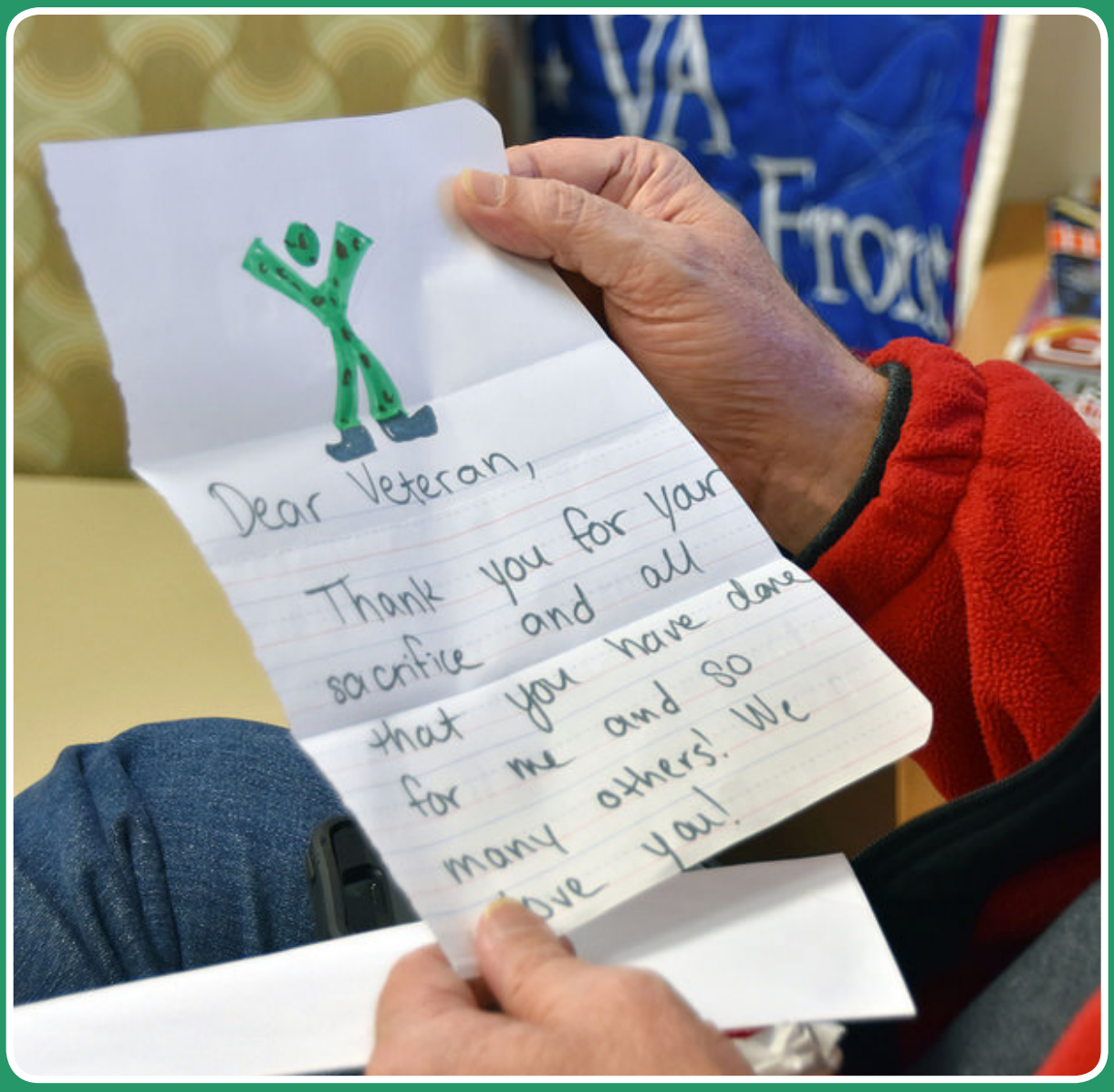
Department of Veterans Affairs

Office of Inspector General



Semiannual Report to Congress

Issue 75 | October 1, 2015 – March 31, 2016

Message from the Deputy Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to Public Law 95-452, *Inspector General Act of 1978*, as amended, this report presents the results of our accomplishments during the reporting period October 1, 2015–March 31, 2016. Highlighted below are some of the key findings and conclusions that were the result of our work during this reporting period.

The Office of Inspector General (OIG) issued 158 reports and work products on VA programs and operations and made 741 recommendations for improvements and efficiencies in the areas of quality of and access to care, accuracy of benefits, financial management, economy in procurement, and information security. The OIG Hotline received over 20,000 contacts from sources alleging wrongdoing in VA programs and operations. OIG investigators closed 485 investigations and made 185 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, and personal and property crimes. OIG investigative and Hotline work resulted in 651 administrative sanctions and corrective actions. Our work this reporting period identified over $783 million in monetary benefits, for a return on investment (ROI) of $13 for every dollar expended on OIG oversight. This reduction in ROI from the preceding reporting period is not unexpected given that we continue to focus a significant portion of our resources on reviewing allegations related to wait time manipulation. This work generally does not result in a monetary benefit; rather, it focuses on improving access to health care for veterans.

As we have previously indicated, the surfacing of allegations in 2014 concerning veterans' access to care at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, was a watershed event for VA and OIG. The national attention sparked by reporting on PVAHCS led to an increased public awareness of OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline and the number of inquiries and requests sent to us by Members of Congress. A number of these Hotline contacts continue to allege inappropriate practices by Veterans Health Administration (VHA) staff that undermine the integrity and reliability of wait time metrics as well as allege that VHA's initiatives to provide veterans community care are not working.

As such, we have continued to devote significant resources during this reporting period to reviewing allegations and program operations concerning the extent to which veterans are able to receive timely care. The results of the work we completed during this reporting period are consistent—VA continues to face challenges in providing timely access to care and the management of consult appointments at various points of service. For example, we:

- Found the PVAHCS Urology clinic experienced extreme staffing shortages that potentially impacted thousands of patients. Leaders did not have a plan to mitigate the shortage, and we identified 10 patients who experienced significant delays that may have affected their clinical outcomes. Such delays placed patients at unnecessary risk for adverse outcomes. See page 16 for more details on our findings and conclusions.

- Identified problems with the answering system in place for the Veterans Crisis Line (VCL), a telephone suicide crisis hotline for veterans, families of veterans, and military personnel located in Canandaigua, NY. Some calls routed to backup centers went into a voicemail system and the VCL and backup center staff did not always offer immediate assistance to callers. We ranked VA's call center management as a high-risk area based upon our 2014 audit of VHA's National Call Center for Homeless Veterans and this VCL review identified similar weaknesses. See pages 15–16 for more details on our findings and conclusions.

- Determined veterans at the James A. Haley Veterans Hospital in Tampa, FL, and the PFC Floyd K. Lindstrom Community Based Outpatient Clinic in Colorado Springs, CO, continued to face significant barriers accessing medical care through the Veterans Choice Program including cumbersome authorization and scheduling procedures and insufficient provider networks. We also testified on our work related to non-VA care (NVC) in February 2016. See pages 22–23 for more details on our findings and conclusions.

- Continue to publish the findings of our investigations into scheduling manipulation at VA medical facilities throughout the country.

While veterans' access to care was a major focus this reporting period, we also made significant findings in other areas of oversight that deserve recognition. Just a few examples are listed below.

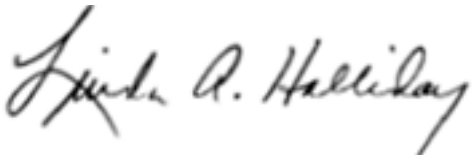
- The Office of Audits and Evaluations determined that with improved cost estimation tools and stronger oversight, VA has opportunities to reduce the over obligation of NVC funds and with better management could potentially free up approximately $358 million annually to acquire more NVC services. See page 23 for more details.

- The Office of Investigations uncovered a scheme by a husband and wife to obtain $14 million in Government set-aside contracts for which they were not eligible. The couple was convicted during a jury trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. They are currently awaiting sentencing. See page 41 for more details.

- The Office of Healthcare Inspections and Office of Audits and Evaluations conducted an inspection to evaluate the circumstances surrounding the death of a patient at the VA San Diego Healthcare System in San Diego, CA. The Office of Healthcare Inspections evaluated the quality of care provided for the patient prior to his suicide and the Office of Audits and Evaluations assessed whether the San Diego VA Regional Office (VARO) Rating Decision accurately decided the patient's compensation claim. We found that the quality of care provided for the patient's chronic pain prior to his death did not adhere to the VA/Department of Defense clinical practice guidelines. The patient was newly diagnosed with traumatic brain injury and post-traumatic headaches during a Compensation and Pension exam but there was no follow-up plan to address the issues. See page 30 for more details.

Our accomplishments this reporting period are the result of the dedicated team of men and women who make up the OIG workforce and their unwavering commitment to accomplishing OIG's mission of rooting out fraud, waste, abuse, and mismanagement to ensure our Nation's veterans and their families receive the best care, benefits, and services possible from VA. I sincerely appreciate the dedication to service routinely exhibited by the OIG staff. Veterans are our priority and our work continues to offer opportunities for positive changes in the delivery of health care and benefits. I am also grateful for the continued support of our mission from Members of Congress, the Secretary, the Deputy Secretary, and VA senior management.

We look forward to continuing these partnerships as we all work together to improve the lives of America's veterans and to help VA address persistent challenges and critical issues while we promote a culture of accountability and continuous improvement.



LINDA A. HALLIDAY
Deputy Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total
Better Use of Funds	$382.2
Fines, Penalties, Restitutions, and Civil Judgments	$19.7
Fugitive Felon Program	$101.8
Savings and Cost Avoidance	$264.4
Questioned Costs	$0
Dollar Recoveries	$15.6
Total Dollar Impact	$783.7
Cost of OIG Operations[1]	$59.1
Return on Investment[2]	**13:1**

Investigative Activities	6-Month Total
Arrests[3]	160
Fugitive Felon Arrests	25
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	8
Indictments	127
Criminal Complaints	36
Convictions	129
Pretrial Diversions and Deferred Prosecutions	21
Administrative Investigations Opened	4
Administrative Investigations Closed	1
Administrative Sanctions and Corrective Actions	256
Cases Opened[4]	420
Cases Closed[5]	485
Administrative Summaries of Investigation[6]	68

Hotline Activities	6-Month Total
Contacts	20,177
Cases Opened	532
Cases Closed[7]	632
Administrative Sanctions and Corrective Actions[8]	395
Substantiation Percentage Rate[9]	38

Reports and Work Products	6-Month Total
Reports Issued	
Audits and Evaluations	15
Benefits Inspections	4
Joint Reviews	1
Peer Reviews of Other OIGs	1
National Healthcare Reviews	2
Hotline Healthcare Inspections	15
Combined Assessment Program Reviews	25
Community Based Outpatient Clinic Reviews[10]	21
Preaward Contract Reviews	38
Postaward Contract Reviews	25
Claim Reviews	6
Subtotal	**153**
Work Products	
Administrative Investigation Advisories	0
Administrative Investigation Closures	0
Audit Work Products	5
Healthcare Closures	0
Subtotal	**5**
Total Reports and Work Products	**158**

Healthcare Inspections Activities	6-Month Total
Clinical Consultations	7

1. The 6-month operating cost for the Office of Healthcare Inspections ($12.1 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.
2. This figure is calculated by dividing Total Dollar Impact by Cost of OIG Operations.
3. Does not include Fugitive Felon arrests by OIG or other agencies.
4. Includes administrative investigations opened.
5. Includes administrative investigations closed. This total also includes cases which opened in previous FYs.
6. During this reporting period, OIG published 68 administrative summaries of investigation in response to allegations regarding patient wait times received since April 2014. These are listed in Appendix A.
7, 8, & 9. Includes cases which opened in previous FYs.
10. Encompassing 132 facilities for the 6-month period.

Glossary

ADPCS	Associate Director of Patient Care Services
AIG	Assistant Inspector General
ARRA	*American Recovery and Reinvestment Act*
BTP	Beneficiary Travel Program
CAP	Combined Assessment Program
CAVHCS	Central Alabama VA Health Care System
CBOC	Community Based Outpatient Clinic
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIGIE	Council of the Inspectors General on Integrity and Efficiency
COOP	Continuity of Operation Plan
DAIG	Deputy Assistant Inspector General
DBQ	Disability Benefit Questionnaire
DCIS	Defense Criminal Investigative Service
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DIG	Deputy Inspector General
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
ECHCS	Eastern Colorado Health Care System
ED	emergency department
EHR	electronic health record
EOC	environment of care
FBI	Federal Bureau of Investigation
FCA	Facility Condition Assessment
FDA	Food and Drug Administration
FFMIA	*Federal Financial Management Improvement Act of 1996*
FISMA	*Federal Information Security Management Act of 2002*
FSS	Federal Supply Schedule
FY	fiscal year
HCBS	Home and Community Based Services
HCS	Health Care System
HHS	Health and Human Services
HIPAA	*Health Insurance Portability and Accountability Act*
HIV	human immunodeficiency virus
IG	Inspector General
IRS	Internal Revenue Service
IRS CID	Internal Revenue Service Criminal Investigation Division
IT	information technology
IU	Individual Unemployability
JAHVH	James A. Haley Veterans' Hospital
MH	mental health
MRI	Magnetic Resonance Imaging
MST	military sexual trauma
NVC	Non-VA Care
NVCC	Non-VA Care Coordination
OAE	Office of Audits and Evaluations
OALC	Office of Acquisition, Logistics, and Construction
OHI	Office of Healthcare Inspections
OI	Office of Investigations
OIG	Office of Inspector General
ONDCP	Office of National Drug Control Policy
OR	operating room
OWCP	Office of Workers' Compensation Program
PCS	Permanent Change of Station
PI	performance improvement
P.L.	Public Law
PTSD	post-traumatic stress disorder
PVAHCS	Phoenix VA Health Care System
ROI	return on investment
RRTP	Residential Rehabilitation Treatment Program
SAH	Specially Adapted Housing
SBA	Small Business Administration
SDVOSB	Service-Disabled Veteran-Owned Small Business
SMC	Special Monthly Compensation
SSA	Social Security Administration
TBI	traumatic brain injury
USB	Under Secretary for Benefits
USH	Under Secretary for Health
USPS	United States Postal Service
VAMC	VA Medical Center
VANTHCS	VA North Texas Health Care System

(continued on next page)

VARO	VA Regional Office
VATC	VA Transplant Center
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VCL	Veterans Crisis Line
VCP	Veterans Choice Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by the *Inspector General Act of 1978*, as amended.

Reporting Requirements	Section(s)
§ 4 (a) (2) to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA	Other Significant OIG Activities
§ 5 (a) (1) a description of significant problems, abuses, and deficiencies relating to the administration of VA programs and operations disclosed during the reporting period	Office of Healthcare Inspections Office of Audits and Evaluations Joint Review Office of Investigations Office of Contract Review Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period	Office of Healthcare Inspections Office of Audits and Evaluations Joint Review
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed	Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted	Office of Investigations
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided	Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use	Appendix A
§ 5 (a) (7) a summary of each particularly significant report	Office of Healthcare Inspections Office of Audits and Evaluations Joint Review Office of Investigations

(continued on next page)

Reporting Requirements	Section(s)
§ 5 (a) (8) and (9) Statistical tables showing the total number of reports and the total dollar value of both questioned costs and recommendations that funds be put to better use by management	Appendix A
§ 5 (a) (10) a summary of each audit report issued before the commencement of the reporting period for which no management decision has been made by the end of the reporting period	Appendix A
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period	Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement	Appendix A
§ 5 (a) (13) the information described under section 05(b) of the *Federal Financial Management Improvement Act of 1996*	Office of Audits and Evaluations
§ 5 (a) (14) an appendix containing the results of any peer review conducted by another OIG during the reporting period or a statement identifying the date of the last peer review conducted by another OIG	Other Significant OIG Activities
§ 5 (a) (15) a list of any outstanding recommendations from any peer review conducted by another OIG that have not been fully implemented	Other Significant OIG Activities
§ 5 (a) (16) a list of any peer reviews conducted by the VA OIG of another OIG during the reporting period and a list of any recommendations made from any previous peer review that remain outstanding or have not been fully implemented	Other Significant OIG Activities

VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

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

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2016, VA is operating under a $167.5 billion budget, with over 365,000 employees serving an estimated 22 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

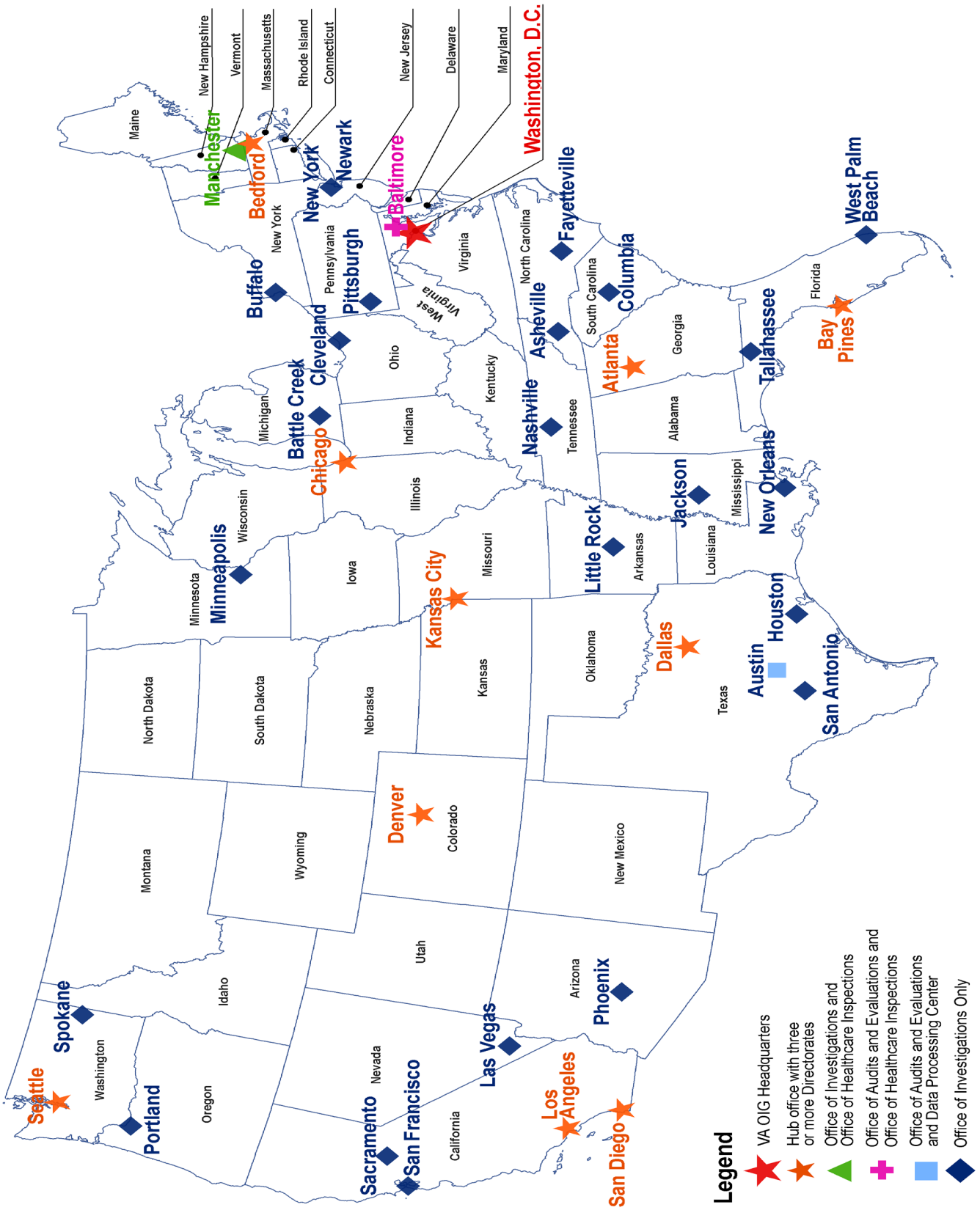
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

