Department of Veterans Affairs
Office of Inspector General

Semiannual Report to Congress

Issue 64 | April 1, 2010—September 30, 2010

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Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to the Congress of the United States. Pursuant to the *Inspector General Act of 1978,* as amended, this report presents the results of our most significant accomplishments during the reporting period April 1 – September 30, 2010.

During this reporting period, the Office of Inspector General (OIG) issued 143 reports on VA programs and operations. OIG inspections, audits, evaluations, investigations, and other reviews identified over $1.2 billion in monetary benefits, for a return of $26 for every dollar expended on OIG oversight.

Our criminal investigators closed 418 investigations and made 257 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 301 administrative sanctions. Fourteen defendants previously indicted on charges relating to conspiracy, bribery, theft, and money laundering were sentenced, with most receiving between 12 to 30 months' incarceration. The defendants included a former VA Regional Office employee, a former Veterans Service Officer, and family members and other acquaintances of these individuals. The defendants had been indicted in November 2008 for filing fraudulent claims with VA in order to receive large, retroactive disability compensation payments, which resulted in a loss to VA of approximately $2 million.

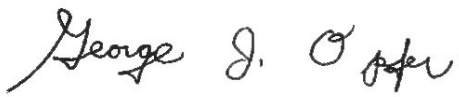
Additionally, an OIG administrative investigation substantiated that a senior official within the Office of Human Resources and Administration (OHRA) engaged in prohibited personnel practices, abused his authority, misused his position to appoint two subordinates, and made false statements. The investigation also substantiated allegations of misconduct against five other OHRA employees.

Oversight work performed by OIG's Office of Audits and Evaluations determined that Veterans Health Administration (VHA) made net overpayments of $120 million on non-VA inpatient care for Veterans in fiscal year (FY) 2009. Without improvements in payment processes, overpayments of $600 million could be made over the next 5 years. In addition, by consolidating the Non-VA Inpatient Care Fee Program's claim processing system and achieving economies of scale, OIG auditors conservatively estimate that VHA would achieve a cost savings of $26.8 million in FY 2009, or $134 million over the next 5 years.

Our Office of Healthcare Inspections staff published Combined Assessment Program reviews of 33 VHA medical centers, focusing on a variety of actions critical to ensuring that Veterans receive high quality medical care. In reviews of 42 community based outpatient clinics, inspectors made recommendations to ensure that Veterans receive the same high quality of care whether they are treated at medical centers or freestanding clinics.

We appreciate the ongoing support we receive from the Secretary, Deputy Secretary, and senior management. We look forward to continuing our partnership with VA and Congress to ensure the

Department is transformed into a 21st Century organization that honors America's Veterans by providing them the proper care, support, and recognition they have earned in service to our country.



GEORGE J. OPFER
Inspector General

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		Reporting Period	FY
DOLLAR IMPACT (in Millions)	Better Use of Funds	$226	$502
	Fines, Penalties, Restitutions, and Civil Judgments	$37.5	$83.4
	Fugitive Felon Program	$107.5	$171.1
	Savings and Cost Avoidance	$121.4	$403.7
	Questioned Costs	$725.5	$725.6
	Dollar Recoveries	$23.1	$28.1
	Total Dollar Impact	**$1,241**	**$1,913.7**
	Cost of OIG Operations[1]	**$47**	**$94**
	Return on Investment (Total Dollar Impact/Cost of OIG Operations)	**26:1**	**20:1**
OTHER IMPACT	***Reports Issued***		
	Administrative Investigations	3	5
	American Recovery and Reinvestment Act	4	7
	Audits and Reviews	13	22
	Benefits Inspections	8	14
	Combined Assessment Program Reviews	33	55
	Community Based Outpatient Clinic Reviews (encompassing 42 facilities)	6	8
	Healthcare Inspections	27	53
	Preaward Contract Reviews	35	70
	Postaward Contract Reviews	13	28
	Counselor to the Inspector General Special Reports	1	1
	Total Reports Issued	**143**	**263**
	Investigative Activities		
	Arrests (Non-Fugitive Felon)	230	465
	Fugitive Felon Arrests	27	61
	Fugitive Felon Apprehensions by Other Agencies with OIG Assistance	17	25
	Indictments	148	298
	Criminal Complaints	90	170
	Convictions	175	344
	Pretrial Diversions	19	39
	Administrative Sanctions	301	533
	Cases Opened	560	988
	Cases Closed	418	842
	Healthcare Inspections Activities		
	Clinical Consultations	4	5
	Administrative Case Closures	9	19
	Hotline Activities		
	Contacts	14,737	29,337
	Cases Opened	460	885
	Cases Closed	394	908
	Administrative Sanctions	19	41
	Substantiation Rate	44%	45%

1. This figure does not include the $9.4 million operating cost for the Office of Healthcare Inspections. We do not include this figure because oversight work performed by OHI results in saving lives and not dollars.

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) 2010, VA operated under a $127.1 billion budget, with nearly 300,000 employees serving an estimated 23.1 million living Veterans. To serve the Nation's Veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Republic of the Philippines.

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

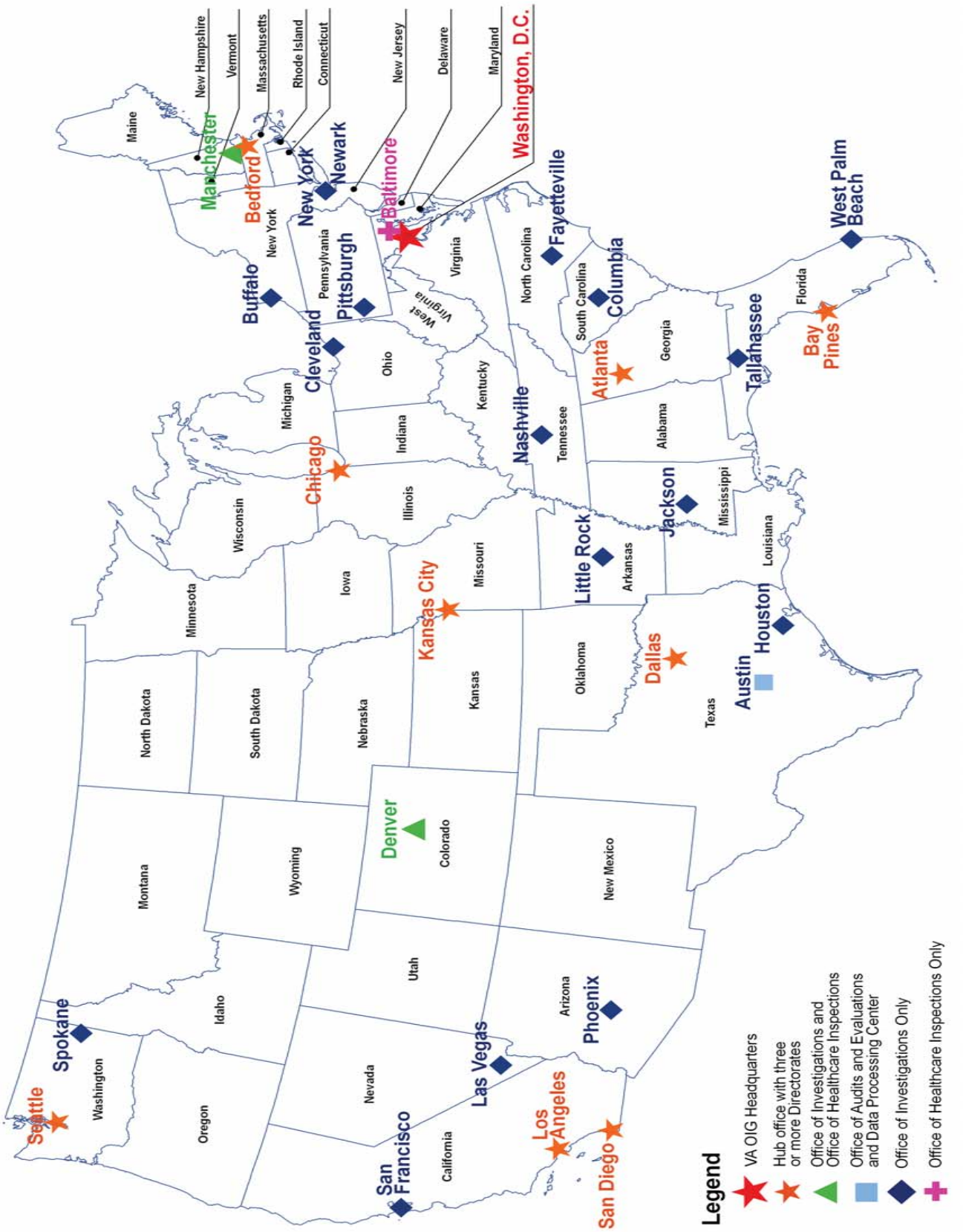
VA Office of Inspector General

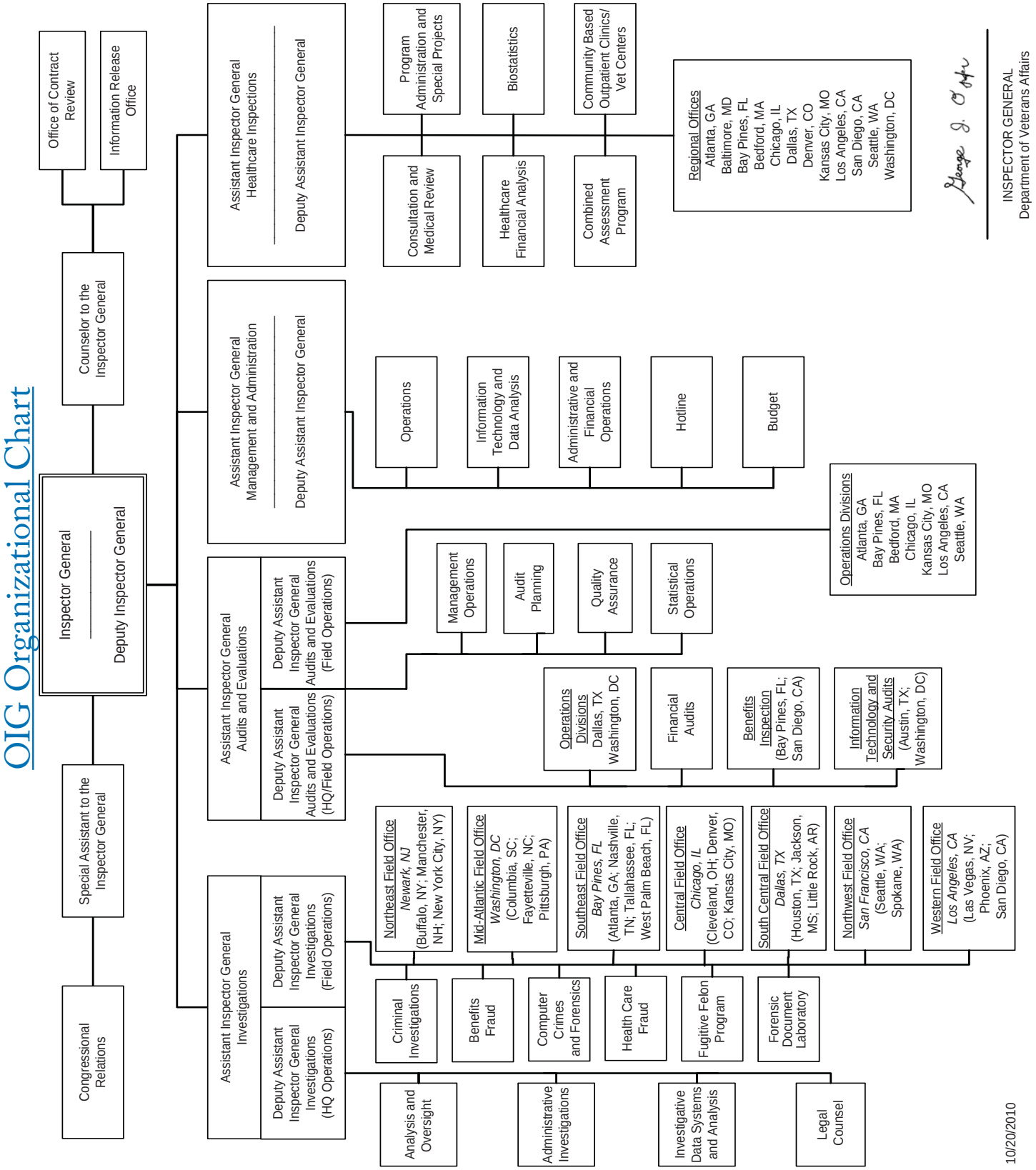
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General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

OIG, with about 600 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2010 funding for OIG operations provided $109 million from ongoing appropriations. The Office of Contract Review, with 25 employees, received $3.9 million through a reimbursable agreement with VA for contract review services, including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS) contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country.

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

OIG Field Offices Map




OIG Organizational Chart
Inspector General
Deputy Inspector General
Office of Contract Review
Information Release Office
Counselor to the Inspector General
Special Assistant to the Inspector General
Congressional Relations
Assistant Inspector General Healthcare Inspections
Deputy Assistant Inspector General
Program Administration and Special Projects
Biostatistics
Community Based Outpatient Clinics/ Vet Centers
Consultation and Medical Review
Healthcare Financial Analysis
Combined Assessment Program
Regional Offices
Atlanta, GA
Baltimore, MD
Bay Pines, FL
Bedford, MA
Chicago, IL
Dallas, TX
Denver, CO
Kansas City, MO
Los Angeles, CA
San Diego, CA
Seattle, WA
Washington, DC
Assistant Inspector General Management and Administration
Deputy Assistant Inspector General
Operations
Information Technology and Data Analysis
Administrative and Financial Operations
Hotline
Budget
Assistant Inspector General Audits and Evaluations
Deputy Assistant Inspector General Audits and Evaluations (Field Operations)
Deputy Assistant Inspector General Audits and Evaluations (HQ/Field Operations)
Management Operations
Audit Planning
Quality Assurance
Statistical Operations
Operations Divisions
Atlanta, GA
Bay Pines, FL
Bedford, MA
Chicago, IL
Kansas City, MO
Los Angeles, CA
Seattle, WA
Operations Divisions
Dallas, TX
Washington, DC
Financial Audits
Benefits Inspection
(Bay Pines, FL; San Diego, CA)
Information Technology and Security Audits
(Austin, TX; Washington, DC)
Assistant Inspector General Investigations
Deputy Assistant Inspector General Investigations (Field Operations)
Deputy Assistant Inspector General Investigations (HQ Operations)
Northeast Field Office
Newark, NJ
(Buffalo, NY; Manchester, NH; New York City, NY)
Mid-Atlantic Field Office
Washington, DC
(Columbia, SC; Fayetteville, NC; Pittsburgh, PA)
Southeast Field Office
Bay Pines, FL
(Atlanta, GA; Nashville, TN; Tallahassee, FL; West Palm Beach, FL)
Central Field Office
Chicago, IL
(Cleveland, OH; Denver, CO; Kansas City, MO)
South Central Field Office
Dallas, TX
(Houston, TX; Jackson, MS; Little Rock, AR)
Northwest Field Office
San Francisco, CA
(Seattle, WA; Spokane, WA)
Western Field Office
Los Angeles, CA
(Las Vegas, NV; Phoenix, AZ; San Diego, CA)
Criminal Investigations
Benefits Fraud
Computer Crimes and Forensics
Health Care Fraud
Fugitive Felon Program
Forensic Document Laboratory
Analysis and Oversight
Administrative Investigations
Investigative Data Systems and Analysis
Legal Counsel
INSPECTOR GENERAL
Department of Veterans Affairs
10/20/2010

The health care that VHA provides Veterans is consistently ranked among the best in the Nation, whether those Veterans are recently returned from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 11 national healthcare inspections; 16 Hotline healthcare inspections; 33 Combined Assessment Program (CAP) reviews; and 6 Community Based Outpatient Clinic (CBOC) reports, covering 42 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 fraud and integrity awareness briefings. During this reporting period, OIG issued 33 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 January 2010 are:

- Coordination of care.
- Environment of care.
- Magnetic resonance imaging safety.
- Medication management.
- Physician credentialing and privileging.
- Quality management (QM).
- Reusable medical equipment.
- Suicide prevention safety plans.

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

Community Based Outpatient Clinic Reviews

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, FY 2009, OIG initiated a systematic review of VHA CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of four components: CBOC site-specific information gathering and review, medical record reviews for determining compliance with VHA performance measures, onsite inspections, and CBOC contract review. The objectives of the reviews are to determine: (1) whether CBOC quality of care measures are comparable to the parent facility clinics, (2) whether CBOC providers are appropriately credentialed and privileged in accordance with VHA policy, (3) whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health needs of OEF/OIF era Veterans, (4) whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency management planning, (5) the effect of CBOCs on Veterans' perception of care, and (6) whether CBOC contracts were administered in accordance with contract terms and conditions.

