Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 76 | April 1–September 30, 2016

OIG MISSION

To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs (VA) through independent audits, inspections, and investigations.

VISION

To meet our mission and enhance the trust and confidence of veterans and their families, Veterans Service Organizations, Congress, VA employees, and the public, we must:

- Ensure that our work is independent and avoid any appearance of impairment to our independence.
- Prevent and detect fraud, waste, and abuse in VA programs and operations.
- Be proactive and strategic in identifying impactful issues.
- Produce reports that are:
  - ◊ Accurate
  - ◊ Timely
  - ◊ Fair
  - ◊ Objective
  - ◊ Thorough
- Make meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations.
- Be fully transparent by promptly releasing reports that are not otherwise prohibited from disclosure.
- Promote accountability of VA employees if they fail to perform as expected.
- Attract, develop, and retain the highest quality staff in the Office of Inspector General (OIG).
- Treat whistleblowers and others who provide information to the OIG with respect and dignity and protect their identities if they so desire.

VALUES

Our conduct will be guided and informed by adherence to the following values:

- Meet the highest standards of professionalism, character, ethics, and integrity.
- Work as one organization by encouraging teamwork and collaboration across directorates and offices.
- Establish a positive and engaging work environment.
- Promote diversity, individual perspectives, and equal opportunity throughout the OIG.
- Respect the role and expertise that each staff member brings to the OIG.
- Continually improve our performance.
- Ensure equitable opportunities for professional growth and development.
- Accept responsibility for our behavior and performance.

Message from the 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 April 1, 2016–September 30, 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 179 reports and work products on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $3.3 billion in monetary benefits, for a return on investment of $55 for every dollar expended on OIG oversight. The OIG Hotline received over 17,000 contacts from sources concerning VA programs and operations. OIG investigators closed 444 investigations and made 203 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 717 administrative sanctions and corrective actions.

The Office of Investigations continues to combat fraud in VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) Program. One case uncovered a scheme by a non-veteran to obtain $112 million in Government SDVOSB set-aside contracts for which he was not eligible. The investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. The non-veteran was convicted during a jury trial of conspiracy to defraud the United States and wire fraud. He was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million fine. Criminal asset forfeiture proceedings are still pending. See page 56 for more details on these findings.

The Office of Healthcare Inspections (OHI) continues to report on the impact that mental illness and narcotic dependence have upon veterans and the VA medical system. Below are some examples:

- In our report, *Healthcare Inspection - Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina*, OHI noted the clinical and administrative environment in which community based outpatient clinic providers prescribed opioids and managed the pain-related needs of their patients and found several processes that negatively affected the delivery of quality patient care. See page 18 for more details on these findings and conclusions.

- In the report, *Healthcare Inspection – Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington*, OHI substantiated that facility leaders failed to comply with Veterans Health Administration (VHA) requirements for suicide prevention training and that not all health care providers who required training had completed the Suicide Risk Assessment for Clinicians course within the required first 90 days of hire. See page 18 for more details

on these findings and conclusions. Mental health issues, which may manifest as suicide attempts, substance use disorder, or other mental health conditions, must remain a priority for VHA when addressing the healthcare needs of veterans.

During this reporting period, the Office of Audits and Evaluations (OAE) issued several reports on improper payments made through the VA benefits and health care systems. Improper payments were found in the reviews of Post 9/11 GI Bill tuition and fee payments, compensation and pension payments to incarcerated veterans, special monthly compensation housebound benefits, and OAE's follow-up review of invoice splitting at the New Jersey Health Care System. The improper payments in these four projects totaled an estimated $2.8 billion in questioned costs. Below is a summary of the results of each project:

- OAE evaluated the Veterans Benefits Administration's (VBA) oversight of Post-9/11 GI Bill tuition and fee payments to determine if payments were appropriate and accurate. OAE found VBA staff at the Regional Processing Offices made improper payments and missed recoupments. Based on the more than $5.2 billion in tuition and fee payments made to schools during academic year 2013–2014, OAE projected that VBA issued an estimated $247.6 million in improper payments and had a projected error rate of about 5 percent. In addition, VBA did not recoup an estimated $205.5 million annually. As a result, VBA might issue an estimated $1.2 billion in improper payments and may not recoup an estimated $1 billion from students and schools within the next five academic school years if it does not strengthen payment and recoupment controls. This equates to an estimated $2.3 billion in improper tuition and fee payments and missed recoupments. See page 33 for more details on findings and conclusions.

- In our report, *Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans*, OAE determined that the VA Regional Office (VARO) and Pension Management Center (PMC) staff did not consistently take action to adjust compensation and pension (C&P) benefits for incarcerated veterans in Federal, state, and local penal institutions. Without improvements, OAE estimated VBA could make additional improper benefits payments totaling about $41.8 million for Federal incarceration cases from fiscal year 2016 through 2020. In addition, VARO and PMC staff also did not take consistent and timely action to adjust C&P benefits for veterans incarcerated in state and local penal institutions. In total, OAE estimated improper benefit payments of about $307.9 million. See page 34 for more details on findings and conclusions.

- In our report of special monthly compensation housebound benefits, OAE identified errors in which veterans were entitled to statutory benefits based on having a single disability rated as 100 percent disabling and one or more disabilities independently rated at 60 percent or more. Errors included failure to grant housebound benefits, failure to pay housebound benefits that had been granted, and prematurely reducing housebound benefits. OAE also found errors in which veterans were being paid compensation at the housebound rate. Veterans entitled to statutory housebound benefits did not consistently receive correct benefits decisions. Based on sample projection results, OAE estimated that these errors resulted in veterans being underpaid $110.1 million through February 2015, and receiving recurring underpayments of $1.8 million per month as of March 2015. In addition, OAE estimated that VBA staff delayed paying veterans $54.3 million. Errors for veterans receiving compensation at the housebound rate also resulted in incorrect benefits decisions. Based on sample projection results, OAE estimated that these errors resulted in veterans being overpaid $44.3 million through February 2015, with ongoing overpayments of $1.1 million per month as of March 2015. In total, OAE estimated improper special monthly compensation housebound benefits payments totaling $154.4 million. See page 34 for more details on findings and conclusions.

- OAE determined VA New Jersey Health Care System (VANJHCS) employees at the East Orange and Lyons VA Medical Centers made inappropriate split purchases due to a disregard for internal controls that are an integral part of every Federal Government purchase card program. As a result, OAE estimated that split purchasing resulted in approximately $8.9 million in unauthorized commitments and increased the risk of fraud, waste, and abuse of taxpayer resources at VANJHCS. See page 28 for more details on findings and conclusions.

I was sworn in as the Inspector General on May 2, 2016, and this is my first submission of the Semiannual Report to Congress. I would like to express my enthusiasm for the present and future days ahead in leading the OIG team forward in its efforts to conduct effective oversight of VA's programs and operations. To support these efforts, I have communicated to our OIG team our new mission, vision, and values that will help us produce timely, fair, objective, thorough, and accurate reports and products of the highest quality. The mission, vision, and values are located on our public website at www.va.gov/oig and the inside cover of this Semiannual Report. I would also like to express my deepest gratitude and appreciation to the hardworking and dedicated OIG staff for embracing this new chapter of our organization's history. We are committed to being a transparent organization that conducts itself with the highest standards of professionalism, character, and integrity.

Additionally, I am thankful for the productive relationships that we have established and maintained with Congress, the Secretary, the Deputy Secretary, VA senior management, Veteran Service Organizations, and other stakeholders. Their support of our mission creates the necessary collaborative environment so that we can best serve our Nation's veterans, their families, and taxpayers.

MICHAEL J. MISSAL
Inspector General

Statistical Highlights

Monetary Impact (in Millions)	Apr-Sept	FY
Better Use of Funds	$19.4	$401.6
Fines, Penalties, Restitutions, and Civil Judgments	$63.5	$83.1
Fugitive Felon Program	$160.9	$262.7
Savings and Cost Avoidance	$315.7	$580.1
Questioned Costs	$2,741.2	$2,741.2
Dollar Recoveries	$8.9	$24.5
Total Dollar Impact	$3,309.6	$4,093.2
Cost of OIG Operations[1]	$60.4	$120.8
Return on Investment[2]	**55:1**	**34:1**

Investigative Activities	Apr-Sept	FY
Arrests[3]	189	349
Fugitive Felon Arrests	14	39
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	11	19
Indictments	163	290
Criminal Complaints	42	78
Convictions	134	263
Pretrial Diversions and Deferred Prosecutions	17	38
Administrative Investigations Opened	2	6
Administrative Investigations Closed	8	9
Administrative Sanctions and Corrective Actions	242	498
Cases Opened[4]	384	804
Cases Closed[5]	444	929
Administrative Summaries of Investigation[6]	10	78

Hotline Activities	Apr-Sept	FY
Contacts	17,899	38,076
Cases Opened	645	1,177
Cases Closed[7]	631	1,263
Administrative Sanctions and Corrective Actions[8]	475	870
Substantiation Percentage Rate[9]	40	39
Individuals Claiming Retaliation/ Seeking Whistleblower Protection[10]	60	60
Individuals Provided Office of Special Counsel Contact Information[11]	46	46
Individuals Provided Merit Systems Protection Board Contact Information[12]	3	3
Individuals Provided Office of Resolution Management Contact Information[13]	93	93

Statistical Highlights

Reports and Work Products	Apr-Sept	FY
Reports Issued		
Audits and Evaluations	29	44
Benefits Inspections	1	5
Joint Reviews	0	1
Peer Reviews of Other OIGs	0	1
National Healthcare Reviews	8	10
Hotline Healthcare Inspections	23	38
Combined Assessment Program Reviews	14	39
Community Based Outpatient Clinic Reviews[14]	15	36
Administrative Investigations	3	3
Preaward Contract Reviews	40	78
Postaward Contract Reviews	14	39
Claim Reviews	4	10
Subtotal	**151**	**304**
Work Products		
Administrative Investigation Advisories	4	4
Administrative Investigation Closures	0	0
Audit Work Products	24	29
Healthcare Closures	0	0
Subtotal	**28**	**33**
Total Reports and Work Products	**179**	**337**

Healthcare Inspections Activities	Apr-Sept	FY
Clinical Consultations	**14**	**21**

1. The 6-month operating cost for the Office of Healthcare Inspections ($10.2 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 10 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, 11, 12, & 13. OIG began reporting the OIG Whistleblower Ombudsman contact information in this reporting period. Contacts in previous reporting periods were not included.
14. Encompassing 94 facilities for the 6-month period.

Glossary

ADA	*Americans with Disabilities Act*
AFR	Agency's Financial Report
AIG	Assistant Inspector General
BVA	Board of Veterans Appeals
C&P	Compensation and Pension
CAP	Combined Assessment Program
CAVHCS	Central Alabama VA Health Care System
CBOC	Community Based Outpatient Clinic
CCL	Cardiac Catherization Laboratory
CDC	Centers for Disease Control and Prevention
CEA	Criminal Enforcement Agreement
CID	Criminal Investigation Division
CLC	community living center
COE	Center of Excellence
COS	Chief of Staff
CRC	colorectal cancer
CT	cardiothoracic
DCIS	Defense Criminal Investigative Service
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DOJ	Department of Justice
DOL	Department of Labor
EHR	electronic health record
eCMS	Electronic Contract Management System
ED	emergency department
EOC	Environment of Care
FAR	Federal Acquisition Regulation
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FSS	Federal Supply Schedule
FY	fiscal year
HCS	Health Care System
IG	Inspector General
IOP	Integrated Oversight Process
IPERA	*Improper Payments Elimination and Recovery Act*
IRS	Internal Revenue Service
ISO	Information Security Officer
IT	information technology
LOS	length of stay
MRI	magnetic resonance imaging
MSI	Mortgage Security, Inc.
NCA	National Cemetery Administration
NECC	New England Compounding Center
NOD	notice of disagreement
NYHHS	New York Harbor Healthcare System
OAE	Office of Audits and Evaluations
OALC	Office of Acquisitions, Logistics, and Construction
OAR	Office of Accountability Review
OHI	Office of Healthcare Inspections
OI	Office of Investigations
OIG	Office of Inspector General
OIT	Office of Information and Technology
OLSCM	Office of Logistics and Supply Chain Management
OM	Office of Management
OMB	Office of Management and Budget
OR	operating room
OSP	Office of Operations, Security, and Preparedness
P.L.	Public Law
PACT	Patient Aligned Care Team
PAR	Performance and Accountability Report
PC	primary care
PC3	Patient-Centered Community Care
PCP	primary care provider
PII	personally identifiable information
PMAS	Project Management Accountability System

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PMC	Pension Management Center
PSS	peer support services
PTSD	post-traumatic stress disorder
QM	quality management
QRT	Quality Review Team
RME	reusable medical equipment
RMO	Records Management Officer
RPO	Regional Processing Office
SCO	school certifying official
SDE	Service, Delivery, and Engineering
SDVOSB	Service-Disabled Veteran-Owned Small Business
SMC	special monthly compensation
SPS	sterile processing service
SSA	Social Security Administration
SSVF	Supportive Services for Veteran Families
TAC	Technology Acquisition Center
TBI	traumatic brain injury
TV	television
UCC	urgent care clinic
USB	Under Secretary for Benefits
USH	Under Secretary of Health
USPIS	United States Postal Inspection Service
USPS	United States Postal Service
VAAA	Veterans Affairs Acquisition Academy
VACOLS	Veterans Appeals Control and Locator System
VALU	VA Learning University
VAMC	VA Medical Center
VANJHCS	VA New Jersey Health Care System
VAPIHCS	VA Pacific Islands Health Care System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VJO	Veterans Justice Outreach
VLJ	Veterans Law Judge
VOA	Volunteers of America
WDVA	Wisconsin Department of Veterans Affairs

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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 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 Office of Investigations
§ 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 Office of Investigations

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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) (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 $168.8 billion budget, with over 369,000 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.

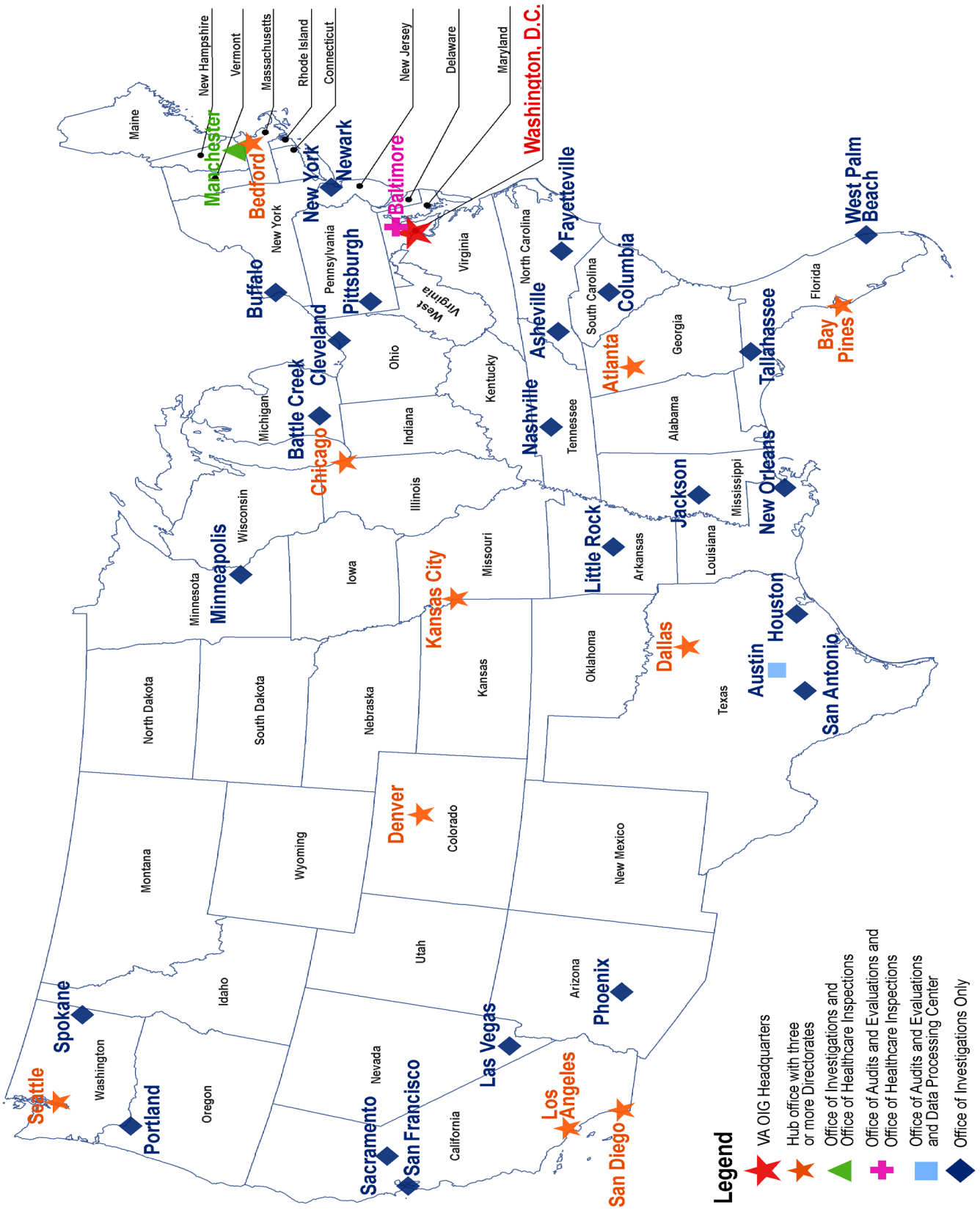
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

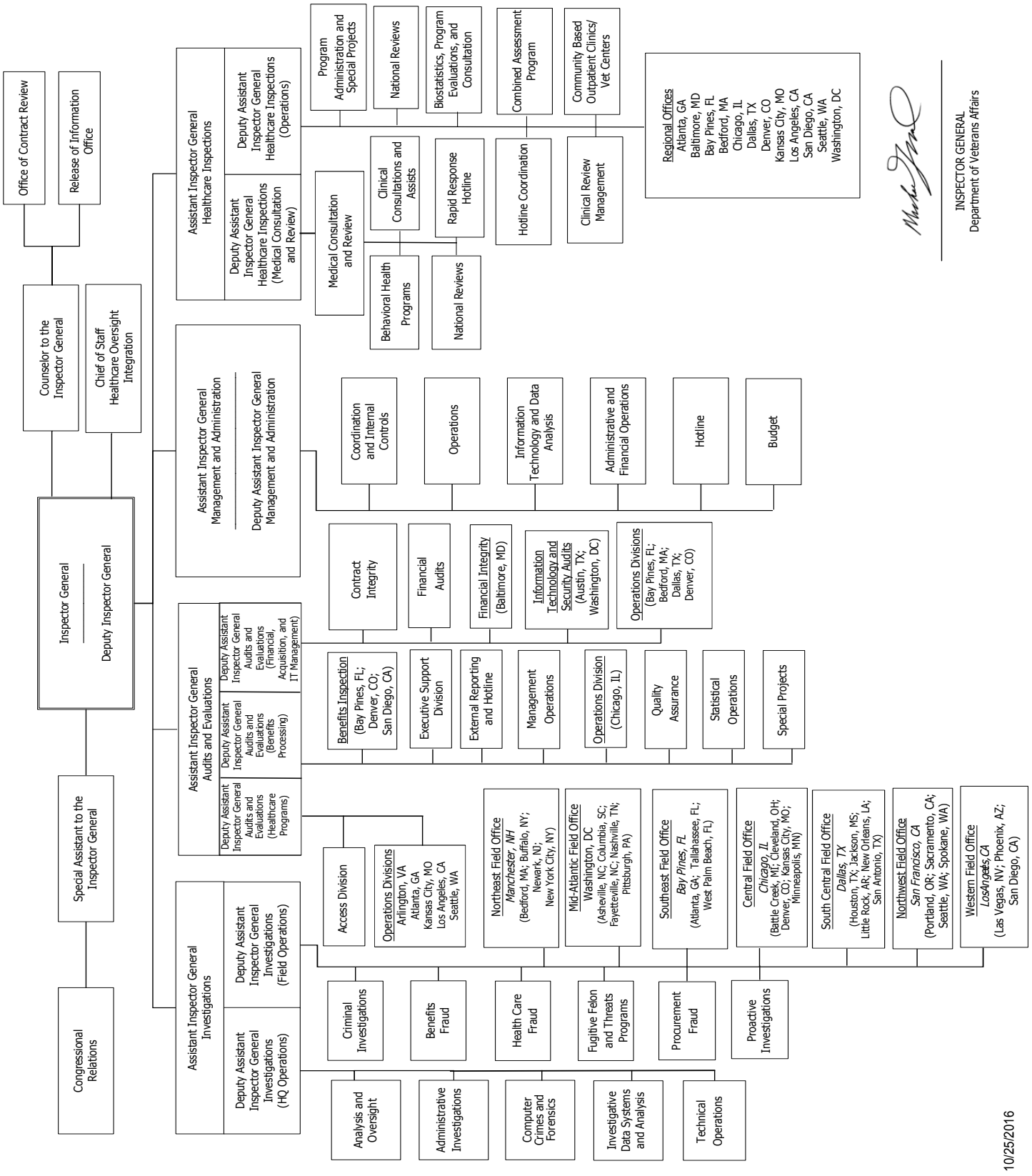
The Office of Inspector General's (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, and investigations. OIG was administratively established on January 1, 1978, to consolidate audits and investigations 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 692 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 26 employees, received $4.4 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS), 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 8 national healthcare reviews; 23 Hotline healthcare inspections; 14 Combined Assessment Program (CAP) reviews; and 15 Community Based Outpatient Clinic (CBOC) reviews, covering 94 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 14 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 six CAP summary reports, which are highlighted in the National Healthcare Reviews section. The Deputy IG notified Congress that OIG planned to stop work on the CAP program for 6 months to assign more staff to complete allegations received by the OIG Hotline. This workload increased significantly after OIG issued its Access to Care Reports of the VA Health Care System (HCS) in Phoenix, AZ.

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 all outpatient clinics, including 94 CBOCs that reported to 15 parent facilities and 11 Veterans Integrated Service Networks (VISNs). Site visits were made and physical inspections were performed at 15 of these CBOCs. These reviews are captured in 15 reports. The topics covered this reporting period include: EOC, Outpatient Lab Results Management, Home Telehealth Enrollment, and Post-Traumatic Stress Disorder (PTSD) care.

National Healthcare Reviews

OIG Determination of VHA Occupational Staffing Shortages

OIG conducted its third determination of VHA occupations with the largest staffing shortages as required by P.L. 113-146, *Veterans Access, Choice, and Accountability Act of 2014*. OIG analyzed VHA facility rankings of critical occupations, to interpret "largest staffing shortages." This is a broader deliberation than simply the number needed to replace or backfill vacant positions. OIG performed a rules-based analysis on VHA data to identify these occupations, analyzed data on gains and losses for occupations with the largest staffing shortages, and assessed VHA's progress with implementing staffing models. OIG determined that the largest critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, Physical Therapist, and Medical Technologist. Because of a tie for 5th place, OIG identified six occupations in our determination. OIG's analysis of the staffing gains and losses for the first full year after implementation of P.L. 113-146, *Veterans Access, Choice, and Accountability Act of 2014* shows that for critical need occupations, a significant percentage of the total gains continues to be offset by staff losses. OIG also determined that the percentage of regrettable losses to total onboard staff in many critical need occupations was high relative to net increases in onboard staff. While VHA has made progress in developing and implementing staffing models, OIG did not identify a plan that included a set of milestones and timelines for further staffing model development to achieve full implementation. VHA has a draft report on staffing models which is pending presentation to senior leadership. OIG made four recommendations, two of which are repeat recommendations.

CAP Summary Report on the Evaluation of Advance Directives in VHA Facilities

OIG completed an evaluation of advance directives in VHA facilities. The purpose of the review was to determine whether VHA facilities complied with selected requirements for advance care planning and advance directives for veterans. OIG conducted this review at 48 VHA medical facilities during CAP reviews performed across the country from April 1, 2015, through March 31, 2016. OIG observed many positive practices, including that facilities had policies addressing advance directive notification, screening, and discussions; employees generally screened inpatients to determine whether they had advance directives; and the advance directive posting in the electronic health record (EHR) generally reflected patients' advance directive statuses. However, OIG identified system weaknesses regarding advance directive discussions and documentation thereof. OIG made two recommendations.

CAP Summary Report on the Evaluation of Emergency Airway Management in VHA Facilities

This evaluation assessed compliance with selected VHA requirements related to emergency airway management performed outside of a facility's operating room. OIG performed this evaluation in conjunction with 55 CAP reviews conducted from October 1, 2014, through September 30, 2015. Although OIG noted high compliance in many areas, including that facilities' policies incorporated most required components, facilities designated a subject matter expert consistent with VHA requirements, and videolaryngoscopes were readily accessible in designated facility locations, OIG identified opportunities for improvement and made seven recommendations.

CAP Summary Report on the Evaluation of Safe Medication Storage Practices in VHA Facilities

This evaluation determined whether facilities established safe medication storage practices in accordance with applicable VHA policy and Joint Commission standards. OIG performed this evaluation in conjunction with 54 CAP reviews conducted from October 1, 2014, through September 30, 2015. Although OIG noted high compliance in several areas, including that facilities maintained a list of look-alike and sound-alike

medications they stored, dispensed, and administered and that patient care areas were free from multi-dose high concentration heparin, potassium chloride vials for injection, and multi-dose insulin pens, OIG identified opportunities for improvement and made four recommendations.

CAP Summary Report on the Evaluation of Coordination of Inpatient Consults in VHA Facilities

This review evaluated the consult management process and the completion of clinical consults that clinicians order and expect to be completed during inpatient admissions. OIG performed this review at 54 VHA medical facilities during CAP reviews performed across the country from October 1, 2014, through September 30, 2015. Although OIG observed many positive practices, including oversight committees implementing corrective actions when they identified opportunities for improvement, requesters stating adequate reasons for consult requests, and consultants generally addressing the reasons for the consults, OIG identified an opportunity for improvement and made one recommendation.

CAP Summary Report on the Evaluation of Quality Management in VHA Facilities for Fiscal Year 2015

This evaluation determined whether VHA facility senior managers actively supported quality management (QM) efforts and appropriately responded to QM results and whether VHA facilities complied with selected requirements related to QM activities. OIG conducted this review at 56 VHA medical facilities during CAP reviews performed across the country from October 1, 2014, through September 30, 2015. Although all 56 facilities had established QM programs and performed ongoing reviews and analyses of mandatory areas, OIG identified opportunities for improvement and made five recommendations.

CAP Summary Report on the Evaluation of Surgical Complexity Support Services in VHA Facilities

This review determined whether VHA facilities complied with selected requirements to provide support services for their designated surgical complexity level and to assess whether employees had documented competencies to provide certain services after operational hours. OIG conducted this review at 41 VHA medical facilities during CAP reviews performed across the country from October 1, 2014, through September 30, 2015. OIG observed high compliance with requirements to provide basic laboratory and radiology coverage as well as 12-lead electrocardiograph service. As the individual facility CAP reports were published, the VHA National Surgery Office was proactive in addressing problems and made several positive changes. OIG identified an opportunity for improvement and made one recommendation.