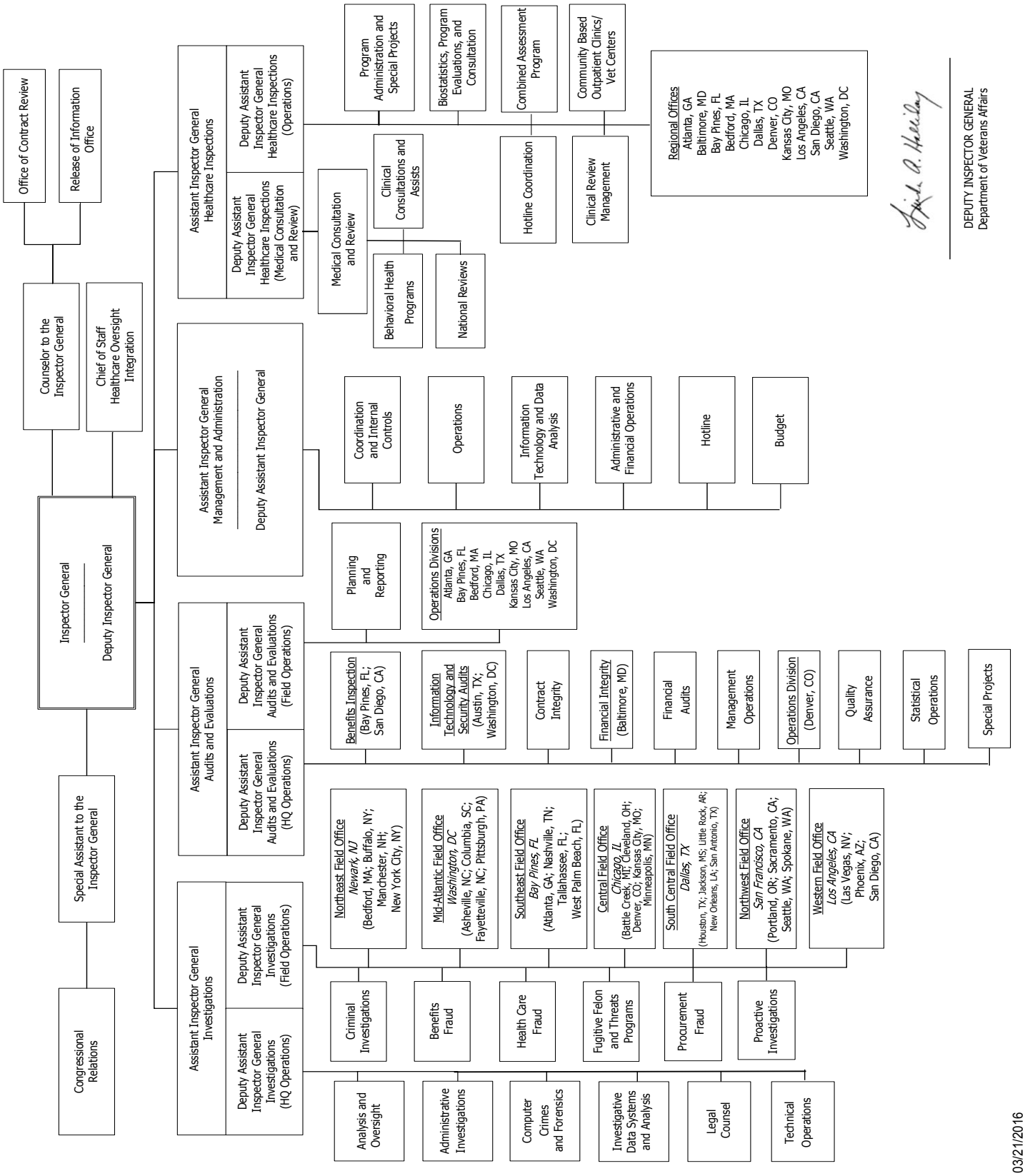
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, Public Law (P.L.) 95-452, *Inspector General Act*, was enacted, establishing a statutory Inspector General (IG) 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. In addition, P.L. 100-322, *Veterans Benefits and Services Act of 1988*, passed on May 20, 1988, charged OIG with the oversight of the quality of VA health care. 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 690 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 2016 funding for OIG operations provides $136.8 million from ongoing appropriations. The Office of Contract Review, with 31 employees, received $5.7 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), construction, and health care provider contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country. OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG internet home page at www.va.gov/oig.

OIG Field Offices Map



OIG Organizational Chart



Office of Healthcare Inspections

For many years, VHA has been a national leader in the quality of care provided to patients when compared with the major U.S. health care providers. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 2 national healthcare reviews; 1 joint review; 15 Hotline healthcare inspections; 25 Combined Assessment Program (CAP) reviews; and 21 Community Based Outpatient Clinic (CBOC) reviews, covering 132 facilities, to evaluate the quality of veteran care. All reports issued this reporting period are listed in Appendix A.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to veterans. CAP reviews provide cyclical oversight of VHA health care facilities. Their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 25 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 12 months. The topics covered this reporting period include: Quality, Safety, and Value; Environment of Care (EOC); Medication Management; Coordination of Care; Computed Tomography Radiation Monitoring; Advance Directives; and Suicide Prevention Program. When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use. During this reporting period, OIG issued two CAP summary reports, which are highlighted in the National Healthcare Reviews section.

Community Based Outpatient Clinic Reviews

The purpose of these 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 three primary activities: CBOC information gathering and review, medical record reviews for determining compliance with VHA requirements, and onsite inspections. During this reporting period, OIG performed reviews covering 132 CBOCs reporting to 21 parent facilities and 15 Veterans Integrated Service Networks (VISNs). Site visits were made and physical inspections were performed at 21 of these CBOCs. These reviews are captured in 21 reports. The topics covered this reporting period include: EOC, Alcohol Use Disorder, Human Immunodeficiency Virus (HIV) screening, Outpatient Documentation, Outpatient Lab Results Management, Home Telehealth Enrollment, and post-traumatic stress disorder (PTSD) care.

National Healthcare Reviews

CAP Summary Report on the Evaluation of Acute Ischemic Stroke Care in VHA Facilities

The purpose of the review was to determine the extent to which VHA facilities complied with selected requirements for the assessment and treatment of patients who had acute ischemic stroke symptoms. OIG conducted this review at 50 VHA medical facilities during CAP reviews performed across the country from April 1, 2014, through March 31, 2015. Although OIG observed many positive practices, OIG identified several opportunities for improvement. Discussion with managers at several levels of VHA indicated that considerable activity is underway to reassess the requirements for stroke care and make improvements across the system. OIG recommended that the Under Secretary for Health (USH) improve the availability of expertise in stroke treatment across the system. OIG also recommended that the USH, in conjunction with the VISN and facility senior managers, ensure compliance with stroke care requirements, including prompt and thorough assessment, treatment, and patient education, and ensure the gathering and reporting of required stroke data elements.

CAP Summary Report on the Evaluation of Magnetic Resonance Imaging Safety in VHA Facilities

The purpose of the evaluation was to determine whether facilities ensured safety in magnetic resonance imaging (MRI) in accordance with VHA requirements related to patient screening, employee safety training, and risk assessment of the MRI environment. OIG performed this evaluation in conjunction with 49 CAP reviews conducted from April 1, 2014, through March 31, 2015. OIG noted high compliance in many areas, including patients or caregivers signing the second MRI patient safety screening form and Level 2 MRI personnel receiving annual level-specific MRI safety training. OIG recommended that the USH, in conjunction with the VISN and facility senior managers, ensure that: (1) employees consistently conduct initial MRI patient safety screenings, (2) Level 2 MRI personnel consistently document when they review the second MRI patient safety screening forms, (3) Level 2 MRI personnel document resolution of all identified potential contraindications prior to the MRI exam, (4) facilities routinely conduct contrast reaction drills in MRI areas, and (5) all designated Level 1 ancillary employees receive annual level-specific MRI safety training.

Hotline Healthcare Inspections

Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York

OIG conducted an inspection at the Veterans Crisis Line (VCL), located in Canandaigua, NY, in response to allegations involving unanswered phone calls or calls routed to a voicemail system, lack of immediate assistance to callers, ambulance timeliness, untrained staff, and confusing contact information. OIG also received complaints from the U.S. Office of Special Counsel that VCL social service assistants were not properly trained and that callers to the VCL were forwarded to volunteer backup call centers that lack appropriately trained staff. OIG substantiated that some calls routed to backup centers went into a voicemail system and that the VCL and backup center staff did not always offer immediate assistance to callers. OIG also substantiated that VCL management did not provide social service assistants (who do not answer calls) with adequate orientation and ongoing training. The VCL program does not provide or monitor backup centers' staff training; therefore, OIG could not substantiate that backup center staff did not receive adequate training. OIG did not substantiate the allegations that staff who respond to callers did not receive proper training or that VCL staff were responsible for the 3-hour delay a veteran experienced while waiting for an ambulance. In addition, OIG did not substantiate that the VCL phone number was difficult to use during a crisis. OIG identified gaps in the VCL quality assurance process: an insufficient number of required staff supervision reviews, inconsistent tracking

and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data. OIG determined that a contributing factor for the lack of organized VCL quality assurance processes was the absence of a VHA directive or handbook to provide guidance for VCL quality assurance and other processes and procedures. OIG made seven recommendations.

Phoenix Health Care System Leaders Did Not Plan or Respond Adequately to Urology Shortage, 10 Patients Placed at Unnecessary Risk

OIG conducted an inspection to evaluate access to care concerns in the Urology Service at the Phoenix VA Health Care System (PVAHCS), Phoenix, AZ. OIG determined that PVAHCS leaders did not have a plan to provide urological services during unexpected provider shortages in the Urology Service. PVAHCS leaders did not promptly respond to the staffing crisis, which may have contributed to patients being "lost to follow-up" and staff frustration due to lack of direction. OIG determined that non-VA providers' clinical documents were not available for PVAHCS providers to review timely. OIG concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to non-VA clinical records. OIG also concluded that PVAHCS Urology Service and Non-VA Care Coordination (NVCC) staff did not provide timely care or ensure timely urological services were provided to patients needing care. OIG identified 10 patients who experienced significant delays that may have affected their clinical outcomes in some instances. Such delays placed patients at unnecessary risk for adverse outcomes. OIG found that the quality of non-urological care in two cases was not acceptable, which placed these patients at unnecessary risk for harm. OIG recommended the PVAHCS Interim Facility Director ensure that: (1) resources are in place to deliver timely urological care to patients; (2) non-VA care providers' clinical documentation is available in VA electronic health records (EHR) in a timely manner for review; and (3) cases identified in this report are reviewed, and for patients who suffered adverse outcomes and poor quality of care, confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

OIG Makes Three Recommendations To Improve VA's National Transplant Program

OIG assessed the merit of allegations regarding how liver transplantation referrals were processed by the Houston VA Transplant Center (VATC) and timeliness of care for patients referred for liver transplant evaluations at all VATCs. The allegations included policy concerns. In the absence of specific allegations of wrongdoing or patient harm, OIG determined these concerns pertained to decisions that must be made by VHA in conjunction with congressional oversight bodies and were outside the scope of this review. OIG substantiated that three stable patients referred to the Houston VATC for liver transplant evaluations were referred more than once because information was missing or additional information was needed. Those patients represent about 2 percent of patients referred from January 1, 2013, through December 31, 2014. OIG did not find that the Houston VATC's requirement that referring facilities resubmit referrals for a small number of patients represented a noteworthy program inefficiency. OIG substantiated that some patients referred for liver transplant evaluations at all VATCs experienced delays. OIG estimated that 6.9 percent of emergency referrals were not responded to in VHA's electronic transplant referral system within 48 hours, as required. Among stable patient referrals, OIG estimated that 9.6 percent of referrals were not responded to in VHA's electronic transplant referral system within 5 business days, as required. About half of stable patients who were deemed eligible for further evaluation did not receive an initial patient evaluation within 30 days, as required. OIG made three recommendations.

Review Substantiates Delay in a Surgical Consult at Oxnard, California, Clinic, Delays in Neurology Consults Also Found

OIG conducted an inspection at the request of Representative Julia Brownley to assess the merit of allegations regarding a delay in a surgical consult at the Oxnard CBOC, VA Greater Los Angeles Healthcare System (system), Los Angeles, CA, that may have resulted in the death of a patient in August 2012. The complainant

alleged that a veteran experienced a delay in surgical consultation for placement of a feeding tube and that the delay resulted in the veteran's death. OIG substantiated that the patient experienced a delay in obtaining a surgical consult to address his complaints of dysphagia, or difficulty swallowing. OIG determined that this delay resulted from the primary care provider's failure to diagnose the patient's dysphagia timely and/or failure to coordinate the patient's care by following up on the requested neurology consult, as well as the neurologist's failure to classify the July 2012 surgical consult as urgent. OIG could not substantiate that the patient died as a result of the failure to address his dysphagia. The patient did not die in a hospital, and OIG found no indication that an autopsy was performed. In the course of the review, OIG found that the system had significant numbers of neurology consults open longer than 90 days. System staff explained that this resulted from a failure to close consults properly after the patients had been seen. However, OIG determined that the next available appointment in the neurology clinic was approximately 6 weeks in the future, suggesting that some patients may experience delays in obtaining timely neurology consults. OIG made three recommendations.

OIG Recommends VHA Require Facilities To Develop Plans for Care Needs of Patients on Home Health Services Wait Lists

OIG conducted an inspection at the request of Senator Barbara Mikulski to assess the merit of allegations regarding access to purchased home and community based services (HCBS) at the Washington, DC, VA Medical Center (facility), Washington, DC. OIG substantiated that the facility had wait times exceeding a year for patients needing homemaker/home health aide services, a component of HCBS. However, the facility reduced the electronic wait list from 584 patients in December 2013 to 0 patients in February 2015. OIG also substantiated that multiple VHA facilities had patients waiting for HCBS. Incidental to our review, OIG found that local HCBS program managers did not comply with all elements of national and local policy regarding quality of care, patient communication, and EHR documentation. In addition, despite being required to use an electronic wait list for HCBS patients since 2006, the facility used a manual wait list until early 2014. OIG recommended that the Interim USH require facilities to develop action plans to address the care needs of patients on HCBS electronic wait lists. OIG also recommended that the Facility Director ensure HCBS staff comply with all elements of national and local policies and that oversight and management of HCBS is adequate and in compliance with national policies.

Allegations of Lapses in Medical Record Documentation Substantiated at Perry Point, Maryland, VA Medical Center Residential Rehabilitation Program

OIG conducted an inspection in response to complaints regarding documentation and follow-up of clinical events at the Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) located at the Perry Point VA Medical Center (VAMC). The program is part of the Maryland VA Health Care System (HCS), headquartered in Baltimore, MD. OIG did not substantiate the allegation that facility staff did not follow sufficient practices to manage significant clinical events. OIG substantiated the allegation that some staff did not consistently document significant clinical events in patients' EHR. OIG did not substantiate the allegation that subject policy-makers knew of documentation lapses but took no action to correct them. Prior to OIG's inspection, and for unrelated reasons, the current MH Clinical Center Director identified concerns and took steps to revise and improve MH RRTP documentation processes. OIG found that the MH RRTP medical provider staffing of 1.2 providers was not compliant with VHA's required minimum core staffing guidelines of 2.3 providers and that staff did not consistently comply with all safe medication management documentation elements. On September 24, 2014, the Chief of Staff approved the hiring of one additional physician and two mid-level practitioners to cover MH programs. OIG recommended that the System Director ensure that MH RRTP medical providers document information pertinent to medical decision-making related to clinical events in the EHR, managers review and address medical provider staffing needs, and staff document in the EHR all required elements of safe medication management for MH RRTP patients.

Lapses in Training and Patient Identification Noted in Review of In-House Laboratory Testing at VAMC, Cleveland, Ohio

OIG conducted an inspection in response to complaints about lapses in policy compliance and quality oversight for the point of care testing program by Pathology and Laboratory Management Service at the Louis Stokes Cleveland VAMC (facility), Cleveland, OH. A complainant alleged that some facility staff members improperly shared point of care operator identification barcodes with those who had not been issued identification barcodes or whose identification barcodes had lapsed due to lack of training. The complainant also alleged that some patient point of care laboratory values could not be linked to the correct patient's EHR because operators entered incorrect patient identifiers; that management failed to track misuse of operator identifications and incorrect patient identifiers, including unresolved errors; and that testing operators were not trained in accordance with facility policy. OIG substantiated the allegations that some staff shared test operator identifications and improperly entered patient identifiers. OIG did not substantiate the allegation that management failed to track misuse of operator identifiers and incorrect patient identifiers including unresolved errors. The facility had a process established to track missing or incorrect patient identifiers; however, OIG found that managers did not consistently track errors to resolution. OIG substantiated that staff not trained in accordance with facility policy and procedure were performing tests, and OIG found weaknesses in the training and competency assessment process, which may have been a contributing factor. OIG made four recommendations.

Unapproved Wait List, Intra-Departmental Discord Identified in Review of Allegations Concerning Eye Care at Eastern Kansas HCS

OIG conducted an inspection to assess the validity of allegations concerning eye care at the Topeka, KS, and Leavenworth, KS, divisions of the Eastern Kansas HCS. OIG substantiated the allegation that staff used an unapproved wait list for patients awaiting cataract surgery and determined that system leadership did not ensure the staff were adequately trained to use the required surgical scheduling software package. OIG did not substantiate that the unapproved wait list was created to falsify cataract surgery wait times. However, at the time of OIG's onsite review, system leadership had instructed staff to reduce the cataract surgery wait time to no more than 90 days and, to achieve this, had been authorizing Non-VA Care (NVC) more frequently. OIG substantiated that providers did not consistently enter eye care requests for new Leavenworth VAMC and Topeka VAMC Eye Clinic patients using the consult referral process as required. However, OIG could not substantiate that providers did not follow the required consult process in an attempt to falsify wait times. OIG did not substantiate that cataract surgeries were completed unnecessarily for two identified patients nor that patients were harmed while awaiting surgery. OIG substantiated that ophthalmologists' productivity was below expected thresholds. OIG determined that improved productivity may reduce cataract surgery wait times. OIG found intra-departmental discord and poor communication at the Topeka VAMC and Leavenworth VAMC Eye Clinics and learned that both Eye Clinics had not had a chief for 6 years. OIG recommended that the System Director ensure Eye Clinic Leavenworth VAMC staff use only an approved cataract surgery wait list, that providers use the Computerized Patient Records System for eye care consults, and that system leadership explore and implement measures to improve communication and operations.

Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VAMC, Columbia, South Carolina

OIG conducted a review of Pulmonary Medicine Clinic appointment cancellations in calendar years 2013–2014 at the William Jennings Bryan Dorn VAMC (facility), Columbia, SC. The purpose of this inspection was to determine whether facility managers had assessed the history and causes of the appointment cancellations, taken appropriate actions to evaluate and provide follow-up for patients affected by the cancellations, and implemented process improvements to prevent recurrence of similar conditions. OIG confirmed that facility managers had evaluated the history and contributing causes of the Pulmonary Medicine Clinic appointment cancellations. OIG confirmed that the facility conducted an evaluation of the patients affected by the Pulmonary Medicine

Clinic appointment cancellations. Due to the protected nature of the facility's review, OIG is unable to discuss the results. OIG reviewed 50 patients whose appointments were cancelled and found they had received appropriate follow-up. OIG confirmed that process improvements including the hiring of pulmonologists as well as the use of non-VA medical care providers were implemented. Facility managers had also augmented the Pulmonary Medicine Clinic staff and implemented processes to improve communication. OIG made no recommendations.

Patient Care Deficiencies and MH Therapy Availability, Overton Brooks VAMC, Shreveport, Louisiana

OIG conducted inspections in response to two complaints received from Senator Richard Burr, then-Ranking Member of the Senate Veterans' Affairs Committee, concerning patient care deficiencies and the availability of MH therapy at the Overton Brooks VAMC (facility), Shreveport, LA. OIG did not substantiate that patients did not have enough linen or that it was of insufficient or poor quality. OIG substantiated the allegation that toiletries were provided by volunteer organizations and unit staff. OIG did not substantiate that a general lack of concern exists among nursing staff for patients or that nursing assistants do not follow the nursing chain of command. OIG substantiated that a patient died on a telemetry unit while not being actively monitored as ordered at the time of his death. OIG's Office of Investigations reviewed the events surrounding the patient's death, reviewed the findings from a facility-conducted Administrative Investigation Board, and ultimately closed the case. OIG did not substantiate that MH group therapy programs are being dismantled or decimated. OIG did not substantiate that MH staff have had to maintain large support groups in order to keep veterans stable while waiting for individual treatment. OIG did not substantiate that the facility is severely understaffed with MH therapists. OIG substantiated an allegation received onsite that some patients who received MH care were lost to follow-up. In early 2014, during the planning and implementation phases of establishing two Behavioral Health Interdisciplinary Program teams, the facility identified roughly 400 patients receiving MH care who were lost to follow-up and subsequently took appropriate actions. OIG recommended that the Facility Director ensure patients are notified and reassigned timely when their MH providers leave the facility.

Alleged Unsafe Patient Transportation Practices, VA Hudson Valley HCS, Montrose, New York

OIG conducted a review in response to allegations of unsafe patient transportation practices. Specifically, the allegations concerned VA sponsored shuttle service between the VA Hudson Valley HCS, Montrose, NY, and the James J. Peters VAMC, Bronx, NY. OIG did not substantiate a lack of proper supervision of patients who utilized the shuttle program. OIG also did not substantiate the allegation that patients were at risk for wandering and/or going missing because shuttle drivers drop off vulnerable patients without regard to final destination. While not one of the complainant's allegations, OIG found that the locally developed Passenger Fitness Criteria card used as a guide by VA Hudson Valley HCS shuttle bus drivers to determine patients' fitness for traveling was not vetted adequately to ensure that this new requirement was within the drivers' scope of employment. OIG recommended that VA Hudson Valley HCS Director consult with VA NY/NJ Healthcare Network leadership and Regional Counsel (recently restructured as the Offices of Chief Counsel) regarding the acceptability of shuttle bus drivers' use of the Passenger Fitness Criteria card.

