Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 66 | April 1—September 30, 2011

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Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress. Pursuant to the *Inspector General Act of 1978*, as amended, this report presents the results of our most significant accomplishments during the reporting period April 1 – September 30, 2011.

During this reporting period, the Office of Inspector General (OIG) issued 161 reports on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified nearly $4.1 billion in monetary benefits, for a return on investment of $86 for every dollar expended on OIG oversight.

OIG criminal investigators closed 503 investigations, and made 290 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 264 administrative sanctions. Settlements in nine cases brought against companies under the *qui tam* provisions of the *False Claims Act* recovered $24,306,091 for VA as a direct result of the work of the Offices of the Counselor and Investigations (OI).

A primary focus for OIG investigative and audit work this reporting period has been VA's Veteran-Owned and Service-Disabled Veteran-Owned Small Business (VOSB and SDVOSB) programs. OIG's OI is aggressively pursuing allegations regarding ineligible businesses that obtain VOSB and SDVOSB contract awards. Recent investigative work resulted in the successful prosecution of the Chief Executive Officer of a business that had been awarded SDVOSB set-aside construction contracts valued at over $16 million for which the company was not eligible. VA's Suspension and Debarment Committee subsequently debarred the defendant and his company from doing business with the Federal government. In a separate investigation, a company and four defendants were indicted after a multi-agency investigation determined that the SDVOSB acted as a pass-through company for a larger company and that the owner of the SDVOSB was not a service-disabled Veteran. Based on information provided by OIG, the company and the four defendants were also suspended by VA's Suspension and Debarment Committee from doing business with the Government.

In July, Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, testified before Congress on the results of OIG's recent audit and investigative work involving the VOSB and SDVOSB programs. Our audit report found that 76 percent of the businesses OIG reviewed were ineligible for the program and/or the specific VOSB or SDVOSB contract award, potentially resulting in $2.5 billion awarded to ineligible businesses over the next 5 years.

OIG's Benefits Inspection Division issued a summary report identifying systemic issues found at 16 VA Regional Offices (VAROs) inspected from April 2009 to September 2010. The report found that VARO management teams face multiple challenges in providing benefits and services to Veterans. Challenges include providing additional oversight and training for personnel responsible for processing disability compensation claims related to temporary 100 percent disability evaluations, post-traumatic stress disorder, traumatic brain injury, herbicide-related disabilities, and Haas cases. Haas claims involve Veterans who

served in waters off Vietnam and did not set foot in Vietnam, potentially precluding those Veterans from entitlement to presumption of exposure to herbicide agents, including Agent Orange. OIG projected that VARO staff did not correctly process 23 percent of approximately 45,000 claims. As a result of the 16 inspections, OIG made 86 recommendations to improve VARO operations regarding the systemic issues addressed. VARO Directors concurred with all of the recommendations.

A retrospective review conducted by the Office of Healthcare Inspections (OHI) found that the Veterans Health Administration (VHA), in response to OIG's 2008 recommendation to the Under Secretary for Health, successfully implemented a mechanism to ensure that VHA facilities had appropriate infrastructure to support surgeries performed. OIG identified no adverse patient outcomes clearly attributable to facility infrastructure, and found that under circumstances where it was unable to provide service, VHA referred complex surgeries to non-VHA facilities with sufficient capabilities to support the surgeries performed.

OHI also issued a follow-up report to a comprehensive 2009 review of VHA residential mental health (MH) care facilities. The 2011 review found that progress was made in some areas, but VHA made little interim progress in one key area—ensuring contact with patients during the time interval between acceptance into a MH residential rehabilitation program and the start of the program. The follow-up inspection identified actual staffing at the Residential Rehabilitation Treatment Programs and referral for additional vocational rehabilitation and employment services based on program size and urban-rural status as new areas of concern.

Office of Contract Review (OCR) staff conducts preaward reviews to assist VA contracting officers in negotiating fair and reasonable contract prices for health care resources procured on a sole-source basis that are valued at more than $500,000. OCR's collective findings since 2006 determined that VHA has not effectively implemented all the requirements set forth in VA Directive 1663, *Healthcare Resources Contracting – Buying, Title 38 U.S.C. § 8153,* under which VA may enter into non-competitive (sole-source) contracts with affiliated institutions for health care resources. This was due to lack of resources, training, and enforcement, which resulted in recurring contracting and pricing issues with sole-source contracts with affiliated institutions. The report also discusses OIG's findings regarding conflict of interest issues and recommends that VA seek personal services contracting authority. OCR also recovered more than $2 million in contract overcharges for VA.

We thank the Secretary, Deputy Secretary, and other senior Department officials and their staffs for their support of our work and receptiveness to our recommendations for improving VA programs and operations. We look forward to continuing our partnership with the Department and Congress in the months ahead to meet the many challenges facing VA as it works to ensure our Nation's heroes receive the care, support, and recognition they have earned in service to our country.

GEORGE J. OPFER
Inspector General

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	Reporting Period	Fiscal Year
Monetary Impact (in Millions)		
Better Use of Funds	$889.3	$3,202.3
Fines, Penalties, Restitutions, and Civil Judgments	$39.7	$519.7
Fugitive Felon Program	$82.8	$200.0
Savings and Cost Avoidance	$264.5	$397.7
Questioned Costs	$2,770.1	$2,773.9
Dollar Recoveries	$5.4	$28.0
Total Dollar Impact	**$4,051.8**	**$7,121.6**
Cost of OIG Operations[1]	$47.0	$94.0
Return on Investment (Total Dollar Impact/Cost of OIG Operations)	**86:1**	**76:1**
Reports Issued		
Combined Assessment Program Reviews	29	54
Community Based Outpatient Clinic Reviews (encompassing 37 facilities)	5	10
Healthcare Inspections	33	64
Joint Review	1	2
Audits and Reviews	15	25
Benefits Inspections	14	20
Administrative Investigations	1	4
Preaward Contract Reviews	48	92
Postaward Contract Reviews	15	30
Total Reports Issued	**161**	**301**
Investigative Activities		
Arrests (Not including Fugitive Felons)	260	488
Fugitive Felon Arrests	30	60
Fugitive Felon Apprehensions by Other Agencies with OIG Assistance	27	46
Indictments	188	360
Criminal Complaints	100	167
Convictions	176	344
Pretrial Diversions and Deferred Prosecutions	21	56
Administrative Sanctions	264	427
Cases Opened	490	990
Cases Closed	503	979

Statistical Highlights

	Reporting Period	Fiscal Year
Congressional Activities		
Cases Opened	7	13
Healthcare Inspections Activities		
Clinical Consultations	1	6
Administrative Case Closures	6	20
Hotline Activities		
Cases Opened	628	1,184
Cases Closed	637	1,018
Administrative Sanctions	27	37
Substantiation Rate	40%	40%
Contacts	15,286	30,222

1. Beginning in 2009, the 6-month and fiscal year cost of operations for the Office of Healthcare Inspections ($9.5 million and $19 million, respectively), whose oversight mission results in improving the health care provided to Veterans rather than saving dollars, is not included in the return on investment calculation.

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, the Republic of the Philippines, and the U.S. Virgin Islands.

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

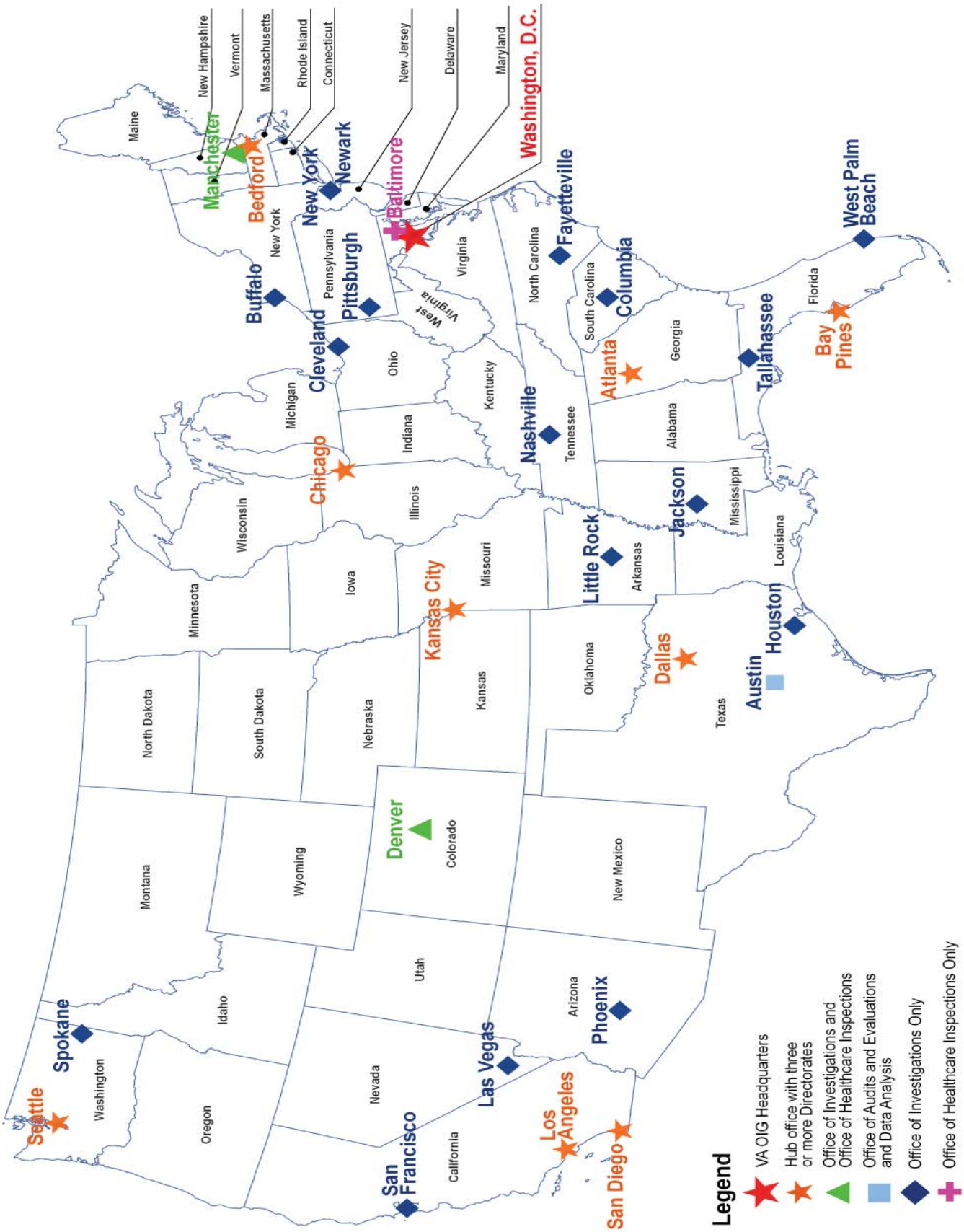
VA Office of Inspector General

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

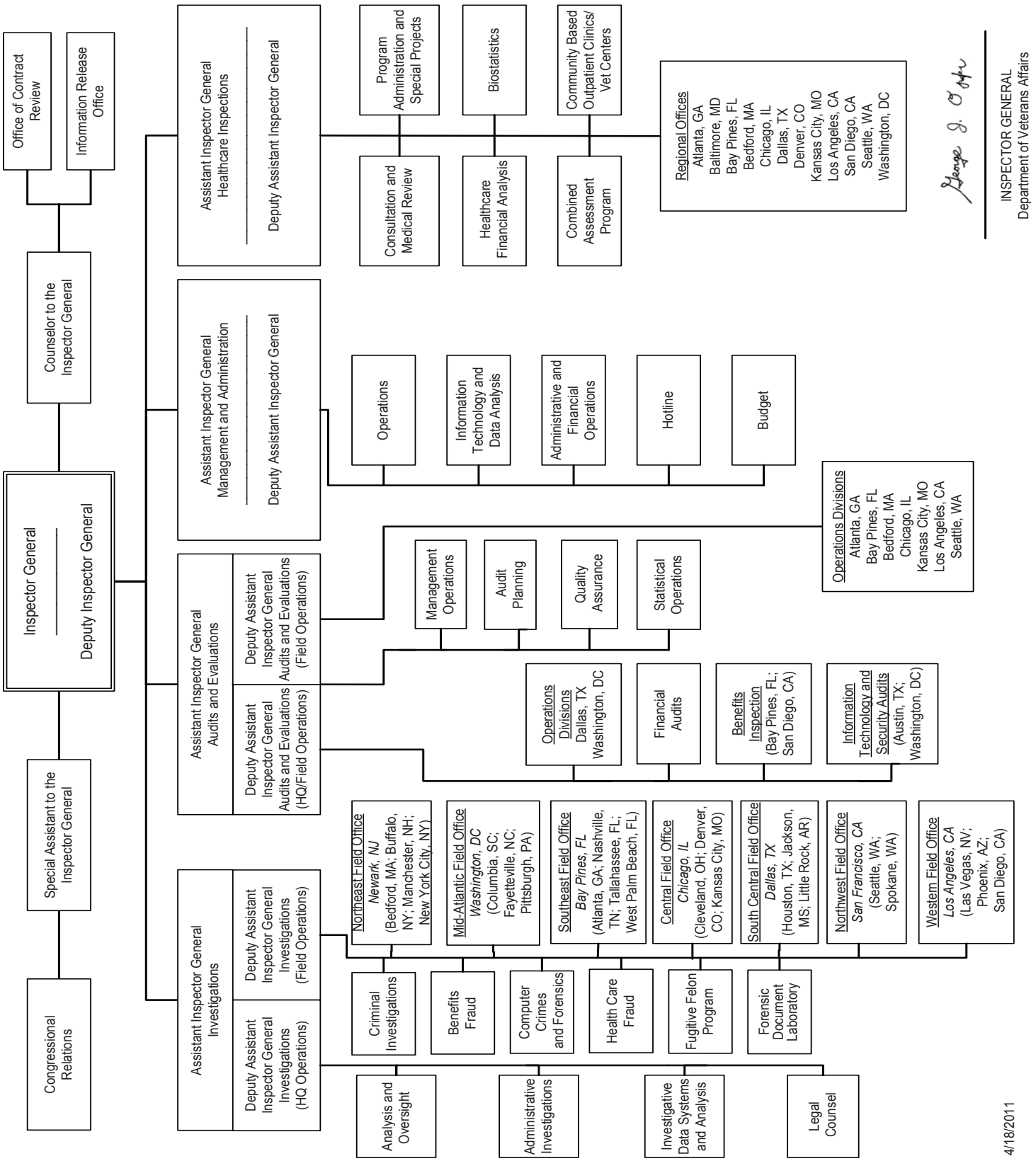
OIG, with 609 employees from appropriations, is organized into three line elements: the Offices of Investigations (OI), Audits and Evaluations (OAE), and Healthcare Inspections (OHI), plus a contract review office and a support element. FY 2011 funding for OIG operations provides $109 million from ongoing appropriations. The Office of Contract Review (OCR), with 24 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.

VA and OIG Mission, Organization, and Resources



VA and OIG Mission, Organization, and Resources



Office of Healthcare Inspections

The health care that VHA provides Veterans is ranked consistently among the best in the Nation, whether those Veterans are recently returned from Operations Enduring Freedom, Iraqi Freedom, or New Dawn or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. The OIG OHI focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OHI published 8 national healthcare inspections; 25 Hotline healthcare inspections; 1 joint review with OAE; 29 Combined Assessment Program (CAP) reviews; and 5 Community Based Outpatient Clinic (CBOC) reviews, covering 37 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 29 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.
- Quality management.

When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use. During this reporting period, OIG issued two CAP summary reports regarding VHA's management of test results and infection control practices.

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 whether: (1) CBOCs comply with selected standards in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, regarding the management of mental health (MH) emergencies, (2) CBOCs have a skills competency assessment and validation policy and process in place and if individuals performing competency assessment and validation have the education, background, experience, or knowledge related to the skills assessed, (3) Short-Term Fee Basis authorization and follow-up processes for outpatient radiology consults including computerized tomography, magnetic resonance imaging (MRI), positron emission tomography scan, and mammography ensure quality and timely patient care, (4) CBOCs comply with selected VHA requirements regarding the provision of mammography services for women Veterans, (5) CBOCs are in compliance with standards of operations

according to VHA policy in the areas of environmental safety and emergency planning, (6) CBOC providers are appropriately credentialed and privileged in accordance with VHA policy, (7) primary care active panel management and reporting are in compliance with VHA policy, and (8) primary care and MH services provided at contracted CBOCs are in compliance with the contract provisions and evaluate the effectiveness of contract oversight provided by the VA.

During this reporting period, OIG performed 37 CBOC reviews throughout 13 Veterans Integrated Service Networks (VISNs). These reviews were captured in 5 reports. We made recommendations for improvements at the following facilities:

- VISN 1: Springfield, MA
- VISN 4: Georgetown, DE; Ventnor, NJ; and Camp Hill, McKean County, Pottsville/Frackville, and Venango County, PA
- VISN 6: Morehead City and Raleigh, NC
- VISN 8: Guayama and Ponce, PR
- VISN 9: Clarksville and Cookeville, TN
- VISN 11: Goshen, IN
- VISN 15: Belton and Nevada, MO
- VISN 16: Harrison, AR; Hammond and Houma, LA; Branson, MO; and Conroe, Lufkin, and Wichita Falls, TX
- VISN 17: San Antonio (North Central Federal Clinic), Tyler, and Uvalde, TX
- VISN 18: Alamogordo and Artesia, NM; and Bellemont and Kingman, AZ
- VISN 20: Klamath Falls, OR
- VISN 21: Capitola and French Camp (Stockton), CA
- VISN 23: Hibbing and Rochester, MN; Mission, SD; and Newcastle, WY

A roll up report for the CBOCs reviewed in FY 2010 and two informational reports for FYs 2011 and 2012 were also published during this reporting period.

National Reports

Readjustment Counseling Services Show Improvement But Issues Remain

The purpose of OIG's inspection was to assess the quality of Readjustment Counseling Service (RCS) Vet Centers' post-traumatic stress disorder (PTSD) counseling services to determine how clients are screened for PTSD, if treatment documentation complies with policy, and if providers are trained to provide PTSD counseling services according to policy. OIG found that counselors utilized appropriate tools to screen clients for PTSD, client treatment case file documentation improved from the FY 2009 report, and staff training improved. Although RCS made improvements from the previous review, OIG found that Vet Center Team Leaders were not consistently providing supervision and consultation to Vet Center providers in accordance with RCS policy. OIG recommended that Vet Center Team Leaders perform monthly provider's record reviews, and provide supervision and consultation to providers in compliance with RCS policy. Additionally, OIG recommended that corrective action be taken when supervision and consultation issues are identified through the annual clinical quality reviews.

