Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 78 | April 1 – September 30, 2017

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 Semiannual Report to Congress that highlights our activities and accomplishments for the April 1 to September 30, 2017 reporting period. I believe this report reflects VA Office of Inspector General (OIG) staff's strong commitment to ensuring that veterans receive the health care, benefits, and other services they have earned.

In the past 6 months, we continued to make significant enhancements to our organization to conduct more effective oversight of VA's programs and operations. This includes advancing our collaborative efforts to identify the underlying causes of problems and then produce timely, accurate, and high-quality reports. Our reports typically include recommendations to VA. These recommendations are carefully developed to help improve effectiveness while preventing or redressing fraud, waste, abuse, and other misconduct. For example, we have launched a Rapid Response Team that draws on healthcare professionals, auditors, criminal investigators, and other experts across OIG to quickly respond to allegations of compromised patient safety. This team investigated allegations at the Washington, DC VA Medical Center (VAMC) and produced an Interim Report with recommendations for immediate action to reduce risks to patients and Federal Government assets. Although our work on the DC VAMC is not yet completed, improvements at the facility are already being implemented. OIG has expanded the inspection of the DC VAMC, and we are preparing a final report with detailed recommendations. Meanwhile, the Rapid Response Team has deployed to other VA facilities where there is a critical need to assess imminent risk to veterans' care.

Another enhancement has been implementing the redesign of our Combined Assessment Program into the Comprehensive Healthcare Inspection Program. Unannounced OIG visits to facilities follow a newly developed protocol that examines high-risk areas and results in a more useful written review for facility and other VA leaders to make needed improvements. In addition to the Office of Healthcare Inspections (OHI), other directorates also have been realigned to address key VA challenges. Finally, to better ensure OIG's independence and transparency, we are now directing and funding the work of the Office of Contract Review, which was previously supported through a reimbursable agreement with VA. These and other changes have been made to advance OIG's mission and values. In that spirit, we have also developed a new dashboard for our website that allows users to track both monetary impact and open recommendations associated with our reports.

OIG issued 194 reports and work products on VA programs and operations during this reporting period. Those investigations, inspections, audits, evaluations, and other reviews identified more than $9 billion in monetary impact, for a substantial return on investment of $134 for every dollar expended on OIG oversight. Approximately $5 billion of that amount is attributed to potential cost-savings OIG identified in relation to a Hepatitis C drug contract.

The OIG Hotline received more than 20,000 contacts over 6 months from sources concerning VA programs and operations. OIG investigators closed 295 investigations and made 162 arrests for crimes including fraud, bribery,

embezzlement, identity theft, drug diversion and illegal distribution, and personal and property offenses. OIG investigative and Hotline work resulted in 1,123 administrative sanctions and corrective actions.

Our staff, at all levels and across each directorate, has played an integral role in providing effective oversight work that reflects our mission, vision, and values. I am grateful for their efforts and thankful for the support of our Nation's veterans, Congress, Veteran Service Organizations, and stakeholders. We look forward to working with dedicated VA leaders and staff to foster a culture of continuous improvement for the benefit of veterans and their families.

MICHAEL J. MISSAL
Inspector General

Highlights of VA OIG Activities

Pursuant to Public Law (P.L.) 95-452, *Inspector General Act of 1978*, as amended, this Report presents our accomplishments during the reporting period April 1–September 30, 2017. Highlighted below are some of the activities conducted during this reporting period and their impact.

Office of Investigations

The Office of Investigations continues to coordinate with other law enforcement agencies to identify a wide range of criminal activity. Among notable cases were these regarding serious allegations of fraud. A VA OIG, Housing and Urban Development OIG, and Federal Housing Administration (FHA) OIG investigation determined that a mortgage company failed to comply with certain VA, Fannie Mae, Freddie Mac, and FHA origination, underwriting, and quality control requirements. The mortgage company and its subsidiaries agreed to pay the United States $74,453,802 to resolve allegations that they violated the *False Claims Act* by knowingly originating and underwriting mortgage loans insured, guaranteed, and purchased by Government programs that did not meet applicable requirements. The VA portion of the settlement was $6,464,000.

A nationwide VA OIG, Federal Bureau of Investigation, and Department of Justice OIG investigation resulted in charges that alleged between 2011 and 2015 the defendant, the school's president, the school's former vice president, and veterans conspired to defraud VA of more than $4.3 million in education benefits. The school received inflated, unearned tuition and fees ranging between $5,000 and $13,000 per course, while the veterans received basic housing allowance and a books and supplies stipend totaling over $2,000 per month. The former student coordinator of a trucking school pled guilty to wire fraud for his part in enrolling at least 108 veterans who allegedly never attended or received training at the school.

OIG investigators completed nearly 300 investigations and made more than 160 arrests for fraud, bribery, embezzlement, identity theft, drug crimes, and personal and property crimes. More than 1,000 administrative sanctions and corrective actions were taken as a result of investigations.

Office of Healthcare Inspections

OHI published 77 reports that range from reviews of the performance and effectiveness of leadership at individual VA hospitals, to reviews of national VA Suicide programs and to the evaluation of single veterans treated at VA hospitals. OHI continues to focus and report on VA's efforts to improve Veterans Health Administration's (VHA's) opioid prescribing practices and delivery of mental health (MH) services to veterans. Below are some examples of our reports in these critically important areas:

- In *Healthcare Inspection – Review of Opioid Prescribing Practices, Clement J. Zablocki VAMC, Milwaukee, Wisconsin,* OHI reviewed the prescribing practices related to controlled substances at the Clement J. Zablocki VAMC, Milwaukee, WI and made recommendations to improve oversight of narcotic prescribing practices to ensure providers employ the most appropriate treatments for veterans with chronic pain.