Emergency Department Concerns, Central Alabama VA HCS, Montgomery, Alabama

OIG conducted a review in response to allegations of Emergency Department (ED) concerns at the Central Alabama VA Health Care System (CAVHCS), Montgomery, AL. OIG substantiated that the CAVHCS was not meeting VHA's ED timeliness measures and that, at times, staff were stretched to provide appropriate special observation to MH patients in the ED. OIG did not substantiate that the CBOC providers refused to see walk-in patients and instead referred them to the ED, that ED patients' vital signs were not checked as required, that having just one physician on duty in the ED was routinely problematic, that patients were inappropriately

referred to other facilities, or that social work staffing in the ED was inadequate. OIG was unable to fully evaluate seven additional allegations due to insufficient information and/or details. OIG did not identify conclusive evidence to either sustain or refute these allegations. OIG made three recommendations.

EOC and Safety Concerns in Operating Room Areas, Edward Hines Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection at the request of Senator Mark Kirk to assess allegations of EOC and safety concerns at the Edward Hines Jr. VA Hospital, Hines, IL. OIG substantiated the allegation that water had flooded the new surgical operating room (OR) areas and that mold was present. The water infiltration problem was resolved, and the mold was remediated prior to the OR's first use for patient care. OIG substantiated the allegation of years of flooding and water damage in the old OR. OIG observed that no patient care was being conducted in this area. OIG substantiated the allegation that the overhead paging and emergency system was not audible throughout the entire surgical OR area. Review of patients' EHRs noted no delays in initiating the codes. OIG substantiated the allegation that the adjustment of temperature and humidity in new OR areas was difficult to control. OIG substantiated the allegation that surgical booms (equipment management systems used to store and move surgical equipment) located in the new OR were difficult to manipulate and maneuver around. OIG did not substantiate the allegation that opening of the OR doors required staff to use their backs to push into the doors. OIG recommended that the Acting Facility Director: (1) implement an action plan to remediate water damage in the basement of Building 200; (2) initiate a safety analysis of the current overhead paging and emergency system for communication of a code throughout the entire surgical OR, including the post anesthesia care units, and take action as necessary; (3) implement processes to maintain recommended ranges for temperature and humidity in OR areas; and (4) take actions to prevent staff injury from surgical booms in ORs.

Quality of MH Care Concerns, VA Long Beach HCS, Long Beach, California

OIG conducted an inspection in response to complaints about the quality of care for patients with MH conditions at the VA Long Beach HCS (system), Long Beach, CA. OIG did not substantiate that female patients with military sexual trauma (MST) 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 MST-related MH conditions, that these patients waited months for medical treatments, or that the NVCC 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.

Alleged Employee Intimidation Related to Research Study Results, VA North Texas HCS, 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.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, reviews, and inspections of VA programs, functions, and facilities. This work addresses the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, veterans' eligibility for benefits and benefits administration, resource utilization, financial and contract management, forensic auditing, fraud prevention, and information security. During the reporting period, OAE published 15 audits and evaluations of VA programs and operations, conducted 4 benefits inspections of VA Regional Office (VARO) operations, published 5 additional work products, and participated in 1 joint healthcare inspection. These are listed in Appendix A.

Veterans Health Administration Audits and Evaluations

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.

Review of Alleged Patient Scheduling Issues at the VAMC in Tampa, Florida

OIG determined the merits of allegations received in December 2014 about the Veterans Choice Program (VCP) at the James A. Haley Veterans' Hospital (JAHVH). OIG substantiated the allegation that JAHVH staff did not always cancel the VA appointment when a VCP appointment was made. OIG examined 56 records of veterans who completed a VCP appointment and found that for 12 of the veterans (21 percent), staff did not cancel the veterans' corresponding VA appointment. This occurred because NVCC staff did not receive prompt notification from the contractor, Health Net, when a veteran scheduled a VCP appointment and no longer needed the VA appointment. OIG also substantiated that prior to May 2015, the Performance Improvement (PI) supervisor did not notify schedulers of errors identified during scheduling audits. The PI supervisor stated that the PI team corrected the errors and notifying schedulers was not his priority. In addition, OIG substantiated that JAHVH did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List. This occurred because JAHVH schedulers thought they were appropriately removing the veteran from the Electronic Wait List when they were actually removing the veteran from the Veterans Choice List. OIG recommended the Director of JAHVH ensure the facility receives prompt notification of scheduled VCP appointments and determine if the contractor complies with the requirements. OIG also recommended the Director ensure appropriate staff receive scheduling audit results, PI staff verify correction of errors, and staff receive training regarding management of the Veterans Choice List. The Director of the JAHVH concurred with OIG's report and recommendations. Based on actions already implemented, OIG considered four of the recommendations closed and will follow up on the implementation of the one remaining recommendation

Review of Alleged Untimely Care at VHA's CBOC, Colorado Springs, Colorado

In January 2015, OIG received an allegation that the PFC Floyd K. Lindstrom Outpatient Clinic, a CBOC in Colorado Springs, CO, did not provide veterans access to VCP when the CBOC did not provide veterans timely VA care. One affected veteran sent the complaint, along with examples of issues affecting clinic services provided in audiology, MH, neurology, optometry, orthopedic, and primary care. OIG substantiated the allegation that the veteran, as well as other eligible Colorado Springs veterans, did not receive timely care

in the six reviewed services. OIG reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the Veterans Choice List in a timely manner. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days. For 229 of the 288 veterans with appointments over 30 days, NVCC staff did not add 173 veterans at the CBOCs in the Eastern Colorado Health Care System (ECHCS) to the Veterans Choice List in a timely manner and did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. As a result, VA staff did not fully use VCP funds to afford CBOC Colorado Springs veterans the opportunity to receive timely care. OIG recommended that the ECHCS Director take actions to ensure appointments are scheduled using clinically indicated or preferred appointment dates, all veterans eligible for the VCP are added to the Veterans Choice List in a timely manner, and scheduling staff timely act on consults and appointment requests. The Acting Director of the ECHCS concurred in principle with our recommendations. The ECHCS executed a number of corrective actions to become compliant with current VHA scheduling guidance. Based on actions already implemented, OIG considers Recommendation 1 closed. OIG will follow up on the implementation of the remaining recommendations until all proposed actions are completed.

Audit of VHA's Non-VA Medical Care Obligations

The OIG assessed whether VHA adequately managed non-VA medical care miscellaneous obligation cost estimates and related management and system controls. The NVC Program expenditures of about $4.8 billion included $1.9 billion in obligated funds that remained unspent as of the end of FY 2013. Significant under- or over-obligation of these program funds could affect overall VHA operations. OIG found VHA medical facilities did not adequately manage the obligations used to purchase NVC. From October 1, 2013, through March 31, 2015, VHA medical facility officials determined that they had overestimated the funds needed to pay for these services by about $543 million. The unnecessary obligation of these funds prevented VHA from using $543 million of the $1.9 billion (29 percent) obligated for NVC for any purpose during FY 2013. This occurred because VHA did not: (1) provide the facilities with adequate tools to reasonably estimate the costs of NVC services; (2) require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs; (3) ensure NVC staff adjusted the estimated amount of obligated funds in the Veterans Health Information Systems and Technology Architecture after payments are complete; and (4) require facilities to analyze the accuracy of prior year obligation balances. Reducing the over-obligation of NVC funds from about 29 to 10 percent would have freed up about $358 million to acquire additional NVC services. OIG recommended the USH improve cost estimation tools, update system software to ensure unused NVC funds can be periodically deobligated, require facilities to adjust cost estimates for individual authorized services, and monitor VA medical facility NVC obligation estimates. The USH provided a responsive action plan to address OIG's recommendations. OIG will follow up on VA's implementation until all proposed actions are completed.

OIG Finds Improper Beneficiary Travel Payments at Three Facilities

VA has the authority to assist eligible beneficiaries in offsetting the cost associated with traveling for certain medical care or services. From December 2014 through April 2015, OIG received three separate allegations of Beneficiary Travel Program (BTP) processing irregularities at the Hudson Valley HCS, located in Montrose, New York; Hampton VAMC, Hampton, VA; and Lexington VAMC, Lexington, KY. OIG either partially or fully substantiated all three allegations. BTP staff at the 3 medical facilities did not consistently approve mileage reimbursement vouchers appropriately and made 1 or more processing errors for 31 of 149 (21 percent) vouchers OIG reviewed for claims during calendar year 2014. As a result, OIG projected these medical facilities improperly approved reimbursements totaling approximately $37,400 for beneficiaries who claimed travel during 2014. Although individual approved travel reimbursements averaged less than $26 per trip for the facilities within the scope of this review, if program weaknesses identified occur across VA's facilities nationwide, they

have the potential to be significant. Generally, errors occurred because the medical facilities did not fully use all Chief Business Office BTP enhancements and had not developed or implemented formal, routine quality reviews of approved mileage reimbursement vouchers. OIG recommended the USH ensure facilities improve controls over beneficiary travel mileage processing and determine whether the improper payments identified by the review warrant establishing bills of collections or reimbursing beneficiaries, where applicable. The USH concurred with the findings and recommendations and provided an appropriate action plan.

Review of Alleged Wasted Funds in VHA's Southern Arizona VA HCS, Tucson, Arizona

OIG received an allegation in February 2015 that the Southern Arizona VA HCS Tucson facility was leasing $1.5 million worth of urology equipment that had not been used since October 2014. The complainant alleged that the HCS had not used the equipment because of installation delays and the updating of equipment cleaning procedures. OIG substantiated the allegation that the HCS leased, but did not use, approximately 360 pieces of urology equipment from November 2014 through March 2015. The 3 year lease was valued at about $1.8 million. The HCS delayed using the urology equipment because of inadequate acquisition planning and coordination with its support services. The lack of coordination occurred, in part, because the HCS had not established policies and procedures to ensure support services staff review leased equipment requests during acquisition planning. As a result, the HCS missed the opportunity to provide veterans services using endoscopic urology equipment with improved visualization. In addition, OIG estimated the HCS spent approximately $217,000 on wasteful lease expenses while the equipment was idle from November 2014 through March 2015. OIG recommended the VISN 18 Director ensure the HCS develop and implement a policy requiring coordination and review of leased equipment requests with HCS support services during the acquisition process. The Director of VISN 18 concurred with our finding and recommendation. The HCS management provided evidence of its new local policy, and OIG considers the recommendation closed.

Veterans Benefits Administration Audits and Evaluations

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

Follow Up Review on the Mismanagement of Informal Claims Processing at the VARO in Oakland, California

In OIG's previous report, *Review of Alleged Mismanagement of Informal Claims Processing at VARO Oakland, California* (Report Number 14-03981-119, February 18, 2015), OIG substantiated the allegation that VARO Oakland staff had not processed or properly stored informal claims for benefits. During an April 2015 House Committee on Veterans' Affairs testimony, OIG received a request from Congressman Doug LaMalfa to conduct a follow up review at VARO Oakland. This request was based on an allegation that management had a list of 13,184 unprocessed informal claims for benefits. Additionally, Congresswoman Jackie Speier asked OIG to determine whether VARO staff altered dates of claim. OIG did not find evidence of the existence of the alleged list of approximately 13,184 informal claims even after interviews with current and former VARO staff, whistleblowers, and members of a previous VBA management support team. OIG reviewed 60 of 1,308 informal claims and found VARO staff had incorrectly processed 6 claims. Five errors contained incorrect effective dates that resulted in approximately $26,325 in improper payments. OIG also determined Oakland staff did not timely process 9 of the 60 claims, resulting in significant delays in benefit payments to veterans. The delays ranged from approximately 5 years to 7 years and 8 months. Through information obtained from VARO staff, OIG obtained an additional list of 690 claims. OIG provided management with the list to determine whether staff had correctly processed these potential informal claims. VARO management did not provide the oversight

needed to ensure timely and accurate processing of informal claims, to include the 1,308 identified in March 2015. As a result, veterans did not receive accurate or timely benefits payments. OIG recommended the VARO Oakland Director provide training to staff on proper informal claims processing procedures, conduct a complete review of the additional list of 690 claims that may be informal claims, and to conduct another review of the remaining 1,248 informal claims. The VARO Director concurred with OIG's recommendations. VA's planned actions are responsive, and OIG will follow up as required.

Review of Alleged Problems With VBA's Veterans Benefit Management System and Claims Processing

In July 2014, the VA OIG Hotline received an allegation from an anonymous complainant stating that significant problems existed with claims processing and the Veterans Benefit Management System (VBMS) at the VARO in St. Petersburg, FL. The complainant also alleged that a VBMS claims processing tool, "Evaluation Builder," broke down often and incorrectly calculated veterans' disability claims, potentially costing the Government millions of dollars. OIG substantiated the allegation regarding a significant backlog of unprocessed hard copy veteran material resulting from inefficient preparation and handling of veteran-provided documentation at a contractor facility. More specifically, according to VBA personnel and OIG's observation of VBA portal metrics, the St. Petersburg VARO had more than 41,900 mail packages of veterans' claims material that were backlogged and over 1,600 boxes awaiting processing at the CACI International, Inc., scanning facility. OIG also observed a significant amount of hard copy veterans' claims evidence that was improperly stored, comingled with contractor documentation, or was disorganized and not ready for scanning. The significant backlog of unprocessed claims evidence occurred due to a large increase in volume of veterans' claims at the end of 2014 and the VARO's inadequate preparation of hard copy veteran material for scanning at the contractor facility. Furthermore, VBA did not provide effective oversight of contractor personnel to ensure timely processing or safeguarding of veteran information at the contractor facility. OIG did not substantiate the allegation that "Evaluation Builder" broke down often or incorrectly calculated veterans' disability claims. OIG recommended that the Under Secretary for Benefits (USB) ensure the St. Petersburg VARO consistently organizes and mails hard copy veteran material to contractor scanning facilities. Additionally, OIG recommended that the USB initiate onsite reviews of the contractor scanning facilities to ensure efficient scanning practices and the proper safeguarding of sensitive VA information at those facilities. The Acting USB concurred with OIG's findings and recommendations.

Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at the VARO in New York, New York

On July 24, 2014, the OIG received an anonymous allegation that a supervisor working at the New York VARO instructed claims processing staff to expedite a disability claim belonging to a friend. The supervisor admitted taking these actions to help a friend, an elderly Korean War veteran, obtain benefits as quickly as possible. Despite completing ethics training, the supervisor did not find actions to expedite processing a friend's claim unethical. At the time of their review, OIG benefits inspectors determined claims processing staff at the New York VARO completed this veteran's claim in 117 days, which was 36 days quicker than similar claims. OIG benefits inspectors determined the supervisors actions involved one claim and was considered an isolated incident. Additionally, OIG benefits inspectors reviewed the veteran's claim for accuracy but did not find any irregularities relating to the disability determinations or evaluations. The New York VARO Director agreed to take appropriate action to ensure similar incidents do not occur in the future as well as to ensure there is a venue to report such incidents, should any occur.

Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires

OIG conducted this audit to assess VBA's implementation of our 2012 recommendations to strengthen internal controls over public-use Disability Benefit Questionnaires (DBQs) and determine whether VBA could use DBQs

more effectively. OIG found VBA did not establish adequate controls to identify and minimize potential DBQ fraud or fully implement OIG's prior recommendations to address control weaknesses. OIG estimated during the 6 months ending March 2014, claims processors did not identify approximately 23,100 of approximately 24,700 claims (93 percent) including DBQs. Specifically, OIG found they did not consistently and correctly record special issue indicators in VBA's electronic systems to identify claims that included DBQs. VBA controls also did not electronically capture DBQ information, adequately ensure DBQs provide notification that information is subject to verification, confirm claims processors consistently and correctly identify claims including DBQs, or ensure DBQ clinician information was complete. Once VBA strengthens controls, VBA can use DBQs more effectively to improve claims processing. Control weaknesses existed because VBA did not evaluate options to capture DBQ information and revise DBQ forms promptly. VBA also lacked adequate policies and procedures and quality assurance reviews. As a result, VBA lacked reasonable assurance of detecting potential fraud when processing claims including DBQs. Further, unnecessary medical examinations caused veterans and VA to needlessly expend time and money and may have delayed veterans receipt of benefits. If VBA does not use DBQs more effectively, OIG estimates VHA will spend at least $4.8 million annually and at least $24 million over the next 5 years for unnecessary examinations. OIG recommended the Acting USB develop controls to electronically capture DBQ information, revise DBQ forms, establish and revise policies and procedures, and revise quality assurance reviews.

Review of Alleged Untimely Processing of VBA'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 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 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.

Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VAROs, focusing on disability compensation claims processing and performance of Veterans Service Center operations. The

objectives of the Benefits Inspection Program are to evaluate how well VAROs are accomplishing their mission of providing veterans with convenient access to high-quality benefits services and report systemic trends in VARO operations. Benefits Inspections also determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses. These inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders. The Benefits Inspection Division issued four reports during this reporting period, which are listed in Appendix A.

Overall, 12 percent of benefit claims we reviewed requiring a rating decision were processed in error. These errors involved claims related to temporary 100 percent disability evaluations and special monthly compensation (SMC) and ancillary benefits. We also review disability claims related to traumatic brain injury (TBI); however, none of the cases contained errors. Further, we determined VARO staff did not timely process benefit reductions, causing improper benefits payments to veterans.

Key findings included:

- Temporary 100 Percent Disability Evaluations: 12 percent of these claims were processed in error. OIG identified processing errors resulting in 44 improper payments to 7 veterans totaling approximately $48,300.
- TBI claims: None of these claims were processed in error.
- SMC and Ancillary Benefits: 40 percent of these claims were processed in error. OIG identified processing errors resulting in 90 improper payments to 4 veterans totaling approximately $47,900.
- Benefit Reductions: 24 percent of benefits reductions were delayed or incorrectly processed. OIG identified processing errors resulting in 155 improper payments to 24 veterans totaling approximately $107,200.

Other Audits and Evaluations

OIG performs audits of administrative support functions and financial management operations, focusing on adequacy of VA management systems in providing managers information needed to efficiently and effectively manage and safeguard VA assets and resources. OIG oversight work satisfies P.L. 101-576, *Chief Financial Officers Act of 1990*, audit requirements for Federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

OIG performs audits of information technology (IT) and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and safeguarding veterans and VA employees, facilities, and information. OIG's audit reports present VA with constructive recommendations needed to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with P.L. 107-347, *Federal Information Security Management Act of 2002* (FISMA), as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit. These evaluations have led OIG to report information security and security of data and data systems as a major management challenge for VA.

Audit Finds VA Not Effective in Identifying 15 of 97 Critical Buildings Located in High Seismic Zones

OIG conducted an audit to assess VA's earthquake preparedness based on a request received from Senator Dianne Feinstein. OIG found VA did not effectively identify seismic risks for 15 of 97 critical and essential buildings located in high and very high seismic zones. This occurred because Facility Condition Assessments (FCAs) did not identify structural deficiencies that would be uncovered by more in-depth seismic studies and VA guidance did not require FCA contractors to review design documents, resulting in sometimes reporting building conditions improperly. VA has also not mitigated 28 structural and 65 nonstructural seismic deficiencies discovered in these 97 buildings. This occurred because limited funding has slowed progress and medical facilities did not always submit construction project applications to correct the nonstructural deficiencies. In addition, contracting officers did not confirm the seismic safety of 23 of 46 leased buildings by obtaining seismic certificates or plans to mitigate seismic risks. VA also did not have a process for ensuring two enhanced use lease buildings remain seismically safe over the terms of their leases. Lastly, VA has not adequately developed and tested Continuity of Operations Plans (COOPs) for the 18 health care systems and medical centers OIG evaluated. As a result, VA will be more susceptible to the risk of injury and loss of life to veterans and employees who might find themselves in seismically deficient buildings. OIG recommended the Principal Executive Director for the Office of Acquisition, Logistics, and Construction (OALC), the USH, and the Acting Assistant Secretary for Management implement procedures to improve seismic risks in VA's buildings and the USH establish procedures to improve COOP development and testing.

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 OIG's attention that caused OIG to believe that management's assertions included in VA's Submission are not fairly stated in all material respects based on the set criteria.

Independent Review of VA's FY 2015 Performance Summary Report to the ONDCP

As required by the ONDCP's Drug Control Accounting Circular, the OIG reviewed VA's FY 2015 Performance Summary Report to the 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 OIG's attention that caused OIG 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.

Chief Financial Officers Act of 1990 Compliance

OIG contracted with an independent public accounting firm to audit VA's consolidated financial statements for FY 2015, in accordance with P.L. 101-576, *Chief Financial Officers Act of 1990*. VA received an unmodified opinion, meaning that its financial statements were materially accurate. The contractor identified four material weaknesses: IT security controls; procurement, undelivered orders, and reconciliations; purchased care processing and reconciliations; and financial reporting. They also identified two significant deficiencies: accrued operating expenses and Chief Financial Officer (CFO) organizational structure for VHA and VA. The contractor reported VA's substantial noncompliance with applicable Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under the P.L. 104-208, *Federal Financial Management Improvement Act of 1996* (FFMIA). They noted improvements were needed in complying with

P.L. 97-255, *Federal Managers' Financial Integrity Act*. They cited instances of noncompliance with Section 5315, Title 38, United States Code, pertaining to the charging of interest and administrative costs, and three possible violations of P.L. 97-258, *Antideficiency Act,* with VA in the process of reporting two others.