During this reporting period, OIG performed 42 CBOC reviews throughout 13 Veterans Integrated Service Networks (VISNs). These reviews were captured in 6 reports. We made recommendations for improvements at the following facilities:

- VISN 1: Greenfield and Pittsfield, MA
- VISN 2: Dunkirk and Niagara Falls, NY
- VISN 4: Foxburg (Clarion County) and Hermitage (Marzano), PA
- VISN 5: Cumberland, MD, and Harrisonburg, VA
- VISN 8: Boca Raton, Coral Springs, Delray Beach, Key West, Stuart, and Vero Beach, FL
- VISN 9: Smithville, MS; Chattanooga, Knoxville, Memphis (Memphis-South), and Nashville (Vine Hill), TN; and Norton, VA
- VISN 10: Cambridge, Canton, Painesville, and Portsmouth, OH
- VISN 11: Muncie and South Bend, IN
- VISN 17: Corpus Christi, Denton, Fort Worth, and New Braunfels, TX
- VISN 18: Payson and Sun City, AZ
- VISN 19: Fort Collins, CO, and Sidney, NE
- VISN 21: Eureka and Ukiah, CA
- VISN 22: Commerce (East Los Angeles), El Centro (Imperial Valley), Long Beach (Cabrillo), Oxnard, San Diego (Mission Valley), and Santa Fe Springs (Whittier), CA

National Reports

Quality Management Lapses Cited in Review of Brachytherapy Treatment

At the request of the VA Secretary and Members of Congress, OIG performed a comprehensive review of prostate brachytherapy performed at the Philadelphia, PA, VA Medical Center (VAMC) and elsewhere in VHA. OIG found that an incident at the Philadelphia VAMC involving a prostate cancer patient being inadvertently implanted with radioactive seeds of the wrong strength was an isolated occurrence; however, there were numerous process deficiencies at the VAMC in quality management, information technology, and contracting with the University of Pennsylvania. The VAMC also had numerous Nuclear Regulatory Commission compliance issues. Despite these issues, recurrence and disease-relapse rates of VAMC prostate brachytherapy patients appear within the norm and complication and adverse event rates were not excessive. OIG made five recommendations to correct these deficiencies.

VHA Quality Assurance Programs and Contract Services Reviewed

As requested by the Senate Appropriations Committee, OIG completed a review of VHA quality assurance and oversight programs, including peer review activities at VAMCs and guidance in place to ensure proper oversight of contract services. OIG examined pertinent VHA directives, handbooks, and memoranda, meeting minutes, and other publications, and interviewed VHA executives. VHA has extensive programs in place for the oversight of medical delivery at its facilities and collaborates with numerous external agencies and with the OIG. Substantial organizational innovations are currently being initiated to improve the effectiveness of professional peer review and contracting. OIG made no recommendations and will continue to monitor VHA's progress in these areas.

OIG Review Found Progress, Barriers in Implementation of VHA Mental Health Handbook

OIG conducted a review of VA's progress in implementing VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (the Handbook), as directed in House of Representatives Report 111-188 to accompany H.R. 3082, the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2010. The review also assessed the metrics

developed by VA to ensure implementation of Handbook requirements, the system developed to track use of evidence-based post-traumatic stress disorder (PTSD) therapies, whether VA has sufficient inpatient capability available for substance use treatment, and the identification of any barriers to full implementation. OIG made five recommendations to the Under Secretary for Health to achieve full implementation of the Handbook.

Fee Care Providers Not Consistently Providing VA with Mammogram Results

OIG evaluated VA clinicians' access to documented results for primary care services provided to women Veterans and their acknowledgement of these results. OIG found that results for Pap smears and bone mineral density studies were readily accessible and abnormal results acknowledged in nearly 95 percent of cases. Abnormal results not acknowledged were limited to bone mineral density studies in patients with osteopenia or treated osteoporosis. Mammography results were accessible and abnormal results acknowledged in 97 percent of cases when these tests were performed at VHA facilities. However, when mammograms were performed through fee basis arrangements, results were accessible to VA clinicians in only 74 percent of cases.

VHA Needs to Ensure Patients with Hip or Vertebral Fractures Treated for Osteoporosis

OIG's Office of Healthcare Inspections assessed the extent to which VHA patients who experience a fracture of the hip or vertebra are appropriately evaluated and treated for osteoporosis. Using the Healthcare Effectiveness Data and Information Set measure for post-fracture osteoporosis management, OIG determined that compliance among patients with two or more VHA primary care visits in the prior year was 45 percent. Men were less likely to be appropriately managed for osteoporosis after a fracture. Additionally, hip fractures were less likely to be associated with osteoporosis management when compared with vertebral fractures. OIG recommended that the Under Secretary for Health implement a plan to ensure that patients with hip or vertebral fractures are appropriately evaluated and treated for osteoporosis.

OIG Evaluated VHA's Quality Management Programs at 44 Facilities

An evaluation was conducted by OIG to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts. Furthermore, the evaluation reviewed whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. Although all 44 facilities reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. Senior managers at all facilities reported that they support their QM programs and actively participate. The Under Secretary for Health concurred with OIG's five recommendations to improve operations.

VHA Needs to Ensure Compliance with Physician Credentialing and Privileging

The purpose of this evaluation was to determine whether VHA facilities complied with selected requirements for credentialing and privileging physicians. OIG performed the review at 35 VHA medical facilities during CAP reviews conducted from July 2009 through March 2010. VHA facilities generally met the VHA credentialing requirements reviewed; however, privileging practices could be strengthened if efforts were made to more thoroughly discuss, document, and monitor physicians' competence to perform the requested privileges. OIG recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure compliance with VHA privileging requirements.

VHA Must Ensure Requirements Met for Contracted/Agency Registered Nurses

The purpose of OIG's evaluation was to determine whether Registered Nurses (RNs) working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. VHA facilities generally met requirements regarding contracted/agency RNs; however, not all facilities completed required verifications, evaluations, and training prior to contracted/agency RNs caring for patients and accessing medical records. OIG noted opportunities for improvement in licensure verification, background checks, competency evaluations, completion of information security awareness and privacy awareness training, and maintenance of Advanced Cardiac Life Support certification. OIG made recommendations to ensure that all requirements are met.

VHA Shows Improvements to Missing Patient Policies and Procedures

A follow-up review to a November 2000 OIG report on VHA missing patient policies and procedures determined that VHA facilities were appropriately following up on missing patients and documenting the outcomes of those efforts. Furthermore, the review found that staff are reporting missing patient events in accordance with guidelines. Since the last evaluation, VHA has also shown substantial improvement in the areas of elopement/wandering risk assessment and implementation of safety measures; however, additional actions are needed related to applying assessment criteria, timing of assessments, documenting proactive and concurrent safety measures, and placing Patient Record Flags. OIG also found that VHA Directive 2008-057 provides confusing guidance related to the timing of risk assessments, and that local policies did not always comply with other requirements as outlined in the Directive. The Under Secretary for Health agreed with the findings and conclusions and provided acceptable improvement plans.

Emergency Departments, Urgent Care Clinics Meet VHA Standards for Uniform Delivery of Healthcare

OIG performed a healthcare inspection of 46 VHA emergency departments (EDs) and urgent care clinics (UCCs). The review found that VHA facilities' EDs and UCCs generally met VHA guidelines; however, ED/UCC operations could be strengthened in the areas of documentation, competency evaluations, and privileging requirements. OIG recommended that VHA reinforce compliance with transfer and discharge documentation requirements, and ensure compliance with VHA competency evaluations and privileging requirements.

Hotline Reports

Endoscope Reprocessing Issues Substantiated at St. Louis, Missouri, VAMC

OIG conducted an inspection in response to allegations of ongoing endoscope reprocessing issues and breakdowns in communication with regard to adverse events and outcomes at the VAMC in St. Louis, MO. OIG substantiated the allegations and identified several items related to reusable medical equipment reprocessing and staff safety that need improvement to meet VHA policy requirements.

Poor Coordination and Communication Resulted in Delays in Veteran Care at Orlando VAMC

OIG conducted an inspection in response to allegations of inadequate coordination of care with Fee Basis Service (FB), Interfacility Consults (IFC), and Project Health Effectiveness through Resource

Optimization (HERO) at the Orlando, FL, VAMC. OIG confirmed that Veterans experienced delay of medical care due to poor coordination and communication in the care management system; however, no patients were harmed because of these delays. OIG confirmed that the FB authorization letter and communication between FB staff and Veterans needed improvement, and that the VAMC had not established a formalized system to ensure timeliness of care for Veterans requiring IFCs. The inspection found that Project HERO was not meeting its contractual performance benchmarks of 100 percent compliance for timely referrals and communication with FB providers. HERO's current performance benchmarks regarding access to care and return of medical records average 90 percent. The VISN and VAMC Directors concurred with the findings and recommendations.

VA Care Not a Factor in Veteran's Suicide

A congressional request prompted OIG to evaluate the care of a Veteran who committed suicide 5 days after discharge from a VHA medical facility. The patient was hospitalized for treatment of depression and anxiety, but denied having any suicidal ideations. OIG found that the patient received appropriate care and that clinicians made reasonable decisions and acceptable discharge plans based on what they knew about the patient's home safety situation. At the time of discharge, the patient was competent to make decisions and did not voice suicidal ideations. The VISN and VAMC Directors agreed with the findings and OIG made no recommendations.

VAMC's Oversight of Human Subjects' Research Activities Inadequate

OIG conducted a healthcare inspection to determine the merit of allegations related to inadequate oversight of human subjects' research and improper Institutional Review Board (IRB) actions that resulted in patient harm at a VAMC. No evidence was found that indicated the patient was harmed because of his removal from Protocol X or because of medical decisions made by an oncologist. Additionally, the IRB acted within its authority and took appropriate actions. OIG substantiated that responsible managers did not assure adequate oversight of human subjects' research activities. Furthermore, some deficiencies previously identified by external review groups still existed, and OIG found inadequate documentation. OIG also questioned some management decisions related to peer review, study audits, and provider reprivileging. Management agreed with the findings and recommendations and provided acceptable improvement plans.

Mortality Review Finds Allegations Not Substantiated at Saginaw, Michigan, VAMC

OIG reviewed the validity of allegations regarding deaths at the Aleda E. Lutz VAMC in Saginaw, MI. The complainant specifically alleged that clinical staff failed to obtain appropriate requests for autopsy and did not appropriately report deaths to the Medical Examiner. OIG did not substantiate the allegations but did identify aspects of care warranting improvement for one patient. The VISN and VAMC Directors concurred with OIG recommendations to ensure that staff follow acute coronary syndrome guidelines, appropriately monitor patients at all times, follow national resuscitation guidelines and review all resuscitation efforts for compliance with those guidelines, and comply with VHA policy for Out-of-Operating Room Airway Management.

ICU Alarm Turned Off at Lexington, Kentucky, VAMC

OIG reviewed allegations that poor post-operative nursing care in the intensive care unit (ICU) led to complications resulting in a patient's death at the Lexington, KY, VAMC. OIG concluded the nursing care provided in the intensive care unit was appropriate. OIG substantiated the allegation that the pulse oximeter alarm was turned off during a nursing shift. In addition, OIG found that nursing care

flow sheets and progress notes in the medical record were difficult to navigate. OIG recommended that alarm systems in the ICU remain activated and functional at all times, and that processes be established to improve medical record documentation of nursing care in the intensive care unit.

Respiratory Care, Nurse Staffing Issues Unfounded at Memphis, Tennessee, VAMC

Two anonymous complaints regarding respiratory therapy (RT) and nurse staffing issues at the Memphis, TN, VAMC prompted a review by OIG. OIG confirmed that two RTs and a surgery resident were unable to intubate a patient; however, OIG did not substantiate that this contributed to the patient's death. Medical record documentation clearly reflects that the patient was ventilated between intubation attempts and RT competency files reflected appropriate certification and competence in airway management. OIG did not substantiate the other allegations and noted that actions were being taken to enhance RT and nurse staffing in both areas. OIG made no recommendations.

OIG Confirmed Incorrect Administration of Medication to Battle Creek, Michigan, VAMC Employee

OIG performed an inspection at the Battle Creek, MI, VAMC to determine the validity of allegations regarding quality of care and privacy violations. OIG substantiated that an employee had an allergic reaction and that epinephrine was administered incorrectly. Five of the complainant's allegations resulted in recommendations to the VISN and Medical Center Directors.

Abuse Allegations Not Substantiated Against Cleveland, Ohio, VAMC

OIG reviewed allegations related to patient abuse and quality of care at the Louis Stokes VAMC in Cleveland, OH. The complainant provided limited information related to the alleged abuse; however, we found no evidence of abuse based on our review of relevant documents and staff interviews. Further, while the patient's death did result from a perforated bowel during hernia repair surgery, this is an unfortunate but known potential complication of the procedure. When the perforated bowel and subsequent sepsis were discovered, clinical staff aggressively treated the patient's multiple and complex medical issues. OIG did not make any recommendations.

Review Confirmed Inaccurate Documentation, Diagnosis at Dallas Health Care System

OIG reviewed the validity of allegations on quality of care issues in Geriatrics and Extended Care Service at the VA North Texas Health Care System (HCS) in Dallas, TX. OIG substantiated that a diagnosis of a coronary artery bypass graft was inaccurately documented in a patient's history and physical, and that a physician recommended removal of a patient's cognitive impairment diagnosis based on a brief cognitive exam. However, neither of these occurrences adversely affected patient care. OIG made no recommendations.

Wait Times Allegations Not Substantiated Against Gainesville, Florida, VAMC

OIG performed a review of the Malcom Randall VAMC in Gainesville, FL, to determine the validity of allegations relating to excessive wait times for radiology biopsies and cardiac catheterizations; lack of sedation and inadequate recovery time for radiology biopsies; and radiology biopsies performed by staff uncertified in Basic Life Support and Advanced Cardiac Life Support. OIG did not substantiate the allegations and made no recommendations.

Healthcare Inspection Confirms Delay in Cancer Diagnosis at Iowa City, Iowa, VAMC

The purpose of OIG's review was to determine the validity of allegations regarding a delay in cancer diagnosis and treatment and quality of care issues at the Iowa City, IA, VAMC. OIG substantiated that 52 days elapsed from the time the patient's initial computed tomography scan showed an abnormality to the biopsy indicating pancreatic cancer. OIG also substantiated that the patient was misinformed regarding non-VA care and reimbursement for travel. OIG recommended that the VISN and VAMC Directors monitor reporting of abnormal tests and make provisions for staff to refer patients to the appropriate administrative support offices when there are questions related to eligibility and travel pay.

VHA Research and Development Expense Reporting Needs Improvement

OIG conducted a healthcare inspection to review allegations concerning whether VA Research and Development (R&D) expenses were being over-reported by VAMCs to gain increased reimbursement funding. The review was initiated after an Administrative Investigation Board found inappropriate reporting of R&D projects that increased the Veterans Equitable Resource Allocation (VERA) funding for R&D expenses at the VA Maryland HCS by $15,500,000. The scope of the review was limited due to underlying R&D data integrity and validation issues. OIG recommended that the Under Secretary for Health establish: (1) a process that validates the Enterprise Project Management Information System and Research and Development Information System data with the VISN chief financial officers prior to submission to the Allocation Resource Center, and (2) an R&D management and tracking system to help facilities meet Congressional and other reporting requirements. Additionally, historical records should be maintained so that the Office of Research and Development has the ability to support and explain any data variances between supporting data and the data reported in the VERA Table 8 allocation.

Alaskan Patient Referrals and Transfers to the Lower 48 States Appropriate

At the request of Senator Lisa Murkowski, OIG conducted a review of patient referrals and transfers from the VA HCS in Anchorage, AK, to VA specialty care providers in the lower 48 states. Factors related to Alaska's location and geography pose challenges to providing a full range of health care services. In FY 2009, the system referred 4 percent of patients to the lower 48 states for specialty care either not available or with limited availability in Alaska such as spinal cord injury, neurosurgery, and neurology. The system complied with existing laws and regulations related to providing health care to Alaskan VA enrollees, and the transfer of these patients appears to be a reasonable use of resources. OIG made no recommendations.

OIG Determines Wisconsin Patient's Care Appropriate Despite Allegations

At the request of the VA Secretary and Representative David R. Obey, the OIG performed a review to determine the validity of allegations regarding multiple care deficiencies at the Tomah VAMC and William S. Middleton Memorial Veterans Hospital in Tomah and Madison, WI, respectively. The complainant alleged that a patient died as a direct result of mismanagement of his antiarrhythmic cardiac medications and that the patient was denied benefits for exposure to Agent Orange while stationed in Thailand during the Vietnam War. OIG did not substantiate most of the complainant's specific allegations and determined that there was disparity between the complainant's perception of the patient's care and the actual care that was documented in the patient's medical records. OIG made no recommendations.

Patient's Allegations Not Substantiated Against Portland, Oregon, VAMC

OIG conducted a healthcare inspection at the Portland, OR, VAMC to determine the validity of allegations that a woman Veteran received inappropriate treatment. OIG confirmed that the patient was placed in a room with a shared bathroom; however, the adjacent room was empty. Although OIG could neither confirm nor refute that unit employees were insensitive to the patient's disability, facility managers agreed to conduct sensitivity awareness training. OIG made no recommendations.

Veterans Health Administration Reports

OIG audits and evaluations of VHA programs focus on the effectiveness of health care delivery for Veterans. These audits and evaluations identify opportunities for enhancing management of program operations and provide VA with constructive recommendations to improve health care delivery.