CBOC Summary Report on the Evaluation of Alcohol Use Disorder Care at CBOCs and Other Outpatient Clinics

This systematic review of VHA's CBOCs and other outpatient clinics evaluated compliance with selected VHA requirements regarding alcohol use screening and follow-up in the primary care setting. OIG conducted this focused review at 56 VA medical centers (VAMCs) through the evaluation of the EHRs of 2,088 patients who had positive scores of 5 and above on the Alcohol Use Disorders Identification Test during July 1, 2013, through June 30, 2014. The objectives were to determine whether outpatient clinics (CBOCs, primary care clinics, and other outpatient clinics) complied with the requirements to provide: (1) further assessment of patients with a positive alcohol screen to determine the level of misuse; (2) education and counseling for patients who identified consumption exceeding National Institute on Alcohol Abuse and Alcoholism guidelines; (3) brief motivational counseling, referral to specialty providers, or other interventions for patients whose excessive alcohol use was persistent; (4) brief treatments for alcohol use disorder through face-to-face, tele-mental health, or phone

encounters within 2 weeks of the time that the positive screen is completed; and (5) Patient Aligned Care Team (PACT) clinical staff training in motivational interviewing and National Center for Health Promotion and Disease Prevention health coaching within 12 months of appointment to the PACT. OIG recommended that: (1) clinic staff complete diagnostic assessments for patients with a positive alcohol screen, (2) clinic staff document the offer of further treatment to patients diagnosed with alcohol dependence, (3) clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care, (4) clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to PACTs, and (5) clinic providers and clinical associates receive health coaching training within 12 months of appointment to PACTs.

Hotline Healthcare Inspections

Alleged Inappropriate Opioid Prescribing Practices, Rutherford County CBOC, Rutherfordton, North Carolina

OIG conducted an inspection in response to complaints about inappropriate opioid prescribing practices at the Rutherford County CBOC, Rutherfordton, NC, associated with the Asheville VAMC, Asheville, NC. OIG did not substantiate that CBOC primary care physicians were being forced to write prescriptions for opioids. However, during OIG's review, we noted the clinical and administrative environment in which CBOC providers prescribed opioids and managed the pain-related needs of their patients and found several processes that negatively impacted the delivery of quality patient care. OIG recommended that the Facility Director ensure that: (1) primary care physicians are able to assess, treat, monitor, and reassess patients on chronic opioid therapy within the appropriate timeframe; (2) the Veterans' Integrated Pain Management Clinic meets non-opioid pain management needs of patients as evidenced by timely consultation completions; (3) clinical and administrative demands of chronic opioid therapy care are considered when determining appropriateness of primary care physician staffing and that staffing plans are in place for planned and unplanned provider vacancies and absences; (4) benzodiazepine appropriateness evaluations are completed as required for chronic opioid therapy patients with PTSD; (5) primary care and mental health providers communicate and coordinate care for PTSD patients receiving both opioids and benzodiazepines; and (6) regular communication occurs between facility leadership and CBOC leadership to support consistent high quality care.

Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VAMC, Spokane, Washington

OIG conducted an inspection at the request of Senator Patty Murray at the Mann-Grandstaff VAMC, Spokane, WA, in response to allegations of failures in Emergency Department (ED) care, mental health services, and suicide prevention training. OIG did not substantiate a failure to actively recruit and retain qualified ED providers. OIG did not substantiate that the VAMC's change from an ED to an Urgent Care Clinic (UCC) with a reduction in operating hours resulted in a deficiency in care. OIG determined that the VAMC was thoughtful in planning an approach to align the delivery of care with resources thereby reducing the potential for adverse events after the loss of ED providers. VAMC leaders took steps to inform the public before changing to a UCC and tracked after-hour attempts to access care once the change occurred. OIG did not substantiate that quality of care issues contributed to the death by suicide of a patient. OIG determined that from the time of his initial contact until his last contact with the VAMC's mental health staff, the patient was assessed by an interdisciplinary team for risk of suicide and determined to be not at risk for self-harm. OIG substantiated that VAMC leaders failed to comply with VHA requirements for suicide prevention training. OIG found that not all health care providers who required training had completed the Suicide Risk Assessment for Clinicians course

within the required first 90 days of hire and the VAMC lacked a process to assign and track the required training that has since been resolved. Only three staff were delinquent in completion of the training as of May 17, 2016. At the time of publication, OIG closed the recommendation that the Interim VAMC Director strengthen processes to ensure suicide prevention training is completed per VHA requirements and monitor compliance.

Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA HCS, Bay Pines, Florida

OIG conducted an inspection at the request of Congressman Daniel Webster to assess the merit of allegations that staff inappropriately restrained a patient both physically and chemically; failed to provide anticoagulation medications (Coumadin), fluids, food, and nursing/medical care; and failed to effectively communicate with the patient's family at the Bay Pines HCS (facility), Bay Pines, FL. OIG found that the patient was not inappropriately restrained during a computed tomography scan. Computed tomography technicians placed straps during the procedure for patient safety and to avoid sudden patient movement. OIG substantiated that during his ED and inpatient stay, the patient was physically restrained on three occasions due to his combativeness and attempts to interfere with medically necessary treatments. Nursing documentation of the use of restraints was consistent with facility policy; however, OIG did not find a physician's order for the episode of restraint use when in the ED. OIG did not substantiate that the patient failed to receive care. The patient was admitted to a constant observation room on a medical unit. Staff was continuously present to immediately assist the patient if needed. OIG did not substantiate that the patient was not provided Coumadin because the facility did not have the medication in stock. The patient's medication administration records showed appropriate adjustments of the times and doses of Coumadin. OIG substantiated that two patient advocates failed to act professionally when communicating with the patient's family. OIG did not substantiate that facility staff refused to release the patient's EHR to the family or that the EHR was altered. OIG substantiated that facility staff failed to effectively communicate with the patient's family on multiple occasions.

Quality of Care Concerns in the Management of a Hepatitis C Patient, Grand Junction Veterans HCS, Grand Junction, Colorado

OIG assessed quality of care concerns in the management of a Hepatitis C patient at the Grand Junction Veterans HCS, Grand Junction, CO. OIG substantiated the allegation that follow-up care was inadequate and led to further hospitalization. The Hepatitis C Care Provider often did not provide the care or assess the patient thoroughly when seen. The circumstances of discontinuity of care and the lack of a thorough analysis of the patient's condition may have contributed to his progressive decline and slower recovery. Although not part of the original allegations, OIG also found that contingency plans were not in place to account for reduced availability of the Hepatitis C Care Provider as he started to decrease his hours. OIG did not substantiate that a non-qualified physician provided Hepatitis C treatment. Neither VA policy nor general practice regarding physicians' credentialing and privileging, ongoing professional practice evaluations, and documentation of education hours require that clinicians have specific evidence of competency to manage Hepatitis C patients. OIG did not substantiate that the patient should have been admitted earlier to the hospital based on laboratory results. OIG found that the patient had an elevated ammonia level that was acknowledged timely and appropriately treated with medication. OIG made one recommendation.

Alleged Improper Management of Dermatology Requests, Fayetteville VAMC, Fayetteville, North Carolina

OIG reviewed allegations that dermatology appointments and consults were improperly cancelled or discontinued in 2011–2012 at the direction of the Director and Chief of Staff at the Fayetteville VAMC (facility), Fayetteville, NC. OIG substantiated that 1,993 dermatology clinic appointments were cancelled and that

3,272 dermatology consults were cancelled or discontinued between January 2011 and December 2012. OIG reviewed 344 randomly selected patient EHRs and found that 86 percent of patients with cancelled appointments, who still required dermatology care, received care; however, 30 percent waited more than 3 months, and some waited more than 1 year. OIG found no evidence that 45 patients received dermatologic care after their appointments were cancelled. OIG reviewed 299 randomly selected patient EHRs and found that while 65 percent of patients with cancelled or discontinued consults, who still required dermatology care, received care, the average wait time was about 13 months. OIG found no evidence that 89 patients received dermatologic evaluation or care after the consults were cancelled or discontinued. A look-back of patients with diagnosed skin malignancies did not disclose cases where cancelled or discontinued dermatology consults in 2011–2012 negatively impacted patients' subsequent diagnoses or treatment. OIG could not substantiate that facility leadership improperly instructed employees to cancel dermatology appointments. Staff OIG interviewed did not report instances when they were instructed to cancel dermatology appointments without consideration for patients' needs. For the cases reviewed, OIG did not identify instances where patients experienced clinically significant delays in diagnosis or treatment. A shortage of dermatologists at the facility in 2011–2012 contributed to the appointment scheduling and consult completion delays. The facility has since hired additional dermatology providers at its Wilmington location and continues to use teledermatology and Non-VA Care Coordination to meet demand. OIG made two recommendations.

Operating Room Concerns, Marion VAMC, Marion, Illinois

OIG reviewed whether leadership responded to complaints at the Marion VAMC (facility), Marion, IL, that the vacuum suction in the operating room (OR) was not adequate for safe patient care and that patients were harmed as a result of inadequate vacuum suction. OIG did not substantiate that facility leadership failed to respond to complaints regarding insufficient vacuum suction in the OR. Facility leadership initiated multiple actions. OIG did not substantiate that the vacuum suction was unacceptable for safe airway management. In mid-June 2014, testing showed the vacuum suction was meeting the Advanced Cardiovascular Life Support guideline recommendation. OIG did not substantiate the allegation that three patients were harmed as a result of inadequate vacuum suction in the OR. The allegation did not specifically identify the patients who had reportedly been harmed. OIG identified one patient with similar clinical circumstances as one of the three patients described in the allegation. OIG interviewed staff who were involved in the patient's procedure who indicated that, for this patient, the vacuum suction level was adequate. OIG were unable to identify the other two patients who may have suffered harm as alleged. While not part of the original complaint, OIG found inconsistent documentation of repairs and follow-up testing of the facility's medical gas system. On September 22, 2015, OIG requested and subsequently reviewed 4 quarters of the facility's engineering service monitoring tool showing implementation of the action plan to monitor the medical gas system in the OR and post-anesthesia care unit. Because the facility had initiated activities to review the finding and implemented action items, OIG made no recommendations.

Evaluation of Reported Wait Times, VA Greater Los Angeles HCS, Los Angeles, California

OIG evaluated the accuracy of reported wait times at VA Greater Los Angeles HCS, Los Angeles, CA, for January and March 2015, at the request of Senator David Vitter. The first objective was to evaluate whether information presented in a February 3, 2016, letter from Secretary Robert A. McDonald to Senator Vitter (Secretary's letter) accurately represented wait times at the VA Greater Los Angeles HCS. The second was to explain the discrepancies between reported wait times in the Secretary's letter and what CNN reported on March 14, 2015. VHA generates a number of measures that collectively provide a comprehensive view of appointment wait times. To avoid the perception of misrepresentation of wait times, it is imperative that VA, the media, and others clearly indicate both the source of the data and the type of wait time measure being referenced. OIG found the wait times reported in the Secretary's letter were generally consistent with VHA's historical wait time data. With

respect to the January 2015 completed appointment wait times for new and established patients, OIG noted differences of less than 1 day between the two data sources. OIG concluded that those small differences are likely due to the fact that the information used in the Secretary's letter was from February 5, 2015, and wait time data were not finalized in VA's centralized data repository until February 14, 2015. With respect to the March 2015 completed appointment wait times for new patients for primary care, those data were consistent with VHA's historical wait time data. OIG found that discrepancies between information contained in the Secretary's letter and CNN's article were likely the result of (a) the CNN authors' inaccurate assertion that appointments and consults are synonymous and (b) the Secretary and CNN authors referenced different wait time measures. OIG made no recommendations.

Access and Quality of Care Concerns, Phoenix VA HCS, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA HCS, Minneapolis, Minnesota

At the request of Congressman Tim Walz, OIG inspected the Phoenix VA HCS, Phoenix, AZ, for allegations regarding wait times in the ED, cleanliness, the Allergy Clinic, the VA Police Department, outpatient pharmacy services, and primary care provider (PCP) assignment. An additional allegation at the Minneapolis VA HCS in Minneapolis, MN, involved test result notification. OIG substantiated the length of stay (LOS) patients experienced on a day in 2015 was the longest ED patients experienced from March 1, 2014, through March 31, 2015. The Phoenix VA HCS' ED median wait time (190 minutes) for the period reviewed did not exceed the VHA's LOS threshold. OIG determined an effective mechanism was not in place to recognize episodic, increased demand to adjust processes. OIG substantiated examination areas separated by curtains created a risk for inadvertent protected health information disclosure and patients brought to the Radiology Department from the ED were not always supervised. OIG identified an opportunity for improvement regarding timeliness of prescription delivery for discharged ED patients. OIG substantiated some Phoenix VA HCS treatment and public areas were not clean. OIG determined Environmental Management Services' understaffing was a contributing factor. OIG substantiated Allergy Clinic staff did not consistently dispose of oral temperature probe covers properly. OIG could not substantiate the allegation that a VA police officer mishandled a veteran. OIG substantiated the Phoenix VA HCS pharmacy should have provided the patient a recommended medication or appropriate substitution. OIG substantiated the patient was not assigned a PCP at the Phoenix VA HCS; however, he was assigned a PCP at the Minneapolis VA HCS. OIG substantiated Minneapolis VA HCS staff did not ensure the patient received magnetic resonance imaging (MRI) results within 14 days, as required. OIG made ten recommendations.

Alleged Patient Safety Concerns, Miami VA HCS, Miami, Florida

OIG conducted an inspection at the request of Chairman Jeff Miller, Committee on Veterans' Affairs, U.S. House of Representatives, and Chairman Mike Coffman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives. The OIG team assessed allegations that the Miami VA HCS (system), Miami, FL, lacked adequate patient safety policies and procedures to safeguard patients when they "come and go" from the Community Living Center (CLC) and whether additional safety measures could have prevented a patient's suicide. OIG did not substantiate the allegation that the CLC lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. OIG found that the system had policies and procedures addressing various aspects of patient safety in the CLC. However, OIG found that system staff did not consistently enforce certain policies and procedures when the patient did not comply with them. OIG could not substantiate the allegation that the system should have instituted additional safety precautions given the patient's past medical and mental health history. However, OIG identified additional potential suicide risk factors known to at least one staff member that were not documented or discussed in the CLC Interdisciplinary Team meetings. OIG also found that staff did not initiate an Integrated Ethics consult, which could have been done to assist them and the patient in making informed decisions and applying

appropriate health care ethics standards regarding medical care, treatment, and patient autonomy. By failing to consistently enforce certain policies and procedures and initiate an Integrated Ethics consult, system staff missed opportunities to intervene with this patient. Although a system internal review addressed some specific issues pertaining to patient care, it did not reflect and document an in-depth exploration of possible event causes. OIG made four recommendations.

Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VAMC, Mountain Home, Tennessee

OIG conducted an inspection at the request of Senator Lamar Alexander and Congressman John Duncan to assess allegations of mental health service concerns at the Knoxville VA Outpatient Clinic, Knoxville, TN, which is part of the James H. Quillen VAMC (facility), Mountain Home, TN. OIG substantiated the allegation that facility managers did not have Peer Support Services (PSS) available to veterans at the Clinic for several years. OIG did not substantiate the allegation that the PSS Specialist hired by the Clinic was expected to provide PSS related functions for groups hosted by the Knoxville Regional Mental Health Council (Council). OIG substantiated that patients were discharged from a non-evidence based PTSD group without immediate PSS follow-up. OIG substantiated the allegation that facility managers delayed hiring a Veterans Justice Outreach (VJO) Specialist to service veterans in Knox County and surrounding counties. OIG did not substantiate the allegation that medication confirmation requests take 3–5 days for incarcerated veterans. OIG did not substantiate the allegation that facility and Clinic managers failed to uphold agreements with the Council regarding: (1) providing meeting space for the group hosted by the Council, (2) sponsoring PSS facilitator training for members of the Council, and (3) providing travel pay for Council group members. OIG recommended that the Facility Director improve processes for communicating with community-based consumer-run groups that provide mental health services to veterans enrolled at the Clinic and ensure the Clinic's VJO Specialist provides comprehensive services including outreach for veterans in Knox County and surrounding counties in accordance with VHA policy.

Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA HCS, Oklahoma City, Oklahoma

At the request of former Senator Tom Coburn and an anonymous complainant, OIG conducted reviews to evaluate the alleged closure of the Cardiothoracic (CT) Surgery program and assess Cardiac Catheterization Laboratory (CCL) medication administration and Omnicell® medication dispensing system access issues at the Oklahoma City VA HCS, Oklahoma City, OK. OIG did not substantiate that the VA HCS closed the CT surgery program. Rather, VAHCS leadership paused CT surgeries in order to evaluate the program following patient deaths. OIG did not substantiate the allegation that CCL nurses administered medications to patients in the CCL without a physician's order or that the two patients OIG reviewed suffered harm related to CCL medication administration practices. OIG could not substantiate that a nurse manager had staff passwords to the Omnicell® and could use the passwords to access and remove medications under another nurse's account. In response to this request and additional requests from Senator James Inhofe, OIG is continuing work to evaluate the VA HCS' QM program, analyze data from VA's Strategic Analytics for Improvement and Learning Value Model report, and follow up on the results of an Employee Assessment Review survey. OIG's results from these reviews will be addressed in a future report. OIG made no recommendations.

Review of Primary Care Ghost Panels, VISN 23, Eagan, Minnesota

OIG conducted an inspection in response to allegations received by Congressman Timothy J. Walz regarding whether some primary care (PC) panels at facilities within VISN 23 were ghost panels. The term "ghost panel" is VA wording used to describe patients assigned to PC providers who were not actively providing care, such as a provider who retired or resigned. OIG found that 4 of 674 (0.6 percent) PC panels in VISN 23 were ghost

panels. In total, 2,301 of 287,095 (0.8 percent) of active PC patients in VISN 23 were assigned to one of those panels. The Iowa City VA HCS and VA Black Hills HCS each had two ghost panels. OIG did not identify PC ghost panels at the other VISN 23 facilities. The existence of PC ghost panels in VISN 23 is inconsistent with VHA policy, which requires patients to be reassigned or redistributed to other PC teams when PC providers discontinue employment. However, OIG did not identify a negative impact on patients since the facilities had enacted efforts to ensure ongoing patient care for patients assigned to the PC ghost panels. OIG recommended that the VISN 23 Acting Director ensure that facility Directors reassign or redistribute PC patients to other PC teams as required by VHA and monitor compliance.

Reported PC Staffing Concerns at St. Cloud VA HCS, VISN 23, Eagan, Minnesota

OIG assessed allegations made regarding a September 14, 2015, letter from the VISN 23 Acting Director to Congressman Timothy J. Walz concerning PC at the St. Cloud VA HCS, St. Cloud, MN. While OIG substantiated that part of the VISN 23 response did not accurately represent HCS gains and losses of physicians and mid-level providers, it appeared to be an inadvertent error. OIG substantiated that the VISN 23 response inaccurately represented PCP panel sizes at the HCS. The reported average PC panel size was based upon a simple average of panel sizes across all HCS providers and did not include adjustment for factors such as whether the provider was a part-time employee. OIG found that most PCPs had panel sizes outside VHA expected panel sizes range, which affects the timeliness of patients seeing a provider. OIG also reviewed the accuracy of data provided in a response from the VISN to the OIG Hotline Case at issue. OIG found that the HCS-reported average panel size for November 2013 was generally accurate compared to the historical PC Management Module data for November 2013.

Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA HCS, Minneapolis, Minnesota

OIG conducted an inspection in response to allegations received by Congressman Timothy J. Walz concerning the Psychiatry Partial Hospitalization program and management concerns at the Minneapolis VA HCS, Minneapolis, MN. OIG did not substantiate the allegation that patients in the Psychiatry Partial Hospitalization program who were diagnosed in the community, military, or through the compensation and pension process with mental health, substance use, or PTSD diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong. Since the complainant was anonymous, OIG was unable to clarify the allegation or identify specific patients or services that may have been the subject(s) of the complaint. OIG could not substantiate the allegation that psychologists were performing inappropriate psychological testing on patients in the Psychiatry Partial Hospitalization program to meet productivity numbers. OIG could not substantiate the allegation that supervisory staff were absent in their leadership roles and were not trained in the areas they supervised.

Diagnosis and Treatment of a Patient's Adrenal Insufficiency at a Virginia VAMC

OIG conducted a review to assess allegations of misdiagnosis of Addison's disease and adverse outcomes resulting from long-term steroid treatment in a patient with multiple medical problems. OIG substantiated that the patient's EHR problem list first reflected the patient had Addison's disease in 2004 although laboratory tests did not support this diagnosis. The patient received steroid medications after developing signs and symptoms of adrenal insufficiency in 2004. Because steroid medication was the appropriate treatment option for adrenal insufficiency that was caused by either Addison's disease or another disease process, the patient received appropriate care at the time the steroids were initially started. Between 2004 and 2006, VA providers were not able to assure routine follow-up of the patient's condition due to irregular use of health care services. When the patient re-established routine care with a VA PCP in 2007, actions should have been taken to reassess the patient and confirm the adrenal disease-related diagnosis. Ultimately, a comprehensive evaluation of the patient's medical history, co-occurring conditions, laboratory and imaging tests, and medication actions and

interactions was completed in 2012 and an endocrinologist was able to wean the patient off chronic steroid therapy. OIG could not substantiate the allegation that the patient experienced adverse health events including avascular necrosis of the hip joints solely as a result of prolonged steroid treatment for adrenal insufficiency. The patient had a complex medical history, and OIG believes the most likely cause of the avascular necrosis and need for bilateral hip replacement was a combination of long-term steroid use and the various treatments used to manage his other comorbidities.

Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas HCS, Dallas, Texas

OIG conducted a review to determine if system leadership took appropriate administrative actions in response to reports of deaths and quality of care irregularities at the Dallas VAMC, part of the VA North Texas HCS. OIG substantiated that in 2012, a patient died after sustaining head trauma from a fall in the Radiology Department. OIG found HCS leadership had investigated the incident and disclosed the fall to the patient's family. OIG identified quality of care concerns related to the timely completion and interpretation of imaging study results for the patient. OIG substantiated that in 2011, a patient died following baptism in a VAMC pool. OIG found the HCS conducted a review of the incident. However, OIG found HCS leadership did not follow up on an ethics consultation recommendation that the VAMC consider revising its "Do Not Resuscitate" policy to include re-addressing the status of "Do Not Resuscitate" orders with patients prior to any hospital procedures. OIG substantiated that in 2012, a VAMC employee died of an overdose and a patient died of a self-inflicted gunshot wound in facility restrooms. Related to the overdose death, OIG found HCS leadership did not improve employee drug testing procedures. OIG substantiated that in 2013, an employee was injured during transport of a patient undergoing cardiopulmonary resuscitative effort. OIG did not substantiate that the patient being resuscitated fell from a gurney during the resuscitative efforts. OIG found HCS leadership was apprised of these events, had conducted internal reviews, and taken appropriate actions. OIG did not substantiate poor wound care during the site visit. Nevertheless, in 2012, HCS staff identified an increase in pressure ulcer prevalence and implemented several new initiatives with positive outcomes. OIG also found no evidence that licensed vocational nurses were administering intravenous medications.

Alleged Manipulation of Outpatient Appointments, Central Alabama VA HCS, Montgomery, Alabama

OIG reviewed an allegation that clinics cancelled appointments 30 minutes prior to the appointments, indicating manipulation of performance measures at Central Alabama VA Health Care System (CAVHCS), Montgomery, AL. OIG did not substantiate the allegation that clinics cancelled appointments 30 minutes prior to the appointments in an attempt to manipulate performance measures. OIG randomly selected and reviewed 276 EHRs for patients with appointments cancelled by selected clinics prior to appointment times during the 1st and 2nd quarters of FY 2015. OIG found that two appointments were cancelled within 30 minutes of the scheduled appointment times; both patients had subsequent visits within 14 days of the appointment dates. OIG found that of 42 same-day clinic cancellations, 39 (93 percent) appointments were rescheduled; however, 26 (67 percent) appointments were not rescheduled within 14 days of the original appointment date. Although some appointments were not rescheduled "timely," OIG found that 267 (97 percent) appointments were rescheduled and that 253 (95 percent) rescheduled appointments resulted in completed visits. OIG did not find indications in the EHRs reviewed that the cancellations were suspicious. OIG did not identify suspicious patterns or trends in CAVHCS-wide data that could indicate non-compliance with VHA scheduling guidelines. Further, as CAVHCS has consistently performed in the bottom 20 percent of all VHA facilities in access to care measures, it appears less plausible that staff participated in large-scale, coordinated efforts to manipulate appointment times.

Colorectal Cancer Screening Practices, Charlie Norwood VAMC, Augusta, Georgia

OIG conducted a review to assess the merit of allegations involving Colorectal Cancer (CRC) screening practices at the Charlie Norwood VAMC in Augusta, GA. OIG substantiated that patients over the age of 50 were only being scheduled for preventative [screening] colonoscopies if blood was detected in their stools; however, OIG did not substantiate the implied inappropriateness of this process for patients with average risk for developing CRC. VHA and the Centers for Disease Control and Prevention (CDC) have identified several effective CRC screening methods, including a fecal occult blood test, for patients at average risk. However, OIG found that facility staff did not fully comply with VHA guidelines on shared decision-making for patients who preferred screening colonoscopies rather than fecal occult blood tests. VAMC managers have since revised the screening colonoscopy consult process. However, VAMC providers did not have a common understanding about the current local process for requesting screening colonoscopies for average risk patients. OIG did not substantiate the allegation that patients have been diagnosed with CRC because they did not receive appropriate preventative [screening] colonoscopies. OIG found that, in general, the patients included in the sample received fecal occult blood tests in accordance with VHA and VISN 7 guidance and CDC guidelines.

Lack of Follow-Up Care for Positive CRC Screening, New Mexico VA HCS, Albuquerque, New Mexico

OIG conducted an inspection in response to allegations concerning the lack of follow-up care for patients with positive CRC screening at the New Mexico VA HCS, Albuquerque, NM. OIG did not substantiate that laboratory staff had a list of 300 patients who had tested positive for fecal occult blood, but no follow-up had been done. OIG determined that laboratory personnel do not keep lists of patients with positive fecal occult results. However, OIG found that laboratory staff flagged positive results in patients' EHR which generated a "view alert" to providers and that providers did not consistently notify patients of positive fecal immunochemical tests (used to determine presence of occult blood) in FYs 2013 and 2014. As a result, some patients did not receive timely follow-up care. OIG identified nine patients diagnosed with CRC who experienced delays and, in some instances, significant delays that may have affected the patients' clinical outcomes. Such delays placed patients at unnecessary risk for adverse outcomes. OIG determined that during FYs 2013 and 2014, the HCS did not have a process in place to monitor provider compliance with CRC screening. In 2012, HCS leaders assigned a registered nurse to follow up on positive fecal immunochemical tests and report to the Chief of Staff monthly. However, the employee transferred from the HCS, and the position had been vacant for over 2 years. OIG found that HCS leaders did not institute processes for monitoring provider compliance with CRC screening and reporting to ensure that patients received timely notification of results and appropriate follow-up care.

Summarization of Select Aspects of the VA Pacific Islands HCS, Honolulu, Hawaii

OIG conducted a review of the VA Pacific Islands Health Care System (VAPIHCS), Honolulu, HI, to collect and summarize supplementary data in support of an August 2015 CAP review and to respond to Senator Mazie K. Hirono's concerns about access to care, travel benefits, cultural diversity, homeless services, and mental health care. OIG reviewed VHA's 6-point plan to address capacity and access to care within VAPIHCS PC clinics. OIG found VAPIHCS has similar administrative and clinician availability issues found across the VA system for non-VA care compounded by a shortage of providers, the complexity of island logistics, and the diversity of the population served. VAPIHCS Beneficiary Travel Program's expenditures are substantial due to providing care for patients across multiple islands. VAPIHCS acknowledged a delay in processing travel benefits claims, but expected to resolve the backlog by January 2016. As of August 2016, all but 21 of the unprocessed claims were resolved. OIG found that while there may be occasions when a provider's management of a situation could potentially lack cultural sensitivity and competence, interviewees did not report this was a wide-spread problem. OIG also found VAPIHCS offers a comprehensive array of services for homeless veterans, a variety of general and specialty mental health services, and has improved staffing in the Suicide Prevention Program. In February 2014, VAPIHCS had one of the highest wait lists VA-wide for patients wanting PC appointments. VAPIHCS

implemented a 6-point plan to increase PC panel sizes, extend clinic hours, increase PC staffing at the CBOCs, contact and schedule appointments for wait-listed veterans, and educate veterans on the importance of keeping appointments or calling to cancel. OIG found VAPIHCS had substantially improved access to care for new patients awaiting PC appointments.