Federal Information Security Management Act Compliance

In compliance with FISMA, the FY 2015 audit determines the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. OIG contracted with an independent accounting firm to perform this audit. 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, database, 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.

Federal Financial Management Improvement Act of 1996 Compliance

FFMIA requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The audit of VA's FY 2015 consolidated financial statements reported that VA did not substantially comply with Federal financial management systems requirements and the United States Standard General Ledger at the transaction level, as required by FFMIA. This condition was due to VA's complex, disjointed, and legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continued to be challenged in its efforts to apply consistent enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego HCS, San Diego, California

OIG conducted an inspection to evaluate the circumstances surrounding the death of a patient at the VA San Diego HCS (system), San Diego, CA. OHI evaluated the quality of care provided for the patient prior to his suicide. OAE assessed whether the San Diego VARO Rating Decision accurately decided the patient's compensation claim. OIG determined that the quality of care provided for the patient's chronic pain did not adhere to the VA/Department of Defense (DoD) clinical practice guidelines. OIG determined that the patient was newly diagnosed with TBI and post-traumatic headaches during a Compensation and Pension examination in January 2014, but there was no follow-up plan to address these issues. Although the San Diego VARO decided the patient's claim prematurely without obtaining all relevant service treatment records, OIG did not find that the outcome of the patient's compensation claim was incorrect. OIG recommended that the USH ensure that Compensation & Pension examiners document that patients with new diagnoses are counseled on the need for follow-up care and provided assistance in obtaining VA care, and that all clinically relevant communications are documented in the EHR; the System Director implement processes to ensure that providers adhere to the VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including follow-up assessment at appropriate intervals, when treating patients with chronic opioid therapy, and confer with Regional Counsel for possible disclosure(s) to the surviving family member(s) of the patient; and the San Diego VARO Director review a sample of the specific rater's work and determine whether failure to obtain relevant service treatment records is a systemic issue with this rater when making compensation claim decisions.

Office of Investigations

Veterans Health Administration Investigations

The Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 106 cases; made 84 arrests; obtained over $4.4 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $1.3 million in savings, efficiencies, and cost avoidance; and recovered over $150,000.

During this reporting period, OIG opened 21 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 23 individuals were charged with various crimes relating to drug diversion. These investigations resulted in over $47,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and nearly $347,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OI initiated 14 investigations related to the fraudulent receipt of health benefits, which resulted in 5 arrests for various related crimes. These investigations resulted in nearly $988,000 in fines, restitution, penalties, and civil judgments; and nearly $132,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OIG also initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, who grossly inflate reported mileage to and from VA facilities in order to increase reimbursement for travel expenses. During this reporting period, OIG opened three investigative cases and made eight arrests. The investigations resulted in over $131,000 in court ordered payment of fines, restitution, penalties, and civil judgments and $182,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OI opened 25 investigations regarding criminal activities carried out by VHA employees (excluding crimes related to drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from veterans, and theft of VA property or funds. As a result of OIG work in this area, 15 individuals were arrested which resulted in nearly $3.1 million in court ordered payments of fines, restitution, and penalties as well as over $84,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

The case summaries that follow provide a representative sample of the type of VHA investigations conducted during this reporting period.

Former Memphis, Tennessee, VAMC Employee and Co-Conspirator Sentenced for Fraud

A former Memphis, TN, VAMC employee and a non-veteran co-conspirator were each sentenced to 30 months' incarceration, 3 years' supervised release, and were ordered to pay restitution of $1,137,694 after pleading guilty to conspiracy, theft of Government funds, wire fraud, and engaging in monetary transactions in property derived from specified unlawful activity. An OIG, Department of Justice (DOJ), and VA Police Service investigation revealed that the defendants created a fictitious medical supply company and then the former VAMC employee had the company approved as a vendor to provide medical supplies to VA. From 2007 to 2013, the defendants created fraudulent purchase orders for medical supplies that were never delivered to VA. Fraudulent invoices were then paid using the former VAMC employee's Government-issued purchase card. The fraudulently obtained payments were then divided between the defendants.

Miami, Florida, VAMC Nurse Sentenced for Obstruction and Altering Computer Records

A Miami, FL, 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.

Former Hampton, Virginia, VAMC Nurse Convicted of Aggravated Sexual Abuse and Making a False Statement

A former Hampton, VA, VAMC nurse was convicted at trial of aggravated sexual abuse and making a false statement. An OIG investigation revealed that the defendant administered morphine to a patient against the patient's wishes and then sexually assaulted her multiple times. When questioned by investigators, the defendant lied about the assault.

Former Sacramento, California, VAMC Engineer Sentenced for Receiving Illegal Gratuity

A former Sacramento, CA, VAMC engineer was sentenced to 5 months' house arrest, 2 years' probation, a $2,000 fine, and was ordered to forfeit the $2,250 value of a 2010 vacation package after pleading guilty to receipt of a gratuity by a public official. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that while acting as a Contracting Officer's Representative on several construction projects, a VA contractor provided the defendant with at least $25,000 in cash, a new Ford F-150 pickup truck, and Disneyland vacation packages. After providing the illegal gratuities, the VA contractor received favorable treatment from VA.

Former Palo Alto, California, VAMC Contracting Officer's Representative Sentenced for Receiving Illegal Gratuity

A former Palo Alto, CA, VAMC Contracting Officer's Representative was sentenced to 12 months' house arrest, 5 years' probation, and a $25,000 fine after pleading guilty to receipt of a gratuity by a public official. An OIG and FBI investigation revealed that while overseeing a project to install a new MRI scanner, the defendant received $7,000 in cash from a VA sub-contractor and $9,230 worth of roofing work on his home paid for by a VA general contractor.

Former Northampton, Massachusetts, VAMC Nursing Assistant Sentenced for Assault

A former Northampton, MA, VAMC nursing assistant was sentenced to 27 months' probation after pleading guilty to the assault on an elderly and disabled veteran. An OIG and VA Police Service investigation revealed that the defendant forcefully took the veteran to the ground during a psychiatric intervention on a locked ward, causing injury. The defendant continued to verbally and physically assault the veteran after the patient had been taken to his room. Additionally, administrative action was taken against three employees who witnessed the matter and did not report it to management or law enforcement. Two nursing assistants received a suspension and a charge nurse resigned after VA proposed removal.

Former Bronx, New York, VAMC Warehouse Supervisor Sentenced for Conspiracy To Distribute and Possess With Intent To Distribute Cocaine

A former VA warehouse supervisor was sentenced to 6 months' home confinement and 30 additional months' supervised release after pleading guilty to conspiracy to distribute and possess with intent to distribute cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Administration's (DEA)

New York Organized Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service (USPS) parcels, each containing 1 to 2 kilograms of cocaine, were mailed from Puerto Rico to the Bronx, NY, VAMC. Five defendants have been charged in this case, including two former VA employees.

Former Greenville, North Carolina, CBOC Physician Sentenced for Drug Possession

As part of a Conditional Discharge Agreement, a former Greenville, NC, CBOC physician was sentenced to 12 months' supervised probation, 48 hours' community service, and was ordered to attend and complete a drug education school and the North Carolina Medical Board Physicians Assistance Program for substance abuse treatment after pleading guilty to felony possession of a Schedule II controlled substance (oxycodone). An OIG, local police, North Carolina Medical Board, and DEA diversion investigation revealed that the defendant treated a veteran for a period of time while a legitimate provider/patient relationship existed. However, that relationship became personal and after leaving VA employment the physician continued to prescribe controlled medications to the veteran using VA prescriptions. OIG forensic evidence analysis determined that the defendant authored the illegal prescriptions. Both the defendant and the veteran received pills from the prescriptions that were filled at outside pharmacies. The defendant also surrendered her medical license and DEA number as a result of this investigation.

Buffalo, New York, VAMC Nurse Arrested for Drug Diversion

A Buffalo, NY, VAMC licensed practical nurse was arrested for diversion of controlled substances (hydromorphone). An OIG investigation revealed that the defendant had been stealing doses of hydromorphone since January 2015 by exploiting lax waste procedures on her ward. The defendant would remove a hydromorphone ampule from the Pyxis machine (an automated medication dispensing system) larger than the patient's prescribed amount, administer the patient's prescribed dose, then draw the remainder of the ampule into an insulin syringe for her own use.

Former Manchester, New Hampshire, VAMC Pharmacist Arrested for False Statements

A former Manchester, NH, VAMC pharmacist was arrested after being indicted for false statements. An OIG and VA Police Service investigation, initiated as a result of a possible drug diversion, revealed that the defendant failed to disclose on his employment application that he was terminated by two prior employers for gross misconduct related to suspected drug diversion and lack of clinical competence.

Mountain Home, Tennessee, VAMC Nurse Arrested for Theft of Controlled Substance

A Mountain Home, TN, VAMC nurse was indicted and arrested for theft of a controlled substance (hydromorphone). An OIG and VA Police Service investigation revealed that the defendant diverted hydromorphone from the medical center on numerous occasions. When confronted, the defendant had in her possession a stolen 4 milliliter hydromorphone syringe. The defendant subsequently confessed to stealing narcotics for several months and resigned from her position with VA.

Defendants Sentenced for Drug Conspiracy

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 DEA 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 Albany, New York, VAMC Nurse Pleads Guilty to Drug Tampering

A former Albany, NY, VAMC licensed practical nurse pled guilty to tampering with a consumer product with reckless disregard and extreme indifference to the danger of death or bodily injury, and obtaining a controlled

substance by deception and subterfuge. The defendant, assigned to the hospice ward, removed oxycodone hydrochloride from syringes inside the locked narcotic dispensing unit and replaced it with the anti-psychotic medication Haloperidol. The defendant's actions caused the incorrect medication to be administered which resulted in undue patient pain and suffering. Due to the potential number of victims and the seriousness of his actions, the defendant is facing a sentencing guideline of 78 to 97 months' incarceration.

Former Providence, Rhode Island, VAMC Nurse Pleads Guilty to Drug Diversion

A former Providence, RI, VAMC registered nurse pled guilty to theft of Government property and making false statements. An OIG and DEA investigation revealed that the defendant diverted oxycodone, morphine, hydrocodone, hydromorphone, and lorazepam from the Pyxis system. A search warrant was executed at the defendant's residence and VA controlled pharmaceuticals, empty controlled substance packaging, and syringes were seized from the residence. The defendant admitted to stealing 240 controlled substances and ingesting them either while on duty or at her residence. In addition, the investigation revealed that the defendant had previously been terminated from a private hospital for allegedly diverting controlled substances. However, the defendant falsely denied this information in response to VA employment application questions.

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 HCS 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 USPS packages containing prescription medication and stole a portion of the contents.

Former Montrose, New York, VAMC Union President Indicted for Wire Fraud and False Statements

A former Montrose, NY, VAMC American Federation of Government Employees President was indicted for wire fraud and false statements. An OIG and Department of Labor (DOL) Office of Labor-Management Standards investigation revealed that the defendant used a union debit card to withdraw money and incur charges for personal use. The loss to the union is approximately $120,000.

Pittsburgh, Pennsylvania, VAMC Contract Specialist Sentenced for Theft of Government Property

A Pittsburgh, PA, VAMC contract specialist, currently suspended from duty without pay, was sentenced to 3 years' probation and ordered to pay VA restitution of $28,361 after pleading guilty to theft of Government property. An OIG and VA Police Service investigation revealed that from September to November 2012 the defendant made 29 unauthorized transactions using a VA-issued Government purchase card. The defendant purchased merchandise and gift cards for personal use.

Former Perry Point, Maryland, VAMC Nursing Assistant and Boyfriend Indicted for Theft

A former Perry Point, MD, VAMC certified nursing assistant and her boyfriend were indicted for theft of Government property, altering of money orders, and aiding and abetting. An OIG and U.S. Postal Inspection Service investigation revealed that the former VA employee stole 26 USPS money orders that were intended to pay for veterans' Housing and Urban Development–Veterans Affairs Supportive Housing. The stolen money orders were then altered and negotiated by the former employee's boyfriend. The loss to VA is $4,660.

Former White River Junction, Vermont, VAMC Canteen Chief Sentenced for Theft

The former White River Junction, VT, VAMC canteen chief was sentenced to 1 to 3 years' suspended sentence, 30 days' on a pre-approved furlough work crew, and was ordered to pay restitution of $1,320 after pleading guilty to a false pretense charge. An OIG investigation revealed that in 2013 the defendant falsified canteen petty cash records to make it appear as though the funds had been spent on office supplies when, in fact, they were used for her personal expenses.

Bedford, Massachusetts, VAMC Employee Charged With Stealing Government Property

A Bedford, MA, VAMC employee was charged with stealing Government property. An OIG and VA Police Service investigation revealed that the defendant stole approximately $10,000 worth of laptop computers from the VAMC. During the investigation, two of the stolen computers were recovered.

VA Contractor Sentenced for Theft of VA Computers at Hampton, Virginia, VAMC

A VA contractor was sentenced to 10 years' incarceration (8 years suspended), 10 years' supervised probation, and was ordered to pay two victims restitution of $1,250. An OIG and VA Police Service investigation revealed that the defendant, who was contracted by Dell, Inc., to work as a computer technician at the Hampton, VA, VAMC, stole and then sold two Lenovo T530 laptop computers belonging to the VAMC.

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.

Non-Veteran Sentenced for Drug Distribution at Canandaigua, New York, VAMC

A non-veteran was sentenced to 4 months' incarceration and 5 years' probation after pleading guilty to the criminal sale of a controlled substance and criminal possession of a controlled substance. An OIG and local sheriff's office investigation revealed that the defendant brought 4 grams of crack cocaine to the Canandaigua, NY, VAMC with the intent to sell to a veteran who was undergoing substance abuse treatment.

Veteran Arrested for Possession with Intent To Distribute a Controlled Substance

A veteran was arrested for possession with intent to distribute a controlled substance. An OIG, VA Police Service, and local law enforcement investigation revealed that the defendant, who was previously enrolled in an in-patient substance abuse treatment program, was selling crack cocaine at the Canandaigua, NY, VAMC. The defendant was arrested at the Charleston, SC, VAMC after it was discovered that he had relocated and was working as a housekeeping employee.

Veteran Indicted for Health Care Fraud and False Statements

A veteran was indicted for health care fraud and false statements relating to health care fraud. An OIG investigation revealed that the defendant made false statements regarding his MH condition that resulted in his receiving SMC from 1999 to 2013 that he was not entitled to receive. The loss to VA is $156,925.

Subject Indicted for 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 (Certificate of Release or Discharge from Active Duty) 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.

Non-Veteran Sentenced for Theft of VA Health Care Benefits

A non-veteran was sentenced to 15 months' incarceration, 3 years' probation, and was ordered to pay nearly $30,000 in restitution for receiving VA health care benefits that she was not entitled to receive. An OIG investigation revealed that the defendant falsely claimed to have served in the Army National Guard from 1996 to 2010, to suffer from PTSD, and to have served in combat during two tours in Afghanistan. The defendant never served in the military and was incarcerated during the same time period that she claimed to have been in the military. For over 2 years, the defendant received VA health care benefits in addition to non-VA care paid by VA. The defendant also fraudulently received more than 10,000 milligrams of oxycodone from VA.

Final Co-Conspirator Pleads Guilty to Travel Benefit Fraud

The final co-conspirator of a group consisting of nine veterans and two former Seattle, WA, VAMC employees pled guilty to false claims. An OIG investigation revealed that the nine veterans participated in a scheme in which two VA travel clerks recruited them to submit inflated and fictitious travel benefit vouchers. The clerks then received kickback payments from the veterans. The final co-conspirator veteran had been a fugitive since 2013 and was arrested at the Albuquerque, NM, VAMC. The loss to VA is in excess of $180,000.

Veteran Indicted for Travel Benefit Fraud

A veteran was indicted for theft of Government funds and wire fraud. An OIG investigation revealed that for over 4 years the defendant used a fictitious home address on 924 travel benefit claim forms, thus inappropriately increasing travel costs claimed for reimbursement of expenses. The loss to VA is $43,588.

Veteran Arrested for Theft of Travel Benefits

A veteran was arrested for grand larceny. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 747 occasions from 2009 to 2014, the defendant fraudulently requested VA travel benefits while Medicaid reimbursed a taxi service for the same travel to and from the Montrose, NY, VAMC. The loss to VA is $19,079.

Veteran Sentenced for VA Travel Benefit Fraud

A veteran was sentenced to 3 years' incarceration after pleading guilty to grand larceny. A VA OIG, New York State Medicaid OIG, and New York District Attorney's Office investigation revealed that on 513 occasions from 2010 to 2013, the defendant fraudulently received a total of $19,733 in VA travel benefits while Medicaid reimbursed a taxi service for the same travel to and from the Montrose, NY, VAMC.

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.

Veterans Benefits Administration Investigations

VBA administers a number of financial benefits programs for eligible veterans and certain family members, including VA guaranteed home loans, education, insurance, and monetary benefits. Investigations routinely concentrate on payments made to ineligible individuals. For example, a veteran may deliberately feign a medical disability to defraud the VA compensation program. With respect to VA guaranteed home loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of

foreclosed loans or properties. VA appoints fiduciaries for veterans in receipt of VA benefits who are deemed incompetent and for minor children who are receiving VA benefits. OIG investigates allegations of fraud committed by these fiduciaries.

OIG's IT and Data Analysis Division, in coordination with OI conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. During this reporting period, OIG opened 181 investigations, which resulted in 24 arrests and $6.5 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,535 possible cases with over 4,143 investigative cases opened. Investigations have resulted in the actual recovery of $95 million, with an additional $33 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $198 million. To date, there have been 758 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OI opened 260 cases and conducted 311 active investigations involving the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. Various criminal charges were filed which led to 61 arrests for these types of investigations and an additional 3 arrests were made related to employee integrity issues and grant per diem fraud. OIG obtained over $3.7 million in court ordered payment of fines, restitution, penalties, and civil judgements; achieved over $10.6 million in savings, efficiencies, and cost avoidance; and recovered more than $5.4 million.

Former VA Fiduciaries Sentenced for Misappropriation

A former VA fiduciary was sentenced to 366 days' incarceration, 2 years' supervised release, and was ordered to pay full restitution (amount to be determined) after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed that the defendant, who worked as an assisted living facility administrator, stole the disability benefits of a veteran residing in the facility. The loss to the veteran is $293,952.

A second 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.

A third former VA fiduciary was sentenced to 18 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $109,066 after pleading guilty to misappropriation by a fiduciary and converting of a Social Security benefit. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the fiduciary stole funds from two veterans while acting as their fiduciary.

Former VA Fiduciary Sentenced for Theft of Government Funds

A former VA fiduciary was sentenced to 36 months' probation and $69,686 in forfeiture after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report to VA that his son had been incarcerated and during that time used the VA funds for personal expenses.

Former VA Fiduciary Arrested for Misappropriation

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.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for wire fraud, health care fraud, and false statements. An OIG investigation revealed that the defendant falsely claimed to suffer from symptoms of narcolepsy and received a medical discharge from the Navy in 1997. The defendant subsequently applied for VA compensation benefits for service-connected narcolepsy and was subsequently rated 100 percent disabled. The defendant claimed the condition rendered him homebound and unable to work. The defendant later became a Federal employee for the U.S. Army Corps of Engineers and used his Federal Employee Health Benefits to obtain treatment and medication for the fraudulently claimed condition in furtherance of his scheme to defraud VA. The defendant also provided false statements to OIG, a VA physician, and VBA about his condition and symptoms. The loss to VA is over $270,000.

Veteran Convicted of VA Compensation and Social Security Fraud

A veteran was found guilty at trial of theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant, who since 1997 has received SMC to include Aid and Attendance, claimed loss of use of both hands and feet due to Multiple Sclerosis, all while living an active lifestyle to include participating in adult baseball leagues, completing a 2008 "Marine Corps Mud Run," operating a small car with a manual transmission, being a personal trainer and a high school athletic strength coach, and participating in other physically involved activities. The defendant received approximately $8,700 per month from VA due to his reported constant inability to function and care for his daily needs. The defendant also received additional VBA adaptation grants to help him cope with his reported disabilities, all while feigning the severity of his disabilities in front of various VAMC clinicians. The loss to VA is $1,545,890, and the loss to SSA is $133,107.

Veteran Convicted of Multiple Charges Involving Fraud Scheme

A veteran was found guilty at trial of multiple charges. An OIG and Internal Revenue Service Criminal Investigation Division (IRS CID) 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 (IU) benefits. The loss to VA is over $227,000.