Progress Made, But More Work Remains for VHA's Residential MH Care Facilities

OIG conducted a follow-up review to evaluate any improvements made or problems remaining since the completion of a comprehensive 2009 review of VHA's residential MH care facilities. OIG found significant interim progress in meeting some of the prior recommendations, but only moderate or little progress for others, including limiting the dispensing of prescribed narcotics to up to a 7-day supply to Veterans in residential programs. The follow-up inspection identified actual staffing at the Residential Rehabilitation Treatment Programs as a new area of concern. Additionally, the inspection found that patients were assessed for occupational dysfunction, but were referred to vocational rehabilitation services based on program size and urban-rural status. In light of the emphasis on a recovery-based model, this area of concern is also newly addressed in the recommendations.

Roll-Up Inspection Determines Clinic Care Comparable to Parent Facilities

Between March 15 and August 27, 2010, OIG completed an evaluation of 47 VHA CBOCs to determine whether they provide a quality of care that is comparable to their parent VA Medical Center (VAMC) and whether they generally meet VHA directives and guidelines. CBOCs appear to be providing a quality of care that is not substantially different from parent VAMCs, and they generally met VHA directives and guidelines. However, of the 47 CBOCs reviewed, OIG found that only 87 percent complied with the required cardiopulmonary resuscitation (CPR) training; 26 percent did not monitor, collect, or analyze hand hygiene data on a routine basis; and 19 percent did not consistently secure patients' personally identifiable information (PII). Additionally, OIG determined that VHA used four different pricing models to compensate for MH services at 18 contract CBOCs, and Primary Care Management Module Coordinators were not effectively managing primary care provider (PCP) assignments, which resulted in nine contract CBOCs having patients assigned to more than one PCP. OIG made five recommendations to address the identified issues.

OIG Finds VHA Facility Capabilities Appropriate for Level of Surgical Care

OIG conducted a retrospective review to characterize where seven complex and intermediate surgical procedures were performed at VHA facilities and at non-VHA facilities through fee basis arrangements prior to VHA's release of Directive 2010-018, *Facility Infrastructure Requirements To Perform Standard, Intermediate, or Complex Surgical Procedures*, on May 6, 2010. OIG found that VHA facilities had appropriate infrastructure to support surgeries performed. Although some surgeries were performed at VHA facilities with designations of lower complexity than required by the Directive, these surgeries were performed prior to the publication of the Directive, and OIG identified no adverse patient outcomes clearly attributable to facility infrastructure. OIG also found that VHA referred complex surgeries to non-VHA facilities with sufficient capabilities to support the surgeries performed. OIG made no recommendations.

OIG Makes Five Recommendations to Improve Infection Control Practices

OIG evaluated selected infection prevention (IP) practices in VHA facilities by determining whether facilities complied with required IP practices in patient care units, trained employees on the Occupational Safety and Health Administration Bloodborne Pathogens Rule, and performed N95 respirator fit testing. OIG conducted the review at 69 facilities during CAP reviews performed from January 1, 2010, through March 31, 2011. VHA facilities recognized the importance of maintaining consistent IP practices to ensure Veteran safety and reduce the incidence of health care-associated infections. OIG identified five areas where compliance with selected IP requirements needed to improve and recommended that corrective actions are initiated when hand hygiene performance falls below established thresholds, ultraviolet germicidal irradiation fixtures are turned on and functional, negative pressure is monitored and within acceptable levels in occupied airborne infection isolation rooms, employees with occupational exposure

risk complete annual Occupational Safety and Health Administration Bloodborne Pathogens Rule training, and designated employees complete annual N95 respirator fit testing.

OIG Identifies Three Areas in Need of Improvement in Management of Laboratory, Radiology, and Pathology Test Results

OIG evaluated the management of test results in VHA facilities by determining whether facilities complied with VHA policy and Joint Commission standards related to communicating critical clinical laboratory, radiology, and anatomic pathology test results; periodically monitored communication of critical test results to evaluate effectiveness; documented appropriate notification and follow-up actions in medical records when critical test results were generated; and notified patients of normal test results. OIG also followed up on a previous report published in 2002. This review was conducted at 25 facilities during CAP reviews performed from October 1, 2010, through March 31, 2011. In response to OIG's 2002 report, VHA provided system-wide guidance for management of test results and made significant improvements related to diagnostic clinician communication and documentation of critical results. OIG identified three areas where compliance with VHA requirements needed improvement and recommended that facilities' written policies be comprehensive and define processes for monitoring the effectiveness of communicating critical results to practitioners and patients, that ordering practitioners notify patients of all critical results within the defined timeframes, and that practitioners notify patients of normal results and managers monitor compliance.

Hotline Reports

Management Slow to Address Poor Infection Control Practices, Staffing Issues at Dayton, Ohio, Dental Clinic

OIG reviewed infection control issues at the Dayton, OH, VAMC, at the request of the Chairmen and Ranking Members of the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs. The inspection found evidence of a lack of adherence to proper infection control policies and determined that a VAMC dentist did not comply with infection control and related procedures. Dental Service management was aware of these infractions, yet did not act sufficiently on this evidence. Additionally, OIG found Dental Service staffing levels to be suboptimal, which may have increased the likelihood that deviations from approved infection control practices would occur. Moreover, interpersonal relations among Dental Service staff were strained and negatively affected the Dental Service. OIG recommended that the VISN Director review the findings related to the Dayton Dental Service and take appropriate action, in addition to ensuring the Dental Service is required to comply with the relevant infection control policies.

Allegations Regarding Medical Follow-Up for Urology Care Not Substantiated Against Chattanooga, Tennessee, CBOC

OIG conducted a healthcare inspection of the Chattanooga, TN, CBOC in response to a Hotline allegation regarding medical follow-up for elevated prostate-specific antigen (PSA) levels of a patient. The patient experienced periods of elevated PSA levels since 2004, and an August 2010 prostate biopsy revealed cancer. Contrary to the allegations that CBOC staff did not follow up on the elevated PSA levels, OIG found that the patient's CBOC providers routinely measured PSA levels and communicated results to the patient. The patient chose to receive primary care and urology care from community providers. Medical documentation reflected that the patient either reported a recent normal prostate examination by a community provider or refused a CBOC prostate examination. Although CBOC staff requested that the patient provide documentation of visits with community providers, none was provided. OIG did not substantiate the allegation and made no recommendations.

Rescue Medication Policy in Need of Updating at VA Eastern Kansas Health Care System, Topeka, Kansas

OIG reviewed the validity of allegations that local policy regarding rescue medications was inappropriate and unsafe for the Specialized Inpatient Stress Disorders Unit (SIPU) patient population at the VA Eastern Kansas Health Care System (HCS), Topeka, KS. The inspection substantiated that facility policy did not allow patients to carry rescue medications with them when they left the unit. Although SIPU staff identified this problem and implemented a change in practice that allowed patients to carry rescue medications with them when they leave the facility, the facility policy did not reflect the new process. In accordance with OIG's recommendation, the facility developed a policy that includes procedures for administering rescue medications in the SIPU; therefore, OIG considers the recommendation implemented.

Inspection Finds Inadequacies in Patient Care, Airway Management, and Critical Care Coverage at VA Northern Indiana HCS, Fort Wayne, Indiana

OIG conducted an inspection to determine the validity of allegations regarding the quality of care for four patients at the VA Northern Indiana HCS in Fort Wayne, IN. OIG found inadequate management, documentation, and review of Patient 1's cardiopulmonary arrest and inadequate Intensive Care Unit (ICU) monitoring of Patient 2. OIG also found that Patient 3 should not have been accepted in transfer from a community hospital. OIG identified no quality of care issues in the care of Patient 4. OIG did not substantiate allegations against the physician in question. However, OIG determined that during a 6-month period, there were 23 days with periods ranging from 4 to 15 hours during which there were no staff in the facility with demonstrated competence to perform out-of-operating room airway management; Medical Officers of the Day were routinely providing care to patients in the emergency department (ED) and to inpatients, including the ICU, contrary to VHA policy; and that in March 2010 there were two intervals when three patients in the ICU received mechanical ventilator therapy concurrently. OIG did not substantiate that there were no backup ventilators in the facility or that the use of three ventilators simultaneously was in violation of facility policy. OIG made five recommendations to address inspection findings.

Inspection Confirms Delay in Renal Cancer Care at West Palm Beach, Florida, VAMC

OIG conducted an inspection to determine the validity of allegations of delayed cancer care at the West Palm Beach, FL, VAMC. OIG reviewed allegations that patients did not receive timely treatment after a diagnosis of lung or renal cancer; these patients did not receive timely cardiac risk assessment prior to surgery; and management was aware of, but unresponsive to, these issues. While no pattern of delays in care for those patients diagnosed with lung cancer were found, OIG substantiated the allegation that there were delays in treatment for patients diagnosed with renal cancer. OIG found that renal cancer patients referred to the Miami VAMC waited between 3 and 5 months from confirmed diagnosis for their treatment. OIG substantiated the allegation that VAMC management was aware of problems with timely renal cancer care for one patient, but made no effort to follow up on this. OIG did not substantiate the allegation that there were delays in obtaining cardiology risk assessments for lung and renal cancer patients scheduled for surgery. Management agreed with the findings and recommendations and provided acceptable action plans.

Delay in Diagnosis and Communication Issues Found at Chattanooga, Tennessee, CBOC

OIG conducted an inspection in response to allegations of a delay in diagnosis and communication issues at the Chattanooga, TN, CBOC, which is part of the Tennessee Valley HCS, Nashville, TN. OIG also reviewed an additional allegation that the patient had difficulty getting an appointment at the CBOC. OIG substantiated the allegation of a delay in diagnosis, finding no evidence that the patient's CBOC PCP reviewed the MRI results, notified the patient of the abnormal results, or ensured follow-up care. Current

local policy does not delineate responsibility for the follow up of fee basis provider recommendations to ensure continuity of care. OIG could not confirm or refute the allegations that the PCP did not communicate adequately with the patient's TRICARE provider, that the CBOC staff did not allow the patient to change providers, or that the patient had difficulty getting appointments at the CBOC. Management agreed with the findings and recommendations.

Pain Management Clinic Deficiencies Found at Detroit, Michigan, VAMC

OIG evaluated allegations of poor prescribing practices for controlled substances in the Pain Management Clinic (PMC) at the John D. Dingell VAMC in Detroit, MI. A complainant alleged that PMC physicians prescribed controlled substances (CS) without adequate evaluation of patients, supervisors coerced PMC providers to write CS prescriptions for patients not under their care, and patient injuries and deaths occurred because of PMC providers' prescribing practices. OIG substantiated that providers were prescribing CS without adequate evaluation of patients and found that the facility did not have a policy outlining requirements for the ongoing assessment of patients treated with narcotic medications. OIG did not substantiate the allegations that supervisors coerced providers to write CS prescriptions for patients they had not evaluated or that injuries or deaths resulted from the prescribing practices of PMC providers. OIG recommended that the VAMC Director ensure managers define the expected frequency of provider evaluations for patients treated with narcotic medications, and ensure a peer review is conducted of the PMC physician responsible for prescribing narcotic prescriptions without adequate patient evaluation.

Improvements Needed in ICU Patient Assessment, Documentation, and Adverse Event Reporting at Shreveport, Louisiana, VAMC

OIG evaluated the validity of an allegation that a patient became paralyzed after the insertion of an epidural catheter at the Overton Brooks VAMC in Shreveport, LA. OIG did not substantiate the allegation. However, OIG concluded that the patient's hypotension was poorly monitored and should have been treated more aggressively, and that ICU nursing staff did not document required patient assessments. In addition, the VAMC's system of reporting and evaluating adverse events needed improvement. OIG recommended that the VAMC Director ensure that (1) patients in the ICU are assessed appropriately and patient care activities are consistently documented, and (2) processes are in place for reporting and evaluating adverse events. Management agreed with the findings and recommendations and provided acceptable action plans.

Delays in Communication, Colonoscopy Referrals Noted at Contract CBOCs Affiliated with New Mexico VAHCS

OIG conducted a review to determine the validity of allegations regarding patient care at contract CBOCs affiliated with the New Mexico VAHCS. The complainant alleged that contract issues negatively affected patient care; a CBOC physician underwent three level-III peer reviews following the death of a patient; from April to September 2010, four patients with positive colorectal cancer screening tests were not referred to a specialist to determine the cause for bleeding; and there were numerous complaints from Veterans unable to get access to care when needed. OIG substantiated that contract issues that limited communication between clinic and HCS staff negatively affected patient care, and that there were issues with access to care at the CBOC. OIG did not substantiate that there were three level-III peer reviews assigned to a CBOC physician, but did find issues related to peer review timeliness and confidentiality when the results were communicated to facility contracting staff. OIG also did not substantiate the allegation regarding positive colorectal cancer screenings for four patients, but did find that the facility was not timely in referring patients for colonoscopies following positive screening tests; however, they had an acceptable action plan. OIG made four recommendations to address the findings.

Patient Abuse Allegations Not Substantiated at Oklahoma City, Oklahoma, VAMC

OIG evaluated the validity of allegations that a patient at the Oklahoma City, OK, VAMC was abused at the community nursing home (CNH) and that the VAMC provided inadequate CNH oversight. OIG did not substantiate the allegations of patient abuse or inadequate CNH oversight. The patient received appropriate treatment while at the CNH, and the Oklahoma City VAMC and Adult Protective Services thoroughly investigated the complaint and did not find evidence of abuse. OIG made no recommendations.

Provider Privileging and Delayed Patient Care Allegations Unfounded at West Haven, Connecticut, VAHCS

OIG evaluated the validity of allegations regarding a service's administrative practice at the West Haven, CT, VAHCS. The complainant alleged that the service chief did not have recent experience providing direct patient care, did not meet the requirements for physician re-privileging, and intentionally delayed patient care based on the assigned provider. OIG did not substantiate allegations against the service chief; however, facility leadership is taking steps to clarify the requirements for documentation of clinical competence for privileging based on the results of a February 2011 OIG CAP review of the West Haven Campus. OIG also did not substantiate delayed patient care based on the assigned provider. OIG made no recommendations.

Lack of Management Controls Results in Loss of Veterans' Grant Records at Durham, North Carolina, VAMC

At the request of Senator Richard Burr, OIG conducted an inspection of the Prosthetic and Sensory Aids Service at the Durham, NC, VAMC. Specifically, OIG reviewed the potential loss of Veterans' Home Improvement and Structural Alterations (HISA) grant records that contained PII, which may have caused undue delays in providing these critical modifications to Veterans homes. OIG was unable to determine the exact number of HISA records missing but estimates that as many as 90 records are missing. OIG found numerous discrepancies in the oversight and administration of the HISA program, which contributed to the lack of management control over this program. The review found that facility managers did not place appropriate emphasis on protecting, investigating, and reporting lost or stolen files that contained PII. More than 3 weeks passed from the discovery of the lost records to notification of appropriate authorities. Since the discovery of the missing files, personnel and leadership changes in the prosthetics department have been addressed.

OIG Substantiates Inadequate Management of Electronic Waiting Lists at Atlanta, Georgia, VAMC, MH Clinics

OIG conducted an evaluation regarding inadequate management of the electronic waiting list (EWL) for several MH clinics at the Atlanta, GA, VAMC. OIG substantiated that several MH clinics had significantly high numbers of patients on their EWLs over a period of months in FY 2010, and OIG substantiated that facility managers were aware of the EWLs but were slow in taking actions to address the condition. While the facility has since provided resources to eliminate the MH EWLs, ongoing actions are necessary to ensure the condition does not recur. OIG also substantiated that FY 2010 funds were inappropriately used to pay a contractor's FY 2009 expenses and that there were delays in payments to the contractor. OIG recommended that the VAMC Director ensure ongoing actions are taken to minimize and/or alleviate MH EWLs and that responsible staff follow fiscal guidelines. The Acting VISN Director agreed with the findings and recommendations.

OIG Substantiates Lapses in Execution of Suicide Safety Measures at West Palm Beach, Florida, VAMC

OIG performed an inspection at the West Palm Beach, FL, VAMC to determine the validity of allegations regarding a high-risk patient attempting suicide in the ED and again on the MH unit. The complainant also expressed concerns about staff training; poor communication with the family; staff actions regarding an art therapy class; and the patient's transfer to a non-VA treatment center. OIG substantiated that due to lapses in carrying out suicide safety measures, the patient was able to attempt suicide twice while under the care of facility providers. While not part of the allegations, OIG found that the facility's internal reviews of the events did not fully adhere to the National Center for Patient Safety guidelines for completion of root cause analyses. Two of the complainant's allegations resulted in recommendations to the VISN and VAMC Directors.

Allegations Regarding Hospice Care Substantiated at Baltimore, Maryland, VA Rehabilitation and Extended Care Center

OIG conducted a review to determine the validity of two allegations regarding hospice care at the Baltimore VA Rehabilitation and Extended Care Center, which is part of the VA Maryland HCS. OIG substantiated that two patients did not have adequate pain management as defined by VHA policy and hospice industry standards. The review identified five factors that contributed to the pain management deficiencies: (1) facility staff did not develop individualized and comprehensive pain management care plans, (2) patient pain reassessments were not appropriately documented, (3) clinical staff did not have sufficient training on the principles of pain management for hospice patients, (4) hospice interdisciplinary teams were not effectively used, and (5) clinical pharmacists were not actively involved in the pain management process. OIG did not substantiate that the lack of "piped in" oxygen, suction, and air compromised hospice patient safety and comfort. OIG found that the facility provided appropriate oxygen, suction, and air. OIG made four recommendations to address the factors that contributed to the pain management deficiencies. Management agreed with the findings and recommendations.

Hospice and Palliative Care Improvements Needed at Detroit, Michigan, VAMC

OIG evaluated the validity of allegations that facility staff at the John D. Dingell VAMC in Detroit, MI, did not respect a patient's treatment decision, misrepresented the family's wishes, and treated the patient and family disrespectfully. OIG did not substantiate that the patient's attending physician misrepresented the family's wishes and was unprofessional. OIG substantiated: (1) staff did not provide comfort care to the patient prior to the patient's transfer from acute care to hospice care, (2) physicians delayed the patient's transfer to the hospice unit, and (3) nursing staff did not show compassion to a dying patient and the patient's family. OIG recommended that the VAMC Director ensure that all clinical staff receives training in hospice and palliative care and that the VAMC follows hospice care guidelines to ensure all family members have adequate privacy for initial bereavement. The VISN and VAMC Directors concurred with our findings and recommendations and provided acceptable action plans. OIG will follow up until the planned actions are completed.

Allegations of Clinical and Administrative Issues Not Substantiated at Pineville, Louisiana, VAMC

OIG performed an inspection at the Alexandria VAMC, Pineville, LA, to determine the validity of allegations regarding clinical and administrative issues in the Suicide Prevention Program. The complainant alleged that there were more than 600 patients on the "high risk for suicide" list who were not being monitored as required; that confidentiality and privacy were being breached in several program areas; and that Social Work Service leaders were not providing adequate oversight of programs, were not responsive to complaints, and were not appropriately addressing peer review findings. OIG found that at one point, there

were over 400 patients on the "high risk for suicide" list; however, this condition no longer existed at the time of OIG's site visit and OIG found that the revised monitoring system meets VHA requirements. OIG did not substantiate breaches in confidentiality or privacy, lack of management oversight, or inadequate follow-up of peer reviews findings. OIG made no recommendations.