OR Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor HCS, New York, New York

OIG conducted an inspection in response to complaints about OR reusable medical equipment (RME) and Sterile Processing Service (SPS) at the Manhattan Campus of the VA New York Harbor HCS, New York, NY. Following OIG's first site visit, VHA completed external reviews of select components of the OR/SPS program. The HCS made some progress in addressing the recommendations. On a second visit in October 2015, OIG found continued unresolved concerns in aspects of the program. OIG substantiated that some OR RME trays were missing instruments and/or were not properly processed with filters or indicators. OIG found that SPS medical support technicians failed to place external tags on rigid containers or use standardized methods on count sheets. OIG determined there was no significant harm to 14 patients who had SPS-related cancellations or delays of surgeries or other SPS-related concerns during a 5-month period. OIG substantiated that some OR RME containers and packages were heavy and stored above head level, which placed nurses at risk for injury. OIG did not find documentation of training for proper handling of sterile packages for OR staff or a formal process in place to track and trend issues with packages. OIG confirmed that SPS staff were not consistently available in the SPS-OR sterile storage rooms. OIG did not substantiate that OR nurses had to leave patients to get supplies and instruments, creating a dangerous patient care situation. OIG found that SPS staffing levels appeared inadequate and may not support newly expanded hours. OIG found the HCS did not have an effective SPS quality control program and that OR and SPS staff members did not collaborate or communicate well, which created a contentious culture and interfered with resolving problems.

Delay in Care of a Lung Cancer Patient, Phoenix VA HCS, Phoenix, Arizona

At the request of Senator Jeff Flake, OIG determined the merit of allegations regarding a delay in treating a patient diagnosed with lung cancer at the Phoenix VA HCS, Phoenix, AZ. OIG substantiated a delay between the diagnosis of the lung cancer and treatment. OIG could not determine whether this delay impacted the final outcome. OIG substantiated a delay in identification of symptoms of cancer metastasis; however, OIG did not substantiate a delay in treatment once the brain metastasis was discovered. OIG identified lack of patient education and primary care provider involvement in the coordination of subsequent cancer-related specialty appointments as factors contributing to delays in care. OIG did not substantiate the allegation that following his craniotomy there was a failure to communicate the patient's status to the patient and family. The patient and his family received accurate information regarding his status and the plan to transition the patient to a non-VA nursing home and place him in hospice. OIG did not substantiate a failure to adequately manage the patient's pain. Pain management monitoring, decisions, and education were documented in the EHR. OIG identified several additional issues during our review. The patient's risk for depression was not fully assessed following the new diagnosis of lung cancer. Although the EHR contained evidence that system providers were aware of results of non-VA testing, non-VA medical records were not consistently available in the EHR. Service agreements were not active for the oncology and neurology services. Consults placed during the course of the patient's treatment were designated with routine urgency even though the clinical expectation and actual need was for a more urgent response.

Surgical Service Concerns, Fayetteville VAMC, Fayetteville, North Carolina

OIG assessed the merit of allegations from an anonymous complainant regarding the Surgical Service at the Fayetteville VAMC, Fayetteville, NC. OIG substantiated that some patients were not properly evaluated prior to surgery; however, OIG could not substantiate that inadequate preoperative evaluations caused an increase

in surgical complications. OIG substantiated that patient deaths that occurred within 30 days of surgery were not reviewed as required, and that peer reviews were not conducted as required. OIG substantiated that a gynecological procedure was stopped after surgery had begun because of a lack of instruments, and there were ongoing problems with obtaining and maintaining surgical supplies and instruments. OIG substantiated that a surgical technician was placed in charge of the surgery schedule; however, this action was appropriate. OIG did not substantiate that staff were bypassed in the scheduling process or that surgeons had to perform cases without adequate assistance. OIG substantiated that surgical technician positions that were not being actively recruited and that having different service alignments for the surgical technician positions led to confusion. OIG did not substantiate that complication rates of surgical residents exceeded 30 percent. OIG did not substantiate that the Chief of Surgery awarded a contract or that the contract was not offered to other bidders. OIG found that the VAMC's surgical post-operative clinic did not have the same nurse staffing pattern as other outpatient clinics. OIG recommended that recommendations from previous reviews, if any, be implemented; that preoperative patients are adequately evaluated; that peer reviews are completed in accordance with VHA policy; that necessary surgical supplies, equipment, and instruments are available; that the organizational structure for surgical technicians be evaluated; and that the surgical outpatient clinic have the same nurse staffing as other outpatient clinics.

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 29 audits and evaluations of VA programs and operations, conducted one benefits inspection of VA Regional Office (VARO) operations, and published 24 additional work products. 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 the Replacement of the Denver Medical Center, Eastern Colorado HCS

At the request of several members of Congress, OIG reviewed the plans and costs associated with the Denver Medical Center Replacement project (Denver project), which is arguably the most expensive VA medical center built to date. OIG evaluated the significant events that led to major delays in construction and to the increase in cost of the Denver project to the current estimated cost of $1.675 billion. OIG conducted the review from July 2015 through May 2016. The concept for the Denver project dates back to the late 1990s and was in response to the region's growth in the veteran population and the need to replace an aging and inadequate facility built in 1951. The new facility will be larger than the current facility by approximately 600,000 square feet. The Denver project will provide additional functional capability, such as more examination, treatment, and dental procedure rooms, as well as 30 beds designated for Spinal Cord Injury patients (the existing hospital has none). The project took years to start due to decisions under five former VA Secretaries that resulted in extensive changes to the concept, scope, and design of the project from 2000 through 2009. Significant and unnecessary cost overruns and schedule slippages related to the construction of the Denver Medical Center were primarily the result of poor business decisions, inexperience with the type of contract used, and mismanagement by VA senior leaders. OIG's review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and consultant services. VA's 2009 acquisition plan initially estimated construction would be finished in 2013. However, 2015 project estimates placed the final cost at approximately $1.675 billion, or more than twice VA's FY 2009 approved $800 million project budget. The project is estimated to be completed mid-to-late 2018, or almost 20 years after VA identified the need to replace its aging facility.

Review of Potential Inappropriate Split Purchasing at VA New Jersey HCS

In April 2014, OIG's Office of Investigations (OI) briefed VA New Jersey Health Care System (VANJHCS) leadership regarding the results of a criminal investigation of purchase card abuse in the Engineering Service. OAE conducted this review to determine whether inappropriate split purchasing occurred in services other than the Engineering Service at VANJHCS. OIG found the practice of inappropriate split purchasing extended

beyond the Engineering Service at VANJHCS. OIG determined VANJHCS employees made inappropriate split purchases in 64 of the 76 purchase card transactions (84 percent) reviewed totaling $125,270. This included 19 purchase cardholders working in 6 different services. Based on the results of OIG's sample, OIG estimated that VANJHCS staff inappropriately made about 4,750 split purchases totaling approximately $8.9 million from December 2012 through May 2014. This occurred because of a disregard for internal controls that are an integral part of every Federal Government purchase card program. Additionally, management did not provide effective oversight and did not hold VANJHCS purchase cardholders, supervisors, and approving officials accountable for policy violations. OIG estimated that split purchasing resulted in approximately $8.9 million in unauthorized commitments and increased the risk of fraud, waste, and abuse of taxpayer resources at VANJHCS. The lack of oversight and strong controls prevented VANJHCS management from determining whether VANJHCS received all purchased goods and services. Management needs to take immediate corrective action and make long-term improvements to ensure sound financial stewardship of taxpayer resources. OIG recommended the Interim Director of VISN 3 ensure VANJHCS complies with VA purchase card program policies, including stronger management oversight. The Interim Director of VISN 3 concurred with our recommendations and provided plans for corrective action. OIG will monitor planned actions and follow up on their implementation.

Review of Alleged Misuse of eBenefits Accounts by a VA Supportive Services for Veteran Families Provider

OIG reviewed allegations received through the VA OIG Hotline in November 2014. This review sought to assess the merits of allegations of misuse of veterans' eBenefits accounts by a Supportive Services for Veteran Families (SSVF) provider. Allegedly, Volunteers of America in Durango, Colorado (VOA Durango), used a veteran's private information on the eBenefits website to obtain documents including, but not limited to, a Certificate of Release or Discharge from Active Duty (DD Form 214). In addition, the complainant alleged a VOA Durango staff member established eBenefits accounts using private information without the veteran's consent. OIG found no evidence that VOA Durango staff or management misused veterans' private information to access eBenefits accounts, or created eBenefits accounts without a veteran's knowledge. OIG reviewed and analyzed dates of veterans' SSVF participation and reviewed eBenefits accounts associated with the participants listed in the allegation. OIG reviewed documentation in the participants' files, including intake forms, eligibility determinations, DD Forms 214, and the services provided to the participants. OIG reviewed internal controls in place to prevent unauthorized creation and access to eBenefits accounts. OIG found the controls for establishing an eBenefits account required two levels of authentication to access a veteran's DD Form 214 used to verify military service. OIG found no evidence in the case files that eligibility documents were obtained from eBenefits accounts without the veteran's knowledge. OIG made no recommendations, and the Director of the New Mexico VA HCS did not have any comments on this report.

Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, Texas

OIG received an anonymous allegation that leadership was instructing staff at the Michael E. DeBakey VAMC and its associated CBOCs to incorrectly record clinic cancellations as patient cancellations. OIG found no evidence the VAMC Director instructed supervisors or staff to incorrectly record appointment cancellations. OIG substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to incorrectly record cancellations as canceled by the patient. OIG identified 223 appointments incorrectly recorded as patient cancellations during the July 2014 through June 2015 time frame. Of the 223 appointment cancellations, staff rescheduled 94 appointments (42 percent) beyond 30 days. For these 94 appointments, veterans encountered an average 81-day wait, which was 78 days longer than shown in the electronic scheduling system. OIG also found that wait times were understated about 66 days for 50 appointments (22 percent) when they were initially scheduled. These issues have continued despite VHA having identified similar issues during

a May and June 2014 system-wide review of access. These conditions persisted because of a lack of effective training and oversight. As a result, VHA's recorded wait times did not reflect the actual wait experienced by the veterans and the wait time remained unreliable and understated. OIG recommended the VISN 16 Director ensure the VAMC Director confers with VA's Office of Accountability Review (OAR); provides scheduling staff training; improves scheduling audit procedures; and takes actions when the audits identify deficiencies. The VISN Director did not agree with Recommendations 1 and 2 but OIG considered the VISN's decision not to take administrative action the responsibility of the Director. The VISN Director concurred with Recommendations 3 through 6 and provided acceptable planned actions. Based on the actions taken, OIG consider Recommendations 1 and 2 closed, and will monitor the implementation of the remaining recommendations until all actions are completed.

Review of Allegation of Underutilized MRI Scanner in Waco, Texas

OIG received a Hotline allegation that a mobile MRI scanner was underutilized, and represents a waste of taxpayers' funds. VHA purchased the scanner in 2007 for the Center of Excellence (COE) for Research on Returning War Veterans, Waco, TX. OIG substantiated the allegation the MRI scanner was underutilized, representing a waste of taxpayers' funds. VHA paid approximately $2.9 million for the MRI scanner and annual maintenance costs of approximately $200,000. OIG determined the MRI scanner was not used for approximately 64 of 81 months from July 2008 through March 2015. This occurred because: (1) COE leadership did not anticipate the extent to which environmental conditions affected MRI scanner images; (2) the scanner required evaluation, software upgrades and repairs to accomplish the type of research being conducted; and (3) COE did not have staff qualified to operate the scanner or approved research projects. COE demonstrated poor stewardship of the approximately $2.9 million purchase cost of the MRI scanner and approximately $1.1 million in maintenance costs during the 64 months it was not used. The COE began using the scanner again in April 2015, and OIG confirmed the COE was still using the scanner as of February 2016. Since the issues that delayed the COE from using the MRI scanner were resolved, OIG did not make any recommendations. The Under Secretary for Health (USH) concurred with OIG's conclusions concerning the MRI machine. The Under Secretary's response also indicated top researchers have joined VA and relocated to Waco to do research using the device. The Under Secretary's response also noted the MRI was upgraded and that the new leadership has revitalized the program and put the Center on a productive pathway.

Audit of VA's Green Management Program Solar Panel Projects

Senator John Boozman and Congressman French Hill of Arkansas requested that OIG conduct a review of an $8 million, 1.8 million megawatt work-in-progress solar panel system at the John L. McClellan Memorial Veterans Hospital, Little Rock, AR. OIG's objective was to determine whether VA effectively planned and managed its work-in-progress solar photovoltaic projects to meet project timelines and expected project power generation goals. The Little Rock VA medical facility did not effectively plan the installation of a solar panel system. The project experienced significant delays and additional contract costs due to disassembly of previously installed solar panel carport structures to accommodate a parking garage. As a result, the solar project is expected to be fully completed in January 2017, over 4 years beyond its original completion date, with unexpected costs of approximately $1.5 million. OIG reviewed 11 of 15 solar projects awarded from FY 2010 through FY 2013 that were a work-in-progress as of May 2015. At the completion of OIG's audit work in March 2016, only 2 of 11 solar projects were fully completed. In July 2016, VA informed OIG that 5 of 11 solar projects were fully completed. This occurred because of planning errors, design changes, a lengthy interconnection process, and contractor delays. As a result, VA did not increase renewable energy for those solar projects in the time frame planned and incurred additional costs through needed contract modifications. OIG recommended the Interim Assistant Secretary for Management implement additional controls to prevent solar panel conflicts,

share best practices for executing timely interconnection agreements, implement power generation monitoring controls, and conduct lessons learned assessments.

Review of Alleged Waste of Funds at the VAMC in Detroit, Michigan

In January 2016, OIG reviewed an allegation that the VAMC in Detroit, MI, purchased 300 televisions (TVs) and accessories in September 2013 for about $311,000. The complainant alleged the facility never installed the TVs because they were the wrong type. OIG substantiated the allegation the Detroit VAMC had not installed and used 282 of the 300 TVs or associated accessories it had purchased. The facility acquired the equipment in September 2013 as part of a project to replace the patient TV system in the facility, but as of April 2016, 282 of the TVs and associated accessories were not in use. The facility was unable to install the items in the patient rooms because the items did not meet the design specifications identified in the patient TV system architect and engineer services contract. OIG determined Detroit VAMC officials did not communicate with the architect and engineer contractor in a timely manner to ensure the TVs purchased were compatible with the project design and specifications. Thus, the Detroit VAMC issued a contract modification for $19,052 to adjust the project design and specifications to support the TVs purchased. The TVs and related accessories should have been purchased closer to award of the construction contract. By purchasing these items well before a construction contract to install them was awarded, the facility exposed itself to unnecessary financial risk in the event it did not proceed with the project, and the facility also allowed valuable warranties to expire, increasing the risk of incurring additional expenses to replace any faulty TVs. OIG recommended the VISN 10 Acting Director strengthen policy to ensure the proper equipment is purchased at the appropriate time, as well as develop and implement a plan to use the purchased TVs. OIG also recommended the VISN 10 Acting Director determine whether a bona fide needs violation occurred, and take appropriate corrective action if required.

Audit of Modular Ramps Purchased by the Malcom Randall VAMC, Gainesville, Florida

In May 2015, Congressman Tim Walberg requested OIG review an allegation where the complainant alleged the Malcom Randall VAMC, in Gainesville, FL, purchased modular ramps that did not comply with P.L. 110-325, *Americans with Disabilities Act* (ADA) standards. OIG substantiated the allegation. Specifically, for 20 of 33 (61 percent) purchase orders reviewed, staff did not consistently ensure ramps were ADA compliant prior to awarding purchase orders to vendors. Additionally, for all 33 purchase orders reviewed, staff did not perform follow-up to ensure installed ramps complied with ADA. OIG also measured six vendor-installed modular ramps and determined none of the six complied with ADA standards. As a result, OIG estimated staff made errors for modular ramp purchase orders totaling approximately $342,000 from August 2014 through March 2015. This occurred because the VAMC lacked effective controls including a quality review process, formal training program, comprehensive written procedures, and formal requirements for vendors to provide ADA-compliant ramps and measurements. OIG recommended the Director of the Malcom Randall VAMC enhance procedures and controls to help ensure modular ramps are installed in compliance with ADA standard. The VAMC's Director concurred with OIG's findings and requested closure of the recommendations based upon actions taken as a result of OIG's review. Although the VAMC partially addressed OIG's recommendations, additional actions are necessary.

Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor HCS

OIG reviewed an allegation that VA acquisition personnel mismanaged the award of the ambulette services task orders at the New York Harbor Healthcare System (NYHHS). There was also an allegation of contract steering for the re-solicited requirement. OIG's review focused on determining the merit of the allegations. OIG substantiated the allegation that VHA acquisition personnel mismanaged the award of the ambulette services at NYHHS because they improperly awarded two task orders for ambulette services when the

contractor's FSS contract did not offer these services. In addition, the contracting officer's award determination for the re-solicited requirement was not clearly justified. Further, acquisition personnel did not document pertinent contracting actions in VA's Electronic Contract Management System (eCMS). However, OIG did not substantiate the allegation of contract steering for the re-solicited requirement. The award mismanagement occurred because VA's Integrated Oversight Process (IOP) reviews, designed to improve contract quality, were either not completed or not documented for the two task orders valued at $20 million. If performed, these reviews may have revealed the contractor did not offer ambulette services. Further, personnel turnover caused confusion as to who should ensure contract documentation was included in eCMS. As a result, acquisition personnel put VA at risk for protests and payment to protesters for restitution. OIG recommended the USH implement an oversight process to ensure IOP reviews are completed. OIG recommended the Head of Contracting Activity, VHA, Service Area Office East, develop a mechanism to ensure effective coordination between acquisition personnel when transferring contracting responsibilities and implement a process to ensure eCMS is used to record contracting actions. OIG considered the plans acceptable.

Review of Alleged Contractor Information Security Violations in the Alaska VA HCS, Anchorage, Alaska

In December 2014, OIG's Hotline received an allegation that ProCare Home Medical, Inc., (ProCare) was improperly storing and sharing VA sensitive data on contractor personal devices in violation of Federal information security standards. The complainant alleged that ProCare was allowing its employees to use personal computers and phones to access the company computer system and download VA sensitive data, including veterans' personal health information. OIG substantiated the allegation that ProCare employees, according to its staff, accessed electronic sensitive veteran data with their personal computers from home through an unauthorized cloud-based system without encryption controls. OIG also noted that ProCare employees or malicious users could potentially use personal devices on an unauthorized wireless network to access sensitive veteran information. In addition, OIG determined that ProCare was storing sensitive hard copy and electronic veteran information in an unsecured manner at their facility. OIG further noted that ProCare could not provide evidence that applicable ProCare personnel had completed VA required security awareness training or signed the Contractor Rules of Behavior prior to receiving access to VA sensitive data. These security deficiencies occurred because VA did not provide effective oversight of ProCare personnel to ensure the appropriate protection of veteran information at the contractor facility. As a result, veteran sensitive information was vulnerable to loss, theft, and misuse, including identity theft or fraud. OIG found no evidence that veteran sensitive information was compromised. OIG recommended the VA Northwest Health Network management assign a local Contracting Officer's Representative and Information Security Officer to provide oversight of Alaska VA HCS contractors. OIG also recommended the VA Northwest Health Network management, in conjunction with the Assistant Secretary for Information and Technology, conduct a site assessment of ProCare information security controls to ensure compliance with VA information security requirements. The Assistant Secretary for Information and Technology and the VA Northwest Health Network Acting Director provided an appropriate corrective action plan. OIG will follow up on the implementation of the corrective actions.

Review of Alleged Waste of Funds at VHA's Madison VAMC, Madison, Wisconsin

OIG received an allegation regarding the potential waste of funds at the Madison VAMC, located in Madison, WI. The complainant alleged that the VAMC had purchased a laser lead extractor in 2012 for about $1 million and never used it. The complainant also alleged that the VAMC spent approximately $125,000 on a robot to distribute supplies that could not operate autonomously within the hospital and installed a patient lift for about $2,500, despite staff stating that they did not need it and would not use it. OIG substantiated the allegation that the Cardiology department did not use the laser lead extractor. OIG found that the VAMC did not purchase but leased this device at a cost of about $100,000. Even though the laser lead extractor had been on hand for nearly

two and a half years, the Cardiology department was unable to use it because of OR space utilization and staffing issues. Instead, the Cardiology department sent veterans to non-VA facilities to have the procedures performed. OIG determined that VAMC officials involved in the decision to lease the device did not ensure the lease of the laser lead extractor was the most cost-effective approach for extracting pacemaker and defibrillator leads. OIG found that the VAMC purchased two robots for nearly $313,000. OIG substantiated the allegation that the VAMC could not use the robots effectively because, when planning the acquisition, the logistics department did not consider whether the robots could operate effectively within the facility. As a result, the two robots have not been used in about 2 years. OIG concluded that the VAMC could have better used the roughly $410,000 it spent to lease the laser lead extractor and purchase the robots. OIG did not substantiate the allegation regarding the patient lift. The VAMC installed the lift in response to an encounter with a double amputee bariatric patient and Safe Patient Handling Program guidance. OIG found that the lift provides a benefit to employees and ensures the safety of patients when they need to be moved. OIG recommended the VISN 12 Acting Director ensure Madison VAMC management complies with VAMC policy requiring sufficient justification supporting equipment acquisition requests. OIG also recommended the VISN 12 Acting Director conduct an analysis to ensure VISN facilities are effectively utilizing any laser lead extractors. The VISN 12 Acting Director provided plans for corrective action. OIG will monitor planned actions and follow up on their implementation.

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.

Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments

OIG evaluated VBA's oversight of Post 9/11 G.I. Bill tuition and fee payments to determine if payments were appropriate and accurate. Of the $5.2 billion in Post-9/11 G.I. Bill tuition and fee payments made for nearly 796,000 students during academic year 2013-2014 (August 1, 2013, to July 31, 2014), OIG reviewed more than $1.7 million in payments made to 50 statistically-selected schools for 225 students. OIG found VBA staff at the Regional Processing Offices (RPO) made 46 improper payments totaling just under $90,900. In addition, OIG identified 39 overpayments totaling just under $96,400 where the RPOs had not initiated recoupment actions. In total, 32 of the reviewed schools, including 19 for-profit schools, had improper payments and missed recoupments. Furthermore, 20 of the 32 identified schools lacked compliance surveys. Due to program design, VBA must make payments prospectively based on the enrollment information submitted by the schools. Many of these improper payments and missed recoupments occurred because School Certifying Officials' (SCOs) submitted incorrect and/or incomplete information on students' enrollment certifications. To help reduce improper payments and missed recoupments, VBA needs to: (1) improve the SCOs' awareness of program requirements related to the submission of accurate and complete enrollment certifications; (2) refine the school selection process and ensure the completion of required compliance surveys to improve the verification and monitoring of tuition and fee certifications; (3) develop adequate guidance regarding allowable book fees and repeated classes; and (4) verify and obtain supporting documentation for mitigating circumstances. From the more than $5.2 billion tuition and fee payments made for academic year 2013-2014, OIG projected that VBA made about $247.6 million in improper payments and more than $205.5 million in missed recoupments annually. As a result, VBA may have an estimated $2.3 billion in improper tuition and fee payments and missed recoupments ($1.2 billion in improper payments and $1 billion in missed recoupments) over the next 5 academic school years if it does not strengthen program controls. OIG recommended VBA improve school outreach to ensure accurate and complete certifications are submitted, develop risk profiles for schools to periodically review

and verify their certifications, incorporate risk factors into the prioritization and completion of compliance surveys, revise the SCO Handbook, and ensure that mitigating circumstances are properly verified and supporting documentation is obtained. Furthermore, OIG recommended VBA strengthen policies and controls related to the discontinuance and recoupment of payments, repeated classes, and satisfactory academic progress and that it take action, where appropriate, to recover identified improper payments and initiate recoupments.

Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans

OIG conducted this audit to determine whether VBA was adjusting compensation and pension (C&P) benefits payments timely for veterans incarcerated in Federal, state, and local penal institutions. Federal law requires VBA to reduce C&P benefits for veterans incarcerated for more than 60 days in a Federal, state, or local penal institution. VARO and Pension Management Center (PMC) staff did not consistently take action to adjust C&P benefits for veterans incarcerated in Federal penal institutions. Specifically, based on Federal incarceration data ranging from May 2008 through June 2015, VBA did not adjust veterans' C&P benefits, as required, in an estimated 1,300 of 2,500 cases (53 percent), which resulted in improper payments totaling approximately $59.9 million. Without improvements, OIG estimated VBA could make additional improper benefits payments totaling about $41.8 million for Federal incarceration cases from FY 2016 through FY 2020. VARO and PMC staff also did not take consistent and timely action to adjust C&P benefits for veterans incarcerated in state and local penal institutions. Based on incarceration notifications received from March 2013 to August 2014—the most current data available at the time of OIG's audit—VBA did not effectively adjust veterans' C&P benefits in an estimated 3,800 of 21,600 state and local incarceration cases (18 percent), which resulted in significant delays and improper payments totaling approximately $44.2 million. Without improvements, OIG estimated VBA could make additional improper benefits payments totaling about $162 million for state and local incarceration cases from FY 2016 through FY 2020. In total, OIG estimated improper benefit payments of about $307.9 million. In general, VBA did not place priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority. OIG recommended the Acting Under Secretary for Benefits (USB) increase the priority of VBA's incarceration adjustment workload. The Acting USB concurred with OIG's recommendations. Management's planned actions were responsive and OIG will follow up as required.

Review of VBA's Special Monthly Compensation Housebound Benefits

OIG reviewed whether the VBA properly granted entitlement to all statutory housebound special monthly compensation (SMC) benefits for living veterans with a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent. This review focused on whether VBA failed to pay or delayed paying any of these benefits. OIG also assessed the accuracy of SMC evaluations for veterans receiving compensation at the housebound rate, including statutory housebound, and housebound in fact, as well as SMC that had been incorrectly coded as housebound benefits. The first review objective focused on a population of about 186,000 living veterans' cases nationwide that at some point were entitled to statutory housebound SMC benefits based on a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent as of March 10, 2015. To address the second objective, OIG reviewed a population of about 98,400 veterans' cases nationwide receiving compensation at the housebound rate for any reason as of March 10, 2015. OIG estimated errors in 33,400 of 186,000 cases. OIG estimated that these errors resulted in veterans being underpaid $110.1 million through February 2015, and receiving recurring underpayments of $1.8 million per month as of March 2015. In addition, OIG estimated that VBA staff delayed paying veterans $54.3 million. Errors for veterans receiving compensation at the housebound rate also resulted in incorrect benefits decisions. OIG estimated errors in 2,600 of 9,800 cases for which veterans' combined evaluations were 90 percent or less. OIG estimated that these errors resulted in veterans being overpaid $44.3 million through

February 2015, with ongoing overpayments of $1.1 million per month as of March 2015. These overpayments included $21.4 million in benefits that were improper, which were ongoing at a rate of $678,000 per month. The remaining overpayments of $22.9 million were not supported by adequate documentation and were ongoing at a rate of $427,000 per month. Veterans' monthly recurring overpayments generally continue for at least 5 months. OIG recommended the then Acting USB establish plans to update the electronic system, conduct reviews of cases in which housebound benefits are being paid, provide updated training, remind staff to use the SMC Calculator in all SMC cases, and clarify the meaning of "substantially confined." The Principal Deputy USB concurred with OIG recommendations.

