allegations of Quality of Care Issues Not Substantiated at Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

OIG conducted an inspection to determine the validity of allegations regarding medical education physician trainee supervision and the quality of care provided by a physician at the Captain James A. Lovell Federal Health Care Center in North Chicago, IL. OIG substantiated that a trainee worked prior to the contract start date. However, there was no harm to patients, and senior managers took appropriate actions to ensure students are scheduled according to their contract. The inspection found that senior managers did not grant privileges based on documented clinical competence and the Executive Committee of the Medical Staff meeting minutes did not reflect the rationale used to support the physician's re-privileging. OIG could neither confirm nor refute that the physician was not competent to perform or supervise a specific procedure. OIG did not substantiate that the physician failed to review patient image test results prior to co-signing student report documentation, co-signed a report that contained an incorrect diagnosis, or neglected patient care duties. One recommendation was made to correct the findings.

Allegations Regarding Customer Care and Satisfaction Not Substantiated at Southern Arizona VAHCS, Tucson, Arizona

OIG conducted an inspection to determine the validity of allegations regarding customer care and satisfaction at the Casa Grande, AZ, CBOC, which is part of the Southern Arizona VAHCS in Tucson, AZ. OIG substantiated that a patient came to the CBOC for evaluation of bleeding, and a Licensed Practical Nurse (LPN) took the patient's vital signs but did not document them in the medical record. However, OIG did not substantiate that the LPN referred the patient to a local ER, two patients received inappropriate examinations, CBOC staff harass or treat patients rudely, or patient complaints about speaking with pharmacy representatives have increased. Allegations that CBOC staff harassed a patient or that CBOC providers have abandoned that patient were also not substantiated. Since steps were taken to correct documentation issues at the CBOC, OIG made no recommendations.

Alleged Continuity of Care Issues for Homeless Los Angeles, California, Veterans Not Substantiated

OIG inspected the VA Greater Los Angeles, CA, HCS to determine the validity of allegations that staff discharged a homeless Veteran to a shelter against his will and without the ability and appropriate supplies to care for himself. OIG did not substantiate the allegations. At the time of discharge, staff appropriately determined that the patient had the capacity to make decisions, was medically stable, and was able to care for himself. OIG found that staff made multiple and reasonable efforts to negotiate acceptable and safe disposition plans with the patient while also respecting his right to make his own decisions. No recommendations were issued.

Office of Healthcare Inspections and Office of Audits and Evaluations Joint Review

Review of Combat Stress in Veterans Receiving VA Health Care and Disability Benefits

As directed by the Conference Report to Accompany the *Consolidated Appropriations Act of 2010*, OIG conducted a review to assess VA's capacity to address combat stress in women Veterans. Using integrated data from VA and the Department of Defense, OIG observed that VA generally diagnosed higher proportions of female Veterans with MH conditions after separation, while lower proportions were diagnosed with the specific MH condition of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). OIG also identified several issues pertaining to military sexual trauma (MST) that require the attention of VBA's leadership. In addition, OIG found that most regional offices do not post signs informing Veterans about the services available through the Women Veterans Coordinators. Furthermore, many of the Women Veterans Coordinators and claims processors that OIG spoke with stated they often felt unprepared to communicate effectively with Veterans regarding their MST-related disability claims. OIG found that although VBA does provide some instruction on processing MST-related claims as part of PTSD training, they have not assessed the feasibility of requiring additional MST-related training and testing. OIG issued four recommendations to VBA to address the identified issues.

Veterans Health Administration Audit and Review

OIG audits and reviews 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 Finds Veterans at Risk of Not Receiving Needed Nursing Home Care in VHA's State Home Per Diem Program

In an audit to evaluate whether VAMCs reimbursed State Veterans Homes (SVHs) accurately for providing care to eligible Veterans and provided access to care for Veterans denied admittance to SVHs, OIG found that VAMCs accurately reimbursed SVHs for Veteran nursing home care. However, OIG also found that two states were denying care to eligible Veterans and none of the eight VAMCs OIG visited had strengthened their outreach efforts to ensure Veterans denied access to SVH nursing home care obtained access to care from other VA sources. In addition, of 400 sampled Veterans, VAMCs did not properly document or ensure timely SVH submission of eligibility determinations for 32 percent of Veterans and medical care approval requests for 55 percent of Veterans. There is an increased risk that Veterans will not receive needed nursing home care and SVHs will not provide appropriate medical care. OIG made 10 recommendations to improve operations.

Review Finds Inappropriate Retention Incentive Payments at Providence, Rhode Island, VAMC

In response to a Hotline allegation, OIG reviewed the Providence, RI, VAMC compliance with VA policy on employee retention incentive payments. Retention incentive payments were not adequately justified and supported in accordance with VA policy, indicating a lapse in the management of retention incentives. OIG questioned the appropriateness of payments made in 17 of the 20 cases reviewed, which together totaled $179,000. Approving officials did not exercise due diligence when approving the payments since there was not adequate justification provided. Further, some retention incentives were misused to supplement employees' pay in order to compensate for perceived inconsistencies in official position classification decisions. OIG made five recommendations to correct the findings and increase controls to ensure future compliance with VA policy.

Veterans Benefits Administration Audits and Evaluations

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

Weaknesses in 100 Percent Disability Evaluation Could Cost VA $1 Billion Over Next 5 Years

An OIG audit of VBA concluded that, despite numerous audit and inspection reports since 2004, VBA continues to lack adequate procedures to process 100 percent disability evaluations correctly or monitor and adjust temporary 100 percent disability evaluations. In addition, VA Regional Office (VARO) staff did not always comply with VBA regulations when granting permanent evaluations, entitlements to special monthly compensation, or ancillary benefits. OIG projected that since January 1993, VBA paid Veterans a net amount of approximately $943 million without adequate medical evidence. Without corrective actions, VBA could make unsupported payments valued at $1.1 billion over the next 5 years. The Acting Under Secretary for Benefits did not agree with the findings, particularly as they relate to the projected overpayment amounts; however, he did agree to implement the recommendations and provided responsive implementation plans.

Audit Identifies $2.9 Million in Unrecoverable Overpayment of Education Benefits

OIG conducted an audit to determine whether VBA processed claims and payments for students and schools timely and accurately under the Post-9/11 GI Bill. Although claims processing times were slow throughout the fall 2009 school term, they were generally accurate and at or near the VBA performance standard. Processing delays and some systemic errors occurred due to limited software functionality and inadequate staffing. VBA underpaid $294,000 in housing allowances and overpaid $2.9 million for books and supplies. VBA will need to pay the housing underpayments; however, VA regulations state that recipients are not liable for education assistance overpayments that are administrative errors. VBA has begun implementing corrective actions to address these issues which, if implemented consistently and successfully, should reduce the claim delays and systemic payment issues. OIG recommended that the Acting Under Secretary for Benefits address the education benefits payment errors identified during the audit.

Audit Finds Changing Priorities, Overlapping Systems Requirements Continue to Challenge Veterans Service Network

OIG conducted an audit of the Veterans Service Network (VETSNET), a replacement system to consolidate compensation and pension benefits processing, to determine whether VA implemented effective controls to address previously identified program governance deficiencies; met schedule, cost, and performance goals for the program; and implemented effective change controls to support the planning, testing, and implementation of the VETSNET suite of applications. OIG found that VA addressed prior program governance deficiencies by establishing oversight groups, risk management processes, and software development gate reviews to provide greater visibility and control of VETSNET program activities. Despite these improvements, VETSNET faces the continuing challenge of managing competing mandates and new systems initiatives that have repeatedly changed the scope and direction of the program. These changes have adversely affected achieving schedule, cost, and performance goals over the life of the VETSNET program. Additionally, planned system functionality enhancements remain unaddressed. OIG recommended the Office of Information and Technology (OI&T) clarify goals, align resources, establish a schedule for accomplishing the goals of VETSNET, and implement improved processes to address software development deficiencies.

Timelier Income Verification Can Save Pension Management Centers $205 Million

OIG reviewed VBA's Pension Management Centers (PMCs) to determine if pensioners receive timely benefit payments. OIG also assessed the implementation of prior recommendations from its FY 2007 audit of VBA's Pension Maintenance Program. The review found VBA did not timely process original death pension claim benefits because PMCs were not adequately prepared to process additional claims added to their workload from VAROs in FY 2008 and 2009. In addition, VBA did not timely process Internal Revenue Service (IRS) and Social Security Administration (SSA) Income Verification Matches, which resulted in overpayments. Lastly, VBA's PMC performance measures in the 2010 Performance and Accountability Report did not adequately measure all the work processed. OIG made four recommendations to correct the findings, with one recommendation potentially saving $205 million in overpayments.

$128.5 Million at Risk Without Better Controls Over Retroactive and One-Time Payments to Veterans Unable to Manage Own Finances

To determine if VBA properly managed retroactive and one-time payments of $10,000 or greater awarded to incompetent beneficiaries served by legal custodians, OIG conducted an audit of VBA's Fiduciary Program. OIG found VBA's controls for managing retroactive and one-time payments to incompetent beneficiaries have significant weaknesses. VBA did not ensure that payments valued at $10,000 or greater were effectively coordinated among VBA offices or that Fiduciary Activities completed required account management and estate protection actions. This occurred because of VBA's reliance on manual notifications, a lack of program policies and procedures, insufficient management oversight, and inadequate staff training. OIG estimates that over the next 5 years $128.5 million in payments will be at risk because VBA failed to perform at least one required account management or estate protection action. OIG made five recommendations to improve operations.

Veterans Benefits Administration Benefits Inspections

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

The Benefits Inspection Divisions issued 6 reports during the period October 1, 2010, through March 31, 2011. Key summary results from claims files we reviewed include:

- Claims processing: 30 percent of benefit claims requiring a rating decision were processed in error. These errors involved claims related to PTSD, TBI, herbicide exposure-related disabilities, and temporary 100 percent evaluations.
- Veterans Appeals and Record Locator System (VACOLS) compliance: 43 percent of Notice of Disagreements were not timely controlled for workload management in VACOLS.
- Systematic Analyses of Operations (SAOs): VARO staff did not timely and accurately complete 27 percent of SAOs. The inadequate SAOs represent missed opportunities for VAROs to identify existing or potential problems and propose corrective actions.
- Mail Handling Procedures: 30 percent of mail was not properly controlled or processed. Consequently, beneficiaries may not have received accurate and timely benefit payments.
- Incompetency Determinations: VARO staff unnecessarily delayed making final decisions in 37 percent of incompetency determinations reviewed at 4 VAROs. Delays increase the risk of an incompetent beneficiary receiving benefits payments without a fiduciary to manage those benefits and ensure the beneficiary's welfare.

Other Review

VA Receives Unqualified Opinion on Consolidated Financial Statements

OIG contracted with the independent public accounting firm, Clifton Gunderson LLP, to audit VA's consolidated financial statements as of September 30, 2010, and for the year then ended. This audit is an annual requirement of the *Chief Financial Officers Act of 1990.* Clifton Gunderson LLP provided an unqualified opinion on VA's FY 2010 consolidated financial statements. They also identified one material weakness, information technology (IT) security controls, which is a repeat condition. The Department has taken corrective actions sufficient to eliminate one material weakness previously cited last year and reduce two others to significant deficiencies in this year's internal control report. Clifton Gunderson LLP reported that VA is not in substantial compliance with the *Federal Financial Management Improvement Act of 1996*, P.L. 104-208, (FFMIA) because VA did not substantially comply with Federal financial management systems requirements. They also noted instances of non-compliance with the *Debt Collection Improvement Act of 1996*.

Veterans Health Administration Investigations

The OIG Office of Investigations conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of Veterans. In the area of health care delivery, OIG opened 209 cases, made 105 arrests, and obtained over $175,262,486 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, OIG opened 66 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Forty defendants were charged with various crimes relating to drug diversion. OIG also initiated 20 investigations regarding fraudulent receipt of health benefits. Eight 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 $306,888.

Former West Los Angeles, California, VAMC Pharmacist Charged with Stealing Pharmaceuticals

A former West Los Angeles, CA, VAMC pharmacist was charged with the transportation of stolen goods after a OIG, Food and Drug Administration (FDA) OIG, and Immigration and Customs Enforcement (ICE) investigation revealed that for over 5 years, the defendant stole non-controlled pharmaceuticals valued at $190,000 from the VAMC pharmacy warehouse. The stolen goods were then sold through the internet to an individual in Florida, who has also been charged in a related case.

Former Jackson, Mississippi, VAMC Nurse Pleads Guilty to Drug Diversion

A former registered nurse at the Jackson, MS, VAMC pled guilty and entered into a pretrial diversion agreement for a period of 3 years after being indicted for prescription fraud. An OIG investigation disclosed that the nurse falsified 47 prescriptions using the names of numerous Veterans. For over 7 months, the defendant diverted over 6,000 tablets of pain medication from the VAMC and admitted to stealing the drugs for her personal use.

Portland, Oregon, VAMC Nurse Sentenced for Drug Diversion

A Portland, OR, VAMC nurse was sentenced to 15 days' incarceration, 36 months' probation, and ordered to pay $710 in restitution to VA. An OIG and VA Police investigation revealed that the nurse used his position to gain access to the identities of patients no longer under his care to access a VA narcotic dispensing machine, falsely recording that the narcotics were for these patients. The defendant then self-administered the narcotics, to include fentanyl and midazolam, while on duty and providing health care services to Veterans.

Veteran Admits to Doctor Shopping to Obtain Narcotics

A Veteran was granted an 18-month Deferred Entry of Judgment for obtaining a controlled substance by fraud and was ordered to complete a substance abuse program. The defendant admitted that he had received 5,454 doses of hydrocodone, oxycodone, and methadone from both VA and his private physician in a 12-month period. The Veteran admitted to making false statements to both doctors about not receiving narcotics from other sources.

Defendants Arrested for Drug Distribution

Two defendants were arrested for distribution of heroin and conspiracy to violate drug laws. An OIG, Drug Enforcement Administration (DEA), VA Police, and local police investigation determined that the defendants were selling illicit drugs to at least two Veterans receiving treatment for substance abuse at the Bedford, MA, VAMC. The director of the VAMC informed OIG that the Veterans complained about the illicit drugs being dealt in and around the VAMC. A search of the defendant's residence and two vehicles conducted after their arrest led to the discovery of illegal drug packaging material and customer lists.