Deficiencies Noted in Prescribing Practices at Tyler, Texas, VA Primary Care Clinic

OIG's OHI conducted an evaluation to determine the validity of allegations regarding inadequate medical and MH care for a patient at the Tyler VA Primary Care Clinic in Tyler, TX. The complainant further alleged that the patient had dementia and facility providers disregarded her concerns. OIG substantiated the allegation that facility providers improperly prescribed opioids and alprazolam to the patient. Specifically, the following deficiencies were identified in prescribing practices: (1) inconsistent documentation of pain assessments, (2) absence of a written opioid treatment agreement or urine drug tests, (3) no consideration of nonpharmalogical approaches for pain management, and (4) absence of evaluations of opioid therapy effectiveness. However, OIG could neither substantiate nor refute the allegation that prescribing practices contributed to his overdose and death. OIG found no evidence to support the allegation that the patient had dementia or otherwise lacked decision-making capacity. OIG recommended that the System Director ensures that providers document pain assessments for patients on opioid therapy and monitor and evaluate these patients in accordance with VHA policies.

OIG Substantiates Poor Management of Patient Abuse Cases at the Charlie Norwood VAMC, Augusta, Georgia

OIG conducted an inspection to determine the validity of allegations that two patient abuse cases were not managed properly, and as a result, patients were placed at risk at the Charlie Norwood VAMC, Augusta, GA. OIG substantiated that some staff members and managers did not comply with policies for reporting patient abuse or evaluating victims and events, and that some managers did not take appropriate or timely administrative action. OIG found no evidence, however, that patients were actually harmed by these procedural breaches. OIG substantiated that a senior executive acted improperly in the administrative action involving substantiated patient abuse and that responsible managers did not report a nurse to the State Licensing Board as required. VISN and Medical Center Directors concurred with OIG's recommendations and provided acceptable action plans.

Allegation of Surgeon Privileging and Resident Supervision Issues Substantiated at the W.G. (Bill) Hefner VAMC, Salisbury, North Carolina

OIG conducted an inspection to determine the validity of allegations of surgeon privileging and resident supervision issues at the W. G. (Bill) Hefner VAMC in Salisbury, NC. OIG substantiated the allegation that some surgeons performed certain operative procedures without the appropriate corresponding privileges; however, OIG did not find evidence that poor surgical outcomes resulted. OIG substantiated the allegation that residents in Surgical Service were not supervised as required by VHA policy, and that there was no surgeon on site 2 days per week while residents were seeing patients in the clinic. OIG found that resident-authored progress notes were not consistently co-signed by a supervising surgeon in the timeframe verbalized as acceptable by clinical leadership. OIG also found that interval notes documenting patients' current condition and need for surgery were not consistently entered into the medical record by the attending surgeon. The VISN and VAMC Directors concurred with OIG's findings and recommendations and provided acceptable action plans.

Allegations of Poor Quality of Care Substantiated at the VA Nebraska-Western Iowa HCS, Omaha, Nebraska and VA Central Iowa HCS, Des Moines, Iowa

OIG conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient at both the Omaha, NE and Des Moines, IA, HCSs. The complainant alleged that while at the Omaha HCS, a patient suffered a stroke that was unnoticed by staff, did not receive assistance with activities of daily living (ADLs), did not receive rehabilitative therapy, did not receive a pulmonary treatment, did not receive pain medication timely, and had a delay in receiving medication by mail. The complainant also alleged that while at the Des Moines HCS, the patient did not receive assistance with his ADLs, speech therapy, and discharge planning. OIG substantiated that the patient did not receive one pulmonary treatment, medication by mail timely, and was not reassessed for pain medication effectiveness. OIG recommended the Omaha HCS Director ensure clinicians review the delay in medication by mail and ensure pain assessments and reassessments are done according to policy.

Allegations of Poor Quality of Care Substantiated at the Corpus Christi CBOC, Harlingen, Texas

OIG evaluated the validity of allegations regarding quality of care at the Corpus Christi CBOC in Corpus Christi, TX. OIG substantiated the allegation that a CBOC primary care provider did not diagnose a patient's fractured ankle when the patient presented for evaluation. The facility had taken appropriate action prior to the review. OIG substantiated that a CBOC primary care provider prescribed antibiotics without first obtaining wound cultures. OIG identified two factors that affected this patient's care: failure to implement the facility's Skin Integrity Management Program Policy for managing the skin integrity of outpatients and fee-basis records not always being available in the medical record. The facility identified opportunities for improvement prior to OIG's review, which were found to be acceptable. OIG recommended that the VAMC Director ensure that the CBOC follow the Skin Integrity Management Program Policy.

Diagnosis of Pulmonary Embolism Not Adequately Pursued at the Oklahoma City, Oklahoma, VAMC

OIG conducted a review to determine the validity of allegations of misdiagnosis by providers at the VAMC in Oklahoma City, OK. The complainant alleged that a patient was given a diagnosis of communicable pneumonia, placed in a room with four other patients in the facility's emergency room (ER), and then incorrectly given a diagnosis of lung cancer. When the patient left the facility and went to a community hospital, the patient was found to have acute pulmonary embolism. OIG did not substantiate that the patient was placed in a room with four other patients or that the patient was given a diagnosis of lung cancer. OIG found that providers did not adequately pursue a possible diagnosis of pulmonary embolism at initial presentation or upon admission to the facility. OIG recommended that the VAMC Director obtain a peer review assessment of the care provided to this patient during both presentations to the ER and subsequent admission. The VISN and VAMC Directors concurred with OIG's findings. OIG will follow up until the planned actions are completed.

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

OIG conducted an inspection to determine the validity of multiple allegations regarding the quality of care in the MH and two medical specialty clinics at the Captain James A. Lovell Federal Health Care Center, Chicago, IL. The complainant alleged that a patient did not have drug screens completed prior to being prescribed narcotics and that the patient's death was not properly reported and investigated. OIG substantiated the allegation that urine drug screens were not performed. OIG found that the case was properly reported and investigated; however, the peer reviewer of the case was not certified in pain

management. OIG did not substantiate the other allegations related to MH providers issuing narcotics outside the narcotic agreement, the contract physician self-referring, the physician in a specialty clinic taking multiple weeks of annual leave, or that managers were aware that multiple patients did not receive care during that time. OIG recommended that the Center Director ensure that patients with narcotic agreements are appropriately monitored for compliance with prescription medications and a physician certified in pain management review this case.

OIG Finds Bedsores Not Caused by Neglect or Abuse at Fresno, California, VAHCS

OIG evaluated the validity of an allegation regarding patient neglect and abuse at the VA Central California HCS, Fresno, CA. The complainant alleged that a patient developed bedsores (pressure ulcers) due to neglect and abuse while an inpatient on the HCS's medical units and as a resident in the community living center. OIG did not substantiate the allegation. OIG found that the patient developed pressure ulcers while being treated by the HCS as well as subsequent pressure ulcers that developed when not an inpatient. OIG concluded that these were not the result of neglect or abuse but more likely the result of his debilitated catabolic state, and the insertion of a Foley catheter used in the treatment of life-threatening urosepsis. OIG determined that the patient was assessed for skin breakdown and pressure ulcer interventions were initiated by the system in a timely manner. OIG made no recommendations.

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

No Significant Differences in Delivery of Health Care, Disability Benefits Found Between Veterans Residing in U.S. Virgin Islands and Puerto Rico

At the request of Congresswoman Donna Christensen, U.S. Virgin Islands (USVI) Delegate to Congress, OIG evaluated whether Veterans residing in the USVI receive disparate health care services and benefits compared to Veterans living in Puerto Rico. OIG partially substantiated that USVI Veterans do not have access to the same level of health care services as Puerto Rico Veterans; however, because of liberal use of fee basis authorization for local care, USVI Veterans' care is not limited or less than that of Puerto Rico Veterans. Although English-speaking USVI Veterans could face language barriers with non-direct patient care staff at the San Juan, PR, VAMC, these barriers did not negatively affect patient care. OIG found no evidence that the VBA processed claims differently based on a Veterans' residency, and that applications from USVI Veterans were processed on average 4 days sooner than Veterans from Puerto Rico. OIG made seven recommendations to address health care services and benefits.

Veterans Health Administration Audits and Reviews

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 Questions Use of $273 Million in Rural Health Care Program

OIG audited the VHA's Office of Rural Health (ORH) to determine if it effectively planned and managed $533 million allocated during FYs 2009 and 2010 to improve access and quality of care for Veterans residing in rural areas. The audit concluded that ORH lacks reasonable assurance that its expenditure of $273.3 million in funding received actually improved access and quality of care for Veterans residing in rural areas. This occurred because of program weaknesses such as a lack of financial controls, the absence of policies and procedures to ensure staff followed management directives, inadequate communication with key stakeholders, an ineffective project monitoring system, the absence of procedures to monitor performance measures, and an inadequate process to assess rural health needs. OIG recommended that VHA take steps to strengthen the management of rural health care funding in order to improve accountability of funds entrusted to ORH and measure the impact of their program on the health care of rural Veterans and their families.

VHA Could Reduce Workers' Compensation Costs by $264 Million Over 5 Years

OIG conducted an audit to determine whether VHA has effectively managed Workers' Compensation Program (WCP) claims to reduce VA's overall WCP costs. VHA has nearly doubled its timeliness in initiating WCP claims since 2001. However, evidence was sometimes lacking and VHA had not consistently updated files or made job offers to employees who could work. Fraud detection was lacking due to competing priorities. OIG projected VHA could reduce costs by $264 million over 5 years. Additionally, converting claimants 65 years of age or older to more appropriate benefit programs could reduce VHA's costs about $463.9 million over 5 years; legislation has been proposed to address this issue. OIG recommended the Under Secretary for Health provide adequate staff, clear oversight, standard guidance, and fraud detection procedures to improve WCP case management. OIG recommended the Assistant Secretary for Human Resources and Administration (HRA) propose legislation to move retirement age individuals to appropriate retirement programs. The Assistant Secretary for HRA plans to develop a letter of support for the proposed legislation to provide to the Department of Labor (DOL).

Improved Third-Party Billings Could Increase VHA Revenue by $552 Million

OIG conducted an audit to determine the extent to which VHA's Medical Care Collection Fund (MCCF) Program bills third-party health insurers for non-VA care. OIG found VHA missed opportunities to increase MCCF revenue by not billing third-party insurers for 46 percent of billable fee care claims. This occurred because VHA does not have an effective process to identify billable fee claims and lacks a system of controls to maximize the generation of MCCF fee care revenue. OIG estimates that with an improved process and system of controls, VHA could increase third-party revenue by $110.4 million annually or by as much as $552 million over the next 5 years. OIG issued four recommendations to correct the findings.

Accuracy in Part-time Physicians' Time and Attendance Improves, But Better Controls Still Needed

OIG conducted a follow-up audit to assess the effectiveness of implementation actions from two prior OIG audits that identified weaknesses in VHA's management controls over part-time physicians' time and attendance. Implementation of prior recommendations has reduced the number of days part-time physicians might not be meeting their employment obligations. OIG noted a decrease in the percentage of days with no evidence of VA activity from 33 percent in 2003 to 11 percent in 2010. Also, only 3 percent of

part-time physicians were not on duty as required—a drop from prior audits, which reported 11 and 8 percent, respectively. OIG found VHA abolished written physician service agreements and other controls were not implemented, such as monitoring the type of time logged, validating attendance according to current procedures, and timely and accurately recording actual hours. OIG recommended VHA reinstitute written agreements for all part-time physicians, require management establish oversight on time and attendance, and clarify standard operating procedures for time and attendance monitors. VHA agreed with OIG's findings and recommendations.

Beneficiary Travel at Increased Risk for Improper Payments at Cincinnati, Ohio, VAMC

OIG reviewed the validity of allegations of mismanagement and fraud at the Cincinnati, OH, VAMC Beneficiary Travel Office (BTO). The Beneficiary Travel program provides reimbursements to offset travel costs associated with obtaining VA health care services. OIG partially or fully validated four of nine allegations, and identified processing inconsistencies in the BTO. BTO staff approved some travel reimbursement claims for uncompleted medical appointments, and approved travel vouchers associated with patient-cancelled and no show appointments that staff preprinted prior to the beneficiaries' appointments. OIG also identified one occurrence where a beneficiary was inappropriately approved travel reimbursement to the Cincinnati VAMC, and determined a former supervisor improperly authorized wheelchair van services under an expired contract. The Cincinnati VAMC Director concurred with all recommendations.

Chicago VAMC Moves Homeless Female Veterans After OIG Reports Safety, Security, and Privacy Issues

OIG advised VHA of serious safety, security, and privacy issues affecting female Veterans in a homeless facility identified during ongoing audit work that required immediate management attention. The OIG site visit to the Jesse Brown VAMC, Chicago, IL, revealed that since 2002, the VAMC's Grant and Per Diem (GPD) program staff has placed 22 homeless female Veterans, some with a history of sexual trauma and domestic violence, in a male-only facility without adequately addressing the safety, security, and privacy needs of female Veterans, needlessly exposing homeless female Veterans to safety, security, and privacy risks. After OIG discussed this issue with senior VAMC officials, they arranged for the immediate move of the women to a non-VA funded facility that provided services to homeless females. OIG recommended the GPD staff better understand the contents and requirements of the grant proposals, review policies and procedures, and make program changes as needed. OIG also recommended an inventory of all active homeless grant programs, and remove females from male-only or other inappropriate facilities, then prevent future placement of female Veterans in these facilities.

Veterans Benefits Administration Audits

VBA Claims Brokering Process Not Effective at Improving Timeliness, Accuracy of Claims

OIG evaluated the effectiveness of VBA claims brokering. To help address VBA's major challenge of processing the increased number of Veterans' compensation benefit claims, VBA has increased claims brokering from Veterans Service Centers (VSCs) to resource centers or other VSCs to better align workload with staffing resources. OIG found VBA can improve the effectiveness of claims brokering by ensuring area offices consider additional factors affecting timeliness and accuracy. For nearly 171,000 brokered claims completed during FY 2009, OIG projected the average processing time of 201 days would have been 49 days less if VBA had avoided the claims processing delays identified in this report. Of nearly 117,000 claims VBA brokered for ratings, OIG projected area offices brokered about

54,000 (46.2 percent) to facilities with lower rating accuracy rates than original VSCs. In addition, staff at three of seven VA Regional Offices (VAROs) OIG visited brokered claims without area office approval. Increased effectiveness will reduce the risks of claims-processing inaccuracies. OIG recommended the VBA revise brokering policies and procedures to help improve claims-processing timeliness and accuracy, include brokered claims-processing timeliness and accuracy performance measurements in director performance plans, and evaluate VSC compliance with revised brokering policies and procedures.

Veterans Benefits Administration Benefits Inspections

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

The Benefits Inspection Divisions issued 14 reports during the period April 1 through September 30, 2011. Key results our inspections are as follows:

- Claims processing: 29 percent of benefit claims we reviewed requiring a rating decision were processed in error. These errors involved claims related to PTSD, traumatic brain injury, herbicide exposure-related disabilities, and temporary 100 percent evaluations.

- Veterans Appeals and Record Locator System (VACOLS) compliance: 30 percent of Notice of Disagreements were not timely controlled for workload management in VACOLS.

On June 2, 2011, the Assistant Inspector General (AIG) for Audits and Evaluations provided testimony before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives on issues related to under-performing VAROs. Our inspections of 16 VAROs from April 2009 through September 2010 discussed multiple challenges that management teams face in providing timely and accurate disability benefits and services to Veterans, including:

- Systematic Analyses of Operations (SAOs): VARO staff did not timely and accurately complete 30 percent of SAOs. The inadequate SAOs represent missed opportunities for VAROs to identify existing or potential problems and propose corrective actions.

- Mail Handling Procedures: 24 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 34 percent of incompetency determinations reviewed at 10 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 Audits and Reviews

VA at Risk of Awarding $2.5 Billion to Ineligible Businesses over Next 5 Years

OIG audited VA's Veteran-Owned Small Business and Service-Disabled Veteran-Owned Small Business (VOSB and SDVOSB) programs to assess whether businesses met program and contract eligibility requirements and VA provided effective management oversight. OIG found that VA awards ineligible businesses at least 1,400 VOSB and SDVOSB contracts valued at $500 million, annually. Moreover, VA will award $2.5 billion to ineligible businesses over the next 5 years if it does not strengthen contracting officer oversight and business verification procedures. Seventy-six percent of the reviewed businesses were ineligible to participate in the programs or to receive the contracts, which totaled $46.5 million in awards, including $26.7 million in *American Recovery and Reinvestment Act of 2009* (ARRA) contracts. VA's FY 2010 socioeconomic goal accomplishment data may also be overstated by 3 to 17 percent due to awards made to ineligible businesses. OIG recommended VA implement comprehensive program controls to ensure awards are not made to ineligible businesses and improve adherence to Federal and VA regulations. The Under Secretary for Health, the Office of Small and Disadvantaged Business Utilization, and the Office of Acquisition, Logistics, and Construction agreed with OIG's findings.

More Work Needed To Fully Execute Information Technology Project Management Accountability System

At the request of the Chief Information Officer (CIO), OIG evaluated the effectiveness of Project Management Accountability System (PMAS) planning and implementation. VA has a history of problems managing its information technology (IT) development projects. VA launched PMAS in 2009 to improve its IT development success rate. OIG found the Office of Information and Technology (OIT) has made progress establishing PMAS. It published a PMAS Guide, developed a prototype system for monitoring project status, and used the oversight approach to better meet incremental deliverable due dates for all active IT development projects. However, OIT created and instituted the PMAS concept without a roadmap, adequate leadership, and staffing to effectively implement and manage this new methodology. OIG made six recommendations that the CIO agreed to implement.

Audit Leads to Quick Action to Correct Deficiencies in Verifying Personal Identity for Government Identification Cards

An audit was conducted by OIG to assess whether VA's Enrollment Centers met Homeland Security Presidential Directive 12 and other Government-wide requirements when providing Personal Identity Verification (PIV) credentials. OIG found significant control lapses and missing procedures that compromised the integrity of the credentialing process. VA's PIV credentialing operation was never evaluated and certified to Government standards. VA may have issued thousands of PIV credentials without determining whether applicants are known or suspected terrorists; the authenticity of applicants' documents were not verified; some applicant background investigations were uninitiated or results were incomplete; and staff compromised system integrity by disregarding separation of duties. OIG recommended the Enrollment Centers stop issuing PIV credentials until control deficiencies in the credentialing process are addressed, and VA assesses and accredits the existing processes to meet Government-wide requirements. The Assistant Secretary for Operations, Security, and Preparedness concurred with OIG's findings and recommendations and took immediate actions to mitigate risk associated with the program.

