Department of Veterans Affairs
Office of Inspector General
March 2016 Highlights

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General for Audits and Evaluations Tells House Subcommittee that Despite Some Progress, Information Technology System Development Remains a Challenge for VA

Mr. Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Information Technology, Committee on Oversight and Government Reform, United States House of Representatives, on the effectiveness of VA's information security program. Mr. Arronte highlighted several Office of Inspector General (OIG) audits conducted in recent years that show information technology (IT) system development at VA is a longstanding high-risk challenge susceptible to cost overruns, schedule slippages, performance problems, and in some cases complete project failures. He explained that IT systems and networks are critical to VA in carrying out its mission of providing medical care and a range of benefits and services to veterans, and that without proper safeguards in place, the systems and networks are vulnerable to intrusions by groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other systems. He added that IT shortfalls constitute poor financial stewardship and counterproductive investments of taxpayer dollars. Mr. Arronte acknowledged that VA has made some improvements in information security management with the launch of the Continuous Readiness in Information Security Program, but he warned that additional work is required to address OIG recommendations related to the security and development of IT systems. Mr. Arronte was accompanied by Mr. Michael Bowman, Director, Information Technology and Security Audits Division. **[Click here to access testimony.]**

OIG REPORTS

Review of Alleged Untimely Processing of Veterans Benefits Administration's Specially Adapted Housing Grants at the Regional Loan Center in Phoenix, Arizona

OIG conducted this review in response to an allegation received through OIG's Hotline pertaining to VA's Specially Adapted Housing Grant Program. This review specifically assessed why the Veterans Benefits Administration (VBA) Regional Loan Center, located in Phoenix, AZ, was taking more than 2 years to process and approve grants for veterans with certain service-connected disabilities in the Specially Adapted Housing Grant Program. OIG substantiated the allegation that the Phoenix Regional Loan Center has taken more than 2 years to process and approve Specially Adapted Housing (SAH) and Special Housing Adaptation grants. For the 191 grants approved from October 1, 2013, through the first quarter of fiscal year (FY) 2015, OIG identified 45 of 191 grants (24 percent) that had periods of inactivity before approval. OIG defined a period of inactivity as the span of time from when a grant becomes inactive to returning to an active status. A case becomes inactive when the veteran chooses to stop pursuing the grant. The reasons a grant may become inactive could include veterans who are hospitalized or who want to suspend the process. By excluding the periods of

inactivity from the timeliness calculation, OIG determined that out of the 191 grants reviewed, there were: (1) 109 (57 percent) approved within 1 year; (2) 56 (29 percent) approved greater than 1 year and less than 2 years; and (3) 26 (14 percent) approved at 2 years or longer. Of the 191 cases OIG reviewed, SAH agents documented required monthly and annual communication with veterans who have applied for grants. SAH agents are required to contact each veteran every 30 business days to provide follow-up by telephone, email, or regular mail. Follow-up by SAH agents provides veterans the opportunity to ask questions and obtain assistance throughout the approval process. Although it is essential that VBA approve these grants timely so eligible veterans may live in homes that accommodate their disabilities, OIG made no recommendations concerning this allegation. OIG found the current approval process relies upon veterans and external agencies, such as contractors, to complete required actions. OIG's review of SAH documentation shows that SAH agents are communicating with veterans monthly and are assisting veterans in completing required actions. **[Click here to access report.]**

Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California

OIG conducted an inspection in response to complaints about the quality of care for patients with mental health (MH) conditions at the VA Long Beach Healthcare System (system), Long Beach, CA. OIG did not substantiate that female patients with military sexual trauma were denied MH counseling and did not receive individual counseling because of the lack of trained therapists. OIG did not substantiate that the system denied medical care to female patients with 100 percent military sexual trauma-related MH conditions, that these patients waited months for medical treatments, or that the Non-VA Care Coordination referral process was inefficient. OIG did not substantiate that a male patient committed suicide in 2014 because he was denied MH treatment. However, OIG identified quality of care concerns related to chronic pain management for one patient. The primary care provider did not refer the patient to specialists for second level review. OIG recommended that the System Director ensure that primary care providers follow established guidelines for referral of patients with chronic pain as required by VA policy. **[Click here to access report.]**

Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, Texas

OIG reviewed an allegation by a third party that an employee conducting research was intimidated by managers after notifying them of preliminary research study data that, per the complainant, reflected negatively on the VA North Texas Health Care System (VANTHCS) in Dallas, TX. OIG could not substantiate that VANTHCS managers threatened the employee with job reassignment after she presented the preliminary findings of her research study. OIG found that the current Associate Director for Patient Care Services (ADPCS) was performing appropriate stewardship of resources when reassigning staff in unapproved positions back to either their former positions or equivalent vacant positions within the Nursing Service. The current ADPCS made good faith efforts to meet the employee's needs and requests while ensuring adequate staffing. OIG also could not substantiate that the employee's professional reputation

was threatened. Managers did not prohibit the employee from continuing to work on the study and offered to provide data analysis support—actions that were inconsistent with a finding that the employee's job and reputation were threatened because of the preliminary study results. As of April 2015, the employee was analyzing the data and summarizing the results. The timing of the current ADPCS' position management actions and the employee's notification to managers of her preliminary research findings appeared coincidental. OIG made no recommendations.
[Click here to access report.]

VA's Federal Information Security Modernization Act Audit for FY 2015
The Federal Information Security Modernization Act (FISMA) requires agency Inspectors General to annually assess the effectiveness of agency information security programs and practices. In FY 2015, OIG audited VA's information security program to evaluate its compliance with FISMA requirements and applicable National Institute of Standards and Technology guidelines. VA has made progress developing policies and procedures but still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, this FISMA audit continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems. Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, databases, and server platforms VA-wide. Further, VA has not remediated approximately 9,500 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its information security posture. As a result, the FY 2015 consolidated financial statement audit concluded that a material weakness still exists in VA's information security program. OIG recommended the Assistant Secretary for Information and Technology implement comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems. **[Click here to access report.]**

Independent Review of the FY 2015 Detailed Accounting Submission to the Office of National Drug Control Policy
OIG is required to review the VA's FY 2015 Detailed Accounting Submission to the Office of National Drug Control Policy (ONDCP). The Submission concerns assertions on VA's drug methodology, reprogrammings and transfers, and fund control notices. Based upon OIG's review, nothing came to our attention that caused us to believe that management's assertions included in VA's Submission are not fairly stated in all material respects based on the set criteria. **[Click here to access report.]**

Independent Review of VA's FY 2015 Performance Summary Report to ONDCP
As required by ONDCP's Drug Control Accounting Circular, OIG reviewed VA's FY 2015 Performance Summary Report to ONDCP. OIG attested to VA's ability to capture performance information accurately and if the current system was properly applied to generate the performance data reported in the Performance Summary Report. Based

upon OIG's review and the criteria of the Circular, nothing came to our attention that caused us to believe that VA does not have a system to meet its FY 2015 targets for the continuity of care performance measure (Patient Care) and the substance abuse disorder on-going studies performance measure (Research and Development), in all material respects**.** **[Click here to access report.]**

Combined Assessment Program Reviews
In March 2016, OIG published three Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following seven activities:

(1) Quality, Safety, and Value
(2) Environment of Care
(3) Medication Management
(4) Suicide Prevention Program
(5) Alcohol Use Disorder Care
(6) Coordination of Care
(7) Computed Tomography Radiation Monitoring

James A. Haley Veterans' Hospital, Tampa, Florida
Charlie Norwood VA Medical Center, Augusta, Georgia
VA Manila Outpatient Clinic, Manila, Philippines

Community Based Outpatient Clinic Reviews
In March 2016, OIG published two Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities:

(1) Environment of Care
(2) Home Telehealth Enrollment
(3) Outpatient Lab Results Management
(4) Post-Traumatic Stress Disorder Care

Northern Arizona VA Health Care System, Prescott, Arizona
James A. Haley Veterans' Hospital, Tampa, Florida