Portland, Oregon, VAMC Technician Indicted for Drug Theft

A Portland, OR, VAMC medical technician was indicted for identity theft and computer crime after an OIG and VA Police investigation revealed that she diverted controlled substances from a VA Acudose medication dispensing machine. The defendant admitted to diverting the narcotics for over a year by using fictitious identities or identities of patients that were no longer under her care. The employee also admitted to using the narcotics while on-duty.

Former Lexington, Kentucky, VAMC Nurse Sentenced for Prescription Fraud

A former Lexington, KY, VAMC nurse was sentenced to 36 months' supervised release and ordered to complete a 5-year substance abuse program with the State Board of Nursing after an OIG investigation revealed that the defendant phoned in narcotic prescriptions to local pharmacies using the name of her estranged husband as the patient's name and then picked up the prescriptions herself. The defendant used the name of a nurse co-worker when calling the pharmacies and also used a VAMC physician's DEA number to complete the fraudulent transactions.

Former Providence, Rhode Island, Nurse Indicted for Drug Diversion

A former Providence, RI, VAMC intensive care nurse was indicted for diversion of a controlled substance after an OIG and VA Police investigation revealed that he obtained hydromorphone and falsified VA controlled substance records to conceal his theft of the drug. This case was initiated following an internal VA analysis that showed a high frequency of Pyxis system overrides performed by the defendant compared to other nurses on the ward.

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

A former Mountain Home, TN, VAMC registered nurse was sentenced to 3 years' supervised probation and 200 hours' community service after pleading guilty to obtaining a controlled substance by fraud. An OIG and VA Police investigation revealed that on approximately 24 occasions between March and June 2009, the defendant stole morphine, hydromorphone, hydrocodone, and oxycodone intended for Mountain Home VAMC patients.

Former Lexington, Kentucky, VAMC Nurse Pleads Guilty to Involuntary Manslaughter

A former Lexington, KY, VAMC registered nurse, previously indicted for murder, pled guilty to involuntary manslaughter. An OIG investigation revealed that, without proper authority, the defendant infused over 75mg of morphine into a 90 year-old Veteran in a period of 6 hours. These doses were found to have contributed to the patient's death.

Defendant Indicted for Stolen Valor Fraud

A former National Guard member, ineligible for VA health care benefits, was indicted for theft of Government property and making a false statement after an OIG investigation revealed that he fraudulently received VA health care benefits between 1998 and 2010. The investigation determined that the defendant falsely claimed to have served in Vietnam by using altered military discharge documents. The defendant also falsely claimed to have earned the Vietnam Service Ribbon and the Purple Heart. The loss to VA is $143,606.

Former Palo Alto, California, VAMC Patient Sentenced for Assault of Physician

A former VA patient at the Palo Alto, CA, VAMC was sentenced to 33 months' incarceration, 3 years' probation, and 500 hours' MH treatment after pleading guilty to forcibly assaulting a VA physician while in the performance of her official duties. An OIG and VA Police investigation revealed that the defendant attacked the VA physician from behind and struck her in the head with a closed fist. The physician was knocked unconscious and sustained severe injuries that required hospitalization.

Veteran Sentenced for Assaulting VA Police Officers at Cleveland, Ohio, VAMC

A Veteran was sentenced to 38 months' incarceration and 36 months' probation after pleading guilty to the assault of a VA Police Officer. An OIG and VA Police investigation revealed that the defendant assaulted and injured three VA Police officers who were attempting to calm him while he was a patient at the Cleveland, OH, VAMC.

VA Patient Arrested for Assault of VA Police Officer

A VA patient at the Palo Alto, CA, VAMC was arrested and charged with assaulting an on-duty VA Police Officer. The defendant entered the VAMC ER complaining about knee pain and demanded specific types and quantities of narcotics. The defendant became belligerent after the attending physician denied his request and VA Police Officers were dispatched to the ER. The patient lunged at the first responding officer, spit in his face, and called him a derogatory racial term. The officer was immediately taken for bio-hazard evaluation and treatment because the defendant's saliva went into the officer's eyes and mouth.

Veteran Sentenced for Assault on VA Physician

A Veteran was sentenced to 2 years' probation and ordered to pay $1,816 in restitution after pleading guilty to assaulting a VA physician at the Tuskegee, AL, VAMC. An OIG investigation revealed that after the defendant's request for prescription narcotics was denied, he trapped the VA physician in an examination room and threatened to assault and kill him.

Veteran Found Guilty of Assaulting Spokane, Washington, VAMC Employees

A Veteran was found guilty at trial of assaulting medical staff at the Spokane, WA, VAMC that resulted in bodily injury. The Veteran invoked a temporary insanity defense based upon PTSD; however, inconsistencies in his statements were used to impeach his credibility.

Defendant Sentenced for Theft of VA Computers at Decatur, Georgia, Clinic

A defendant was sentenced to 8 years' incarceration after pleading guilty to burglary and theft at a Decatur, GA, VA OPC. An OIG, VA Police, and local police investigation revealed that the defendant burglarized the clinic on two occasions and stole two VA computers and accessories. No personal or confidential data was stored on either computer. Subsequent to the defendant's arrest, additional warrants were issued by other police agencies for other burglaries committed throughout the metropolitan Atlanta, GA, area.

Veteran Sentenced for Travel Fraud from Loma Linda, California, VAMC

A Veteran was sentenced to 44 months' incarceration after pleading guilty to forgery. An OIG investigation determined that the defendant submitted multiple copies of a travel voucher to a Loma Linda, CA, VAMC agent cashier in order to receive additional cash reimbursements. The investigation revealed that the defendant traced over the VAMC budget officer's signature in order to make it appear the signature was an original and then altered a VA appointment form to reflect different dates of treatment.

Veterans Indicted for Travel Fraud from Albuquerque, New Mexico, VAMC

Four Veterans were indicted for fraud after an OIG investigation determined that the defendants submitted fraudulent vouchers for cash reimbursement for travel expenses. The Veterans were fraudulently claiming to travel between 150 and 475 miles roundtrip from their homes to the Albuquerque, NM, VAMC. The loss to VA is approximately $88,000.

Veteran Sentenced for Theft of Travel Funds from the Albuquerque, New Mexico, VAMC

A Veteran was convicted of theft and sentenced to 223 days' incarceration, 24 months' probation, and ordered to pay $16,027 in restitution. An OIG investigation determined that the defendant submitted 96 fraudulent vouchers for reimbursement of travel expenses. The defendant was claiming to travel over 400 miles roundtrip from his home to the Albuquerque, NM, VAMC.

Former Veterans Service Officer Sentenced for Travel Fraud

A former Arizona Department of Veterans Services employee was sentenced to 36 months' probation and ordered to pay $18,531 in restitution after pleading guilty to theft. An OIG investigation determined that the defendant, who lived in the local Phoenix, AZ, area, fraudulently claimed to have traveled 500 miles roundtrip to the Phoenix, AZ, VAMC for his medical appointments.

Veteran Indicted for Filing Fraudulent Travel Claims

A Veteran was indicted for theft of Government funds after an OIG investigation revealed that from April 2009 to December 2010, he filed fraudulent travel claims at the Gainesville, FL, VAMC. The defendant claimed that he was traveling 240 miles roundtrip while his actual residence was approximately 30 miles from the VAMC. The loss to VA is $21,738.

Non-Veteran Sentenced for Theft of VA Benefits

A Veteran impersonator was sentenced to 6 months' incarceration, 36 months' supervised release, and ordered to pay $33,000 in restitution after pleading guilty to theft of Government property. An OIG investigation revealed that the defendant, who never served in the military, created fraudulent documentation in order to receive medical treatment and medication from VA.

Veteran Arrested for Assault of Nurse at White River Junction, Vermont, VAMC

OIG agents arrested a Veteran for assaulting a VA nurse at the White River Junction, VT, VAMC. An OIG and VA Police investigation revealed that while in the ER, the defendant locked the door, took a scalpel from a hospital cart, and physically gained control of the nurse by holding the scalpel to her throat. VA Police were able to subdue the Veteran and the nurse sustained no injuries.

Veteran Arrested for Theft of VA Health Care Benefits

A Veteran was arrested for the theft of Government property and for making a false statement after an OIG investigation revealed he fraudulently submitted military discharge documents to the Bay Pines, FL,

VAMC. The defendant falsely claimed to have served in Vietnam and to have earned the Vietnam Service Medal. The loss to VA is $143,606 in health care benefits.

Family Member Charged with Theft of Veteran's Identity

A felony complaint was filed charging the cousin of a Veteran with identity theft and grand theft. An OIG investigation determined that the defendant stole the identity of his cousin and over several years obtained medical care from VA to include hip replacement surgery. The loss to VA is $98,274.

Veteran Charged with Identity Theft

A Veteran was charged with identity theft after an OIG and local police investigation revealed that he submitted benefit applications to a Vet Center and VAMC with a false DD-214 certificate. The defendant falsely claimed that he was an officer in the U.S. Marine Corps with combat service in Vietnam, Laos, and Cambodia, and falsely claimed he was awarded the Silver Star, two Bronze Stars, and two Purple Hearts. The defendant submitted the same false documentation to a VARO for PTSD, adding fictitious "buddy" letters attesting to this military service as verification of his combat experiences in Vietnam. The investigation revealed that the defendant was an enlisted Navy Veteran and had never served in the U.S. Marine Corps, never deployed overseas, never served in Vietnam, and was not awarded any of the claimed medals and was not entitled to Vet Center or VA medical services. The defendant paid $8,322 in restitution to the Vet Center and VAMC.

Veteran and Two Accomplices Indicted for Thefts from Palo Alto, California, VAMC

A Veteran and one accomplice were arrested after being indicted for access device fraud, conspiracy to commit access device fraud, and aggravated identity theft. A third defendant, indicted on the same charges, is still being sought. An OIG and VA Police investigation determined that the defendants were responsible for the theft of credit cards stolen from purses that were left in the offices of Palo Alto, CA, VAMC employees. The defendants used the credit cards to purchase approximately $10,000 dollars in gift cards, merchandise, and gas. The Veteran admitted knowledge of the scheme, but denied any involvement in the thefts. However, the other two defendants provided information that the Veteran developed this scheme and had been burglarizing VAMCs, private hospitals, and business offices for the past 10 years.

Veterans Benefits Administration Investigations

VA's Compensation & Pension (C&P) Service administers a number of financial benefits programs for eligible Veterans and certain family members, including VA guaranteed home loans, education, insurance, and monetary benefits. C&P investigations routinely concentrate on payments made to ineligible individuals. For example, a beneficiary may deliberately feign a medical disability to defraud the VA compensation program. OIG conducts an ongoing and proactive income verification match to identify possible pension fraud committed by individuals who fail to disclose income to the VA pension program, which calculates payments according to the beneficiary's income, in order to stay below the eligibility threshold. Additionally, OIG operates an ongoing death match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. Generally, family members of the deceased are responsible for this type of fraud. With respect to VA guaranteed home loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. VA appoints fiduciaries for Veterans in receipt of VA benefits who are deemed incompetent and for minor children who are receiving VA benefits. OIG investigates allegations of fraud committed by these fiduciaries.

In the area of monetary benefits, OIG opened 222 investigations, made 121 arrests, and had a monetary impact of over $15.3 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries during this reporting period. OIG opened 180 investigations involving deceased payee cases, fiduciary fraud, identity theft, and Veterans/widows fraudulently receiving VA C&P funds, which resulted in criminal charges filed against 129 defendants. Court ordered payment of fines, restitution, and penalties amounted to $920,702, while OIG achieved an additional $6.8 million in savings, efficiencies, cost avoidance and recoveries. The death match project recovered $3.63 million, with another $42,000 in anticipated recoveries. Twenty-eight "Stolen Valor" cases were opened resulting in charges filed against 20 defendants and $1,789,480 in court ordered payment of fines, restitution, and penalties.

Veteran Who Feigned Blindness Sentenced for Defrauding VA of Over $800,000

A Veteran was sentenced to 63 months' incarceration and ordered to pay $804,522 in restitution after being previously found guilty at trial of health care fraud and false statements relating to health care matters. Additionally, the defendant previously pled guilty and was sentenced to 60 months' incarceration for having been a felon in possession of a firearm. Both sentences will run concurrently. An OIG and the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATFE) investigation revealed that for over 20 years the defendant, a convicted felon, falsely represented to VA that he had extreme loss of vision in both eyes. The Veteran received VA compensation for blindness that included a special monthly compensation. The investigation revealed that the Veteran drove a vehicle, read, hunted with firearms, and performed numerous other activities that would not be possible with his purported vision loss.

Veteran Who Altered Military Records Charged with Theft of VA Funds

A Veteran was charged with theft of Government funds after an OIG investigation revealed that he provided false information to VA in support of his claim for VA disability compensation benefits. Between 1998 and 2009, the defendant submitted VA forms along with altered DD-214s, Department of Defense, and Department of the Army documents attesting to his claims that he was in Special Forces, the airborne infantry, and was wounded in Vietnam. The altered DD-214s included fraudulent additions of Purple Heart medals, "Silver Wings," and military specialties of airborne infantry and Special Forces. A search warrant conducted at the Veteran's residence yielded a typewriter ribbon containing keystrokes used on one of the many fraudulent DD-214s, as well as blank DD-214s manufactured by the Veteran. The investigation also revealed that VA relied on the defendant's statements to award service connection for PTSD. The loss to VA is over $324,000.

Veteran Who Altered Military Records Pleads Guilty to Fraud

A Veteran pled guilty to possession of an altered/forged military discharge document, felon in possession of a firearm, misuse of a Federal certificate, wearing false military medals, and wire fraud. An OIG, ATFE, Department of State Diplomatic Security Service, and U.S. Coast Guard investigation revealed that the Veteran, while serving in the Navy, gained access to the Navy's personnel system and altered his military service record. The Veteran's DD-214 contained fraudulent information reflecting that he was a Navy SEAL with combat service in Vietnam and that he was awarded numerous medals and commendations. The Veteran submitted the fraudulent DD-214 to VA in support of a fraudulent compensation claim for PTSD. The Veteran's VA claim also contained a PTSD questionnaire fraudulently reflecting that he served in Vietnam, was a member of a SEAL team, and that he had been wounded in combat. The loss to VA is $173,000.