Misinterpretation of Reporting Guidance Results in Unreported Overpayments

As required by Executive Order 13520 on reducing improper payments, OIG reviewed VA's FY 2010 First Quarter High-Dollar Overpayments Report to determine if it was complete and the process to identify susceptible programs was adequate. OIG found that the report was incomplete primarily because VBA misinterpreted guidance and did not report 143 high-dollar overpayments totaling $623,434. VBA also did not adequately consider including an additional 39,208 potential high-dollar overpayments totaling $213 million. VBA made adjustments after the first quarter to improve compliance, but VBA's process still did not fully follow guidance for identifying the high-dollar overpayments. OIG also found VHA's FY 2009 risk assessment did not adequately assess the level of risk associated with their programs. OIG recommended the Under Secretary for Benefits report prior period overpayments and administrative errors as required; and the Under Secretary for Health implement planned improvements to risk assessments.

National Contract Oversight Processes Need Improvement at VA's National Acquisition Center

Systemic weaknesses in VA's procurement activities represent a major management challenge for VA. OIG focused on National Acquisition Center (NAC) operations, the largest combined contracting activity in VA. OIG found general contract development and award actions were in accordance with Federal and VA Acquisition Regulations. However, NAC management did not ensure staff fully utilized VA's mandatory Electronic Contract Management System (eCMS) to develop and award national contracts. Limited oversight and compliance monitoring of eCMS resulted in an impaired and diminished visibility of procurement actions, which in turn may have lead to significant delays in the contract awards and inadequate controls to ensure timeliness. VA agreed with OIG's findings and recommendations and plans to complete all corrective actions by September 30, 2012.

OIG Finds Contractors Failed to Comply with VA Information Security Policies

OIG substantiated allegations that a contractor did not comply with VA information security policies for accessing mission critical systems and networks. Specifically, contractor personnel improperly shared user accounts when accessing VA networks and systems; did not readily initiate actions to terminate accounts of separated employees; and did not obtain appropriate security clearances or complete security training for access to VA systems and networks. In addition, VA has not implemented oversight to ensure the contractor complies with VA information security policies and procedures, making sensitive data at risk of inappropriate disclosure or misuse. VA agreed with OIG's findings and recommendations.

VA's Compliance with *Federal Information Security Management Act* Evaluated

OIG contracted with the independent accounting firms Ernst & Young and Clifton Gunderson LLP to perform the FY 2010 *Federal Information Security and Management Act* (FISMA) assessment. The results of this annual review of the agency's information security program are reported to the Office of Management and Budget (OMB). OMB uses this data to assist in its oversight responsibilities and to prepare an annual report to Congress on agency compliance with FISMA. VA has made progress developing policies and procedures, but still faces challenges implementing components of its agency-wide information security program to meet FISMA requirements. The report provides a total of 34 recommendations for improving VA's information security program, including recommendations still open from prior years' assessments.

Veterans Health Administration Investigations

The OIG OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of Veterans. In the area of health care delivery, OIG opened 198 cases, made 165 arrests, and obtained $16,517,458 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, OIG opened 58 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Eighty-one defendants were charged with various crimes relating to drug diversion. OIG also initiated 23 investigations regarding fraudulent receipt of health benefits. Fourteen 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 $1,761,057. The following entries provide a representative sample of the type of VHA investigations conducted during this reporting period.

Substance Abuse Counselor at Bedford, Massachusetts, VAMC, Arrested for Selling Cocaine to Patients

A Bedford, MA, VAMC employee, who supervised Veterans undergoing substance abuse treatment at the VAMC, was arrested for selling cocaine to the patients he was responsible for supervising. An OIG, VA Police Service, and Drug Enforcement Administration (DEA) investigation revealed that the employee sold cocaine to a cooperating witness on three separate occasions while on VA property.

Multiple Arrests Made in Major Palm Beach, Florida, Drug Distribution Investigation

A 7-month OIG and Palm Beach County, FL, multi-agency diversion task force undercover investigation resulted in the arrests of 7 VA employees, 3 Veterans, and 10 associates for numerous felony drug charges. This operation focused on combating the sale and distribution of illicit and controlled pharmaceutical drugs at the West Palm Beach, FL, VAMC and the surrounding community. The investigation resulted in the recovery of 6,000 oxycodone pills and $180,920.

Bay Pines, Florida, VAMC Nurse Arrested for Drug Diversion

A Bay Pines, FL, VAMC nurse was arrested after being charged in a criminal information with a scheme to defraud VA. An OIG investigation determined that the defendant diverted hydromorphone and Demerol on approximately 80 occasions.

Former Augusta, Georgia, VAMC Nurse Who Diverted Drugs Enters into Pretrial Diversion Agreement

A former Augusta, GA, VAMC registered nurse entered into a 12-month agreement for pretrial diversion for obtaining controlled substances by deception. An OIG and VA Police investigation revealed that, from August 2009 to June 2010, the defendant stole VA narcotics from a medical center Pyxsis machine. The defendant admitted to diverting approximately 2–3 hydrocodone and/or oxycodone pills per shift for personal use.

Roseburg, Oregon, VAMC Pharmacy Technician Arrested for Theft

A Roseburg, OR, VAMC pharmacy technician was arrested for theft of Government property after an OIG and DEA investigation revealed that the technician diverted more than 6,000 tablets of Oxycotin, oxycodone, Vicodin, and clonazepam from the pharmacy. For at least 18 months, the defendant created

and posted false drug orders in the VistA database claiming that the narcotics were being dispensed from the VA pharmacy inventory as "refills" to the Accudose machines located throughout the facility. The loss to VA is approximately $26,000.

Former Salem, Virginia, VAMC Nurse Pleads Guilty to Obtaining Drugs by Fraud

A former Salem, VA, VAMC registered nurse pled guilty to obtaining drugs by fraud. An OIG investigation revealed that the nurse engaged in a variety of schemes to divert over 7,000 micrograms of fentanyl from OmniCell machines. The defendant admitted to using the stolen narcotics while working at the VAMC.

Former Prescott, Arizona, VAMC Registered Nurse Indicted for Obtaining Controlled Substances by Deception

A former Prescott, AZ, VAMC registered nurse was indicted for obtaining controlled substances by deception. An OIG investigation revealed that the defendant was removing hydromorphone and morphine at a rate of five times the average of any other full-time nurse. The defendant admitted that between August 2009 and January 2010 she stole drugs and injected herself while on duty.

Former Portland, Oregon, VAMC Medical Technician Sentenced for Identity Theft

A former Portland, OR, VAMC medical technician was sentenced to 4 days in jail and ordered to perform 160 hours' community service after pleading guilty to identity theft. An OIG and VA Police Service investigation revealed that the defendant diverted controlled substances from a VA computerized medication dispensing machine by using patient identities. The defendant self-administered the drugs and then returned to duty monitoring patients undergoing cardiac catheter procedures.

Three Arrested for Stealing Patient Information in Order to Obtain Narcotics

Three individuals were arrested for attempting to obtain a controlled substance by fraud. In addition, one of the defendants pled guilty and was sentenced to 12 months in a drug treatment program. An OIG, VA Police Service, and local police investigation revealed that the defendants conspired with an employee of the American Lake Division of the VA Puget Sound HCS in Tacoma, WA, to steal patient information in order to obtain narcotics, to include oxycodone. As part of the scheme, the VA employee and the other defendants obtained veteran information from VA patient records and from a local Veterans of Foreign Wars facility. The VA employee then used the veteran information on fraudulent VA prescriptions sent to local pharmacies. The employee previously pled guilty to her part of the scheme and resigned from VA employment.

Former Great Lakes Consolidated Mail Outpatient Pharmacy Employee Pleads Guilty to Stealing Viagra

A former employee of the Great Lakes Consolidated Mail Outpatient Pharmacy located in Hines, IL, pled guilty to theft after an OIG and Food and Drug Administration (FDA) Office of Criminal Investigation investigation determined that he stole numerous vials of Viagra. The loss to VA is $53,004.

Postmaster Pleads Guilty to Theft of VA Drugs

A U.S. Postal Service (USPS) postmaster pled guilty to mail theft after an OIG and USPS OIG investigation determined that, between March 2009 and December 2010, he diverted approximately 19 shipments of VA prescribed narcotics that were mailed to Veterans residing in the eastern Washington State area.

Veteran Arrested for Drug Possession

A Veteran was arrested for possession and delivery of a controlled substance after an OIG, Federal Bureau of Investigation (FBI), and local police investigation revealed that he sold controlled pharmaceuticals to an undercover OIG agent on three separate occasions.

Veteran and Girlfriend Sentenced for Drug Distribution

A Veteran was sentenced to 12 months' incarceration and 3 years' supervised release, while his girlfriend was sentenced to 8 months' incarceration and 3 years' supervised release. The sentences are the result of an OIG investigation that revealed the pair sold the Veteran's VA-prescribed hydrocodone tablets to relatives and associates.

Veteran Arrested for "Doctor Shopping" to Obtain Oxycodone

A Veteran, who is also a local sheriff's deputy, was arrested for withholding information from a practitioner and prescription fraud. An OIG and local task force investigation revealed that the defendant simultaneously acquired oxycodone and other scheduled drugs from VA and multiple non-VA providers. The defendant violated her pain management contract with VA by not informing VA that she received oxycodone from non-VA providers.

Former Bay Pines, Florida, VAMC Nurse Arrested for Sexual Battery

A former VA-licensed practical nurse was arrested for sexual battery against an inpatient at the Bay Pines, FL, VAMC. An OIG and VA Police Service investigation determined that the defendant sexually assaulted at least two male inpatients at the VAMC.

Columbia, South Carolina, VAMC Nurse's Aide Indicted for Sexual Assault

A Columbia, SC, VAMC nurse's aide was indicted for criminal sexual conduct, sexual battery of a physically helpless adult, and false statements. The employee gave a sworn statement denying the charges, but following an OIG polygraph exam, he confessed to sexually assaulting the patient. The Veteran patient was an amputee and a resident of the VAMC's nursing home.

Former West Los Angeles, California, VAMC Pharmacist Sentenced for Theft

A former West Los Angeles, CA, VAMC pharmacist was sentenced to 6 months' home confinement, 3 years' probation, a $3,000 fine, and ordered to surrender her license after pleading guilty to interstate transportation of stolen property. The defendant had previously resigned from VA and paid $180,000 in restitution. A multi-agency investigation revealed that for approximately 5 years the defendant stole more than 11,000 boxes of test strips from the VA pharmacy and then sold them to another defendant involved in the sale of stolen medical supplies.

Jackson, Mississippi, VAMC Employees Indicted for Stealing VA Property

Four VA employees, to include three facility maintenance workers and one VA supervisory police officer, were indicted for grand larceny. An OIG investigation disclosed that for over 18 months the defendants stole VA property from the Jackson, MS, VAMC. These items included flat panel televisions, commercial cleaning supplies, commercial cleaning equipment, computer equipment, and other miscellaneous property. Over 100 stolen items were recovered during the execution of numerous search warrants. The VA Police Service officer has been accused of using his position to facilitate the thefts and receiving some of the stolen property.

Palo Alto, California, HCS Employees and Construction Company Owner Arrested for Bribery

A VA contracting officer, two VA engineers with the VA Palo Alto, CA, HCS, and the owner of a construction company were indicted for bribery and other offenses. An investigation by OIG and FBI revealed that the VA employees accepted bribes from the construction company owner in exchange for influencing the awarding of a large percentage of the minor construction and nonrecurring maintenance contracts at the VAHCS. The construction company owner provided bribes to the other three defendants in the form of cash, airline tickets, vehicles, payment of personal debts, and other gifts totaling at least $140,000.

Buffalo, New York, VAMC Employee Pleads Guilty to Bribery

A Buffalo, NY, VAMC employee pled guilty to bribery after an OIG investigation revealed that, from approximately 1992 to 2008, he received gift certificates, gift cards, and cash totaling $46,075 from a vendor's sales agents in exchange for making purchases from that vendor.

Former Durham, North Carolina, VAMC Employee Arrested for Purchase Card Fraud

A former Durham, NC, VAMC employee was arrested on fraud charges after an OIG investigation revealed that she purchased $7,200 worth of home furnishings using her VA purchase card. All of the purchased items were discovered during a search of the defendant's home. The defendant's VA employment was terminated following a pattern of misconduct.

Former Long Beach, California, VAMC Nurse Arrested on Identity Theft Charges

A former Long Beach, CA, VAMC nurse was arrested after an OIG and local police investigation revealed that she stole the personal identifying information of 45 patients and used it to commit identity theft by making purchases using their identities.

Former West Los Angeles, California, VAMC Chief Financial Officer Indicted for Possession of Child Pornography

A former West Los Angeles, CA, VAMC Chief Financial Officer was indicted for possession of child pornography. During an OIG and Internet Crimes Against Children Task Force investigation, numerous DVDs, CDs, and a computer hard drive containing images of child pornography were found in the defendant's residence, which was located on VA property.

Former Leavenworth, Kansas, VAMC Canteen Employee Pleads Guilty to Theft

A former Leavenworth, KS, VAMC canteen employee pled guilty to theft of Government funds after an OIG and DOL OIG investigation revealed that between 2003 and 2008 the defendant concealed approximately $577,000 in earnings from VA and DOL while managing a subcontracting business and receiving workers' compensation benefits. The defendant also stole, forged, and negotiated approximately $27,000 in Office of Workers' Compensation benefit checks intended for her deceased brother, a former USPS employee and service-connected Veteran. The loss to VA is approximately $175,000.

Former Chicago, Illinois, VAMC Employee Sentenced for Personal Use of Government Purchase Card

A former Chicago, IL, VAMC employee was sentenced to 2 years' probation and ordered to perform 500 hours' community service after pleading guilty to theft. The defendant was also ordered to surrender her $9,000 bond to VA as restitution. An OIG investigation determined that the defendant used her Government purchase card to pay for $23,769 in personal expenses.

Former Dallas, Texas, VAMC Employee Arrested for Fraudulent Overtime Claims

A former Dallas, TX, VAMC employee was arrested for theft of Government funds after admitting that he submitted fraudulent overtime forms. An OIG and VA Police Service investigation revealed that the defendant had submitted $103,585 in fraudulent overtime claims between February 2007 and March 2010.

Former Agent Cashier at the Fayetteville, Arkansas, VAMC Indicted for Theft

The former agent cashier at the Fayetteville, AR, VAMC was indicted for theft of Government property. An OIG and U.S. Secret Service investigation revealed that the defendant failed to make nine deposits to the Federal Reserve Bank and stole cash from other deposits between January and June 2010. The defendant was interviewed and admitted to the theft. The loss to VA is $32,000.

Phoenix, Arizona, Nursing Home Owner Arrested for Vulnerable Adult Abuse

A Phoenix, AZ, nursing home owner was arrested for vulnerable adult abuse and forgery. An OIG and local law enforcement investigation determined that the defendant, who is also a nurse at the Phoenix, AZ, VAMC, provided inadequate care and treatment to Veterans placed under her care by VA at three assisted living facilities she owned and operated. The State of Arizona shut down her facilities and condemned the buildings. The Veterans were returned to the VAMC or placed in other facilities. The defendant forged CPR certifications for her unqualified staff by forging the name of a VAMC CPR trainer.

Former VA Police Service Officer Sentenced for False Statements

A former VA Police Service officer was sentenced to 14 months' incarceration after being convicted of false statements. An OIG investigation revealed that the former officer made numerous false statements on various VA applications for employment, as well as his Office of Personnel Management (OPM) Questionnaire for Public Trust Positions. The investigation also revealed that the former officer served 32 months in a military prison related to charges of false statements that he made while in the U.S. Army. Additional weapon possession charges are pending.

Veteran Pleads Guilty to Reckless Homicide at Brecksville, Ohio, VAMC

A Veteran pled guilty to reckless homicide after his altercation at the Brecksville, OH, VAMC resulted in the death of another Veteran. An OIG and VA Police Service investigation that included numerous witness interviews, the defendant's own statement, and autopsy results revealed that the victim died from subdural hematomas caused by blunt force trauma to his head.

Veteran Indicted for Arson at Chicago, Illinois, VAMC

A Veteran was indicted for aggravated arson after setting fire to his room at the Chicago, IL, VAMC. The fire caused damage to the room and extensive smoke and water damage throughout the ward. The investigation further revealed that the defendant tampered with the ceiling-mounted fire suppression sprinkler heads, causing them to malfunction during the fire.

Subject Arrested for Robbery of Veteran at Fayetteville, North Carolina, VAMC

A subject was arrested for robbery after an OIG and local law enforcement investigation revealed that he assaulted and robbed a Veteran on the grounds of the Fayetteville, NC, VAMC. The Veteran sustained a broken nose and several lacerations and contusions to his face. The defendant has an extensive criminal record to include assault with a deadly weapon with intent to kill and narcotic-related offenses.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 16 months' incarceration and ordered to pay restitution to VA after pleading no contest to felony identity theft. An OIG investigation determined that the defendant, who was not a Veteran, stole the identity of his cousin and obtained over $98,274 in VA medical services.

Veteran's Brother Indicted for Health Care Fraud

The brother of a Veteran was indicted for health care fraud and false statements after an OIG investigation determined that he used his brother's identity to fraudulently receive health care from the Denver, CO, VAMC. The loss to VA is $148,123.

Veteran Sentenced After Pleading Guilty to Theft of Health Care Benefits in Connection with "Stolen Valor" Fraud

A Veteran was sentenced to 6 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $143,606 after pleading guilty to theft of Government property and making a false statement. An OIG investigation revealed that the defendant submitted fraudulent military discharge documents to the Bay Pines, FL, VAMC that resulted in the defendant receiving VA health care benefits he was not entitled to receive.

Veterans Indicted for Travel Benefit Fraud from Oklahoma City, Oklahoma, VAMC

A Veteran was indicted for theft of Government funds after an OIG and VA Police Service investigation revealed that from December 2008 to July 2010, the Veteran filed approximately 313 fraudulent travel benefit claims. The defendant claimed to reside at a Kansas residence that was 165 miles from the Oklahoma City, OK, VAMC, when in fact he resided a few miles away from the VAMC. The loss to VA is $36,175. A second Veteran was indicted for theft of Government funds after an OIG and VA Police Service investigation revealed that for approximately 1 year the Veteran filed approximately 175 fraudulent travel benefit claims. The defendant claimed his residence was 117 miles away from the Oklahoma City, OK, VAMC, when in fact he resided a few miles away from the VAMC. The loss to VA is $16,560.

Veteran Pleads Guilty to Committing Travel Benefits Fraud Against Gainesville, Florida, VAMC

A Veteran pled guilty to theft of Government funds after an OIG investigation determined that the Veteran filed 227 fraudulent travel claims at the Gainesville, FL, VAMC. The defendant claimed that he was traveling 300 miles roundtrip when in reality he was living 33 miles away. The loss to VA is approximately $28,650.