Review of Alleged Lack of Audit Logs for Veterans Benefits Management System

In April 2015, OIG received an anonymous allegation that VBA failed to integrate suitable audit logs into Veterans Benefits Management System (VBMS). OIG substantiated the allegation that VBA failed to integrate suitable audit logs that clearly reported all security violations occurring in VBMS. OIG tested the existence and accuracy of audit logs by having 17 employees at 3 VAROs attempt to access same station veteran employee compensation claims in VBMS. Although audit logs identified security violations for 15 of the 17 employees, the logs did not show that the security violations occurred within VBMS. Instead, the audit logs indicated that the violations occurred in the Share application used by VARO employees or an unknown system. The other two employees did not appear on the audit logs; we could not determine why this happened. This occurred because VBA officials did not develop sufficient system requirements to ensure that audit logs exist and are accessible to ISOs. As a result, information security officers (ISOs) were unable to effectively detect, report, and respond to security violations occurring within VBMS. Until VBA resolves this issue, its VAROs will be more susceptible to fraudulent compensation claims processing. OIG recommended the Acting USB develop system requirements for integrating audit logs into VBMS. OIG also recommended the Assistant Secretary for Information and Technology integrate audit logs into VBMS based on the requirements provided by the Acting USB. Finally, OIG recommended the Acting USB test the audit logs to ensure the logs capture all potential security violations. The Acting USB and the Assistant Secretary for Information and Technology concurred with our recommendations and provided acceptable corrective action plans. OIG will monitor their implementation. The Acting USB also provided technical comments, which OIG took into consideration.

Review of Alleged Shredding of Claims-Related Evidence at the Los Angeles, California, VARO

This is the final report that replaced the Interim Report published under this same title on August 17, 2015. This report is reprinted and includes comments and an action plan from VARO Los Angeles, CA. OIG substantiated that VARO Los Angeles staff were not following VBA's policy on management of veterans' and other Governmental paper records. OIG found nine pieces of claims-related mail that VARO staff failed to properly process. Eight of the documents had the potential to affect veterans' benefits, while one had no effect on a veteran's benefits. Although OIG could not substantiate that the VARO inappropriately shredded some claims-related documents, OIG found sufficient evidence to conclude the VARO staff likely would have inappropriately shredded the nine documents found. OIG's review determined that VARO Los Angeles' implementation of VBA's established processes for the disposition of paper records was not adequate. OIG found that the VARO Los Angeles' Records Management Officer (RMO) position was vacant from August 2014 until the inspection in February 2015. This was because the VARO's Assistant Director had determined that it was not necessary to fill the RMO position when the incumbent was promoted. Not filling the RMO position eliminated the final certification in the VARO's authorized shredding process, which VBA established to prevent improper shredding of claims-related documents. If not for OIG's review, it is likely that the VARO staff would have inappropriately destroyed these nine claims-related documents OIG found. OIG recommended the VARO Director implement a plan and provide training to ensure all VARO staff comply

with VBA's policy for handling, processing, and protection of claims-related documents and other Government records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect veterans' benefits. OIG recommended the VARO Director implement a plan and assess the effectiveness of training to ensure VARO staff comply with VBA's policy for handling, processing, and protection of claims-related documents and other Governmental records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect veterans' benefits. The VARO Director concurred with the recommendations. OIG will follow up as required.

Review of Claims-Related Documents Pending Destruction at VAROs

In January 2015, OIG received an anonymous allegation that VARO Los Angeles staff were inappropriately shredding mail related to veterans' disability compensation claims. OIG could not substantiate Los Angeles VARO staff inappropriately shredded claims related documents prior to our review. However, OIG identified that VARO Los Angeles' staff were not following VBA policy on the management of veterans' and other Governmental paper records. In August 2015, OIG made recommendations to the VARO Los Angeles Director and published the interim report on August 17, 2015. OIG then conducted unannounced random inspections at 10 other VAROs to determine if this was a systemic issue. Those 10 sites were Atlanta, GA; Baltimore, MD; Chicago, IL; Houston, TX; New Orleans, LA; Oakland, CA; Philadelphia, PA; Reno, NV; San Juan, PR; and St. Petersburg, FL. OIG focused this review on the improper destruction of veterans' claims related documents at those 10 VAROs. OIG found VBA's controls were not effective to prevent VARO staff from potentially destroying claims related documents. OIG identified 69 of 155 claims related documents improperly scheduled for destruction, which staff at 6 of the 10 VAROs had not properly associated with veterans' claims folders. Two of these documents affected benefits, 9 had the potential to affect benefits, and 58 did not affect benefits, but were still required to be included in the veterans' claims folders or VBA's electronic systems and could have been destroyed thereafter. As OIG identified problems at 6 of the 10 VAROs, OIG concluded this is a systemic issue within VBA. Noncompliance with policy, inadequate controls, and outdated guidance can lead to the potential destruction of claims related documents. Both VARO staff and management found VBA's policy confusing and did not always receive annual training as required. Further, records management staff did not consistently review documents or maintain violation logs. These actions put documents at risk for inappropriate destruction, which could result in loss of claims and medical evidence, incorrect decisions, and delays in claims processing. OIG recommended the Acting USB ensure VARO compliance with policy, update and clarify policy and procedures, and provide training where needed. The Acting USB concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required.

Review of VBA's Alleged Inappropriate Prioritization of Appeals at the Roanoke, Virginia, VARO

OIG received an anonymous allegation that staff at the Roanoke VARO were prioritizing the processing of newer appeals before older appeals, resulting in thousands of incomplete appeals dating back from 2010 to 2013. OIG substantiated the allegation that Roanoke VARO appeals staff focused on completing newer appeals instead of processing older appeals. As of June 4, 2015, Roanoke VARO had 12,890 appeals pending at various stages of the appeals process, of which 3,350 dated back from October 2008 through FY 2013. OIG interviewed 14 of Roanoke's 23 appeals staff and 13 of them stated they primarily focused their FY 2014 efforts on working the newer appeals with fewer issues. Another indicator that Roanoke VARO appeals staff focused on completing newer appeals was the number of completed appeals that were less than a year old. At the Roanoke VARO, the number of appeals completed in less than a year increased by 16 percent, from 66 percent in FY 2013 to 82 percent of the appeals completed in FY 2014. This compared to an increase of 1 percent at the Atlanta VARO, 2 percent at the St. Petersburg VARO, and 4 percent at the Winston-Salem VARO. This occurred because Roanoke VARO leadership did not follow workload management plans, which required that appeals staff

prioritize their work based on the appeals with the longest days pending. Instead, as directed by the Southern Area Office Director to reduce appeals inventory, the Roanoke VARO's management implemented a Notice of Disagreement (NOD) reduction plan that focused on processing less complex, newly initiated appeals. OIG recommended that the Roanoke VARO Director ensure that leadership and appeals staff follow the workload management plan to prioritize work based on the appeals pending the longest. The Roanoke VARO Director concurred with OIG's finding and recommendation. Based on actions already implemented, OIG considered the recommendation closed.

Review of Alleged Data Manipulation of Appealed Claims at the Wichita, Kansas, VARO

In April 2015, OIG received an allegation that Wichita VARO management instructed staff to input inaccurate data when entering NODs into the Veterans Appeals Control and Locator System (VACOLS). Allegedly, VARO staff entered inaccurate data to improve timeliness measures associated with appealed claims processing actions. VBA uses VACOLS, an electronic records system, to track and manage its appeals workload. The effectiveness of tracking appeals is dependent upon the accuracy and timeliness of the information entered in VACOLS. OIG substantiated the allegation that VARO management instructed staff to enter inaccurate data when recording NOD information into VACOLS rather than entering the actual diagnostic code for the disability or disabilities being appealed, as required. OIG found that in all 36 appealed claims, staff did not follow VBA policy when entering the NODs in VACOLS. OIG could not determine whether VARO management took these actions to improve timeliness measures. Data integrity issues identified at the Wichita VARO occurred because of the lack of management oversight and the subsequent conflicting guidance provided by Compensation Service that required VARO staff to enter incomplete and/or inaccurate information in VACOLS. As a result, VARO staff did not always update VACOLS with accurate information. This may have resulted in veterans not having received the correct information regarding their claims. In addition, inaccurate claims information in VBA's system of records would result in unreliable appeals workload reporting, as well as an inefficient research and inaccurate responses to inquiries. OIG recommended the Wichita VARO Director take action to correct the 36 NODs established in VACOLS and implement a plan to provide adequate oversight to ensure staff establish NODs using accurate data. OIG recommended the Acting USB develop a plan to notify staff at its 56 VAROs of the modified policy, effective July 29, 2015, to ensure correct processing of an appellate claim. The Acting USB and VARO Director concurred with our findings and the corrective actions were responsive to the recommendations. OIG considered Recommendation 1 closed and will follow up as required on the remaining recommendations.

Review of Alleged Manipulation of Quality Review Results at the San Diego, California, VARO

In February 2015, OIG received allegations that data integrity and mismanagement issues were occurring at the San Diego VARO. The complainant alleged VARO staff altered individual quality review results and hid claims from the quality review process by completing them during overtime hours. To support the allegations, the complainant provided 23 individual quality reviews completed by Quality Review Team (QRT) staff that VARO management had inappropriately overturned. OIG assessed the merits of the allegations and did not substantiate that VARO management inappropriately overturned, altered, or interfered with established procedures for reconsideration of individual quality review errors. OIG also did not substantiate the allegation that staff at the San Diego VARO worked some cases during overtime hours to avoid having the cases undergo individual quality reviews by QRT staff. During the course of the OIG review, OIG observed that VARO management did not provide adequate oversight to ensure staff followed its local policy to correct individual quality review errors within 5 days. Of the 50 errors sampled, 39 required corrective actions, such as revised decision documents, while the 11 remaining errors related to actions, such as improper development for evidence, and did not require revised decision documents. OIG also confirmed that VBA did not have a timeliness standard for staff to correct individual quality review errors at its 56 VAROs. Delays in correcting the individual quality review errors at the

San Diego VARO resulted in improper benefits payments to some veterans. OIG recommended the San Diego VARO Director implement a plan to ensure staff comply with local policy to correct individual quality review errors, as well as take action to correct the backlog of individual quality review errors pending correction. Furthermore, OIG recommended the USB establish a timeliness standard for VBA staff to correct individual quality review errors. The USB and VARO Director concurred with OIG findings and the corrective actions were responsive to the recommendations.

Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VARO

In October 2015, OIG received a request from U.S. Senators Richard Blumenthal and Tammy Baldwin to review an incident concerning the improper dissemination of veterans' personally identifiable information (PII) by a Wisconsin Department of Veterans Affairs (WDVA) employee to an unauthorized recipient over VA's email server. OIG substantiated the allegation that on April 1, 2015, a WDVA employee improperly disseminated over VA's email server a monthly claims report. The report contained updates of Wisconsin veterans' disability claims to unaccredited County and Tribal Veterans Service Organization employees not authorized to handle sensitive information, as well as to a Wisconsin veteran. The Milwaukee VARO sharing of claims information with WDVA was consistent with Federal policy. This incident occurred because VA did not have adequate processes and information security controls in place to safeguard against unauthorized disclosure of PII. VA's Office of Information and Technology (OIT) did not adequately configure VA's information security filtering software to block the dissemination of unencrypted sensitive data before releasing information to WDVA. In addition, the VARO did not have a formal agreement with WDVA for sharing PII. VA put Wisconsin veterans' PII at unnecessary risk of interception and misuse. Further, VA's 2015 Federal Information Security Modernization Act audit reported security deficiencies similar in type to those identified in this report as material weaknesses over the last few years. OIG recommended the Assistant Secretary for Information and Technology improve VA's email security filtering software controls, establish formal agreements with third-party organizations, evaluate whether permanent encryption controls are needed for non-VA employees with VA accounts, and conduct reviews of processes and controls at VAROs collaborating with third party organizations to ensure security of sensitive veterans' information. The Assistant Secretary for Information and Technology nonconcurred with OIG's recommendations and stated that VA's position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs. The Assistant Secretary noted that all policies, procedures, and required training were already in place. However, OIG continues to maintain its position that VA did not have adequate processes and information security controls in place to safeguard against unauthorized disclosure of PII.

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 one report during this reporting period regarding protocols established to review related to temporary 100 percent disability evaluations, traumatic brain injury (TBI), and SMC and ancillary benefits. During this review, OIG determined that staff at one VARO incorrectly processed 13 of 47 (28 percent) temporary 100 percent disability claims. As a

result, OIG identified processing errors resulting in 77 improper payments to 6 veterans totaling approximately $89,853. All 13 TBI claims and all 4 SMC and ancillary benefits claims completed by VARO staff were accurately processed.

In addition to the its regular inspection protocol reviews, the Benefits Inspections divisions completed two reviews regarding VBA's SMC Housebound Benefits and VARO shredding procedures. During the review of housebound benefits we identified errors in 45 of 250 cases (18 percent) in which veterans were entitled to statutory housebound benefits based on having a single disability rated as 100 percent disabling and one or more disabilities independently rated at 60 percent or more. Errors included failure to grant housebound benefits, failure to pay housebound benefits that had been granted, and prematurely reducing housebound benefits.

OIG also found errors in 127 of 247 cases (51 percent) in which veterans were being paid compensation at the housebound rate. In 10 additional cases, we could not determine whether housebound in-fact benefits were accurate because VBA's eligibility criteria were unclear. OIG identified different error rates within each group of our stratified sample. As a result, OIG estimated an overall error rate of 10 percent for veterans being paid compensation at the housebound rate, and a 27 percent error rate for veterans with combined evaluations that were 90 percent or less. Generally, the inaccuracies we identified involved housebound benefits for unemployable veterans, entry of SMC codes into the electronic system, and housebound benefits on an in-fact basis.

Also, the review of VARO shredding procedures was performed based on an anonymous allegation OIG received that staff at the VARO in Los Angeles, CA, were shredding mail related to veterans' disability compensation claims. The complainant also alleged that supervisors were instructing staff to shred these documents. In February 2015, we conducted an unannounced inspection at VARO Los Angeles to assess the merits of the allegation.

OIG substantiated that the VARO staff were not following VBA policy on management of veterans' and other Governmental paper records. Although OIG cannot quantify or identify claims-related documents that the VARO may have shredded prior to the review, OIG found nine claims-related documents that VARO staff incorrectly placed in personal shred bins for non-claims-related documents. Eight of the nine documents had the potential to affect veterans' benefits and one had no effect on the veteran's benefits. Since VARO staff placed these nine claims-related documents in shred bins for non-claims-related documents, these nine documents bypassed the first VBA control requiring supervisory review of claims-related documents before shredding. Of the nine claims-related documents, five did not have required initials of both the employee and supervisor and the remaining four had only the employee's initials. If VARO staff and their supervisors had followed VBA policy, these nine claims-related documents would not have been placed in personal shred bins that are designated for non-claims-related documents.

Inspection of VARO Montgomery, Alabama

VBA has 56 VAROs that process disability claims and provide services to veterans. OIG evaluated the Montgomery, AL, VARO to see how well it accomplishes this mission. OIG sampled claims considered at increased risk of processing errors; thus, these results do not represent the overall accuracy of disability claims processing at this VARO. VARO staff did not accurately process 13 of the 47 disability claims (28 percent) reviewed, resulting in 77 improper payments to 6 veterans totaling $89,853. The 13 cases with errors related to temporary 100 percent disability evaluations. Most of the errors occurred because VARO staff delayed scheduling medical reexaminations despite receiving reminder notifications—taking on average 1 year and 3 months to do so. All 13 TBI claims VARO staff completed from January to June 2015 were accurate. In addition, all four SMC and ancillary benefits claims completed by VARO staff from July 2014 through June 2015 were accurately processed. VARO staff established the correct dates of claim for 30 cases reviewed in

the electronic record. However, 10 of the 30 benefits reduction cases OIG reviewed had processing delays. Generally, the errors related to prioritization of workload. Effective management of this workload can reduce the risk of improper payments and provide better stewardship of taxpayer funds. OIG recommended the VARO Director implement plans to ensure staff take timely action to schedule required medical re-examinations and to review the 15 temporary 100 percent disability evaluations remaining from the inspection universe. OIG also recommended the Acting USB implement a time frame in which staff are required to schedule medical re-examinations after receiving reminder notifications. Furthermore, OIG recommended the VARO Director implement a plan to prioritize actions related to benefits reductions to minimize improper payments to veterans. The VARO Director concurred with OIG's recommendations. The Acting USB agreed the timely scheduling of medical examinations promotes efficiency and financial stewardship; however, VBA did not reinstate a timeliness goal. OIG determined the planned actions lacked urgency and financial stewardship. OIG will follow-up as required.

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*, 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 of VA's Conference Management for FY 2014

In September 2012, OIG issued an Administrative Investigation of FY 2011 Human Resources Conferences in Orlando, Florida, which identified inadequate controls resulting in wasteful spending. OIG conducted this audit of FY 2014 conferences to assess the adequacy of the actions VA took to address identified control weaknesses. OIG identified policy and oversight weaknesses that could undermine the cost effectiveness of conferences and increase the risk of inappropriate spending. VA organizations did not comply with policy for 11 of 12 randomly selected FY 2014 conferences. VA organizations did not prepare Conference Packages in accordance with policy for 10 conferences with budgets totaling approximately $11.6 million. VA organizations also did not prepare Final Conference Reports in accordance with policy for 11 of 12 conferences, with expenditures totaling approximately $7.9 million. Weaknesses in policy implementation occurred because VA did not issue adequate guidance or implement adequate oversight procedures to ensure VA organizations submitted Conference Packages and Final Conference Reports compliant with VA policy. In addition, VA did not provide adequate accountability to ensure that VA organizations complied with conference policies. As a result, these weaknesses contributed to VA reporting approximately $3.9 million in conference expenditures to Congress that could not be adequately traced to source documentation to verify their accuracy and appropriateness.

Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Website

OIG evaluated the merits of an allegation that VA launched an enhanced version of its MyCareer@VA website even though it was not compliant with Section 508 of the P.L. 93-112, *Rehabilitation Act of 1973*. OIG substantiated the allegation and found that VA Learning University (VALU) project officials did not address nearly 200 known Section 508 compliance issues and did not seek certification of compliance prior to the deployment of the website. Therefore, they failed to ensure individuals with disabilities had access to information and data on the MyCareer@VA website comparable to those who do not have disabilities, as required by law. Despite no evidence to show testing was complete or a certification of compliance, VALU certified acceptance of all deliverables and deployed the website in November 2014. OIG also determined VALU added work, at a cost of $34,011, to the follow-on contract with a current contractor to remedy the outstanding Section 508 noncompliance issues. The deployment of the website prior to the determination of Section 508 compliance occurred because VA policy is not specific regarding Electronic IT compliance with Section 508 requirements. In addition, OIG found that VALU management did not provide adequate oversight of the project. OIG recommended the Assistant Secretary for Human Resources and Administration complete testing of the MyCareer@VA website, address outstanding issues, and seek certification for compliance with Section 508 requirements. OIG also recommended the Assistant Secretary for Human Resources and Administration take steps to improve controls over ensuring the products VALU develops are Section 508 compliant. In addition, OIG recommended the Assistant Secretary for OIT strengthen VA policy for ensuring Electronic IT products are Section 508 compliant.

Review of Alleged Improper Contract Awards in OIT's Service, Delivery, and Engineering Office

OIG conducted a review based on an anonymous allegation to assess whether a senior level Service, Delivery, and Engineering (SDE) official from OIT coerced Technology Acquisition Center (TAC) contracting officers to violate Federal competition requirements when awarding contracts to perform a study of SDE operations. OIG did not substantiate the allegation that the contracting officers were coerced to violate the Federal competition requirements. Furthermore, OIG determined that the contracting officers complied with Federal competition requirements under the Federal Acquisition Regulation (FAR) when they awarded the contracts. In June 2014, a TAC contracting officer awarded a task order valued at approximately $972,000 to a FSS contractor for a study of SDE operations. The contracting officer met the FAR competition requirements for orders above the simplified acquisition threshold of $150,000. In January 2015, another TAC contracting officer awarded a task order valued at approximately $4.5 million to the same contactor to complete the study. The initial task order was for a period of 3 months while the second task order was for a period of 13 months. The first task order only required 2 major deliverables while the follow-on task order required 11 major deliverables as a result of an expansion and implementation of the original effort. The FAR allows for limiting competition in the interest of economy and efficiency if the new work is a logical follow-on to an original FSS order. The contracting officer met the requirements under the FAR related to limiting competition for orders exceeding the simplified acquisition threshold.

Review of Alleged Lack of Access Controls for VA's Project Management Accountability System Dashboard

OIG received an allegation that OIT had ineffective access controls over the Project Management Accountability System (PMAS) Dashboard and related project management data and metric reporting information. OIG substantiated the allegation that PMAS Dashboard access controls were inadequate. OIT did not configure 17 of the 18 PMAS Dashboard access groups to provide the least needed access privileges even though VA policy required OIT grant access to VA systems based on the least need (the practice of limiting access to the minimal level that will allow normal performance of duties). Instead, OIT designed these 17 groups to have full

user access privileges to the PMAS Dashboard data, regardless of individual user need. This occurred because the OIT director concluded that the PMAS data were not at risk; thus, OIT should not spend limited funds to develop group access ranging from read only to full access. When requested, OIT staff could not provide a cost analysis identifying the costs to develop access controls. In addition, OIT did not develop user access logs. This prevented OIT from identifying active users and periodically validating their actions. Thus, OIT could not effectively manage its risk to data integrity. Without configuring all the PMAS Dashboard groups to restrict user access to the data, VA does not comply with Federal IT security requirements and VA Handbook 6500, and has assumed unnecessary risks to the integrity of its project management data. OIG recommended the Assistant Secretary for OIT create read only access to PMAS and ensure each user's access is based on the least needed privilege. OIG also recommended that the Assistant Secretary develop Dashboard access logs and periodically review all users' access to ensure users still have legitimate needs for system access. The Assistant Secretary for OIT concurred with OIG recommendations and provided acceptable corrective action plans. OIG will monitor their implementation.

Review of VA's Guidance on Protecting Religious Beliefs

In the report to accompany House of Representatives (H.R.) 2029, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2016, the House Appropriations Committee requested OIG review VA's guidance to ensure religious sensitivity. VA's religious tolerance guidance generally aligned with Federal laws and included policies that provided reasonable assurance of ensuring sensitivity to the religious beliefs of veterans and their families, and employees at VA facilities. However, as of February 2016, VA was operating with eight policies governing the protection of religious beliefs that VA had not reviewed for recertification or rescission as required by VA policies. This included five from NCA and three from VHA. Although OIG's review did not find evidence that VA's outdated guidance contributed to religious insensitivity, VA should have recertified or rescinded these eight policies. The length of time VA was past due in performing these actions ranged from about 14 months to approximately 22 years. VA had not updated these policies because NCA and VHA did not complete timely reviews to compensate for the time needed for drafting guidance and to obtain necessary staff concurrences. By updating guidance, VA will help mitigate future risks of religious insensitivity. OIG recommended the Interim Under Secretary for Memorial Affairs and the USH recertify or rescind and replace religious tolerance guidance documents and develop mechanisms to ensure staff begin the process of updating guidance and compensate for the time needed to draft guidance and obtain staff concurrence. OIG also recommended the USH provide a means to assist in obtaining timely concurrences. The Interim Under Secretary for Memorial Affairs and the USH concurred with OIG's recommendations and provided acceptable corrective action plans. OIG will monitor planned actions and follow up on their implementation.

Review of VA's Alleged Improper Termination of the e-Learning Task Order

In March 2015, U.S. Senator Mark Warner requested that OIG evaluate an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated. OIG did not substantiate that VA's decision to terminate the e-learning task order was improper, as the FAR provides broad latitude for termination for convenience of the Government. In February 2014, VA awarded the e-learning task order for approximately $2.8 million. In September 2014, Office of Logistics and Supply Chain Management (OLSCM) officials determined the development of the e-learning training was not meeting its needs because the curriculum included courses not needed and did not include sufficient content. OLSCM officials decided to use existing VA online training. In February 2015, the task order was terminated for the convenience of the Government after paying the contractor approximately $1.9 million, which included settlement fees of approximately $56,000. According to the contracting officer's representative, the $1.9 million was spent on various deliverables, including project management, quality assurance, curriculum, implementation and evaluation plans, a curriculum design document, a prototype, weekly progress reports, and eight courses in various stages of completion. The termination occurred because of the lack of coordination between Veterans

Affairs Acquisition Academy (VAAA) and OLSCM to identify Office of Acquisition and Logistics' e-learning training needs and the best method to deliver that instruction. VAAA's personnel developed the e-learning requirement without coordinating the development with OLSCM. If the planning of the task order had been properly coordinated between VAAA and OLSCM, it might not have resulted in the termination of the task order and the payment of approximately $1.9 million for supply management courseware that was not completed. OIG recommended the Deputy Assistant Secretary for Acquisition and Logistics implement a mechanism to ensure proper coordination between VAAA and OLSCM when developing logistics training. The Principal Executive Director provided evidence of the agreement made to ensure proper coordination when developing logistics training. OIG considers the recommendation closed.

Review of VA's Award of the Patient-Centered Community Care Contracts

OIG reviewed VA Patient-Centered Community Care (PC3) contracts to determine whether they were adequately developed and awarded. In September 2013, VA awarded the PC3 contracts to provide veterans with a comprehensive, nationwide network of high quality, specialty health care services. The contracts were awarded for an estimated $9.4 billion, with a potential cost to VA of $27 billion. OIG found significant weaknesses in the planning, evaluation, and award of the PC3 contracts. The PC3 contracts were not developed or awarded in accordance with acquisition regulations and VA policy intended to ensure services acquired are based on need and at fair and reasonable prices. The contracting officials solicited proposals from vendors without clearly articulating VA's requirements. Thus, the vendors bidding on the solicitation did not have sufficient information on the type of specialty health care services they would need to provide, where to provide them, and the frequency. Therefore, VA increased the risk of not achieving the objectives of PC3 by inadequately identifying its health care service requirements. OIG found that documentation supporting vital contract award decisions was either not in VA's eCMS or incomplete. Of the documents available, OIG noted that the awarded costs were actually negotiated at a higher rate than originally proposed by one of the vendors. The evidence for these decisions was not documented in the price negotiation memo. Accountability for ensuring the effective award of these contracts was not vested with a senior executive at VA. Although the contracting officer had the authority to execute these contracts, the level of oversight for this degree of contract risk did not provide reasonable assurance that VA's interests were adequately protected. OIG recommended the Principal Executive Director for OALC improve oversight and accountability, and ensure sufficient planning on all high-dollar value and complex acquisitions. An acceptable corrective action plan was provided and OIG will follow up on its implementation.

Improper Payments Elimination and Recovery Act Compliance

The Office of Management and Budget (OMB) Circular A-123, Appendix C, Requirements for Effective Estimation and Remediation of Improper Payments, specifies that each agency's IG annually review improper payment reporting in the agency's Performance and Accountability Report (PAR) or the Agency Financial Report (AFR). According to OMB guidance, compliance with P.L. 111-204, *Improper Payments Elimination and Recovery Act* (IPERA) means that the agency met the following six requirements:

1. Published a PAR or AFR for the most recent fiscal year and posted that report and any accompanying materials required by OMB on the agency Website;

2. Conducted a specific risk assessment for each program or activity that conforms with title 31, United States Code, section 3321;

3. Published improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment;

4. Published programmatic corrective action plans in the PAR or AFR;

5. Published and met annual reduction targets for each program assessed to be at risk and measured for improper payments; and

6. Reported a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR.

OIG's review found VA did not fully comply with IPERA. VA met four of six IPERA requirements for FY 2015 by publishing the AFR; performing risk assessments; publishing improper payment estimates; and providing information on corrective action plans. VA did not comply with two of six IPERA requirements by not maintaining a gross improper payment rate of less than 10 percent and meeting reduction targets for all programs published in the AFR. Two programs exceeded the 10 percent threshold: VA Community Care and Purchased Long Term Care Support and Services. Eight programs did not meet reduction targets: Compensation; Education Chapter 1606; Education Chapter 1607; VA Community Care; Purchased Long Term Services and Support; Beneficiary Travel; Supplies and Materials; and P.L. 113-2, *Disaster Relief Act— Hurricane Sandy.*

In addition, VHA underestimated improper payments for one program and did not achieve the expected level of accuracy for two others. Likewise, VBA expended considerable effort to collect improper payments because of a program design issue with drill pay, and it needs to develop a plan and seek the assistance of OMB to coordinate future resolution.