Veteran Indicted for Fraud

A Veteran was indicted for wire fraud and health care fraud after fraudulently claiming PTSD symptoms and other extreme physical disabilities that qualified him for a higher rate of compensation. An OIG investigation revealed that the defendant falsely reported his physical disabilities to the VAMC staff and the VARO in his claim for benefits. Witness interviews and surveillance videos of the Veteran using lawn mowers, tilling a garden, and lifting 95 pound landscape boulders revealed that the defendant was able-bodied and capable of strenuous work. The defendant also engaged an undercover agent in a conversation and coached him on how to fraudulently represent symptoms of PTSD to VA, even after being told by the agent that he did not have any PTSD symptoms. VA rescinded the defendant's compensation for PTSD and has downgraded his percentage for other disabilities, reducing his overall benefits. The loss to VA is over $200,000.

Veteran Admits to Defrauding VA

A Veteran who entered into a pre-trial diversion agreement was ordered to pay $66,661 in restitution and comply with all other conditions of the agreement for 12 months. During an OIG investigation, the Veteran admitted that he deliberately failed to report his employment income to VA. As a result, he fraudulently received VA pension benefits to which he was not entitled.

Veteran Pleads Guilty to Bank Fraud

A Veteran pled guilty to bank fraud and aggravated identity theft after an OIG, Secret Service, and Federal Bureau of Investigation (FBI) investigation revealed the he used a false Social Security number and other false identification documents in order to secure a $204,000 VA home loan. The loss to VA is approximately $36,000.

Veteran Pleads Guilty to Stolen Valor Fraud

A Veteran pled guilty to forgery after an OIG investigation revealed that he had altered his DD-214, falsely claimed to have served in Vietnam, and that he earned a Purple Heart and the Vietnam Service Medal. The defendant submitted the fraudulent DD-214 to the VARO to establish support for a fraudulent claim for VA disability compensation benefits, to include PTSD. The DD-214 was accompanied by multiple statements claiming heroic combat action in Vietnam and wounds incurred from that action. The loss to VA is approximately $22,000.

Individual Sentenced for Stolen Valor

An individual was sentenced to 60 days' house arrest, 5 years' probation and ordered to pay restitution of $20,548 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant filed a fraudulent claim for VA compensation benefits for PTSD by using an altered DD 214. The defendant admitted altering his DD-214 to falsely indicate military service as a sniper in Vietnam and award of a Combat Action Ribbon and Purple Heart Medal. The defendant was actually discharged from the Marine Corps during basic training after going absent without official leave.

Veteran Found Guilty of Stolen Valor Fraud

A Veteran was found guilty at trial of unlawful possession of an altered discharge certificate, false representation of earning military decorations, false statements, and mail fraud. The defendant, a former elected county official, claimed to be a recipient of the Vietnam Campaign and Service medals while running for re-election in 2007. During the investigation into false representations of earning military

decorations, the Veteran resigned his position as county Commissioner of Revenue. The investigation also determined that the defendant made false statements to VA, related to an October 1973 murder at Fort Bragg, while applying for VA benefits associated with PTSD. The loss to VA is approximately $53,000.

Veteran and Wife Indicted for Theft of Government Funds

A Veteran and his wife were indicted for theft after an OIG and SSA OIG investigation revealed that they used false identities to obtain VA and Social Security benefits. The Veteran obtained VA pension benefits under his true identity, while working and eventually retiring under a false identity. Both defendants also obtained Social Security benefits to which they were not entitled. The defendants' scheme to defraud VA and SSA lasted over 40 years, and the fraud amount is approximately $328,000. The loss to VA is $61,460.

Veteran and Spouse Sentenced for Theft of Government Funds

A Veteran and his spouse were each sentenced to 60 months' probation and ordered to pay restitution of $71,816 to VA and $48,174 to the SSA after pleading guilty to theft of Government funds. An OIG, SSA OIG, and U.S. Secret Service investigation revealed that the Veteran received VA unemployability and Social Security disability benefits, but failed to disclose his employment as a long haul truck driver. The spouse, who worked for the same company, received his wages under her Social Security number to conceal his employment from VA and SSA.

Veteran and Wife Indicted for Fraud

A Veteran and his wife were indicted for theft of funds, concealment of a material fact related to Social Security funds, conspiring to defraud the Government, obtaining Title IV Department of Education funds by fraud and false statements, filing false tax returns, and causing another to file a false tax return. An OIG, SSA OIG, IRS Criminal Investigations Division (CID), and Department of Education OIG investigation revealed that the defendant failed to disclose his employment income to VA and SSA while collecting VA unemployability benefits. Both defendants also conspired to defraud the United States by under-reporting their income and using fraudulent tax returns to apply for Federal student aid for two daughters. The loss to VA is $224,473.

Widow Pleads Guilty to Theft of Government Funds

The widow of a Veteran pled guilty to theft of Government funds and false statements. An OIG investigation determined that the defendant fraudulently received VA Dependency and Indemnity Compensation (DIC) benefits from March 1997 to December 2009 by failing to report her remarriage. The loss to VA is $148,943.

Widow Sentenced for Theft of VA Pension Benefits

The widow of a deceased Veteran was sentenced to 15 months' incarceration, 36 months' probation, and ordered to pay $70,000 in restitution after pleading guilty to the theft of Government property. An OIG investigation revealed that the defendant remarried and continued to receive VA surviving spouse pension benefits that she was no longer entitled to receive.

Widow Sentenced for Defrauding VA

A widow was sentenced to 8 months' electronic monitoring, 4 years' probation and ordered to make restitution of $221,474 to VA. An OIG investigation revealed that the defendant failed to notify VA that she had remarried and subsequently received DIC benefits to which she was not entitled.

Widow Indicted for Theft of Government Funds

The widow of a deceased Veteran was indicted for theft of Government funds after an OIG investigation determined that she failed to notify VA of her remarriage in 2003 and fraudulently received DIC benefits to which she was no longer entitled. The loss to VA is $87,463.

Defendant Who Stole Deceased Veteran's Identity Indicted for Theft of VA Funds

A defendant, believed to be the son of a deceased beneficiary, was indicted for bank fraud and additional charges after an OIG and Postal Inspection Service investigation revealed that the defendant stole the identities of numerous individuals, to include the deceased Veteran's identity. The defendant used the identity of the deceased Veteran to steal VA benefits that were issued after the beneficiary's death in September 1996. The loss to VA is $127,661.

Non-Veteran Sentenced for Identity Theft

A non-Veteran was sentenced to 15 months' incarceration, 3 years' probation, and ordered to pay $125,285 in restitution after pleading guilty to misuse of a Social Security number and false statements related to health care matters. An OIG and SSA OIG investigation revealed that the defendant stole the identity of a Veteran and redirected the Veteran's VA compensation benefits and military retirement to his own bank account. The loss is approximately $150,000.

Fiduciary Pleads Guilty to the Theft of VA Funds

A certified legal assistant acting as the VA-appointed fiduciary for two Veterans pled guilty to a criminal information charging her with theft of Government funds. An OIG investigation revealed that for 2 years the defendant stole approximately $57,600 from the Veterans' accounts.

Fiduciary Sentenced for Theft

A Veteran's daughter was sentenced to 8 years' probation and ordered to pay $11,391 in restitution after pleading guilty to the misapplication of fiduciary property of the elderly. An OIG investigation revealed that the defendant misappropriated approximately $72,500 in VA and Social Security benefits intended for her father, an elderly Veteran confined to a nursing home. The defendant had been serving as her father's legal custodian under a Durable Power of Attorney.

Former Fiduciary Sentenced for Embezzlement

A former VA appointed fiduciary was sentenced to 6 months' home confinement, 36 months' probation, 100 hours' community service, and ordered to pay restitution of $57,504. An OIG investigation revealed that for several years the fiduciary embezzled money from two Veterans who were under her guardianship. The restitution will be used to benefit the victimized Veterans.

Nephew of Deceased Beneficiary Sentenced for Theft

The nephew of a deceased VA beneficiary was sentenced to 3 years' probation and ordered to pay restitution of $56,067 after pleading guilty to theft of Government funds. The defendant, who held a Power of Attorney for his aunt, failed to notify VA of her death and subsequently stole VA funds that were direct deposited after her death in October 2004.

Daughter of Deceased Beneficiary Charged with Theft

The daughter of a deceased beneficiary was charged with theft of Government property after an OIG

investigation determined she continued to access a joint bank account after her mother's death. For more than 9 years, the defendant used the VA benefits to pay for personal expenses, to include remodeling her house. The loss to VA is $129,839.

Daughter of Deceased Beneficiary Changes Plea to Guilty

The daughter of a deceased VA beneficiary changed her plea to guilty during her trial for theft of Government funds. The defendant stole VA benefits that were issued after her mother's death in March 1994. The loss to VA is $136,885.

Son of Deceased Veteran Found Guilty of Fraud and Identity Theft

The son of a deceased Veteran was found guilty at trial of bank fraud and aggravated identity theft. An OIG and U.S. Postal Inspection Service investigation determined that the defendant failed to report his father's death to VA, assumed his identity, and utilized the VA benefits for his personal use. The loss to VA is $126,276.

Wife of Deceased Veteran Pleads Guilty to Theft of Government Funds

The wife of a deceased Veteran pled guilty after being indicted for theft of Government funds. A competency hearing is pending in State court concerning charges that the defendant also murdered her husband. An OIG, U.S. Secret Service, SSA OIG, and local police investigation determined that the defendant stole her husband's Government benefits after killing him and burying his body in their backyard. The defendant accessed a joint bank account after her husband's death in April 2007 and used the VA and SSA benefits to pay for personal expenses. The loss to VA is $103,839 and the loss to SSA is $25,353.

Daughter of Deceased Beneficiary Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 5 years' probation and ordered to pay restitution of $93,648 to VA after pleading guilty to theft of Government funds and false statements. An OIG and U.S. Postal Inspection Service investigation determined that the defendant failed to report her mother's August 2004 death to VA, forged her deceased mother's signature on VA documentation, and attempted to transfer and hide the VA benefit payments from investigators. After sentencing, funds were seized from the defendant's bank account by court order for payment of the restitution.

Daughter of Deceased VA Beneficiary Pleads Guilty to Fraud

The daughter of a deceased beneficiary pled guilty to wire fraud after an OIG investigation revealed that she stole VA benefits that were direct deposited into a joint bank account after her mother's death in October 2004. The approximate loss to VA is $59,000.

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 20 cases, made 2 arrests, and had a monetary impact of $283,732,284 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Pharmaceutical Company Pleads Guilty to Distribution of Adulterated Drugs

The subsidiary of a major pharmaceutical company agreed to plead guilty to charges relating to the manufacturing and distribution of certain adulterated drugs made at their now-closed manufacturing facility.

The resolution includes a criminal fine and forfeiture totaling $150 million and a civil settlement under the *False Claims Act* and related state claims of $600 million. The criminal information was filed as a result of a multiagency investigation that alleged that the manufacturing plant's operations failed to ensure that various drugs were free of contamination from microorganisms. This is the first time the civil *False Claims Act* was used to recover damages for current Good Manufacturing Practices (cGMPs) violations. The major pharmaceutical company expressly certified in VA contracts that they would comply with cGMPs, as laid out in the *Food, Drug and Cosmetic Act*. From 2001 to 2005, VA purchased approximately $13.5 million worth of the four suspect drugs, which is the amount considered to be single damages and will be returned directly to the VA Pharmaceutical Supply Fund. VA's entire portion of the civil settlement is $40,705,753.

Pharmaceutical Company Ordered at Sentencing to Pay $164 Million in Fines, Forfeits for Multiple Violations

Forest Pharmaceuticals was ordered at sentencing to pay a $150 million criminal fine and forfeit $14 million in substituted assets after having previously pled guilty to obstructing justice, distributing an unapproved new drug in interstate commerce, and distributing a misbranded drug in interstate commerce. This sentencing was the final judicial action against the company and closes out the global settlement in which the company paid $313 million to resolve criminal and civil allegations that were investigated by OIG, the FBI, Health and Human Services (HHS) OIG, and the FDA Office of Criminal Investigations.

Pharmaceutical Subsidiary Ordered at Sentencing to Pay Over $100 Million in Fines, Forfeits For Drug Misbranding

Elan Pharmaceuticals, Incorporated (EPI), the U.S. subsidiary to Ireland-based Elan Corporation, Public Limited Company (Elan), pled guilty to the misbranding of Zonegran, an anti-epileptic drug, and was ordered at sentencing to pay a $97,050,266 criminal fine and forfeit $3.6 million in substituted assets. Both Elan and EPI had previously agreed to a $203.5 million global settlement to resolve criminal and civil liability arising from the illegal promotion of the drug. The Government alleged that the subsidiary promoted the sale of its drug for a variety of improper off-label uses, to include psychiatric disorders, pain management, eating disorders, weight loss, and monotherapy.

University Pays $879,000 to Resolve Allegations of Contract Billing Irregularities

A VA-affiliated university entered into a Civil Settlement Agreement in order to resolve potential *False Claims Act* violations after an OIG review and subsequent investigation revealed improper conduct by agents and employees of the university involving contracts between VA and the university. The Government alleged that the university violated a law prohibiting Federal employees from receiving compensation from a private source for performing their public duties, and that the university's submission of certain invoices to VA constituted a violation of the *False Claims Act*. The irregularities with some of the contracts were initially discovered during a CAP review. Following the review, the university returned $467,000 of VA funds. A subsequent OIG investigation resulted in the university returning an additional $137,000. The university agreed to pay an additional $275,000 in the settlement agreement, for a total return of $879,000. Additionally, the university agreed to enhance its existing policies by requiring agents and employees working on Federal grants and contracts to better identify conflicts of interest and to provide for additional tiers of review with respect to the disposition of contract funds.