Veteran Sentenced to Incarceration for Travel Fraud

A Veteran was sentenced to 6 months' incarceration, 3 years' supervised release, and ordered to pay $20,464 in restitution after pleading guilty to making a false claim. An OIG investigation determined that for approximately 1 year the defendant filed 202 false travel vouchers at the Spokane, WA, VAMC, claiming that he commuted 182 miles during each visit. The Veteran actually resided less than 2 miles from the medical center.

Veteran Pleads Guilty to Firearms Possession

A Veteran pled guilty to a felony charge of possession of firearms in a Federal facility after an OIG, VA Police, and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation revealed that he brought a duffel bag into the Cleveland, OH, VAMC containing three loaded handguns, a fully loaded automatic assault rifle, and two hunting knives.

Veterans Benefits Administration Investigations

VBA administers a number of financial benefits programs for eligible Veterans and certain family members, including VA guaranteed home loans, education, insurance, and monetary benefits. Investigations routinely concentrate on payments made to ineligible individuals. For example, a beneficiary may deliberately feign a medical disability to defraud the VA compensation program. OIG conducts 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.

An ongoing proactive Death Match project is being conducted by the VA OIG Information Technology and Data Analysis Division in coordination with the Office of Investigations. This work is designed to identify individuals who may be defrauding VA by receiving VA benefits intended for Veterans or beneficiaries who have passed away. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. Since the inception of the Death Match project in 2000, OIG has identified 16,212 possible cases with over 2,785 investigative cases opened. Investigations have resulted in the actual recovery of $54.2 million, with an additional $20.8 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $135.8 million. To date, there have been 514 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 213 investigations, made 82 arrests, and had a monetary impact of $16,482,811 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries during this reporting period. OIG opened 189 investigations involving the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary, and identity theft fraud; as well as beneficiaries fraudulently receiving these benefits, which resulted in criminal charges filed against 34 defendants. Court ordered payment of fines, restitution, and penalties amounted to $984,038, while OIG achieved an additional $8.2 million in savings, efficiencies, cost avoidance and recoveries. Two “Stolen Valor” cases were opened resulting in charges filed against four defendants and $563,762 in court ordered payment of fines, restitution, and penalties; and an additional $254,520 in savings. The following entries provide a representative sample of the type of VBA investigations conducted during this reporting period.

Former VA Field Examiner and Fiduciary Plead Guilty to Embezzling $900,000

A former VA Field Examiner and a court appointed fiduciary pled guilty to a criminal information that charged both defendants with theft of Government funds and conspiracy. An OIG and FBI investigation revealed that for approximately 10 years the defendants stole nearly $900,000 from 12 Veterans’ bank accounts. The defendants lost large sums of the embezzled money gambling in casinos. The OIG OAE provided significant assistance with this case.

Fiduciary’s Assistant Pleads Guilty to Bank Fraud

An administrative assistant working for a VA appointed fiduciary pled guilty to bank fraud. An OIG investigation revealed that the defendant forged the fiduciary’s signature on more than 325 checks from several VA beneficiary accounts. The checks were made payable to the defendant and were deposited into the defendant’s personal bank account. In furtherance of the scheme, the defendant transferred funds

from one Veteran's account to another to conceal the thefts. The loss to VA is $626,107.

Former Federal Fiduciary Charged with Misappropriation by a Fiduciary

A former Federal Fiduciary pled guilty to misappropriation by a fiduciary. The defendant, who had been a DOL employee, is charged with stealing VA funds for approximately 18 months from three incompetent Veterans while she was their VA legal custodian. The loss to the Veterans is approximately $62,000.

Former Muskogee, Oklahoma, VARO Employee and Nephew Sentenced for Fraudulent Claims

A former Muskogee, OK, VARO claims examiner was sentenced to 366 days' incarceration and 36 months' supervised release, and his nephew was sentenced to 36 months' probation for conspiring to defraud VA by submitting fraudulent claims for VA education benefits. The judge also ordered that total restitution of $40,098 be paid jointly by both defendants. The loss to VA is approximately $45,000.

Veteran Pleads Guilty to Theft of Compensation Benefits in Connection with Fraudulent Military Records

A Veteran pled guilty to the theft of Government funds after an OIG investigation revealed that he submitted fraudulent military discharge documents to VA and fraudulently received $324,000 in VA compensation benefits.

Veteran Sentenced for VA Compensation Fraud

A Veteran was sentenced to 5 years' probation and ordered to pay $110,238 in restitution after pleading guilty to making false statements. An OIG investigation revealed that since 2003 the defendant, who was collecting VA compensation due to unemployability, was employed full-time with a Government contractor and submitted false documentation to VA claiming he was unemployed.

Navy Deserter Sentenced for Identity Theft

An active duty U.S. Navy sailor was sentenced to 21 months' incarceration, 3 years' supervised probation, and ordered to pay $64,986 in restitution to VA. An OIG investigation revealed that the defendant deserted the U.S. Navy in 1985 after the theft of over $8,000 in Navy funds and then assumed his brother's identity to avoid arrest. The defendant subsequently received VA pension benefits using his brother's identity. The defendant is also scheduled for a military court-martial on desertion and theft charges.

Non-Veteran Indicted for Fraud and Identity Theft

A non-Veteran was indicted on charges of wire fraud, false statements, health care fraud, theft, and aggravated identity theft. An OIG and Defense Criminal Investigative Service (DCIS) investigation was initiated after a referral from a VARO that noticed numerous discrepancies in the defendant's claim forms. The defendant fraudulently obtained and submitted the DD-214 of a retired military Veteran to obtain VA medical services, as well as TRICARE benefits for his spouse. The defendant also obtained VA and Department of Defense identification cards and diverted the Veteran's VA compensation and Army retirement pay to his own bank account. The defendant filed numerous documents with VA in an attempt to obtain additional compensation, education, and vocational rehabilitation benefits.

Veteran's Son Sentenced for Theft of VA Funds

The son of a deceased Veteran was sentenced to 10 years' probation and ordered to pay $47,409 in restitution to VA and OPM after pleading guilty to misapplication of fiduciary property and theft. An OIG and OPM OIG investigation revealed that for 4 years the son routinely moved the Veteran from one nursing home to another, relocating the Veteran when the nursing home demanded payment. During this time

period, approximately $20,000 in VA benefits and $36,000 in OPM benefits were stolen by the defendant from his father's bank account. The Veteran died shortly after being moved to his final nursing home.

Sister and Niece Sentenced for Theft of Veteran's Benefits

The sister of an incompetent Veteran was sentenced to 8 years' incarceration (suspended), 10 years' probation, and ordered to pay the Veteran restitution of $100,000. The Veteran's niece was sentenced to 10 years' probation and ordered to pay an additional $100,000 in restitution after both defendants pled guilty to the theft of approximately $180,000 in VA and Social Security benefits. The investigation revealed that the defendants obtained a Power of Attorney from the Veteran, who is permanently hospitalized at the San Antonio, TX, VAMC, and subsequently used the document to misappropriate all of the Veteran's savings and divert his direct-deposited VA and Social Security funds for their personal use.

Son-in-Law of Incompetent Veteran Sentenced for Elder Abuse

The son-in-law of an incompetent and disabled Veteran was sentenced to 19 to 23 months' incarceration and ordered to participate in a substance abuse program after pleading guilty to the exploitation of a disabled or elderly adult. An OIG, Social Security Administration (SSA) OIG, local law enforcement, and social services investigation revealed that the defendant and his wife stole $213,662 from the Veteran and that they physically and mentally abused the Veteran for several years. Collaborative efforts resulted in the Veteran being placed in a safe environment with a fiduciary.

Veteran Sentenced for "Stolen Valor" Fraud

A Veteran was sentenced to 18 months' probation, 80 hours' community service, and ordered to write a letter of apology to VA after pleading guilty to forgery. An OIG investigation revealed that the defendant purchased a fraudulent DD-214 discharge certificate online, which reflected that he had served as a corporal in the U.S. Marine Corps and had been awarded a Silver Star, Bronze Star, and three Purple Hearts. The Veteran then submitted the false DD-214 with his VA application for benefits claiming he suffered from PTSD from wounds he incurred during combat in Vietnam. The investigation revealed that the Veteran was dishonorably discharged from the U.S. Air Force and was never awarded any of the claimed medals, nor had he served in combat.

Veteran Sentenced for Theft of VA Benefits

A Veteran was sentenced to 2 years' incarceration and ordered to pay $70,749 in restitution after being found guilty at trial of unlawful possession of an altered discharge certificate, false representation of earning military decorations, false statements, and mail fraud. An OIG and DCIS investigation revealed that the defendant, a former elected county official, claimed to be a recipient of 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 for his PTSD claim.

Veteran Indicted for Education Fraud

A Veteran was indicted for identity fraud and false statements after an OIG investigation revealed that he submitted a fraudulent DD-214 to VA in support of an application for education benefits under the Montgomery GI Bill.

Veteran Pleads Guilty to Theft Charges in Connection with PTSD Claim

A Veteran pled guilty to theft charges after an OIG investigation revealed that he provided fraudulent information to a VARO and a VAMC in support of his claim for VA disability compensation benefits. Between 2003 and 2006, the defendant submitted documents and photos and later made statements to VA that he allegedly participated in combat activities while serving in the Persian Gulf War. The false claims included hand-to-hand combat in the trenches, killing enemy combatants, seeing fellow soldiers die, seeing dead bodies inside burned-out tanks, and being under chemical attack. Based on these false statements, the VAMC diagnosed the Veteran with PTSD relating to his purported military service, and the VARO subsequently awarded the Veteran disability compensation. Since the conclusion of the investigation, VA terminated the disability compensation. The loss to VA is approximately $173,000.

Veteran and Wife Found Guilty of Defrauding VA in Tax Evasion Scheme

A Veteran and his wife were found guilty at trial of tax evasion, VA benefits fraud, Social Security fraud, and education benefits fraud. An OIG, Internal Revenue Service (IRS) Criminal Investigation Division (CID), SSA OIG, and Department of Education (DOE) OIG investigation revealed that the Veteran and his wife conspired to falsify their own and others' tax returns and in the process hide their income from VA, SSA, and DOE. The loss to VA is approximately $240,000 and the total loss to the Government exceeds $500,000.

Veteran Sentenced in VA Loan Guaranty Investigation

A Veteran was sentenced to 45 months' incarceration, 5 years' supervised release, and ordered to pay $65,386 in restitution after pleading guilty to bank fraud and identity theft. An OIG and U.S. Secret Service investigation revealed that the defendant was using multiple fraudulent social security numbers in order to acquire VA home loans.

Son of Deceased VA Beneficiary Sentenced for Theft

The son of a deceased beneficiary was sentenced to 48 months' incarceration, 3 years' probation, and ordered to pay restitution of $79,265. An OIG investigation revealed that the defendant failed to report his father's March 1999 death and collected the benefits for over 8 years. The defendant secretly transported the deceased Veteran's remains to another state and buried them in an unmarked grave in a national forest. OIG assisted State and local authorities in the recovery of the Veteran's remains.

Daughter of Deceased Beneficiary Sentenced for Theft

The daughter of a deceased beneficiary was sentenced to 5 years' probation and 100 hours' community service, fined $25,000, and ordered to pay $1,254 in restitution after having pled guilty to theft of Government funds. An OIG investigation determined that the defendant failed to notify VA of her mother's death in March 1994 and admitted she used the VA benefits for personal expenses. The loss to VA is $136,885.

Daughter-in-Law of Deceased VA Beneficiary Sentenced for Theft of VA Funds

The daughter-in-law of a deceased VA beneficiary was sentenced to 10 months' electronically monitored home confinement, 5 years' probation, and ordered to pay $114,683 in restitution after pleading guilty to the theft of Government property. An OIG investigation determined that the defendant withdrew funds from her deceased mother-in-law's bank account after her death in September 2002 and subsequently redirected the monthly VA benefit checks to three separate addresses in order to continue to defraud VA. The defendant admitted to receiving, forging, and negotiating the benefit checks through multiple bank accounts and converting the funds to her own use.

Veteran Pleads Guilty to Theft of Government Funds

A Veteran pled guilty to theft of Government funds after an OIG and SSA investigation revealed that he fraudulently received VA individual unemployability benefits and SSA disability benefits. The defendant concealed earned income from both VA and SSA. The loss to VA is $72,921 and the loss to SSA is $28,765.

Former Cleveland, Ohio, VARO Employee Sentenced for Theft of Government Funds

A former Cleveland, OH, VARO employee was sentenced to 5 years' probation and ordered to pay $11,259 in restitution to VA after pleading guilty to theft of Government funds. An OIG investigation revealed that while employed by VA the defendant diverted retroactive payments intended for Veterans by changing the direct deposit information to her own account. After the retroactive payments were deposited into her account, she changed the deposit information back to the Veterans' bank accounts.

Widow Sentenced for Fraudulently Receiving VA Benefits

The widow of a Veteran was sentenced to 4 months' home confinement, 8 months' community service, 3 years' probation, and ordered to pay restitution of $4,345. An OIG investigation determined the defendant fraudulently received VA Dependency and Indemnity Compensation (DIC) benefits from March 1997 to December 2009 by failing to report her remarriage to VA. The loss to VA is $148,943.

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 18 cases, made 11 arrests, and had a monetary impact of $9.5 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries. The monetary impact includes settlements in four criminal cases brought under the *qui tam* provisions of the *False Claims Act*, P.L. 111-148, which resulted in recoveries totaling $7.58 million.

OI also investigates theft of IT equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened three cases, made two arrests, and had $29,130 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Former VA OIT Employee Sentenced for Identity Theft

A former VA OIT employee was sentenced to 11 years' incarceration, 3 years' supervised release, and ordered to pay $464,599 in restitution. An OIG and IRS CID investigation revealed that the defendant, while employed by VA, stole the PII of at least 160 Veterans to create fraudulent tax documents without the Veterans' knowledge.

Chief Executive Officer Convicted of Fraudulently Obtaining Over $16 Million in Contracts Set Aside for Veterans

The Chief Executive Officer (CEO) of a construction management and general contracting company, who received VA and Department of the Army construction contracts set aside for SDVOSB and VOSB, was convicted of committing major frauds against the United States, witness tampering, false statements, and mail fraud. An OIG, Small Business Administration (SBA) OIG, and Department of the Army CID investigation revealed that the defendant falsely certified that his company qualified as an SDVOSB and VOSB in order to obtain over $16 million in contracts fraudulently. During the investigation, the defendant

made false statements to a Federal agent claiming that another person who had served in the military was the majority owner of his company. VA's Suspension and Debarment Committee subsequently debarred the defendant and his company from doing business with the Federal government.

Company and Four Defendants Indicted for SDVOSB Fraud

A company and four defendants were indicted for conspiracy to defraud the Government, major program fraud, wire fraud, money laundering, and false statements. Subsequently, the four defendants were arrested and eight search and seizure warrants were executed. A joint VA OIG, SBA OIG, General Services Administration OIG, and DCIS investigation determined that the SDVOSB acted as a pass-through company for a larger company and that the owner of the SDVOSB was not a service-disabled Veteran. Based on information provided by OIG, VA's Suspension and Debarment Committee suspended the company and the four defendants from doing business with the Federal government.

Subject Arrested for Sexual Assault at Perry Point, Maryland, VAMC

An AmeriCorps member, residing in leased housing at the Perry Point, MD, VAMC, was arrested after being indicted on various charges related to committing a sexual assault. An OIG and State police investigation revealed that the defendant sexually assaulted a female AmeriCorps member at her residence, located on the grounds of the VAMC. The defendant remains in custody pending trial.

Former Accountant Sentenced for Embezzling over $1 Million from Non-Profit VA Research and Education Corporation

A former employee of the Louisiana Veterans Research and Education Corporation (LVREC) was sentenced to 33 months' incarceration, 3 years' probation, and ordered to pay $1,009,605 in restitution after pleading guilty to embezzlement of Federal program funds and mail fraud. The defendant also consented to an asset forfeiture decree and surrendered approximately $650,000 in cash, vehicles, and real estate to the Government. An OIG, DCIS, and Department of the Army CID investigation revealed that for over 4 years the defendant, who was a bookkeeper and accountant with LVREC, embezzled approximately $1,013,700 through Department of Defense grants given to the VA Gulf Coast HCS. The LVREC is a domestic non-profit organization employing VA research specialists and contractors responsible for neurological research studies on Veterans before and after deployment to war zones. The defendant issued payroll checks in the names of employees of the corporation, forged their signatures on the endorsement line, and then cosigned the checks in order to deposit the funds to her own accounts. To conceal the scheme, she also falsified the annual accountings of the corporate assets.

Physician Sentenced for Money Laundering, Defrauding VA and the Department of Health and Human Services

A physician who owned a private medical clinic and treated Veterans and private patients was sentenced to 4 years' probation, a $700,000 fine, ordered to pay $297,215 in restitution, and is barred from engaging in business with VA, the Department of Health and Human Services (HHS), and any other agency impacted by his offense. The defendant, who was paid approximately $828,000 by VA, entered into a corporate plea agreement and pled guilty to health care fraud and money laundering. An OIG and HHS OIG investigation revealed that from May 2003 to December 2004, the defendant 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. A civil suit is pending.

Fee Basis Dentist Charged with Wire Fraud

A VA fee basis dentist was charged with wire fraud after an OIG and FBI investigation revealed that she fraudulently billed VA for dental treatments on homeless Veterans that were never performed. The dental treatments were offered to Veterans as part of the VA Palo Alto HCS's Homeless Veteran Rehabilitation Program (HVRP). Fifteen Veterans participating in the VA's HVRP were authorized treatment from the defendant, and 12 of the 15 Veterans never received any treatment. The investigation also revealed that the defendant had a conscious sedation permit and was diverting controlled substances from her dental practice to support her personal addiction. The loss to VA is $27,898.

Physician's Assistant and Wife Arrested for Defrauding VA

A physician's assistant and his wife were arrested for conspiracy to commit health care fraud, false claims, and aiding and abetting after an OIG investigation revealed that the two defendants were fraudulently conducting disability rating examinations of Veterans. The company's contract with VA required that a physician perform all disability rating examinations conducted at the clinic. However, the investigation determined that the defendants conducted 337 of the 347 exams performed at the clinic between September 2005 and August 2008 and forged the signature of the company's medical director, who is a physician, on all of the reports. The defendants then submitted the reports and claims to VA for payment. The loss to VA is $154,219.

Former Pharmaceutical CEO Sentenced for Off-Label Marketing

The former CEO of a pharmaceutical company, previously convicted at trial of wire fraud, was sentenced to 6 months' home detention, 3 years' probation, 200 hours' community service, and a $20,000 fine. A multi-agency investigation revealed that under the direction of the defendant, who is also a medical doctor, the company marketed and sold a drug as a treatment for idiopathic pulmonary fibrosis (IPF), despite the fact that it was not approved by the FDA. This investigation further revealed that the defendant and other senior officials were aware that a clinical trial involving the use of this drug to treat patients with IPF failed. However, when the trial results were publicized, the defendant caused the issuance and distribution of a false and misleading press release to portray that the trial established that patients lived longer using this drug. The company previously agreed to pay the Government nearly $37 million to resolve criminal charges and civil liability in connection with its illegal marketing and sales. VA's portion of this civil settlement was approximately $3.2 million.