Office of Investigations

Veterans Health Administration 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 120 cases; made 100 arrests; obtained over $2.5 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $5.6 million in savings, efficiencies, and cost avoidance; and recovered over $23,000.

During this reporting period, OIG opened 28 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 32 individuals were charged with various crimes relating to drug diversion. These investigations resulted in over $11,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and over $190,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OI initiated 6 investigations related to the fraudulent receipt of health benefits, which resulted in 7 arrests for various related crimes. These investigations resulted in approximately $355,000 in fines, restitution, penalties, and civil judgments; and nearly $1 million 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 five investigative cases and made eight arrests. The investigations resulted in over $66,000 in court ordered payment of fines, restitution, penalties, and civil judgments. In addition, a fee basis fraud investigation resulted in more than $1 million in savings and a suspicious death investigation resulted in over $2.4 million in cost avoidance.

OI opened 30 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, 16 individuals were arrested which resulted in over $1.2 million in court ordered payments of fines, restitution, and penalties as well as nearly $315,000 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 Augusta, Georgia, VAMC Chief of Fee Basis Convicted of Making False Statements

The former Augusta, GA, VAMC Chief of Fee Basis was found guilty at trial of making false statements in relation to health care and making a false statement to a Federal agent. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 non-VA care coordination consults at the VAMC. Specifically, the defendant directed his subordinates to falsely document, "Services provided or patient refused services" in the patients' VA electronic medical records even though employees had not reviewed the records or contacted the patients. OIG's OHI conducted a review of approximately 2,700 patient records and determined that over 450 patients never received care and/or refused services. This case was the first OIG "Wait Time" investigation that resulted in criminal charges and a subsequent conviction.

Former Director of the Phoenix, Arizona, VAMC Sentenced for Making a False Statement

The former Director of the Phoenix, AZ, VAMC was sentenced to 2 years' probation after pleading guilty to making a false statement. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant received over $50,000 in gifts from a consultant and failed to report those gifts on her financial disclosure reports. The consultant was a former VISN Director who previously served as the defendant's supervisor before working for a Washington, DC, consulting and lobbying firm.

Former Hampton, Virginia, VAMC Nurse Sentenced for Aggravated Sexual Abuse and False Statements

A former Hampton, VA, VAMC registered nurse was sentenced to 17 years' incarceration, 20 years' probation, was ordered to pay the victim $122,211 in restitution, and to register as a sex offender after being found guilty at trial of aggravated sexual abuse and false statements. An OIG investigation resulted in the defendant being charged with administering morphine to a patient against her wishes and then sexually assaulting her multiple times.

Wyoming CBOC Nurse Sentenced for Vulnerable Adult Abuse

A VA nurse assigned to a Wyoming VA CBOC was sentenced to 1 to 4 years' incarceration and was ordered to pay the victim $39,000 in restitution after being convicted at trial of vulnerable adult abuse. Through her position at the medical facility, the defendant met an elderly veteran and convinced him to give her $39,000 to attend school. The defendant never used the funds for school, instead spending the funds on personal expenses and a vacation.

Waco, Texas, VAMC Employee Arrested for Aggravated Sexual Assault

A Waco, TX, VAMC employee was arrested after being indicted for aggravated sexual assault. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted a mentally challenged co-worker while at the medical center.

Lexington, Kentucky, VAMC Physician Sentenced for Assault by Offensive Contact

A Lexington, KY, VAMC physician pled guilty to Assault by Offensive Contact. In its final Order, the court sentenced him to 6 months' incarceration (suspended) and11 months and 29 days' supervised probation. The defendant was also ordered to stay away from the victim and to suspend his employment with the Lexington, KY, VAMC.

Former Albany, New York, VAMC Hospice Nurse Sentenced for Drug Diversion

A former Albany, NY, VAMC hospice nurse was sentenced to 82 months' incarceration and 3 years' supervised release after pleading guilty to tampering with a consumer product and obtaining controlled substances by deception and subterfuge. An OIG and Food and Drug Administration (FDA) Office of Criminal Investigation investigation revealed that the defendant stole oxycodone hydrochloride from syringes and replaced the contents with Haldol, an anti-psychotic medication. The investigation further revealed that the defendant may have inflicted pain and suffering on dying hospice patients by diverting their pain medication for his own use and replacing it with a drug that was subsequently administered by other nurses.

Little Rock, Arkansas, Pharmacy Employee Indicted for Diversion of a Controlled Substance

A VA pharmacy employee was indicted for diversion of a controlled substance. An OIG and Drug Enforcement Administration (DEA) investigation revealed that three Little Rock, AR, VAMC pharmacy employees allegedly conspired to divert approximately 4,000 dosages of oxycodone, 1,500 dosages of hydrocodone, 13,200 dosages of

Viagra, 1,320 dosages of Cialis, and 308 ounces of promethazine with codeine. All three employees have been removed from their pharmacy positions. Additional charges are pending in this investigation.

Six Jackson, Mississippi, VAMC Employees/Veterans Arrested for Sale of a Controlled Substance and Conspiracy

Six Jackson, MS, VAMC employees/veterans were arrested for sale of a controlled substance and conspiracy. An OIG and state Bureau of Narcotics investigation revealed that numerous transactions involving the sale of VA-issued hydrocodone occurred on VA property between these employees and were later sold to members of the community. The employees involved were assigned to VA Police Service, human resources, transportation services, housekeeping, and pharmacy. Three employees resigned as a result of the investigation and others have been placed on administrative leave pending further judicial action.

Former Bronx, New York, VAMC Pipefitter Sentenced for Drug Distribution

A former Bronx, NY, VAMC pipefitter was sentenced to 36 months' incarceration and 36 months' supervised release after pleading guilty to conspiracy to distribute and possession with intent to distribute cocaine. An OIG, United States Postal Inspection Service (USPIS), VA Police Service, and DEA's New York Organized Crime Drug Enforcement Strike Force investigation revealed that six United States Postal Service (USPS) Priority Mail parcels, each containing 1 to 2 kilograms of cocaine, were mailed to the defendant from Puerto Rico to a Bronx, NY, VAMC warehouse. Five defendants have been charged in this case, including two former VA employees.

Former Providence, Rhode Island, VAMC Nurse Sentenced for Drug Diversion

A former Providence, RI, VAMC registered nurse was sentenced to 2 years' probation and was ordered to pay VA $1,000 in restitution after pleading guilty to theft of Government property and false statements. An OIG and DEA investigation revealed that the defendant diverted oxycodone, morphine, hydrocodone, hydromorphone, and lorazepam from the VAMC Pyxis medication dispensing system. Specifically, the defendant would remove medication from the system and indicate in the Pyxis entry that the medication was being removed in order to be administered to a patient who had a doctor's order for the medication. A search warrant was executed at the defendant's residence and VA pharmaceuticals, empty controlled substance packaging, and syringes were seized from the residence. The defendant admitted to stealing 240 controlled substances for a month 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 during her application for VA employment.

West Haven, Connecticut, Employee Sentenced for Drug Distribution

A West Haven, CT, VAMC Food and Nutrition Service employee was sentenced to 5 years' incarceration (suspended) and 3 years' probation after pleading guilty to the sale of a hallucinogenic/narcotic. The defendant had previously been arrested during an OIG and state narcotics task force investigation that was initiated after it was learned that he was selling drugs to veterans and other employees at the VAMC. In a separate case, a former West Haven, CT, VAMC employee was arrested for sale of a hallucinogenic/narcotic. An OIG, VA Police Service, and local police investigation resulted in the defendant being charged after he sold crack cocaine and prescription narcotics to an informant. After his arrest, a search warrant was executed at the defendant's residence where drug paraphernalia was discovered. Two other criminal complaints have been filed against individuals who supplied the defendant with the illicit drugs.

Former Ann Arbor, Michigan, VA Canteen Chief Sentenced for Theft

A former Ann Arbor, MI, VA canteen chief was sentenced to 15 months' incarceration, 2 years' supervised release, and was ordered to pay restitution of $314,400 after pleading guilty to Theft of Government Funds. An OIG investigation revealed the defendant used the stolen funds for gambling, prostitutes, and at adult entertainment clubs.

Former West Los Angeles, California, VAMC Payroll Technician Indicted for Wire Fraud and Theft of Government Funds

A former West Los Angeles, CA, VAMC payroll technician was indicted for wire fraud and theft of Government funds. An OIG investigation revealed that the former employee diverted 136 payroll allotments, totaling $4,689, from the pay of other employees to his own bank account. During the investigation, the employee confessed to the misappropriation and resigned. Subsequent investigative efforts revealed that the defendant allegedly engaged in another embezzlement scheme involving VA's Financial Service Center (FSC). The former employee generated fraudulent vendor forms and sent them to the FSC in order to redirect VA suspense payments to bank accounts under his control. The loss associated with this second scheme is $110,424.

Former Montrose, New York, VAMC American Federation of Government Employees President Sentenced for Wire Fraud

A former Montrose, NY, VAMC American Federation of Government Employees president was sentenced to 15 months' incarceration, 24 months' supervised release, and was ordered to pay $150,000 in restitution after pleading guilty to wire fraud. An OIG and Department of Labor (DOL) Office of Labor Management Standards investigation resulted in the defendant being charged with using a union debit card to withdraw cash and pay for personal expenses. Some of the expenses included Armani suits, $30,000 in U.S. Postal money orders, and electronics.

Former Palo Alto, California, VAMC Employee Sentenced for Fraud

A former Palo Alto, CA, VAMC employee was sentenced to 8 months' home detention, 3 years' supervised release, and was ordered to pay restitution of $3,019 after pleading guilty to conspiracy, access device fraud, fraud in connection with identification information, and aiding and abetting. An OIG and VA Police Service investigation resulted in the VA employee and three other defendants being charged with conspiracy to steal the personal identifying information of a VAMC employee and use the information to create unauthorized credit card accounts and counterfeit checks that were then used to make purchases at various retail stores. The purchased items were then either sold or traded for narcotics. Two of the other defendants were previously sentenced, and the fourth defendant was given a pretrial diversion.

Former Manchester, New Hampshire, VAMC Pharmacist Convicted of False Statements

A former Manchester, NH, VAMC pharmacist was found guilty at trial of 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 diversion and lack of clinical competence.

Former Mississippi VA CBOC Contract Employee Indicted for Making Threats

A former Mississippi VA CBOC contract employee, who worked as a social therapist, was indicted for making threats. An OIG investigation revealed that the defendant was terminated from employment for egregious administrative violations that included an outside relationship with a female veteran patient. Four days post-termination, the defendant returned to the CBOC with a weapon and paraded in front of the facility.

Little Rock, Arkansas, VAMC Employee Sentenced for Making a Threatening Communication

A Little Rock, AR, VAMC employee, who is also a veteran, was sentenced to 6 months' incarceration, 2 years' supervised released, and was ordered to participate in mental health counseling/anger management classes after pleading guilty to making a threatening communication. An OIG investigation revealed that the defendant made threats to engage in a mass shooting spree at the VAMC.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 12 months' incarceration and 3 years' supervised release after pleading guilty to possession with intent to distribute a controlled substance. An OIG, VA Police Service, and local law enforcement investigation resulted in the defendant, who was previously enrolled in an inpatient substance abuse treatment program, being charged with selling crack cocaine at the Canandaigua, NY, VAMC. The defendant has been held in custody for violating his order of release.

Non-Veteran Sentenced for Drug Distribution

A non-veteran was sentenced to 5 years' incarceration (2 years suspended) and 3 years' probation after pleading guilty to drug distribution. The defendant was arrested after selling heroin during an undercover operation. An OIG, VA Police Service, and local police investigation was initiated after a veteran inpatient died from a heroin overdose at the West Haven, CT, VAMC.

Subject Pleads Guilty to Health Care Fraud

An OIG and VA Police Service investigation resulted in a defendant being charged with, and subsequently pleading guilty to, fraudulently receiving $63,000 in VA services to include medical care, housing benefits, compensated work therapy pay, and beneficiary travel pay. The defendant was ineligible for these benefits as he failed to complete boot camp in the National Guard. The defendant's false statements to the White River Junction, VT, VAMC, included claims that his DD-214 was destroyed in the St. Louis fire and that he was shot twice as a door gunner while rescuing Prisoners of War in Vietnam. The investigation further disclosed that during the time period the defendant claimed to be in Vietnam, he spent a portion of that time incarcerated in New Hampshire.

Non-Veteran Sentenced for "Stolen Valor"

A non-veteran was sentenced to 18 months' incarceration, 12 months' probation, and was ordered to pay VA restitution of $13,623. An OIG investigation revealed that the defendant falsely represented himself as both a decorated U.S. Marine Corps and California Army National Guard veteran in order to obtain health care benefits from the Redding, CA, VA CBOC. The loss to VA is $13,623.

Final Co-Conspirator Sentenced for VA Travel Fraud

The final co-conspirator of a group consisting of nine veterans and two former Seattle, WA, VAMC travel clerks was sentenced to 22 weeks' incarceration, 3 years supervised release, and was ordered to pay restitution of $4,222 after pleading guilty to False Claims. An OIG investigation revealed that the veterans participated in a scheme with the VA travel clerks to submit inflated and fictitious travel benefit vouchers. In return for processing the fraudulent travel vouchers, the VA travel clerks received cash kickbacks from the veterans. The loss to VA is in excess of $180,000.

Veterans Sentenced for Travel Benefit Fraud

A veteran in Mobile, AL, was sentenced to 4 months' incarceration, 3 years' supervised release, and was ordered to pay VA restitution of $43,588 after pleading guilty to theft of Government funds. An OIG investigation

resulted in the defendant being charged with using a fictitious address on 924 beneficiary travel claims for approximately 4 years. The loss to VA is $43,588.

A veteran was sentenced to 60 months' probation and was ordered to pay restitution of $10,878 after pleading guilty to false claims. An OIG investigation revealed that the veteran filed approximately 115 false travel claims at the Spokane, WA, VAMC.

Three Veterans Indicted for Travel Benefit Fraud

Three veterans were indicted for false, fictitious or fraudulent claims against the U.S. Government. An OIG investigation revealed that for approximately 2 years the three defendants submitted false addresses to the Asheville, NC, VAMC in order to receive travel reimbursements to which they were not entitled. One defendant received $15,391 by claiming an address over 100 miles from the medical center, when in fact he lived only 8 miles away. The loss to VA was $39,549.

Veteran Pleads Guilty to Travel Benefit Fraud

A veteran pled guilty to Grand Larceny. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation resulted in the defendant being charged with receiving Medicaid-funded transportation to and from the Montrose, NY, VAMC on 747 occasions while also claiming and receiving VA travel benefits for the same travel. The loss to VA is $19,079.

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 122 investigations, which resulted in 28 arrests and $6.4 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,535 possible cases with over 4,265 investigative cases opened. Investigations have resulted in the actual recovery of $101 million, with an additional $34.1 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $205 million. To date, there have been 786 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OI opened 235 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 80 arrests for these types of investigations. OIG obtained over $15 million in court ordered payment of fines, restitution, penalties, and civil judgements; achieved over $9.1 million in savings, efficiencies, and cost avoidance; and recovered more than $5.1 million.

Former VA Fiduciary Arrested for Misappropriation

A former VA fiduciary was arrested after being indicted for theft of Government funds and misappropriation by a fiduciary. An OIG investigation revealed that the defendant, appointed as a VA fiduciary to manage three veterans' financial affairs, embezzled approximately $130,000 of VA funds for her own use.

Fiduciary Sentenced for Theft and Other Charges

A fiduciary was sentenced to 48 months' incarceration and was ordered to pay $117,635 in restitution ($35,962 to VA beneficiaries) after pleading guilty to criminal mistreatment, aggravated theft, theft, money laundering, and personal income tax evasion. A VA OIG, Social Security Administration (SSA) OIG, and Oregon Department of Justice Medicaid Fraud Unit investigation revealed that the defendant, who was assigned to over 100 veterans and other non-VA beneficiaries, embezzled funds from numerous accounts.

VA-Appointed Fiduciary Indicted for Theft of Government Funds

A VA-appointed fiduciary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with misusing VA funds intended for her veteran brother. The defendant is alleged to have used her brother's money for church tithes, to pay her own mortgage, and for various other personal expenses. The veteran sustained a loss of $55,621.

Former VA Fiduciary Pleads Guilty to Theft of Public Money

A former VA fiduciary pled guilty to theft of public money. The defendant, an attorney at the time, was appointed as a guardian for a 64-year-old veteran. An OIG investigation resulted in the defendant being charged with stealing approximately $36,000 in VA benefits from the veteran's bank account between October 2009 and March 2011. The defendant used the embezzled funds for personal expenses.

Veteran's Niece Arrested for Criminal Mistreatment

A veteran's niece was indicted and subsequently arrested for criminal mistreatment and other charges. An OIG and local sheriff's investigation resulted in an allegation that the defendant removed the veteran's VA-assigned fiduciary from a joint account and then took control of the veteran's finances. The defendant then used the embezzled funds to make unauthorized purchases of a home and recreational vehicles. A financial analysis identified $124,174 in potential theft to include $15,500 in VA funds.

Former VA Fiduciary Arrested for Embezzlement

A former VA fiduciary was indicted and arrested for wire fraud, misappropriation by a Federal fiduciary, making false statements, and preparing fraudulent tax returns. An OIG, FBI, and Internal Revenue Service (IRS) Criminal Investigation Division (CID) investigation determined that from 2007 to 2012 the defendant served as a VA fiduciary for eight disabled veterans and allegedly embezzled VA-issued funds. The defendant allegedly used the stolen funds to pay down the mortgage on his house. The total embezzlement amount is still being determined.

Veteran Convicted of Health Care Fraud

A veteran was found guilty at trial of health care fraud. An OIG and FBI investigation revealed that from March 1995 to June 2013, the defendant misrepresented his vision loss to VA and as a result was granted a 100 percent service connection for vision loss, SMC, and other program benefits to which he was not entitled. The defendant was observed walking without assistance, driving with a valid driver's license, and even receiving a speeding ticket. In addition to approximately$700,000 in monthly VA compensation benefits, the defendant also received a $10,000 VA grant to purchase an automobile, which was intended for another person to drive the defendant, and an $11,000 VA grant towards the installation of an in-ground swimming pool at his residence.

In addition, the defendant received over $75,000 in VA health care benefits to which he was not entitled, to include Civilian Health and Medical Program of VA (CHAMPVA), dental services, beneficiary travel pay, blind rehabilitation training, and prosthetics equipment and devices. The loss to VA is approximately $800,000.

Veteran and Wife Indicted for VA Compensation Fraud

A veteran and his wife were indicted for fraud following an OIG investigation of allegations that the veteran provided VA with false information regarding his vision loss. The veteran had been rated with a 100 percent service-connected disability rating for blindness; however, the veteran was able to drive, shoot firearms, and perform most functions of daily living without the assistance of another person or low vision aids. The veteran received approximately $311,000 in VA compensation payments.

Veteran Pleads Guilty to Theft of VA Compensation Benefits

A veteran pled guilty to theft of public money. An OIG investigation revealed that in 1998 the defendant provided VA with a medical report from a non-VA ophthalmologist reporting that his visual acuity was "hand motion only," his vision would not get better, and that it could not be corrected by surgery. Based on this information, the defendant was rated 100 percent service-connected disabled for blindness. The investigation further revealed that the defendant possessed a valid driver's license, rode a motorcycle, and worked for 6 years as a mail clerk at a private business. A VA ophthalmologist recently examined the defendant and determined that he was not and could never have been blind. The loss to VA is $518,486.

Veteran Indicted for Theft of VA Compensation Benefits

A veteran was indicted for theft of Government funds related to the fraudulent receipt of disability compensation benefits for blindness. Following an OIG investigation, the defendant admitted to making multiple false statements over a 15-year period in order to obtain VA benefits related to her visual and mental health. The loss to VA is $395,596.

Veteran Indicted for Fraud Involving VA Programs

A veteran was indicted for false, fictitious or fraudulent claims, theft of Government funds, false statements relating to health care matters, and health care fraud. The defendant allegedly manufactured a fraudulent DD-214 claiming a Purple Heart, Special Forces Service, and combat service in Vietnam. The defendant was subsequently awarded 100 percent service-connected disability for PTSD and as a result, fraudulently received VA compensation benefits, health care benefits, education benefits, and travel reimbursement benefits. In fact, the defendant received an "Other than Honorable" discharge for being absent without leave and he never served in combat. The loss to VA is $137,240.

Veteran and Sister Plead Guilty To Committing Fraud Against VA

The sister of a veteran pled guilty to delivery of a false writing and the veteran pled guilty to wire fraud. An OIG investigation revealed that both defendants filed forged documents with VA that lead to the issuance of VBA compensation benefits to the veteran and VHA Caregiver Support Program payments to the sister. The veteran claimed to be totally disabled due to a TBI and other injuries sustained in Iraq and that he was unable to perform tasks of daily living. As a result, VA appointed the veteran's sister to be the full-time caregiver. In actuality, the veteran did not suffer from a TBI and lived a lifestyle that required no assistance. The sister facilitated the ongoing fraud by continually making statements to VA that she was the full-time caregiver. The loss to VA is approximately $82,000.

Veteran Sentenced for Fraud

A veteran was sentenced to 25 years' incarceration, 3 years' supervised release, and was ordered to pay $2,316,862 in restitution ($79,362 to VA) after previously being found guilty at trial of conspiracy to commit wire fraud, wire fraud, false claims, theft of public funds, fictitious obligation, false statements, and failure to file a tax return. An OIG and IRS CID investigation resulted in the defendant being charged with orchestrating a large-scale Nigerian oil investment scheme that defrauded investors of over $2 million. While perpetrating the investment scheme, the veteran fraudulently received individual unemployability compensation benefits from VA.

Veteran's Former Wife Indicted for Theft of Government Funds

The former wife of a deceased VA pension beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with allegedly stealing her former husband's VA benefits after his death in August 2009. The defendant is also alleged to have divorced the veteran in July 1982 in order to ensure that her husband's VA pension benefits continued. The defendant's employment income would have made the veteran ineligible for pension benefits if the couple had not divorced. The veteran and the defendant lived together as husband and wife following the divorce. The loss to VA is approximately $290,000.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced to 5 months' incarceration, 5 months' home confinement, and 2 years' probation after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged after it was discovered that he worked numerous construction and home remodeling jobs for three different companies from 2006 to 2014 while in receipt of VA pension benefits. The defendant claimed on his VA application that he was unable to work due to a degenerative back disease and reported no net worth or monthly income. The loss to VA is $121,156.

Veteran Pleads Guilty to Theft of Government Funds

A veteran receiving VA compensation benefits pled guilty to theft of Government funds. An OIG investigation resulted in the defendant, who was employed from 2011 to 2014 at the local district attorney's office and the Oregon Department of Justice (DOJ), being charged with fraudulently collecting individual unemployability benefits. The loss to VA is $51,698.

Veteran Arrested for Making False Statement to VA

A veteran was arrested after being indicted for making a false statement. An OIG investigation revealed that the defendant falsely claimed that he suffered from PTSD caused by his deployment to Iraq. Military records revealed that the defendant received a General Discharge for Misconduct after 16 months of service and was never deployed overseas. The loss to VA is approximately $60,000.

Muskogee, Oklahoma, VARO Employee Pleads Guilty to Theft of Government Funds

A Muskogee, OK, VARO employee pled guilty to theft of Government funds. An OIG investigation revealed that on three separate occasions the defendant fraudulently processed Chapter 33 education benefits using the account of a veteran who was not currently receiving education benefits. The defendant had the funds sent to a Green Dot card account that he opened in his brother's name. The loss to VA was $41,991.

Son of Deceased VA Beneficiary Indicted for Theft

The son of a deceased VA beneficiary was indicted for theft. An OIG investigation revealed that the defendant stole funds that were direct deposited after his father's death in July 2007 by forging the name of his deceased mother, who was still listed as a joint account holder. The loss to VA exceeds $300,000.

Friend of Deceased Veteran Beneficiary Sentenced for Theft of VA Benefits

The friend of a deceased veteran beneficiary was sentenced to 3 years' probation, during which the defendant must serve three 10-day sentences of incarceration and 9 months' home confinement. The defendant was also ordered to pay VA restitution of $265,483. An OIG investigation revealed that the defendant stole VA compensation benefits that were direct deposited after the veteran's death in April 2006.

Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds

After pleading guilty to theft of Government funds, the son of a deceased VA beneficiary was sentenced to 12 months' incarceration, 36 months' supervised release, and was ordered to pay VA restitution of $178,789. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after his mother's death in November 2003.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after her mother's death in November 2003. VA was able to recover $35,535 via reclamation. The loss to VA is $166,289.

Friend of Deceased VA Beneficiary Indicted for Theft of Government Funds

The friend of a deceased VA widow beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to a joint account after the widow's death in February 2008. The loss to VA is $127,288.

Great-Nephew of Deceased VA Beneficiary Pleads Guilty To Theft of Government Funds

The great-nephew of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the death of his great-aunt in November 2009. The loss to VA is $109,292.

Son of Deceased VA Beneficiary Indicted for Theft of Government Funds

The son of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were issued after his mother's death in February 2009. During the investigation, the defendant initially claimed that his mother was alive. The indictment also included a forfeiture allegation listing a monetary judgement of $106,583 (VA loss) and a boat, which the defendant purchased with proceeds from the theft.

Nephew of Deceased VA Beneficiary Arrested for Theft of Government Funds

The nephew of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that following the beneficiary's death in August 2007, the mailing address on the beneficiary's checking account was changed to the defendant's home address. The defendant then utilized the bank debit card to make numerous cash withdrawals from the account. The loss to VA is $102,622.

Daughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 8 months' home confinement, 5 years' probation, and was ordered to pay VA restitution of $98,510. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after her father's death in August 2012. The defendant admitted to using the stolen VA funds for personal use.

Daughter of Deceased VA Beneficiary Sentenced for Theft

The daughter of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay VA restitution of $95,658. An OIG investigation resulted in the defendant being charged with stealing 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.

Son of Deceased Dependency and Indemnity Compensation Beneficiary Pleads Guilty to Theft of Government Funds

The son of a deceased dependency and indemnity compensation (DIC) beneficiary pled guilty to theft of Government funds. During an OIG investigation, the defendant admitted to not notifying VA of his mother's death in June 2008 and to using the stolen VA benefits for personal expenses. The loss to VA is $94,317.

Former Daughter-in-Law of Deceased VA Beneficiary Indicted for Theft of Government Funds

The former daughter-in-law of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with using her Power of Attorney to steal VA benefit checks and direct deposits that were issued after the beneficiary's death in November 2005. The defendant allegedly used the stolen funds for personal expenses. The loss to VA is $89,868.

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

The neighbor of a deceased VA beneficiary pled guilty to theft of Government funds. The defendant had been assisting his neighbor, a VA beneficiary, before her death and had access to her checkbook. The defendant allegedly wrote 70 checks to himself from the beneficiary's account after her death in December 2009, forging her signature on each check. The loss to VA is $79,958.