CRIMINAL INVESTIGATIONS
Construction Corporation Agrees To Pay $5 Million To Resolve Allegations
A construction corporation agreed to pay $5 million to resolve allegations that its Chairman and Chief Executive Officer, President, and other employees and company affiliates engaged in conduct designed to exploit contracting opportunities reserved for service-disabled veterans, all in violation of the False Claims Act. A VA OIG, Defense

Criminal Investigative Service, and Small Business Administration OIG investigation determined that the corporation created and controlled a Service-Disabled Veteran-Owned Small Business (SDVOSB) by utilizing their warehouse manager's status as a disabled veteran. For over 3 years, VA awarded $14,623,959 in SDVOSB contracts to the company.

Charges Filed Against Former Biopharmaceutical Company Official for Conspiracy and Health Care Fraud

A criminal information was filed charging the former Federal sales division vice president of a biopharmaceutical company with conspiracy and health care fraud. An OIG and Federal Bureau of Investigation investigation revealed that several VA clinicians, working at various facilities across the country, accepted gratuities from the company while employed at VA. The company provided cash, all-expense paid trips, concert tickets, and expensive meals to these clinicians in exchange for various actions the clinicians took to promote the company's product within VA. Relationships that began as approved speaking engagements changed over time into situations where these clinicians were functioning as de facto sales representatives. As a result, after 3 years the sale of this product to VA increased 1,875 percent. Prosecution of other involved individuals is pending.

Miami, Florida, VA Medical Center Nurse Sentenced for Obstruction and Altering Computer Records

A Miami, FL, VA Medical Center (VAMC) nurse was sentenced to 60 months' incarceration and 36 months' supervised release after pleading guilty to obstruction and altering computer records. The defendant is also required to surrender his nursing license and is prohibited from practicing in the field of medicine. An OIG investigation revealed that the defendant provided substandard care and manipulated patient information that caused a patient in the Surgical Intensive Care Unit to be discharged to a less acute care unit where the patient later died. The defendant confessed to altering the patient's record to reflect that the vital signs were stable, when in fact they were not. The investigation further revealed that the defendant made additional alterations to the patient's record after his death to conceal the patient's true condition and that he failed to provide medications prescribed by the treating physicians.

Husband and Wife Sentenced for Theft and Fraud

A husband and wife were sentenced after being convicted at trial of various charges to include conspiracy, theft, fraudulent claims, and mail fraud. The wife was sentenced to 6 months' incarceration, 6 months' home confinement, and 24 months' supervised release. The husband was sentenced to 3 months' incarceration, 3 months' home confinement, and 24 months' supervised release. In addition, the defendants were ordered to jointly pay VA $54,688 in restitution; the wife was also ordered to pay $21,268 in additional restitution. An OIG and Internal Revenue Service (IRS) investigation revealed that the defendants embezzled funds from the Wounded Marine Careers Foundation, funds that were intended to provide job training, benefits, and equipment for injured Marines. The defendants made numerous false and misleading statements to VA and then did not provide all the training or equipment to the veterans.

Although the defendants claimed to have donated over $200,000 to start the Foundation, they ended up embezzling over $400,000 from the Foundation's accounts and used the funds for personal expenses. The defendants routinely commingled the finances of the Foundation with their personal finances, thereby obstructing the ability of the IRS to monitor the Foundation's tax-exempt status and determine the defendants' personal income tax liability.

Former VA Fiduciaries Sentenced for Misappropriation
A former VA fiduciary was sentenced to 14 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $141,734 after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed that for 5 years the defendant embezzled funds from multiple veterans.

Also, a former VA-appointed fiduciary was indicted and arrested for misappropriation by a fiduciary and theft of Government funds. An OIG investigation revealed that the defendant embezzled $39,515 in VA benefits from an incompetent veteran. The defendant also used a power of attorney to embezzle an additional $23,509 in social security benefits from the same veteran.