Defendants Sentenced for Robbing and Killing Veteran

A defendant was sentenced to 22 years' incarceration and 5 years' supervised release after pleading guilty to manslaughter in the first degree and a co-defendant pled guilty to attempted robbery. An OIG and local police investigation of the robbery and murder of a Veteran participating in the VA's Supportive Housing initiative with Housing and Urban Development revealed that the Veteran was murdered in his subsidized apartment and that his checkbook, debit card, and vehicle were stolen. Both defendants were known to the Veteran. The defendants used the money they stole from the bank account to purchase drugs.

VA Contractor Enters into Agreement with Government

A VA contractor entered into a Civil Settlement Agreement with the Department of Justice (DOJ) and agreed to pay $150,000 to VA after an OIG and Small Business Administration (SBA) OIG investigation revealed that the company submitted false statements in order to obtain a Historically Underutilized Business Zone (HUBZone) set-aside contract from the Fayetteville, NC, VAMC. In order to obtain their HUBZone certification, the contractor submitted a HUBZone application to SBA falsely stating that the location of the company's principal office was located in a HUBZone. Based upon this fraudulently obtained HUBZone certification, VA awarded a $462,500 fire alarm upgrade contract to the company.

Subject Arrested for Theft from VA Construction Site

A defendant was arrested for burglary, grand theft, and resisting arrest after an OIG and local police investigation revealed that since June 2010, there had been multiple thefts of copper from a VA construction site. During this investigation, OIG agents and local police arrested the defendant in the act of burglarizing the site. The thefts delayed the construction project and created a loss of approximately $5,000.

Corporation and Subsidiary Sentenced for Medical Device Fraud

Synthes Incorporated and Norian Corporation, a wholly-owned subsidiary of Synthes, were each sentenced after pleading guilty to shipping adulterated and misbranded products in interstate commerce and conspiracy to impair and impede the lawful functions of the FDA, and to commit crimes against the United States. Synthes was fined $200,000, ordered to pay $469,800 in restitution ($30,000 being paid to VA), and divest itself of Norian. Norian was fined $22.5 million. They were also excluded from conducting future business with any federally funded program. The sentencing of four executives previously convicted for their roles in the fraud is pending.

Realtor Sentenced for Making False Statements

A realtor was sentenced to 36 months' probation, fined $10,000, and ordered to pay restitution of $25,000 to VA after pleading guilty to making a false statement. An investigation conducted by OIG and the FBI revealed that the defendant was working for a property management firm hired by VA to rehabilitate foreclosed homes. The defendant and a local contractor conspired to submit bogus bids to ensure that the contractor was awarded all of the realtor's repair work on the foreclosed properties. For his part of the scheme, the defendant received 15 percent of the payments.

Nursing Home Manager Pleads Guilty to Health Care Fraud

A regional accounts receivable manager pled guilty to health care fraud and making a false or fraudulent return. The guilty plea stems from a multiagency investigation into various health care frauds and embezzlement of funds by the Chief Executive Officer and senior employees of a nursing home chain.

The defendant stole funds from the company's patient trust account that included VA benefit payments for a Veteran residing in one of the company's nursing homes.

Contractor Arrested for Theft, Other Charges for Construction Projects in Vancouver, Washington

The owner of a drywall installation company was arrested after being indicted for criminal antitrust, theft, tampering with physical evidence, obstruction of Governmental administration, racketeering, forgery, criminal conspiracy, and money laundering. An OIG, ICE, and Oregon DOJ investigation revealed that the company falsely certified payroll records for employees and did not pay employees the prevailing Government contract rate while working on *American Recovery and Reinvestment Act* (ARRA) funded construction contracts at the Vancouver, WA, campus of the VAMC Portland, OR.

UPS Supervisor Arrested for Embezzlement of VA Drugs

A United Parcel Service (UPS) supervisor was arrested for embezzlement as the direct result of an OIG and local law enforcement investigation. The investigation utilized electronic and other surveillance methods to monitor a UPS facility where approximately 35 VA parcels containing drugs had previously been stolen. During the surveillance, the defendant stole a VAMC parcel and after being arrested admitted to stealing approximately 40 VA parcels containing drugs, which he then sold for approximately $10,000 and also traded for cocaine. A search of the defendant's vehicle yielded two additional VA pill bottles and four bags containing suspected cocaine.

Veteran Indicted on Multiple Charges of Fraud

A Veteran was charged in a superseding indictment with wire fraud, mail fraud, forging official U.S. Department or agency seals, impersonating an officer or employee of the U.S., and aggravated identity theft. A multi-agency investigation revealed that the defendant was operating an internet printing business which sold counterfeit military awards and training certificates from all branches of the service, as well as law enforcement awards and training certificates. The indictment charges the defendant with falsely certifying that he was an officer of the U.S. and also with using the names and identifying information of U.S. officials. The fraud associated with this investigation is estimated at more than $260,000.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG issued three reports and four advisories containing nine recommendations for administrative and corrective actions. The Division also investigated 23 allegations that it did not substantiate.

Investigation Substantiates Improper Funding of Academic Degree by Former OI&T Official

An administrative investigation substantiated that a former OI&T Executive Assistant improperly authorized $75,000 worth of academic degree funding in order for a former Special Assistant to the VA Secretary and Deputy Secretary to obtain an Executive Master of Business Administration degree. Additionally, the investigation concluded that the Special Assistant was improperly detailed for an extended period and failed to cooperate with an OIG investigation.

Investigation Substantiates IT Policy Violations by Senior OI&T Official

An administrative investigation substantiated that an OI&T senior official violated VA policy when he failed to properly safeguard and report the theft of a VA-issued laptop computer in September 2007. The

employee also misused his VA-issued computers, cellular telephones, and e-mail account to create and send messages and pornographic images to another person. He additionally failed to testify freely and honestly about his past behavior and actions.

Senior OI&T Official Paid Washington, DC, Salary Rate, But Worked Elsewhere

A spin-off investigation of the same OI&T senior official cited in the laptop theft and pornography case above substantiated that he improperly received Washington, DC, locality pay despite the fact that he lived and worked outside of the Washington, DC, area. The investigation determined that the senior official received over $41,330 in improper pay for which he was not entitled.

Employee-Related Investigations

During this reporting period, OIG opened 27 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. Sixteen defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to $132,398.

Former Hines, Illinois, VAMC Employee Sentenced for Sexual Assault

After pleading guilty to aggravated criminal sexual abuse, a former VA employee was sentenced to 36 months' incarceration, 2 years' supervised release, ordered to register as a sex offender in the State of Illinois for 10 years, and pay an administrative fee of $1,585. An OIG investigation revealed that between June and August 2006, while employed at the Hines, IL, VAMC, the defendant sexually assaulted his minor daughter in his apartment located on the Hines campus. The investigation also revealed that the defendant sexually assaulted the same daughter in a Las Vegas, NV, hotel room sometime between June and July 2007. The defendant was arrested by the Las Vegas Police Department and was convicted for child abuse, neglect, and open or gross lewdness in the case.

Private Physician Charged with Fraud and Money Laundering

A physician who owned a private medical clinic that treated Veterans and private patients was charged in a criminal information with health care fraud and money laundering. An OIG and HHS OIG investigation revealed that from May 2003 to December 2004, the doctor defrauded VA and HHS by submitting false claims for services not rendered, falsely up-coding services, billing for false "incident to" services, and double-billing. The loss to the Government is $297,215.

Former Boston, Massachusetts, VAMC Employee Sentenced for Drug Theft

A former Boston, MA, VAMC employee was sentenced to 24 months' probation after pleading guilty to the acquisition of oxycodone by subterfuge or deception. An OIG, VA Police, DEA, and local police investigation determined that since January 2010, the defendant, who was a VA mail courier, had taken approximately 1,300 oxycodone pills from outgoing packages being mailed to VAMC patients. The defendant opened the prescription bottles while the shipping envelopes remained sealed, emptied a portion of the pills, replaced the cap on the bottle, and tore a small hole in the envelope from which the pills were removed. In most instances, when the envelopes arrived the patients were unaware they were missing narcotics. At the time of his arrest, the defendant had stolen narcotics in his possession. The defendant subsequently confessed to being addicted to pain medications and to selling a portion of the narcotics off VA property.

Nashville, Tennessee, VAMC Employee Found Guilty of Fraud

A Nashville, TN, VAMC employee was found guilty at trial of activities related to time and attendance fraud and making false statements to Federal agents. An OIG investigation revealed that the defendant had taught classes as a professor at a local university during his scheduled tour of duty at the VAMC since 1995. The loss to VA is over $47,000.

West Los Angeles, California, VAMC Employee Charged with Sale of Marijuana and Theft

A West Los Angeles, CA, VAMC employee was charged with grand theft and possession of marijuana after an OIG investigation determined that the employee was selling marijuana at work and defrauding the transit benefit program.

Phoenix, Arizona, VAMC Employee Pleads Guilty to Drug Possession

A Phoenix, AZ, VAMC employee, who was terminated from her employment, pled guilty to possession or use of drug paraphernalia and was sentenced to 50 hours' community service and 12 months' probation. Additionally, a VARO employee resigned from his position, and a second former VARO employee pled guilty to criminal facilitation to commit possession of dangerous drugs for sale and was sentenced to 2 years' probation. An OIG and DEA Drug Diversion Task Force investigation determined that the VAMC employee purchased VA narcotics from the two former VARO employees. The investigation revealed that for approximately 2 years the subjects illegally sold their narcotics to the VAMC employee in and around the parking lot of VA offices.

Former Lyons, New Jersey, VAMC Employee and Associate Sentenced for Fraud

A former Lyons, NJ, VAMC employee and an associate in the employee's private practice were sentenced on previous convictions for health care fraud. The former employee was sentenced to 366 days' incarceration and 36 months' probation. Her associate was sentenced to 30 months' incarceration and 36 months' probation. Both defendants were also ordered to pay $76,496 in restitution. A multiagency investigation revealed that the VA employee and the associate devised a scheme to misrepresent the associate's qualifications and bill Government and private insurers at inflated prices and for greater services than actually provided.

Former Las Vegas, Nevada, VAMC Employee Sentenced for VA Beneficiary Fraud

A former Las Vegas, NV, VAMC employee, who is also a Veteran, was sentenced to 366 days' incarceration for theft of Government funds, 10 months' incarceration for the unlawful wearing of a service medal, 3 years' probation, and ordered to pay $180,000 in restitution to VA. An OIG investigation revealed that the defendant filed fraudulent paperwork with the U.S. Air Force and VA claiming to have been awarded a Purple Heart for being wounded in Vietnam. Based upon the fraudulent claims and counterfeit documents submitted by the Veteran, the U.S. Air Force awarded him a Purple Heart. The defendant then used the Purple Heart and a self inflicted gunshot wound, received 20 years after his military service, to obtain compensation benefits from VA.

Two Former Gainesville, Florida, VAMC Employees Sentenced for Fraud

Two former Gainesville, FL, VAMC employees were sentenced to 2 years' probation and ordered to pay restitution of $5,398 after pleading guilty to the embezzlement of Government funds. An OIG investigation revealed that the two defendants, a VA Travel Clerk and a VA Agent Cashier, conspired to file 62 fraudulent travel vouchers and embezzle the funds.

Former Union Official Sentenced for Fraud

The former President of an American Federation of Government Employees (AFGE) Chapter located at the Albuquerque, NM, VAMC was sentenced to 4 months' incarceration, 36 months' probation, and ordered to pay $77,458 in restitution to AFGE after pleading guilty to wire fraud and deprivation of honest services. An OIG and Department of Labor (DOL) investigation determined that the defendant embezzled AFGE funds by making ATM withdrawals and personal charges using an AFGE bank card.

Former Montgomery, Alabama, VARO Employee Sentenced for Identity Theft

A former Montgomery, AL, VARO employee was sentenced to 20 consecutive weekends in jail and 3 years' probation after pleading guilty to theft of Government property. An OIG, IRS CID, and local police investigation revealed that the defendant obtained Veterans' personal information while employed at the VARO and provided the information to co-conspirators outside of VA, who then used the personal information to file fraudulent tax returns.

Former East Orange, New Jersey, VAMC Employee Sentenced for Health Care Fraud

A former East Orange, NJ, VAMC employee was sentenced to 23 months' incarceration, 24 months' probation, and ordered to pay a $10,000 fine and restitution of $253,727 to the Office of Personnel Management (OPM). An OIG, FBI, and OPM OIG investigation revealed that the defendant submitted false claims to the Federal Employee Health Benefits program for medical procedures that the defendant claimed were performed during periods he was overseas.

Former OI&T Employee Found Guilty of Fraud and Identity Theft

A former OI&T employee, assigned to the Fayetteville, NC, VAMC was found guilty at trial of false and fraudulent tax returns, wire fraud, and aggravated identity theft. An OIG and IRS CID investigation revealed that the defendant used his position to obtain approximately 160 Veterans' personal identifiers and then utilized the identifiers on tax documents without the Veterans' knowledge. The defendant used his computer and tax consulting business to prepare and file the fraudulent tax documents.

Long Beach, California, VAMC Nurse Charged with Fraudulent Impersonation

A Long Beach, CA, VAMC nurse was charged with fraudulent impersonation of another to obtain credit. An OIG and local police department investigation revealed that the defendant stole the personal identifying information of 45 patients and used that information to make fraudulent purchases.

Former Leavenworth, Kansas, VAMC Employee Arrested for Theft of Government Funds

A former Leavenworth, KS, VAMC employee was arrested after being indicted for the theft of Government funds. An OIG and DOL OIG investigation revealed that between 2003 and 2008, the defendant concealed approximately $577,000 in earnings from DOL while managing a subcontracting business. The defendant also stole, forged, and negotiated approximately $27,000 in workers' compensation benefit checks intended for her deceased brother, a former U.S. Postal Service employee and service-connected Veteran. The loss to VA is approximately $175,000.

VA Employee and Nephew Plead Guilty to Theft of Government Funds

A VA employee and his nephew pled guilty to theft of Government funds. The VA employee was terminated after he entered his guilty plea. An OIG investigation revealed the defendants conspired to defraud VA by submitting fraudulent claims for VA education benefits. The approximate loss to VA is $45,000.