Improper Payments in Fee Care Program Could Reach $600 Million in 5 Years

An OIG audit of the Non-VA Inpatient Fee Care Program determined that VAMCs improperly paid 28 percent of claims due to inadequate guidance or a lack of understanding by fee staff on how to determine eligibility. OIG estimates that VHA made net overpayments of $120 million on inpatient care claims for Veterans in FY 2009. OIG estimated that without management action to strengthen the payment process that VHA could make $600 million in improper payments over the next 5 years. Additionally, inefficiencies occurred in the Fee Program because of its decentralized structure and labor-intensive payment system. Consolidating the Fee Program's claim processing system could achieve a cost savings of $26.8 million in FY 2009, or $134 million over the next 5 years.

VA Could Save $92 Million in Patient Transportation Contracts

An OIG audit determined that VISN contract managers did not effectively provide the oversight needed to develop, administer, award, and monitor VHA patient transportation contracts. Additionally, Contracting Officer's Technical Representatives did not adequately review invoices before certifying payments. VHA missed opportunities to provide full and open competition in soliciting offers and awarding patient transportation contracts. Because Contracting Officers did not always award transportation services competitively, and instead extended or awarded sole-source contracts, VA cannot be assured of obtaining the best price for the services. OIG made eight recommendations to improve VHA's oversight of patient transportation contracts that could save VA $92 million over 5 years if implemented.

VA Could Save $38.5 Million on Health Care Staffing Services with Better Contracting Practices

An audit of VISN procurements of FSS health care staffing services determined that contracting officers did not adequately review order prices and ensure compliance with Federal Acquisition Regulation (FAR) ordering and competition requirements during the period of review. In addition, the Procurement and Logistics Office lacked an effective oversight process for health care staffing services procurements and had not worked effectively with the National Acquisition Center (NAC) to implement adequate FSS procurement policies, procedures, and training. OIG projected that medical facilities overpaid FSS vendors about $5.8 million for labor and $1.8 million for travel expenses. Consequently, VHA could reduce its FSS health care staffing services costs by about $38.5 million over the next 5 years if it strengthened its price evaluation and ordering practices and met competition requirements.

CBOC System Needs Comprehensive Controls

An OIG audit determined that VHA lacks a comprehensive CBOC management control system. VHA also lacks reasonable assurance that CBOCs provide consistent, quality care in accordance with VA policy. To address these findings, VHA needs to establish CBOC-specific monitors and evaluations that can identify systemic problems and deviations from the standard of care.

Millions at Risk to Fraud in Non-VA Fee Care Program

OIG's review of fraud management for the Non-VA Fee Care Program found that although Federal law requires agencies to maintain controls that safeguard against fraud, VHA has not established controls designed to prevent and detect fraud primarily because it had not identified fraud as a significant risk to the Fee Program. OIG estimates that the Fee Program could be paying between $114 million and $380 million annually for fraudulent claims. OIG recommended that the Under Secretary for Health establish a fraud management program with controls such as data analysis and high-risk payment reviews, system software edits, employee fraud training, and fraud awareness and reporting.

VHA Lacks Formal Guidance for Issuing Guide and Service Dogs

OIG evaluated VHA's progress in providing guide and service dogs to qualified Veterans. While VHA has assisted visually impaired Veterans in obtaining guide dogs for several decades, VHA only began assisting mobility and hearing impaired Veterans with service dogs in 2008—6 years after originally being authorized. Since 2008, VHA's authorization of service dogs has been limited to only eight Veterans. VAMCs lack sufficient guidance to ensure consistent decisions on Veterans' requests for service dogs. Additionally, VHA is unsure of the actual demand for service dogs and is in the process of determining the appropriateness of using service dogs to assist Veterans with mental impairments. OIG recommended that VHA issue comprehensive interim guidance until VHA's draft regulation addressing service dogs is finalized. The Under Secretary for Health agreed and stated that immediately after the draft regulation is published, VHA will issue a directive defining VHA's policy on issuing service dogs.

System Failed to Send Reminder Postcards for Optical Patients at Portland, Oregon, VAMC

OIG reviewed the validity of an allegation that senior officials in VISN 20 instructed employees at the Portland, OR, VAMC to use unauthorized wait lists to hide access and scheduling problems. OIG did not substantiate the allegation. However, OIG found that the VAMC's automated recall system failed to generate and distribute postcards to over 2,900 patients to remind them to schedule follow-up eye appointments, which resulted in delayed care. To address this issue, VAMC staff stated that in September 2009, they enabled the recall system to print the postcards and began monitoring to ensure the recall system mailed the postcards. OIG recommended that the VAMC ensure patients who did not receive a reminder postcard are contacted to remind them to schedule their follow-up care. In response, the VAMC took immediate actions to ensure reminder notifications were issued.

Veterans Benefits Administration Audits and Evaluations

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

Program Weaknesses Result in $111 Million in Improper Post-9/11 GI Bill Emergency Payments

OIG reviewed a hotline allegation that inadequate controls during VBA's emergency payment initiative resulted in payments to ineligible recipients. The review substantiated that VA inappropriately provided 37,700 emergency payments totaling approximately $111 million to ineligible recipients. VA rushed to plan and execute the initiative in order to prevent further hardship to students affected by significant delays in implementing the Post-9/11 GI Bill. VA lacked a contingency plan for emergency payments,

did not clearly communicate eligibility rules, and lacked adequate controls to determine eligibility for emergency payments. As such, the emergency payment initiative resulted in increased administrative burdens and an estimated loss of about $87 million in unrecoverable debts. OIG recommended that the Acting Under Secretary for Benefits develop a contingency plan for future advance payments that includes clear communication on service member eligibility and controls to check for eligibility.

VBA Call Centers Can Do Better Job Providing Veterans with Timely, Accurate Information

OIG audited the VBA's call centers and internet-based Inquiry Routing and Information System (IRIS) to determine whether Veterans are provided with timely and adequate information. For FY 2009, OIG concluded that any one call placed by a unique caller had only a 49 percent chance of reaching an agent and getting the correct information. This occurred because VBA did not have a central entity to provide leadership and guidance, establish sufficient performance standards to evaluate timeliness and accuracy, provide adequate training, and implement an efficient call-routing system. VBA initiated some corrective measures and plans to implement a new process in FY 2011 to route calls more efficiently. After modifying procedures and providing refresher training, call center and IRIS staff compliance with safeguard personal information increased to 96 and 93 percent, respectively.

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 VA Regional Offices (VAROs), focusing on disability compensation claims processing and performance of Veteran Service Center operations. The objectives are to evaluate how well VAROs are accomplishing their mission of providing Veterans with convenient access to high quality benefits services; determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; minimize the risk of fraud, waste, and other abuses; and identify and report systemic trends in VARO operations. Benefits Inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

The Benefits Inspection Division issued 8 reports during the period April 1, 2010, through September 30, 2010. In August 2010, the Benefits Inspection Division expanded its capacity to provide recurring oversight of VAROs by adding a second field office located in San Diego, CA. The addition of the San Diego field office will enable the OIG to conduct inspections at all VAROs on a more frequent basis and perform follow-up visits to ensure continuous oversight. Key summary results from those inspections include:

- Claims processing: 27 percent of benefit claims 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: 37 percent of Notice of Disagreements were not timely controlled for workload management in VACOLS.

- Systematic Analyses of Operations (SAOs): VARO staff did not timely and accurately complete 24 (29 percent) of 82 SAOs. The inadequate SAOs represent missed opportunities for VAROs to identify existing or potential problems and propose corrective actions.

- Mail Handling Procedures: 17 percent of search mail was not properly controlled or associated with the claims files. Consequently, beneficiaries may not have received accurate and timely benefit payments.

- Incompetency Determinations: VARO staff unnecessarily delayed making final decisions in 54 (50 percent) of the 127 incompetency determinations reviewed at 5 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.

American Recovery and Reinvestment Act of 2009 Reports

Risk Management Plan Would Improve Accountability, Transparency in ARRA-Funded State Home Construction Projects

OIG performed an audit of VHA's expenditure of American Recovery and Reinvestment Act of 2009 (ARRA) funds provided to the State Home Construction Grant Program (SHCGP). ARRA provided $150 million to SHCGP, and VHA is required to obligate these funds by September 30, 2010. As of December 31, 2009, VHA had obligated about 94 percent. OIG determined that SHCGP managers need to improve accountability and transparency by developing a risk management plan that identifies all potential risks and implements adequate strategies to mitigate these risks.

Deployment of Post 9/11 GI Bill Long Term Solution Has Been Partially Effective

OIG also evaluated the effectiveness of the Office of Information and Technology's (OI&T's) plan for developing a Long Term Solution (LTS) for Post 9/11 GI Bill implementation. OI&T's plan for LTS deployment has been partially effective; however, OI&T could improve the effectiveness of future LTS releases by conducting periodic independent reviews and instituting cost controls to help address system development and implementation issues. OIG recommended that OI&T develop and implement processes and controls to help ensure that future LTS releases achieve performance and cost objectives as well as meet scheduling timelines. OI&T concurred with the findings and recommendations and outlined plans to complete all corrective actions by August 2011.

VHA Needs to Strengthen ARRA Contract Review Processes and Monitoring

An OIG review evaluated VHA's regulatory compliance for awarding ARRA funds for non-recurring maintenance at VAMCs. Although VHA's ARRA awards generally met competition objectives and requirements, OIG determined that contract review processes needed strengthening to ensure Contracting Officers properly evaluated prospective contractors and completed required contractor responsibility determinations before they awarded contracts and orders. In addition, 13 awards lacked required ARRA clauses that are intended to ensure the efficient and effective use of funds. OIG made five recommendations for VA to develop a comprehensive policy on contractor responsibility determinations and to strengthen its contract monitoring.

NCA Needs to Improve Management Processes Over ARRA Funds

OIG conducted a review to determine if NCA implemented effective policies and procedures to ensure accountability and transparency for $50 million it received from ARRA. NCA needs to improve management processes to guarantee efficient administration of funds in line with ARRA accountability and transparency objectives. OIG recommended the Acting Under Secretary for Memorial Affairs

develop a formal process to document the prioritization and selection of future work requirements, ensure complete procurement information is recorded in the Electronic Contract Management System, and establish performance measurements that facilitate the monitoring and management of ARRA-related project outcomes.

Other Reviews

Inadequate Controls Could Double Cost of FLITE Strategic Asset Management Pilot Project

OIG audited the Financial and Logistics Integrated Technology Enterprises (FLITE) program to assess the quality of oversight of the Strategic Asset Management (SAM) pilot project. Program managers did not effectively control project cost, schedule, performance, or ensure timely deliverables. As a result, VA is considering extending the SAM pilot project from 12 to 29 months, and potentially more than doubling the original contract cost of $8 million. OIG recommended the Assistant Secretary for OI&T and the Executive Director, Office of Acquisition, Logistics, and Construction (OALC) establish stronger program management controls as well as mitigate risks related to the successful accomplishment of the SAM project. Department leadership recently increased its scrutiny of FLITE management and placed additional project contracts on hold. Unless improvements are made, the outlook for the SAM pilot project remains tenuous.

In a related review, OIG reviewed allegations regarding management of the SAM pilot project. OIG substantiated that FLITE program managers needed to improve their overall management of the SAM pilot project and partially substantiated that FLITE program managers did not ensure certain elements, normally considered necessary for a successful software development effort, were included in the FLITE program. The review did not substantiate that the SAM Project Manager pressured VA personnel to complete the contractor's deliverables. OIG made additional recommendations to the Assistant Secretary for OI&T aimed at strengthening management controls.

Teleradiology Contracts Lacking Information Security Protections and Oversight

OIG evaluated the merits of a hotline complaint alleging a specific contractor was not appropriately protecting sensitive patient data while performing teleradiology services for VHA. OIG evaluated whether VHA was providing adequate oversight of specific vendor contracts to ensure they met VA's information security requirements. Specific allegations of inadequate protections of sensitive patient data were substantiated, and OIG determined comprehensive procedures had not been effectively implemented to mitigate the risk of unauthorized disclosure of sensitive information. The Under Secretary for Health and Assistant Secretary for OI&T agreed with OIG's recommendations to implement procedures to effectively mitigate the risk of unauthorized disclosure of sensitive patient data.

Implementation of Homeland Security Presidential Directive 12 Over 2 Years Behind Deadline

OIG evaluated VA's progress in implementing a reliable and effective system of Personal Identity Verification (PIV), in compliance with Homeland Security Presidential Directive 12 (HSPD-12), to improve the security of its facilities and to protect sensitive information stored in VA networks. Overall, VA has made little progress in meeting compliance with HSPD-12, and is almost 2 years behind the Government-wide October 2008 deadline. As of June 2010, VA had only issued approximately 9 percent of the necessary credentials to its workforce, including contractors, and some were issued

without the required background investigations. VA's lack of progress occurred because it did not make HSPD-12 implementation a priority and does not have an effective management structure in place to adequately direct the Department-wide effort. The PIV system does not meet all critical mission requirements, and controls needed to track and provide accountability over program costs are weak. The Assistant Secretary for Operations, Security, and Preparedness concurred with OIG's findings and recommendations and provided target dates to complete planned actions.

Veterans Health Administration Investigations

The OIG Office of Investigations conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of Veterans. In the area of health care delivery, OIG opened 179 cases, made 129 arrests, and obtained over $3 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

During this reporting period, the OIG opened 48 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Forty-two defendants were charged with various crimes relating to drug diversion. OIG also initiated 11 investigations regarding fraudulent receipt of health benefits. Seven 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 $307,610.

Oklahoma City, Oklahoma, VAMC Nurse Sentenced for Assault

An Oklahoma City, OK, VAMC nurse was sentenced to 6 months' incarceration and 1 year of probation after pleading guilty to assault and making a false statement. Additionally, the defendant must report his conviction to the Oklahoma Nursing Board. An OIG and VA Police investigation revealed that the defendant assaulted an 82 year-old dementia patient, who offered no resistance. The patient suffered a fractured leg and severe bruising and swelling on his arm and hand. Additionally, when interviewed by OIG agents, the defendant initially denied assaulting the patient.

Veteran Indicted for Involuntary Manslaughter at Brecksville, Ohio, VAMC

A Veteran was indicted on involuntary manslaughter and assault charges related to a fight with another Veteran, now deceased, at the Brecksville, OH, VAMC. An OIG and VA Police investigation revealed that the decedent had complained of head and neck pain following an altercation with the defendant. Witness interviews and a forensic autopsy performed by the local coroner determined that the victim died of a traumatic head injury. The coroner ruled this case a homicide.

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

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

Veteran Pleads Guilty to Assaulting Physician at the Tuskegee, Alabama, VAMC

A Veteran pled guilty to assaulting a VA physician at the Tuskegee, AL, VAMC after an OIG investigation revealed that he trapped the physician in an examination room and then threatened to assault and kill the physician after his request for prescription narcotics was declined.

Patient Arrested at the White River Junction, Vermont, VAMC for Assault

A patient was arrested at the White River Junction, VT, VAMC after assaulting the VA Chief of Police Services. An OIG and VA Police investigation revealed that the defendant was approached by law enforcement after making threatening remarks, to include declaring war on the Government. While being restrained, the defendant struck the chief multiple times in the face.

Veteran Arrested for Possession of Firearms at Palo Alto, California, VAMC

A Veteran was arrested for possession of firearms on Federal property. An OIG and VA Police investigation determined that the defendant, a recent Iraq war Veteran suffering from PTSD, made statements to a Palo Alto, CA, VAMC physician that he wanted to harm and/or kill others. A search of the defendant's bag by VA Police revealed a loaded .22 caliber pistol, an unloaded .357 magnum revolver, and ammunition for the .357 magnum. The defendant was subsequently interviewed and arrested by OIG.

Veteran Arrested for Assaulting Philadelphia, Pennsylvania, VAMC Employee

A Veteran inpatient was arrested at the Philadelphia, PA, VAMC for assault after an OIG and VA Police investigation revealed that the Veteran assaulted a VA employee while she was providing care to the Veteran.

Veteran Arrested for Weapon Possession at Phoenix, Arizona, VAMC

A Veteran was arrested for possession of a stolen firearm while at the Phoenix, AZ, VAMC. An OIG, VA Police, and Bureau of Alcohol, Tobacco, Firearms and Explosives (ATFE) investigation determined that the defendant, a recent Iraq war Veteran, made statements to VAMC staff that if he "did something crazy to be on television maybe that would help the next guy to get his benefits." A search of the defendant's car by VA Police revealed a loaded M-4 carbine that was reported stolen from the U.S. Army and a combat Kevlar ballistic vest.

Veteran Arrested for Making Threats at Martinsburg, West Virginia, VAMC

A Veteran was arrested after threatening to shoot others and himself at the Martinsburg, WV, VAMC. The Veteran stated that he was frustrated with the quality of his medical care.

Veteran Sentenced for Bomb Threat Made Towards Jackson, Mississippi, VAMC

A Veteran was sentenced to 18 months' incarceration and 3 years' supervised release after being convicted of conveying threatening communications by telephone to the Jackson, MS, VAMC. An OIG investigation disclosed that the defendant told VA employees that he was going to use plastic explosives to blow up the facility. He provided specific locations where he was going to place the explosives, including elevator shafts and the radiology department. During a subsequent interview, the defendant described how to make homemade explosive devices and detonators.

Veteran Arrested for Leaving Threatening Voicemails at White River Junction, Vermont, VAMC

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

Veteran Charged for Threatening Brecksvillle, Ohio, VAMC Employee

A criminal complaint was filed against a Veteran, residing in the Brecksville, OH, VAMC domiciliary, charging him with aggravated menacing. An OIG investigation determined that the defendant made a threat to shoot a medical center employee in the head.