Pharmaceutical Company Agrees to Pay $34.3 Million for Off-Label Marketing

A pharmaceutical company entered into a settlement agreement with the Government after an OIG, FBI, and FDA investigation determined that the company promoted an antiepileptic drug to physicians for several off-label indications, which included treatment for migraines, pain, anxiety, and bipolar disorder. As a result of this agreement, the company pled guilty to a misdemeanor count of misbranding under the *Federal Food, Drug, and Cosmetic Act*. This pharmaceutical company agreed to pay over $25.7 million to settle civil liabilities associated with the investigation. VA's portion of the civil settlement is approximately $669,000. The company also agreed to pay a criminal fine of $7.55 million and an asset forfeiture of $1.078 million.

Pharmaceutical Company Enters into Settlement Agreement in Off-Label Marketing Scheme

A pharmaceutical company entered into a settlement agreement with the Government after an OIG and HHS OIG investigation disclosed that two VA doctors received kickbacks from the pharmaceutical company for off-label marketing of the company's prescription medications. The investigation further revealed that the pharmaceutical company had a national policy for paying substantial inducements to

encourage providers to prescribe their drugs instead of their competitors'. In a civil agreement reached in December 2010, the pharmaceutical company agreed to pay over $41 million to settle civil and criminal liabilities. The VA's portion of the civil settlement is approximately $3.4 million dollars. The company also agreed to pay a $3.36 million criminal fine as a condition of the deferred prosecution agreement.

Contract Employee Arrested for Theft of Government Property

A contract employee working as the fire safety director in Federal and private buildings, including a VARO, was arrested for theft of Government property. A multi-agency investigation that included covert surveillance equipment and undercover purchases revealed that the defendant used his access to the buildings to enter various locked storage areas and unlawfully remove handcuffs, belly-chains, stab resistant vests, and other property, which were subsequently sold for profit. Additional Government property, as well as what appeared to be stolen property from a private company, was discovered during a search of the defendant's residence. The actual loss to VA and other Federal agencies likely exceeds $100,000; however, the exact monetary figure has yet to be determined.

Former Gainesville, Florida, Credit Union Teller Sentenced for Stealing VA Canteen Service Deposits

A former teller for a Federal credit union located on the Gainesville, FL, VAMC campus was sentenced to 1 year of incarceration, 10 years' probation, and ordered to pay restitution of $34,064 after pleading guilty to grand theft for embezzling funds from the credit union, to include $20,197 in deposits from VA Canteen Services. The teller confessed to stealing VA deposits and manipulating the credit union computer systems to hide the loss.

Company Manager Sentenced for Perjury and Forgery

A regional accounts receivables manager of a company that provided nursing home services was sentenced to 10 months' incarceration after pleading guilty to perjury and forgery. The state judge ordered the defendant to serve the sentence concurrently with an earlier sentence of 18 months' incarceration. A Federal and state investigation revealed that the defendant provided false documents concerning a resident receiving nursing home care and lying about the matter in civil court.

Ambulance Service Company Enters into $2.7 Million Settlement Agreement with Government

An ambulance company that provided services to and received payment from various Federal programs to include VA entered into a settlement agreement, agreeing to pay over $2.7 million in damages. The settlement was the result of a VA OIG, HHS OIG, FBI, OPM OIG, and United States Postal Inspection Service investigation that revealed the ambulance company engaged in questionable billing practices by up-coding transactions to include billing for advanced life support transport when only a basic life support transport occurred or transporting patients by ambulance when other forms of transportation were more appropriate and less expensive. VA received $11,327 as a result of this investigation.

Defendants Arrested for Theft of Government Checks

A former USPS mail clerk and another defendant were arrested for theft and forgery. A multi-agency investigation revealed that the defendants participated in a scheme to steal and negotiate stolen U.S. Treasury and state revenue checks. A search of the mail clerk's residence resulted in the recovery of approximately 650 stolen U.S. Treasury checks. The clerk is believed to be the source for all of the stolen checks in this case which has led to 15 arrests to date. The loss to VA is approximately $95,000 and the total loss to the U.S. Government is approximately $590,000.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG opened 17 administrative investigations, issued 1 report containing 1 recommendation for corrective action, and issued 4 advisory memos with 6 suggestions for corrective action. The Division also issued 10 administrative memos containing 19 allegations that OIG did not substantiate.

Investigation Substantiates Misuse of Over $130K in VHA Travel Funds

An administrative investigation substantiated that a VHA senior official was improperly assigned to a duty station outside the Washington, DC, commuting area, requiring his frequent travel to Washington, DC, to perform the responsibilities of his position. This resulted in the official, with the knowledge and approval of his supervisor, misusing over $130,900 in travel funds for commuting to and from his personal residence to Washington, DC, to avoid relocating.

Threats Made Against VA Employees

During this reporting period, OIG initiated nine criminal investigations resulting from threats made against VA facilities and employees. Eight 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:

- A Veteran was sentenced to 10 months' incarceration and 36 months' supervised release after pleading guilty to making threats. An OIG and VA Police Service investigation revealed that the defendant left threatening voicemail messages at the White River Junction, VT, VAMC stating that he would blow up the place and use an AK-47 and MAC-10 to "go out in a blaze of glory." During an 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 intimidated another VAMC by threatening to make an ammonium nitrate bomb.

- A Veteran was sentenced to 99 days' incarceration and 3 years' supervised release after pleading guilty to threatening to murder a VA employee. An OIG and VA Police Service investigation determined that the Veteran made a telephonic threat to a VA employee in the patient advocate's office at the Seattle, WA, VAMC.

- A Veteran was arrested and subsequently indicted after attempting to sexually assault a Phoenix, AZ, VAMC employee. An OIG investigation was initiated after VA Police Service responded to a call regarding a Veteran assaulting a VA social worker in her office at the VAMC. The defendant is in custody pending a mental competency evaluation.

- A Veteran, who is also a former VA employee, was indicted for transmitting an interstate e-mail communication that threatened to injure the director of the White River Junction, VT, VAMC. An OIG and VA Police Service investigation disclosed that the Veteran, whose employment was terminated in 2008, submitted numerous harassing e-mails to VAMC personnel, including one that caused a 6-hour facility shutdown in anticipation of his arrival.

- A Veteran was indicted for assaulting a VA nurse at the White River Junction, VT, VAMC. An OIG and VA Police Service investigation revealed that, while in the emergency room, 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 officers were able to subdue the Veteran, and the nurse sustained no injuries.

- A Veteran was sentenced to 40 months' incarceration and 3 years' supervised release after being found guilty at trial of assaulting a Federal employee. The Veteran seriously injured two VA nurses during a visit to the Spokane, WA, VAMC ED.

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, 42.4 million felon warrants have been received from the National Crime Information Center and participating states resulting in 58,849 investigative leads being referred to law enforcement agencies. Over 2,198 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 $849.3 million in estimated overpayments with an estimated cost avoidance of $972.5 million. During this reporting period, OIG opened 41 investigations and made 30 fugitive felon arrests, with an additional 27 arrests made by other law enforcement agencies. Six of these arrests were of VAMC employees at various medical centers wanted on larceny, drug violations, failure to register as a sex offender, parole, and forgery. Apprehensions included the following:

- Local police, with the assist of OIG and VA Police Service, arrested an employee of the VA CBOC in Bradenton, FL. The employee was wanted on an outstanding felony warrant for trafficking illegal drugs.

- A Veteran was arrested by local officers with the assistance of OIG. The fugitive was wanted on felony warrants for aggravated battery with a deadly weapon, assault with a deadly weapon, violation of probation, and other charges.

- A Veteran was arrested at the Houston, TX, VAMC with the assistance of OIG on a felony warrant for failing to register as a sex offender. The fugitive was previously convicted of aggravated sexual assault on a child.

- The OIG, working with a United States Marshals Fugitive Apprehension Strike Team, arrested a Veteran wanted for the sexual abuse of a child. The Veteran had previously been convicted of murder and manslaughter.

- The U.S. Marshals Service, with the assistance of OIG, arrested a Veteran as he was being released from the Phoenix, AZ, VAMC. The Veteran was a known member of a white supremacist group and was wanted on a probation violation stemming from a Federal weapons conviction.

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 9:00 AM to 4:00 PM Eastern Time. Phone calls, letters, and e-mails are received from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 15,286 contacts, 628 of which became OIG cases. The Hotline also closed 637 cases during this reporting period, substantiating allegations 40% percent of the time. The following cases were initiated as a direct result of Hotline contacts:

Supervisor Demoted at Indianapolis, IN, VAMC After Misrepresenting Himself as a Care Provider

A review conducted by the Indianapolis, IN, VAMC substantiated that a supervisor misrepresented himself as a Licensed Practical Nurse and improperly administered intravenous solutions to approximately eight patients. None of the patients were harmed. Management took appropriate administrative action as a result of the review.

Review Finds Senior Official Misused Official Travel and Government Resources

In response to an anonymous call to the Hotline, a review initiated by the Veterans Canteen Service at the St. Louis, MO, VAMC found that a senior official repeatedly misused official travel and Government resources from January 2010 through June 2011 to conduct personal business. As a result, management took appropriate administrative action.

Review Finds Attempt to Bypass Merit Promotion Policy at Independence, Ohio, VHA Service Center

A review conducted at the VHA Service Center in Independence, OH, found that a senior official placed undue pressure on Human Resources Management staff to upgrade a position with the intent to promote a subordinate without competition. The review recommended a classification review by VA Central Office and that the Service Center announce the position in accordance with applicable merit promotion policy.

Philadelphia, Pennsylvania, VAMC Delinquent in Payments to University Affiliate Totaling $3 Million

A Philadelphia, PA, VAMC review found that the facility was delinquent in payments of more than $3 million to its university affiliate and had expired service contracts. The facility took several actions to correct the problems, including reassigning and training staff.

Deceased Veteran's Pension Benefit Terminated After Family Members' Failure to Report Death

A review at the VARO in Manila, Philippines, determined that family members improperly received VA pension benefits for a deceased Veteran. The Veteran's death, which occurred in 2008, was not reported to the VARO. As a result of the Hotline referral, the VARO terminated the decedent's benefits, resulting in cost savings of $73,770 over a 5-year period.

Widow's Failure to Report Additional Income Results in Improper Receipt of Pension Benefits

A review conducted by the Philadelphia, PA, VARO and Insurance Center determined that a surviving spouse improperly received pension benefits because she did not inform the VARO of her employment and additional income. As a result, the beneficiary was assessed an overpayment of $70,548.

Widow's Benefits Terminated After Unreported Remarriage Discovered Via Social Media

A review conducted by the St. Petersburg, FL, VARO found that a surviving spouse improperly continued to receive DIC benefits after remarrying. A complainant reported the remarriage to the OIG Hotline based on information posted to a social media website. The VARO subsequently terminated her benefits, resulting in a recovery of $36,683.

Offices of Contract Review and Counselor to the Inspector General

The OIG 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 63 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 $248 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included eight health care provider proposals—accounting for over $10.2 million of the identified potential savings.

	April 1–September 30, 2011	FY Total
Preaward Reports Issued	**48**	**92**
Potential Cost Savings	**$247,789,339**	**$370,631,428**

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 $2.1 million, including over $1.5 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, 7 involved voluntary disclosures. In two of the seven reviews, OCR identified additional funds due. OCR recovered 100 percent of recommended recoveries for postaward contract reviews.

	April 1–September 30, 2011	FY Total
Postaward Reports Issued	**15**	**30**
Dollar Recoveries	**$2,143,678**	**$21,480,417**

Recurring Contracting and Pricing Issues Persist in Health Care Resource Contracts

In August 2006, the VA Secretary signed into policy VA Directive 1663, *Healthcare Resources Contracting – Buying, Title 38 U.S.C. § 8153*, under which VA may enter into non-competitive (sole-source) contracts with affiliated institutions for health care resources. VA Directive 1663 requires a preaward review for health care resources procured on a sole-source basis that are valued at more than $500,000. The report advised VA of OIG's collective findings in preaward reviews since VA Directive 1663 became effective. OIG determined that VHA has not effectively implemented all the requirements set forth in VA Directive 1663 due to lack of resources, training, and enforcement, which resulted in recurring contracting and

pricing issues with sole-source contracts with affiliated institutions. OIG's report also discusses findings regarding conflict of interest issues and recommends that VA seek personal services contracting authority. The Under Secretary for Health concurred with all OIG findings and recommendations.

Qui Tam Cases

Settlements in five civil cases brought under the *qui tam* provisions of the *False Claims Act,* resulted in recoveries totaling $16,723,905. Three of the cases involved off-label marketing and anti-kickback violations. Another case involved billing for services not provided by a home health care vendor, and the fifth case involved the failure to comply with contract warranty provisions. Total civil recoveries for VA in FY 2011 were $34,171,823.

Congressional Testimony

AIG for Audits and Evaluations Testifies on VA's Contract Management

Belinda Finn, AIG for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on VA's contract management. Ms. Finn discussed the deficiencies of VA's acquisition processes and infrastructure as well as the impact these deficiencies have on VA operations. She stated that VA needs to exercise greater organizational discipline over its primary management oversight tool, the eCMS, to ensure the transparency needed to manage a multi-billion dollar acquisition program. Ms. Finn also recommended that VA continue its efforts to integrate eCMS into existing and future financial systems. Ms. Finn was accompanied by Cherie Palmer, Director, Chicago Office of Audits and Evaluations.

AIG for Healthcare Inspections Testifies on Review of Infection Controls at the Dayton, Ohio, VA Medical Center

John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified at a field hearing of the Committee on Veterans' Affairs, United States Senate, on OIG's oversight review of VA's handling of the infection control breaches at the Dayton, OH, VAMC Dental Clinic. Dr. Daigh discussed the reviews conducted by VA after learning of the allegations of improper infection control procedures at the Dental Clinic. He concluded that established infection control practices and policies were not properly or consistently adhered to, that there was evidence Dental Clinic staff and management were aware of these unacceptable practices, and that definitive action was not taken until a VA Central Office review body was at the Dayton VAMC conducting a routine inspection. Dr. Daigh was accompanied by George Wesley, M.D., Director, Medical Consultation and Medical Review Division, and Kathleen Shimoda, BNS, Healthcare Inspector, Los Angeles Office of Healthcare Inspections.

AIG for Healthcare Inspections Testifies on Patient Safety Concerns at VHA Facilities

John D. Daigh, Jr., M.D., testified before the Committee on Veterans' Affairs, United States House of Representatives, on patient safety issues at VHA facilities. Dr. Daigh discussed several OIG reviews of allegations that reusable medical equipment (RME) was not properly cleaned or sterilized and the processes used to notify Veterans of improper sterilization. Dr. Daigh made recommendations related to improving the notification process based on the experiences in those medical centers where the RME allegations were substantiated.

AIG for Audits and Evaluations Testifies on VA's Information Technology Program

Belinda J. Finn testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on VA's IT strategy for the 21st Century. Ms. Finn discussed the results of OIG audits that continue to find that VA struggles to manage IT development projects that will deliver the desired results within cost, schedule, and performance objectives. Ms. Finn was accompanied by Maureen Regan, Counselor to the Inspector General.

AIG for Audits and Evaluations Testifies on VA's Regional Offices Performance

Belinda J. Finn testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, United States House of Representatives, on the performance of VAROs. Ms. Finn discussed the results of OIG inspections and audits of the programs and operations of VBA, specifically focusing on the results of inspections conducted at 16 individual VAROs from April 2009 through September 2010. Since September 2009, OIG has consistently reported the need for enhanced

policy guidance, oversight, workload management, training, and supervisory review to improve the timeliness and accuracy of disability claims processing and VARO operations. Ms. Finn was accompanied by Brent Arronte, Director, Bay Pines Benefits Inspection Division.

Deputy AIG for Investigations Testifies on Sexual Assaults and Safety Incidents at VA Facilities

Joseph G. Sullivan, Jr., Deputy AIG for Investigations, testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on sexual assaults and safety incidents at VA facilities. Mr. Sullivan discussed the role of the OIG investigating these incidents, how the OIG interacts with the VA Police Service, and a recent report by the Government Accountability Office (GAO) on this subject. Under the Code of Federal Regulations, VA Police Service must report any alleged felonies to the OIG. However, 33 percent of the incidents examined by the OIG for the GAO study were not reported as required. Mr. Sullivan expressed his support for VA's decision to generate automated reminders to VA Police Service and notices to OIG field offices, which are expected to reduce the number of felonies not reported to the OIG.

AIG for Healthcare Inspections Testifies on VA MH Care: Progress Made, But More Work Needs To Be Done

John D. Daigh, Jr., M.D., testified before the Committee on Veterans' Affairs, United States Senate, on VA MH care. Dr. Daigh discussed the results of the OIG's work in the area of MH, including reports on system-wide reviews and reports on the care provided to individual Veterans. Specifically, he focused on the importance of the coordination of care between primary care providers and MH care providers. He also discussed the recent follow-up review of VA's MH Residential Rehabilitation Treatment Programs where OIG evaluated any improvements made or problems remaining since OIG's 2009 report. Dr. Daigh concluded that continued attention must be given to improving staffing and access to care; providing continuity during integral care transitions; coordinating care for individual Veterans with MH issues; and linking pain management, MH, and substance use programs. Dr. Daigh was accompanied by Michael Shepherd, M.D., Senior Physician, in OIG's Office of Healthcare Inspections.

Ineligible "Veteran-Owned" Firms Receive VA Contracts, AIG for Audits and Evaluations Tells House Panel

Belinda J. Finn testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work related to VA's VOSB and SDVOSB programs. OIG's recent report found that 76 percent of the businesses OIG reviewed were ineligible for the program and/or the specific VOSB or SDVOSB contract award, potentially resulting in $2.5 billion awarded to ineligible businesses over the next 5 years. Ms. Finn was accompanied by Mr. James J. O'Neill, AIG for Investigations, whose office's work recently resulted in the successful prosecution of the CEO of a business that had been awarded SDVOSB set-aside construction contracts for which the company was not eligible.

Special Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

Charles Cook, a Healthcare Inspector in the Bay Pines OHI, was deployed by the Army in June 2007 and was stationed in Pinellas, Florida. In 2008, Charles briefly served in Seoul, South Korea, and Atlanta, GA. Charles returned from deployment on October 24, 2011.

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

Randy Snow, Director, Washington, DC, OHI, was deployed by the Air Force in March 2011 and was stationed in Afghanistan. Randy returned from deployment on October 1, 2011.