Former Lexington, Kentucky, Contract Nurse Sentenced for Theft of Government Funds

A former Lexington, KY, VAMC contract nurse was sentenced to 6 months' home detention, 5 years' probation, and ordered to pay restitution of $35,605 to VA after pleading guilty to theft of Government funds. An OIG investigation revealed that for approximately 18 months the defendant submitted false time sheets and invoices to VA. The defendant admitted to forging nearly 15 different supervisory signatures on the false invoices.

Former Fort Mitchell, Alabama, Cemetery Employee Arrested for Theft of Vehicle Involved in Homicide

A former Fort Mitchell, AL, NCA Compensated Work Therapy employee was arrested for theft of a Government vehicle after an OIG, VA Police, and local sheriff's office investigation revealed that the stolen Government vehicle was used in a homicide. The homicide is currently an ongoing local police investigation.

Former Fayetteville, North Carolina, Employee Charged with Damage to Government Property

A former Fayetteville, NC, VAMC employee was charged in a criminal information with damage to Government property and theft of Government property. An OIG and VA Police investigation disclosed that the defendant intentionally damaged a canister of ethylene oxide (EtO) and exposed himself and other VA employees to the hazardous chemicals on two separate occasions. Ethylene oxide is a highly carcinogenic chemical, which is hazardous to humans. All of the VA employees exposed to EtO will be tested annually due to their exposure.

Former Fayetteville, North Carolina, VAMC Nurse Sentenced for Workers' Compensation Fraud

A former Fayetteville, NC, VAMC nurse was sentenced to 5 years' supervised probation, 500 hours' community service, and ordered to pay $82,300 in restitution. An OIG and DOL OIG investigation determined that the defendant was receiving Workers' Compensation benefits, based on a VA-related injury, while employed as a full-time nurse in a private nursing home. The defendant had reported that she was unable to return to her VA employment due to her injury.

Former VA Employee Sentenced for Misuse of Government Purchase Card

A former VA employee was sentenced to pre-trial diversion for 6 months and ordered to pay $3,945 in restitution to VA. An OIG investigation revealed that from 2006 through 2008, the defendant misused her Government purchase card. When interviewed, the employee admitted to wrongfully using the purchase card to buy food, medication, gasoline, and manicures. The employee retired shortly after her interview.

Threats Made Against VA Employees

During this reporting period, OIG initiated 21 criminal investigations resulting from threats made against VA facilities and employees. Nine defendants were charged with making threats as a result of the investigations. The following summaries provide representative samples of threats made against VA facilities and employees.

Veteran Sentenced for Making Threats to VA Employees at Dayton, Ohio, VAMC

A Veteran was sentenced to 180 days' incarceration, which was suspended, and was placed on 5 years' community control after pleading guilty to aggravated menacing. An OIG investigation determined that the defendant made threats to kill two Vocational Rehabilitation & Employment (VR&E) counselors if he was

denied VR&E benefits. The Veteran was ordered not to have contact with the complaining witnesses and to report to the VA Police when attending his appointments at the Dayton, OH, VAMC.

Veteran Indicted for Threats to VA Physician at Sierra Vista, Arizona, OPC

A Veteran was indicted for threats to murder a Government employee. An OIG investigation determined that the defendant made specific threats to kill his Sierra Vista, AZ, OPC VA physician because the Veteran claimed he did not receive the treatment he requested. The defendant has prior felony convictions involving firearms.

Veteran Arrested for Making Threats to VA Employees

A Veteran was arrested for making telephonic threats to employees of a VA Fiduciary Hub. An OIG, Federal Protective Service, and local law enforcement investigation determined that the defendant stated that he was coming to the VA facility because "he was not afraid to die and to take 30 or 40 people with him." The defendant has prior arrests and felony convictions for assault.

Veteran Pleads Guilty to Making Threats Against White River Junction, Vermont, VAMC

A Veteran pled guilty to making threats after leaving threatening voicemail messages at the White River Junction, VT, VAMC. An OIG and VA Police investigation revealed that the defendant stated he would blow up the place and use an AK-47 and MAC-10 to "Go out in a blaze of glory." During the interview, the defendant admitted to making the phone calls and provided a written statement that said, "If you take away my disability, I will go on a killing spree." In 2009, the Veteran had threatened another VAMC by threatening to make an ammonium nitrate bomb.

Veteran Pleads Guilty to Threatening VA Employees

A Veteran pled guilty to charges of assaulting and intimidating a Federal employee and was sentenced to time served (60 days), 5 years' probation, 120 hours' community service, and ordered to attend anger management and substance abuse counseling. On two separate occasions, the Veteran threatened to kill VA employees with his AK-47 if he was not granted his VA disability rating.

Veteran Sentenced for Making Threats to Salisbury, North Carolina, VAMC Employee

A Veteran was sentenced to 20 days' incarceration (suspended) and 12 months' probation after being found guilty of threatening to kill a Salisbury, NC, VAMC patient advocate. The defendant left a voicemail for the employee advising that he knew where to find her and stated that all he had to do was walk through the front door and kill her. Following his arrest and subsequent release for that threat, the defendant went to the office of the employee in an effort to confront her. The Veteran was arrested a second time for violating his release conditions and a third time for failure to appear in court.

Veteran Sentenced for Making Threats to Salt Lake City, Utah, VA Police Officer

A Veteran was sentenced to 1 year of incarceration and 3 years' probation after pleading guilty to threatening to kill a Salt Lake City, UT, VAMC police officer and the officer's wife. An OIG investigation determined the Veteran left a threatening telephone message after receiving a citation for vandalism.

Veteran Arrested for Threatening to Shoot Columbia, South Carolina, VARO Employees

A Veteran was arrested by OIG agents after making a threat against Columbia, SC, VARO employees while using VA's Inquiry Routing and Information System. At the time of his arrest, the Veteran was wearing

body armor and armed with a concealed firearm. A U.S. Magistrate Judge ordered the Veteran detained. The defendant admitted making the threats and admitted traveling to a VAMC in a neighboring state earlier the same day while carrying a concealed handgun and wearing body armor. The Veteran claimed to have a plan of violence that included robbing local banks to finance his "crime spree" and shooting VARO employees.

Former Contractor at Martinez, California, Pleads Guilty to Bomb Threat Hoax

A former Martinez, CA, VA OPC contract housekeeping employee pled guilty to false information and hoaxes after using the VA Public Address (PA) system to make phony bomb threats on two separate occasions. The defendant stated over the PA system that there were bombs in the CLC, which houses Veterans in need of rehabilitation, skilled nursing, and hospice care. The Veterans housed in the CLC had to evacuate the building after the second bomb threat was made. The defendant admitted to making the bomb threats to get out of work.

Veteran Arrested for Making Threats to Blow Up VA Clinic in Georgia

A Veteran was arrested for making terroristic threats to a VA clinic associated with the Atlanta, GA, VAMC. An OIG and local police investigation revealed that the defendant called the clinic and informed an employee that he was going to blow up the clinic with a grenade, specifically targeting the employee because he did not receive his requested medication.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend Veterans and VA employees as a direct result of the OIG Fugitive Felon Program. To date, 38.9 million felon warrants have been received from the National Crime Information Center and participating states resulting in 56,697 investigative leads being referred to law enforcement agencies. Over 2,141 fugitives have been apprehended as a direct result of these leads. Since the inception of the OIG Fugitive Felon Program in 2002, OIG has identified $812.3 million in estimated overpayments with an estimated cost avoidance of $926.7 million. During this reporting period, OIG made 30 fugitive felon arrests with an additional 19 arrests made by other law enforcement agencies. Four of these arrests were of VAMC employees at various medical centers wanted on drug and probation violations. Apprehensions included the following:

- OIG assisted a U.S. Marshals Service Fugitive Apprehension Task Force with arresting a Veteran at the Dallas, TX, VAMC for aggravated sexual assault of a 6-year-old child.

- A Veteran wanted for over 21 years for the sexual assault of his 12-year-old niece was arrested based on information provided by OIG. The Veteran's current address in South Carolina was forwarded to California law enforcement officers, resulting in the fugitive's arrest and subsequent extradition.

- The OIG assisted a U.S. Marshals Service Fugitive Apprehension Task Force with locating and arresting a Veteran at a VAMC homeless facility. The Veteran, categorized as a violent sexual predator, was wanted for failure to register as a sex offender.

- A Veteran receiving VA medical services was arrested by a U.S. Marshals Service Fugitive Apprehension Task Force for failure to comply with registration as a sexual offender, aggravated indecent assault (under age 16), and corruption of minors. The OIG and task force investigators used an address and contact information to locate the fugitive, who was publicized in the local media as one of the Top Ten Most Wanted fugitives in the area.

Office of Management and Administration

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

Operations Division

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

Information Technology and Data Analysis Division

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

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

Administrative and Financial Operations Division

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

Budget Division

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

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 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 14,936 contacts, 556 of which became OIG cases. The Hotline also closed 381 cases during this reporting period, substantiating allegations 46 percent of the time. The following cases were initiated as a direct result of Hotline contacts:

Cleveland, Ohio, VAMC Employees Disregard Patient Safety Procedures

An Administrative Board investigation conducted by the Cleveland, OH, VAMC found that a phlebotomist and staff improperly directed 14 applicants for employment to perform phlebotomy procedures on 107 VA patients. The applicants were asked to perform phlebotomy procedures under VA supervision to determine if they were as experienced as they claimed on their written applications. The VAMC took administrative action against responsible employees and provided clarification concerning how future prospective employees should be evaluated.

Expired FY 2008 Appropriations Unlawfully Used at New York Harbor HCS

A review by the New York Harbor HCS substantiated that fiscal employees unlawfully used $1.1 million in expired FY 2008 appropriations to purchase food supplies for FY 2009. The review also found that HCS employees frequently did not retain required audit trail documentation to support changes in suspense dates or adjustments in the Financial Management System. In response to the Hotline, the HCS agreed to correct the misuse of expired funds and to provide training to responsible fiscal staff.

Salt Lake City, Utah, VAMC Failed to Provide Pay Differential to Activated Reservists

A review conducted by the Salt Lake City, UT, VAMC substantiated an allegation that military reservists serving on Active Duty were not receiving their authorized pay differential because VA had not issued a policy implementing the payments. VHA plans to begin making the payments as soon as a policy is implemented, including retroactive payments for employees on qualifying orders on or after March 15, 2009.

Veteran Receiving VA Pension Concealed Marital Status and Spouse's Income

A review conducted by the Cleveland, OH, VARO found that a Veteran in receipt of a VA pension concealed that he had been married since 1983 and that his spouse was receiving Social Security income. The Veteran's pension award was terminated and VA began collecting $72,104 in benefit overpayments.

Failure to Report Remarriages Resulted in Benefit Overpayments

A Houston, TX, VARO review substantiated that a surviving spouse improperly received DIC due to failure to report to VA two subsequent marriages. As a result, VA began collecting $67,263 in benefit overpayments. In another instance, the Philadelphia, PA, VARO initiated collection of $59,548 from another surviving spouse who did not report to VA her remarriage.

South Texas Veterans HCS Improperly Suspended Pay Reviews for Physicians and Dentists

The South Texas Veterans HCS acknowledged it suspended required biannual pay reviews for physicians and dentists in July 2010 due to oversight activities by the Heart of Texas Health Care Network. The HCS plans to resume the pay reviews in 2011 and to authorize back pay, when appropriate, for recipients impacted by the review delays.

Detroit, Michigan, VAMC Employee Disciplined for Unauthorized Medical Care

An employee of the John D. Dingell VAMC, Detroit, MI was disciplined and issued a bill of collection for $3,176 for repeatedly utilizing the resources of the VAMC in a fraudulent manner. The employee submitted his daughter's specimen under his name and was provided services by the Pathology and Laboratory Medicine Service. Although a Veteran, the employee was not enrolled or authorized to receive care. Other employees were also disciplined.

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 59 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 nearly $123 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included 24 health care provider proposals—accounting for almost $55 million of the identified potential savings.

	October 1, 2010—March 31, 2011
Preaward Reports Issued	44
Potential Cost Savings	$122,842,089

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 $19.3 million, including $3.2 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 15 postaward reviews performed, 6 involved voluntary disclosures. In three of the six reviews, OCR identified additional funds due. OCR recovered 100 percent of recommended recoveries for postaward contract reviews.

	October 1, 2010—March 31, 2011
Postaward Reports Issued	15
Dollar Recoveries	$19,336,739

Inadequate Planning and Significant Modifications Caused Cost Escalation for Firm-Fixed Price Contract for Wi-Fi Installation

OIG reviewed the contract awarded to Catapult Technology, Ltd. for the installation of Wi-Fi services at 236 VA sites to determine the validity of six allegations regarding the award and administration of the contract. OIG substantiated five of the six allegations and partially substantiated the sixth allegation. OIG determined that inadequate planning and incomplete information regarding requirements caused VA to process modifications that led to significant increases in contract costs. OIG also determined that VA processed modifications adding additional sites, even though there is no provision in the contract that permits VA to increase the number of sites. Furthermore, OIG also determined that VA was improperly

paying Catapult on a milestone basis rather than a completed site basis as required in the contract. Seven recommendations were issued to correct the findings.

Qui Tam Cases

Settlements in four cases against pharmaceutical companies brought under *qui tam* provisions of the *False Claims Act,* P.L. 111-148, recovered $17,447,919 for VA. Three of the cases involved off-label marketing and anti-kickback violations. The fourth case involved a manufacturer who was selling products manufactured in a facility that was not approved by the FDA.

Congressional Testimony

Deputy IG Testifies on State of VA Programs and Operations

Deputy IG Richard Griffin testified on March 9, 2011, before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, on the state of VA programs and operations. Mr. Griffin noted that VA has opportunities to achieve savings, reduce risks, and improve performance and highlighted OIG reports that focused on the effectiveness of benefits delivery to Veterans, dependents, and survivors; the effectiveness of health care delivery, specifically, patient care and safety issues; and the effectiveness of VA's business operations. Mr. Griffin was accompanied by Belinda Finn, Assistant Inspector General (AIG) for Audits and Evaluations; John D. Daigh, Jr., MD, AIG for Healthcare Inspections; and Maureen Regan, Counselor to the IG.