Martinez, California, VA Outpatient Clinic Contract Employee Arrested for Bomb Hoaxes

A former contract housekeeping employee, who worked at the Martinez, CA, VA Outpatient Clinic, was arrested after being indicted for using the VA public address (PA) system to make phony bomb threats on two separate occasions. The defendant stated over the PA system that there were bombs in the Community Living Center (CLC). The Veterans housed in the CLC were forced to evacuate the building after the second bomb threat was made. The defendant admitted to making the bomb threats to get out of work.

Boston, Massachusetts, HCS Employee Charged with Theft of Drugs

A Boston, MA, VA HCS employee was charged in a criminal information with acquisition of a controlled substance by deception or subterfuge. An OIG, VA Police, and local police investigation revealed that the defendant, a VA courier who transported prescription narcotics between various VA facilities, stole controlled substances, particularly oxycodone and Percocet, from prescription bottles packaged for Veterans.

Portland, Oregon, VAMC Nurse Charged with Theft of Drugs

A Portland, OR, VAMC nurse was charged with felony computer crime and identity theft. An OIG and VA Police investigation revealed that the defendant used his position to gain access to the identities of patients no longer under his care and then used the identities to access a VA narcotic dispensing machine, falsely recording that the narcotics were for these patients. The defendant then used the narcotics, to include fentanyl and midazolam, while on duty and providing health care services to Veterans.

Brockton, Massachusetts, VAMC Employee Arrested for Drug Possession

A Brockton, MA, VAMC environmental management service employee and a co-defendant were arrested for possession of controlled substances with intent to distribute. The arrests resulted from a 7-month OIG, Drug Enforcement Administration, and VA Police investigation involving undercover purchases. The VA employee was interviewed and confessed to selling prescription pills to individuals in and around the VAMC. The second defendant sold oxycodone to an undercover agent on two separate occasions during the operation.

Former Martinsburg, West Virginia, Employee Sentenced for Drug Distribution

A former Martinsburg, WV, VAMC food service employee was sentenced to 70 months' incarceration and 60 months' probation after pleading guilty to possession with intent to distribute cocaine base. During an OIG, Federal Bureau of Investigation (FBI), and VA Police investigation, the defendant sold crack cocaine to a confidential informant on three occasions. During an unrelated investigation coordinated by a local drug task force, the defendant sold crack cocaine and heroin to another confidential informant on two occasions. In addition, during a traffic stop, state troopers found 238 grams of crack cocaine in the defendant's vehicle.

Former Sacramento, California, VAMC Employee Charged with Drug Theft

A former Sacramento, CA, VAMC employee was charged with obtaining controlled substances by misrepresentation or fraud. The defendant, a registered nurse, admitted to OIG agents that he had been diverting fentanyl, morphine, hydromorphone, and methadone for several months and ingesting the controlled substances while working.

Veterans Arrested for Drug Distribution at Philadelphia, Pennsylvania, VAMC

Four Veterans were arrested for distribution of class II and class III narcotics, to include Percocet, Xanex, and Suboxone pills. An OIG, VA Police, and local police investigation at the Philadelphia, PA, VAMC revealed that the defendants sold various drugs during an undercover operation to a confidential informant and an undercover police officer over a period of several months. A fifth Veteran who was charged remains a fugitive, and a sixth Veteran expired prior to being arrested.

Nashville, Tennessee, VAMC Registered Nurse Arrested for Drug Diversion

A Nashville, TN, VAMC registered nurse was arrested after being indicted for obtaining a controlled substance by fraud and theft of property. An OIG investigation revealed that the defendant diverted hydrocodone and hydromorphone intended for patients on at least eight occasions between January and March 2010.

Veteran Arrested for Drug Distribution at Hampton, Virginia, VAMC

A Veteran was arrested for multiple charges of possession with intent to distribute heroin and a charge for the sale of narcotics in the vicinity of a school. On several occasions, the Veteran sold heroin to confidential informants at the Hampton, VA, VAMC and on the streets in proximity to a school. At the time of his arrest, the defendant possessed 70 bags of heroin.

Man Convicted of Theft for Using Brother's Identity

The brother of a Veteran was convicted of theft of Government funds after an OIG and Social Security Administration (SSA) OIG investigation determined that the defendant utilized the Veteran's identity to obtain medical care from two VAMCs, as well as VA pension benefits and SSA identification cards in the name of the Veteran. The loss to the Government is $120,063.

Veterans Charged with Travel Voucher Fraud

Ten Veterans were indicted for fraud after OIG investigations determined that they submitted fraudulent vouchers for cash reimbursement for travel expenses. The Veterans were claiming to travel hundreds of miles roundtrip from their residences to VAMCs. In each case the defendants grossly exaggerated the distance traveled to and from the VAMCs.

Veterans Benefits Administration Investigations

VA administers a number of financial benefits programs for eligible Veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the Compensation and Pension (C&P) Service. With respect to VA guaranteed loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. In the area of monetary benefits, OIG opened 319 cases, made 88 arrests, and had nearly $28 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program.

OIG also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. Generally, family members of the deceased are responsible for this type of fraud. In this reporting period, the death match project recovered $4.4 million, with another $2.6 million in anticipated recoveries. During this reporting period, OIG opened 271 investigations regarding death match cases, fiduciary fraud, identity theft, and Veterans/widows fraudulently receiving VA compensation and pension funds. One-hundred fifty-eight defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to over $8,987,875 million. These investigations include 17 "Stolen Valor" cases resulting in 5 defendants being charged and $240,048 in court ordered payment of fines, restitution, and penalties.

Fourteen Defendants Sentenced for Fraud

Fourteen defendants, previously indicted on charges of conspiracy to defraud the United States, bribery of a public official, theft of Government funds, and money laundering stemming from an investigation by OIG and FBI have been sentenced. The defendants included a former VARO employee, a former Veterans Service Officer (VSO), a former Marine F-18 pilot, the mother of the VSO, and other Veterans. Sentences in this case ranged from probation to 68 months' incarceration; most of the 14 defendants received between 12 to 30 months' incarceration. In November 2008, the defendants were indicted for filing fraudulent claims with VA. The investigation revealed that the former VA employee and former VSO employee recruited friends, family members, and other acquaintances to submit fraudulent VA disability claims. All fraudulent claims were supported with counterfeit or altered medical documentation from either VA or private physicians as proof of the disability. The former VA employee and the former VSO employee received kickbacks from the Veterans receiving large retroactive checks. Most of the Veterans were rated 100 percent disabled and were deemed "permanent and total," which could have resulted in no future review of their claim. The majority of Veterans received monthly payments in excess of $2,700. The loss to VA is approximately $2 million.

Fiduciary and Wife Indicted for Misappropriation

An attorney and his wife, who worked with him at his law office, were indicted for misappropriation by a fiduciary, conspiracy, false statements, and tax fraud. A joint investigation conducted by VA OIG, SSA OIG, and Internal Revenue Service (IRS) Criminal Investigations Division revealed that while the attorney was serving as both a court-appointed guardian and fiduciary, he and his wife stole approximately $2.3 million from the bank accounts of 54 Veterans. Additionally, they failed to report the misappropriated funds as income on their tax returns. The attorney also served as a representative payee for 14 of those Veterans' Social Security benefits.

Former Fiduciary Arrested for Larceny

A former VA fiduciary was arrested for larceny in regard to the theft of a disabled Veteran's funds. An OIG investigation revealed that the defendant, who served as the Veteran's VA fiduciary from June 2005 through May 2008, stole over $40,000 from the Veteran for her own personal use and took steps to deceive VA, to include creating and submitting fraudulent bank statements.

Former Fiduciary Pleads Guilty to Misappropriation

A former fiduciary pled guilty to a criminal information charging her with misappropriation by a fiduciary. An OIG investigation revealed that the former fiduciary stole $47,000 from a Veteran and

used the funds for personal use.

Son of VA Beneficiary Indicted for Misappropriation of Benefits

The son of a VA beneficiary was indicted for making false statements. An OIG investigation revealed that from 2003 to 2006, while serving as his father's fiduciary, the defendant misappropriated $157,517 of his father's funds for his personal use and falsified annual accounting reports to the VARO.

Veteran's Daughter and Son-In-Law Arrested for Exploitation

The daughter and son-in-law of an incompetent Veteran, who were acting as primary caregivers, were arrested for exploitation of the disabled/elderly, obtaining property by false pretenses greater than $100,000, and conspiracy to obtain property by false pretenses. Just prior to this arrest, the son-in-law and his brother were arrested for breaking into and entering the Veteran's residence, and then stealing and pawning the Veteran's property. An OIG, SSA OIG, local law enforcement, and social services investigation revealed that the defendants stole $213,662 from the Veteran and physically and mentally abused him for several years. The Veteran receives funds from VA, SSA, and the Defense Finance and Accounting Service, as well as a monthly inheritance from his deceased mother's estate. Based on the investigation, the Veteran was assigned a fiduciary and moved to a safe residential environment.

Woman accused of exploiting elderly person for $150,000

Daily News Staff

A Swansboro woman has been accused of exploiting an elderly person for more than $150,000, according to warrants.

Angela S. Carter, 43, of Swansboro Loop Road, was charged Thursday by the Onslow County Sheriff's Office with exploiting disabled/elderly trust, obtaining property by false pretense greater or equal to $100,000 and conspiracy to obtain property by false pretense.

Carter is accused of utilizing $152,282.61 for her own personal use, depriving the victim of medical and psychological care and medication, and failing to provide for the victim's basic day to day necessities, according to warrants.

She is also accused of obtaining the money by fraud and false pretense from Jan. 3, 2007 to Dec. 31, 2009 and failure to use the money for its intended purpose to care for the victim, and conspiring with another person to obtain the money by false pretense, according to warrants at the magistrates office.

Bond was set at $20,000.

Veteran's Daughter Sentenced for Theft of Government Funds

The daughter of a Veteran, who was also the wife of a state judge, was sentenced to 24 months' incarceration, 320 hours' community service, and a $50,000 fine after pleading guilty to theft of Government funds. An OIG investigation determined that between 2001 and 2008, the defendant fraudulently received VA pension benefits on behalf of her father based on false financial statements made to VA. The investigation revealed that the defendant and her three siblings created an investment company for the purpose of hiding their parents' financial assets. This action then made the parents eligible for various Government benefit programs, to include VA benefits. The investment company's partnership agreement and company itself were created by the defendant's husband while he was still in office. The defendant, who was also her father's fiduciary, subsequently stole most of the fraudulently obtained VA pension benefits. The loss to VA is $110,848.

Veteran and Wife Plead Guilty to Fraud Involving Nearly $500,000 in Government Benefits

A Veteran and his wife pled guilty to conspiracy, theft of Government funds, and wire fraud. Additionally, a VSO entered a pretrial diversion agreement for coaching the Veteran to defraud VA. An OIG and SSA OIG investigation determined that the Veteran received VA and SSA benefits for the

loss of use of both his feet and that he and his wife made numerous statements dating back to 1999 alleging his inability to ambulate without a wheelchair. However, the Veteran was observed on several occasions partaking in activities that would not have been possible with his purported ambulatory loss. Based upon the false statements, the Veteran fraudulently received $329,673 in VA benefits and $165,234 in SSA benefits.

Veteran Who Fraudulently Obtained Purple Heart Pleads Guilty to Theft of VA Funds

A Veteran, who was also a VA employee, pled guilty to the theft of Government funds and the unlawful wearing of a service medal after an OIG investigation revealed he filed fraudulent documents with the U.S. Air Force and VA claiming to have been wounded in Vietnam. Based upon the fraudulent claims and counterfeit documents, the U.S. Air Force awarded the Veteran a Purple Heart. The Veteran then used the Purple Heart and a self-inflicted gunshot wound, received 20 years after his military service, to obtain compensation benefits from VA. The loss to VA is approximately $180,000.

ROANOKE

Vet who embellished record to serve 1 year

A man who falsely claimed he earned numerous military medals was sentenced Thursday to a year and a day in prison and was ordered to repay $11,098 in veterans benefits he shouldn't have received.

Thomas James Barnhart, 59, had 21 years of legitimate Navy and Coast Guard service, including offshore duty in Vietnam. But starting in 1979, he began inflating his experience in claims for promotions and benefits, Assistant U.S. Attorney Jake Jacobsen told U.S. District Court Judge James Turk in Roanoke.

Among Barnhart's lies, according to the prosecutor: that he was a Navy SEAL; he received elite low-altitude parachute training; and he received five Purple Hearts, three Bronze Stars, two Silver Stars and a Vietnamese medal of honor.

He also falsely claimed that a downed U.S. helicopter pilot died in his arms and that he saw other U.S. soldiers die around him.

Jacobsen, a veteran of the current Iraq war, called Barnhart's conduct "repugnant."

Barnhart wept in court and said he lied because neither the Navy nor the U.S. public appreciated his real service. "I just can't punish myself enough," he sobbed. "Every day I ask forgiveness."

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 366 days' incarceration and ordered to pay restitution of $11,098 to VA after pleading guilty to theft of Government funds and false claims about receiving military decorations. An OIG and U.S. Coast Guard Investigative Service investigation revealed that the defendant falsified a DD-214 when transferring from the Navy to the Coast Guard in 1979. During his service with the Coast Guard, the defendant continued to falsify his DD-214 and service record. The defendant retired from the Coast Guard after 11 years, during which time he represented himself as a Navy Seal who received multiple Silver Stars, Bronze Stars, Purple Hearts, and other medals for valor. The defendant applied for and received PTSD benefits from VA based on multiple false combat stressors.

Veteran Indicted for Fraud Exceeding $500,000 in Government Benefits

A Veteran was indicted for VA benefits fraud, Social Security fraud, education benefits fraud, and tax evasion. A multiagency investigation revealed that the Veteran and his wife conspired to falsify their own and others' tax returns while hiding their income from VA, SSA, and the Department of Education in the process. The loss to VA is over $200,000, with the total loss to the Government exceeding $500,000.

Veteran and Wife Plead Guilty to Fraud Charges for Feigned Paralysis

A Veteran and his wife pled guilty to conspiracy, false statements, and fraud charges. An OIG and SSA OIG investigation determined that the Veteran was receiving both VA and Social Security benefits for paralysis caused by a 2004 automobile accident occurring while the Veteran was in the military. During the investigation, it was determined that the Veteran could walk with no apparent difficulties and, along with the assistance of his wife, had been feigning paralysis in order to fraudulently collect VA and Social Security benefits. The loss to the Government is approximately $175,000.

Veteran and Wife Plead Guilty to Theft Involving Unemployability Benefits

A Veteran and his wife pled guilty to theft of Government funds after an OIG and SSA OIG investigation revealed that the Veteran fraudulently received VA and SSA benefits after claiming that he was unemployable due to his disabilities. The investigation determined that the Veteran was employed as a long haul truck driver and allowed his employer to knowingly pay him using his wife's social security number in order to continue to receive fraudulent unemployability compensation benefits. The employer was also charged in this investigation with making false statements; plea negotiations are continuing. The loss to VA is $71,816, and the loss to SSA is $48,174.

Veteran Convicted of Healthcare Fraud

A Veteran was found guilty at trial of health care fraud and false statements relating to health care matters. An OIG and ATFE investigation revealed that for over 20 years the defendant, who is a convicted felon, falsely represented to VA that he had extreme loss of vision in both eyes. The Veteran received VA compensation for blindness that included a special monthly compensation. The investigation revealed that the Veteran drove a vehicle, read, hunted with firearms, and performed numerous activities that would not be possible with his purported vision loss. The Veteran still faces two gun charges related to a felon in possession of a firearm and making a false statement to purchase a firearm. The loss to VA is approximately $804,500.

Defendant Pleads Guilty to Misuse and False Statements

A non-Veteran pled guilty to misuse of a social security number and to making false statements related to health care matters and was ordered to pay criminal forfeiture in the amount of $143,766. An OIG and SSA OIG investigation revealed that the defendant stole the identity of a Veteran and then redirected the Veteran's VA benefits and military retirement to his own bank account. The defendant also used the Veteran's personal information to enroll for VA health care and apply for an increase in VA benefits. The defendant subsequently attended a VA medical exam and was granted an increase in compensation benefits. The true Veteran was unaware that his benefits had been diverted to another account until contacted by OIG agents.

Veteran Sentenced for Tax Fraud

A Veteran was sentenced to 5 months' incarceration, 5 months' home confinement, 1 year of probation, and ordered to pay restitution of $113,297 to VA and $25,076 to the IRS after pleading guilty to filing a false tax return. An OIG and IRS Criminal Investigation Division investigation revealed that the defendant was receiving VA individual unemployability compensation benefits while employed in a fulltime position earning $90,000 annually.

Veteran Who Submitted False Statements of Combat Activities Charged with Theft from VA

A Veteran was charged with theft after an OIG investigation revealed that the Veteran provided false information to a VARO and a VAMC in support of his claim for VA disability compensation benefits. Between 2003 and 2006 the defendant submitted VA forms, along with pictures, and made false statements attesting to his claims that he participated in combat activities while serving in the first Gulf War. The claims included hand-to-hand combat in the trenches, seeing fellow soldiers die, seeing dead bodies inside burned-out tanks, and being "hit" in a chemical attack. The investigation also revealed that the VARO relied on those statements when basing its decision to award service connection for PTSD. The loss to VA is over $173,000.