Son of Deceased VA Beneficiary Indicted for Theft of Government Funds

The son of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after the veteran's death in February 2009. The defendant used the funds for personal expenses. The loss to VA is $70,211.

Daughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The daughter of a deceased VA beneficiary was sentenced to 4 years' probation, 150 hours' community service, and was ordered to pay VA restitution of $61,469 after pleading guilty to the theft of public money. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in November 2009.

Former Roommate of Deceased VA Beneficiary Sentenced for Theft

The former roommate of a deceased VA beneficiary was sentenced to 2 years' probation and was ordered to pay restitution of $26,647 after pleading guilty to theft of public money. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited to a joint account after the beneficiary's death in December 2012. The defendant used the VA funds to pay her expenses.

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 12 cases and made 9 arrests. These investigations resulted in over $45 million in court ordered payment of fines, restitution, penalties, and civil judgments; and over $366,000 in savings, efficiencies, cost avoidance, and more than $328,000 in dollar recoveries.

Non-Veteran Business Owner Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

A non-veteran owner of a Service-Disabled Veteran-Owned Small Business (SDVOSB) was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million fine after previously being found guilty at trial of conspiracy to defraud the United States and wire fraud. Criminal asset forfeiture proceedings are still pending. A VA OIG, Small Business Administration OIG, General Services Administration OIG, Army CID, and Navy Criminal Investigative Service investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service-disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts. The case involved over 200 VA construction contracts that occurred in at least 7 states.

Pharmaceutical Manufacturer Warner Chilcott Public Limited Company Pleads Guilty to Health Care Fraud

DOJ announced that Warner Chilcott U.S. Sales Limited Liability Company (LLC), a subsidiary of pharmaceutical manufacturer Warner Chilcott Public Limited Company (PLC), pled guilty to health care fraud and was sentenced that same day. As part of a global settlement with the United States, the company 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 VA OIG, FBI, Health and Human Services OIG, FDA Office of Criminal Investigations, Defense Criminal Investigative Service (DCIS), and Office of Personnel Management OIG investigation, the company pled 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, manipulating prior authorizations to induce insurance companies to pay for prescriptions of Atelvia that the insurers may not have otherwise paid for, and making unsubstantiated marketing claims for the drug Actonel. Under the terms of the agreement, the company will pay a $20.7 million criminal fine, $2 million criminal forfeiture, and has also entered into a civil settlement agreement under which it agreed to pay $102.1 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. Individuals charged to date in this health care fraud scheme include the former president of the company; three district managers, all of whom pled guilty; and a private physician. The investigation continues and criminal charges against other individuals are anticipated.

Veteran's Widow Sentenced for Murder

A veteran's widow was sentenced to 50 years' incarceration after being found guilty at trial of attempted first degree murder and conspiracy to commit first degree murder. This case was initiated pursuant to information that was developed during a previous VA compensation benefits fraud investigation. A VA OIG, SSA OIG,

Tennessee Bureau of Investigation, and State District Attorney's Office investigation resulted in the defendant and her previous boyfriend/current spouse being charged with conspiracy to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on his VA prescribed drugs and then staging a crime scene to make it appear that he had committed suicide. The defendant later applied for DIC benefits and falsely claimed that her husband's drug overdose was related to his service connected PTSD. The defendant'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. The loss to VA is approximately $107,000.

Business President Arrested for Conspiracy To Commit Wire Fraud

The president of a private business was arrested for conspiracy to commit wire fraud while attempting to fly to Guatemala. A VA OIG, FBI, and Department of Education OIG investigation revealed that the defendant engaged in a conspiracy to defraud VA by fraudulently obtaining tuition assistance and other education-related benefits under the Post 9/11 GI Bill. Over the course of the conspiracy, the defendant partnered with a New Jersey university to obtain approval from VA to receive tuition and other education benefits for several online non-credit training and certification courses. These courses were purportedly developed, taught, and administered by the faculty of the university, but were actually developed, taught, and administered by undisclosed and unapproved subcontractors of the private business. The defendant and others developed marketing materials and a script to be used by the private business' salespersons at various military bases around the United States in order to market to and enroll thousands of veterans in the courses. While most courses at the correspondence school cost between approximately $600 and $1,000 in tuition, the university charged between approximately $5,000 and $26,000 per course. Over the course of the conspiracy, the defendant and others caused VA to pay out over $35 million.

Millennium Laboratories Agrees to Pay $256 Million

DOJ announced that Millennium Laboratories, a global urinary drug testing lab, has agreed to pay the United States $256 million to resolve allegations that Millennium filed false claims in violation of the P.L. 97-258, *False Claims Act*. The agreement was the result of a VA OIG, FBI, DCIS, and Health and Human Services OIG investigation that alleged that Millennium submitted false claims to Federal health care programs for excessive urinary drug testing and pharmacogenetics testing, which were also deemed to be medically unnecessary. VA's portion of the total civil damages is $723,880.

Medical Device Manufacturer Acclarent, Inc., Agrees to Pay $18 Million

Medical device manufacturer Acclarent Inc., a subsidiary of Ethicon, a Johnson & Johnson company, has agreed to pay $18 million to resolve allegations that it caused health care providers to submit false claims to Federal health care programs, including VA, by marketing and distributing one of its products, the Relieva Stratus, for use as a drug delivery device without FDA approval. This agreement was the result of an OIG, FBI, DCIS, and the FDA Office of Criminal Investigations investigation that alleged despite Acclarent receiving the FDA clearance to market the Stratus as a spacer to be used only with saline, Acclarent marketed the device to be used to deliver corticosteroids. VA's portion of the settlement will be determined at a later date. Also, the former Chief Executive Officer and Vice President of Sales of Acclarent, Inc., were found guilty at trial of introducing adulterated and misbranded medical devices into interstate commerce.

Architect Sentenced for Bribery of Former Director of the Cleveland and Dayton VAMCs

An architect, formerly employed by a VA contractor, was sentenced to 33 months' incarceration, a $12,500 fine, and was ordered to forfeit $70,801 after being convicted at trial of conspiracy, wire fraud, mail fraud, theft of Government property, and violating the P.L. 114-38, *Hobbs Act*. An OIG and FBI investigation revealed that the defendant bribed the former Director of the Cleveland and Dayton VAMCs in order to receive non-public

information concerning VA contracts. As a result, the defendant was able to obtain an advantage over other companies in the awarding of VA contracts. The former VAMC Director pled guilty to corruption-related charges in 2014. Also, the company the architect worked for entered into a Criminal Enforcement Agreement (CEA) with the Government to resolve criminal liability for its employee(s) criminal conduct. Per the CEA, the contractor accepted legal responsibility for the criminal conduct and agreed to pay a $12 million penalty. Attached to the CEA are a Criminal Information, signed Waiver of Indictment, and Statement of Facts that will be filed in U.S. District Court if the contractor fails to comply with the terms of the CEA.

Former Palo Alto, California, VAMC Sub-Contractor Sentenced for Providing a Gratuity to a Public Official

A former Palo Alto, CA, VAMC sub-contractor was sentenced to 12 months' home confinement, 3 years' probation, and a $27,500 fine after pleading guilty to providing a gratuity to a public official. An OIG and FBI investigation determined that the defendant provided VA officials with approximately $80,000 in bribes and gratuities to include cash, vehicles, airline tickets, hotel stays, payment of credit card bills, and residential construction work. In exchange for the gifts, the VA officials awarded projects to prime contractors who used the defendant as their sub-contractor. As a result of this investigation, two former VA contract officer representatives who received bribes from the defendant were sentenced, and a former VA contracting officer is scheduled to be sentenced next month.

Former VA Contracting Officer Sentenced for Receiving a Bribe

A former VA contracting officer was sentenced to 6 months' incarceration, 6 months' home detention, and 3 years' probation after pleading guilty to receipt of a bribe by a public official. A VA OIG and FBI investigation revealed that the defendant accepted bribes from VA contractors in exchange for ensuring that the contractors received continuous construction work at various VA campuses. The bribes received by the defendant included cash, two vehicles, airplane tickets, hotel stays, and professional football tickets totaling $105,741 and affected VA contracts worth nearly $27 million.

Former VA Contractor Sentenced for Providing a Gratuity to a VA Contracting Officer

A former VA contractor was sentenced to 3 years' probation and was ordered to pay a $5,000 fine after pleading guilty to providing a gratuity to a VA contracting officer. A VA OIG and FBI investigation revealed that after receiving VA contracts, the contractor paid for the contracting officer and her friends to travel to Las Vegas for her birthday in 2008, 2009, and 2010. The gratuities included payment of airline tickets and hotel accommodations.

Former VA Contractor Sentenced for Wire Fraud

A former VA contractor was sentenced to 1 year of home confinement, 3 years' supervised release, and was ordered to pay $169,677 in restitution after pleading guilty to wire fraud. An OIG investigation resulted in the contractor and a VA employee being charged with conspiring to order goods and services that were not needed and were never provided to the West Roxbury, MA, VAMC. For approximately 2 years, the VA employee, who was responsible for the maintenance and information technology support of medical equipment, created the false purchase orders and then paid the contractor using his VA purchase card. The investigation determined that for over 82 purchases VA paid the contractor and his company a total of $222,242. The employee and contractor then divided the fraudulently obtained payments. The VA employee died after being charged.

Veteran and Others Indicted for Procurement Fraud

A veteran was one of seven individuals and two corporations indicted for procurement fraud related to the award of nearly $350 million in Federal Government construction contracts. The indicted veteran claimed to control and operate a SDVOSB, and other defendants claimed to control and operate minority-owned and woman-owned businesses in order to obtain Government set-aside contracts. However, a multi-agency investigation resulted in the defendants being charged with hiding the fact that construction companies that actually performed the work were not controlled by disabled veterans, minorities, or women.

Six Subjects Indicted for Fraud

Six subjects have been indicted and three have pled guilty to various charges to include conspiracy to defraud the United States, major fraud against the United States, and wire fraud. A multi-agency investigation revealed that a fraudulent SDVOSB construction company contracted with VA to build a 400-space parking structure at the Durham, NC, VAMC. When the contractor defaulted on the project after completing about 70 percent of the work, VA attempted to activate the performance and payment bonds to compensate subcontractors and suppliers and to complete the project. The company is alleged to have purchased fake bonds because they lacked the working capital to purchase legitimate bonds. The fraudulent bond company was owned and operated by individuals who operated other fraudulent companies established to provide an illusion of legitimacy and share in the profits of their scheme. The fraudulent companies were found to have been conducting fraudulent bonding business for at least 10 years and had significantly impacted both state and Federal contracts. The total amount of the bonds was approximately $11 million, including $6.5 million for VA projects. The fraudulent company also had Cease and Desist Orders issued against them in at least seven states.

Company Owner Indicted for Conspiracy To Commit Mail Fraud

The owner of three companies that contracted with various Government agencies was indicted for conspiracy to commit mail fraud. A multi-agency investigation revealed that beginning as early as February 2010 the defendant received numerous contracts from the Government, to include a VA contract, through FedBid.com. Once the subject companies received a contract from the Government, they arranged for victim-vendors to provide the goods to the Government. In order to induce the victim-vendors to agree to provide the goods and extend credit to the subject companies, the defendant made fraudulent representations regarding his companies' creditworthiness and association with the Government. As part of the conspiracy, the defendant and his co-conspirators falsely promised to pay the victim-vendors for the goods. The defendant and his co-conspirators subsequently failed to pay more than 40 victim-vendors over $1 million for goods provided to various Government agencies.

Non-Veterans Sentenced for Conspiracy to Commit Mail and Wire Fraud

Two non-veterans were sentenced after pleading guilty to conspiracy to commit mail and wire fraud. The first defendant was sentenced to 30 months' incarceration, 2 years' supervised release, and was ordered to participate in a mandatory drug treatment program and to forfeit $1,108,735. The second defendant was sentenced to 12 months' home detention, 2 years' supervised release, and was ordered to forfeit $130,173. A multi-agency investigation resulted in the discovery of 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 over $10 million in bonding fees. The affected VA contracts totaled more than $97 million, including some American Reinvestment and Recovery funds.

Defendant Sentenced for Mail Fraud

A defendant was sentenced to 53 months' incarceration (to run concurrently with additional state imposed sentences) and to pay restitution of $2,043,702 after pleading guilty to mail fraud. A VA OIG and USPIS investigation revealed that the defendant utilized the mail to defraud veterans through the use of fraudulent businesses that were incorporated by the defendant to ostensibly assist veterans in applying for VA benefits. The defendant falsely represented that she was investing the veterans' VA funds in annuities. In addition to veterans, the defendant also defrauded other non-veteran senior citizens. The loss to veterans was $394,000.

Subject Arrested for Mortgage Fraud and Wire Fraud

A subject was indicted and arrested for mortgage fraud and wire fraud relating to a VA Home Loan Guarantee. An OIG investigation revealed that the defendant was an acquaintance of a service-connected veteran and used her access to the veteran's personal information to obtain a fraudulent VA Home Loan Guarantee of approximately $165,000. In order to qualify for the loan and VA Home Loan Guaranty, the defendant provided fraudulent information and documents to the bank.

Mortgage Company President Arrested for Conspiracy and Wire Fraud

The president and founder of a now-defunct mortgage company, Mortgage Security, Inc. (MSI), was indicted and arrested for conspiracy and wire fraud. The charges were the result of a VA OIG, Housing and Urban Development OIG, Department of Agriculture OIG, and FBI investigation involving the defendant's alleged scheme to defraud Ginnie Mae, a Government-run corporation. MSI was contracted with Ginnie Mae to pool eligible residential mortgage loans and then sell Ginnie Mae-backed mortgage bonds to investors. MSI was responsible for servicing the loans in the pools it created, including collecting principal and interest payments from borrowers, as well as loan payoffs, and placing those funds into accounts held in trust by Ginnie Mae. Among other things, Ginnie Mae required issuers, like MSI, to provide regular reports to Ginnie Mae concerning the status of the loans in the pools. Beginning in 2011, the defendant allegedly began diverting money that borrowers were sending to MSI in order to pay off several Federal Housing Administration and two VA loans. Specifically, the defendant is alleged to have deposited large-dollar loan-payoff checks into secret accounts and then used those funds for personal and business uses. The defendant allegedly stole nearly $3 million, which Ginnie Mae then had to reimburse to the guaranteed investors.

Defendants in Multiple Cases Sentenced for Conspiracy To Commit Health Care Fraud

A former DOL claims supervisor was sentenced to 51 months' incarceration, 3 years' supervised release, and was ordered to pay approximately $2 million in restitution to DOL after pleading guilty to bribery of a public official. A second defendant was sentenced to 36 months' probation and was ordered to pay approximately $299,000 in restitution ($7,192 to VA), after pleading guilty to Conspiracy to Commit Health Care Fraud.

A licensed professional counselor was sentenced to 78 months' incarceration, 3 years' supervised release, and was ordered to pay approximately $7.7 million in restitution after pleading guilty to conspiracy to commit health care fraud. A second licensed professional counselor was sentenced to 6 months' home confinement, 3 years' probation, and was ordered to pay $199,796 in restitution after pleading guilty to conspiracy to commit health care fraud. Three former VA employees were also sentenced to between 6 months and 1 year of probation and were ordered to pay restitution of between $868 and $4,500 after pleading guilty to false statements and/or fraud to obtain Federal employee's compensation.

Twenty-eight defendants, comprised of Office of Workers' Compensation Programs (OWCP) claimants (former Postal Service 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 this health care fraud

scheme. A multi-agency investigation revealed that the defendants' actions caused more than $9.5 million to be fraudulently billed to DOL OWCP.

Huntsville, Alabama, CBOC Medical Support Assistant Arrested for Attempting to Seduce a Child

A Huntsville, AL, CBOC medical support assistant was arrested for use of a computer service to seduce a child to commit an illegal act. An OIG, Georgia Bureau of Investigation, and local police investigation revealed that the defendant engaged in sexually explicit email correspondence from his VA computer in an attempt to engage in sexual activity with a police detective posing as a minor child. At the time of the defendant's arrest, OIG agents found pornographic images on his computer screen. The defendant was held pending extradition to Georgia.

Veteran Arrested for Larceny

A veteran was arrested for larceny. An OIG, IRS CID, and state police investigation resulted in the defendant being charged with fraudulently taking payments from several veterans with the promise of getting the veterans VA compensation and Social Security benefits. The defendant allegedly told his victims their payments would be used to pay an attorney to do research and file their claims with VA and/or SSA. The defendant allegedly took over $500,000 from his victims and never filed a single claim on their behalf.

Settlement Agreement Reached Between Remington College and a United States Attorney's Office

A settlement agreement was reached between Remington College and the United States Attorney's Office, District of Hawaii, after the college agreed to pay $295,000 to resolve alleged P.L. 99-562, *False Claims Act* violations. The agreement was the result of an OIG investigation that alleged that Remington College submitted false statements and false claims in order to obtain educational benefit payments from VA for beneficiaries who were enrolled in an unapproved program.

Settlement Agreement Between Company and United States Attorney's Office

A settlement agreement was reached between Holiday Acquisition Corporation and Fortress Investment Group, LLC (collectively Holiday), and the United States Attorney's Office, District of Oregon. Holiday agreed to pay $8.86 million to resolve alleged P.L. 99-562, *False Claims Act* violations. An OIG investigation revealed that Holiday recruited veteran tenants to reside in their facilities and promised to assist them in obtaining VA pensions with aid and attendance benefits. Holiday also assisted veterans and surviving spouses of veterans in applying for benefits and completed paperwork, including the care expense report. The facilities were described as assisted living facilities, although they were actually retirement facilities. This misrepresentation allowed VA beneficiaries, who would normally exceed the income limits for pension benefits, to qualify by categorizing their rent at the facilities as a deductible medical expense, thereby lowering their income level.

Majority Owner of New England Compounding Center and Husband Plead Guilty to Structuring Cash Withdrawals

The majority owner of New England Compounding Center (NECC) and her husband pled guilty to structuring cash withdrawals after learning that NECC was the subject of a Federal investigation. The defendants admitted to making structured withdrawals totaling approximately $124,000 following the initiation of an OIG, FBI, FDA, USPIS, and DCIS investigation that alleged that NECC products caused the deaths of 64 people and caused fungal infections in approximately 700 others. Although no known VA patients died or became ill as a result of receiving a NECC product, VA did purchase approximately $516,000 of products from NECC, all of which were

allegedly produced in unsanitary conditions and in an unsafe manner. Neither defendant had an active role in the operations or management of NECC.

Veteran Charged With Mail Fraud and Structuring Financial Transactions

A criminal information was filed charging a veteran with mail fraud and structuring financial transactions. An OIG and IRS CID investigation revealed that the defendant fraudulently took payments from 16 veterans by promising them that they would receive VA compensation benefits at a 100 percent rating. The veterans believed the payments to the defendant were to be used to pay an attorney to research and file claims with VA. The defendant subsequently stole over $400,000 from the veterans and never filed a single claim on their behalf.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 51 months' incarceration, 36 months' supervised release, and was ordered to pay $234,461 in restitution and to forfeit $20,252 after pleading guilty to False Claims Act and student loan fraud. An OIG and U.S. Department of Education investigation revealed that the defendant, a non-veteran, fraudulently received VA benefits by using the stolen identity of a veteran. The defendant obtained a VA Identification Card and VA health care benefits at the Kansas City, MO, VAMC using the identity of a veteran who has been incarcerated in Florida for the past 10 years. The defendant also obtained Veterans Retraining Assistance Program education benefits and Federal Student Aid at a local college using the veteran's identity. In addition, the defendant admitted to stealing other veterans' identities to receive VA medical care in Delaware, Florida, Georgia, Maryland, and Pennsylvania. The loss to VA is $214,710.

Subject Indicted for Identity Theft

A subject was indicted for use of an unauthorized access device for transactions, aggravated identity theft, and filing false tax returns. An OIG, IRS, and Tampa Police Department investigation revealed that the defendant used patient inquiry sheets that had been stolen from the Tampa, FL, VAMC by a former VA employee in order to facilitate stolen identity refund fraud. The attempted loss is $795,446, and the actual loss of Government funds is $167,120.

Veteran's Son Sentenced for Identity Theft

The son of a service-disabled veteran was sentenced to 69 months' incarceration and 36 months' supervised release after previously being found guilty at trial of theft and aggravated identify theft. No restitution was ordered due to services being provided; however, a Notice of Intent to Seek Criminal Forfeiture requesting interest in $1,270,304 was filed. A VA OIG, Army CID, DCIS, General Services Administration OIG, and SSA OIG investigation resulted in the defendant being charged with using his father's identity and military history to create two SDVOSB companies. The defendant fraudulently certified both businesses as SDVOSBs and subsequently 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 the Federal Government is $2.7 million, which includes a loss to VA of $1.2 million.

Non-Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft

A non-veteran was indicted for theft of Government funds and aggravated identity theft. An OIG investigation revealed that the defendant assumed the identity of a veteran and began receiving VA health care and other services at the West Palm Beach, FL, VAMC. The defendant met the veteran while living in Nashville, TN, and later assumed the veteran's identity after moving to southern Florida. In addition, the defendant failed to register as a sex offender stemming from the sexual assault of an 8-year-old child. The loss to VA is $68,655.

Non-Veteran Sentenced for Bank Fraud and Aggravated Identity Theft

A non-veteran was sentenced to 27 months' incarceration and 24 months' probation after being found guilty at trial of bank fraud and aggravated identity theft. An OIG investigation resulted in the defendant being charged with using the identity of his father, a decorated veteran, in an attempt to obtain a VA mortgage loan for a home valued at approximately $490,000. The defendant fraudulently claimed that he served in the military for 30 years and was awarded a Purple Heart.

VA Loan Guaranty Program Beneficiary Pleads Guilty to Making a False Statement To Obtain a Loan

A VA loan guaranty program beneficiary pled guilty to making a false statement to obtain a loan. A VA OIG, USPIS, SSA OIG, and local police investigation resulted in the defendant being charged with using allegedly falsified information (including employment and income information) to obtain a $423,000 home loan guaranteed by VA. The defendant subsequently defaulted on the home loan. The defendant was also alleged to have provided false information to obtain a vehicle loan, and then manufactured a scheme to remove the first lien from the vehicle title in order to resell the vehicle for $55,000 to a legitimate second vehicle dealer.

Former USPS Employee and Private Medical Clinic Administrator Plead Guilty to Conspiracy and Kickbacks

A former USPS employee, who was also a union president, along with an administrator of a private medical clinic pled guilty to conspiracy and kickbacks. A VA OIG, USPS OIG, DOL OIG, and Department of Homeland Security OIG investigation revealed that the former union official conspired with the clinic administrator to refer injured Federal employees, to include VA employees, to the clinic in order to receive care through the Federal Workers Compensation Program. The former union official received more than $1 million in kickbacks, $250,000 of which was funneled through his daughter, a legal assistant in the Hillsborough County, FL, public defender's office. The daughter, as well as the chief executive officer of the clinic, previously pled guilty to charges relating to this case.

Educational Program Vendor Enters Into Civil Settlement with Government

New Horizons Guam, an educational program vendor, entered into a civil settlement with the Government after the U.S. Attorney's Office, Civil Division, Territory of Guam, filed a complaint under the P.L. 99-562, *False Claims Act*. The vendor has already made one payment of $90,000 and is required to make a final payment in the amount of $60,000 by the end of August 2016. An OIG and FBI investigation revealed that the company falsified information in order to obtain VA educational benefits for several veterans. The company verified that veterans attended and completed an IT program; however, many of these veterans were not aware they were enrolled in the classes or did not complete the classes. The loss to VA was $73,578.

Veteran Sentenced for Theft and Assault

A veteran was sentenced to 10 months' incarceration and 1 year of supervised release after pleading guilty to theft and assault. 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 medical center, the defendant assaulted three veterans who were trying to stop him.

Veteran's Son Arrested for Theft of VA Equipment

The son of a veteran was arrested for commercial burglary, grand theft, and probation violation. An OIG and VA Police Service investigation revealed that the defendant stole two sets of video teleconferencing equipment worth $7,700 from the Martinez, CA, outpatient clinic. The equipment was stolen during two separate VA

medical appointments the defendant attended with his father. Both sets of equipment were sold on eBay at large discounts although OIG was able to later recover the stolen equipment. A search warrant at the defendant's residence revealed other stolen items and methamphetamine on his person.

Assaults and Threats Made Against VA Employees

During this reporting period, OI initiated 32 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 16 individuals. Investigations resulted in over $123,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and nearly $199,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Sentenced for Felony Menacing With a Weapon

A veteran was sentenced to time served (6 months) and 2 years' probation after pleading guilty to felony menacing with a weapon. An OIG and VA Police Service investigation resulted in the weapons charge after the defendant brought a handgun into the Denver, CO, VAMC and held a nurse hostage.

Veteran Sentenced for Assault on a Federal Officer

A veteran was sentenced to 3 years' probation after pleading guilty to assault on a Federal officer. The defendant has a history of assaulting VA police officers and this is his second assault conviction involving VA. During the most recent incident at the East Orange, NJ, VAMC, the defendant was charged with assaulting several VA police officers resulting in injuries to two officers.

Veteran Arrested for Menacing at Buffalo, New York, VAMC

A veteran was arrested for menacing following an altercation at the Buffalo, NY, VAMC. An OIG and VA Police Service investigation revealed that the defendant got into a verbal confrontation with a female veteran at the medical center and then pulled what was believed to be a pistol from his pocket and threatened to shoot the victim. The defendant then fled the scene and hid the weapon, which was recovered at the medical center and discovered to be a BB gun.

Veteran Arrested for Making Threats to San Diego, California, VAMC Employees

A veteran was arrested for influencing, impeding, or retaliating against a Federal official by threatening or injuring a family member. An OIG investigation revealed that the defendant, who was displeased with the way a VA doctor spoke to his wife, repeatedly left voicemail messages for the San Diego, CA, VAMC program support specialist and his supervisor who scheduled the exam. In the messages, the defendant said he was "in killing mode" and repeatedly threatened to kill the VA employees and their family members. The subject has a documented history of making similar threats to kill other Government employees. A 9mm handgun was found in the defendant's residence when he was arrested.

Veteran Arrested for Making Threats to Knoxville, Tennessee, VA Physician

A veteran was indicted and arrested for extortion and making threats toward his VA physician. An OIG investigation revealed that the defendant made several previous threats toward VA staff. In the most recent incident, the defendant contacted the VA Crisis Hotline and stated that he was going to murder his VA physician at the VA CBOC in Knoxville, TN, because she would not give him the amount of hydrocodone he thought he needed. Three weapons were subsequently seized from the defendant's residence.

Veteran Indicted for Making Threats to the Albany, New York, VAMC

A veteran was indicted for making threats to commit a mass shooting at the Albany, NY, VAMC. The defendant allegedly made phone calls to the medical center threatening to "kill everybody" and go to the VAMC "with [his] Uzi and start shooting people up." The defendant is being held pending further judicial action. The defendant was previously arrested in 2015 for making similar threats to the Canandaigua, NY, VAMC.

Veteran Sentenced After Pleading Guilty to Threatening a Federal Official

A veteran was sentenced to time served and 3 years' probation after pleading guilty to threatening a Federal official. An OIG and VA Police Service investigation resulted in the defendant being charged with threatening to assault the White River Junction, VT, VAMC chief of staff and his family. The judge ordered additional supervised release terms, to include no contact with the victims in this case, participating in a mental health program, and submitting to the search of his person and property upon reasonable suspicion that the defendant has violated a condition of supervision.