Subject Charged with Health Care Fraud
A subject was charged with health care fraud after an OIG and VA Police Service investigation revealed that he received $63,000 in VA services to include medical care, housing benefits, compensated work therapy pay, and beneficiary travel pay that he was not entitled to receive. The defendant was ineligible for these benefits as he failed to complete boot camp in the National Guard. The defendant's false statements to VA included the claims that his DD-214 was destroyed in the 1973 National Archives fire and that he was shot twice as a door gunner while rescuing Prisoners of War in Vietnam.

Veteran Convicted of Multiple Charges Involving Fraud Scheme
A veteran was found guilty at trial of multiple charges. An OIG and IRS Criminal Investigation Division investigation revealed that the defendant orchestrated a large-scale Nigerian oil investment scheme that defrauded investors of over $2 million. While perpetrating the Nigerian oil investment scheme, the defendant fraudulently received VA individual unemployability benefits. The loss to VA is over $227,000.

Veteran Arrested for Theft of Government Funds and False Statements
A veteran was indicted and arrested for theft of Government funds and false statements. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant fraudulently applied for and received VA and SSA disability benefits, claiming loss of use of her right hand, when in fact she had full use of the hand. The defendant also provided false statements to Veterans Health Administration medical staff regarding the extent of her disabilities. The loss to VA is $187,656, and the loss to SSA is $103,274.

Veteran Pleads Guilty to Wire Fraud
A veteran pled guilty to wire fraud after a multi-agency investigation revealed that he and his sister provided false medical documentation to VA, SSA, and the Washington State Department of Social and Health Services in order to fraudulently obtain monetary benefits from those agencies. The subjects filed forged documents with VA that led to the issuance of VA compensation benefits and VA Caregiver Support Program stipend payments to the veteran's sister. The loss to VA is approximately $185,000.

Son of Deceased VA Beneficiary Arrested for Theft of Government Funds
The son of a deceased VA beneficiary was indicted and arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after his mother's death in December 2005. The defendant admitted to stealing the funds for personal expenses. The loss to VA is $124,808.

Daughters of Deceased VA Beneficiaries Plead Guilty to Theft of Government Funds
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA and stole VA benefits that were direct deposited after her mother's death in May 2008. The defendant admitted to using the VA funds for personal expenses. The loss to VA is $95,658.

Another daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA Dependency and Indemnity Compensation benefits that were direct deposited after her mother's death in February 2010. The defendant admitted to using the funds and also failing to report the stolen VA funds as income on her food assistance benefits application. The loss to VA is $82,310.

Son of Deceased VA Beneficiary Charged with Theft of Government Funds
The son of a deceased VA beneficiary was charged in a criminal information with theft of Government funds. The defendant admitted that he failed to notify VA of his mother's death in June 2008 and subsequently used the VA benefits that were issued after her death for personal expenses. The loss to VA is $94,317.

Veteran's Widow Indicted for Theft of Government Funds and Providing a False Claim for Pension Benefits
A veteran's widow was indicted for theft of Government funds and providing a false claim for pension benefits. An OIG investigation revealed that after her husband's VA pension benefits were terminated because of his death in February 2012, the defendant telephoned VA and informed the VA Regional Office (VARO) employee that her husband was still alive. The widow also placed a friend on the phone who identified himself as the deceased veteran. The loss to VA is $88,938.

Vendor Arrested for Aggravated Identity Theft and Use of Unauthorized Access Devices
A former employee of a durable medical equipment vendor for the Miami, FL, VAMC was indicted and arrested for aggravated identity theft and use of one or more unauthorized access devices. An OIG investigation revealed that the defendant used the VA purchase card information of six VA employees to fraudulently purchase items. The loss to VA is $18,418.

Veteran Arrested for Making Threats Against St. Petersburg, Florida, VARO
A veteran was arrested for making threats after an OIG investigation revealed that he called the VA National Suicide Hotline in Canandaigua, NY, and described a plan where he intended to purchase a firearm once he received his social security check and travel to the St. Petersburg, FL, VARO and "kill as many people as possible," before committing suicide. During a subsequent interview, the defendant admitted to making the threat.