Veteran's Widow Charged with Theft of VA Benefits

A criminal information was filed against the widow of a Veteran, charging her with theft of Dependency and Indemnity Compensation (DIC) benefits. An OIG investigation revealed that the defendant failed to notify VA of her remarriage in September 1991 and that she continued to receive VA benefits for which she was no longer eligible. The loss to VA is $221,474.

Veteran's Widow Sentenced for Theft of VA Funds

The widow of a Veteran was sentenced to 18 months' incarceration, 3 years' probation, 80 hours' community service, and ordered to pay VA $207,892 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that, between August 1990 and December 2008, the defendant fraudulently received VA DIC benefits by failing to report her remarriage.

Son of Deceased Beneficiary Sentenced for Theft of Government Funds

The son of a deceased VA beneficiary was sentenced to 7 months' incarceration, 3 years' probation, and ordered to pay restitution of $175,839 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in October 1996.

Veteran Sentenced for Compensation Fraud

A Veteran was sentenced to 27 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $280,161 after being convicted of wire fraud, mail fraud, false statements, and Social Security fraud. An OIG and SSA OIG investigation revealed that the defendant fraudulently claimed to have suffered from PTSD after alleging that he witnessed a fellow sailor being badly burned in 1984. The defendant was able to convince VA staff that he was so traumatized by the event that he was rated 100 percent service-connected with individual unemployability, along with Social Security disability benefits. The investigation revealed that the defendant did not disclose to VA or SSA his activities as a volunteer firefighter, his membership on the county dive team, his memberships in various organizations, or that he was the owner and operator of a local tavern. The defendant also falsely claimed to associates that he was a Navy Seal and to VHA personnel that he saw combat in Grenada, Panama, and Lebanon. He subsequently recanted that he was ever a Navy Seal or in combat. The loss to VA is $166,116.

Son of Deceased Beneficiary Sentenced for Theft

The son of a deceased VA beneficiary was sentenced to 3 years' probation and ordered to pay $204,032 in restitution after pleading guilty to theft. An OIG investigation revealed that the defendant submitted fraudulent documents to VA in order to continue to receive the VA benefits for his own personal use after his mother's death in April 1987.

Veteran's Brother Sentenced for Identity Theft

The brother of a deceased Veteran was sentenced to 18 months' incarceration and ordered to pay $173,000 in restitution after pleading guilty to wire fraud. An OIG and VA Police investigation determined that the defendant obtained VA medical and pension benefits using his brother's identity.

Daughter of Deceased Beneficiary Agrees to Pay Restitution

The daughter of a deceased VA beneficiary was found responsible for the theft of VA funds after a

civil suit was filed by the United States Attorney's Office. An OIG investigation disclosed the daughter stole VA benefits issued after her mother's death in July 2005. The daughter entered into a Consent Judgment and agreed to pay VA $151,000, plus interest, and $350 in court costs.

Son of Deceased Beneficiary Pleads Guilty to Theft

The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to inform VA of his father's death in March 2004 and subsequently stole VA benefits that were deposited to his father's account. The loss to VA is approximately $94,000.

Son of Deceased VA Beneficiary Sentenced for Forgery

The son of a deceased VA beneficiary was sentenced to 12 months' incarceration, 3 years' probation, and ordered to pay $191,669 in restitution after pleading guilty to forgery. An OIG investigation determined that the defendant stole, forged, and negotiated VA benefit checks issued after his mother's death in February 1990.

Former Wife of Deceased Veteran Pleads Guilty to Theft

The former wife of a deceased Veteran pled guilty to theft of public money and was subsequently sentenced to 1 day of incarceration, 3 years' probation, and ordered to pay VA restitution of $102,860. An OIG investigation determined that the defendant submitted a fraudulent claim for death pension benefits and an altered death certificate indicating that she was married to the Veteran at the time of his death. The defendant also submitted a fraudulent claim for a dependent child. The Veteran's claim file contained no record indicating that the child was his dependent.

Son of Deceased Beneficiary Sentenced for Theft of VA Funds

The son of a deceased VA beneficiary was sentenced to 24 months' incarceration, 36 months' probation, a $5,000 fine, and ordered to pay $92,596 in restitution after pleading guilty to the theft of Government funds. In 2001, the defendant, who was a loan officer at a bank, assisted the Veteran in opening a joint bank account at the defendant's bank. In March 2004, the beneficiary died in a foreign country and the son was notified of the death by the U.S. Department of State. The defendant concealed the death from VA and then subsequently used VA benefits for his personal benefit. The investigation revealed that the defendant used his position at the bank to facilitate the scheme to defraud VA.

Veteran Sentenced for Mortgage Fraud

A Veteran was sentenced to 6 months' incarceration, 10 years' probation, and a $10,000 fine after pleading guilty to making false statements to obtain property or credit over $200,000. As part of his plea agreement, the defendant agreed to testify against a mortgage broker who is also a target of the investigation. As a result of this investigation, the mortgage broker was indicted for engaging in organized criminal activity.

Realtor Charged with Making a False Statement

A realtor was charged in a criminal information with making a false statement. An OIG and FBI investigation revealed that the defendant was working for a property management firm hired by VA to rehabilitate foreclosed VA homes. The defendant and a local contractor conspired to submit bogus bids to ensure that the contractor was awarded all of the realtor's repair work on these foreclosed

properties. For his part of the scheme, the defendant received 15 percent of the payments.

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 28 cases, made 12 arrests, and had over $24 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

OIG also investigates theft of Information Technology equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened 2 cases, made 1 arrest, and had $15,052 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Defendant Pleads Guilty to Embezzling $1 Million from Gulf Coast Veterans HCS Grants

A defendant pled guilty to embezzlement of Federal program funds, mail fraud, and also consented to an asset forfeiture decree after a multiagency investigation revealed that, for over 4 years, she embezzled approximately $1,013,700 from the Louisiana Veterans Research and Education Corporation (LVREC) through Department of Defense grants given to the Gulf Coast Veterans HCS. LVREC is a 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, who was a bookkeeper/accountant with LVREC, issued payroll checks to employees of the company, forged their signatures in order to deposit the funds to her own accounts, and falsified annual accountings of the assets for the LVREC. The defendant surrendered approximately $650,000 in cash, vehicles, and real estate to the Government.

Veteran Arrested for Fraud and Forgery

A Veteran was arrested after being indicted for wire fraud, mail fraud, and forgery of official U.S. Department or Agency seals. A multiagency investigation revealed that the Veteran was operating an internet-based printing business that sold counterfeit military and law enforcement awards and training certificates, including some documents bearing the official VA seal. The Veteran was not authorized to produce certificates bearing official U.S. Department or Agency seals. The investigation also revealed that advertising on the Veteran's website contained several false statements, including that his certificates were authentic and exact reproductions of the original issue, and that he was the only civilian provider of military certificates with open contracts with the Navy, Army, and Coast Guard. The public fraud associated with this investigation has been determined to be over $260,000.

TENNESSEE

Man indicted in sale of fake papers

A federal grand jury in Nashville indicted a Smithville man on wire fraud, mail fraud and other charges after authorities say he was selling fake military service documents online.

According to a news release from prosecutors, Robert E. Neener, 63, was indicted Wednesday on 14 counts of wire and mail fraud and 15 counts of charging the false use of a federal agency seal.

Prosecutors say Neener claimed the documents were real and could be used to show proof that a person was a disabled veteran or received an honorable discharge, a presidential citation or other military achievements.

If convicted, he could face up to 20 years for each count of wire or mail fraud and up to five years for each count of false use of agency seals.

— ASSOCIATED PRESS

Defendants Arrested for Murder and Robbery

Two defendants were arrested for the murder and robbery of a Veteran participating in the The Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing Program. An OIG and a local police investigation revealed that the Veteran was murdered in his subsidized apartment and his checkbook, debit card, and vehicle were stolen. The defendants, who were known to the victim, overdrew the Veteran's bank account into which his VA benefits were deposited. The murder of the Veteran appears to be financially motivated as the defendants used the stolen funds to purchase drugs.

Former CEO Sentenced for Fraud Involving Improvements for Nursing Home Facilities

The former Chief Executive Officer (CEO) of a nursing home chain that received Federal funds was sentenced to 366 days' incarceration, 3 years' probation, a $6,000 fine, and ordered to forfeit $500,000 to the Government after pleading guilty to fraud charges. A multiagency investigation determined that the defendant conspired to create false invoices to obtain loans from lenders. The loans were intended for the improvement of the nursing home facilities; instead, the funds were used to pay for the CEO's personal expenses, including the purchase of a number of apartment complexes. Three other defendants were previously convicted in this case and are currently awaiting sentencing.

Pharmaceutical Subsidiaries Agree to $81 Million Settlement

Two subsidiaries of a major pharmaceutical company, Ortho-McNeil, agreed to an $81 million global settlement to resolve criminal and civil liability arising from the illegal promotion of its epilepsy drug. One of the subsidiaries agreed to plead guilty to a misdemeanor and pay a $6.14 million criminal fine for the misbranding of Topamax, an anti-epileptic drug approved for the treatment of partial onset seizures, but not for psychiatric use. In addition to the criminal fine, the second subsidiary will pay $75.37 million to resolve civil allegations that it illegally promoted the drug and caused false claims to be submitted to Government health care programs, to include VA, for a variety of psychiatric uses that were not medically accepted indications. VA will receive approximately $2.9 million of the civil settlement.

Pharmaceutical Company Settles in Off-Label Promotion Case for $72.5 Million

A major pharmaceutical company, Novartis, agreed to pay $72.5 million to resolve a civil false claims act allegation that it illegally promoted the drug Tobi, an inhaled antibiotic used for the treatment of certain cystic fibrosis patients. The company marketed the drug for unapproved uses in patients that did not meet the parameters of the FDA approved indicators. VA will receive $989,893 as part of the settlement.

Executive Arrested for Fraud in Veteran Owned Set Aside Contracts

The CEO of a construction management and general contracting company that received VA and Department of the Army construction contracts set aside for Service-Disabled Veteran-Owned Small Businesses (SDVOSB) and Veteran-Owned Small Businesses (VOSB) was arrested for defrauding the Government. An OIG, Small Business Administration OIG, and Army Criminal Investigation Division investigation revealed that the defendant falsely self-certified that his company was an eligible SDVOSB and VOSB when he bid on several Government contracts that he was later awarded. The company presently has over $16 million in contracts with work ongoing at various VA facilities.

Former Corporate Recruiter Pleads Guilty to Defrauding Government

A former recruiter for a corporation providing home health care services to VA pled guilty to knowingly and willfully defrauding a health care program. A multiagency investigation revealed that the defendant misrepresented dates and hours on corporation time sheets for services not rendered and forged signatures on timecards for a health care provider who never actually worked for the corporation. The time sheets were ultimately used to bill various health care programs.

Defendants Arrested for Identity Theft

A VA-contracted home health care provider and her cousin were arrested after being indicted for conspiracy, wire fraud, identity fraud, and bank fraud. An OIG and local law enforcement investigation revealed that the home health care provider stole the identity of a disabled Veteran during home visits and shared the information with her cousin. The defendants then used the information to steal nearly $36,000 from the Veteran's bank account.

Girlfriend of Las Vegas, Nevada, VAMC Employee Arrested for Theft

The girlfriend of a Las Vegas, NV, VAMC employee was arrested for burglary, fraudulent use of a credit card, and retail theft after an OIG, General Services Administration OIG, and U.S. Secret Service investigation revealed that she and several co-conspirators used a VA credit card to make approximately $27,767 worth of fraudulent purchases.

Shipping Supervisor Arrested for Drug Theft from Oklahoma City, Oklahoma, VAMC

A United Parcel Service (UPS) supervisor was arrested for larceny of a controlled dangerous substance. An OIG, VA Police, and UPS investigation revealed that the defendant was stealing prescription morphine and oxycodone shipped from the Oklahoma City, OK, VAMC. The defendant confessed to stealing the drugs to support a drug habit. During the investigation, three other UPS employees were interviewed and subsequently resigned.

Former Mail Carrier Sentenced for Theft

A former U.S. Postal Service (USPS) rural carrier was sentenced to 24 months' probation and a $1,000 fine after having previously pled guilty to obstruction of U.S. mail and drug possession. An OIG and USPS OIG investigation revealed that the defendant stole VA prescription medication parcels, gift cards, and other valuables from the mail. In at least one instance, the defendant intercepted a Veteran's pain medication and replaced it with acetaminophen.

Former USPS Employee Sentenced for Theft of VA Narcotics

A former USPS employee was sentenced to 60 months' probation after pleading guilty to destruction of mail. An OIG and USPS OIG investigation determined that the defendant was stealing VA packages from the mail. Stolen VA narcotics were found on the defendant and in his vehicle at the time of his arrest.

Former USPS Employee Arrested for Theft of Mail

A former USPS employee was arrested after being indicted for theft of mail. During a VA OIG and USPS OIG investigation, the defendant admitted to stealing more than 2,000 tablets of VA medications from the mail and then selling the stolen medications.

USPS Employees Plead Guilty to Theft of VA Pharmaceuticals

A former USPS employee pled guilty to mail theft after an OIG and U.S. Postal Inspection Service investigation, which included a sting operation, revealed that the defendant stole packages of VA pharmaceuticals from the mail. Stolen VA narcotics were found in the defendant's vehicle at the time of his arrest. He subsequently admitted to stealing VA narcotics during the past year. A second USPS employee pled guilty to theft by mail, after an OIG and USPS OIG investigation determined that between December 2009 and April 2010 he diverted 12 shipments of VA prescribed narcotics from the mail. Finally, a former USPS clerk, who is a service-connected Veteran, was sentenced to 2 years' probation and 100 hours' community service after pleading guilty to the destruction of U.S. mail. An OIG and USPS OIG investigation revealed that the defendant stole 8 VA controlled substance shipments, containing approximately 1,200 tablets of oxycodone, methadone, and hydrocodone between September 2009 and January 2010.

Veteran Sentenced for Using Child Pornography at Palo Alto Nursing Home

A Veteran was sentenced to 5 years' incarceration after pleading guilty to sexual exploitation of minors. The defendant, a former inpatient at a VA nursing home, had two previous child pornography convictions. During an OIG and VA Police investigation, the defendant admitted to using a computer at the VA nursing home to access the internet and download sexually explicit images of minors. An analysis by the OIG Computer Crimes and Forensics Lab found over two hundred child pornography images on electronic media associated with the defendant.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG issued 3 reports and 2 advisories containing 21 recommendations for administrative and corrective actions, resulting in $28,614 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries. The Division also investigated 25 allegations that were not substantiated.

Investigation Substantiates Prohibited Personnel Practices, Abuse of Authority, Misuse of Position, and False Statements in Office of Human Resources and Administration

An administrative investigation substantiated that an Office of Human Resources and Administration senior official engaged in prohibited personnel practices, abused his authority, misused his position to appoint two subordinates, and that he made false statements. Further, one of the subordinates misused her official time; another misrepresented her income for a higher than minimum rate of pay and made false statements; a Human Resources Specialist and a former Management Analyst engaged in prohibited personnel practices; and a former Personnel Officer failed to follow policy in setting the higher than minimum rate of pay.

Prohibited Personnel Practices, Misuse of Position Substantiated in VHA HR Office

An administrative investigation substantiated that a VHA Director of Human Resources Development engaged in prohibited personnel practices when he twice gave preference in hiring to a friend. OIG also found that a Human Resources Specialist, as a conference planner, improperly accepted gifts from prohibited sources when she solicited and accepted hotel reward points and that she failed to

testify honestly about receiving the points. The Human Resources Specialist further misused her official time, position, and VA-owned equipment to conduct personal business as well as business for her privately-owned company.

Investigation Substantiates Improper Title 38 Pay for Administrative Assistant

An administrative investigation substantiated that a Dental Hygienist worked as a fulltime Administrative Assistant and performed only Title 5 duties that did not require the knowledge, skills, and abilities of a Title 38 health care professional, resulting in her receiving over $28,000 in special pay supplementation to which she was not entitled. OIG also found that the VAMC Director, as well as other VAMC officials, failed to take appropriate action to discontinue the Title 38 special pay for the Dental Hygienist performing fulltime in a Title 5 capacity.

Employee-Related Investigations

During this reporting period, OIG opened 27 investigations regarding criminal activities by VA employees (not including drug diversion). The types of crimes investigated included Workers' Compensation Fraud, theft from Veterans, and theft of VA property or funds. Nine defendants were charged with crimes and court ordered payment of fines, restitution, and penalties amounted to $1,302,774. Among them were the following:

- Two former Bedford, MA, VAMC employees were sentenced after being convicted of conspiracy, identity fraud, and access device fraud. The first defendant was sentenced to 366 days' incarceration and 2 years' supervised release. The second defendant was sentenced to 6 months' home confinement and 2 years' probation. Both defendants were ordered to pay joint restitution of $3,365. An OIG, VA Police, and U.S. Secret Service investigation revealed that the defendants stole checks, credit card numbers, and bank account numbers from several disabled Veterans who lived at the VAMC's long-term care facility. The defendants shared the information with a third co-conspirator who was previously sentenced after pleading guilty. The three defendants used the Veterans' accounts and identities to purchase goods and services over the telephone and internet.