Assistant IG Testifies on VA's IT Program

AIG for Audits and Evaluations Belinda Finn testified on October 6, 2010, before the Committee on Veterans' Affairs, United States Senate, at an oversight hearing, VA's Information Technology Program – Looking Ahead. Ms. Finn's testimony focused on VA's planning and management of IT investments over recent years, specifically in the area of IT governance and project management. Historically, VA has struggled to manage IT project development within cost, schedule, and performance objectives. VA recently implemented a Project Management Accountability System to strengthen IT project management and improve the rate of success of VA's IT projects. OIG will continue to provide oversight of VA's IT initiatives, which will provide valuable information to VA as it moves forward in managing IT capital investments.

Special Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

Charles Cook, a Healthcare Inspector in the Bay Pines Office of Healthcare Inspections, was deployed by the Army in June 2007 and is currently stationed in Pinellas, Florida. In 2008, Charles briefly served in Seoul, South Korea, and Atlanta, GA.

Kenneth Sardegna, an Auditor at OIG Headquarters, was deployed by the Army in June 2007 and is currently stationed at Camp Lemonier, Djibouti. Kenneth also served at the Pentagon for 2 years between 2007-2009.

Randall Snow, Director, Washington, DC, Office of Healthcare Inspections, was deployed by the Air Force in March 2011 and is currently stationed in Afghanistan.

Michael Whitlock, a Special Agent in the Tallahassee Office of Investigations, returned from Active Duty service in Stuttgart, Germany, where he had been deployed by the Army since November 2009.

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
AUDITS AND REVIEWS			
Education Claims and Payments for the Post-9/11 GI Bill *Report No. 09-03458-18, Issued 11/3/2010*	-	-	$2,900,000
VA's Consolidated Financial Statements for Fiscal Year 2010 *Report No. 10-01406-20, Issued 11/10/2010*	-	-	-
Retention Incentive Payments at VA Medical Center, Providence, Rhode Island *Report No. 10-01937-68, Issued 01/20/2011*	-	-	$894,790
VBA's 100 Percent Disability Evaluations *Report No. 09-03359-71, Issued 01/24/2011*	$2,073,000,000	-	-
Veterans Service Network *Report No 09-03850-99, Issued 02/18/2011*	$35,000,000	$35,000,000	-
VHA's State Home Per Diem Program *Report No. 10-01529-108, Issued 03/02/2011*	-	-	-
VBA's Retroactive and One-Time Payments to Incompetent Beneficiaries *Report No. 10-01607-110, Issued 03/03/2011*	-	-	-
Independent Review of VA's Fiscal Year 2010 Performance Summary Report to the Office of National Drug Control Policy *Report No. 11-00314-123, Issued 03/17/2011*	-	-	-
Independent Review of VA's FY 2010 Detailed Accounting Submission to the Office of National Drug Control Policy *Report No. 11-00315-126, Issued 03/22/2011*	-	-	-
Veterans Benefits Administration Review of Pension Management Centers *Report No. 10-00639-135, Issued 03/30/2011*	$205,000,000	$205,000,000	-
BENEFITS INSPECTIONS			
VA Regional Office, Milwaukee, Wisconsin *Report No. 10-03565-69, Issued 01/21/2011*	-	-	-
VA Regional Office, St. Paul, Minnesota *Report No. 10-03604-75, Issued 01/25/2011*	-	-	-
VA Regional Office, Boston, Massachusetts *Report No. 10-03564-86, Issued 02/10/2011*	-	-	-
VA Regional Office, Boise, Idaho *Report No. 10-03858-92, Issued 02/17/2011*	-	-	-

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VA Regional Office, Portland, Oregon *Report No. 11-00070-93, Issued 02/22/2011*	-	-	-
VA Regional Office, Houston, Texas *Report No. 10-03770-125, Issued 03/21/2011*	-	-	-
JOINT REVIEW			
Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits *Report No. 10-01640-45, Issued 12/16/2010*	-	-	-
COMBINED ASSESSMENT PROGRAM REVIEWS			
VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Report No. 10-00052-10, Issued 10/19/2010*	-	-	-
Northport VA Medical Center, Northport, New York *Report No. 10-00474-14, Issued 10/27/2010*	-	-	-
Sioux Falls VA Medical Center, Sioux Falls, South Dakota *Report No. 09-03747-15, Issued 10/28/2010*	-	-	-
Beckley VA Medical Center, Beckley, West Virginia *Report No. 10-02383-27, Issued 11/10/2010*	-	-	-
Memphis VA Medical Center, Memphis, Tennessee *Report No. 10-00046-32, Issued 11/22/2010*	-	-	-
Edward Hines, Jr., VA Hospital, Hines, Illinois *Report No. 10-02384-33, Issued 11/22/2010*	-	-	-
Robley Rex VA Medical Center, Louisville, Kentucky *Report No. 10-00047-34, Issued 11/29/2010*	-	-	-
Canandaigua VA Medical Center, Canandaigua, New York *Report No. 10-00475-38, Issued 11/30/2010*	-	-	-
VA Boston Healthcare System, Boston, Massachusetts *Report No. 10-02980-50, Issued 12/22/2010*	-	-	-
Boise VA Medical Center, Boise, Idaho *Report No. 10-02984-54, Issued 01/10/2011*	-	-	-
VA North Texas Health Care System, Dallas, Texas *Report No. 10-02983-55, Issued 01/12/2011*	-	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
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Philadelphia VA Medical Center, Philadelphia, Pennsylvania *Report No. 10-02385-62, Issued 01/13/2011*	-	-	-
West Palm Beach VA Medical Center, West Palm Beach, Florida *Report No. 10-01192-63, Issued 01/18/2011*	-	-	-
John D. Dingell VA Medical Center, Detroit, Michigan *Report No. 10-02993-70, Issued 01/21/2011*	-	-	-
Alexandria VA Medical Center, Pineville, Louisiana *Report No. 10-02982-73, Issued 01/24/2011*	-	-	-
Re-Evaluation of Reusable Medical Equipment and Environment of Care at the Central Texas Veterans Health Care System, Temple, Texas *Report No. 10-03926-76, Issued 01/26/2011*	-	-	-
Hunter Holmes McGuire VA Medical Center, Richmond, Virginia *Report No. 10-02987-78, Issued 01/31/2011*	-	-	-
VA Salt Lake City Health Care System Salt Lake City, Utah *Report No. 10-03093-82, Issued 02/07/2011*	-	-	-
Bay Pines VA Healthcare System, Bay Pines, Florida *Report No. 10-02992-83, Issued 02/08/2011*	-	-	-
Northern Arizona VA Health Care System, Prescott, Arizona *Report No. 10-02996-84, Issued 02/10/2011*	-	-	-
VA Connecticut Healthcare System, West Haven, Connecticut *Report No. 10-03090-87, Issued 02/14/2011*	-	-	-
Ralph H. Johnson VA Medical Center, Charleston, South Carolina *Report No. 10-03091-88, Issued 02/14/2011*	-	-	-
Coatesville VA Medical Center, Coatesville, Pennsylvania *Report No. 10-02991-96, Issued 02/23/2011*	-	-	-
John J. Pershing VA Medical Center, Poplar Bluff, Missouri *Report No. 10-02994-103, Issued 02/24/2011*	-	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Richard L. Roudebush VA Medical Center, Indianapolis, Indiana *Report No. 10-03092-129, Issued 03/23/2011*	-	-	-
COMMUNITY BASED OUTPATIENT CLINIC REVIEWS			
Fredericksburg, Danville, and Lynchburg, VA; Greenville and Rock Hill, SC; Elgin and Oak Lawn, IL; Wisconsin Rapids and Loyal, WI *Report No. 10-00627-09, Issued 10/19/2010*	-	-	-
Farmington and Espanola, NM; Show Low and Buckeye, AZ; Maui and Kona, HI; Sonora and Modesto, CA *Report No. 10-00627-17, Issued 11/2/2010*	-	-	-
Framingham, MA; Charlottesville, VA; Jennings and Lafayette, LA; Bridgeport (Decatur) and Sherman, TX; Caldwell and Twin Falls, ID *Report No. 11-00839-79, Issued 02/03/2011*	-	-	-
Spring City and Springfield, PA; Sarasota and Sebring, FL; Paragould, AR, and Salem, MO; Cottonwood and Lake Havasu City, AZ *Report No. 11-00840-104, Issued 02/28/2011*	-	-	-
Community Based Outpatient Clinic Reviews: Stamford and Waterbury, CT North Charleston (Goose Creek), SC and Savannah, GA Nephi, UT and Pocatello, ID *Report No. 11-00841-122, Issued 03/16/2011*	-	-	-
NATIONAL REPORTS			
Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 *Report No. 10-03103-12, Issued 10/21/2010*	-	-	-
Tracking of Medical License Expiration Dates *Report No. 09-01275-35, Issued 11/29/2010*	-	-	-
Evaluation of Magnetic Resonance Imaging Safety in Veterans Health Administration Facilities *Report No. 09-01038-77, Issued 01/26/2011*	-	-	-
Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2010 *Report No. 10-00415-90, Issued 02/16/2011*	-	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Radiation Safety in Veterans Health Administration Facilities *Report No. 10-02178-120, Issued 03/10/2011*	-	-	-
Combined Assessment Program Summary Report Evaluation of Reusable Medical Equipment Practices in Veterans Health Administration Facilities *Report No. 10-00135-121, Issued 03/14/2011*	-	-	-
Combined Assessment Program Summary Report Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities *Report No. 11-01380-128, 03/22/2011*	-	-	-
HEALTHCARE INSPECTIONS			
Wound Care Management, Boise VA Medical Center, Boise, Idaho *Report No. 10-03194-01, Issued 10/05/2010*	-	-	-
Re-Evaluation of the Quality Management Program at the Marion VA Medical Center, Marion, Illinois *Report No. 10-03640-02, Issued 10/05/2010*	-	-	-
Alleged Quality of Care, Personnel, and Other Community Living Center Issues, Hampton VA Medical Center, Hampton, Virginia *Report No. 10-03275-04, Issued 10/12/2010*	-	-	-
Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia *Report No. 10-01167-06, Issued 10/12/2010*	-	-	-
Quality of Care Issues, St. Louis VA Medical Center, St. Louis, Missouri, and Minneapolis VA Health Care System, Minneapolis, Minnesota *Report No. 10-03313-08, Issued 10/14/2010*	-	-	-
Electronic Ordering of Chemotherapy, Fargo VA Medical Center, Fargo, North Dakota *Report No. 10-02882-11, Issued 10/20/2010*	-	-	-
Alleged Community Living Center Quality of Care Issues, VA Palo Alto Health Care System, Palo Alto, California *Report No. 10-03526-13, Issued 10/26/2010*	-	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Suicide After an Emergency Department Visit at the Dayton VA Medical Center, Dayton, Ohio *Report No. 10-02278-26, Issued 11/9/2010*	-	-	-
Alleged Residency Training Issues in Nuclear Medicine Service, Northport VA Medical Center, Northport, New York *Report No. 10-01576-28, Issued 11/12/2010*	-	-	-
Alleged Issues in Fee Basis Care, Martinsburg VA Medical Center, Martinsburg, West Virginia *Report No. 10-02006-29, Issued 11/16/2010*	-	-	-
Quality of Care at a VA Medical Center *Report No. 10-03237-41, Issued 12/9/2010*	-	-	-
Alleged Clinical and Administrative Issues at the Alexandria VA Medical Center, Pineville, Louisiana *Report No. 10-02875-80, Issued 02/03/2011*	-	-	-
Issues with Quality of Patient Care and Communication, Hampton VA Medical Center, Hampton, Virginia *Report No. 10-03656-89, Issued 02/15/2011*	-	-	-
Alleged Imminent Danger to Patients Southern Arizona VA Health Care System Tucson, Arizona *Report No. 10-01175-91, Issued 02/16/2011*	-	-	-
Alleged Quality of Care Issues, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois *Report No. 11-00163-109, Issued 03/02/2011*	-	-	-
Alleged Continuity of Care Issues, VA Greater Los Angeles Healthcare System, Los Angeles, California *Report No. 11-00910-118, Issued 03/04/2011*	-	-	-
Reprocessing of Dental Instruments, John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri *Report No. 10-03346-112, Issued 03/07/2011*	-	-	-
Telemetry Unit Issues John Cochran Division, St. Louis VA Medical Center, St. Louis, Missouri *Report No. 10-00231-113, Issued 03/07/2011*	-	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Alleged Poor Quality of Care in Radiation Therapy VA Long Beach Healthcare System, Long Beach, California *Report No. 10-03861-119, Issued 03/09/2011*	-	-	-
Alleged Poor Quality of Patient Care Marion VA Medical Center Marion, Illinois *Report No. 10-03080-124, Issued 03/16/2011*	-	-	-
Alleged Quality of Care Issues Martinez Outpatient Clinic and Center for Rehabilitation and Extended Care, Martinez, California *Report No. 10-02468-131, Issued 03/23/2011*	-	-	-
Emergency Room Discharge of a Hospice Patient, Hampton VA Medical Center, Hampton, Virginia *Report No. 10-04043-136, Issued 03/30/2011*	-	-	-
Quality of Care Issues, VA Northern Indiana Health Care System, Fort Wayne, Indiana *Report No. 10-02810-139, Issued 03/30/2011*	-	-	-
Customer Care and Satisfaction, Southern Arizona VA Health Care System, Tucson, Arizona *Report No. 11-00233-137, Issued 03/31/2011*	-	-	-
ADMINISTRATIVE INVESTIGATIONS			
Improper Locality Rate of Pay, Office of Information & Technology, VA Central Office *Report No. 10-02858-07, Issued 10/14/2010*	-	-	-
Improper Academic Degree Funding, Improper Detail and Failure to Cooperate with an OIG Investigation, OI&T VA Central Office *Report No. 09-01123-16, Issued 10/29/2010*	-	-	-
Failure to Safeguard and Misuse of VA Equipment and Lack of Candor, OI&T, Fayetteville, Arkansas *Report No. 10-02858-102, Issued 02/23/2011*	-	-	-
PREAWARD REVIEWS			
Review of Proposal Submitted Under Solicitation Number VA-256-08-RP-0135 *Report No. 10-03614-03, Issued 10/06/2010*	$414,820	-	-
Review of Proposal Submitted Under Solicitation Number VA-263-09-RP-0204 *Report No. 10-02915-05, Issued 10/07/2010*	$1,844,712	-	-