Veteran Sentenced for Bank Fraud and Fraudulently Altering a Military Discharge Certificate

A veteran was sentenced to 12 months' incarceration after pleading guilty to bank fraud and fraudulently altering a DD-214. An OIG investigation revealed that the defendant altered his DD-214 to appear that he had received a Purple Heart and an honorable discharge in order to receive VA disability benefits for PTSD. Additionally, the defendant provided VA's Loan Guaranty with manufactured tax records and fraudulent employment and income information in order to secure a $246,171 VA home loan. In actuality, the defendant was serving a Federal prison sentence stemming from a previous bank fraud conviction during the same period he claimed to be receiving income in order to secure the VA loan.

Veteran Pleads Guilty to Theft of Government Funds

A veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant, who was in receipt of VA benefits to include IU reported to VA that he was unemployed and had no income. However, the investigation revealed that the defendant was the owner, operator, and a senior instructor of a karate and mixed martial arts business. After retiring from the U.S. Marine Corps with multiple reported physical ailments and being granted IU, the defendant opened his martial arts business with two simultaneous operating locations. While still reporting to VA that he was unable to obtain and maintain gainful employment, the defendant became one of the highest ranked instructors in Okinawan Shorin Ryu Karate. The defendant also sponsored tournaments, produced demonstration and instructional videos, and traveled abroad learning and teaching martial arts. The loss to VA is $190,842.

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 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 VHA 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.

Veteran Indicted for Theft of Government Funds and False Statements

A veteran, who was receiving VA IU benefits beginning in 2011, was indicted for theft of Government funds and false statements. An OIG investigation revealed that the veteran was employed by a local district attorney's office and the Oregon Department of Justice from June 2012 through May 2014. The loss to VA is $51,000.

Friend of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The friend of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks that were issued after the veteran's death in September 2005. The loss to VA is $403,291.

Four Daughters of Deceased VA Beneficiaries Indicted for Theft of Government Funds

The daughter of a deceased VA Dependency and Indemnity Compensation (DIC) beneficiary was indicted for theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant failed to report her mother's death to VA and SSA. The defendant subsequently received, forged, and negotiated VA and SSA benefit checks that were issued after her mother's death in October 1988. The loss to VA is $307,000, and the loss to SSA is $248,000.

The daughter of a second deceased beneficiary was indicted for theft of Government funds. An OIG and SSA investigation revealed that the defendant stole VA and SSA benefits that were direct deposited after her father's death in February 2009. The loss to VA is $99,349 and the loss to SSA is $19,435.

The daughter of a third deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant failed to notify VA of her mother's death and then stole VA benefits that were direct deposited after her mother's death in December 2009. The loss to VA is $86,281.

The daughter of a fourth deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in July 2009. The loss to VA is approximately $77,000.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after her mother's death in March 2005. The loss to VA is $142,494.

Daughters of Deceased VA Beneficiaries Sentenced for Theft

The daughter of a deceased VA beneficiary was sentenced to 60 months' probation and was ordered to pay restitution of $137,763 (forfeiture order) after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in June 2008.

The daughter of a deceased VA beneficiary was sentenced to 6 months' home confinement, 5 years' probation, and was ordered to pay restitution of $110,354 to VA and $62,876 to SSA after pleading guilty to mail fraud and theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated her deceased mother's VA and SSA benefit checks after her mother's death in June 2005.

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.

Niece of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The niece of a deceased VA beneficiary was sentenced to 5 months' incarceration, 5 months' home detention, 3 years' probation, and was ordered to pay restitution of $107,452 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her aunt's death in July 2007.

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.

A former Columbus, OH, police officer, who resigned during the course of the investigation, pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA DIC benefits that were direct deposited after her mother's death in December 2009. The defendant admitted to using the funds and also to failing to report the stolen VA funds as income on a Free Application for Federal Student Aid form. The loss to VA is $89,646.

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA DIC 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.

The daughter of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay restitution of $63,197. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in September 2005. The defendant admitted to using the VA funds for personal expenses.

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated her mother's VA benefit checks after her mother's death in February 2007. The defendant admitted to using the VA funds for personal expenses. The loss to VA is approximately $66,000.

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 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.

Other Investigations

OI investigates a wide array of criminal offenses in addition to those listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices, OI opened 16 cases and made 12 arrests. These investigations resulted in over $6.5 million in court ordered payment of fines, restitution, penalties, and civil judgments; and over $96,000 in savings, efficiencies, cost avoidance, and more than $1 million in dollar recoveries.

OI also investigates information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. During this reporting period, in the area of information management crimes, these investigations resulted in more than $58,000 in savings, efficiencies, and cost avoidance.

Husband and Wife Convicted of Major Fraud Against the Government, Wire Fraud, and Conspiracy To Commit Wire Fraud

A husband and wife were convicted at trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. A VA OIG, Department of the Interior OIG, and Small Business Administration (SBA) OIG investigation revealed that the defendants used a "pass-through" scheme to create a Service-Disabled Veteran-Owned Small Business (SDVOSB) in order to qualify for and obtain VA SDVOSB set-aside construction contracts in Kentucky, Tennessee, North Carolina, and other states. The defendants used a service-disabled veteran who was a full-time truck driver and had no construction experience or equipment to establish a construction business and provided fraudulent references to VA and other Government agencies in order to obtain the work. The defendants also created another business to obtain SBA 8(a) set-aside contracts with the two businesses sharing employees, financial assets, and then subcontracting out the work on most projects. The loss to VA is $4 million, including P.L. 111-5, *American Recovery and Reinvestment Act* (ARRA) funds. The total loss to the Government is approximately $14 million.

Veteran's Widow Convicted of Murder

A veteran's widow was convicted at trial of attempted first degree murder and conspiracy to commit first degree murder. The widow's current spouse previously pled guilty to conspiracy to commit first degree murder and testified against her at trial in exchange for a reduced sentence of 25 years' incarceration. A VA OIG, SSA OIG, Tennessee Bureau of Investigation, and District Attorney's Office investigation revealed that the defendant and her current spouse conspired to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on prescription drugs and then staging a crime scene to make it appear that he committed suicide. The widow later applied for DIC benefits and falsely claimed that her husband's drug overdose was

related to his service-connected PTSD. The homicide investigation was initiated pursuant to information that was developed during the compensation benefits fraud investigation. The widow and her current spouse were subsequently convicted of defrauding VA and SSA of over $457,000 in disability compensation. The widow was sentenced to 20 months' incarceration and her current spouse to 30 months' incarceration for the compensation fraud. The loss to VA is approximately $105,000.

Pharmaceutical Manufacturer Agrees To Plead Guilty to Health Care Fraud and Pay $125 Million

DOJ announced that Warner Chilcott U.S. Sales LLC, a subsidiary of pharmaceutical manufacturer Warner Chilcott PLC, has agreed to plead guilty to health care fraud. The plea agreement is part of a global settlement with the United States in which the company has agreed to pay $125 million to resolve its criminal and civil liability arising from the company's illegal marketing of the drugs Actonel, Asacol, Atelvia, Doryx, Enablex, Estrace and Loestrin. VA purchased over $40 million of these drugs. As a result of this joint VA OIG, FBI, Health and Human Services (HHS) OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, Defense Criminal Investigative Service (DCIS), and Office of Personnel Management OIG investigation, the company has agreed to plead guilty to criminal charges that they committed a felony violation by paying kickbacks to physicians throughout the United States to induce them to prescribe its drugs, manipulated prior authorizations to induce insurance companies to pay for prescriptions of Atelvia that the insurers may not have otherwise paid for, and made unsubstantiated marketing claims for the drug Actonel. Under the terms of the agreement, the company will pay a criminal fine of $22.94 million and has also entered into a civil settlement agreement under which it agreed to pay $102.06 million to the Federal government and the states to resolve claims arising from its conduct, which allegedly caused false claims to be submitted to Government health care programs, including VA. As part of this civil settlement, VA damages are estimated to be approximately $5 million. On the same day as the global settlement announcement, OIG and FBI agents arrested the former president of the company for conspiring to pay kickbacks to physicians. Four additional individuals were also charged as part of the health care fraud scheme. Two district managers pled guilty to conspiracy to commit health care fraud and P.L. 104-191, *Health Insurance Portability and Accountability Act* (HIPAA) violations; one district manager pled guilty to wrongful disclosure of individually identifiable health information for commercial advantage (a HIPAA violation); and a private physician was charged with obstruction of justice, accepting free meals and speaker fees from the company in return for prescribing its osteoporosis drugs, and HIPAA violations.

Civil Settlement Reached with Spiracur, Inc.

The United States Attorney's Office for the Western District of Washington in Seattle has reached a $3,000,000 civil settlement agreement with Spiracur, Inc., the manufacturer of a wound care product. An OIG investigation revealed the company paid gratuities and bribes to VA clinicians at multiple locations throughout the United States. The company sold approximately $18,100,000 of the product to VA between January 2011 and September 2015. Sales employees utilized schemes such as paying $15,000 in "preceptorships" to a full-time VA physician to allow new Spiracur employees to observe the VA employee treat veteran's wounds while the VA physician was on-duty. In addition, the company paid several VA clinicians "honorariums" to give lectures about wound treatment to other VA clinicians. These lectures usually were held at expensive restaurants during off-duty hours. The company paid two other VA clinicians to give presentations at Spiracur national sales meetings regarding how to identify sales opportunities at VA.

Charges Filed Against Former Biopharmaceutical Company Official for Conspiracy and Healthcare 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 FBI 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.

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 (CEO), President, and other employees and company affiliates engaged in conduct designed to exploit contracting opportunities reserved for service-disabled veterans, all in violation of P.L. 97-258, *False Claims Act*. A VA OIG, DCIS, and SBA OIG investigation determined that the corporation created and controlled a 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.

Three Defendants Sentenced for SDVOSB Fraud in San Juan, Puerto Rico

Three defendants were sentenced to a combined total of 48 months' probation, 250 hours' community service, and a $2,700 fine. The defendants also agreed to pay $30,000 in civil monetary penalties to VA as part of the related civil case. A VA OIG and SBA OIG investigation revealed that the defendants used a "pass-through" scheme to create a SDVOSB in order to qualify for and obtain VA SDVOSB set-aside construction contracts at the San Juan, PR, VAMC. The defendants created the fraud scheme by using a service-disabled sibling who was a full time USPS employee and had no construction experience or equipment to establish a new construction business. The defendants created the SDVOSB after learning that construction contracts would only be awarded to SDVOSBs as a result of a Government stimulus package. The VA contracts included ARRA funds and were worth approximately $8.4 million.

Son of Service-Disabled Veteran Convicted of Theft and Aggravated Identity Theft

The son of a service-disabled veteran was convicted at trial of theft and aggravated identity theft. A VA OIG, Army Criminal Investigation Command, DCIS, General Services Administration OIG, and SSA OIG investigation revealed that the son used his father's identity and military history to create two SDVOSB companies. The son fraudulently certified both businesses as SDVOSBs and obtained 15 SDVOSB set-aside contracts. The service-disabled veteran was not aware that his identity was used and was not involved with either business. The loss to VA is $1.2 million, and the total loss to the U.S. Government is $2.7 million

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 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.

Kerrville, Texas, VAMC Employee Sentenced for Possession of Child Pornography

A Kerrville, TX, VAMC employee was sentenced to 46 months' incarceration and 30 years' supervised release after pleading guilty to Possession of Child Pornography. An OIG investigation revealed that while the defendant was working a midnight shift, he regularly searched for and downloaded child pornography using the VA computer in his work area. The defendant admitted to routinely engaging in similar conduct while at home

Subjects Arrested for Surety Bond Fraud

A veteran was indicted and arrested for major fraud against the Government, mail fraud, and false statements. Two non-veterans were also arrested for conspiracy to commit mail and wire fraud. A multi-agency investigation revealed an extensive Surety Bond fraud scheme involving multiple Federal agencies and over $935 million in Government construction contracts. The defendants along with other co-conspirators used Government owned lands or fraudulent trusts as assets to back Bid, Payment, and Performance bonding while accepting approximately $10 million in bonding fees. The affected VA contracts totaled more than $97 million, including some ARRA funds.

Former Nursing Home Company CEO and CFO Sentenced for Wire Fraud

The former CEO and CFO of a nursing home company, funded by various Federal health care programs to include VA, were ordered to pay restitution of $956,050 (jointly) after pleading guilty to wire fraud. A Federal Health Care Fraud Task Force investigation revealed that the defendants conspired when submitting fraudulent loan documents, claiming that the loan was needed to make federally mandated improvements to some of their company's nursing homes. The defendants falsely certified that the improvements had been completed when, in fact, the CEO had spent the loan proceeds on numerous personal expenses.

Former VA Contractor Sentenced for Paying Gratuity

A former VA contractor was sentenced to 8 months' home detention, 3 years' probation, and a $20,000 fine after pleading guilty to paying a gratuity. An OIG and FBI investigation revealed that the contractor paid gratuities to a Sacramento, CA, VAMC contracting officer between July 2009 and March 2011. The contractor provided the contracting officer with cash payments, Disneyland® tickets, and hotel accommodations worth approximately $43,400. Additionally, the investigation also revealed that the former contractor provided a VA contracting officer's representative with cash, a new Ford F-150 truck, and two Disneyland® vacation packages. In exchange for the payments, the former contractor received 27 VA contracts and task orders worth approximately $7,411,000. Both VA employees previously pled guilty and are awaiting sentencing.

Local Business Owner Pleads Guilty to Conspiracy To Commit Wire Fraud

A local business owner pled guilty to conspiracy to commit wire fraud. An OIG investigation revealed that the defendant filed multiple fraudulent name entities with a county clerk's office, which the filed entities purported to be property management companies. The defendant then conspired with a former Goodwill Industries program manager to steal VA Supportive Services for Veteran Families grant funds by claiming to house homeless veterans in the defendant's non-existent properties. The loss to VA is $237,793.

Government Contractor Sentenced for Conspiracy To Commit Major Program Fraud and Wire Fraud

A Government contractor was sentenced to 51 months' incarceration and ordered to pay a criminal forfeiture of $30,000 after pleading guilty to conspiracy to commit major program fraud and wire fraud. During an OIG investigation, the defendant admitted that he assisted his father and mother in making false claims to VA in order to help their company obtain more than $6.7 million in VA contracts.

Twenty-Eight Defendants Charged for Their Roles in Health Care Fraud Scheme

A total of 28 defendants, comprised of Office of Workers' Compensation Program (OWCP) claimants (former USPS and VA employees), doctors and medical provider employees, a DOL Claims Examiner, and a claims representative were charged with various crimes related to their roles in a health care fraud scheme. A VA OIG, USPS OIG, DOL OIG, IRS CID, Treasury Inspector General for Tax Administration, and SSA OIG investigation revealed that the defendants' actions caused more than $9.5 million to be fraudulently billed to DOL OWCP.

Non-Veterans Sentenced for Identity Theft

A non-veteran was sentenced to 48 months' incarceration, 3 years' supervised release, a $2,000 fine, and was ordered to participate in drug treatment therapy and to pay VA restitution of $42,912 after pleading guilty to theft of Government funds and aggravated identity theft. An OIG investigation revealed that the defendant stole monthly VA compensation benefits from a veteran by use of a fraudulently established eBenefits account. In addition, the defendant assumed the identity of the veteran in order to fraudulently receive VA health care benefits.

Another non-veteran was sentenced to 70 months' incarceration and 3 years' supervised release after pleading guilty to conspiracy to commit theft of Government funds, wire fraud, aggravated identity theft, false claims, and theft of Government funds. An OIG and IRS CID investigation revealed that the defendant, using stolen VA medical information, conspired to use the personally identifiable information of veterans to file $165,317 in fraudulent tax returns.

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.

Non-Veteran Pleads Guilty to "Stolen Valor"

A non-veteran pled guilty to theft in connection with health care, theft of Government property, a fraudulent demand against the United States, and fraudulently holding oneself out to be a recipient of military decorations or medals. An OIG investigation revealed that the defendant falsely represented himself as both a decorated U.S. Marine Corps veteran and a California Army National Guard veteran in order to obtain VA health care benefits. The defendant has spent the majority of his adult life in prison. The loss to VA is $13,623.

Funeral Home Director Arrested for Filing False Claims

A funeral home director was arrested for filing false claims to VA. An OIG investigation revealed that the defendant submitted numerous fraudulent claims for reimbursement to VA for burial and transportation services that were never provided to the families of deceased veterans who were participants in a university's anatomical gift program. The veterans had donated their bodies to medical research, and their remains were returned directly to their families after cremation by the university.

Former Rhode Island State Cemetery Employee Sentenced for Theft of VA-Provided Gravestones

A former Rhode Island State cemetery employee was sentenced to 1 year of probation and 200 hours' community service after pleading guilty to stealing granite gravestones VA provided to the Rhode Island Veterans Memorial Cemetery. An OIG and Rhode Island State Police investigation revealed that for several years the defendant removed worn or broken grave markers from the cemetery and brought them to his residence. A search of the

defendant's property revealed that approximately 150 VA-provided grave markers were being used as flooring for a shed and two make-shift garages.

Coatesville, Pennsylvania, VAMC Employee Arrested for Preparing False Tax Returns and Theft of Government Funds

A Coatesville, PA, VAMC employee was arrested for preparing false tax returns and theft of Government funds. An OIG and IRS criminal investigation revealed that the defendant prepared approximately 176 Federal income tax returns for other individuals, including co-workers, that fraudulently sought tax refunds of approximately $610,526. The tax returns the defendant prepared contained false financial information regarding the filers' business expenses, medical expenses, and charitable deductions. In addition to charging his co-workers a fee for preparing their returns, the defendant stole a portion of the refunds that he generated for his clients. The investigation also revealed that the defendant used VA computers to commit some of the fraud.

USPS Employee Arrested for Theft of VA Drugs

A USPS employee was arrested after being indicted for theft of mail and possession of a controlled substance by fraud. An OIG and U.S. Postal Inspection Service investigation revealed that for over 6 months the defendant opened VA medication packages, removed some of the medication before resealing, and then delivered the tampered packages to the intended veterans. The defendant confessed to stealing VA narcotics and was found to be in possession of stolen VA narcotics.

Assaults and Threats Made Against VA Employees

During this reporting period, OI initiated 28 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 14 individuals. Investigations resulted in over $62,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OI investigative work resulted in the following:

- A veteran was initially arrested for assaulting and impeding a Federal employee. An OIG and VA Police Service investigation revealed that the defendant produced a handgun during his medical appointment and held a Denver, CO, VAMC nurse hostage. The defendant later released the nurse and was disarmed by the VA police. The assault charge was dismissed and the defendant was subsequently indicted for kidnapping, felony menacing, and introducing a weapon into a Federal facility.

- A veteran with an extensive history of violence was sentenced to 46 months' incarceration and 3 years' probation after pleading guilty to assaulting an East Orange, NJ, VAMC social worker. An OIG investigation revealed that the defendant attacked the social worker by striking her with a cane and fracturing her elbow. As the victim tried to escape, the defendant stalked and taunted her by asking if she wanted more. The broken elbow required extensive physical therapy, and the victim suffered emotional trauma and an absence from her duties.

- A Hot Springs, SD, VAMC employee pled guilty to assault of a Federal employee. An OIG investigation revealed that the defendant threatened to shoot a VA police officer and grabbed and exposed himself to a VA nurse while receiving medical care at the facility.

- A subject was sentenced to 48 months' incarceration and 12 months' supervised release after being convicted at trial of assault on a Federal officer with a deadly or dangerous weapon and inflicting bodily injury. An OIG and VA Police Service investigation revealed that the defendant and her sister, both non-veterans, were

soliciting at the Little Rock, AR, VAMC when they were approached by a VA police officer. The defendant ignored an order to stop and subsequently struck the police officer with her vehicle as she fled the 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.

- 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.

- A veteran was arrested for threats to commit a crime resulting in death or great bodily injury. An OIG and VA Police Service investigation revealed that the defendant made several threats, both telephonic and via text message, stating that he had purchased a gun and that there would be a mass shooting at the Palo Alto, CA, VAMC. The defendant also threatened one specific VA employee stating that he had a gun and that she was on his "hit list."

- A veteran was arrested for threats to Federal officials. An OIG investigation revealed that the defendant went to the Fayetteville, AR, VAMC and threatened to kill a VA social worker. On the same day, the defendant was arrested by local police for a non-related incident. During a custodial interview, the defendant made additional threats to kill the OIG interviewing agents. The defendant was subsequently arrested for making threats towards Federal officials. The defendant was held pending further judicial action.

- A veteran was sentenced to time served for telephonic harassment. An OIG, VA Police Service, and local police investigation revealed that the defendant had threatened to kill his wife, a Roseburg, OR, VAMC employee, through Facebook messages, telephone texts, and cellular telephone voicemails. The veteran made these threats while homeless in Las Vegas, NV, and was arrested when he arrived in Seattle, WA.