- A former VA Compensated Work Therapy program employee pled guilty to conspiracy and theft of Government property after an OIG and VA Police investigation revealed that the defendant stole two computers from the Providence, RI, VAMC. Neither computer contained personally identifiable information (PII). The defendant admitted to stealing the computers and selling them to buy cocaine.

- A Nashville, TN, VAMC employee was indicted for activities related to time and attendance fraud and making false statements to Federal agents. An OIG investigation revealed that the defendant was teaching classes at a local university during his scheduled tour of duty at VA. The defendant held full-time employment positions at both the VAMC and the university during a 6-month period in 2006. The loss to VA is approximately $32,000.

- A Lyons, NJ, VAMC employee and an associate in the employee's private practice pled guilty to health care fraud. An OIG, FBI, and state regulatory agency investigation revealed that the VA employee and the associate devised a scheme to misrepresent the associate's qualifications and bill Government and private insurers at inflated prices for services not rendered. The employee also identified the VAMC's facsimile number as the business' facsimile number on the practice's web site.

- Two West Los Angeles, CA, VAMC respiratory therapists were arraigned on charges of grand theft for activities related to time and attendance fraud. An OIG investigation revealed that the defendants were working at outside employment during their scheduled working hours. The combined loss to VA is approximately $55,000.

- A former Sepulveda, CA, VAMC employee was sentenced to 3 years' probation and ordered to pay restitution of $20,000 after pleading guilty to grand theft. An OIG and VA Police investigation determined that the defendant fraudulently claimed overtime hours that she did not work.

- A former Montgomery, AL, VARO employee was charged with theft of Government property after an OIG, IRS Criminal Investigation Division, and local police investigation disclosed that the former employee stole the names, social security numbers, and dates of birth of six Veterans from VARO files in order to file fraudulent tax returns. The fraudulently obtained refunds were then deposited into various bank accounts.

- A St. Louis, MO, VAMC employee pled guilty to theft charges after admitting to stealing computers, monitors, and other VA property to pawn or trade for drugs and money. None of the computers contained PII. The approximate loss to VA is $122,000.

- A Dallas, TX, VAMC employee was arrested for possession of child pornography after an OIG investigation revealed that the defendant used his VA computer to access and view child pornography while at the VAMC.

- A former Phoenix, AZ, VAMC mail room employee was sentenced to 60 days' deferred incarceration, 18 months' probation, and ordered to pay restitution of $2,786 after pleading guilty to theft. An OIG and VA Police investigation determined that the defendant stole two VA desktop computers, a Government-issued credit card, and mail from the VA mail room. No PII was stored on the stolen computers.

- A VA medical support assistant at the Alexandria, LA, VAMC pled guilty to false representation of a social security number after an OIG investigation determined that the defendant used his position to access and then use a VA patient's social security number in order to fraudulently obtain credit cards and loans. The patient subsequently received multiple inquiries from creditors alleging that he had failed to pay on various lines of credit totaling approximately $16,000. As a result of this investigation, the victim was cleared of any responsibility for the fraudulent activity.

Threats Made Against VARO Employees

During this reporting period, OIG initiated 25 criminal investigations resulting from threats made against VA facilities and employees. Sixteen defendants were charged with making threats as a result of the investigations. Among them was the following:

- A Veteran pled guilty to making threats against VA employees. An OIG investigation revealed that the defendant contacted his VSO representative at the Jackson, MS, VARO, after nine of his VA claims were denied and stated that he was going to kill one VA employee for each claim that the VARO had denied him. The defendant is also facing additional State charges for threats made to employees of a cellular phone company.

Fugitive Felons Arrested with OIG Assistance

Veterans and VA employees continue to be identified and apprehended as a direct result of the OIG Fugitive Felon Program. To date, 37.1 million felon warrants have been received from the National Crime Information Center and participating states resulting in 54,385 investigative leads being referred to law enforcement agencies. Over 2,092 fugitives have been apprehended as a direct result of these leads. Since the inception of the program in 2002, OIG has identified $753.3 million in estimated overpayments with an estimated cost avoidance of $868.5 million. Twenty-seven fugitive felon arrests were made by VA OIG agents with an additional 17 by other law enforcement agencies during this reporting period. Four of these arrests were of VAMC employees at various medical centers who were wanted on charges to include drug and probation violations. Apprehensions included the following:

- OIG, working with a U.S. Marshals Service Fugitive Apprehension Strike Team, arrested a Texas Department of Public Safety Top 10 Sex Offender. The Veteran was wanted for a parole violation stemming from a sex offense against a child and indecency with a child by sexual contact. The Veteran was arrested in Mississippi after fleeing from Texas.

- A Veteran was arrested at the Jackson, MS, VAMC by OIG, assisted by local police, pursuant to felony warrants. The Veteran initially conveyed threats to blow up the Jackson, MS, VARO. The threats were vague in nature; however, during the course of the investigation, it was determined that the Veteran had outstanding felony warrants in both Mississippi and Alabama for selling and possessing cocaine. The Veteran's criminal history spanned over 20 years and included prior arrests for assault, burglaries, bank robbery, drug offenses, and sexual battery. The Veteran is currently being held without bond pending extradition.

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 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 is responsible for processing and reconciling all OIG financial transactions; implementing the standards and procedures for the design, construction, furnishing, operation, maintenance and repair of all OIG headquarters and field office buildings by way of space planning and facility management; as well as providing a diverse array of key support services to OIG Headquarters and the field, including real and personal property management; lock and key services; and development and issuance of internal controls policy for administrative services.

Budget Division

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

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 8:30 AM to 4:00 PM Eastern Time. Phone calls, letters, and e-mails are received from employees, Veterans, the general public, Congress, the Government Accountability Office, and other Federal agencies reporting issues of criminal activity, waste, abuse, and mismanagement. During this reporting period, the Hotline received 14,737 contacts, 460 of which

became OIG cases. The Hotline also closed 394 cases during this reporting period, substantiating allegations 44 percent of the time. The following cases were initiated as a direct result of Hotline contacts:

Contract Specialist Inappropriately Splits a Work Requirement Worth More than $6 Million

A review conducted by the OALC confirmed that a contract specialist gave preferential treatment to a Service-Disabled Veteran-Owned Small Business when she inappropriately split a planned work requirement and awarded two contracts to the business for more than $6 million. The review team also found that the contracts were fraught with a number of irregularities, but found no evidence of fraud or criminal intent. The review team recommended numerous changes in the processing of contracts, oversight reviews, and additional training to prevent recurrence.

Widows Assessed Overpayments for Failing to Disclose Remarriages

As a result of a telephone contact, the Montgomery, AL, VARO determined a widow who was granted DIC failed to notify the VARO of her 2006 remarriage. The widow was assessed an overpayment of $126,964. In a second review initiated by a hotline inquiry, another widow was also found to have withheld her remarriage from the VARO. She was assessed an overpayment of $114,488.

Employee Receives Suspension for Intimidation, Harassment, and Coercion of Subordinates

An Administrative Investigation Board (AIB) review conducted by the Atlanta, GA, VAMC found that a Licensed Practical Nurse (LPN) intimidated, harassed, and coerced coworkers and subordinates into contributing money for gifts for the Nurse Manager. The LPN also pressured employees to contribute $10 of their bonus money to the Nurse Manager as a “thank you” gesture. The AIB proposed suspensions and face-to-face ethics training for both employees. Additionally, refresher ethics training was proposed for all Unit employees.

VARO Releases Personal Identifiable Information of Several Veterans

A Montgomery, AL, VARO review determined that a Veteran, who requested a copy of his claim file, also erroneously received a list of Veterans’ names and social security numbers. The VARO notified the affected Veterans and provided credit monitoring. Employees also received refresher training in safeguarding PII.

Employee on VA-approved Sick Leave Found to be Employed at Local College

A review conducted by the Topeka, KS, VAMC Administrative Review Board, along with information received from a *Freedom of Information Act* request, found that an employee was teaching classes at a local college on some of the dates for which she was approved to take sick and *Family and Medical Leave Act* leave. Management proposed removal based on the review findings.

Fee Basis Irregularities Found at Las Vegas, Nevada, VAMC

A VISN 21 review found that the Las Vegas, NV, VAMC provided air and ground travel to its allergy patients and their companions to travel from Las Vegas to Los Angeles, CA, to receive allergy immunizations. The review estimated that each patient received 10 treatments. As a result of this Hotline inquiry, the facility will establish an agreement with a local Las Vegan allergist to provide treatment. Based on an estimated air fare of $320 round trip for patients and companions and $40 ground transportation, the facility will realize a cost savings of $20,400.

Office of Contract Review

The Office of Contract Review (OCR) operates under a reimbursable agreement with 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 48 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 $103 million in potential cost savings during this reporting period. In addition to FSS proposals, preaward reviews during this reporting period included 18 health care provider proposals—accounting for $21 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For 12 reports, the sustained savings rate was 72 percent.

	October 1, 2009—March 31, 2010	April 1—September 30, 2010	FY Total
Preaward Reports Issued	35	35	70
Potential Cost Savings	$271,015,783	$103,428,550	$374,444,333

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the *Veterans Health Care Act of 1992*, P.L. 102-585, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling over $19 million, including $1.3 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 13 post award reviews performed, 9 involved voluntary disclosures. In 6 of the 9 voluntary disclosure post award reviews, OCR identified additional funds due.

	October 1, 2009—March 31, 2010	April 1—September 30, 2010	FY Total
Postaward Reports Issued	15	13	28
Dollar Recoveries	$2,280,262	$19,352,244	$21,632,506

NAC Not Leveraging Volume Buying Power in Health Care Services Contracts

OIG conducted a series of pre- and postaward reviews of proposals and contracts awarded by VA's NAC for Professional and Allied Health Care Staffing Services under FSS Schedule 621I.

The reviews found that the prices awarded at the contract level were not fair and reasonable and the methodologies used by VA contracting officers to determine fair and reasonable pricing were inadequate. OIG made several recommendations to the Deputy Assistant Secretary for Acquisition and Logistics to correct these issues.

Counselor to the Inspector General Special Report

Review of Allegations of Improper Contract Awards to Watkins Sinclair, LLC

OIG reviewed contract awards to Watkins Sinclair, LLC, in response to a complaint that VISN 7 made improper sole source contract awards to the business. OIG identified 7 contracts and 11 purchase orders that were awarded to Watkins Sinclair between October 2007 and July 2009. Only one purchase order was awarded by VISN 7, which was a sole source award. The contract file for this award did not provide adequate justification for the sole source award. Of the remaining awards to Watkins Sinclair, six did not comply with the *Competition in Contracting Act* and the FAR. Another award was an Indefinite Delivery-Indefinite Quantity contract of which eight of the task orders to the contract did not comply with the FAR. OIG recommended that VHA ensure compliance with the Competition in Contracting Act and the FAR and provide training to Contracting Officers regarding these provisions.

Qui Tam Cases

The OIG protected VA's interest in four additional cases filed under the *qui tam* provisions of the *False Claims Act,* P.L. 111-148.

- In May 2010, The Department of Justice (DOJ) entered into an agreement with AstraZeneca to settle allegations that the company engaged in illegal conduct in the marketing of the drug Seroquel for unapproved uses. AstraZeneca agreed to pay the Government and the Medicaid Participating States $520 million to settle the claims. VA's Supply Fund will be reimbursed approximately
$15.8 million.

- In August 2010, a settlement was reached between DOJ and Allergan, Inc. to settle allegations that Allergan illegally promoted the sale of Botox for uses that were not approved by the Food and Drug Administration (FDA), made and/or disseminated unsubstantiated and/or misleading representations that the drug was safe and effective for these unapproved uses, and offered and paid illegal remuneration to health care professionals to induce them to promote and prescribe the drug. VA's share of the $210 million settlement was $1.6 million, which will be paid to the Supply Fund.

- In September 2010, a settlement was reached between the DOJ and Novartis Pharmaceutical Corporation to settle allegations that Novartis knowingly promoted the sales and use of the drug Trileptal for uses not approved by the FDA and offered and paid illegal remuneration to health care professions to induce them to promote and prescribe the drug in violation of *The Medicare and Medicaid Patient and Program Protection Act of 1987* (the "Anti-kickback Statute"), P.L. 100-93. VA's share of the $55 million to settle the civil case was $1.57 million, which will be paid to the Supply Fund.

- In September 2010, a settlement was reached between the DOJ and Gilbane Building Company to settle allegations that Gilbane submitted false certifications to various Government entities that subcontractors and suppliers had been paid and, based on these false representations, the Government made progress payments to Gilbane under the applicable contracts. VA's portion of the $1.3 million settlement was $5,366.

Congressional Testimony

Assistant Inspector General for Audits and Evaluations Testifies on VA's Fiduciary Program

Assistant Inspector General (AIG) for Audits and Evaluations Belinda Finn testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on OIG audit findings related to VA's Fiduciary Program. The audit showed that many of the program weaknesses that OIG identified in 2006 persist today. Specifically, VBA still needs to improve its management infrastructure in the areas of information systems, staffing models, and management oversight to support the program. Ms. Finn was accompanied by Timothy Crowe, Director, Bay Pines Office of Audits and Evaluations.

AIG for Audits & Evaluations Testifies on VA's Information Security Program

AIG for Audits & Evaluations Belinda Finn testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, on OIG audit of VA's implementation of the *Federal Information Security Management Act of 2002* (FISMA), which requires that VA develop, document, and implement an agency-wide information security program. Ms. Finn told the Subcommittee that while VA has made progress, its highly decentralized and complex system infrastructure poses significant challenges for implementing effective access controls, system interconnection controls, configuration management controls, and contingency planning practices to protect mission critical systems from unauthorized access, alteration, or destruction. Ms. Finn was accompanied by Michael Bowman, Director, Information Technology and Security Audits.

Deputy Inspector General Testifies on VA's Implementation of OIG Recommendations

Deputy IG Richard Griffin testified before the Committee on Veterans' Affairs, U.S. House of Representatives, on OIG's follow-up program and VA's implementation of OIG recommendations. Mr. Griffin discussed the follow-up process between OIG and VA and reported that while VA generally implements OIG recommendations in a timely manner (about 94 percent of recommendations are implemented within 1-year of issuance), there are still significant unrealized savings and program changes that could improve benefits and services to Veterans. He was accompanied by Richard Ehrlichman, AIG for Management and Administration.

Assistant Inspector General Testifies on Veterans Health Administration Contracting and Procurement Practices

AIG for Audits and Evaluations Belinda Finn testified before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives, on VHA contracting and procurement practices. Ms. Finn's testimony followed up on a December 2009 hearing regarding deficiencies in VHA's acquisition of health care goods and services, which in FY 2009 totaled $9.05 billion in expenditures. OIG work continues to identify systemic weaknesses that were previously identified in December, including compliance issues with FAR and VA Acquisition Regulations, and incomplete and unreliable data in acquisition support information systems. OIG noted improvements with the use of an automated acquisition information system in VHA procurements utilizing American Recovery and Reinvestment Act of 2009 (ARRA) funds. Ms. Finn was accompanied by Maureen Regan, Counselor to the Inspector General.

Special Recognition

OIG Employee Honored at the 2010 National Veterans TEE Tournament

Paula Chapman, Deputy Director of the Combined Assessment Program, was selected as the recipient of the 2010 Tom Heitzman Golf Buddy of the Year Award. This award was one of four presented at the National Veterans TEE Tournament held in Iowa City, IA, in September 2010, and is presented to one volunteer who performs an exceptional job as a Golf Buddy to a blinded golfer. Attracting more than 150 participants this year, the National Veterans TEE Tournament is a unique rehabilitation event that provides Veterans the opportunity to develop new skills and strengthen their self-esteem through adaptive golf, bowling, and other recreational sports activities. Participation is open to male and female U.S. military Veterans who are visually impaired, as well as those with other disabilities that include amputations, TBI, psychological trauma, certain neurological conditions, spinal cord injuries and other disabilities. Ms. Chapman, a Certified Therapeutic Recreation Specialist, has been a volunteer for the event since 1997.

Paula Chapman, recipient of the 2010 Tom Heitzman Golf Buddy of the Year Award, poses with Army Veteran and Tournament participant James Skuggevik. Ms. Chapman provided assistance to Mr. Skuggevik throughout the tournament.