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Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted Under Solicitation Number VA-244-10-RP-0103 *Report No. 10-04055-19, Issued 11/02/2010*	$409,110	-	-
Review of the Proposal Submitted Under Solicitation VA-260-10-RQ-0519 *Report No. 10-02886-21, Issued 11/03/2010*	$1,744,073	-	-
Review of Proposal Submitted Under Solicitation Number SPM2D1-10-R-0011 *Report No. 10-02537-23, Issued 11/05/2010*	-	-	-
Review of Proposal Submitted Under Solicitation Number SPM2D1-10-R-0011 *Report No. 10-02536-24, Issued 11/08/2010*	$21,458,580	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 10-03266-25, Issued 11/08/2010*	$116,750	-	-
Review of Proposal Submitted Under Solicitation Number SPM2D1-10-R-0011 *Report No. 10-02538-36, Issued 11/24/2010*	$2,882,401	-	-
Review of Proposal Submitted Under Solicitation Number VA-69D-10-RP-0443 *Report No. 10-04052-37, Issued 11/30/2010*	$3,572,352	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 *Report No. 10-02766-39, Issued 12/01/2010*	$17,239,790	-	-
Review of Proposal Submitted Under Solicitation Number VA-256-10-RP-0201 *Report No. 10-03046-22, Issued 12/02/2010*	$1,032,745	-	-
Review of Proposal Submitted Under Solicitation Number VA-251-10-RP-0030 *Report No. 11-00145-04, Issued 12/07/2010*	$2,441,246	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. RFP-797-FSS-99-0025-R6 *Report No. 10-02552-42, Issued 12/09/2010*	$4,183,528	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 10-02259-44, Issued 12/14/2010*	$947,371	-	-

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. RFP-797-FSS-03-0001-R1 *Report No. 10-03686-46, Issued 12/15/2010*	$14,496,082	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 10-03608-47, Issued 12/15/2010*	-	-	-
Review of Proposal Submitted Under Solicitation Number VA-256-10-RP-0239 *Report No. 11-00774-48, Issued 12/20/2010*	$881,364	-	-
Review of Proposal Submitted Under Solicitation Number VA-257-10-RP-0036 *Report No. 11-00605-49, Issued 12/21/2010*	$19,143,062	-	-
Review of Proposal Submitted Under Solicitation Number VA-257-10-RP-0035 *Report No. 11-00606-43, Issued 12/22/2010*	$3,240,215	-	-
Review of Proposal Submitted Under Solicitation Number VA-257-10-RP-0020 *Report No. 11-00773-51, Issued 01/03/2011*	$5,307,102	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation Number 797-FSS-03-0001-R1 *Report No. 10-03843-56, Issued 01/07/2011*	-	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. RFP-797-FSS-99-0025-R6 *Report No. 10-03883-57, Issued 01/07/2011*	$1,952,809	-	-
Review of Proposal Submitted Under Solicitation Number VA-251-10-RP-0097 *Report No. 11-00376-59, Issued 01/10/2011*	$444,571	-	-
Review of Proposal Submitted Under Solicitation Number VA-243-10-RQ-0161 *Report No. 11-00658-60, Issued 01/11/2011*	$1,626,257	-	-
Review of Proposal Submitted Under Solicitation Number SPM2D1-10-R-0011 *Report No. 10-02535-61, Issued 01/11/2011*	-	-	-
Review of Federal Supply Schedule Extension Proposal *Report No. 10-03782-64, 01/12/2011*	-	-	-

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Federal Supply Schedule Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-00409-67, Issued 01/13/2011*	-	-	-
Review of Proposal Submitted Under Solicitation Number VA-257-10-RP-0207 *Report No. 11-00607-66, Issued 01/20/2011*	$641,193	-	-
Review of Proposal Submitted Under Solicitation Number VA-263-10-RP-0238 *Report No. 11-00846-74, Issued 01/27/2011*	$400,232	-	-
Review of Proposal Submitted Under Solicitation Number VA-69D-11-RP-0079 *Report No. 11-01043-65, Issued 01/28/2011*	$817,792	-	-
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R1 *Report No. 11-00036-81, Issued 02/02/2011*	-	-	-
Review of Proposal Submitted Under Solicitation Number VA-247-10-RP-0081 *Report No. 11-00784-94, Issued 02/16/2011*	$1,233,791	-	-
Review of Proposal Submitted Under Solicitation Number VA-255-10-RQ-0023 *Report No. 11-01097-95, Issued 02/24/2011*	$1,299,214	-	-
Review of Proposal Submitted Under Solicitation Number VA-257-10-RP-0022 *Report No. 11-00909-107, 02/24/2011*	$5,489,453	-	-
Review of Proposal Submitted Under Solicitation Number VA-69D-11-RP-0038 *Report No. 11-01657-106, Issued 02/28/2011*	-	-	-
Review of Federal Supply Schedule Extension Proposal Submitted Under Contract Number V797P-4921a *Report No. 11-00727-114, Issued 03/04/2011*	$2,277,768	-	-
Review of Federal Supply Schedule Proposal *Report No. 10-03969-115, Issued 03/04/2011*	-	-	-
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-00696-116, Issued 03/04/2011*	-	-	-
Review of Proposal Submitted Under Solicitation Number VA-247-11-RP-0025 *Report No. 11-01498-117, Issued 03/10/2011*	$208,484	-	-

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted Under Solicitation Number VA-260-10-RQ-0215 *Report No. 11-01431-111, Issued 03/14/2011*	$437,606	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation Number RFP-797-FSS-99-0025-R6 *Report No. 11-00775-127, Issued 03/18/2011*	$2,131,274	-	-
Review of Federal Supply Schedule Proposal Submitted Under Solicitation Number M5-Q50A-03-R2 *Report No. 11-00954-130, Issued 03/22/2011*	-	-	-
Review of Proposal Submitted Under Solicitation Number VA-244-10-RP-0256 *Report No. 11-01036-132, Issued 03/25/2011*	$1,886,406	-	-
Review of Proposal Under Solicitation Number VA-244-10-RP-0295 *Report No. 11-01037-133, Issued 03/31/2011*	$639,936	-	-
POSTAWARD REVIEWS			
Review of Overcharges Under a Federal Supply Schedule Contract *Report No. 09-02510-30, Issued 11/16/2010*	-	-	$173,925
Review of Voluntary Disclosures Under Section 603 of Public Law 102-585 for a Federal Supply Schedule Contract *Report No. 08-00592-31, Issued 11/17/2010*	-	-	$ 2,035,188
Review of Overcharges and Refund Offer Under a Federal Supply Schedule Contract *Report No. 10-02390-40, Issued 12/07/2010*	-	-	$20,854
Postaward Review of a Federal Supply Schedule Contract *Report No. 07-00434-52, Issued 12/23/2010*	-	-	$9,587,631
Review of Compliance with Section 603 of Public Law 102-585 Under a Federal Supply Schedule Contract *Report No. 04-02587-58, Issued 01/11/2011*	-	-	$542,338
Post-Award Review of a Federal Supply Schedule Contract *Report No. 10-01178-53, Issued 01/18/2011*	-	-	$14,581

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Voluntary Disclosure Submitted Under a Federal Supply Schedule Contract *Report No. 10-00772-72, Issued 01/20/2011*	-	-	$1,167
Post-Award Review of a Federal Supply Schedule Contract *Report No. 09-02324-85, Issued 02/07/2011*	-	-	$5,946
Review of Addition of Covered Drugs Under a Federal Supply Schedule Contract *Report No. 10-02202-97, Issued 02/22/2011*	-	-	-
Review of Overcharges Relating to Federal Ceiling Price Recalculations Under a Federal Supply Schedule Contract *Report No. 11-01235-100, Issued 02/22/2011*	-	-	$217,693
Review of Overcharges Under a Federal Supply Schedule Contract *Report No. 09-02982-101, Issued 02/23/2011*	-	-	$252,693
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Report No. 10-01869-105, 02/24/2011*	-	-	$39,246
Report of Monetary Recovery from Overbillings Under a VA Contract *Report No. 06-03090-98, Issued 02/24/2011*	-	-	$4,020,650
Review of Supplemental Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Report No. 08-01945-134, Issued 03/24/2011*	-	-	$2,424,827
Review of Allegations of Acquisition Planning Weaknesses and Cost Overruns on the Contract Awarded to to Catapult Technology, Ltd. *Report No. 10-02868-138, Issued 03/31/2011*	-	-	-
Total Funds Recommended for Better Use	**$2,313,000,000**	**$240,000,000**	**-**
Total Questioned Costs	**-**	**-**	**$3,794,790**
Total Preaward Savings and Cost Avoidance	**$122,842,089**	**-**	**-**
Total Postaward Dollar Recoveries	**-**	**-**	**$19,336,739**

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 1 year 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 table summarizes the status of all unimplemented OIG reports and recommendations. Results are sorted by the action office responsible for implementation. Additionally, the table indicates how many of these unimplemented OIG reports and recommendations are less than or more than 1 year.

As of March 31, 2011, there are 135 open reports and 703 open recommendations. However, some of these reports and recommendations are counted more than once in the table below because they have actions at more than one office. Of the reports open less than 1 year, 2 reports and 6 recommendations have actions at two or more offices. Although the FY 2009 Federal Information Security Management Act (FISMA) audit contains unimplemented OIG recommendations from previous years' FISMA audits, the report and its recommendations are considered to be open less than 1 year because it was issued after March 31, 2010.

Table 1: Total Unimplemented OIG Reports and Recommendations

	Reports Open Less Than 1 Year	Reports Open More Than 1 Year	**Total Reports Open**	Recommendations Open Less Than 1 Year	Recommendations Open More Than 1 Year	**Total Recommendations Open**
Veterans Health Administration	96	7	**103**	525	23	**548**
Veterans Benefits Administration	12	2	**14**	64	3	**67**
National Cemetery Administration	1	0	**1**	3	0	**3**
Office of Information & Technology	8	6	**14**	29	29	**58**
Office of Operations, Security, and Preparedness	1	0	**1**	11	0	**11**
Office of Acquisitions, Logistics, and Construction	1	2	**3**	7	4	**11**
Chief of Staff	1	0	**0**	11	0	**11**
Total	**120**	**17**	**137**	**650**	**59**	**709**

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans *Report No. 06-02238-163, Issued 07/11/2006*	OI&T	1 of 6	-

Recommendation d: *We recommend that the Secretary ensure that all position descriptions are evaluated and have proper sensitivity level designations, that there is consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.*

Healthcare Inspection, Review of VA Use of Animals in Research Activities Report No. 07-01148-109, Issued 04/15/2009	VHA	4 of 6	-

Recommendation 1: *We recommended that the Under Secretary for Health work with all VA animal research programs to require university affiliates' compliance with the requirements of VHA Handbook 1200.7.*

Recommendation 2: *We recommended that the Under Secretary for Health ensure that all VA animal research programs have an active occupational health program.*

Recommendation 4: *We recommended that the Under Secretary for Health ensure that the VHA work orders submitted for repairs to ARFs [Animal Research Falities] are completed in a timely fashion.*

Recommendation 6: *We recommended that the Under Secretary for Health define minimum qualification standards for VMOs [Veterinary Medical Officers] and VMCs [Veterinary Medical Consultants] performing duties described in VHA Handbook 1200.7.*

Follow-Up Audit of VA's Major Construction Contract Award and Administration Process Report No. 08-01960-112, 04/29/2009	OALC	1 of 4	-

Recommendation 3: *We recommended the Executive Director for OALC develop written QA [Quality Assurance] policies and procedures, and program performance measures addressing all QA Service areas of responsibilities.*

Audit of VA's Management of Information Technology Capital Investments Report No. 08-02679-134, Issued 05/29/2009	OI&T	1 of 5	-

Recommendation 4: *We recommend that the Acting Assistant Secretary for Information and Technology clearly define the roles of the IT governance boards responsible for providing oversight and management of VA's IT capital investments.*

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Audit of Veterans Health Administration's Management of Non-Controlled Drugs Report No. 08-01322-114, Issued 06/23/2009	VHA	2 of 6	-

Recommendation 2: *We recommended the Under Secretary for Health develop appropriate internal controls to ensure pharmacy managers and staff accurately and consistently record drug-dispensing activity in VistA.*

Recommendation 6: *We recommended the Under Secretary for Health develop standardized electronic annual physical inventory reporting formats; develop standards to ensure that annual physical inventory reports are reasonably accurate; and establish a procedure to hold VA health care facility pharmacy managers accountable for the accuracy of annual physical inventory reports.*

Healthcare Inspection, Review of VHA Residential Mental Health Care Facilities Report No. 08-00038-152, Issued 06/25/2009	VHA	9 of 10	-

Recommendation 2: *We recommended that the Acting Under Secretary for Health should ensure that VISN Directors include programming specific for OIF/OEF veterans in residential programs.*

Recommendation 3: *We recommended that the Acting Under Secretary for Health ensure that VISN Directors should make sure that residential program managers ensure that patients on waiting lists are periodically contacted and/or engaged in treatment while awaiting placement in a residential program.*

Recommendation 4: *We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that medical screening precedes admission for all patients in all residential programs and be documented accordingly.*

Recommendation 5: *We recommended that the Acting Under Secretary for Health ensure that VISN Directors make sure that minimum programming requirements are met 7 days per week.*

Recommendation 6: *We recommended that the Acting Under Secretary for Health should further develop formal guidelines for mental health clinician staffing by mental health discipline for programs using an all-inclusive staffing model and for programs using a residential type clinical staffing model.*

Recommendation 7: *We recommended that the Acting Under Secretary for Health should require the presence of at least one staff member on each separate wing and floor of residential programs on all shifts.*

Recommendation 8: *We recommended that the Acting Under Secretary for Health ensure that residential programs limit dispensing of narcotic self-medication to no more than a 7-day supply for residential program patients.*

Recommendation 9: *We recommended that the Acting Under Secretary for Health ensure that all patients on self-medication have a documented order for self-administration.*

Recommendation 10: *We recommended that the Acting Under Secretary for Health ensure that missed appointments by residential program patients should be captured, addressed, and case managed in a uniform manner.*