Veteran Arrested for Making a Terroristic Threat

A veteran was arrested for making a terroristic threat. An OIG and New York Police Department investigation revealed that the defendant made a series of increasingly violent threats on his Facebook page against his VA psychiatrist, VA staff, OIG agents, and their families. The defendant expressed intent to kill as many VA employees as possible before committing suicide.

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, 67 million felony warrants have been received from the National Crime Information Center and participating states resulting in 79,676 investigative leads being referred to law enforcement agencies. Over 2,565 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.29 billion in estimated overpayments with an estimated cost avoidance of $1.61 billion. During this reporting period, OIG opened 15 and closed 21 fugitive felon investigations, identifying $160.9 million in estimated overpayments. OIG investigative work resulted in the arrest of 14 fugitive felons, including 2 VA employees. VA employees were apprehended on charges related to insurance fraud and other fraud. Based on the information provided by OIG, at least 11 additional arrests were made by other law enforcement agencies.

- A VA employee was arrested at the Long Beach, CA, VAMC by the local police with the assistance of OIG. The fugitive was wanted for insurance fraud.
- A VA employee was arrested at a Phoenix, AZ, VA clinic by the local police with the assistance of OIG. The employee was wanted for a probation violation related to computer fraud.
- A veteran was arrested at the Sepulveda, CA, VA Ambulatory Care Center by the local police, with the assistance of OIG and the VA Police Service. The fugitive was wanted in Arizona for charges that included molestation of a child, sexual conduct with a minor, sexual assault, sexual abuse, indecent exposure, and public sexual indecency.
- A veteran was arrested at the Nashville, TN, VAMC by the U.S. Marshals Service with the assistance of OIG. The veteran was wanted on a probation violation related to child pornography.

- A veteran was arrested at the Bedford, MA, VAMC by the state police with the assistance of OIG. The veteran was wanted for failure to register as a sex offender.

- A veteran was arrested at the West Palm Beach, FL, VAMC by a fugitive task force with the assistance of OIG. The veteran was wanted in two different states for multiple warrants for charges to include battery and bribery.

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 two administrative investigations and closed eight administrative investigations. The work resulted in the issuance of three reports. These reports are listed in Appendix A.

The Administrative Investigations Division issues advisory memoranda when an allegation has been substantiated and OIG suggests VA take some action based on the investigation, but where the violation does not rise to the level of a formal recommendation. During this reporting period, the Administrative Investigations Division issued four advisory memorandums.

Alleged Prohibited Personnel Practice, Board of Veterans Appeals, Washington, DC

The OIG Administrative Investigations Division did not substantiate an allegation that Ms. Laura H. Eskenazi, Board of Veterans (BVA) Appeals Executive in Charge and Vice Chairman, engaged in a prohibited personnel practice or directed members of a screening panel to increase an applicant pool to include a particular employee or that a favored employee would be promoted to a Veterans Law Judge (VLJ) position. This VLJ recruitment action was a highly sensitive and important matter, since the appointments required the approval of the President of the United States, and it was necessary, due to a shortage of VLJs. During the course of the investigation, we found that members of the screening panel compromised this recruitment action when they disclosed applicant information as well as a request to expand the applicant pool to non-panel members. This caused rumors to spread throughout BVA that falsely accused Ms. Eskenazi of trying to influence the recruitment process. There was no guidance given to the panel members prohibiting such disclosures, but a subsequent requirement put into place as a result of this compromise provides specific guidance and requires future panel members to sign confidentiality agreements for these recruitment efforts. We also discovered BVA employees misusing their official VA time and resources to send unprofessional and inappropriate email messages. We referred this matter to VA to investigate and to consult with the Offices of General Counsel and Human Resources Management to take any appropriate action.

Alleged Preferential Treatment and Potential Misuse of Travel Funds, VBA, VA Central Office, Washington, DC

The OIG Administrative Investigations Division investigated and did not substantiate allegations that a VBA employee was given preferential treatment or that she misused VA travel funds to commute to and from VA Central Office. OIG found that the employee was competitively selected and promoted into a GS-15 position a year prior to requesting a downgrade to a non-supervisory GS-14 virtual position and that she was properly reassigned to an existing vacancy which allowed for 100 percent telework. Staffing and reassigning employees is at management's discretion as to what is best for the organization. OIG found no evidence that she received this downgrade as a result of favoritism or an abuse of position by any VBA official. In reference to her travel, OIG found that the employee's travel to VA Central Office, as confirmed by her supervisor, was essential to official

VA business and a requirement of her position, as well as others working on the same team, to interact with VA contractor employees and VBA facilitators.

Misuse of Official Time, Denver VARO, Denver, Colorado

The Chairman of the House Committee on Veterans' Affairs, after receiving a complaint letter, asked VA's OIG to investigate allegations that the Director of the Denver VARO was habitually absent from work during her designated duty hours and submitted incorrect timecards. OIG substantiated that she misused her official time when she arrived to her duty station late without taking the appropriate leave; when she was absent without leave; and when she improperly split her workday between her duty station, a non-VA location, and teleworking from home. OIG also found that she maintained an improper credit hour system for herself and her office staff. OIG did not substantiate an allegation that she was absent for several weeks at a time without taking sick leave, and OIG administratively closed that allegation. OIG discovered that VA's OAR began an investigation concurrent to OIG's. To avoid any duplicative efforts, OIG accepted the misuse of time and timecard allegations, and OAR accepted all other allegations for investigation.

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 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 in such areas as employee travel, logistical coordination, purchase card coordination, and space 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 17,899 contacts. Each contact to the Hotline is reviewed initially by OIG staff. Of these contacts, 511 became external Hotline cases, while an additional 351 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 631 cases, substantiating allegations 40 percent of the time. External Hotline cases resulted in 475 administrative sanctions and corrective actions and $2.8 million in monetary benefits. In addition, the Hotline responded to more than 867 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.

False Diagnoses and Unnecessary Surgeries by Fee-Basis Doctors

The Gainesville, FL, VAMC determined that fee-basis surgical retina specialists at an affiliate hospital were falsifying diagnoses and performing unnecessary surgical procedures on veterans referred for ophthalmology consultation. As a result of the findings, the VAMC discontinued referring patients to that hospital for ophthalmology care.

DIC Fraud

The PMC conducted a review of a widow's benefits to determine if she was receiving DIC payments even though she was remarried. After issuing a due process letter and allowing the widow time to respond, the PMC took action and terminated her DIC benefits effective to January 1, 2012; the first day of the month following the veteran's death. In addition to terminating her benefits, the PMC initiated a bill of collections for $115,380.

Weekend Premium Pay Owed to Thousands of VA Employees

A Hotline case resulted in the identification of 70,000 current and former VA employees, who were entitled to weekend premium pay from 2004 to 2014, had received no updates on the status of their back payments since 2014. OAR reviewed the allegations and confirmed that employees had not been provided any status updates in 2 years. As a result, the Office of Human Resources Management must release a bulletin to update employees on the status of payments and to provide assurance that disbursement of funds will be made as soon as possible. The estimate for retroactive payments is more than $135 million not including interest.

Disability Fraud by a Veteran

A veteran rated as 90 percent service connection for lumbosacral strain with degenerative arthritis and degenerative arthritis of the right ankle and right elbow was granted individual unemployability in 2010. While allegedly suffering from his level of reported disability, the veteran was actively farming, raising cattle, and making a profit from his crops. The VARO conducted a review and discontinued the veteran's entitlement of individual unemployability, reduced his service connected disabilities from 90 percent to 60 percent, and discontinued his dependents educational assistance. As a result of these actions, the VARO also issued a bill of collections of $82,568 to the veteran.

Password Security Issue

The OIG Hotline received an allegation that passwords for the GI Bill application, Veterans On-Line Application, were stored in plain text and were easily hackable. The concerns were investigated by VA's OIT who confirmed that the passwords were, in fact, saved in a plain text format. OIT tasked OIG's Enterprise Web Infrastructure Support to fully implement encryption of 'data-at-rest' to prevent unauthorized individuals from gaining access to the information and to ensure the passwords will not be compromised moving forward.

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 58 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. Forty preaward reviews identified approximately $281.9 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 nine health care provider proposals, accounting for approximately $25 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2015–March 31, 2016	38	$244,860,096
April 1 –September 30, 2016	40	$281,899,295
Fiscal Year	78	$526,759,391

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 $3.4 million, including approximately $3 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 14 postaward reviews performed, 5 involved voluntary disclosures. In three of the five 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
April 1 –September 30, 2016	14	$3,390,375
Fiscal Year	39	$12,296,106

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 four claims and determined that approximately $15.6 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
April 1 –September 30, 2016	4	$15,557,674
Fiscal Year	10	$21, 453, 740

Other Significant OIG Activities

Congressional Testimony

Two Years After Phoenix, Assistant Inspector General for Audits and Evaluations Tells House Committee that Problems with Access to Care Persist

Larry M. Reinkemeyer, Assistant Inspector General (AIG) for OAE, testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing titled "A Continued Assessment of Delays in Veterans' Access to Health Care" on recent OIG work in this area. Mr. Reinkemeyer discussed recently completed and ongoing OIG work evaluating the extent to which veterans are able to receive timely care. He explained that the results of OIG's completed work are consistent—VA continues to face challenges in providing timely access to care and managing consult appointments at various points of service. He also noted that a number of OIG Hotline contacts continue to allege inappropriate practices by VHA staff that undermine the integrity and reliability of wait time metrics and that VHA's initiatives to provide veterans community care are not working. Mr. Reinkemeyer told the Committee that the administration of its purchased care programs is a major challenge for VHA, in part because VHA schedulers and their supervisors do not follow established VHA scheduling guidance. Mr. Reinkemeyer was accompanied by Mr. Gary Abe, Deputy AIG for OAE.

IG Testifies at Congressional Field Hearing on Past Inspections of Tomah, Wisconsin, VAMC and Opioid Prescribing Practices

Mr. Michael J. Missal, IG, testified at a field hearing held in Tomah, WI, by the Committee on Homeland Security and Governmental Affairs, United States Senate, on May 31, 2016. Mr. Missal, who was sworn in as the VA IG on May 2, 2016, discussed the OIG's past inspections at the Tomah VAMC, in Tomah, WI, and the OIG's work in the areas of pain management and opioid prescribing practices. He also discussed actions he has taken since becoming the IG, to include meeting with the Committee on Homeland Security and Governmental Affairs staff on two occasions to ensure they have the necessary information about the OIG's work as it pertains to the Tomah VAMC. Mr. Missal's testimony outlined a timeline of events related to the OIG's Tomah VAMC administrative closure and the reasons why OIG staff believed at the time that an administrative closure was appropriate. He discussed two additional OIG inspections completed in 2015 regarding allegations at the Tomah VAMC as well as two 2016 OIG inspection reports addressing various aspects of VA opioid prescribing practices. The OIG's recent work on opioid prescribing practices identified many of the same issues previously reported in the OIG's May 2014 national review of VA outpatient opioids and monitoring of patients on opioid therapy—that VA providers were in general non-compliance with VA/Department of Defense Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain. Mr. Missal emphasized that the issues associated with the use of opioids to treat chronic pain and other conditions are a serious concern not just at the Tomah VAMC, but throughout the nation. Clinicians vary widely in their chronic opioid therapy prescribing practices within VA and the nation, and there is little agreement regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain. He was accompanied by John D. Daigh, Jr., MD, CPA, AIG for OHI.

Deputy AIG for OAE Tells House Subcommittee That Concerns Remain Regarding Records Disposition and Shredding of Claims-Related Documents at VAROs

Mr. Brent Arronte, Deputy AIG for OAE, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on two OIG reports on records disposition for veterans' claims-related documents. OIG found documents inappropriately scheduled for destruction at 11 VAROs. The inappropriate destruction or mishandling of claims-related documents can

lead to incorrect disability decisions and can affect the integrity of the VBA reported workload. Mr. Arronte highlighted OIG's historical work on this issue, which substantiated that VARO staff were not following VBA's policy on the management of veterans' and other Governmental paper records, were not training employees, and were not filling records-management staff positions. Mr. Arronte acknowledged that VA has made some improvements in their compliance with records disposition over the years and that inappropriate document destruction will decrease with VBA's move to a paperless environment. He cautioned that there will be a need for oversight to ensure documents are actually scanned into veterans' electronic records and to guard against the mishandling of documents containing personally identifiable information. Mr. Arronte was accompanied by Ms. Dana Sullivan, Director of OIG's San Diego Benefits Inspection Division.

IG Testifies before the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs

Mr. Michael J. Missal, IG, testified before the Subcommittee on Disability Assistance and Memorial Affairs, House Veterans' Affairs Committee, on September 27, 2016, on the results of OIG's Audit of C&P Pension Benefit Payments to Incarcerated Veterans. Mr. Missal's testimony pertained to necessary adjustments that VBA needs to make regarding compensation and pension benefits for veterans incarcerated in Federal, state, or local penal institutions as required by Federal law. OIG also reported that there was a lapse in the computer matching agreement between VA and the Bureau of Prisons for almost 7 years so no matching was occurring with regards to veterans in Federal penal institutions. The lack of a computer matching agreement and a lack of focus on these non-rating claims indicate weak financial stewardship. In total, OIG estimated that overpayments by VBA on these cases alone totaled approximately $307.9 million. Mr. Missal was accompanied by Mr. Nick Dahl, Director, OIG's OAE Division in Bedford, Massachusetts.

False Claims Act Settlements

For this reporting period, VA received payments totaling $15,155,535 from settlement agreements in complaints filed under the *qui tam* provisions of P.L. 97-258, *False Claims Act*. This amount represents VA's damages in five cases which are detailed in the OI section of this report.

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. Due to circumstances beyond VA OIG's control, the U.S. Agency for International Development was unable to complete the peer review of VA OIG's audit operation during this reporting period as planned. Therefore, at the direction of the Council of Inspectors General on Integrity and Efficiency, the U.S. DOJ OIG assumed the responsibility for completing the external peer review of VA OIG for the 2015 peer review cycle in July 2016. The final peer review report is expected in the first quarter of FY 2017.

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 did not complete any peer reviews during this reporting period.

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*, as amended, 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 176 proposals and made 17 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 Audit Director 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, returned from active duty from the U.S. Army in May 2016.
- 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.

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	Report Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
4/6/2016 15-01227-129	Audit of VA's Conference Management for Fiscal Year 2014			
4/7/2016 15-02781-153	Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Web Site	$34,011	$34,011	
4/14/2016 15-04652-146	Review of Claims-Related Documents Pending Destruction at VA Regional Offices			
4/14/2016 15-04652-266	Review of Alleged Shredding of Claims-Related Evidence at VARO Los Angeles, CA			
4/19/2016 15-02384-212	Review of VBA's Alleged Inappropriate Prioritization of Appeals at VARO Roanoke, VA			
4/26/2016 15-03581-204	Review of Alleged Data Manipulation of Appealed Claims at VARO Wichita, Kansas			
4/26/2016 11-00826-261	Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System			$8,900,000
4/28/2016 15-03802-222	Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System			
5/5/2016 15-01951-281	Review of Alleged Misuse of eBenefits Accounts by a VA Supportive Services for Veteran Families Provider			
5/9/2016 15-02376-239	Review of Alleged Manipulation of Quality Review Results at VARO San Diego, CA			
5/9/2016 15-02459-260	Review of Alleged Lack of Access Controls for VA's PMAS Dashboard			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Report Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
5/12/2016 15-04252-284	Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015			
6/16/2016 15-03700-283	Review of VA's Guidance on Protecting Religious Beliefs			
6/20/2016 15-03073-275	Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, TX			
6/23/2016 15-01887-282	Review of Allegation of Underutilized MRI Scanner in Waco, Texas			
6/28/2016 13-02255-276	Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans			$307,900,000
6/29/2016 15-04248-305	Audit of Modular Ramps Purchased by the Malcom Randall VAMC Gainesville, Florida			
7/12/2016 15-04231-223	Review of Alleged Improper Contract Awards in OI&T's Service, Delivery, and Engineering Office			
8/3/2016 15-03688-304	Audit of VA's Green Management Program Solar Panel Projects			
8/9/2016 16-02729-350	Review of Alleged Waste of Funds at the VAMC in Detroit, Michigan	$311,544	$311,544	
8/18/2016 15-04945-331	Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System			
9/7/2016 15-01994-238	Review of Alleged Contractor Information Security Violations in the Alaska VA Healthcare System			
9/15/2016 16-00623-306	Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VARO			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Report Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
9/19/2016 15-02776-240	Review of VA's Alleged Improper Termination of the e Learning Task Order	$1,862,856	$1,862,856	
9/21/2016 15-03706-330	Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System			
9/22/2016 15-01396-525	Review of VA's Award of the PC3 Contracts	$16,800,000	$16,800,000	
9/29/2016 15-02707-277	Review of VBA's Special Monthly Compensation Housebound Benefits			$154,400,000
9/30/2016 14-05118-147	Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments			$2,270,000,000
9/30/2016 15-00650-423	Review of Alleged Waste of Funds at VHA's Madison VA Medical Center	$409,771	$409,771	
	Total Monetary Impact	**$19,418,182**	**$19,418,182**	**$2,741,200,000**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
4/11/2016	15-04987-198	Inspection of VA Regional Office Montgomery, AL

Office of Audits and Evaluations | Work Products		
Issue Date	Number	Title
8/11/2016	11-00458-376	Review of Endoscope Leasing Agreement at Loma Linda, CA Health Care System
8/11/2016	11-01391-377	Review of Alleged Contracting Irregularities for Leadership VA
8/11/2016	11-02258-378	Review of Allegations of Contract Funding Mismanagement at the Office of Business Oversight
8/11/2016	11-04093-379	Review of Alleged VA Network Security Operations Center Staffing Irregularities
8/11/2016	12-00456-380	Review of Alleged Unauthorized Destruction of Documents
8/11/2016	12-01041-381	Review of VA Purchases Made on Behalf of the Department of Defense
8/11/2016	12-01081-382	Review of Allegations Concerning the Flight Training Benefits Provided Under the Post 9/11 GI Bill
8/11/2016	12-03705-383	Review of Alleged Manipulation of Gravesite Reporting Errors at the National Cemetery Administration

Office of Audits and Evaluations | Work Products		
Issue Date	**Number**	**Title**
8/11/2016	13-01419-384	Review of Alleged Inappropriate Use of System Authority to Operate
8/11/2016	13-01738-385	Review of Alleged Inappropriate Consideration in Award of SCIDO Task Order
8/11/2016	13-03380-386	Review of Alleged Overcharging for POV Shipping During PCS
8/11/2016	13-04097-387	Review of Alleged Violation of Medical Exam Policy Relating to Claims Over Two Years Old
8/11/2016	13-04639-388	Review of Alleged Manipulation of the Claims Processing System at the VARO Indianapolis, Indiana
8/11/2016	14-01750-389	Review of Claims Processing at VA Regional Office/VA Medical Center, Lincoln, Nebraska
8/11/2016	14-01879-390	Review of Alleged Incorrect Use of Date of Claim Related to VBA Two Year Claims Processing Initiative
8/11/2016	14-01880-391	Review of VHA's Alleged Lack of Cost Effectiveness of Wounded Warrior Contracted Health Care Services
8/11/2016	14-02790-393	Review of Alleged Redirected Inbound Email (PII)
8/11/2016	14-04819-394	Review of Alleged Billing to Third Party Insurance Providers for Service-Connected Care
8/11/2016	14-05166-395	Review of Alleged Unapproved Software Installation at the Wichita, Kansas VAMC
8/11/2016	15-00417-396	Review of Alleged Inflated Rating Decision for Disabled American Veteran Service Organization Staff at the VARO Denver, Colorado
8/11/2016	13-02987-397	Review of Alleged Over-Evaluation of Mental Disabilities at the VARO Providence, Rhode Island
8/11/2016	14-04140-398	Review of Alleged Unauthorized Contracting Document Change in IFCAP
8/11/2016	14-04307-399	Review of Alleged Misappropriation of Funds in Wounded Care and Coordination Task Force
8/11/2016	16-01949-401	Cybesecurity Act of 2015 Report Under P.L. 114-113

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	**Number**	**Facility**
4/6/2016	16-00104-230	Fargo VA Health Care System, Fargo, North Dakota
4/7/2016	15-04695-231	Kansas City VA Medical Center, Kansas City, Missouri
4/8/2016	16-00110-246	Cheyenne VA Medical Center, Cheyenne, Wyoming
4/8/2016	16-00107-256	Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
4/14/2016	16-00102-253	Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
4/19/2016	16-00115-263	Carl Vinson VA Medical Center, Dublin, Georgia
4/21/2016	16-00112-267	James H. Quillen VA Medical Center, Mountain Home, Tennessee
4/28/2016	16-00108-274	Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
5/11/2016	16-00101-300	VA Greater Los Angeles Health Care System, Los Angeles, California

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	**Number**	**Facility**
5/12/2016	15-04704-297	Northern Arizona VA Health Care System, Prescott, Arizona
5/19/2016	16-00111-310	Richard L. Roudebush VA Medical Center, Indianapolis, Indiana
6/9/2016	16-00121-320	Jesse Brown VA Medical Center, Chicago, Illinois
6/14/2016	16-00118-321	Amarillo VA Health Care System, Amarillo, Texas
6/23/2016	16-00116-323	VA Connecticut Health Care System, West Haven, Connecticut

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	**Number**	**Parent Facility**
4/8/2016	16-00016-241	Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
4/14/2016	16-00013-242	Kansas City VA Medical Center, Kansas City, Missouri
4/14/2016	16-00019-249	Cheyenne VA Medical Center, Cheyenne, Wyoming
4/14/2016	16-00023-252	Fargo VA Health Care System, Fargo, North Dakota
4/14/2016	16-00011-259	Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
4/19/2016	16-00012-251	Charlie Norwood VA Medical Center, Augusta, Georgia
4/20/2016	16-00017-245	Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
4/21/2016	15-05154-271	Sheridan VA Health Care System, Sheridan, Wyoming
5/11/2016	16-00010-302	VA Greater Los Angeles Health Care System, Los Angeles, California
5/11/2016	16-00020-303	Richard L. Roudebush VA Medical Center, Indianapolis, Indiana
5/12/2016	16-00024-299	James H. Quillen VA Medical Center, Mountain Home, Tennessee
5/12/2016	16-00025-301	Carl Vinson VA Medical Center, Dublin, Georgia
6/9/2016	16-00029-322	Jesse Brown VA Medical Center, Chicago, Illinois
6/10/2016	16-00027-318	VA Connecticut Health Care System, West Haven, Connecticut
6/23/2016	16-00028-337	Amarillo VA Health Care System, Amarillo, Texas

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
4/11/2016	16-00969-257	Combined Assessment Program Summary Report - Evaluation of Emergency Airway Management in Veterans Health Administration Facilities
4/20/2016	16-00693-269	Combined Assessment Program Summary Report – Evaluation of Safe Medication Storage Practices in Veterans Health Administration Facilities
5/23/2016	16-01489-311	Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities
6/22/2016	16-01040-324	Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2015
6/22/2016	16-01613-326	Combined Assessment Program Summary Report – Evaluation of Surgical Complexity Support Services in Veterans Health Administration Facilities

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
6/23/2016	15-01296-203	Community Based Outpatient Clinics Summary Report – Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics
9/27/2016	16-03960-428	Evaluation of Advance Directives in Veterans Health Administration Facilities
9/28/2016	16-00351-453	OIG Determination of VHA Occupational Staffing Shortages

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
4/13/2016	15-01432-264	Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA Health Care System, Bay Pines, Florida
5/3/2016	14-02890-286	Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina
5/5/2016	14-04310-280	Operating Room Concerns Marion VA Medical Center Marion, Illinois
5/11/2016	15-01599-289	Quality of Care Concerns in the Management of a Hepatitis C Patient, Grand Junction Veterans Health Care System, Grand Junction, Colorado
6/7/2016	14-04435-265	Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee
6/7/2016	14-03183-317	Alleged Patient Safety Concerns, Miami VA Health Care System, Miami, Florida
6/23/2016	15-03867-287	Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota
6/30/2016	16-02197-339	Evaluation of Reported Wait Times, VA Greater Los Angeles Health Care System, Los Angeles, California
8/4/2016	14-04361-348	Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma
8/11/2016	16-01708-340	Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016	15-05490-367	Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016	14-04655-369	Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA Health Care System, Minneapolis, Minnesota
8/25/2016	14-04505-346	Diagnosis and Treatment of a Patient's Adrenal Insufficiency at a Virginia VA Medical Center
8/26/2016	14-02725-316	Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas Health Care System, Dallas, Texas
9/14/2016	15-03713-288	Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington

Office of Healthcare Inspections | Hotline Healthcare Inspections

Issue Date	Number	Report Title
9/21/2016	15-03942-392	Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama
9/22/2016	15-05328-373	Colorectal Cancer Screening Practices, Charlie Norwood VA Medical Center, Augusta, Georgia
9/22/2016	15-04655-347	Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii
9/27/2016	15-00018-349	Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA Health Care System, Albuquerque, New Mexico
9/29/2016	15-01982-113	Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina
9/29/2016	14-04274-418	Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Health Care System, New York, New York
9/30/2016	14-00875-325	Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona
9/30/2016	15-00084-370	Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina

Office of Investigations | Administrative Investigations

Issue Date	Number	Report Title
5/17/2016	15-02747-314	Alleged Prohibited Personnel Practice, Board of Veterans Appeals, Washington, DC
6/1/2016	15-02997-307	Alleged Preferential Treatment and Potential Misuse of Travel Funds, Veterans Benefits Administration, VA Central Office, Washington, DC
8/23/2016	15-02560-365	Misuse of Official Time, Denver VA Regional Office, Lakewood, CO

Office of Contract Review | Preaward Reviews

Issue Date	Number	Report Title	Savings and Cost Avoidance
4/12/2016	16-02382-270	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
4/14/2016	16-00849-272	Review of Proposal Submitted Under a Solicitation	$1,439,100
4/14/2016	16-01225-273	Review of Proposal Submitted Under a Solicitation	$907,766
4/14/2016	16-02175-278	Review of Contract Extension Proposal	$545,965
4/15/2016	16-02775-279	Review of Proposal Submitted Under a Solicitation	$966,972
4/20/2016	16-01143-285	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$67,858,238
4/27/2016	16-02966-294	Review of Proposal Submitted Under a Solicitation	$14,655,799
4/27/2016	16-01666-298	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**
5/5/2016	16-00762-308	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$4,848,640
5/13/2016	16-02559-313	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$4,270,051
6/7/2016	16-02232-332	Review of Proposal Submitted Under a Solicitation	
6/8/2016	16-01539-335	Review of Proposal Submitted Under a Solicitation	$36,514,509
6/21/2016	16-02180-345	Review of Proposal Submitted Under a Solicitation	
6/22/2016	16-02993-343	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$6,526,400
7/12/2016	16-02562-354	Review of Proposal Submitted Under a Solicitation	
7/15/2016	16-02298-356	Review of Proposal Submitted Under a Solicitation	$470,000
7/18/2016	16-03359-351	Review of Request for Modification Under a Federal Supply Schedule Contract	$9,043,290
7/18/2016	16-02975-357	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
7/19/2016	15-05121-360	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$1,150,160
7/20/2016	16-03611-361	Review of Proposal Submitted Under a Solicitation	$354,374
7/22/2016	16-04011-362	Review of Proposal Submitted Under a Solicitation	$1,450,157
8/2/2016	16-03125-364	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$7,527,188
8/2/2016	16-04316-368	Review of Proposal Submitted Under a Solicitation	$1,499,271
8/5/2016	16-02366-372	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$30,164,771
8/5/2016	16-04516-374	Review of Proposal Submitted Under a Solicitation	
8/11/2016	16-02231-375	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$68,497,230
8/13/2016	16-03469-403	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
8/15/2016	16-04393-402	Review of Proposal Submitted Under a Solicitation	$2,052,976
8/23/2016	16-02840-421	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$168,000
8/30/2016	16-04523-426	Review of Proposal Submitted Under a Solicitation	$2,921,547
8/30/2016	16-02570-427	Review of Proposal Submitted Under a Solicitation	$3,647,430
9/6/2016	16-01964-429	Review of Proposal Submitted Under a Solicitation	
9/12/2016	16-01920-431	Review of Contract Extension Proposal Submitted Under a Solicitation	