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
INTERNAL AUDITS AND REVIEWS ($951,494,596)			
Audit of National Call Centers and the Inquiry Routing and Information System Report No. 09-01968-150, Issued 05/13/2010	-	-	-
Audit of Oversight of Patient Transportation Contracts Report No. 09-01958-155, Issued 05/17/2010	$91,994,596	$91,994,596	-
Audit of VISN Procurement Practices for FSS Professional and Allied Healthcare Staffing Services Report No. 08-00270-162, Issued 06/07/2010	-	-	$38,500,000
Review of Fraud Management for the Non-VA Fee Care Program Report No. 10-00004-166, Issued 06/08/2010	-	-	-
Audit of VHA's Guide and Service Dog Program Report No. 10-01714-188, Issued 07/07/2010	-	-	-
Review of Information Security Issues Impacting VA Teleradiology Contracts Report No. 09-03122-198, Issued 07/20/2010	-	-	-
Audit of Community-Based Outpatient Clinic Management Oversight Report No. 09-02093-211, Issued 07/28/2010	-	-	-
Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center, Portland, Oregon Report No. 10-01857-225, Issued 08/17/2010	-	-	-
Audit of Non-VA Inpatient Fee Care Program Report No. 09-03408-227, Issued 08/18/2010	$134,000,000	$134,000,000	$600,000,000
Review of Alleged Improper Program Management within the FLITE Strategic Asset Management Pilot Project Report No. 10-01374-237, Issued 09/07/2010	-	-	-
Audit of the FLITE Strategic Asset Management Pilot Project Report No. 09-03861-238, Issued 09/14/2010	-	-	-
Review of Alleged Improper Emergency Payments for Education Benefits Report No. 10-01248-249, Issued 09/14/2010	-	-	$87,000,000

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	
VA Has Opportunities to Strengthen Program Implementation of Homeland Security Presidential Directive 12 Report No. 10-01575-262, Issued 09/30/2010	-	-	-
ARRA AUDITS AND REVIEWS			
Audit of State Home Construction Grant Program Management of American Recovery and Reinvestment Act Funds Report No. 09-01814-129, Issued 04/15/2010	-	-	-
Review of VHA's Efforts to Meet Competition Requirements and Monitor Recovery Act Awards Report No. 10-00969-248, Issued 09/17/2010	-	-	-
Review of the Management of Recovery Act Funds for Monument and Memorial Repairs Report No. 09-01814-263, Issued 09/30/2010	-	-	-
Audit of VA's Implementation of the Post-9/11 GI Bill Long Term Solution Report No. 10-00717-261, Issued 09/30/2010	-	-	-
BENEFITS INSPECTIONS			
VA Regional Office, Waco, Texas Report No. 09-03848-130, Issued 04/16/2010	-	-	-
VA Regional Office, Albuquerque, New Mexico Report No. 10-00935-156, Issued 05/20/2010	-	-	-
VA Regional Office, Muskogee, Oklahoma Report No. 10-00936-158, Issued 05/21/2010	-	-	-
VA Regional Office, Denver, Colorado Report No. 10-01530-196, Issued 07/19/2010	-	-	-
Veterans Service Center, Cheyenne, Wyoming Report No. 10-02080-197, Issued 07/19/2010	-	-	-
VA Regional Office, Detroit, Michigan Report No. 10-02079-226, Issued 08/19/2010	-	-	-
VA Regional Office, Jackson, Mississippi Report No. 10-02460-240, Issued 09/03/2010	-	-	-
VA Regional Office, Newark, New Jersey Report No. 10-03055-259, Issued 09/29/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
COMBINED ASSESSMENT PROGRAM REVIEWS			
Manchester VA Medical Center, Manchester, New Hampshire Report No. 10-00469-122, Issued 04/06/2010	-	-	-
Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri Report No. 10-00879-126, Issued 04/08/2010	-	-	-
VA Central California Health Care System, Fresno, California Report No. 10-01081-135, Issued 04/22/2010	-	-	-
South Texas Veterans Health Care System, San Antonio, Texas Report No. 10-01233-136, Issued 04/26/2010	-	-	-
William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina Report No. 10-00044-138, Issued 04/27/2010	-	-	-
Michael E. DeBakey VA Medical Center, Houston, Texas Report No. 09-03275-147, Issued 05/13/2010	-	-	-
Aleda E. Lutz VA Medical Center, Saginaw, Michigan Report No. 09-03276-154, Issued 05/18/2010	-	-	-
VA Puget Sound Health Care System, Seattle, Washington Report No. 10-00465-168, Issued 06/09/2010	-	-	-
Chillicothe VA Medical Center, Chillicothe, Ohio Report No. 10-00049-169, Issued 06/10/2010	-	-	-
VA New Jersey Health Care System, East Orange, New Jersey Report No. 10-00470-172, Issued 06/15/2010	-	-	-
Souteast Louisiana Veterans Health Care System, New Orleans, Louisiana Report No. 10-00558-176, Issued 06/17/2010	-	-	-
Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington Report No. 09-03073-177, Issued 06/21/2010	-	-	-
Central Texas Veterans Health Care System, Temple, Texas Report No. 10-01189-187, Issued 07/09/2010	-	-	-

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	
VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska Report No. 09-03743-189, Issued 07/12/2010	-	-	-
Providence VA Medical Center, Providence, Rhode Island Report No. 10-01158-190, Issued 07/13/2010	-	-	-
Portland VA Medical Center, Portland, Oregon Report No. 10-01523-200, Issued 07/21/2010	-	-	-
VA New York Harbor Healthcare System, New York, New York Report No. 10-00471-201, Issued 07/21/2010	-	-	-
Dayton VA Medical Center, Dayton, Ohio Report No. 10-01173-203, Issued 07/22/2010	-	-	-
Carl Vinson VA Medical Center, Dublin, Georgia Report No. 10-00045-207, Issued 07/26/2010	-	-	-
New Mexico VA Health Care System, Albuquerque, New Mexico Report No. 10-01435-210, Issued 07/27/2010	-	-	-
Tomah VA Medical Center, Tomah, Wisconsin Report No. 09-03277-214, Issued 07/28/2010	-	-	-
Martinsburg VA Medical Center, Martinsburg, West Virginia Report No. 10-01619-216, Issued 07/28/2010	-	-	-
North Florida/South Georgia Veterans Health System, Gainesville, FL Report No. 10-00054-218, Issued 08/10/2010	-	-	-
St. Cloud VA Medical Center, St. Cloud, Minnesota Report No. 09-03074-221, Issued 08/12/2010	-	-	-
Erie VA Medical Center, Erie, Pennsylvania Report No. 10-01782-222, Issued 08/16/2010	-	-	-
Bath VA Medical Center, Bath, New York Report No. 10-00473-230, Issued 08/23/10	-	-	-
Los Angeles Healthcare System, Los Angeles, California Report No. 10-01438-231, Issued 08/24/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Southern Arizona VA Health Care System, Tucson, Arizona Report No. 10-02124-232, Issued 08/25/2010	-	-	-
VA Montana Health Care System, Fort Harrison, Montana Report No. 09-03744-233, Issued 08/26/2010	-	-	-
Tuscaloosa VA Medical Center Tuscaloosa, Alabama Report No. 10-00050-247, Issued 09/15/2010	-	-	-
Fargo VA Medical Center, Fargo, North Dakota Report No. 09-03745-250, Issued 09/20/2010	-	-	-
El Paso VA Health Care System, El Paso, Texas Report No. 10-01876-252, Issued 09/21/2010	-	-	-
VA Long Beach Healthcare System, Long Beach, California Report No. 10-02382-254, Issued 09/22/2010	-	-	-
COMMUNITY BASED OUTPATIENT CLINIC REVIEWS			
Coral Springs and Key West, FL; Boca Raton and Vero Beach, FL; Denton and Fort Worth, TX Report No. 09-01446-125, Issued 04/07/2010	-	-	-
Payson and Sun City, AZ; Sidney, NE, and Fort Collins, CO; Eureka and Ukiah, CA Report No. 09-01446-132, Issued 04/21/2010	-	-	-
Smithville, MS, and Memphis (Memphis-South), TN; Knoxville, TN, and Norton, VA; Chattanooga and Nashville (Vine Hill), TN Report No. 10-00627-174, Issued 06/16/2010	-	-	-
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	-	-	-
Delray Beach and Stuart, FL; Portsmouth and Cambridge, OH; Canton and Painesville, OH; South Bend and Muncie, IN Report No. 10-00627-209, Issued 07/27/210	-	-	-

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	
Pittsfield and Greenfield, MA; Dunkirk and Niagara Falls, NY; Hermitage (Marzano) and Foxburg (Clarion County), PA; Cumberland, MD; and Harrisonburg, VA Report No. 10-00627-239, Issued 09/01/2010	-	-	-
NATIONAL REPORTS			
Informational Report, Community Based Outpatient Clinic Cyclical Reports Report No. 10-00627-124, Issued 04/06/2010	-	-	-
Evaluation of Emergency Departments and Urgent Care Clinics in Veterans Health Administration Facilities Report No. 07-03165-139, Issued 04/28/2010	-	-	-
Review of Brachytherapy Treatment of Prostate Cancer, Philadelphia, Pennsylvania and Other VA Medical Centers Report No. 09-02815-143, Issued 05/03/2010	-	-	-
Progress in Implementing the Veterans Health Administration's Uniform Mental Health Services Handbook Report No. 08-02917-145, Issued 05/04/2010	-	-	-
Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2009 Report No. 09-00069-161, Issued 06/02/2010	-	-	-
Oversight of Veterans Health Administration Quality Assurance Programs and Contract Services Report No. 10-02829-183, Issued 06/30/2010	-	-	-
Evaluation of Physician Credentialing and Privileging in Veterans Health Administration Facilities Report No. 10-02381-185, Issued 07/06/2010	-	-	-
Management of Osteoporosis in Veterans with Fractures Report No. 09-03138-191, Issued 07/13/2010	-	-	-
Follow-Up Evaluation of Veterans Health Administration Missing Patient Policies and Procedures Report No. 08-00526-194, Issued 07/15/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Evaluation of Contracted/Agency Registered Nurses in Veterans Health Administration Facilities Report No. 10-02288-193, Issued 07/15/2010	-	-	-
Primary Care Services for Women Veterans: Accessibility and Acknowledgment of Test Results Report No. 08-03299-217, Issued 08/04/2010	-	-	-
HEALTHCARE INSPECTIONS			
Alleged Endoscope Reprocessing Issues, St. Louis VA Medical Center, St. Louis, Missouri Report No. 10-01141-133, Issued 04/21/2010	-	-	-
Alleged Radiology and Cardiology Quality of Care Issues, Malcom Randall VA Medical Center, Gainesville, Florida Report No. 10-00169-134, Issued 04/22/2010	-	-	-
Alleged Quality of Care Issues in the Geriatrics and Extended Care Service, VA North Texas Health Care System, Dallas, Texas Report No. 09-03610-141, Issued 04/29/2010	-	-	-
Post-Operative Care Case Review at the Lexington VA Medical Center, Lexington, Kentucky Report No. 10-00389-146, Issued 05/11/2010	-	-	-
Alleged Quality of Care Issues and Privacy Violations, Battle Creek VA Medical Center, Battle Creek, Michigan Report No. 10-00355-153, Issued 05/14/2010	-	-	-
Alleged Patient Abuse and Quality of Care Issues, Louis Stokes VA Medical Center, Cleveland, Ohio Report No. 10-01312-160, Issued 05/24/2010	-	-	-
Suicide After Hospitalization at a Veterans Health Facility Report No. 10-01346-167, Issued 06/09/2010	-	-	-
Allegations Concerning Respiratory Therapy and Nursing, VA Medical Center, Memphis, Tennessee Report No. 09-03815-170, Issued 06/10/2010	-	-	-

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	
Inadequate Coordination of Care, Orlando VA Medical Center, Orlando, Florida Report No. 10-00219-180, Issued 06/24/2010	-	-	-
Patient Care, IRB, and Research Oversight Issues at a VA Medical Center Report No. 08-01515-199, Issued 07/20/2010	-	-	-
Mortality Review, Aleda E. Lutz Medical Center, Saginaw, Michigan Report No. 10-00687-223, Issued 08/16/2010	-	-	-
Review of Quality of Care Issues Tomah VA Medical Center and William S. Middleton Memorial Veterans Hospital, Tomah and Madison, Wisconsin Report No. 10-02355-242, Issued 09/08/2010	-	-	-
Review of Patient Referrals to the Lower 48 States at the Alaska VA Healthcare System, Anchorage, Alaska Report No. 10-01509-241, Issued 09/09/2010	-	-	-
Delay in Cancer Diagnosis, Iowa City VA Medical Center, Iowa City, Iowa Report No. 10-01409-246, Issued 09/14/2010	-	-	-
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	-	-	-
Alleged Inappropriate Treatment, Portland VA Medical Center, Portland, Oregon Report No. 10-01528-258, Issued 09/28/2010	-	-	-
ADMINISTRATIVE INVESTIGATIONS			
Prohibited Personnel Practices, Gifts from Prohibited Sources, Lack of Candor, and Misuse of Time and Resources, VHA Workforce Management and Consulting Office Report No. 09-03058-171, Issued 06/11/2010	-	-	-
Improper Salary Supplementation, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas Report No. 08-03126-229, Issued 08/20/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Prohibited Personnel Practices, Abuse of Authority, Misuse of Position, and False Statements, Office of Human Resources and Administration, VA Central Office Report No. 10-00853-257, Issued 09/22/2010	-	-	-
PREAWARD REVIEWS (103,428,550)			
Review of Proposal Submitted under Solicitation Number VA-251-09-RP-0264 for Medical Physicist Services at the Richard l. Roudebush VAMC Report No. 10-01799-128, Issued 04/20/2010	$46,322	-	-
Review of Proposal Submitted under Solicitation Number VA-249-09-RP-0154 for Radiology Services at the Louisville VA Medical Center Report No. 10-00913-123, Issued 04/22/2010	$1,972,048	-	-
Review of Contract Extension Proposal under the Federal Supply Schedule Report No. 10-00184-137, Issued 04/26/2010	$1,017,952	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2 Report No. 10-00976-140, Issued 04/27/2010	-	-	-
Review of Annual Capitated Rate Awarded to Provide Primary Care Services at Community Based Outpatient Clinics Report No. 10-01593-142, Issued 04/30/2010	$416,812	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number 797-FSS-99-0025-R6 Report No. 10-00398-144, Issued 04/30/2010	$72,210,493	-	-
Review of Proposal Submitted for Medical Consultant and Attending Services at the Audie L. Murphy Division of the South Texas Veterans Health Care System Report No. 10-01797-157, Issued 04/30/2010	$1,270,677	-	-
Review of Federal Supply Schedule Extension Proposal Report No. 10-01186-152, Issued 05/12/2010	$2,620,044	-	-

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted under Solicitation Number VA-248-09-RP-0653 for Ophthalmology Services at Bay Pines VA Healthcare System Report No. 10-02239-159, Issued 05/26/2010	$1,391,413	-	-
Review of Proposal Submitted under Solicitation Number VA-69D-09-RP-0431 for Heart and Lung Transplant Services for the William S. Middleton Memorial Veterans Hospital Report No. 10-01499-163, Issued 06/03/2010	$625,819	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6 Report No. 10-00937-175, Issued 06/11/2010	$1,298,851	-	-
Review of Proposal Submitted under Solicitation Number VA-69D-09-RP-0576 for Hemodialysis and Continuous Renal Replacement Therapy to the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin Report No. 10-01796-149, Issued 06/14/2010	$1,381,382	-	-
Review of Proposal Submitted under Solicitation Number VA-260-08-RP-0386 for Neuroradiology Services at the VA Medical Center, Portland, Oregon Report No. 10-00912-164, Issued 06/15/2010	$1,085,075	-	-
Review of Proposal Submitted under Solicitation Number VA-244-10-RP-0026 for Neurological Surgery Services at VA Pittsburgh Healthcare System Report No. 10-02551-179, Issued 06/21/2010	$367,599	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6 Report No. 10-01521-181, Issued 06/25/2010	$1,072,800	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R5 Report No. 09-03748-186, Issued 07/01/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted under Solicitation Number VA-261-10-RP-0033 for Hematology/Oncology Services at the VA Sierra Nevada Health Care System Report No. 10-02840-182, Issued 07/05/2010	$725,203	-	-
Review of Proposal Submitted under Solicitation Number VA-258-09-RP-0297 for Otolaryngology Surgeon Services at New Mexico VA Health Care System Report No. 10-02277-195, Issued 07/14/2010	$1,746,390	-	-
Review of Contract Extension Proposal under the Federal Supply Schedule Report No. 10-02221-202, Issued 07/20/2010	-	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2 Report No. 10-02364-205, Issued 07/21/2010	-	-	-
Review of Proposal Submitted under Solicitation Number VA-244-09-RP-0104 for Anesthesiology Healthcare Services at VA Pittsburgh Healthcare System Report No. 10-02540-213, Issued 07/26/2010	$2,959,821	-	-
Review of Proposal Submitted under Solicitation Number VA-256-10-RP-0202 for Neurosurgery Healthcare Services at Oklahoma City VA Medical Center Report No. 10-03044-204, Issued 07/29/2010	$1,286,974	-	-
Review of Contract Extension Proposal under the Federal Supply Schedule Report No. 10-02220-212, Issued 08/11/2010	$710,075	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6 Report No. 10-02396-224, Issued 08/17/2010	$1,351,806	-	-
Review of Proposal Submitted under Solicitation Number VA-263-10-RP-011 for Dermatology Healthcare Services at the Iowa City Medical Center Report No. 10-03366-219, Issued 08/18/2010	$432,185	-	-