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Audit of VA Electronic Contract Management System Report No. 08-00921-181, Issued 07/30/2009	OALC	3 of 8	-

Recommendation 1: *We recommend the Executive Director, Office of Acquisition, Logistics, and Construction develop and implement VA-wide eCMS policy and handbook to ensure consistent use and compliance with system requirements.*

Recommendation 6: *We recommend the Executive Director, Office of Acquisition, Logistics, and Construction in coordination with the Assistant Secretary for Information and Technology establish a plan to evaluate the technical performance of eCMS to ensure improved processing.*

Recommendation 7: *We recommend the Executive Director, Office of Acquisition, Logistics, and Construction coordinate with the Assistant Secretary for Management and the Assistant Secretary for Information and Technology to determine the feasibility of integrating eCMS with the IFCAP or FMS systems in order to eliminate or minimize duplicate data entry and streamline the procurement process.*

Administrative Investigation, Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC Report No. 09-01123-195, Issued 08/18/2009	OI&T	2 of 11	-

Recommendation 5: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of Human Resources to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such corrective action.*

Recommendation 9: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of Human Resources to determine the appropriate corrective action concerning the appointments of the four GS-15s and take such corrective action.*

Administrative Investigation, Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC* Report No. 09-01123-196, Issued 08/18/2009	OI&T	20 of 34	-

Recommendation 2: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s VA appointments, and take such action.*

Recommendation 6: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such action.*

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**

Recommendation 7: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning _____'s appointment, to include her appointment at a rate above the minimum, and take such action.*

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

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

Recommendation 18**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $33,407.88 to recover funds improperly expended to pay for her academic degree.*

Recommendation 19**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $27,930 to recover funds improperly expended to pay for her academic degree.*

Recommendation 20**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $25,711 to recover funds improperly expended to pay for her academic degree.*

Recommendation 21**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $27,561 to recover funds improperly expended to pay for his academic degree.*

Recommendation 22**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $15,153 to recover funds improperly expended to pay for his academic degree.*

Recommendation 23**: *We recommend that the Assistant Secretary for Information and Technology ensure that a bill of collection is issued to _____ in the amount of $9,568 to recover funds improperly expended to pay for her academic degree.*

Recommendation 24: *We recommend that the Assistant Secretary for Information and Technology ensure that OI&T conducts a review of its use of the academic degree funding authority, ensure that all requirements are met, and take appropriate corrective action in cases where funds were improperly expended.*

Recommendation 26: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper FCIP appointments, failure to provide 2-year formal training programs, and subsequent conversions to career-conditional status of _____, and take such action.*

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**

Recommendation 27: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine whether OI&T managers made additional improper FCIP appointments, failed to provide a 2-year formal training program, and subsequently converted employees to career-conditional status, and take appropriate corrective action.*

Recommendation 28: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to ensure that: (1) FCIP hiring is used only in cases when an approved program is established for specific career fields; (2) managers and supervisors are knowledgeable of and adhere to FCIP requirements; (3) interns appointed under FCIP fully participate in the program and are certified to have successfully completed the program prior to conversion to career or career-conditional status; and (4) HR provides the required oversight and guidance as required by VA policy.*

Recommendation 29: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to determine the appropriate corrective action concerning the improper DHA appointments of _____ and take such action.*

Recommendation 30: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to identify any additional improper VA appointments made using DHA, and take appropriate corrective action.*

Recommendation 31: *We recommend that the Assistant Secretary for Information and Technology confer with the Office of HR to ensure that HR personnel and managers with hiring authority are advised of the use and limitations of DHA.*

Recommendation 32: *We recommend that the Assistant Secretary for Information and Technology ensure that OI&T Recommending and Approving Officials receive training on Federal regulations and VA and OI&T policy related to monetary awards, as well as be reminded of their fiscal responsibility.*

Recommendation 33: *We recommend that the Assistant Secretary for Information and Technology ensure that a review of OI&T retention incentives is conducted to ensure that they are necessary and support the mission and program needs and that they fully comply with law, OPM regulations, and VA policy.*

** OIG disagrees with the Office of General Counsel's (OGC's) legal opinions finding that a violation of the nepotism statute did not occur, but closed recommendations 1 and 3 because OI&T is planning no further action in light of OGC's legal opinions.*

*** OIG acknowledges that OGC provided opinions dated July 9 and August 13, 2010, that the nepotism statute was not violated and no legal basis exists for collecting funds from individual employees; however, OIG continues to hold these recommendations open pending receipt of sufficient evidence that the responsible office, OI&T, has determined any tax implications to the employees and any other appropriate administrative actions for inappropriate approval of funding of academic degrees.*

Veterans Benefits Administration's Control of Veterans' Claim Folders Report No. 09-01193-228, Issued 09/28/2009	VBA	2 of 9	-

Recommendation 2: *We recommended the Under Secretary for Benefits establish a mechanism to identify and track the number of claims folders regional office personnel rebuild.*

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Recommendation 9: *We recommended the Under Secretary for Benefits establish a mechanism to ensure regional office personnel enforce the maximum 60 day search established in recommendation 8 and take corrective actions to meet the standard where improvement is needed.*			
Department of Veterans Affairs System Development Life Cycle Process Report No. 09-01239-232, Issued 09/30/2009	OI&T	4 of 4	-
Recommendation 1: We recommend the Assistant Secretary for Information and Technology require OI&T develop and issue a directive that communicates, VA-wide, the mandatory requirements of VA's SDLC process outlined in the existing Program Management Guide to ensure consistent management of VA's IT investment portfolio.			
Recommendation 2: We recommend the Assistant Secretary for Information and Technology require OI&T implement controls to continuously monitor all programs and projects in VA's IT investment portfolio.			
Recommendation 3: We recommend the Assistant Secretary for Information and Technology enforce disciplined performance and quality reviews on all major programs and projects in VA's IT investment portfolio.			
Recommendation 4: We recommend the Assistant Secretary for Information and Technology require OI&T establish and maintain a central data repository to store all program artifacts, including cumulative cost and schedule data.			
Healthcare Inspection, Community Based Outpatient Clinic Reviews, Macon and Albany, GA; Beaver Dam, WI, and Rockford, IL; Sioux City, IA, and Aberdeen, SD; Waterloo, IA, and Galesburg, IL Report No. 09-01446-37, Issued 12/02/2009	VHA	1 of 17	-
Recommendation 12: We recommended that the VISN 23 Director ensure that the Iowa City VAMC Director requires physician privileges are appropriate to the procedures performed at both the Waterloo and Galesburg CBOCs.			
Healthcare Inspection, VistA Outages Affecting Patient Care, Office of Risk Management and Incident Response, Falling Waters, WV Report No. 09-01849-39, Issued 12/03/2009	OI&T	1 of 5	-
Recommendation 3: We recommend that the Assistant Secretary for Information and Technology ensure that the Office for Information Protection and Risk Management performs and reports on risk management for essential medical IT systems.			

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Inspection of VA Regional Office, Roanoke, VA Report No. 09-01995-63, Issued 01/14/2010	VBA	1 of 6	-

Recommendation 6: We recommend the Roanoke VA Regional Office Director research alternative locations to store and safeguard veterans' claims folders and expeditiously relocate these folders to reduce the risk of structural damage to the building and ensure employee safety.

Healthcare Inspection, Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma Report No. 09-01110-81, Issued 02/04/2010	VHA	1 of 3	-

Recommendation 1: We recommended that the Acting Under Secretary for Health ensure the use and implementation of a method specifically designated to track MST-related care at all VHA medical facilities so that MST treatment data are readily accessible across the VA system.

Healthcare Inspection, Hospitalized Community-Dwelling Elderly Veterans: Cognitive and Functional Assessments and Follow-up after Discharge Report No. 09-01588-92, Issued 03/04/2010	VHA	1 of 1	-

Recommendation 1: We recommended that the Under Secretary for Health develop and implement a plan to ensure that vulnerable elders admitted to hospitals have a documented assessment of cognitive functioning.

Audit of VA's Efforts to Provide Timely Compensation and Pension Medical Examinations Report No. 09-02135-107, Issued 03/17/2010	VHA	5 of 10	-

Recommendation 1: We recommend the Acting Under Secretary for Health establish procedures to capture compensation and pension medical examination workload data at the examination level for all examinations conducted by VHA, fee-basis, and local contract providers.

Recommendation 2: We recommend the Acting Under Secretary for Health establish procedures to capture all costs associated with each compensation and pension medical examination conducted by VHA, fee-basis, and local contract providers.

Recommendation 3: We recommend the Acting Under Secretary for Health establish procedures to measure productivity by identifying the number of full-time equivalents who conduct VHA compensation and pension medical examinations and establishing standard times to complete each type of compensation and pension medical examination.

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

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Recommendation 4: We recommend the Acting Under Secretary for Health utilize and monitor data on VHA workload, costs, and productivity to ensure sufficient and appropriate resources are dedicated to completing compensation and pension medical examination requests sent to VA medical facilities. *Recommendation 5: We recommend the Acting Under Secretary for Health establish timeliness performance standards that adequately measure whether veterans receive timely compensation and pension medical examinations conducted by VHA, fee-basis, and local contract providers.*			
TOTALS	**17**	**59**	**$0**

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.

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. VA has made significant progress on the material weaknesses reported in FY 2010. Only the IT Security Controls deficiency was repeated as a material weakness in VA's FY 2010 consolidated financial statements. The prior year report identified four material weaknesses in the areas of (1) Financial Management System Functionality, (2) IT Security Controls, (3) Financial Management Oversight, and (4) Compensation, Pension, and Burial Liabilities. The Financial Management System Functionality and the Compensation, Pension, and Burial Liabilities material weaknesses have been downgraded to significant deficiencies this year. The Financial Management Oversight finding was not repeated.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	351 total reviews commented on 20 times
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 8-44
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 8-44
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 57-65
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 21-39
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 45-56
Section 5 (a) (7)	Summary of each particularly significant report	See pages 8-44
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 67
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 67

Appendix C: Inspector General Act Reporting Requirements

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 66

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 03/31/2010	0	$0
Issued during reporting period	3	$3.8
Total inventory this period	3	$3.8
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	3	$3.8
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	3	$3.8
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 03/31/2010	0	$0
Issued during reporting period	3	$2,313
Total inventory this period	3	$2,313
Management decisions during the reporting period		
Agreed to by management	2	$240
Not agreed to by management	1	$2,073
Total management decisions this reporting period	3	$2,313
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 IG appointed under the *Inspector General Act of 1978* to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued no contract review reports under this requirement.

Appendix E: American Recovery and Reinvestment Act Oversight Activities

Enacted in February 2009, ARRA requires OIG to conduct oversight of the VA projects, programs, grants, and initiatives that received a total of $1.4 billion in funding under the Act. OIG's program of oversight includes audits, evaluations, investigation, fraud awareness and prevention training, and other monitoring activities covering the major VA programs that received ARRA funding. The VA programs and the amounts of their ARRA funding include:

- $1.0 billion for VHA medical facility nonrecurring maintenance (NRM) and energy projects.
- $150.0 million for VHA Grants to States for extended care facilities.
- $50.0 million for NCA headstone, marker, gravesite, and monument repairs; NRM, energy, and road repair projects; and equipment upgrades.
- $150 million for VBA claims processing hiring initiative and support of Veterans economic recovery payments.
- $45 million for OI&T support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

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

As of March 31, 2011, OIG has expended $2.3 million (the entire $1.0 million OIG received under ARRA and $1.3 million from regular appropriations) in conducting its comprehensive program of ARRA oversight. OIG's ARRA-related accomplishments and activities completed to date include:

- Issued seven final audit and evaluation reports and one interim advisory report on VA management of ARRA program activities.
- Conducted 422 fraud awareness training and outreach sessions across the country attended by over 12,300 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 147 and closed 38 criminal investigations, including 12 convictions, 11 referrals for monetary reclamation, and $3,000 in recoveries related to ARRA-funded programs and projects.
- Received 58 Hotline complaints of potential fraud or waste related to ARRA programs or projects.
- Established the OIG Recovery Act Web Site, http://www.va.gov/oig/recovery, which provides access to the VA OIG Hotline and information on OIG ARRA reports, activities, plans, and fraud prevention training materials.

Under ARRA, an employee of any non-Federal employer receiving covered ARRA funds may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing information that the employee reasonably believes is evidence of: 1) gross mismanagement of an agency contract or grant relating to covered funds; 2) a gross waste of covered funds; 3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; 4) an abuse of authority related to the implementation or use of covered funds, or 5) a violation of law, rule, or regulation related to an agency contract or grant, awarded or issued relating to covered funds.

Pursuant to the reporting requirements under this provision, OIG conducted no investigations such as those described above. Consequently, OIG did not request or receive an extension beyond the 180-day period for such investigations.

Appendix F: Restoring American Financial Stability Act Reporting Requirements

Pursuant to the *Restoring American Financial Stability Act of 2010,* P.L. 111-203, OIG reports that no peer reviews were conducted by another OIG during the reporting period ending March 31, 2011. The last peer review was conducted by the U.S. Department of Agriculture OIG on December 23, 2009. This report contains no outstanding recommendations. VA OIG conducted an external peer review of the Department of Transportation OIG and issued the final report on March 3, 2010, which contained no recommendations.

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On the Cover

Veterans use adaptive skies to maneuver snowy mountains during the National Disabled Veterans Winter Sports Clinic, held March 28–April 2, 2010, in Snowmass Village, CO. This event is the world leader in promoting rehabilitation by instructing Veterans with disabilities in adaptive Alpine and Nordic skiing, and introducing them to a number of other adaptive recreational activities and sports. For many newly injured Veterans, including many injured in Iraq and Afghanistan, the Clinic offers their first experience in winter sports and gives them the inspiration to take their rehabilitation to a higher level. Participants include Veterans with spinal cord injuries, amputations, TBIs, neurological challenges, and visual impairments. VA photos by Jeff Bowen. and Mark Arlinghaus.

United States Department of Veterans Affairs
Office of Inspector General

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Department of Veterans Affairs
Inspector General Hotline (53E)
P.O. Box 50410
Washington, DC 20091-0410