- A veteran was arrested for making threats after an OIG investigation revealed that he called the VCL 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.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 64.5 million felony warrants have been received from the National Crime Information Center and participating states resulting in 77,290 investigative leads being referred to law enforcement agencies. Over 2,540 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.23 billion in estimated overpayments with an estimated cost avoidance of $1.51 billion. During this reporting period, OIG opened 33 and closed 27 fugitive felon investigations, identifying $101.8 million in estimated overpayments. OIG investigative work resulted in the arrest of 25 fugitive felons, including 2 VA employees. VA employees were apprehended on charges related to probation violations. Based on the information provided by OIG, at least eight additional arrests were made by other law enforcement agencies.

- A veteran was arrested at the Northampton, MA, VAMC by the VA Police Service and OIG. The fugitive, who was an inpatient and was medically cleared for discharge, was wanted on an outstanding warrant that included indecent assault and battery on a child and open and gross lewdness.
- A veteran was arrested by the North Las Vegas Police Department with the assistance of OIG. The veteran was wanted for a rape charge in Arkansas.
- A veteran was arrested at the Wilmington, DE, VAMC with the assistance of OIG and the VA Police Service pursuant to an extraditable warrant related to heroin charges.
- A veteran was arrested at the Northampton, MA, VAMC by the VA Police Service with the assistance of OIG. The fugitive, who was a resident of the on-site homeless shelter, was wanted on an outstanding warrant that included two drug-related felony charges.
- A veteran was arrested at the Northampton, MA, VAMC by the VA Police Service and OIG. The fugitive was wanted on 8 outstanding warrants that included 14 felony charges.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG opened four administrative investigations and closed one administrative investigation when the case was transferred to another OIG Directorate for project completion.

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.

Coordination and Internal Controls Division

The Coordination and Internal Controls Division has primary responsibilities in three distinct areas: coordination of non-technical/non-specialized training across OIG, operating OIG's own internal controls program, and OIG records management. In addition, the division handles broad coordination of policy and external administrative and management coordination with VA and other Federal agencies.

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 consistent, prompt 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 email by all authorized employees; providing internet document management and control; and providing support to all OIG components.

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

Administrative and Financial Operations Division

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

Budget Division

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

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 9:00 AM to 4:00 PM Eastern Time. OIG receives web submissions, emails, letters, phone calls, and faxes from employees, veterans, the general public, Congress, and other Federal agencies reporting allegations of criminal activity, fraud, waste, abuse, and mismanagement of VA programs and operations. The Hotline also houses the Whistleblower Protection Ombudsman, who provides education about protections provided under Federal law for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation.

During this reporting period, the Hotline received 20,177 contacts, 330 of which became Hotline cases. An additional 250 of the contacts became Hotline non-case referrals. The Hotline makes non-case referrals to the appropriate VA organization if the allegation does not rise to the level of a case but appears to warrant VA action. The Hotline also closed 632 cases, substantiating allegations 38 percent of the time. External Hotline cases resulted in 395 administrative sanctions and corrective actions and $1.43 million in monetary benefits. In addition, the Hotline responded to more than 882 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Disability Overpayment to a Reservist Veteran

Over a period of 4 years, while in active duty status, a reservist continued to receive VA disability payments as well as her military pay. Although the veteran made notification to the VA on every occasion she went on active duty orders, her disability pay was not suspended. The Regional office finally took action and suspended her benefits for the duration of her current set of orders as well as issued a letter of overpayment totaling $13,544.

Benefits Fraud by Incarcerated Veteran

The Reno, NY, VARO confirmed that an incarcerated veteran was still receiving full benefits despite being in prison for a number of years. As a result, the veteran's benefits were reduced to 10 percent because of his incarceration, and an overpayment of approximately $27,679 was established against the veteran's account.

Misappropriation of a Veteran's Funds

The Houston, TX, VARO conducted a review of a veteran's nursing home accounts and concluded that her daughter misappropriated her VA disability benefits for her own personal gain. In response, the VARO appointed a fiduciary for the veteran and reported the situation to Texas Adult Protective Services. The loss to the veteran is estimated at more than $10,000.

Education Benefits Fraud

A veteran was determined to be fraudulently collecting a housing allowance as part of her education benefits despite the fact that she was not attending classes. Over a period of 3 years, at two different schools, the veteran enrolled and then failed to attend classes. The veteran never notified VA and one of the schools continued to collect tuition and fees despite her absence. The veteran was issued a bill of collections in the amount of $9,187, the school was issued a bill of collections in the amount of $6,048, and the state licensing board was notified that one of its institutions was violating its own attendance/remittance policy.

Spousal Benefits Fraud

Over a period of 5 years, the former spouse of an incarcerated veteran continued to receive a special monthly distribution of his disability benefits. Upon a review of the veteran's file, it was determined that he had been divorced for nearly the entire time he was in prison and that he had no dependents. As a result, the former spouse was removed from the veteran's benefits allocation and a bill of collection of $219,616 was issued.

Fraudulent Documentation in the Nuclear Medicine Department

The Utah VAMC was notified that quality control testing in the Nuclear Medicine Department was not being accomplished as required. Upon investigation, the facility confirmed that over a 5-day period the calibration log for the well counter was falsified. As a result of the findings, disciplinary action against three employees was initiated and new oversight procedures for quality control tests were immediately implemented.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's OALC to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 69 reviews in this reporting period. The tables that follow provide an overview of OIG 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. Thirty-eight preaward reviews identified approximately $245 million in potential cost savings during this reporting period. In addition to FSS and Architect/Engineer Services proposals, preaward reviews during this reporting period included 17 health care provider proposals, accounting for approximately $34 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2015–March 31, 2016	38	$244,860,096

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with P.L. 102-585, *Veterans Health Care Act of 1992*, for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over $8.9 million, including approximately $6.7 million related to P.L. 102-585, *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 25 postaward reviews performed, 14 involved voluntary disclosures. In 8 of the 14 voluntary disclosure reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2015–March 31, 2016	25	$8,905,731

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, OIG reviewed six claims and determined that approximately $5.9 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2015–March 31, 2016	6	$5,896,066

Other Significant OIG Activities

Congressional Testimony

Deputy Inspector General Testifies on Inappropriate Use of Position and Misuse of Relocation Program and Incentives at VBA

Linda A. Halliday, Deputy Inspector General (DIG), testified at a hearing before the Committee on Veterans' Affairs, United States House of Representatives, on the results of OIG's report on the use of VA's relocation program and related incentives within VBA. Ms. Halliday explained that her statement was limited in order to preclude any allegation that OIG's testimony could unduly influence VA or DOJ regarding potential administrative or criminal action. She told the Committee that the report concluded VBA misused the permanent change of station (PCS) program for the benefit of its Senior Executive Service workforce and that VA needs to take actions to strengthen controls over, and oversight of, the PCS program in order to improve the financial stewardship of taxpayer funds. She also noted that effective October 1, 2015, VA ceased offering the Appraised Value Offer component of its PCS program which helps employees sell their primary residences. Ms. Halliday was accompanied by Mr. Nicholas Dahl, Director, Bedford OAE, and Ms. Linda Fournier, Director, Administrative Investigations Division.

DIG Testifies at Second Hearing on OIG Findings and Recommendations on Inappropriate Use of Position and Misuse of Relocation Program and Incentives at VBA

Linda A. Halliday, DIG, testified at a second hearing before the Committee on Veterans' Affairs, United States House of Representatives, on the results of OIG's report on the use of VA's relocation program and related incentives within VBA. Ms. Halliday stated that the report concluded VBA misused the PCS program for the benefit of its Senior Executive Service workforce, that VBA management processes need to be strengthened, and culpable individuals need to be held accountable in order to deter a recurrence of similar events. She also indicated that the OIG made criminal referrals to the U.S. Attorney's Office, District of Columbia, regarding official actions orchestrated by two VBA officials, but formal decisions regarding prosecutorial merit were declined in December. Ms. Halliday was accompanied by Mr. Nicholas Dahl, Director, Bedford OAE.

Assistant Inspector General for Investigations' Testimony Explains How Fraud in Set-Aside Program Deprives Contracts from Legitimate Veteran-Owned Businesses

Quentin G. Aucoin, Assistant Inspector General (AIG) for Investigations, testified at a joint hearing before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs and the Subcommittee on Contracting and Workforce, Committee on Small Business, United States House of Representatives, titled, "An Examination of Continued Challenges in VA's Vets First Verification Process." Mr. Aucoin discussed OIG's investigative caseload involving VA's Veteran-Owned Small Business and SDVOSB programs, suspension and debarment actions that will prevent wrongdoers from receiving future contract awards, and significant prosecutions resulting from OIG investigations. He indicated that OIG will continue to devote significant resources to investigate individuals and companies that seek to defraud VA and deprive legitimate service-connected veterans from obtaining contracts earned through their honorable military service. Mr. Aucoin was accompanied by Mr. Gregory Gladhill, Audit Manager, Los Angeles OAE.

Deputy AIG for OAE Testifies on Oversight Findings Related to VA's Paperless Claims System

Mr. Brent Arronte, Deputy AIG (DAIG) for OAE, testified before the Committee on Veterans' Affairs, United States House of Representatives, regarding OIG's recent reports on the implementation of VBMS, which examined how effectively VA managed cost, performance, and schedule in VBMS development to meet its

claims processing accuracy and backlog elimination goals. Mr. Arronte discussed that although VA stayed on schedule in deploying planned VBMS functionality to all VAROs in 2013, total VBMS costs increased significantly over a 6-year period from about $579.2 million to approximately $1.3 billion and total actual system development costs remain unknown. He also explained that VBA reported progress in reducing the backlog and improving claims processing accuracy cannot be specifically attributed to VBMS because it was one of more than 40 initiatives VA has undertaken as part of its transformation plan, and VBA did not put adequate performance metrics in place to reflect the efficiencies gained from using the new system. Furthermore, recent OIG work related to data manipulation at 11 VAROs raises concerns that claims processing data has not been accurately reported. Mr. Arronte also discussed the results of OIG work conducted at one VARO with regards to scanning veteran documentation required for claims processing. Mr. Arronte was accompanied by Mr. Michael Bowman, Director, IT and Security Audits Division.

DIG Testifies Before House Appropriations Subcommittee on Need for Increased Funds to "Right-Size" OIG

Linda A. Halliday, DIG, testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, regarding the FY 2017 budget request for OIG. Ms. Halliday explained OIG's process for prioritizing work based on those areas in VA with the highest risk either to patient care, employee safety, or other financial and contractual risks. She stressed that OIG needs to have the appropriate level of funding to provide for the necessary oversight of VA programs and operations. She thanked Congress for the $10 million increase over the President's request for FY 2016, and noted that the FY 2017 budget request of $160.1 million continues the effort to appropriately proportion OIG's staff and resources to the scale of its oversight mission. Ms. Halliday was accompanied by John D. Daigh, Jr., MD, CPA, AIG for OHI.

DAIG for OAE Discusses Oversight Findings on VA's Purchased Care Programs

Gary K. Abe, DAIG for OAE, testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on OIG's work concerning VA's purchased care programs. He discussed recent OIG reports which have shown that VA faces challenges in administering its purchased care programs in such areas as authorizing, scheduling, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran's VA medical record, and timely and accurate payment for care purchased outside the VA health care system. Mr. Abe explained that while purchasing health care services from non-VA providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA and veterans when adequate controls are not in place. He warned that, without adequate controls, VA's purchased care consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient health care to veterans. Mr. Abe was accompanied by Mr. Larry Reinkemeyer, Director, Kansas City OAE.

DAIG for OAE Tells House Subcommittee that Despite Some Progress, IT System Development Remains a Challenge for VA

Mr. Brent Arronte, DAIG for OAE, 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 OIG audits conducted in recent years that show 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, IT and Security Audits Division.

False Claims Act Settlements

For this reporting period, VA received payments totaling $1,312,969 from settlement agreements in complaints filed under the *qui tam* provisions of P.L. 97-258, *False Claims Act*. This amount represents VA's single damages in this case; the total collected by DOJ on behalf of VA equaled $5 million.

Peer and Qualitative Assessment Reviews

P.L. 111-203, *Restoring American Financial Stability Act of 2010,* requires VA OIG to report the results of any peer review conducted of VA OIG's audit operation by another OIG during the reporting period or to identify the date of the last peer review conducted by another OIG, in addition to any outstanding recommendations that have not been fully implemented. The U.S. Agency for International Development OIG began a peer review of VA OIG OAE operations during this reporting period. However, the review will not be completed until the third quarter of FY 2016. Therefore, we will report the results of the peer review in the next reporting period.

The Act also requires VA OIG to report the results of any peer review it conducted of another OIG's audit operations during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period. VA OIG completed a peer review of General Services Administration OIG audit operations during this reporting period.

A Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review was conducted on October 19, 2015, by the Office of the Special Inspector General for the Troubled Asset Relief Program. The review determined the investigative function of the VA OIG is in compliance with the quality standards established by CIGIE and the Attorney General Guidelines.

On January 27-28, 2016, a review of OIG's Polygraphy Program was completed by the Quality Assurance Program, National Center for Credibility Assessment. This is based upon OIG's participation with DoD's polygraphy quality assurance inspection process. OIG's Polygraphy Program was found to comply with the policies and procedures and met the standards required of a Federal goverment polygraphy program.

Government Contractor Audit Findings

P.L. 110-181, *National Defense Authorization Act for Fiscal Year 2008*, requires each IG appointed under P.L. 95-452, *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 did not issue any reports meeting these requirements.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 162 proposals and made 8 comments.

Refusals To Provide Information or Assistance

P.L. 95-452, *Inspector General Act of 1978*, as amended, authorizes OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes OIG to request information or assistance from any Federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to OIG in the Act. OIG is required to provide a summary of instances when such information or assistance is refused. OIG reports no such instances occurring during this reporting period.

Employee Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

We extend our thanks to OIG employees listed below who are on active military duty or returned from active military duty.

- Kenneth Sardegna, an Auditor at OIG Headquarters, was activated by the U.S. Army in June 2007.
- John Moore, a Hotline Analyst at OIG Headquarters, was activated by the U.S. Army National Guard in March 2013.
- Charles Cook, a Health Systems Specialist in Bay Pines, FL, was activated by the U.S. Army in March 2014.
- Ricardo Wallace-Jimenez, a Criminal Investigator in Spokane, WA, was activated by the U.S. Army National Guard in November 2015.
- Dana Epperson, a Criminal Investigator in Seattle, WA, was activated by the U.S. Army in November 2015.

OIG Employees Recognized for Noteworthy Achievements

We extend our congratulations to the OIG employees listed below who were recognized for noteworthy achievements.

- An OHI story board titled "Alcohol Use Screening and Follow-Up in VHA Outpatient Settings" was accepted for presentation at the March 2016 Institute for Healthcare Improvement's 17th Annual Summit on Improving Patient Care in the Office Practice and the Community. The poster reported on results from a CBOC/Other Outpatient Clinic review conducted by Terri Julian, Ph.D.; Jennifer Reed, RN, MSHI; Lin Clegg, Ph.D.; Mary Toy, RN, MSN; Jarvis Yu, MS; and Marilyn Stones, BS.
- Following the illness and death of a Peace Corps Volunteer stationed in Morocco, the Peace Corps OIG embarked upon an extensive evaluation of issues relevant to this case. These issues included assessing how the Peace Corps oversees its health units, whether it is meeting measurable quality assurance standards, its performance in reporting medical sentinel events, Peace Corps Medical Officer scope of practice policy, and whether Peace Corps clinicians are sufficiently prepared to respond to medical emergencies in often remote

locations. To conduct this review, the Peace Corps OIG enlisted the expert assistance of Dr. Thomas Wong, a VA OIG OHI Senior Physician. The Peace Corps OIG's final report (PEACE CORPS – Office of Inspector General – Final Program Evaluation Report OIG Follow-Up Evaluation of Issues Identified in the 2010 Peace Corps/Morocco Assessment of Medical Care, Report IG-16-01-E, March 2016) thanked Dr. Wong for his "expert assistance in assessing Peace Corps' approach to reviewing sentinel events and conducting root cause analyses."

- One of VA's statutory missions is training and education for health care professionals. As such, medical education oversight is essential to VA OIG's oversight of VHA. During this reporting period, Dr. Amy Zheng, a VA OIG OHI Senior Physician, co-authored a paper that outlined a curriculum for educating 300 plus medical and pharmacy students at the University of California, San Diego, and nursing students from the University of San Diego, using actors and high-tech health care simulation methods. Approximately 100 faculty facilitators from three health professions schools observed student teams and led debriefing sessions to provide feedback. This paper was published under the auspices of the Association of American Medical Colleges, and reaffirms VA OIG's commitment to oversight activities in the field of health care education.

Appendix A: Reports and Work Products Issued During Reporting Period

Table 1: List of Reports and Work Products Issued by Type

Office of Audits and Evaluations | Audits, Evaluations, and Reviews

Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
11/12/2015 14-04756-32	Audit of the Seismic Safety of VA's Facilities			
11/16/2015 15-01708-36	Audit of VA's Financial Statements for Fiscal Years 2015 and 2014			
12/7/2015 15-02400-524	Review of Alleged Beneficiary Travel Irregularities at Husdon Valley HCS, Hampton & Lexington VAMCs			
1/6/2016 14-04816-72	Review of Alleged Problems with Veterans Benefits Management System and Claims Processing			
1/7/2016 14-04302-12	Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at VA Regional Office, New York, New York			
1/8/2016 14-03981-54	Follow Up Review on the Mismanagement of Informal Claims Processing at the VA Regional Office, Oakland, California			
1/12/2016 14-02465-47	Audit of VHA's Non-VA Medical Care Obligations	$358,000,000	$358,000,000	
2/4/2016 15-02472-46	Review of Alleged Untimely Care at VHA's Community Based Outpatient Clinic, Colorado Springs, Colorado			
2/4/2016 15-03026-101	Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, FL			
2/18/2016 15-02413-55	Review of Alleged Wasted Funds in VHA's Southern Arizona VA Health Care System	$217,000	$217,000	
2/25/2016 14-02384-45	Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires	$24,000,000	$24,000,000	
3/15/2016 15-01957-100	Federal Information Security Modernization Act Audit for Fiscal Year 2015			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
3/17/2016 16-01027-141	Independent Review of the FY 2015 Detailed Accounting Submission to the Office of National Drug Control Policy			
3/17/2016 16-01031-142	Independent Review of VA's FY 2015 Performance Summary Report to the Office of National Drug Control Policy			
3/31/2016 15-01651-209	Review of Alleged Untimely Processing of Specially Adapted Housing Grants at the Regional Loan Center in Phoenix, Arizona			
	Total Monetary Impact	**$382,217,000**	**$382,217,000**	**$0**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
12/15/2015	15-04986-42	VA Regional Office, Hartford, Connecticut
2/2/2016	15-04983-86	VA Regional Office, Little Rock, Arkansas
2/11/2016	15-05023-112	VA Regional Office, Oakland, California
2/17/2016	15-05024-97	VA Regional Office, Manila, Philippines

Office of Audits and Evaluations | Work Products		
Issue Date	Number	Facility
1/5/2016	14-04761-09	Review of Alleged Violation of VHA's Datawatch Data Pump Server Software License Agreement
1/5/2016	14-04810-05	Review of Alleged System Access Failures for Veterans' to VBA's eBenefits Program
1/6/2016	14-04152-370	Review of Alleged Misuse of Hurricane Sandy Funds at VA New York Harbor Healthcare System
1/7/2016	14-04979-11	Review of Alleged Unauthorized Devices and Equipment on Networks at VHA's Southern Arizona VA Health Care System
2/5/2016	14-04501-13	Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic, Austin, Texas

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
10/19/2015	15-00622-06	Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

Office of Healthcare Inspections | Combined Assessment Program Reviews

Issue Date	Number	Facility
10/29/2015	15-00618-02	Alaska VA Healthcare System, Anchorage, Alaska
10/29/2015	15-00623-18	Marion VA Medical Center, Marion, Illinois
11/10/2015	15-00621-23	Charles George VA Medical Center, Asheville, North Carolina
11/10/2015	15-00626-28	VA Pacific Islands Health Care System, Honolulu, Hawaii
11/10/2015	15-00600-33	John J. Perishing VA Medical Center, Poplar Bluff, Missouri
11/23/2015	15-00624-31	Louis A. Johnson VA Medical Center, Clarksburg, West Virginia
11/24/2015	15-00625-37	VA Southern Nevada Healthcare System, North Las Vegas, Nevada
12/3/2015	15-00628-49	Salem VA Medical Center, Salem, Virginia
12/16/2015	15-00614-64	Oklahoma City VA Health Care System, Oklahoma City, Oklahoma
12/22/2015	15-04699-65	Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota
1/14/2016	15-04693-79	Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania
1/14/2016	15-04694-80	Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio
1/20/2016	15-00075-87	Follow-Up Review of the VA St. Louis Health Care System, St. Louis, Missouri
1/28/2016	15-04698-99	VA Western New York Healthcare System, Buffalo, New York
1/28/2016	15-04706-104	VA Butler Healthcare, Butler, Pennsylvania
2/9/2016	15-04696-107	VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas
2/9/2016	15-04708-115	Coatesville VA Medical Center, Coatesville, Pennsylvania
2/10/2016	15-04697-105	Sheridan VA Healthcare System, Sheridan, Wyoming
2/11/2016	15-04707-111	VA Central California Health Care System, Fresno, California
2/23/2016	15-05497-132	VA Maryland Health Care System, Baltimore, Maryland
2/24/2016	15-04700-119	Edward Hines, Jr. VA Hospital, Hines, Illinois
3/9/2016	16-00103-160	VA Manila Outpatient Clinic, Manila, Philippines
3/23/2016	15-04709-208	James A. Haley Veterans' Hospital, Tampa, Florida
3/28/2016	16-00106-211	Charlie Norwood VA Medical Center, Augusta, Georgia