Appendix A: List of OIG Reports Issued

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted under Solicitation Number VA-256-10-RP-0116 Dermatology Services at the Oklahoma City VA Medical Center Report No. 10-03113-220, Issued 08/18/2010	$463,710	-	-
Review of Proposal Submitted under Solicitation Number VA-256010-RP-0093 for Radiology Healthcare Services at Oklahoma City VA Medical Center Report No. 10-03114-228, Issued 08/19/2010	$749,362	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number 797-FSS-99-0025-R6 Report No. 10-02498-234, Issued 08/23/2010	-	-	-
Review of Proposal Submitted under Solicitation Number VA-259-09-RP-0044 for Radiology Healthcare Services at George E. Wahlen VA Medical Center Report No. 10-03115-243, Issued 09/02/2010	$3,488,280	-	-
Review of Proposal Submitted under Solicitation Number VA-259-10-RP-0150 for Cardio Stress Tests and Consultation for VA Medical Center, Grand Junction, Colorado Report No. 10-03473-236, Issued 09/08/10	$1,062,405	-	-
Review of Proposal for Oncology and Brachytherapy Systems under Solicitation Number M6-Q6-09 Report No. 10-2533-244, Issued 09/08/2010	$1,553,044	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number M5-Q50A-03-R2 Report No. 10-02863-253, Issued 09/20/2010	-	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number RFP-797-FSS-99-0025-R6 Report No. 10-01942-251, Issued 09/23/2010	-	-	-
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number 797-652F-05-0001-R2 Report No. 10-03022-255, Issued 09/23/2010	-	-	-

Report Title, Number, and Issue Date	Funds Recommended for Better Use		Questioned Costs
	by OIG	Agreed to by Management	
Review of Proposal Submitted under Solicitation Number VA-256-08-RP-0136 for Gastroenterology Services at G.V. (Sonny) Montgomery VA Medical Center Report No. 10-03615-260, Issued 09/29/2010	$122,008	-	-
POSTAWARD REVIEWS ($19,352,244)			
Review of Contract Extension Proposal and Voluntary Disclosure for Defective Pricing Adjustments under the Federal Supply Schedule Report No. 09-03507-109, Issued 04/01/2010	-	-	$269,196
Review of Overcharges Relating to the Failure to Offer Covered Drugs Under the Federal Supply Schedule Report No. 10-00292-127, Issued 04/09/2010	-	-	$327,911
Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule Report No. 09-01654-131, Issued 04/15/2010	-	-	$144,024
Review of Voluntary Disclosure Submitted for Product Additions under the Federal Supply Schedule Report No. 10-00903-48, Issued 05/11/2010	-	-	-
Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule Report No. 09-02433-151, Issued 05/11/2010	-	-	$13,308
Review of Federal Supply Schedule 621 I - Professional and Allied Healthcare Staffing Services Report No. 08-02969-165, Issued 06/07/2010	-	-	-
Review of Supplemental Voluntary Disclosure and Refund Offer under the Federal Supply Schedule Report No. 10-01685-173, Issued 06/10/2010	-	-	$85,279
Review of Off-Label Marketing of a Pharmaceutical Product Report No. 10-03054-184, Issued 06/30/2010	-	-	$15,863,557

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 Overcharges Relating to Failure to Offer a Covered Drug under the Federal Supply Schedule Report No. 10-02210-178, Issued 07/12/2010	-	-	$311,082
Review of Overcharges Relating to Federal Ceiling Price Recalculations and Price Reductions under the Federal Supply Schedule Report No. 08-03209-206, Issued 07/22/2010	-	-	$307,205
Review of Disclosure Memorandum under the Federal Supply Schedule Report No. 09-00967-215, Issued 09/09/2010	-	-	$1,501,876
Review of Voluntary Disclosure and Refund Offer under the Federal Supply Schedule Report No. 10-00192-235, Issued 09/09/10	-	-	$352,916
Review of Overcharges Relating to Federal Ceiling Price Recalculations under the Federal Supply Schedule Report No. 10-00294-245, Issued 09/08/2010	-	-	$175,890
SPECIAL REPORTS			
Review of Allegations of Improper Contract Awards to Watkins Sinclair, LLC Report No. 09-02322-192, Issued 07/14/2010	-	-	-
Total Funds Recommended for Better Use	**$225,994,596**	**$225,994,596**	**-**
Total Questioned Costs	**-**	**-**	**$725,500,000**
Total Preaward Savings and Cost Avoidance	**$103,428,550**	**-**	**-**
Total Postaward Dollar Recoveries	**-**	**-**	**$19,352,244**

Appendix B: Unimplemented OIG Reports and Recommendations

The *Federal Acquisition Streamlining Act of 1994*, P.L. 103-355, requires Federal agencies to complete final action on each OIG report recommendation within 1 year after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This table summarizes the status of all unimplemented OIG reports and recommendations. Results are sorted by the action office responsible for implementation. Additionally, the table indicates how many of these unimplemented OIG reports and recommendations are less than or more than 1 year.

As of September 30, 2010, there are 120 open reports and 674 open recommendations. However, some of these reports and recommendations are counted more than once in the table below because they have actions at more than one office. Of the reports open more than 1 year, 2 reports and 2 recommendations have actions at two or more offices. Of the reports open less than 1 year, 5 reports and 6 recommendations have actions at two or more offices. Although the FY 2009 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, 2009.

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	76	14	**90**	450	34	**484**
Veterans Benefits Administration	12	3	**15**	44	5	**49**
National Cemetery Administration	1	0	**1**	3	0	**3**
Office of Information & Technology	7	6	**13**	63	33	**96**
Office of Operations, Security, and Preparedness	1	0	**1**	11	0	**11**
Office of Acquisitions, Logistics, and Construction	2	2	**4**	10	4	**14**
Office of Public and Intergovernmental Affairs	1	0	**1**	13	0	**13**
Chief of Staff	2	0	**2**	12	0	**12**
Total	**102**	**25**	**127**	**606**	**76**	**682**

Appendix B: Unimplemented OIG Reports and Recommendations

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study Report No. 04-02330-212, Issued 09/30/2005	VHA	1 of 3	-

Recommendation 1: *We recommended that the Under Secretary for Health and the Chief Management Officer initiate formal acquisition planning and proper contracting processes to expeditiously and successfully complete the Study and ensure that assigned project management and contracting staff have the required knowledge and skills to effectively plan, procure, administer, and manage the Study in accordance with pertinent legal, procedural, and technical requirements.*

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.*

Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations Report No. 07-00564-121, Issued 05/05/2008	VHA	3 of 5	-

Recommendation 1: *We recommended that the Under Secretary for Health prepare a recommendation to the Secretary defining the oversight authorities of the NPOB, CFO, and NPPO and update VHA Handbook 1200.17 to incorporate these authorities.*

Recommendation 3: *We recommended that the Under Secretary for Health revise VHA Handbook 1200.17 to clearly define minimum control requirements for all NPCs and provide training to NPC Directors on these requirements.*

Recommendation 5: *We recommended that the Under Secretary for Health develop and implement procedures to review, monitor, and enforce NPC compliance with conflict of interest laws and policies.*

Audit of Veterans Benefits Administration Transition Assistance for Operations Enduring and Iraqi Freedom Service Members and Veterans Report No. 06-03552-169, Issued 07/17/2008	VBA	1 of 8	-

Recommendation 8: *We recommended the Acting Under Secretary for Benefits establish policies and procedures that require staff to provide special outreach to Veterans who do not have a high school diploma or equivalent.*

Appendix B: Unimplemented OIG Reports and Recommendations

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old			
Report Title, Number, and Issue Date	**Responsible Organization**	**Number of Open Recommendations**	**Monetary Impact**
Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreement Report No. 08-00477-211, Issued 09/29/2008	VHA	1 of 7	$95,666

Recommendation 5: *We recommended that the Under Secretary for Health instruct the VISN contracting officers to initiate recovery of overpayments identified by our audit, as appropriate.*

Audit of Procurements Using Prior-Year Funds to Maintain VA Healthcare Facilities Report No. 08-00244-213, Issued 09/30/2008	VHA	1 of 7	-

Recommendation 7: *We recommended the Under Secretary for Health consult with the Assistant Secretary for Management to develop plans to implement controls over obligation of expired funds in other VHA programs, projects, or activities.*

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

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

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

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

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

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

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

Appendix B: Unimplemented OIG Reports and Recommendations

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, Review of Informed Consent in the Department of Veterans Affairs Human Subjects Research Report No. 08-02725-127, Issued 05/15/2009	VHA	4 of 5	-

Recommendation 1: *We recommended that the Under Secretary for Health require that facility Directors ensure sufficient IRB [Institutional Review Board] written documentation of waiver from informed consent.*

Recommendation 2: *We recommended that the Under Secretary for Health establish procedures requiring facility Directors to ensure signed informed consent forms are on file.*

Recommendation 4: *We recommended that the Under Secretary for Health require facility Directors to ensure that witnesses are obtained for all VA consent forms as required.*

Recommendation 5: *We recommended that the Under Secretary for Health establish procedures requiring facility Directors to ensure that IRB-approved informed consent forms consistently contain witness blocks or ensure sufficient IRB written documentation of waiver from the witness requirement.*

Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Accountability Report No. 08-02730-133, Issued 05/28/2009	VHA	1 of 6	-

Recommendation 2: *We recommend the Under Secretary for Health require the Deputy Chief Consultant PBM/CMOP perform a complete inventory analysis to develop and implement a plan of action to mitigate significant variances.*

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.*

Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York Report No. 08-02562-139, Issued 06/03/2009	VHA	1 of 13	-

Recommendation 8: *We recommended that the VISN Director ensure that the Medical Center Director takes action to protect patient privacy and secure medical information in the ED.*

Appendix B: Unimplemented OIG Reports and Recommendations

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 Consolidated Mail Outpatient Pharmacy Contract Management Report No. 09-00026-143, Issued 06/10/2009	VHA	1 of 4	$724,476

Recommendation 2: *We recommended that the Acting Under Secretary for Health require the National CMOP Office to assess the continued need for the current backup data storage contract.*

Audit of Veterans Health Administration's Management of Non-Controlled Drugs Report No. 08-01322-114, Issued 06/23/2009	VHA	5 of 6	-

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

Recommendation 3: *We recommended the Under Secretary for Health require that information on drug stocks transferred within a VA health care facility and drugs dispensed by and returned to a facility's stock is accurately and consistently recorded in VistA.*

Recommendation 4: *We recommended the Under Secretary for Health establish a policy on VA health care facilities' use of drugs returned in the mail; and if returned drugs are restocked by facilities, develop procedures to ensure information on returned quantities of CMOP dispensed drugs that are restocked is consistently captured in inventory records using standardized procedures.*

Recommendation 5: *We recommended the Under Secretary for Health develop policy to limit access to the VistA label reprint function to appropriate pharmacy personnel and develop standard procedures to capture information on drugs dispensed using the reprint function.*

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

Audit of VA Incomplete Compensation and Pension Medical Examinations Report No. 08-01392-144 Issued 06/25/2009	VHA/VBA	2 of 4	-

Recommendation 3: *We recommended the Under Secretary for Benefits establish a process at VA Regional Offices to ensure complete and accurate information is provided on compensation and pension examination requests.*

Recommendation 4: *We recommended the Under Secretary for Health and the Under Secretary for Benefits jointly require the CPEP Office's quality assurance reviews include a routine review of incomplete compensation and pension examination requests, report identified deficiencies, and recommend improvement actions as needed.*

Appendix B: Unimplemented OIG Reports and Recommendations

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

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

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

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

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

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

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

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

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

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

Review of Defects in VA's Computerized Patient Record System Version 27 and Associated Quality of Care Issues Report No. 09-01033-155, Issued 06/29/2009	VHA/OI&T	1 of 5	-

Recommendation 3: *We recommended that the Acting Under Secretary for Health and Acting Assistant Secretary for Information and Technology implement full system functionality and integration testing of Computerized Patient Record System (CPRS) during the Alpha testing to reduce the risk that CPRS functionality defects will adversely affect patient safety during production (Beta) testing.*

Appendix B: Unimplemented OIG Reports and Recommendations

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

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

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

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

Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program Report No. 08-02901-185, Issued 08/03/2009	VHA	1 of 8	$865,419,766

Recommendation 5: *We recommend the Acting Under Secretary for Health establish clear oversight responsibilities for the Fee Program and implement oversight procedures to regularly monitor program compliance and performance.*

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

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

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

Administrative Investigation, Nepotism, Abuse of Authority, Misuse of Position, Improper Hiring, and Improperly Administered Awards, OI&T, Washington, DC Report No. 09-01123-196, Issued 08/18/2009	OI&T	24 of 34	-

Appendix B: Unimplemented OIG Reports and Recommendations

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 1*: *We recommend that the Assistant Secretary for Information and Technology ensure that the total amount of funds unlawfully expended to pay for _____'s salary since his initial OI&T appointment on September 16, 2007, is determined, and ensure that a bill of collection is issued to _____ in that amount.*

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

Recommendation 3*: *We recommend that the Assistant Secretary for Information and Technology ensure that the total amount of funds unlawfully expended to pay for _____'s salary since April 27, 2004, the first instance of Ms. Duncan authorizing the expenditure of VA funds to pay for _____'s education and to advance _____'s career, is determined, and ensure that a bill of collection is issue to _____ in that amount.*

Recommendation 5: *We recommend that the Assistant Secretary for Information and Technology take appropriate administrative action against _____ for not testifying freely and honestly in a matter regarding her employment.*

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

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

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

Recommendation 16: *We recommend that the Assistant Secretary for Information and Technology take appropriate administrative action against _____ for authorizing improper academic degree funding.*

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

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

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

Appendix B: Unimplemented OIG Reports and Recommendations

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

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

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

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

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

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

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

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

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

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

Appendix B: Unimplemented OIG Reports and Recommendations

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 32: *We recommend that the Assistant Secretary for Information and Technology ensure that OI&T Recommending and Approving Officials receive training on Federal regulations and VA and OI&T policy related to monetary awards, as well as be reminded of their fiscal responsibility.*			
Recommendation 33: *We recommend that the Assistant Secretary for Information and Technology ensure that a review of OI&T retention incentives is conducted to ensure that they are necessary and support the mission and program needs and that they fully comply with law, OPM regulations, and VA policy.*			
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	OI&T	4 of 4	-
Recommendation 1: We recommend the Assistant Secretary for Information and Technology require OI&T develop and issue a directive that communicates, VA-wide, the mandatory requirements of VA's SDLC process outlined in the existing Program Management Guide to ensure consistent management of VA's IT investment portfolio.			
Recommendation 2: We recommend the Assistant Secretary for Information and Technology require OI&T implement controls to continuously monitor all programs and projects in VA's IT investment portfolio.			
Recommendation 3: We recommend the Assistant Secretary for Information and Technology enforce disciplined performance and quality reviews on all major programs and projects in VA's IT investment portfolio.			
Recommendation 4: We recommend the Assistant Secretary for Information and Technology require OI&T establish and maintain a central data repository to store all program artifacts, including cumulative cost and schedule data.			
TOTALS	**23 Reports**	**74 Recs**	**$866,239,908**

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

Appendix C: Inspector General Act Reporting Requirements

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

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208, (FFMIA) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. The audit of VA's consolidated financial statements for FY 2009 and 2008 reported four material weaknesses, three of which are repeat conditions from the prior year's audit. The audit also indicated that VA is not in substantial compliance with FFMIA because VA did not substantially comply with Federal financial management systems requirements. VA revised and expanded the corrective action plans for the three repeat material weaknesses identified in the FY 2009 and 2008 audit.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	Commented on 367 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 8-45
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 8-45
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 60-69
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 22-38
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 46-59
Section 5 (a) (7)	Summary of each particularly significant report	See pages 8-45
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 71
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 71

Appendix C: Inspector General Act Reporting Requirements

IG Act References	Reporting Requirements	Status
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See Table 1 and Table 2 below
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 5(b) of FFMIA	See page 70

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2009	0	$0
Issued during reporting period	3	$725.5
Total inventory this period	3	$725.5
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	3	$725.5
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	3	$725.5
Total carried over to next period	0	$0

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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 03/31/2009	0	$0
Issued during reporting period	2	$226
Total inventory this period	2	$226
Management decisions during the reporting period		
Agreed to by management	2	$226
Not agreed to by management	0	$0
Total management decisions this reporting period	2	$226
Total carried over to next period	0	$0

Appendix D: Government Contractor Audit Findings

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

Appendix E: American Recovery and Reinvestment Act Oversight Activities

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.
- $157.1 million for VBA claims processing hiring initiative and support of Veterans economic recovery payments.
- $50.1 million for OI&T support of VBA implementation of the new Post 9/11 GI Bill education assistance programs for Veterans.

As of September 30, 2010, OIG has expended $2.2 million (the entire $1.0 million OIG received under ARRA and $1.2 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 270 fraud awareness training and outreach sessions across the country attended by over 9,000 VA and other officials responsible for managing or overseeing ARRA programs and projects.
- Opened 53 and closed 8 criminal investigations of alleged wrongdoing pertaining to ARRA-funded programs and projects.
- Received 57 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.

Appendix F: Restoring American Financial Stability Act Reporting Requirements

Pursuant to the *Restoring American Financial Stability Act of 2010,* P.L. 111-203, OIG reports that no peer reviews were conducted by another OIG during the reporting period ending September 30, 2010. The last peer review was conducted by the U.S. Department of Agriculture OIG on December 23, 2009. This report contains no outstanding recommendations. VA OIG conducted an external peer review of the Department of Transportation OIG and issued the final report on March 3, 2010, which contained no recommendations.

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On the Cover

William H. Toledo, a U.S. Marine Corps World War II Veteran, looks at the Marine Corps War Memorial statue in Arlington, VA, before the wreath laying ceremony commemorating the 65th anniversary of the Battle of Iwo Jima. Toledo is a surviving Navajo code talker who fought in the battle. Photo taken February 19, 2010, by Sergeant Alvin Williams. Courtesy of Department of Defense.

Office of Inspector General
United States Department of Veterans Affairs

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