AIG for Management and Administration Received Presidential Rank Award

Richard Ehrlichman, AIG for Management and Administration, was the recipient of the Presidential Rank Award of "Meritorious Executive" for outstanding leadership in the Senior Executive Service. Each year, the President recognizes a select group of senior executives with demonstrated track records of exceptional achievements throughout their careers. Richard was recognized for many noteworthy accomplishments since his appointment as a senior executive in 1999, including the direction of one of the premier Hotline operations in the IG community; modernization of the OIG's IT program and establishment of field help desk support; and enhancements to the OIG report follow-up program. Over the last decade, he led the formulation and execution of the OIG's budget, which increased 350 percent during that time, and oversaw the transition of our human resources and payroll programs from VA to the Bureau of Public Debt and the National Finance Center.

Manchester, New Hampshire, Resident-Agent-In-Charge Receives Public Service Award

Donna Neves, Resident-Agent-In-Charge, was the recipient of the Department of Justice Public Service Award for Law Enforcement Service for her "outstanding efforts and tireless pursuit of justice" in *United States ex. rel. Eckard v. GlaxoSmithKline, et al.* and *United States v. SB Pharmco Puerto Rico, Inc.*

OHI Celebrates 20th Anniversary

On July 1, 2011, OHI celebrated its 20th anniversary. This unique medical oversight office was established on July 1, 1991, as a direct result of both Congress' and the VA Secretary's need for upgraded medical and clinical oversight of VA's medical care and quality assurance programs. In 1991, OHI had less than 10 staff, all located in Washington, D.C. Today, OHI conducts inspections covering the entire VA system, with these healthcare inspections performed by more than 100 medical professionals located in 12 regional offices spread across the country.

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			
Audit of the VHA's Office of Rural Health *Report No. 10-02461-154, Issued 04/29/2011*	$73,300,000	$73,300,000	$200,000,000
Federal Information Security Management Act Assessment for FY 2010 *Report No. 10-01916-165, Issued 05/11/2011*			
Systemic Issues Reported During Inspections at VA Regional Offices *Report No. 11-00510-167, Issued 05/18/2011*			
Audit of the Medical Care Collection Fund Billings for Non-VA Care *Report No. 10-02494-176, Issued 05/25/2011*	$552,000,000	$552,000,000	
Review of Cincinnati VA Medical Center Beneficiary Travel Office Allegations *Report No. 10-03292-217, Issued 07/06/2011*			$3,500
Audit of Veteran-Owned and Service Disabled Veteran-Owned Small Business Programs *Report No. 10-02436-234, Issued 07/25/2011*			$2,500,000,000
Review of Alleged Unauthorized Access to VA Systems *Report No. 10-03516-229, Issued 07/27/2011*			
Audit of VA's Implementation of Executive Order 13520, "Reducing Improper Payments" *Report No. 10-2892-251, Issued 08/12/2011*			
Audit of the Project Management Accountability System Implementation *Report No. 10-03162-262, Issued 08/29/2011*			
Audit of National Contract Awards at VA's National Acquisition Center *Report No. 10-01744-265, Issued 09/02/2011*			
VHA's Safety, Security, and Privacy for Female Veterans at a Chicago, IL, Homeless Grant Provider Facility *Report No. 11-00334-267, Issued 09/06/2011*			
Audit of Compensation Program Claims Brokering *Report No. 09-03154-271, Issued 09/27/2011*			
Follow-Up Audit of VHA's Part-Time Physician Time and Attendance *Report No. 11-00308-294, Issued 09/30/2011*			

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	
Audit of VA's Enrollment Centers' Implementation of Personal Identity Verification Requirements *Report No. 10-04037-295, Issued 09/30/2011*			
Audit of VHA's Workers' Compensation Case Management *Report No. 10-03850-298, Issued 09/30/2011*	$264,000,000	$264,000,000	$70,100,000
BENEFITS INSPECTIONS			
Salt Lake City, Utah, VA Regional Office *Report No. 10-03880-142, Issued 04/13/2011*			
Des Moines, Iowa, VA Regional Office *Report No. 11-00511-164, Issued 05/11/2011*			
St. Louis, Missouri, VA Regional Office *Report No. 11-00519-172, Issued 05/20/2011*			
Louisville, Kentucky, VA Regional Office *Report No. 11-00520-174, Issued 05/24/2011*			
Atlanta, Georgia, VA Regional Office *Report No. 11-00512-179, Issued 05/27/2011*			
Chicago, Illinois, VA Regional Office *Report No. 11-00521-183, Issued 06/02/2011*			
New Orleans, Louisiana, VA Regional Office *Report No. 11-00238-184, Issued 06/06/2011*			
Reno, Nevada, VA Regional Office *Report No. 11-00517-204, Issued 06/24/2011*			
Huntington, West Virginia, VA Regional Office *Report No. 11-00522-231, Issued 07/20/2011*			
New York, New York, VA Regional Office *Report No. 11-00516-240, Issued 07/28/2011*			
Columbia, South Carolina, VA Regional Office *Report No. 11-00236-257, Issued 08/24/2011*			
Buffalo, New York, VA Regional Office *Report No. 11-00523-258, Issued 08/25/2011*			
Hartford, Connecticut, VA Regional Office *Report No. 11-00514-264, Issued 09/07/2011*			
Seattle, Washington, VA Regional Office *Report No. 11-00515-266, Issued 09/08/2011*			
JOINT REVIEW			
Review of Healthcare Services and Benefits for Resident U.S. Virgin Islands Veterans *Report No. 10-03882-151, Issued 05/05/2011*			

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	
COMBINED ASSESSMENT PROGRAM REVIEWS			
VA Palo Alto Health Care System, Palo Alto, California *Report No. 11-00028-140, Issued 04/04/2011*			
VA Caribbean Healthcare System, San Juan, Puerto Rico *Report No. 11-00025-144, Issued 04/14/2011*			
VA Northern Indiana Health Care System, Marion, Indiana *Report No. 11-00026-146, Issued 04/19/2011*			
Wilmington VA Medical Center, Wilmington, Delaware *Report No. 11-00024-152, Issue 04/27/2011*			
Tennessee Valley Healthcare System, Nashville, Tennessee *Report No. 11-00030-160, Issued 05/05/2011*			
Kansas City VA Medical Center, Kansas City, Missouri *Report No. 11-00027-162, Issued 05/9/2011*			
Durham VA Medical Center, Durham, North Carolina *Report No. 11-00035-191, Issued 06/10/2011*			
Oklahoma City VA Medical Center, Oklahoma City, Oklahoma *Report No. 11-00031-197, Issued 06/10/2011*			
Northampton VA Medical Center, Leeds, Massachusetts *Report No. 11-00029-193, Issued 06/13/2011*			
Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio *Report No. 11-01101-196, Issued 06/16/2011*			
VA Northern California Health Care System, Sacramento, California *Report No. 11-01106-207, Issued 06/30/2011*			
VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Report No. 11-00032-213, Issued 07/07/2011*			
Cheyenne VA Medical Center, Cheyenne, Wyoming *Report No. 11-01297-222, Issued 07/12/2011*			

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	
Birmingham VA Medical Center, Birmingham, Alabama *Report No. 11-01295-232, Issued 07/21/2011*			
Central Arkansas Veterans Healthcare System, Little Rock, Arkansas *Report No. 11-01296-235, Issued 08/02/2011*			
VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania *Report No. 11-01107-243, Issued 08/02/2011*			
VA Maine Healthcare System, Augusta, Maine *Report No. 11-01294-244, Issued 08/03/2011*			
Miami VA Healthcare System, Miami, Florida *Report No. 11-01099-247, Issued 08/11/2011*			
Battle Creek VA Medical Center, Battle Creek, Michigan *Report No. 11-01104-252, Issued 08/15/2011*			
Jesse Brown VA Medical Center Chicago, Illinois *Report No. 11-01611-250, Issued 08/16/2011*			
Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania *Report No. 11-01298-268, Issued 09/01/2011*			
G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi *Report No. 11-01608-273, Issued 09/08/2011*			
St. Louis VA Medical Center St. Louis, Missouri *Report No. 11-01606-277, Issued 09/13/2011*			
Minneapolis VA Health Care System Minneapolis, Minnesota *Report No. 11-01610-278, Issued 09/13/2011*			
Lebanon VA Medical Center Lebanon, Pennsylvania *Report No. 11-01605-279, Issued 09/14/2011*			
White River Junction VA Medical Center White River Junction, Vermont *Report No. 11-02077-282, Issued 09/15/2011*			
Alaska VA Healthcare System, Anchorage, Alaska *Report No. 11-02080-286, Issued 09/21/2011*			

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	
West Texas VA Health Care System, Big Spring, Texas *Report No. 11-02079-287, Issued 09/21/2011*			
Lexington VA Medical Center, Lexington, Kentucky *Report No. 11-02078-290, Issued 09/27/2011*			
COMMUNITY BASED OUTPATIENT CLINIC REVIEWS			
Georgetown, DE, and Ventnor, NJ; Guayama and Ponce, PR; Goshen, IN; Belton and Nevada, MO; Capitola and French (Stockton), CA *Report No. 11-00843-169, Issued 05/17/2011*			
Springfield, MA; Morehead City and Raleigh, NC; Clarksville and Cookeville, TN; Wichita Falls, TX; Klamath Falls, OR *Report No. 11-00844-220, Issued 07/06/2011*			
Branson, MO, and Harrison, AR; Conroe and Lufkin, TX; Hammond and Houma, LA *Report No. 11-01406-228, Issued 07/18/2011*			
Bradford (McKean County) and Franklin (Venango County), PA; Camp Hill and Pottsville/ Frackville, PA; Mission, SD, and Newcastle, WY; Hibbing and Rochester, MN *Report No. 11-01406-238, Issued 07/29/2011*			
San Antonio (North Central Federal Clinic) and Uvalde, TX; Tyler, TX; Alamogordo and Artesia, NM; Bellemont and Kingman, AZ *Report No. 11-01406-288, Issued 09/26/2011*			
NATIONAL HEALTHCARE INSPECTION REPORTS			
Post Traumatic Stress Disorder Counseling Services at Vet Centers *Report No. 10-00628-170, Issued 05/17/2011*			
Community Based Outpatient Clinic Cyclical Reports FY 2011 *Report No. 11-01406-177, Issued 05/31/2011*			
Evaluation of Community Based Outpatient Clinics Fiscal Year 2010 *Report No. 11-00794-185, Issued 06/07/2011*			
A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) *Report No. 10-04085-203, Issued 06/22/2011*			

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 Facility Capabilities Where Veterans Received Complex Surgical Care *Report No. 10-02302-225, Issued 07/14/2011*			
Combined Assessment Program Summary Report Management of Test Results in Veterans Health Administration Facilities *Report No. 11-02869-272, Issued 09/07/2011*			
Combined Assessment Program Summary Report – Evaluation of Infection Prevention Practices in Veterans Health Administration Facilities *Report No. 11-03361-274, Issued 09/13/2011*			
Informational Report – Community Based Outpatient Clinic Cyclical Reports Fiscal Year 2012 *Report No. 11-03653-283, Issued 09/20/2011*			
HOTLINE HEALTHCARE INSPECTIONS			
Self-Administered Rescue Medications, Specialized Inpatient Stress Disorders Unit, VA Eastern Kansas Health Care System, Topeka, Kansas *Report No. 11-00184-147, Issued 04/20/2011*			
Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, Ohio *Report No. 10-03330-148, Issued 04/25/2011*			
Evaluation of Patient Prostate Care, Tennessee Valley Healthcare System, Nashville, Tennessee *Report No. 11-00181-153, 04/28/2011*			
Alleged Delay in Diagnosis and Communication Issues, Chattanooga Community Based Outpatient Clinic, Tennessee Valley Healthcare System, Nashville, Tennessee *Report No. 11-00599-186, Issued 06/08/2011*			
Contract Community Based Outpatient Clinic Issues New Mexico VA Health Care System, Albuquerque, New Mexico *Report No. 11-00588-189, Issued 06/08/2011*			
Post-Operative Paralysis, Overton Brooks VA Medical Center, Shreveport, Louisiana *Report No. 10-03462-190, Issued 06/08/2011*			

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	
Prescribing Practices in the Pain Management Clinic, John D. Dingell VA Medical Center, Detroit, Michigan *Report No. 11-00057-195, Issued 06/15/2011*			
Quality of Care in the Intensive Care Unit, VA Northern Indiana Health Care System, Fort Wayne, Indiana *Report No. 10-02816-200, Issued 06/20/2011*			
Provider Privileging and Delayed Patient Care, VA Connecticut Healthcare System, West Haven, Connecticut *Report No. 11-01733-208, Issued 06/28/2011*			
Alleged Patient Abuse and Inadequate Community Nursing Home Program Oversight, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma *Report No. 11-01829-209, Issued 06/28/2011*			
Delays in Cancer Care, West Palm Beach VA Medical Center, West Palm Beach, Florida *Report No. 11-00930-210, Issued 06/29/2011*			
Prosthetic and Sensory Aids Service Records Review, Durham VA Medical Center, Durham, North Carolina *Report No. 11-01416-212, Issued 07/07/2011*			
Alleged Pain Management Deficiencies, VA Maryland Health Care System, Baltimore, Maryland *Report No. 11-00904-216, Issued 07/08/2011*			
Electronic Waiting List Management for Mental Health Clinics, Atlanta VA Medical Center, Atlanta, Georgia *Report No. 10-02986-215, Issued 07/12/2011*			
Case Review of a Patient with End-Stage Cancer, John D. Dingell VA Medical Center, Detroit, Michigan *Report No. 11-01194-224, Issued 07/13/2011*			
Attempted Suicide During Treatment West Palm Beach VA Medical Center, West Palm Beach, Florida *Report No. 11-01052-233, Issued 07/25/2011*			

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	
Alleged Improper Care and Prescribing Practices for a Veteran, Tyler VA Primary Care Clinic, Tyler, Texas *Report No. 11-01996-253, Issued 08/19/2011*			
Clinical and Administrative Issues in the Suicide Prevention Program, Alexandria VA Medical Center, Pineville, Louisiana *Report No. 11-02325-263, Issued 08/30/2011*			
Quality of Care Issues, VA Nebraska–Western Iowa Health Care System, Omaha, Nebraska, And VA Central Iowa Health Care System, Des Moines, Iowa *Report No. 11-02275-269, Issued 09/06/2011*			
Surgeon Privileging and Resident Supervision Issues, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina *Report No. 11-01993-281, Issued 09/16/2011*			
Management of Patient Abuse Cases, Charlie Norwood VA Medical Center, Augusta, Georgia *Report No. 11-01997-289, Issued 09/21/2011*			
Alleged Patient Neglect and Abuse, VA Central California Health Care System, Fresno, California *Report No. 11-01184-293, Issued 09/28/2011*			
Quality of Care Provided at Corpus Christi Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas *Report No. 11-02548-291, Issued 09/29/2011*			
Alleged Quality of Care Issues, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois *Report No. 11-00768-292, Issued 09/29/2011*			
Review of a Patient with Pulmonary Embolism, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma *Report No. 11-02385-300, Issued 09/30/2011*			
ADMINISTRATIVE INVESTIGATION			
Improper Duty Station and Misuse of Travel Funds, VHA, VA Central Office Washington, DC *Report No. 10-02328-192, Issued 06/10/2011*			

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	
PREAWARD REVIEWS			
Review of a Contract Extension Proposal Under a FSS Contract *Report No. 11-00859-143, Issued 04/12/2011*			
Review of Proposal Submitted Under Solicitation No. VA-260-11-RQ-0031 *Report No. 11-01768-145, Issued 04/14/2011*	$1,241,638		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-01777-150, Issued 04/20/2011*	$37,821,620		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R1 *Report No. 11-01514-155, Issued 04/28/2011*			
Review of Proposal Submitted Under Solicitation No. RFP-797-652F-05-0001-R2 *Report No. 11-01618-158, Issued 04/29/2011*	$1,274,654		
Review of Proposal Submitted Under Solicitation No. VA-101-11-RP-0017 *Report No. 11-01687-159, Issued 05/02/2011*	$163,389		
Review of Proposal Submitted Under Solicitation No. VA-260-11-RP-0357 *Report No. 11-02019-156, Issued 05/05/2011*	$83,815		
Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0063 *Report No. 11-01860-163, Issued 05/05/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-01685-166, Issued 05/09/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02024-168, Issued 05/11/2011*			
Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0064 *Report No. 11-01861-173, Issued 05/20/2011*			
Review of Proposal Submitted Under Solicitation No. VA-260-11-RP-0364 *Report No. 11-02556-175, Issued 05/24/2011*	$1,759,464		
Review of FSS Proposal Submitted Under Solicitation No. RFP-797-FSS-99-025-R6 *Report No. 11-02091-178, Issued 05/25/2011*	$13,525,617		

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 No. VA-101-10-PR-0064 *Report No. 11-01935-180, Issued 05/27/2011*			
Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0064 *Report No. 11-01934-181, Issued 05/27/2011*			
Review of Proposal Submitted Under Solicitation No. VA-243-10-RP-0459 *Report No. 11-02053-171, Issued 06/02/2011*	$1,023,780		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R4 *Report No. 11-02036-182, Issued 06/03/2011*			
Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0064 *Report No. 11-01948-187, Issued 06/03/2011*			
Review of Proposal Submitted Under Solicitation No. VA-248-10-RP-0557 *Report No. 11-02768-194, Issued 06/13/2011*	$1,463,230		
Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0064 *Report No. 11-03238-198, Issued 06/13/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R4 *Report No. 11-01746-188, Issued 06/14/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q52A-04-R2 *Report No. 11-01928-201, Issued 06/14/2011*	$749,259		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No, 11-01776-199, Issued 06/15/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R4 *Report No. 11-01904-206, Issued 06/24/2011*	$9,918,258		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02037-214, Issued 06/30/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R1 *Report No. 11-01775-219, Issued 07/07/2011*	$44,910,791		

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 FSS Proposal Submitted Under Solicitation No. 797-FSS-99-0025-R6 *Report No. 11-01690-221, Issued 07/07/2011*	$9,120,550		
Review of Product Additions Submitted Under a FSS Contract *Report No. 11-02394-223, Issued 07/07/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02035-230, Issued 07/14/2011*			
Review of Proposal Submitted Under Solicitation No. RFP-797-FSS-99-0025-R6 *Report No. 11-01903-218, Issued 07/19/2011*	$7,111,019		
Review of Proposal Submitted Under Solicitation No. 797-FSS-99-0025-R6 *Report No. 11-02379-236, Issued 07/22/2011*	$5,671,400		
Review of Contract Extension Proposal Submitted Under a FSS Contract *Report No. 11-02395-239, Issued 07/26/2011*			
Review of Proposal Submitted Under Solicitation No. VA-243-10-RP-0484 *Report No. 11-02624-237, Issued 07/27/2011*	$2,185,214		
Review of Contract Extension Proposal Submitted Under a FSS Contract *Report No. 11-01930-246, Issued 08/03/2011*	$43,069,339		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02025-245, Issued 08/04/2011*	$2,263,120		
Supplement to Review of Proposal Submitted Under Solicitation No. VA-101-10-RP-0064 *Report No. 11-03238-254, Issued 08/18/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02028-255, Issued 08/19/2011*			
Review of Proposal Submitted Under Solicitation No. VA-248-10-RP-0314 *Report No. 11-03642-248, Issued 08/22/2011*	$2,025,360		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R4 *Report No. 11-02934-260, Issued 08/22/2011*			