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews

Issue Date	Number	Parent Facility
10/21/2015	15-00163-01	VA New Jersey Health Care System, East Orange, New Jersey
10/21/2015	15-00177-07	Marion VA Medical Center, Marion, Illinois
10/22/2015	15-00155-16	Battle Creek VA Medical Center, Battle Creek, Michigan
11/23/2015	15-00142-35	John J. Pershing VA Medical Center, Poplar Bluff, Missouri
11/24/2015	15-00179-34	VA Southern Nevada Healthcare System, North Las Vegas, Nevada
12/3/2015	15-00157-39	Oklahoma City VA Health Care System, Oklahoma City, Oklahoma
12/7/2015	15-00175-50	Charles George VA Medical Center, Asheville, North Carolina
12/8/2015	15-00181-53	Salem VA Medical Center, Salem, Virginia
12/16/2015	15-00178-56	Louis A. Johnson VA Medical Center, Clarksburg, West Virginia

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	**Number**	**Parent Facility**
12/22/2015	15-05156-69	Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota
1/12/2016	15-05158-74	Edward Hines, Jr. VA Hospital, Hines, Illinois
1/12/2016	15-05148-75	Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania
1/13/2016	15-05151-81	Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio
1/28/2016	15-05149-88	VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas
1/28/2016	15-05155-89	VA Western New York Healthcare System, Buffalo, New York
2/9/2016	15-05163-106	Coatesville VA Medical Center, Coatesville, Pennsylvania
2/11/2016	15-05162-93	VA Central California Health Care System, Fresno, California
2/11/2016	15-05161-98	VA Butler Healthcare, Butler, Pennsylvania
2/23/2016	15-05164-139	VA Maryland Health Care System, Baltimore, Maryland
3/9/2016	15-05160-161	Northern Arizona VA Health Care System, Prescott, Arizona
3/23/2016	16-00007-206	James A. Haley Veterans' Hospital, Tampa, Florida

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
12/3/2015	15-03803-26	Combined Assessment Program Summary Report – Evaluation of Acute Ischemic Stroke Care in Veterans Health Administration Facilities
12/3/2015	15-03804-38	Combined Assessment Program Summary Report – Evaluation of Magnetic Resonance Imaging Safety in Veterans Health Administration Facilities

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
10/15/2015	14-00875-03	Access to Urology Service, Phoenix VA Heath Care System, Phoenix, Arizona
10/28/2015	14-02890-497	Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California
11/5/2015	15-00187-25	Alleged Program Inefficiencies and Delayed Care, Veterans Health Administration's National Transplant Program
11/16/2015	14-03823-19	Access and Oversight Concerns for Home Health Services, Washington, DC, VA Medical Center, Washington, District of Columbia
12/1/2015	14-02576-40	Point of Care Testing Program Concerns, Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio
12/1/2015	14-01910-459	Quality of Care Concerns at a Residential Rehabilitation Treatment Program, VA Maryland HCS, Baltimore, Maryland
12/22/2015	15-00268-66	Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
1/6/2016	15-00992-71	Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
1/7/2016	14-05075-447	Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana
1/13/2016	15-02217-85	Alleged Unsafe Patient Transportation Practices, VA Hudson Valley Health Care System, Montrose, New York
1/14/2016	14-04530-41	Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama
1/19/2016	14-05173-92	Environment of Care and Safety Concerns in Operating Room Areas, Edward Hines, Jr. VA Hospital, Hines, Illinois
2/11/2016	14-03540-123	Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York
3/28/2016	15-01283-220	Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, Texas
3/30/2016	14-04897-221	Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California

Joint Review		
Issue Date	**Number**	**Report Title**
1/5/2016	15-00827-68	Poor Follow-up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System, San Diego, California

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/5/2015	15-03740-04	Review of Request for Modification Under a Federal Supply Schedule Contract	
10/14/2015	15-05383-17	Review of Proposal Submitted Under a Solicitation	$462,116
10/20/2015	15-05335-20	Review of Proposal Submitted Under a Solicitation	$145,359
10/26/2015	15-03903-24	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$2,716,420
10/28/2015	15-03748-27	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$7,236
10/29/2015	15-03647-29	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$30,156,032
11/23/2015	15-05201-52	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
11/23/2015	15-05257-51	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$4,754,831
11/30/2015	15-04839-57	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
12/2/2015	15-04785-59	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$42,551,180
12/4/2015	16-00719-62	Review of Proposal Submitted Under a Solicitation	$7,105,855
12/11/2015	16-00847-70	Review of Proposal Submitted Under a Solicitation	$3,197,633
12/17/2015	16-00057-78	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
12/22/2015	15-05042-82	Review of Proposal Submitted Under a Solicitation	$16,334,658
12/22/2015	16-00881-83	Review of Proposal Submitted Under a Solicitation	$7,326,041
12/29/2015	15-04099-84	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$47,742,020
1/8/2016	16-01039-91	Review of Proposal Submitted Under a Solicitation	$4,349,757
1/11/2016	16-00687-90	Review of Proposal Submitted Under a Solicitation	$832,516
1/11/2016	15-04326-95	Review of Request for Modification Under a Federal Supply Schedule Contract	$1,797,364
1/13/2016	16-00689-96	Review of Proposal Submitted Under a Solicitation	$641,569
1/14/2016	16-01226-102	Review of Proposal Submitted Under a Solicitation	$2,717,805
1/15/2016	16-00738-103	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$319,029
1/22/2016	16-01370-108	Review of Proposal Submitted Under a Solicitation	$4,304,580
2/2/2016	16-01479-117	Review of Proposal Submitted Under a Solicitation	$87,294
2/3/2016	16-01531-118	Review of Proposal Submitted Under a Solicitation	$181,490
2/10/2016	16-00261-131	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$18,977,684
2/11/2016	16-00797-130	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$3,895,260
2/11/2016	16-00773-140	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$21,698,886
2/17/2016	16-01614-144	Review of Proposal Submitted Under a Solicitation	$840,286
2/18/2016	15-03777-145	Review of Proposal Submitted Under a Solicitation	$118,153
3/2/2016	16-01606-172	Review of Proposal Submitted Under a Solicitation	$324,950
3/3/2016	16-01609-182	Review of Proposal Submitted Under a Solicitation	$231,895
3/3/2016	16-00774-184	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$17,617,660
3/7/2016	16-00735-188	Review of Request for Modification Under a Federal Supply Schedule Contract	

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
3/10/2016	16-01607-200	Review of Proposal Submitted Under a Solicitation	$350,176
3/11/2016	16-00760-207	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$1,441,777
3/15/2016	16-02245-210	Review of Proposal Submitted Under a Solicitation	$898,683
3/22/2016	15-04306-234	Review of Proposal Submitted Under a Solicitation	$733,901
		Total Monetary Impact	**$244,860,096**

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
11/2/2015	15-02790-15	Follow-up Review of Public Law Compliance Under a Federal Supply Schedule Contract	$1,508,084
11/20/2015	15-04735-43	Review of Public Law Compliance for a Covered Drug Under a Federal Supply Schedule Contract	$613
11/20/2015	16-00473-48	Review of Late Addition of Two Covered Drugs Under Federal Supply Schedule Contracts	$26,565
12/2/2015	15-03997-58	Review of Voluntary Disclosure on Underpayment of Industrial Funding Fee for a Federal Supply Schedule Contract	$8,014
12/8/2015	15-03086-67	Review of Compliance with Public Law Under a Federal Supply Schedule Contracts	$19,214
12/10/2015	14-04677-60	Review for Potential Overbillings Under a Federal Supply Schedule Contract	$14,624
12/10/2015	14-00716-61	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$5,942
12/10/2015	15-01309-63	Review of Voluntary Disclosure of Public Law Pricing Errors Under Federal Supply Service Contracts	$1,910,613
12/16/2015	12-03499-76	Postaward Review of a Federal Supply Schedule Contract	$104,756
12/18/2015	15-05413-73	Review of Voluntary Disclosure Submitted Under Federal Supply Schedule Contract	$41,935
1/27/2016	15-04850-110	Review of Public Law Overcharges for the Late Addition of a Covered Drug Under a Federal Supply Schedule Contract	$14,395
1/29/2016	15-03979-114	Review of Open Market Government Sales After the Expiration of a Federal Supply Schedule Contract	
2/2/2016	16-01495-116	Follow-Up Review of Voluntary Disclosure of Public Law Pricing Errors Under a Federal Supply Service Contract	$1,456,901
2/23/2016	15-04345-149	Review of Voluntary Disclosure and Refund Offer Submitted Under a Federal Supply Schedule Contract	$111,981

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
2/29/2016	13-03192-159	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$1,461,735
3/2/2016	16-00541-155	Review of Voluntary Disclosure Submitted Under a Federal Supply Schedule Contract	$24,315
3/3/2016	16-00534-181	Review of Voluntary Disclosure of Overcharges Under a Federal Supply Schedule Contract	$1,425,490
3/3/2016	16-00472-185	Review of Voluntary Disclosure Submitted Under a Federal Supply Schedule Contract	$288,384
3/3/2016	15-03977-186	Review of Open Market Government Sales After the Expiration of a Federal Supply Schedule Contract	
3/3/2016	15-03004-187	Review of Self-Audit and Refund Offer Under a Federal Supply Schedule Contract	$99,366
3/7/2016	15-05122-189	Review of Voluntary Disclosure Under a Federal Supply Schedule Contract	$34,242
3/9/2016	15-03003-199	Review of Voluntary Disclosures and Refund Offer Under a Federal Supply Schedule Contract	$331,793
3/22/2016	15-04344-235	Review of Voluntary Disclosure Under a Federal Supply Schedule Contract	$12,829
3/25/2016	14-04661-218	Review of Potential Overbillings and Shipping Charges Under Federal Supply Schedule Contracts	
3/25/2016	15-04782-244	Review of Voluntary Disclosure of Public Law Pricing Errors Under a Contract	$3,940
		Total Monetary Impact	**$8,905,731**

Office of Contract Review | Claim Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/21/2015	16-00279-21	Review of Termination Claim	
10/22/2015	15-00003-22	Review of Certified Claim	$285,496
10/29/2015	15-03865-30	Review of Claim Submitted Under a VA Contract	$1,615,522
11/18/2015	15-03945-44	Review of Certified Claim	$1,214,361
12/17/2015	15-03309-77	Review of Request for Equitable Adjustment Proposal Submitted Under a Contract	$642,044
3/14/2016	15-05147-205	Review of Certified Claim Submitted Under a Lease Contract	$2,138,643
		Total Monetary Impact	**$5,896,066**

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$382,217,000			
Preaward Reviews			$244,860,096	
Postaward Reviews				$8,905,731
Claim Reviews			$5,896,066	
	$382,217,000	**$0**	**$250,756,162**	**$8,905,731**

Table 2: Resolution Status of Reports with Questioned Costs		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	0	$0
Total inventory this period	**0**	**$0**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	0	$0
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**0**	**$0**
Total carried over to next period	**0**	**$0**

Table 3: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	3	$382,217,000
Total inventory this period	**3**	**$382,217,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	3	$382,217,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**3**	**$382,217,000**
Total carried over to next period	**0**	**$0**

OIG reports that there were no significant revised management decisions made during the reporting period, nor any significant management decisions with which OIG is in disagreement.

Office of Investigations | Administrative Summaries of Investigation		
Issue Date	**Number**	**Facility**
2/26/2016	14-02890-120	Lake City VA Medical Center, Lake City, Florida
2/26/2016	14-02890-121	Marianna VA Community Based Outpatient Clinic, Marianna, Florida
2/26/2016	14-02890-124	St. Augustine VA Community Based Outpatient Clinic, St. Augustine, Florida
2/26/2016	14-02890-133	Bay Pines VA Medical Center, Bay Pines, Florida
2/26/2016	14-02890-134	Orlando VA Medical Center, Orlando, Florida, and Daytona Beach VA Outpatient Clinic, Daytona Beach, Florida
2/26/2016	14-02890-135	Gainesville VA Medical Center, Gainesville, Florida
2/26/2016	14-02890-136	Tallahassee VA Outpatient Clinic, Tallahassee, Florida
2/26/2016	14-02890-143	Gainesville VA Medical Center, Gainesville, Florida
2/26/2016	14-02890-151	Miami VA Medical Center, Miami, Florida
2/26/2016	14-03403-128	Jacksonville VA Outpatient Clinic, Jacksonville, Florida
2/29/2016	14-02890-122	Des Moines VA Medical Center, Des Moines, Iowa
2/29/2016	14-02890-125	Minneapolis VA Medical Center, Minneapolis, Minnesota
2/29/2016	14-02890-126	Minneapolis VA Medical Center, Minneapolis, Minnesota, and St. Cloud VA Medical Center, St. Cloud, Minnesota
2/29/2016	14-02890-127	West Palm Beach VA Medical Center, West Palm Beach, Florida
2/29/2016	14-02890-154	Minneapolis VA Medical Center, Minneapolis, Minnesota
3/1/2016	14-03128-158	Wilmington VA Medical Center, Wilmington, Delaware
3/2/2016	14-02890-157	Matsunaga VA Medical Center, Honolulu, Hawaii
3/3/2016	14-02890-168	Southeast Louisiana VA Health Care System, New Orleans/Baton Rouge, Louisiana
3/3/2016	14-02890-173	Shreveport VA Medical Center, Shreveport, Louisiana
3/3/2016	14-02890-174	Danville VA Medical Center, Danville, Illinois
3/3/2016	14-02890-180	Hines VA Medical Center, Hines, Illinois
3/7/2016	14-02890-167	Portland VA Medical Center, Portland, Oregon
3/8/2016	14-02890-137	El Paso VA Health Care System, El Paso, Texas
3/8/2016	14-02890-138	Dallas VA Medical Center, Dallas, Texas
3/8/2016	14-02890-148	Temple VA Medical Center, Temple, Texas
3/8/2016	14-02890-150	Temple VA Medical Center, Temple, Texas
3/8/2016	14-02890-152	Amarillo VA Medical Center, Amarillo, Texas
3/8/2016	14-02890-156	Fort Worth Veterans Integrated Service Network and VA Outpatient Clinic, Fort Worth, Texas
3/8/2016	14-02890-162	San Antonio VA Medical Center, San Antonio, Texas
3/8/2016	14-02890-163	Houston VA Medical Center, Houston, Texas
3/8/2016	14-02890-164	San Antonio VA Medical Center, San Antonio, Texas
3/8/2016	14-02890-165	Harlingen VA Outpatient Clinic, Harlingen, Texas
3/8/2016	14-02890-166	Horsham VA Community Based Outpatient Clinic, Horsham, Pennsylvania

Office of Investigations | Administrative Summaries of Investigation		
Issue Date	**Number**	**Facility**
3/8/2016	14-02890-169	San Antonio VA Medical Center, San Antonio, Texas
3/8/2016	14-02890-170	Central Texas VA Health Care System, Austin, Texas, and South Texas Health Care System, San Antonio, Texas
3/8/2016	14-02890-179	Philadelphia VA Medical Center, Philadelphia, Pennsylvania
3/9/2016	14-02890-177	Huntington VA Medical Center, Huntington, West Virginia
3/9/2016	14-02890-191	Lake Havasu City VA Community Based Outpatient Clinic, Lake Havasu City, Arizona
3/10/2016	14-02890-194	Chattanooga VA Community Based Outpatient Clinic, Chattanooga, Tennessee
3/10/2016	14-02890-195	Chattanooga VA Community Based Outpatient Clinic, Chattanooga, Tennessee
3/10/2016	14-02890-196	Murfreesboro VA Medical Center, Murfreesboro, Tennessee
3/10/2016	14-02890-201	Memphis VA Medical Center, Memphis, Tennessee
3/15/2016	14-02890-190	Brooklyn VA Medical Center, Brooklyn, New York
3/15/2016	14-02890-197	Little Rock VA Medical Center, Little Rock, Arkansas
3/15/2016	14-03542-178	Rochester VA Community Based Outpatient Clinic, Rochester, New York
3/15/2016	14-03542-183	Rochester VA Community Based Outpatient Clinic, Rochester, New York
3/16/2016	14-02890-193	Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
3/17/2016	14-02890-214	Denver VA Medical Center, Denver, Colorado
3/17/2016	14-02890-215	Grand Junction VA Medical Center, Grand Junction, Colorado
3/21/2016	14-02890-219	San Juan VA Medical Center, San Juan, Puerto Rico
3/22/2016	14-02890-171	Wichita VA Medical Center, Wichita, Kansas, and Salina VA Community Based Outpatient Clinic, Salina, Kansas
3/22/2016	14-02890-216	Northampton VA Medical Center, Northampton, Massachusetts
3/22/2016	14-02890-225	Leavenworth VA Medical Center, Leavenworth, Kansas, and Topeka VA Medical Center, Topeka, Kansas
3/22/2016	14-02890-228	Battle Creek VA Medical Center, Battle Creek, Michigan
3/22/2016	14-02890-233	Boise VA Medical Center, Boise, Idaho
3/25/2016	14-02890-175	Chehalis VA Community Based Outpatient Clinic, Chehalis, Washington
3/25/2016	14-02890-192	Louisville VA Medical Center, Louisville, Kentucky
3/25/2016	14-02890-202	Kansas City VA Medical Center, Kansas City, Missouri
3/25/2016	14-02890-217	Louisville VA Medical Center, Louisville, Kentucky
3/25/2016	14-02890-229	American Lake VA Medical Center, American Lake, Washington
3/25/2016	14-03145-176	Spokane VA Medical Center, Spokane, Washington
3/30/2016	14-02890-224	Palo Alto VA Medical Center, Palo Alto, California
3/30/2016	14-02890-227	San Diego VA Medical Center, San Diego, California
3/30/2016	14-02890-236	Los Angeles VA Medical Center, Los Angeles, California
3/30/2016	14-02890-247	San Diego VA Medical Center, San Diego, California
3/31/2016	14-02890-232	Manchester VA Medical Center, Manchester, New Hampshire
3/31/2016	14-02890-243	Manchester VA Medical Center, Manchester, New Hampshire

Office of Investigations | Administrative Summaries of Investigation		
Issue Date	**Number**	**Facility**
3/31/2016	14-03048-226	Dublin VA Medical Center, Dublin, Georgia

Appendix B: Unimplemented Reports and Recommendations

The follow-up reporting and tracking of OIG report recommendations is required by P.L. 103-355, *Federal Acquisition Streamlining Act of 1994*, as amended by P.L. 104-106, *National Defense Authorization Act of 1996*. The Acts require agencies to complete final action on each management decision required with regard to a recommendation in an OIG's report within 12 months of its issuance/publication. If the agency fails to complete final action within the 12-month period, OIG is required to identify the matter in each Semiannual Report to Congress until final action on the management decision is completed.

Table 1 identifies the number of open OIG reports and recommendations with results sorted by action office. As of March 31, 2016, there are 227 total open reports and 1,078 total open recommendations. However, 8 reports and 8 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 58 reports and 160 recommendations that, as of March 31, 2016, remain open for more than 1 year. The total monetary benefit attached to these reports is $2,328,100,000.