Former North Little Rock, Arkansas, VAMC Employee Pleads Guilty to Making Threats to a Federal Employee
A former North Little Rock, AR, VAMC employee, who is also a veteran, pled guilty to making threats to a Federal employee. An OIG investigation revealed that the defendant threatened to kill his supervisor and others at the VAMC. The defendant continues to be held pending a sentencing hearing.

Veteran Pleads Guilty to Assault and Theft at Buffalo, New York, VAMC
A veteran pled guilty to assault and theft. An OIG and VA Police Service investigation revealed that the defendant attempted to steal three North Face jackets from the Veterans Canteen Service at the Buffalo, NY, VAMC. While attempting to elude apprehension within the VAMC, the defendant assaulted three veterans who were trying to stop him.

Veterans Arrested for Drug Distribution at Philadelphia, Pennsylvania, VAMC
An OIG and Pennsylvania State Police investigation resulted in the arrest of 12 veterans for selling prescription and illegal narcotics at the Philadelphia, PA, VAMC. Six of the defendants pled guilty to Possession of Controlled Substances with Intent to Distribute and Conspiracy to Distribute Controlled Substances. Two other defendants were sentenced to 2 years' probation. The remaining four subjects were served with U.S. District Court Violation Notices for Unauthorized Introduction of Narcotics on VA property.

Defendants Sentenced for Drug Conspiracy at Muskogee, Oklahoma, VAMC
Three additional defendants were sentenced after pleading guilty to drug conspiracy. A former Muskogee, OK, VAMC nurse was sentenced to 72 months' incarceration and 36 months' probation. The former nurse's husband was sentenced to 21 months' incarceration and 12 months' probation, and a former medical support assistant was sentenced to 21 months' incarceration and 12 months' probation. An OIG and Drug Enforcement Administration investigation revealed that the defendants were involved

with the theft of VA prescription pads from the VAMC and using those pads to illegally obtain prescription pills. A non-VA employee was previously sentenced in this case.

Former Murfreesboro, Tennessee, VAMC Nurse Arrested for Drug Diversion
A former Murfreesboro, TN, VAMC nurse was arrested after being indicted for obtaining a controlled substance by fraud and theft of property. An OIG investigation revealed that on at least 18 occasions between April 2014 and March 2015 the defendant diverted oxycodone, hydrocodone, morphine, and lorazepam intended for Community Living Center geriatric patients. The defendant admitted to diverting the drugs for personal use and subsequently resigned from her position at VA.

VA Palo Alto, California, Health Care Employee Arrested for Drug Theft
A VA Palo Alto Health Care System, Livermore Division employee was arrested for theft of Government property. An OIG and VA Police Service investigation revealed that the defendant, while working in the warehouse mail room, opened up United States Postal Service packages containing prescription medication and stole a portion of the contents.

Veteran Pleads Guilty to Theft of Travel Benefits
A veteran pled guilty to larceny and made full restitution of $9,679. A VA OIG, New York State Medicaid OIG, and Westchester, NY, District Attorney's Office investigation determined that on 402 occasions the veteran received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also claiming and receiving VA travel benefits.

ADMINISTRATIVE SUMMARIES OF INVESTIGATION

OIG conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through FY 2015, OIG received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

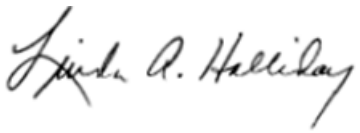
As OIG stated at Congressional hearings, at this time the OIG has completed 77 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. It has always been OIG's intention to release information regarding the findings of these investigations at a time when doing so would not impede any planned prosecutive or administrative action. OIG has begun a rolling publication of these administrative summaries of investigation by state so that veterans and Congress have a complete picture of the work completed in their state. The administrative summaries of investigation released in February and March are listed below. As other reviews are completed, they will be posted to the OIG public website.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at www.va.gov/oig/publications/administrative-summaries-of-investigation.asp and selecting the appropriate state.