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 FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-02205-261, Issued 08/24/2011*			
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-R4 *Report No. 11-02286-259, Issued 08/25/2011*	$50,715,501		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q52A-04-R2 *Report No. 11-03193-270, Issued 08/31/2011*	$8,346,189		
Review of Contract Extension Proposal Submitted Under a FSS Contract *Report No. 11-02283-275, Issued 09/07/2011*	$1,264,982		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R2 *Report No. 11-03397-280, Issued 09/13/2011*			
Review of FSS Proposal Submitted Under Solicitation No. RFP-797-FSS-99-0025-R6 *Report No. 11-03615-284, Issued 09/14/2011*	$4,900		
Review of Proposal Submitted Under Solicitation No. VA-69D-11-RP-0100 *Report No. 11-03383-276, Issued 09/20/2011*	$423,799		
Review of FSS Proposal Submitted Under Solicitation No. M5-Q50A-03-R4 *Report No. 11-03221-297, Issued 09/27/2011*			
Review of Proposal Submitted Under Solicitation No. RFP-797-FSS-99-0025-R7 *Report No. 11-04079-299, Issued 09/28/2011*			
POSTAWARD REVIEWS			
Review of Overcharges Under a FSS Contract *Report No. 10-00298-141, Issued 04/07/2011*			$221,519
Review of Voluntary Disclosure Under a FSS Contract *Report No. 09-02290-149, Issued 04/21/2011*			$1,111,040
Review of Certified Claim Submitted Under a Contract *Report No. 11-01327-157, Issued 04/29/2011*			$271,273
Review of Violations of the Trade Agreements Act Under Multiple Department of Defense and Department of Veterans Affairs Contracts *Report No. 09-02157-161, Issued 05/04/2011*			

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	
Postaward Review of a FSS Contract *Report No. 09-02428-202, Issued 06/14/2011*			$149,986
Review of Voluntary Disclosure Submitted Under a FSS Contract *Report No. 09-03111-205, Issued 06/22/2011*			$57,686
Review of a Self Audit Under a FSS Contract *Report No. 11-01619-211, Issued 06/28/2011*			$6,395
Review of Voluntary Disclosure and Refund Offer Submitted Under a FSS Contract *Report No. 09-01855-226, Issued 07/12/2011*			$37,286
Review of VHA Sole-Source Contracts with Affiliated Institutions *Report No. 09-00981-227, Issued 07/21/2011*			
Review of a Self Audit Under a FSS Contract Number *Report No. 09-03109-241, Issued 07/27/2011*			$76,674
Review of Voluntary Disclosures Under a FSS Contract *Report No. 08-02442-242, Issued 07/28/2011*			$21,813
Review of Voluntary Disclosure and Refund Offer Under a FSS Contract *Report No. 10-03376-249, Issued 08/17/2011*			$105,131
Review of a Self Audit Under a FSS Contract *Report No. 10-02212-256, Issued 08/22/2011*			$69,492
Review of Settlement Proposal Submitted Under a VA Contract *Report No. 11-03024-285, Issued 09/16/2011*	$1,652,451		
Review of Voluntary Disclosure for Public Law Damages Under a FSS Contract *Report No. 11-02174-296, Issued 09/26/2011*			$15,383
Total Funds Recommended for Better Use	**$899,300,000**	**$899,300,000**	**-**
Total Questioned Costs	**-**	**-**	**$2,770,103,500**
Total Preaward Savings and Cost Avoidance	**$247,789,339**	**-**	**-**
Total Postaward Dollar Recoveries	**-**	**-**	**$2,143,678**

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. Table 1 summarizes the status of all unimplemented OIG reports and recommendations. Results are sorted by the action office responsible for implementation. Additionally, Table 2 indicates how many of these unimplemented OIG reports and recommendations are less than or more than 1 year.

As of September 30, 2011, there are 155 open reports and 846 open recommendations. Thirty-five of these reports and 76 of these recommendations remain unimplemented for over 1 year. However, some reports and recommendations are counted more than once in Table 1 below because they have actions at more than one office. Of the reports open less than 1 year, five reports have actions at two or more offices. Of the reports open more than 1 year, one report and five recommendations have actions at two or more offices. Although the FY 2010 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 September 30, 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	19	**115**	627	32	**659**
Veterans Benefits Administration	19	3	**22**	80	7	**87**
National Cemetery Administration	0	1	**1**	0	2	**2**
Office of Information & Technology	5	9	**14**	52	22	**74**
Office of Operations, Security, and Preparedness	1	1	**2**	0	10	**10**
Office of Acquisitions, Logistics, and Construction	2	3	**5**	4	8	**12**
Office of Human Resources and Administration	1	0	**1**	4	0	**4**
Office of Small and Disadvantaged Business Utilization	1	0	**1**	3	0	**3**
Total	**125**	**36**	**161**	**770**	**81**	**851**

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 Facilities] 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.*

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.*

Audit of VA Electronic Contract Management System Report No. 08-00921-181, Issued 07/30/2009	OALC	2 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 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.*

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**
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	1 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.*

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	8 of 34	-

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

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

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

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

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

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

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

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

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**

** OIG disagrees with the Office of General Counsel's (OGC's) legal opinions finding that a violation of the nepotism statute did not occur and no legal basis exists for collecting funds from individual employees, but closed recommendations 1, 3, and 18-24 because OIT is planning no further action in light of OGC's legal opinions. OIG stands by the recommendations, but will not waste any more resources in pursuit of corrective action.*

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.*

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	OIT	2 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 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, VistA Outages Affecting Patient Care, Office of Risk Management and Incident Response, Falling Waters, WV Report No. 09-01849-39, Issued 12/03/2009	OIT	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.

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.

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**
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.

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.

Review of Brachytherapy Treatment of Prostate Cancer, Philadelphia, Pennsylvania and Other VA Medical Centers Report No. 09-02815-143, Issued 05/03/2010	VHA	1 of 5	-

Recommendation 3: VHA should review the controls that are in place to ensure that VA contracts for health care comply with applicable laws and regulations, and where necessary, make the required changes in organization and/or process to bring this contracting effort into compliance.

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 National Call Centers and the Inquiry Routing and Information System Report No. 09-01968-150, Issued 05/13/2010	VBA	4 of 7	-

Recommendation 2: We recommend the Acting Under Secretary for Benefits establish a national performance target for blocked call rate.

Recommendation 3: We recommend the Acting Under Secretary for Benefits establish a national performance standard for productivity at the call agent level.

Recommendation 4: We recommend the Acting Under Secretary for Benefits conduct a review of call agent productivity and call demand to determine what changes in the call center structure and/or additional staffing are needed to ensure performance standards are met.

Recommendation 7: We recommend the Acting Under Secretary for Benefits establish consistent accuracy performance measures and national performance standards for call agents and the IRIS [Inquiry Routing and Information System] manager.

Audit of Oversight of Patient Transportation Contracts Report No. 09-01958-155, Issued 05/17/2010	VHA	3 of 8	$91,944,596

Recommendation 3: We recommend the Under Secretary for Health establish specific controls to provide effective monitoring and oversight in accordance with the OAL [Office of Acquisition and Logistics] issued IL 001AL-09-02 and hold COs [Contracting Officers] responsible and accountable for all patient transportation contracts.

Recommendation 4: We recommend the Under Secretary for Health implement controls to ensure patient transportation invoices are adequately reviewed before certification for payment and initiate recovery of overpayments and reimbursements of underpayments resulting from calculation errors on contractor invoices identified by our audit.

Recommendation 6: We recommend the Under Secretary for Health automate patient transportation billing information in order to maintain and retain data needed to efficiently perform invoice reconciliation.

Audit of VISN Procurement Practices for FSS Professional and Allied Healthcare Staffing Services Report No. 08-00270-162, Issued 06/07/2010	VHA	1 of 5	-

Recommendation 5: We recommend the Under Secretary for Health have the PLO [Procurement and Logistics Office] evaluate the identified health care staffing services orders where facilities exceeded the FSS NTE [Federal Supply Schedule not-to-exceed] rates to determine if any improper payments can be recovered.

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 Federal Supply Schedule 621 I-- Professional and Allied Healthcare Staffing Services Report No. 08-02969-165, Issued 06/07/2010	OALC	5 of 7	-

Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable.

Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC [National Acquisition Center] to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).

Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.

Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.

Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.

Audit of Guide and Service Dog Program Report No. 10-01714-188, Issued 07/07/2010	VHA	1 of 1	-

Recommendation 1: We recommended the Under Secretary for Health issue comprehensive interim guidance, until the draft regulation addressing service dogs is finalized, to ensure VA medical center providers and PSAS [Prosthetics and Sensory Aids Service] employees better understand the benefits offered and process to apply for service dogs.

Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas Report No. 10-01189-187, Issued 07/09/2010	VHA	1 of 15	-

Recommendation 2: We recommended that the Acting VISN Director ensure that the System Director requires that device-specific SOPs and guidelines for LLD [low-level disinfection] are established and consistent with the manufacturers' instructions for all pieces of RME [reusable medical equipment] and that staff comply.

Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island Report No. 10-01158-190, Issued 07/13/2010	VHA	3 of 18	-

Recommendation 15: We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

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 16: We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff provide patients with appropriate written discharge instructions, educate patients regarding discharge instructions, and consistently document these actions. *Recommendation 18: We recommended that the VISN Director ensure that the Acting Medical Center Director requires that skin care assessments and interventions be consistently documented.*			
Combined Assessment Program Review of Information Security Issues Impacting VA Teleradiology Contracts Report No. 10-03122-198, Issued 07/20/2010	VHA	1 of 6	-
Recommendation 3: We recommend that the Under Secretary for Health implement automated mechanisms to ensure that all computers, supporting Teleradiology services, deploy and maintain appropriate security protections, such as firewalls and antivirus solutions, in accordance with VA policy and the terms of the contracts.			
Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York Report No. 10-00471-201, Issued 07/21/2010	VHA	1 of 9	-
Recommendation 9: We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.			
Healthcare Inspection Community Based Outpatient Clinic Reviews: Corpus Christi and New Braunfels, TX; Long Beach (Cabrillo) and Santa Fe Springs (Whittier), CA; San Diego (Mission Valley) and El Centro (Imperial Valley), CA; and Commerce (East Los Angeles) and Oxnard, CA Report No. 10-00627-208, Issued 07/27/2010	VHA	1 of 21	-
Recommendation 19: We recommended that the VISN 22 Director ensure that the Greater Los Angeles HCS Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract for the East Los Angeles CBOC. The Greater Los Angeles HCS should research the overpayments attributable to inactive patients and seek reimbursement for those overpayments.			

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**
Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico Report No.10-01435-210, Issued 07/27/2010	VHA	2 of 13	-

Recommendation 5: We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to harmful atmospheres receive annual respirator fit testing and bloodborne pathogens training, as required.

Recommendation 7: We recommended that the VISN Director require that the System Director ensures that all required disciplines attend EOC [environment of care] rounds and that deficiencies found on EOC rounds are properly recorded, tracked, and prioritized.

Audit of Community-Based Outpatient Clinic Management Oversight Report No. 09-02093-211, Issued 07/28/2010	VHA	1 of 6	-

Recommendation 2: We recommended that the Under Secretary for Health develop a set of comprehensive monitoring mechanisms to evaluate CBOC performance and hold quarterly CBOC reviews with the Networks to discuss CBOC performance results, and as needed, corrective actions.

Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, Florida Report No. 10-00054-218, Issued 08/10/2010	VHA	1 of 12	-

Recommendation 9: We recommended that the VISN Director ensure that the System Director requires that measures be taken to maintain temperature, humidity, and air exchanges in sterile storage areas at prescribed levels.

Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania Report No. 10-01782-222, Issued 08/16/10	VHA	2 of 10	-

Recommendation 4: We recommended that the facility implement interim measures to maintain temperature and humidity ranges in accordance with VA policy until construction is completed.

Recommendation 10: We recommended that staff complete required inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

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**
Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California Report No. 10-01438-231, Issued 08/24/2010	VHA	1 of 11	-

Recommendation 5: We recommended that N95 respirator fit testing be provided annually to staff identified as at risk for exposure to airborne infections.

Audit Review of Alleged Improper Program Management within the FLITE Strategic Asset Management Pilot Project Report No. 10-01374-237, Issued 09/07/2010	OIT	1 of 7	-

Recommendation 6: We recommended the Assistant Secretary for Information and Technology validate that SAM [Strategic Asset Management] project officials complete system migration plans for the SAM project.

Audit of the FLITE Strategic Asset Management Pilot Project Report No. 09-03861-238, Issued 09/14/2010	OIT	2 of 9	-

Recommendation 2: We recommended that within the next 3 months, the Assistant Secretary for Information and Technology in coordination with the SAM project manager develop a new operating model and related roles and responsibilities to provide a clear definition of both VA and contractors' roles and responsibilities for the SAM pilot, beta, and national deployment projects.

Recommendation 8: We recommended that the Assistant Secretary for Information and Technology perform periodic independent quality assurance reviews of closed risks and issues to ensure that they were adequately addressed before closure.

Combined Assessment Program Review of the Tuscaloosa VA Medical Center, Tuscaloosa, Alabama Report No. 10-00050-247, Issued 09/15/2010	VHA	1 of 8	-

Recommendation 8: We recommended that monitoring results be reported quarterly to the MSEC [Medical Staff Executive Committee], as required.

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**
American Recovery and Reinvestment Act Oversight Advisory Report: Review of Efforts to Meet Competition Requirements and Monitor Recovery Act Awards Report No. 10-00969-248, Issued 09/17/2010	OALC	1 of 5	-

Recommendation 2: We recommended the Executive Director of the OALC develop and issue a comprehensive policy that clearly defines the appropriate procedures for the proper completion of adequate contractor responsibility determinations and related justifications.

Healthcare Inspection Inappropriate Research & Development Data Entries Affecting Veterans Equitable Resource Allocation (VERA) Funding VA Maryland Health Care System, Baltimore, MD Report No. 10-01247-256, Issued 09/23/2010	VHA	1 of 2	-

Recommendation 2: We recommended that the CRADO [Chief Research and Development Officer] ensure that ORD [Office of Research and Development] establish an R&D [Research and Development] management and tracking system to help facilities meet Congressional and other reporting requirements.

VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12 Report No. 10-01575-262, Issued 09/30/2010	OSP/OIT	10 of 11	-

Recommendation 1: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, develop a plan to ensure the PIV [Personal Identity Verification] System interfaces with internal and external systems to electronically verify PIV credential applicant information.

Recommendation 3: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, ensure the PIV System is modified to generate standard performance reports to assist the PMO, system administrators, and other users to effectively manage the HSPD [Homeland Security Presidential Directive]-12 Program.

Recommendation 4: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, ensure the PIV System is modified to provide effective monitoring of System users for unlawful, unauthorized, or inappropriate activities.

Recommendation 5: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, ensure the required Privacy Impact Assessment for the PIV System is prepared and approved annually.

Recommendation 6: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information and Technology, define the extent to which PIV credentials will be required to access VA facilities and information systems and develop plans to test and implement the infrastructure necessary to establish these controls.

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 the Assistant Secretary for Operations, Security, and Preparedness staff program vacancies in the HSPD-12 Program Management Office. *Recommendation 8: We recommend the Assistant Secretary for Operations, Security, and Preparedness finalize the VA Directive and VA Handbook defining the roles, responsibilities, and processes for implementation and ongoing operations of the HSPD-12 Program.* *Recommendation 9: We recommend the Assistant Secretary for Operations, Security, and Preparedness develop quantifiable performance measures for the HSPD-12 Program.* *Recommendation 10: We recommend the Assistant Secretary for Operations, Security, and Preparedness implement a formal oversight process to monitor progress in achieving compliance with the requirements of HSPD-12.* *Recommendation 11: We recommend the Assistant Secretary for Operations, Security, and Preparedness establish accountability over program costs and estimated costs of future HSPD-12 operations.*			
American Recovery and Reinvestment Act Oversight Advisory Report, Review of the Management of Recovery Act Funds for Monument and Memorial Repairs Report No. 09-01814-263, Issued 09/30/2010	NCA	2 of 3	-
Recommendation 1: We recommend the Acting Under Secretary for Memorial Affairs establish a formal process for prioritizing and selecting future work requirements that includes maintaining adequate documentation to justify key project decisions. *Recommendation 3: We recommend the Acting Under Secretary for Memorial Affairs establish outcome-based performance measurements that facilitate the monitoring and managing of the selected projects, as well as the dollars obligated and spent on them, to ensure accomplishment of ARRA [American Recovery and Reinvestment Act of 2009] goals.*			
TOTALS		**76**	$91,944,596

Appendix C: Inspector General Act Reporting Requirements

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

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. 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	410 total reviews commented on 42 times
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 9-47
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 9-47
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 61-72
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 25-40
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 48-60
Section 5 (a) (7)	Summary of each particularly significant report	See pages 9-47
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 74
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 74

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 73

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2010	0	$0
Issued during reporting period	4	$2,770,103,500
Total inventory this period	4	$2,770,103,500
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	4	$2,770,103,500
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	4	$2,770,103,500
Total carried over to next period	0	$0

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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2010	0	$0
Issued during reporting period	3	$899,300,000
Total inventory this period	3	$899,300,000
Management decisions during the reporting period		
Agreed to by management	3	$899,300,000
Not agreed to by management	0	$0
Total management decisions this reporting period	3	$899,300,000
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 OIT support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

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

As of September 30, 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 519 fraud awareness training and outreach sessions across the country attended by over 14,600 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 249 and closed 89 criminal investigations, including 28 convictions, 34 referrals for monetary reclamation, and $30,250 in recoveries related to ARRA-funded programs and projects.
- Received 64 Hotline complaints of potential fraud or waste related to ARRA programs or projects.
- 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's OAE reports that no peer reviews were conducted by another OIG during the reporting period ending September 30, 2011. The last peer review was conducted by the U.S. Department of Agriculture OIG on December 23, 2009, and contained no outstanding recommendations. The next peer review will be initiated in September 2012 by the DOL OIG. 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. VA OIG is scheduled to begin a peer review for SSA OIG in March 2012.

Additionally, OIG's OI reports that no Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review (QAR) was conducted by another OIG during the reporting period ending September 30, 2011. The last CIGIE QAR conducted on VA OIG's investigative operation was completed by the U.S. DOE OIG in 2009. The report contained no recommendations. VA OIG conducted a CIGIE QAR of the National Aeronautics and Space Administration OIG's investigative operation and issued the final report on May 1, 2008, which contained no recommendations.

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On the Cover

Returning servicemembers are greeted by their children. Photo courtesy Department of Veterans Affairs.

United States Department of Veterans Affairs
Office of Inspector General

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