Table 1: Number of Unimplemented OIG Reports and Recommendations by Office

	Reports Open More Than 1 Year	Reports Open Less Than 1 Year	Total Reports Open	Recommendations Open More Than 1 Year	Recommendations Open Less Than 1 Year	Total Recommendations Open
Veterans Health Administration	41	144	185	115	790	905
Veterans Benefits Administration	7	21	28	18	77	95
Office of Acquisitions, Logistics, and Construction	3	2	5	9	6	15
Office of Management (OM)	1	2	3	3	2	5
Office of Information and Technology	4	5	9	10	44	54
Office of Human Resources and Administration	2	0	2	5	0	5
Office of Operations, Security, and Preparedness (OSP)	2	0	2	2	0	2
Office of General Counsel	1	0	1	3	0	3
Chief of Staff (COS)	0	1	1	0	2	2
Total	**61**	**175**	**236**	**165**	**921**	**1,086**

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/11/06	**06-02238-163**	**Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans**	**OSP**	**None**
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.				
06/07/10	**08-02969-165**	**Review of Federal Supply Schedule 621 I--Professional and Allied Healthcare Staffing Services**	**OALC**	**None**
Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL [Office of Acquisition and Logistics] direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable. *Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC [most favored customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).* *Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.* *Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.* *Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.*				
02/18/11	**09-03850-99**	**Audit of the Veterans Service Network**	**OIT**	**$35,000,000**
Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 11: We recommend the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.				
03/30/12	11-00312-127	Audit of VHA's Prosthetics Supply Inventory Management	VHA	$35,500,000
Recommendation 5: We recommended the Under Secretary for Health revise the Veterans Health Administration's Inventory Management Handbook to require at least one prosthetic supply inventory manager from each VA medical center to attend VA's Acquisition Academy's Supply Chain Management School and become Certified VA Supply Chain Managers.				
05/30/12	10-03166-75	Audit of VA Regional Offices' Appeals Management Processes	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals. *Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.* *Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.* *Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/28/12	**12-00375-290**	**Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC**	**OM/OGC**	**None**
Recommendation 4: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville EUL [Enhanced Use Lease] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage. *Recommendation 5: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem.* *Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer immediately determine what services VOA [Volunteers of America] is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.*			
09/28/12	**12-01012-298**	**Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation**	**VHA/OALC**	**None**
Recommendation 7: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices. *Recommendation 8: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts.* *Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.*			

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/30/12	12-00165-277	Review of Alleged Delays in VA Contractor Background Investigations	OIT/OSP	None
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.				
03/06/13	12-02802-111	Review of Alleged Transmission of Sensitive VA Data Over Internet Connections	OIT	None
Recommendation 1: We recommend the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements.				
03/28/13	12-02503-151	Administrative Investigation, Misuse of Official Time and Resources and Failure to Properly Supervise, Office of Human Resources and Administration, Washington, DC	OHRA	None
Recommendation 2: We recommend that the Acting Assistant Secretary for Human Resources and Administration determine the total salary paid to _____ for the 39 days that _____ was AWOL [absent without leave] from VA or worked for _____ while on sick leave and ensure that a bill of collection is issued to _____ for that amount, since _____ cannot receive pay for the period of time that _____ was absent without authorization.				
09/04/13	12-00181-299	Audit of VBA's Pension Payments	VBA	$502,000,000
Recommendation 1: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements procedures that ensure continued veteran and beneficiary eligibility. *Recommendation 4: We recommend the Under Secretary for Benefits establish a matching program with Medicaid to automatically identify veterans and beneficiaries that require nursing home adjustments.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/31/14	13-02697-113	Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center	OALC	None
Recommendation 8: We recommended that the Principal Executive Director, OALC require vendors to submit documentation, such as teaming arrangements, that key team members such as architects, engineers, and GCs [general contractor] are committed and able to do the project.				
04/10/14	14-00658-121	Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California	VHA	None
Recommendation 3: We recommended that processes be strengthened to ensure that patient care areas are clean and that water leaks and subsequent structural damage are addressed and resolved timely and that compliance be monitored.				
04/28/14	14-00227-131	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Birmingham VA Medical Center, Birmingham, Alabama	VHA	None
Recommendation 4: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified. *Recommendation 5: We recommended that staff consistently provide written medication information that includes the flouroquinolone.* *Recommendation 6: We recommended that staff consistently provide medication counseling/education that includes the fluoroquinolone.*				
05/28/14	13-03018-159	Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub	VBA	None
Recommendation 5: We recommended the Under Secretary for Benefits ensures the Eastern Area Fiduciary Hub implements a plan to expedite completion of their backlog of field examinations to meet performance standards.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
05/28/14	14-01119-168	Healthcare Inspection – Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi	VHA	None
Recommendation 1: We recommended that the System Director actively recruits and fills approved physician vacancies within the Extended Care Service.				
06/03/14	13-02129-177	Audit of the Management of Concurrent VA and Military Drill Pay Compensation	VBA	$623,100,000
Recommendation 1: We recommended the Under Secretary for Benefits take measures to ensure drill pay offsets identified after fiscal year 2012 are timely processed. *Recommendation 2: We recommended the Under Secretary for Benefits ensure fiscal years 2011 and 2012 drill pay offsets are processed.* *Recommendation 3: We recommended the Under Secretary for Benefits modify existing information technology systems to more effectively monitor, track, and report on drill pay offset activities.*				
06/26/14	14-00235-195	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilmington VA Medical Center, Wilmington, Delaware	VHA	None
Recommendation 8: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				
07/07/14	11-00323-169	Follow-Up Audit of VHA's Workers' Compensation Case Management	VHA	$11,900,000
Recommendation 2: We recommended the Acting Under Secretary for Health establish a directive mandating Workers' Compensation Program specialists implement the workers' compensation guidebook to ensure specialists question the validity of claims lacking adequate supporting evidence.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/11/14	13-01452-214	Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments	VBA	$205,000,000
Recommendation 1: We recommended the Under Secretary for Benefits ensure the Post-9/11 G.I. Bill application provides veterans with clear, adequate information on educational benefits and the requirement to relinquish other education benefits before submission. *Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.*				
07/14/14	13-03699-209	Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years	VBA	$40,400,000
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to identify all provisionally-rated claims and ensure the proper controls are entered in the electronic system to track, manage, and complete them. *Recommendation 2: We recommended the Under Secretary for Benefits implement actions to include provisionally-rated claims in the rating inventory and correct the aging of provisional claims in pending workload statistics.* *Recommendation 3: We recommended the Under Secretary for Benefits implement a plan to expedite final decisions on all issues in provisionally-rated claims.* *Recommendation 4: We recommended the Under Secretary for Benefits implement actions to complete quality reviews to ensure accuracy of all provisionally-rated claims processed under this Special Initiative.*				
07/22/14	14-00931-213	Community Based Outpatient Clinic and Primary Care Clinic Reviews at John D. Dingell VA Medical Center, Detroit, Michigan	VHA	None
Recommendation 2: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
08/01/14	14-02065-230	Combined Assessment Program Review of the Washington DC VA Medical Center, Washington, DC	VHA	None
Recommendation 15: We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.				
08/26/14	14-02603-267	Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System	VHA	None
Recommendation 9: We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care. *Recommendation 13: We recommended that upon the completion of the investigation the VA Secretary confer with appropriate VA staff and determine whether administrative action should be taken against management officials at the Phoenix VA Health Care System and ensure that action is taken where appropriate.* *Recommendation 19: We recommended the VA Secretary provide veterans needed care in a timely manner and minimize the use of the Electronic Wait Lists.* *Recommendation 21: We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.*				
08/28/14	14-00657-261	Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits improve monitoring to ensure Veterans Affairs Regional Office staff establish claims in the Veteran Benefits Administration's data systems within 7 days of receipt. *Recommendation 2: We recommended the Under Secretary for Benefits develop a timeliness standard for Veterans Affairs Regional Office staff making initial requests for service treatment records.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/02/14	**14-02068-264**	**Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado**	**VHA**	**None**
Recommendation 16: We recommended that the facility implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements.				
09/23/14	**14-02198-284**	**Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting**	**VHA**	**None**
Recommendation 1: We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.				
10/01/14	**14-02064-252**	**Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Topeka, Kansas**	**VHA**	**None**
Recommendation 8: We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.				
10/16/14	**14-02077-01**	**Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee**	**VHA**	**None**
Recommendation 12: We recommended that processes be strengthened to ensure that providers complete and document patient discharge instructions and that compliance be monitored.				
11/10/14	**14-00939-27**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at Miami VA Healthcare System, Miami, Florida**	**VHA**	**None**
Recommendation 1: We recommended that the Pembroke Pines CBOC location is clearly identified from the street as a VHA CBOC.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
11/12/14	14-00937-31	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Northern California Health Care System, Mather, California	VHA	None
Recommendation 7: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified. *Recommendation 8: We recommended that staff provide and document medication counseling/education as required.*				
11/18/14	14-02083-24	Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, Minnesota	VHA	None
Recommendation 4: We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.				
11/19/14	12-02576-30	Audit of VHA's Support Service Contracts	VHA	$795,000,000
Recommendation 1: We recommended the Interim Under Secretary for Health implement a quality assurance program that provides sufficient oversight to ensure that contracting issues are corrected by the responsible contracting office. *Recommendation 2: We recommended the Interim Under Secretary for Health implement a mechanism to facilitate and ensure contracting officers' performance can be objectively evaluated against their performance standards.* *Recommendation 3: We recommended the Interim Under Secretary for Health monitor contracting officer performance deficiencies and ensure training is provided to correct identified deficiencies.* *Recommendation 4: We recommended the Interim Under Secretary for Health ensure contracting staff complete Integrated Oversight Process reviews in accordance with established policies and contracting officers' performance standards.* *Recommendation 5: We recommended the Interim Under Secretary for Health revise Integrated Oversight Process review procedures to include a review to ensure Advisory and Assistance services are identified and approved.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
11/25/14	14-02079-10	Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama	VHA	None
Recommendation 1: We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that code data is collected. *Recommendation 2: We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.* *Recommendation 8: We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.* *Recommendation 9: We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.* *Recommendation 11: We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.* *Recommendation 18: We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.* *Recommendation 19: We recommended that processes be strengthened to ensure that secondary patient safety screening forms are scanned into the patients' electronic health records and that compliance be monitored.* *Recommendation 22: We recommended that processes be strengthened to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that compliance be monitored.*				
12/04/14	14-00930-14	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the Central Alabama Veterans Health Care System, Montgomery, Alabama	VHA	None
Recommendation 11: We recommended that the parent facility maintain evidence of the contractor's compliance with facility required education, training, planning, and participation in annual disaster exercises for the Dothan and Wiregrass CBOCs. *Recommendation 14: We recommended that CBOC/Primary Care Clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 15: We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.				
01/12/15	**14-04380-79**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Gulf Coast Veterans Health Care System, Biloxi, Mississippi**	**VHA**	**None**
Recommendation 9: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored. *Recommendation 10: We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.*				
01/14/15	**14-04210-63**	**Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York**	**VHA**	**None**
Recommendation 19: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.				
01/20/15	**14-04214-70**	**Combined Assessment Program Review of the Gulf Coast Veterans Health Care System Biloxi, Mississippi**	**VHA**	**None**
Recommendation 1: We recommended that facility managers review privilege forms annually and document the review. *Recommendation 7: We recommended that facility managers ensure designated employees receive automated dispensing machine training and competency assessment and monitor compliance.* *Recommendation 8: We recommended that requestors consistently include "inpatient" in the consult title and that facility managers monitor compliance.* *Recommendation 10: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.* *Recommendation 11: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 12: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance. *Recommendation 13: We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.* *Recommendation 14: We recommended that the facility revise the emergency airway management policy to include the availability of videolaryngoscopes for use by clinicians and a plan for managing a difficult airway.* *Recommendation 15: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.* *Recommendation 16: We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.* *Recommendation 18: We recommended that the facility consistently schedule follow-up appointments within the timeframes requested by providers.*				
01/22/15	**13-03324-85**	**Follow-up Audit of the Information Technology Project Management Accountability System**	**OIT**	**$6,400,000**
Recommendation 1: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, establish procedures to ensure the Office of Product Development completes all required Planning Reviews (repeat recommendation from the 2011 VA Office of Inspector General audit report). *Recommendation 2: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure personnel performing Compliance Reviews assess the accuracy and reasonableness of cost information reported on the Project Management Accountability System Dashboard (repeat recommendation from the 2011 VA Office of Inspector General audit report).* *Recommendation 3: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure hiring actions are completed by acquiring the vacant Federal employee positions in the Project Management Accountability System Business Office (repeat recommendation from the 2011 VA Office of Inspector General audit report).*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 5: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, complete modification of the Project Management Accountability System Dashboard so that it maintains a complete audit trail of baseline data by including planned, revised, and actual figures for project life-cycle and increment costs (repeat recommendation from the 2011 VA Office of Inspector General audit report). *Recommendation 6: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, complete development and implementation of a sound methodology to capture and report planned and actual total project and increment level costs (repeat recommendation from the 2011 VA Office of Inspector General audit report).* *Recommendation 7: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure project managers capture and report reliable cost data and maintain adequate audit trails to support how the cost information reported on the Project Management Accountability System Dashboard was derived in the interim until actions to automate budget traceability and shift VA's IT projects to increment-based contracts are completed (repeat recommendation from the 2011 VA Office of Inspector General audit report).* *Recommendation 8: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, clearly define the term "enhancement of an existing system or its infrastructure" and require Service Delivery and Engineering project teams to track and report costs associated with enhancements on the Project Management Accountability System Dashboard.*			
02/03/15	**14-05132-90**	**Combined Assessment Program Summary Report – Evaluation of Pressure Ulcer Prevention and Management at Veterans Health Administration Facilities**	**VHA**	**None**
Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that clinicians provide and document patient/caregiver pressure ulcer education and that facility managers monitor compliance. *Recommendation 8: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that clinicians document wound care follow-up plans for patients discharged with unhealed pressure ulcers and that the facility provides needed supplies.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
02/05/15	14-04378-97	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Hudson Valley Health Care System, Montrose, New York	VHA	None
Recommendation 2: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen. *Recommendation 3: We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and drinking alcohol above National Institute on Alcohol Abuse and Alcoholism limits.* *Recommendation 4: We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.* *Recommendation 5: We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.* *Recommendation 7: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.*				
02/05/15	14-04223-100	Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas	VHA	None
Recommendation 9: We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance. *Recommendation 14: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.* *Recommendation 16: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.* *Recommendation 21: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of scopes of practice and includes all required elements and that facility managers monitor compliance.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
02/17/15	14-04386-124	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA North Texas Health Care System, Dallas, Texas	VHA	None
Recommendation 4: We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training and that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams. *Recommendation 6: We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.*				
02/25/15	14-04226-125	Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan	VHA	None
Recommendation 9: We recommend that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance. *Recommendation 11: We recommend that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.*				
02/25/15	14-04229-130	Combined Assessment Program Review of the Beckley VA Medical Center, Beckley, West Virginia	VHA	None
Recommendation 9: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.				
03/02/15	14-00730-126	Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System	VHA	$73,800,000
Recommendation 2: We recommended the Interim Under Secretary for Health seek the return of all medical support and compliance funds used to develop and support the Health Care Claims Processing System. *Recommendation 5: We recommended the Interim Under Secretary for Health confer with the Office of Human Resources and the Office of General Counsel to determine if appropriate administrative action should be taken against any senior officials in the Deputy Chief Business Office for Purchased Care's supervisory chain of command, and ensure that action is taken.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/04/15	14-04222-141	Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon	VHA	None

Recommendation 2: We recommended that facility managers ensure that privileges granted are appropriate for the practitioners' skills and training.

Recommendation 3: We recommended that when conversions from observation bed status to acute admissions are 25-30 percent or more, the facility reassess observation criteria and utilization.

Recommendation 4: We recommended that the Acute Care Advisory Board review each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Recommendation 6: We recommended that the facility analyze electronic health record data at least quarterly and include most services in the review of electronic health record quality.

Recommendation 7: We recommended that the facility implement a process for the destruction of original documents.

Recommendation 8: We recommended that the Safe Patient Handling Committee report patient handling injury data quarterly.

Recommendation 11: We recommended that the facility conduct cardiac arrest, contrast reaction, and fire emergency drills in magnetic resonance imaging and that facility managers monitor compliance.

Recommendation 23: We recommended that domiciliary employees perform and document contraband inspections, rounds of all public spaces, and inspections for unsecured medications and that domiciliary managers monitor compliance.

Recommendation 24: We recommended that domiciliary managers ensure that written agreements are in place acknowledging resident responsibility for medication security.

Recommendation 28: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance.

Recommendation 29: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance.

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 31: We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance. *Recommendation 34: We recommended that facility managers ensure quarterly reporting of emergency airway management data to the designated committee.* *Recommendation 35: We recommended that facility managers ensure reporting of results of completed Focused Professional Practice Evaluations for all newly hired licensed independent practitioners to the Medical Executive Committee.* *Recommendation 36: We recommended that facility managers ensure the Medical Records Committee monitors the copy and paste functions.* *Recommendation 37: We recommended that facility managers ensure patient notification of positive colorectal cancer screening test results within the required timeframe and that clinicians document notification.* *Recommendation 38: We recommended that facility managers ensure responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.* *Recommendation 39: We recommended that facility managers ensure patient notification of diagnostic test results within the required timeframe and that clinicians document notification.*				
03/09/15	**13-00716-101**	**Audit of VHA's Home Telehealth Program**	**VHA**	**None**
Recommendation 1: We recommended that the Interim Under Secretary for Health implement mechanisms that effectively identify demand for Non-Institutional Care services to ensure that veterans who need these services are provided the opportunity to participate in the Home Telehealth Program. *Recommendation 2: We recommended that the Interim Under Secretary for Health develop specific performance measures to promote enrollment of Non-Institutional Care patients into the Home Telehealth Program.*				
03/10/15	**14-04227-147**	**Combined Assessment Program Review of the VA San Diego Healthcare System, San Diego, California**	**VHA**	**None**
Recommendation 15: We recommended that the facility ensure appropriate barriers are in place to restrict unauthorized or accidental access to magnetic resonance imaging Zone IV.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 17: We recommended that clinicians obtain and document informed consent for tissue plasminogen activator and that facility managers monitor compliance. *Recommendation 19: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.* *Recommendation 20: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.* *Recommendation 21: We recommended that facility managers provide a stroke education program for employees involved in assessing and treating stroke patients and that facility managers monitor compliance.* *Recommendation 22: We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.*				
03/26/15	**14-00730-170**	**Administrative Investigation - Prohibited Personnel Practice and Misuse of VA Time and Resources, Veterans Health Administration, Chief Business Office Purchased Care, Denver, Colorado**	**VHA**	**None**
Recommendation 1: We recommend that the Acting Deputy Under Secretary for Health for Operations and Management confer with the Offices of Human Resources and General Counsel to determine the appropriate corrective action to take, if any, concerning the prohibited personnel practice and improper use of a non-competitive hiring authority to reinstate Mr. Sigley.				
03/30/15	**14-02139-156**	**Healthcare Inspection - Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia**	**VHA**	**None**
Recommendation 2: We recommended that the Facility Director ensure development of a process to measure the effectiveness of Veterans Health Administration required suicide risk management training for all staff members who have completed it and to provide remedial training when needed.				
03/30/15	**14-02383-175**	**Audit of VA's Drug-Free Workplace Program**	**OHRA**	**None**
Recommendation 1: We recommended the Deputy Assistant Secretary for Human Resources Management ensure that all final selectees for Testing Designated Positions complete pre-employment drug testing prior to appointment.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 2: We recommended the Deputy Assistant Secretary for Human Resources Management collect data that would ensure accountability that all employees selected for random drug testing are tested. *Recommendation 3: We recommended the Deputy Assistant Secretary for Human Resources Management develop procedures to ensure the Drug Testing coding of employees in Testing Designated Positions is accurate and complete in the Personnel and Accounting Integrated Data system.* *Recommendation 5: We recommended the Deputy Assistant Secretary for Human Resources Management implement processes to adequately monitor local compliance with VA's Drug-Free Workplace Program requirements.*				
03/31/15	**15-00071-158**	**Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida**	**VHA**	**None**
Recommendation 15: We recommended that the facility conduct initial patient safety screenings and that the facility managers monitor compliance. *Recommendation 16: We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that the facility managers monitor compliance.* *Recommendation 17: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.* *Recommendation 20: We recommended that facility managers ensure that all nursing employees who perform 12-lead electrocardiograms have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and have 12-lead electrocardiogram competency assessment and validation completed and documented.* *Recommendation 21: We recommended that facility managers ensure post-anesthesia care competency assessment and validation is included in competency checklists and completed for employees on the 2B-ICU.*				
03/31/15	**15-00113-161**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of West Palm Beach VA Medical Center, West Palm Beach, Florida**	**VHA**	**None**
Recommendation 5: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/31/15	14-04391-162	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Ann Arbor Healthcare System, Ann Arbor, Michigan	VHA	None
Recommendation 1: We recommended that managers ensure review of the hazardous materials inventory occurs twice within a 12-month period at the Jackson VA Outpatient Clinic. *Recommendation 8: We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.* *Recommendation 12: We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.*				
03/31/15	15-01809-163	Combined Assessment Program Summary Report Evaluation of Coordination of Care in Veterans Health Administration Facilities	VHA	None
Recommendation 1: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians provide and document discharge instructions for all identified needs and that facility managers monitor compliance. *Recommendation 2: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions, and that facility managers monitor compliance.* *Recommendation 3: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinicians reconcile conflicting needs and instructions before discharging patients and that facility managers monitor compliance.* *Recommendation 4: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that patients receive ordered post-discharge referrals and that facility managers monitor compliance.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/31/15	14-03927-197	Healthcare Inspection - Patient Telemetry Monitoring Concerns, Michael E. DeBakey VA Medical Center, Houston, Texas	VHA	None
Recommendation 1: We recommended that the Facility Director ensure that the appropriateness of assigning patients to telemetry is reviewed. *Recommendation 2: We recommended that the Facility Director ensure dedicated wireless telephones are continuously carried by unit charge nurses or designees for effective communication between unit and telemetry monitoring technicians as required by local policy.*				
Total				**$2,328,100,000**

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The Human Hug Project stopped by Lexington, KY's VA Medical Center on Tuesday, January 19, 2016. VA photo by Megan Moloney.

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