Administrative Summaries Investigation (February and March 2016)	
Summary Number	**Location**
14-02890-193	Tuscaloosa, Alabama, VA Medical Center
14-02890-191	Lake Havasu City, Arizona, VA Community Based Outpatient Clinic
14-02890-197	Little Rock, Arkansas, VA Medical Center
14-02890-236	Los Angeles, California, VA Medical Center
14-02890-224	Palo Alto, California, VA Medical Center
14-02890-247 14-02890-227	San Diego, California, VA Medical Center
14-02890-214	Denver, Colorado, VA Medical Center
14-02890-215	Grand Junction, Colorado, VA Medical Center
14-03128-158	Wilmington, Delaware, VA Medical Center
14-02890-133	Bay Pines, Florida, VA Medical Center
14-02890-135 14-02890-143	Gainesville, Florida, VA Medical Center
14-03403-128	Jacksonville, Florida, VA Outpatient Clinic
14-02890-120	Lake City, Florida, VA Medical Center
14-02890-121	Marianna, Florida, Community Based Outpatient Clinic
14-02890-151	Miami, Florida, VA Medical Center
14-02890-134	Orlando, Florida, VA Medical Center and Daytona Beach, Florida, VA Outpatient Clinic
14-02890-124	St. Augustine, Florida, Community Based Outpatient Clinic
14-02890-136	Tallahassee, Florida, VA Outpatient Clinic
14-02890-127	West Palm Beach, Florida, VA Medical Center
14-02890-157	Honolulu, Hawaii, VA Medical Center
14-02890-233	Boise, Idaho, VA Medical Center

14-02890-174	Danville, Illinois, VA Medical Center
14-02890-180	Hines, Illinois, VA Medical Center
14-02890-122	Des Moines, Iowa, VA Medical Center
14-02890-225	Leavenworth/Topeka, Kansas, VA Medical Centers
14-02890-171	Wichita, Kansas, VA Medical Center and Salina, Kansas, Community Based Outpatient Clinic
14-02890-217 14-02890-192	Louisville, Kentucky, Community Based Outpatient Clinic and VA Medical Center
14-02890-168	New Orleans/Baton Rouge, Louisiana, VA Medical Center
14-02890-173	Shreveport, Louisiana, VA Medical Center
14-02890-216	Northampton, Massachusetts, VA Medical Center
14-02890-228	Battle Creek, Michigan, VA Medical Center
14-02890-125 14-02890-154	Minneapolis, Minnesota, VA Medical Center
14-02890-126	Minneapolis and St. Cloud, Minnesota, VA Medical Centers
14-02890-202	Kansas City, Missouri, VA Medical Center
14-02890-190	Brooklyn, New York, VA Medical Center
14-03542-178 14-03542-183	Rochester, New York, Community Based Outpatient Clinic
14-02890-167	Portland, Oregon, VA Medical Center
14-02890-166	Horsham, Pennsylvania, Community Based Outpatient Clinic
14-02890-179	Philadelphia, Pennsylvania, VA Medical Center
14-02890-219	San Juan, Puerto Rico, VA Medical Center
14-02890-194 14-02890-195	Chattanooga, Tennessee, Community Based Outpatient Clinic
14-02890-201	Memphis, Tennessee, VA Medical Center
14-02890-196	Murfreesboro, Tennessee, VA Medical Center
14-02890-152	Amarillo, Texas, VA Health Care System

14-02890-170	Central & South Austin/San Antonia, Texas, VA Health Care System
14-02890-138	Dallas, Texas, VA Medical Center
14-02890-137	El Paso, Texas, VA Health Care System
14-02890-156	Fort Worth, Texas, Veterans Integrated Service Network Outpatient Clinic
14-02890-165	Harlingen, Texas, VA Outpatient Clinic
14-02890-163	Houston, Texas, VA Medical Center
14-02890-162 14-02890-164 14-02890-169	San Antonio, Texas, VA Medical Center
14-02890-148 14-02890-150	Temple, Texas, VA Medical Center
14-02890-229	American Lake, Washington, VA Medical Center
14-02890-175	Chehalis, Washington, Community Based Outpatient Clinic
14-03145-176	Spokane, Washington, VA Medical Center
14-02890-177	Huntington, West Virginia, VA Medical Center



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