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
9/13/2016	16-02580-447	Review of Request for Modification Under a Federal Supply Schedule Contract	$133,074
9/14/2016	16-04548-448	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$61,247
9/19/2016	16-02723-450	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$13,687,420
9/23/2016	16-04788-452	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$537,720
9/26/2016	16-02408-454	Review of Proposal Submitted Under a Solicitation	
9/28/2016	16-04183-464	Review of Request for Modification Under a Federal Supply Schedule Contract	
9/29/2016	16-02025-471	Review of Proposal Submitted Under a Solicitation	
		Total Monetary Impact	**$281,899,295**

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
4/6/2016	16-00402-254	Review of Compliance with Public Law Under an Interim Agreement	$192,728
4/27/2016	16-02441-295	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$7,122
6/1/2016	16-01971-315	Review of Late Addition of a Drug Under a Federal Supply Schedule Contract	$220,066
6/6/2016	15-03999-334	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$338,500
6/15/2016	15-01938-341	Review of Public Law and Price Reductions Clause Overcharges Under a Federal Supply Schedule Contract	$99,398
7/14/2016	16-04289-355	Review of Federal Ceiling Price Calculation Error Under a Federal Supply Schedule Contract	
7/18/2016	16-01483-358	Review of Voluntary Disclosures and Refund Offer Under a Federal Supply Schedule Contract	$30,716
7/20/2016	15-00562-359	Review of Compliance with Public Law Under a Federal Supply Schedule Contract	$1,996,870
8/4/2016	16-00669-363	Review of Compliance with Public Law Under a Federal Supply Schedule Contract	
8/16/2016	16-04871-414	Post-Award Review of Federal Supply Schedule Contract	

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
9/13/2016	16-00973-430	Review of Public Law Compliance for the Covered Drug Vibativ	$7,759
9/16/2016	16-04265-451	Review of Public Law Compliance for the Covered Drug Vibativ	$13,204
9/27/2016	16-04793-455	Review of Voluntary Disclosure of Public Law Pricing Errors under a Contract	$62,611
9/27/2016	16-00992-458	Review of Voluntary Disclosure of Public Law Pricing Errors under a Contract	$421,401
		Total Monetary Impact	**$3,390,375**

Office of Contract Review | Claim Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
5/9/2016	15-02013-309	Review of Certified Claims Submitted Under a Contract	$840,026
5/11/2016	15-02014-312	Review of Subcontractor Certified Claims Submitted Under a Contract	$1,581,475
7/27/2016	15-04636-366	Review of Request for Equitable Adjustment Proposal Submitted Under a Contract	$6,108,933
9/28/2016	16-01851-470	Review of Request for Equitable Adjustment Proposal Submitted Under a Contract	$7,027,240
		Total Monetary Impact	**$15,557,674**

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$19,418,182	$2,741,200,000		
Preaward Reviews			$281,899,295	
Postaward Reviews				$3,390,375
Claim Reviews			$15,557,674	
	$19,418,182	**$2,741,200,000**	**$297,456,969**	**$3,390,375**

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	4	$2,741,200,000

Table 2: Resolution Status of Reports with Questioned Costs

Resolution Status	Number	Dollar Value
Total inventory this period	**4**	**$2,741,200,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	4	$2,741,200,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**4**	**$2,741,200,000**
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	5	$19,418,182
Total inventory this period	**5**	**$19,418,182**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	5	$19,418,182
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**5**	**$19,418,182**
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**
4/1/2016	14-02890-237	Fort Collins Outpatient Clinic, Fort Collins, Colorado, and Cheyenne VA Medical Center, Cheyenne, Wyoming
4/1/2016	14-02890-250	Durham VA Medical Center, Durham, North Carolina
4/4/2016	14-02890-248	White River Junction VA Medical Center, White River Junction, Vermont
4/6/2016	14-02890-258	West Haven VA Medical Center, West Haven, Connecticut
4/7/2016	14-02890-262	Augusta VA Medical Center, Augusta, Georgia
4/26/2016	14-02890-292	Tulsa Outpatient Clinic, Tulsa, Oklahoma
5/5/2016	14-02890-291	Mountain Home VA Medical Center, Mountain Home, Tennessee
5/9/2016	14-02890-268	Biloxi VA Medical Center, Biloxi, Mississippi, and Pensacola Joint Ambulatory Care Center, Pensacola, Florida
5/19/2016	14-02890-296	Denver VA Medical Center, Denver, Colorado
6/22/2016	14-02890-344	Albuquerque VA Medical Center, Albuquerque, New Mexico

Office of Investigations | Administrative Investigation Advisories		
Issue Date	**Number**	**Facility**
7/21/2016	14-02190-293	Conflict of Interest and Violation of Ethics Pledge, Office of Secretary, Washington, DC
7/26/2016	15-00749-338	Alleged Prohibited Personnel Practices, Veterans Health Administration, Wm. Jennings Bryan Dorn VA Medical Center, Columbia, SC
7/27/2016	15-02226-327	Alleged Misuse of Travel Funds, Veterans Health Administration, VA National Center for Patient Safety, Ann Arbor, MI
8/2/2016	15-05252-329	Alleged Misuse of Sick Leave, Board of Veterans Appeals (BVA), VA Central Office, Washington, DC

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 September 30, 2016, there are 197 total open reports and 742 total open recommendations. However, 7 reports and 6 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 69 reports and 188 recommendations that, as of September 30, 2016, remain open for more than 1 year. Titles that are italicized represent reports that OIG has suspended until OIG can conduct a follow-up visit to assess the recommendations for closure. The total monetary benefit attached to these reports is $1,454,268,597.

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	47	101	148	128	435	563
Veterans Benefits Administration	12	10	22	31	42	73
National Cemetery Administration	0	1	1	0	4	4
Office of Acquisitions, Logistics, and Construction	2	4	6	8	11	19
Office of Management (OM)	2	3	5	4	11	15
Office of Information and Technology	4	5	9	13	44	57
Office of Human Resources and Administration (OHRA)	2	0	2	2	0	2
Office of Operations, Security, and Preparedness (OSP)	1	0	1	1	0	1
Office of General Counsel (OGC)	1	0	1	3	0	3
Chief of Staff (COS)	1	1	2	4	1	5
Total	**72**	**125**	**197**	**194**	**548**	**742**

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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.				
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.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/30/12	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.*				
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.*				

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 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.*				
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.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
03/28/13	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.*				
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.				
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.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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.				
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	None
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.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/22/14	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.				
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 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.				
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.*				
11/19/14	12-02576-30	Audit of VHA's Support Service Contracts	VHA	None
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.				
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 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.*				

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 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 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. *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.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
01/20/15	**14-04214-70**	**Combined Assessment Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi**	**VHA**	**None**
Recommendation 8: We recommended that requestors consistently include "inpatient" in the consult title 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.* *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 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 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).*				

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 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). *Recommendation 4: We recommended the Assistant Secretary for Information and Technology modify the Project Management Accountability System Dashboard to maintain original baseline data and issue guidance to ensure project performance is measured against both the original and current baselines.* *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.*				
02/17/15	**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.				

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 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.*				
03/30/15	14-02383-175	Audit of VA's Drug-Free Workplace Program	OHRA	None
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.				
4/14/2015	14-03824-155	Healthcare Inspection – Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland	VHA	None
Recommendation 2: We recommended that the System Director ensure that a contingency plan for patient aligned care team provider shortages is developed. *Recommendation 6: We recommended that the System Director ensure that the Access Action Plan for Orthopedic Surgery Services is carried out in an effort to improve access to orthopedic surgical services.* *Recommendation 7: We recommended that the System Director ensure that providers comply with their responsibilities of electronic health record documentation of the community care of co-managed patients.*				
4/15/2015	14-03651-203	Review of Alleged Data Manipulation and Mismanagement at the VA Regional Office Philadelphia, Pennsylvania	VBA	None
Recommendation 24: We recommended the Under Secretary for Benefits develop and implement a timeliness goal for VA Regional Offices to process returned mail.				

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 the Under Secretary for Benefits develop and implement a plan that includes a timeliness goal to ensure mail is associated with electronic or paper claims folders prior to claims processing actions. *Recommendation 35: We recommended the Under Secretary for Benefits conduct an independent review of production standards for Pension Call Center staff to determine if the timeliness standard is reasonable and obtainable without compromising the quality of customer service to callers.*				
5/5/2015	**15-00110-228**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Palo Alto Health Care System, Palo Alto, California**	**VHA**	**None**
Recommendation 2: We recommended that staff protect patient-identifiable information on laboratory specimens during transport from the Fremont CBOC to the parent facility.				
5/5/2015	**15-00129-339**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Roseburg Healthcare System, Roseburg, Oregon**	**VHA**	**None**
Recommendation 4: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.				
5/14/2015	**14-03380-356**	**FY 2014 Review of VA's Compliance With the Improper Payments Elimination and Recovery Act**	**OM**	**None**
Recommendation 5: We recommended that the Acting Assistant Secretary for Management perform risk assessments for programs with a high concentration of vendor payments using revised procedures that include contracting risk.				
5/18/2015	**15-00075-351**	***Combined Assessment Program Review of the VA St. Louis Health Care System, St. Louis, Missouri***	**VHA**	**None**
Recommendation 3: We recommended that the Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms and document the review. *Recommendation 4: We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have properly approved/signed privilege forms.* *Recommendation 5: We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.*				

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 8: We recommended that clinicians report all critical incidents through the facility's adverse event reporting process. *Recommendation 9: We recommended that the facility review the quality of entries in the electronic health record and analyze data at least quarterly.* *Recommendation 11: We recommended that Environment of Care Committee minutes include discussion regarding environment of care rounds deficiencies and that facility managers monitor compliance.* *Recommendation 12: We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance.* *Recommendation 13: We recommended that the facility repair damaged furniture in patient care areas or remove it from service.* *Recommendation 14: We recommended that the facility store oxygen tanks in a manner that distinguishes between empty and full tanks and that facility managers monitor compliance.* *Recommendation 15: We recommended that facility managers ensure all electrical gang boxes have the appropriate covers installed.* *Recommendation 16: We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.* *Recommendation 17: We recommended that the facility promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance.* *Recommendation 18: We recommended that the facility promptly remove expired medications from patient care areas and that facility managers monitor compliance.* *Recommendation 19: We recommended that the facility label medications in accordance with local policy and that facility managers monitor compliance.* *Recommendation 20: We recommended that the facility inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations and that facility managers monitor compliance.* *Recommendation 21: We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and conduct and document annual complete system checks and that facility managers monitor compliance.* *Recommendation 22: We recommended that the facility inspect and tag critical medical equipment in the community living center 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 34: We recommended that the facility revise the stroke policy to address a stroke team and data gathering for analysis and improvement and that facility managers fully implement the revised policy. *Recommendation 35: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.* *Recommendation 36: We recommended that the facility collect and report to the Veterans Health Administration 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 38: We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.* *Recommendation 39: 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 40: We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.* *Recommendation 42: We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.* *Recommendation 43: We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.*				
6/1/2015	**14-01883-371**	**Audit of Fiduciary Program's Management of Field Examinations**	**VBA**	**None**
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to ensure field examination workload is completed in compliance with timeliness standards. *Recommendation 2: We recommended the Under Secretary for Benefits use the percentage of untimely field examinations in addition to the average days pending performance measure to better evaluate completion of field examinations.* *Recommendation 3: We recommended the Under Secretary for Benefits require hub managers to use Beneficiary and Fiduciary Field System reports to identify and correct unscheduled field examinations at least once per quarter.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
6/3/2015	15-00911-362	Healthcare Inspection – Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities	VHA	None
Recommendation 1: We recommended that the Interim Under Secretary for Health ensure that gastroenterology, pathology, nuclear medicine, and radiation oncology program offices define specialty specific criteria or monitors for use in Focused and Ongoing Professional Practice Evaluations and require consistent application across the Veterans Health Administration and that program offices monitor compliance. *Recommendation 2: We recommended that the Interim Under Secretary for Health require a process to obtain input for evaluating professional practice from another physician in the same specialty when a physician is the only one of any specialty at a facility and require each Veterans Integrated Service Network to monitor compliance.*				
6/4/2015	14-04220-363	Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, Arizona	VHA	None
Recommendation 5: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance. *Recommendation 6: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.* *Recommendation 7: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.* *Recommendation 8: We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.*				
6/4/2015	15-00128-359	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Phoenix VA Health Care System Phoenix, Arizona	VHA	None
Recommendation 11: 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
6/11/2015	**14-02195-381**	**Healthcare Inspection – Alleged Magnetic Resonance Imaging Order Deletion and Record Destruction, VA Greater Los Angeles Healthcare System, Los Angeles, California**	**VHA**	**None**
Recommendation 1: We recommended that the Facility Director ensure that Radiology Department managers confirm that ordered magnetic resonance imaging exams are scheduled and completed within the Veterans Health Administration required timeframe. *Recommendation 2: We recommended that the Facility Director require Radiology Department managers to review pending lists of magnetic resonance imaging exams at designated intervals to ensure timely scheduling of these exams and that compliance be monitored.*				
6/16/2015	**14-04573-378**	**Healthcare Inspection – Quality of Care and Access to Care Concerns Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma**	**VHA**	**None**
Recommendation 4: We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director provide appropriate and timely neurosurgical consultation services to patients receiving care at the facility consistent with Veterans Health Administration Directive 2008-056, VHA Consult Policy, September 16, 2008.				
6/17/2015	**14-00730-206**	**Review of Alleged Improper Advances of VHA Appropriated Funds to the U.S. Government Printing Office**	**VHA**	**None**
Recommendation 4: We recommended the Deputy Under Secretary for Health for Operations and Management confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any, against Chief Business Office officials for directing the misuse of approximately $43.1 million of fiscal year 2011 appropriated funds.				
6/17/2015	**14-05158-377**	***Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine***	**VHA**	**None**
Recommendation 2: We recommended the Facility Director reevaluate and make the appropriate changes to the methods for referring patients for mental health care, including the extent to which the consult package is being used appropriately. *Recommendation 3: We recommended the Facility Director ensure that mental health consults are reviewed and closed in accordance with Veterans Health Administration policy.*				

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 4: We recommended the Facility Director ensure that Veterans Health Administration appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate.				
6/24/2015	**15-01721-382**	**Combined Assessment Program Evaluation of Selected Requirements in Veterans Health Administration Community Living Centers**	**VHA**	**None**
Recommendation 3: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that nursing employees provide and document restorative nursing services in accordance with the care plan, and if they do not provide the services, they document the reason. *Recommendation 4: We recommended that the Interim Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that employees complete required restorative summary notes and that the Associate Chief Nurse or designee monitors compliance.*				
6/29/2015	**14-01991-387**	**Audit of Homeless Providers Grant and Per Diem Case Management Oversight**	**VHA**	**None**
Recommendation 2: We recommended the Interim Under Secretary for Health revise policies, if necessary, when a definitive legal position is provided on Grant and Per Diem Program eligibility. *Recommendation 3: We recommended the Interim Under Secretary for Health implement controls to ensure grant applications comply with the definitive legal position on Grant and Per Diem Program eligibility.*				
7/15/2015	**15-00596-429**	**Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas**	**VHA**	**None**
Recommendation 4: We recommended that the facility consistently document actions when data analyses indicated problems or opportunities for improvement and evaluate them for effectiveness in the Quality, Safety, and Value; Critical Care; Medical Records; and Infection Prevention and Control Committees and in the Environment of Care Council.				
7/27/2015	**15-00132-430**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Central Texas Veterans Health Care System, Temple, Texas**	**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 alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.*				

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 that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.				
7/29/2015	**14-04530-414**	**Healthcare Inspection – Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness Central Alabama VA Health Care System, Montgomery, Alabama**	**VHA**	**None**
Recommendation 1: We recommended that the Central Alabama VA Health Care System Director ensure adequate mental health staffing in the community based outpatient clinics to provide timely and appropriate patient care. *Recommendation 2: We recommended that the Central Alabama VA Health Care System Director ensure appropriate review and scheduling of patients on the electronic wait list and Recall Reminder lists provided to management.* *Recommendation 6: We recommended that the Central Alabama VA Health Care System Director ensure that staff receive appropriate training on the policy requirements for managing disruptive behavior.* *Recommendation 7: We recommended that the Central Alabama VA Health Care System Director ensure that the Disturbed Behavior Committee complies with policy on completing and documenting incident/threat assessments and initiating Patient Record Flags.* *Recommendation 8: We recommended that the Central Alabama VA Health Care System Director ensure that all Disturbed Behavior Committee Alert Notes, both recent and remote, have been reviewed and appropriate actions taken, if indicated.* *Recommendation 10: We recommended that the Central Alabama VA Health Care System Director evaluate options available to improve the timeliness of Emergency Department clearance and acute mental health unit admission for high risk patients.* *Recommendation 11: We recommended that the Central Alabama VA Health Care System Director ensure that mental health providers adequately document their clinical reasoning when their treatment decisions do not comply with VA/DoD guidelines for medication management in Post-Traumatic Stress Disorder and Substance Use Disorder patients.* *Recommendation 12: We recommended that the Central Alabama VA Health Care System Director approve and issue a Mental Health Treatment Coordinator policy and train appropriate staff on same.* *Recommendation 13: We recommended that the Central Alabama VA Health Care System Director ensure assignment of Mental Health Treatment Coordinators for all appropriate patients.* *Recommendation 14: We recommended that the Central Alabama VA Health Care System Director monitor to ensure the Dothan Primary Care contractor complies with staffing and care specifications as outlined in the contract.*				

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 the Central Alabama VA Health Care System Director ensure that the Dothan Primary Care contract complies with Veterans Health Administration policy on the treatment of uncomplicated psychiatric disorders. *Recommendation 17: We recommended that the Central Alabama VA Health Care System Director reinitiate ongoing professional practice evaluation-related mental health chart reviews.*				
7/29/2015	**14-04530-452**	**Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama**	**VHA**	**None**
Recommendation 1: We recommended that the Under Secretary for Health provide consistent interim leadership to Central Alabama Veterans Health Care System in the form of highly skilled leaders who can lead systemic improvements and cultural change until such time as the leadership positions can be filled permanently. *Recommendation 2: We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.* *Recommendation 3: We recommended that interim Central Alabama Veterans Health Care System leadership begin, and permanent leadership continue, to make systemic improvements to the Non-VA Care Coordination consult process, to include ensuring that patients receive services timely; that the backlog is resolved; that staff comply with business rules governing the process; and that the program is provided with adequate staffing, training, and a consistent leadership structure.* *Recommendation 7: We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that all previously chartered Administrative Boards of Investigations have been conducted and finalized to include documentation of decision for final action(s), evidence that actions have been implemented and/or addressed, and appropriate certification of completion per Veterans Health Administration guidelines.*				
8/5/2015	**14-00545-343**	**Review of Alleged Mismanagement of VHA's Service-Oriented Architecture Research and Development Pilot Project**	**VHA**	**$2,600,000**
Recommendation 2: We recommended the Under Secretary for Health remedy all Medical Support and Compliance appropriations used to pay for Service-Oriented Architecture Research and Development.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
8/25/2015	15-00001-436	Inspection of VA Regional Office St. Petersburg, Florida	VBA	None
Recommendation 2: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices prioritize processing reminder notifications within 30 days as required. *Recommendation 5: We recommended the St. Petersburg VA Regional Office Director implement a plan to ensure oversight and prioritization of benefits reductions cases.* *Recommendation 6: We recommended the Under Secretary for Benefits direct Veterans Benefits Administration field offices to prioritize benefits reductions cases in order to minimize overpayments.*				
8/27/2015	13-03922-453	Audit of Fiduciary Program Controls Addressing Beneficiary Fund Misuse	VBA	None
Recommendation 2: We recommended the Under Secretary for Benefits retroactively establish debts for all fiduciaries who VBA determined misused beneficiary funds during calendar year 2013. *Recommendation 3: We recommended the Under Secretary for Benefits revise policy to include clear timeliness standards from the time the hubs determine misuse occurred to the time Pension and Fiduciary Service completes the negligence determination.* *Recommendation 4: We recommended the Under Secretary for Benefits ensure the processing of all misuse actions are incorporated into quality reviews of Fiduciary Program operations.*				
8/27/2015	15-00156-490	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of San Francisco VA Health Care System, San Francisco, California	VHA	None
Recommendation 3: We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.				
8/31/2015	15-00606-495	Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan	VHA	None
Recommendation 6: We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. *Recommendation 8: We recommended that facility managers comply with Veterans Health Administration directive requirements for exempted facilities, or if facility managers plan emergency intubation responses with onsite employees, they comply with Veterans Health Administration requirements for non-exempted facilities.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
9/1/2015	**15-00154-500**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Maine Healthcare System, Augusta, Maine**	**VHA**	**None**
Recommendation 4: We recommended that Clinic Registered Nurse Care Managers, providers, and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.				
9/2/2015	**14-01792-510**	**Review of Alleged Mismanagement at the Health Eligibility Center**	**VHA**	**None**
Recommendation 3: We recommended the Under Secretary for Health develop and execute a project management plan to ensure that Enrollment System data are fully evaluated and properly categorized. *Recommendation 4: We recommended the Under Secretary for Health implement controls to ensure that future enrollment data are accurate and reliable before being entered in the Enrollment System.* *Recommendation 5: We recommended the Under Secretary for Health implement effective policies and procedures to accurately and timely identify deceased individuals with records in the Enrollment System and record their changed status in the system.* *Recommendation 6: We recommended the Under Secretary for Health establish appropriate policies and procedures to ensure Health Eligibility Center workload data are not deleted or changed without appropriate management review, approval, and audit trails.* *Recommendation 8: We recommended the Under Secretary for Health confer with the Office of Human Resources and the Office of General Counsel to fully evaluate the implications of the first three allegations, determine if administrative action should be taken against any senior Veterans Health Administration officials involved, and ensure that appropriate action is taken.*				
9/14/2015	**13-00690-455**	**Follow-up Review of VA's Veterans Benefits Management System**	**VBA OIT**	**$27,000,000**
Recommendation 1: We recommended the Executive in Charge for the Office of Information and Technology, in conjunction with the Under Secretary for Benefits, implement improved cost controls and stabilize Veterans Benefits Management System functionality requirements for the remainder of planned system development to restrict further cost increases. *Recommendation 3: We recommended the Executive in Charge for the Office of Information and Technology perform market analyses on all future Space and Naval Warfare Systems Command Atlantic task orders to determine whether the continued use of the interagency agreements is in the best interest of the Department.*				

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 4: We recommended the Executive in Charge for the Office of Information and Technology, in conjunction with the Under Secretary for Benefits, establish a clear strategy and plan to decommission legacy systems, eliminate redundant systems operations, and reduce system maintenance costs.				
9/28/2015	**15-00166-531**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Alaska VA Healthcare System, Anchorage, Alaska**	**VHA**	**None**
Recommendation 3: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen. *Recommendation 4: We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.*				
9/28/2015	**15-02997-526**	**Administrative Investigation, Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA**	**COS**	**None**
Recommendation 2: We recommended the Deputy Secretary review the Department's request and approval process for temporary quarters subsistence expense allowance and make improvements as deemed appropriate. *Recommendation 4: We recommended the Deputy Secretary strengthen the approval process to include requiring an independent review of the Department's Permanent Change of Station program to ensure moves and expenses are appropriate and justified.* *Recommendation 5: We recommended the Deputy Secretary require the Veterans Benefits Administration to establish policies and procedures to standardize its practices regarding annual salary increases when reassigning Senior Executives' positions.* *Recommendation 7: We recommended the Deputy Secretary consult with the Office of General Counsel to determine what actions may be taken to hold the appropriate Senior Officials accountable for processing and approving payments of unjustified relocation incentive payments.*				
9/29/2015	**15-00718-507**	**Review of Patient-Centered Community Care Provider Network Adequacy**	**VHA**	**None**
Recommendation 5: We recommended the Under Secretary for Health require the input of National Provider Identifier information for rendering providers in the Fee Basis Claims System to ensure adequate data are available for program evaluation and planning,				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
9/30/2015	14-04598-461	Review of Allegations Regarding Quality of Care, Professional Conduct, and Contractual Issues for Cardiothoracic Surgery and Perfusion Services at the VA North Texas Health Care System Provided by the University of Texas—Southwestern Medical Center	VHA	None
Recommendation 1: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS [VA North Texas Health Care System] take immediate steps to prioritize awarding a long-term contract for CT [cardiothoracic] surgery and perfusion services that is fully compliant with VA Directive 1663. *Recommendation 2: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a full-time or part-time CT surgeon(s).* *Recommendation 3: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a VA perfusionist(s).* *Recommendation 5: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to determine status and compliance related to all healthcare contracts and services provided by UTSW [University of Texas Southwestern Medical Center] at VANTHS.*				
9/30/2015	15-00180-538	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Pacific Islands Health Care System, Honolulu, Hawaii	VHA	None
Recommendation 4: We recommended that hand hygiene compliance is monitored at the American Samoa VA Clinic and reported to the Infection Control Committee. *Recommendation 14: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.*				
9/30/2015	15-00574-501	Review of Patient-Centered Community Care (PC3) Health Record Coordination	VHA	$5,768,597
Recommendation 4: We recommended the Under Secretary for Health complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.				

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 Under Secretary for Health review the contract disincentives applied to HealthNet and determine if additional funds need to be recouped from the contractor and pursue collection if disincentives were under applied. *Recommendation 7: We recommended the Under Secretary for Health implement procedures to verify whether Patient-Centered Community Care contractors and their network providers correctly and timely report critical findings to VA and impose financial penalties or other remedies when contractors fall below the contract performance threshold.*				
9/30/2015	**15-00605-544**	**Combined Assessment Program Review of the VA Maine Healthcare System, Augusta, Maine**	**VHA**	**None**
Recommendation 4: We recommended that the Special Care Unit Committee 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 7: We recommended that facility managers ensure patient care areas are clean and damaged wall surfaces are repaired and monitor compliance.* *Recommendation 10: We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.*				
9/30/2015	**15-02053-537**	**Review of Alleged Improper Pay at Hudson Valley Health Care System**	**VHA**	**None**
Recommendation 5: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review and consult appropriate VA offices, including the Office of General Counsel, to determine whether administrative action is appropriate for those officials in the Engineering, Environmental Management, and Human Resources Services who did not adequately review or correct employees' official duty stations in response to the 2014 Office of Human Resources and Administration's request for verification of all employees' official duty stations.				
Total				**$1,454,268,597**

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On the Cover

On Monday, December 7, 2015, the 74th anniversary of the surprise attack on Pearl Harbor was commemorated at the National World War II Memorial in Washington, D.C. The Friends of the National World War II Memorial and the National Park Service remembered and honored all those who died in the attack during the special event. As part of the commemoration, nearly twenty World War II veterans presented wreaths at the Freedom Wall in remembrance of the more than 400,000 Americans who lost their lives during World War II, including the more than 2,400 who were killed during the Pearl Harbor attack. Among the veterans participating in the commemoration was Mr. Frank Levingston of Lake Charles, Louisiana who, at 110-years-old, is believed to be the oldest living American World War II veteran, and Pearl Harbor survivor and D-Day veteran Dale "Red" Robinson of Wise County, Texas. Twelve World War II veterans from Honor Flight Dallas-Fort Worth were also honored at the memorial. From Friends of the National World War II Memorial release. VA photo by Robert Turtil.

Department of Veterans Affairs

Office of Inspector General

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