- In *Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*, OHI identified that non-VA providers were not required to adhere to Opioid Safety Initiative guidelines and made recommendations to ensure compliance with those guidelines.

- In *Healthcare Inspection – Alleged Inadequate Mental Health Care, Iowa City VA Health Care System, Iowa City, Iowa*, OHI conducted a healthcare inspection of the MH unit admission policies and practices after a patient committed suicide shortly after allegedly not being admitted for treatment.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) issued impactful reports on a wide range of topics, including health care enrollment controls and non-VA care oversight. These projects identified weaknesses in areas such as VA data integrity and improper billing for treatment of service-connected (SC) conditions, and identified potential monetary benefits totaling approximately $3.1 billion. Recent reports include the following:

- In *Audit of the VHA's Health Care Enrollment Program at Medical Facilities*, OAE evaluated controls over the health care enrollment program administered at VA medical facilities and attempted to determine if enrollment actions were processed timely and supported by required documentation. The audit found VHA did not provide adequate governance to ensure oversight and control over the health care enrollment program. Specifically, VHA required medical facilities to establish procedures for processing enrollment applications without implementing effective processes to monitor those activities. Medical facilities were also permitted to adopt practices that were inconsistent with national policies. OAE found data systems did not have the capability to identify new enrollment applications such that timeliness and supporting documentation could not be independently evaluated. OAE recommended VHA develop standardized national policies and procedures, implement national oversight, and provide mandatory and standardized training for the health care enrollment program at VA medical facilities. OAE also recommended VHA implement a plan to correct the data integrity issues necessary to improve the accuracy and timeliness of health care enrollment data. If recommendations are implemented, VHA will have a more veteran-centric health care enrollment process in which each application is processed uniformly and with due consideration. Additionally, improved health care enrollment data will increase program transparency to veteran applicants and the public, and improve VA leadership's ability to make informed decisions based on that data.

- In *Audit of VHA's Consolidated Patient Account Center Controls To Prevent Improper Billings for SC Conditions,* OAE substantiated the allegation that Consolidated Patient Account Center (CPAC) Controls, which were established to provide standardized and uniform revenue services across VHA's Veterans Integrated Service Networks, improperly billed veterans and third-party payers and used an automated system that billed by default. Of about 15.4 million bills VHA issued during FY 2015, OAE estimated approximately 1.7 million (11 percent) were improper bills for treatment of SC conditions. Of the improper bills, more than 600,000 were sent to veterans. The audit revealed this occurred because CPACs did not provide billing staff access to the Veterans Benefits Management System, failed to establish procedures to review prescriptions, lacked comprehensive quality assurance reviews of SC determinations, and did not provide consistent training to VA medical facility staff. OAE estimated that VHA improperly issued bills totaling about $15 million to veterans and approximately $295.6 million to third-party payers for treatment of SC conditions. OAE estimated that, as a result, VHA inappropriately collected approximately $13.9 million from veterans and at least $13 million from third party payers for the improper bills. OAE recommended action be taken to identify and refund erroneous bills.

OIG's oversight work was greatly enhanced by support received from the Office of Management and Administration (OMA) and the Office of the Counselor. OMA provided a number of different services including human resources, contracting, publications, training, information technology, space management, and budget. The Office of the Counselor provided essential legal support and information disclosure advice across the OIG.

Statistical Highlights

Monetary Impact (in Millions)	Apr-Sept	FY
Better Use of Funds	$2,603.7	$2,771.6
Fines, Penalties, Restitutions, and Civil Judgments	$39.6	$190.9
Fugitive Felon Program	$115	$235.8
Savings and Cost Avoidance	$5,737.5	$6,203.7
Questioned Costs	$538.8	$577.3
Dollar Recoveries	$16.1	$45.6
Total Dollar Impact	$9,050.6	$10,024.9
Cost of OIG Operations[1]	$67.7	$137.5
Return on Investment[2]	**134:1**	**73:1**

Investigative Activities[3]	Apr-Sept	FY
Arrests[4]	161	305
Fugitive Felon Arrests	1	7
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	14	23
Indictments[5]	115	240
Indictments and Informations Resulting from Prior Referrals to Authorities	43	141
Criminal Complaints	38	71
Convictions	139	299
Pretrial Diversions and Deferred Prosecutions	13	34
Case Referrals to Department of Justice for Criminal Prosecution[6]	254	480
Cases Accepted	73	127
Cases Declined	91	198
Cases Pending	90	155
Case Referrals to State and Local Authorities for Criminal Prosecution[7]	37	86
Cases Accepted	29	56
Cases Declined	6	17
Cases Pending	2	13

Investigative Activities[3]	Apr-Sept	FY
Administrative Investigations Opened	10	19
Administrative Investigations Closed	12	26
Administrative Sanctions and Corrective Actions	363	561
Cases Opened[8]	358	664
Cases Closed[9]	295	679
Administrative Summaries of Investigation[10]	17	35

Hotline Activities	Apr-Sept	FY
Contacts	20,204	37,455
Cases Opened (internal and external)	1,240	2,169
Cases Closed[11] (external only)	1,021	1,664
Administrative Sanctions and Corrective Actions[12]	760	1,294
Substantiation Percentage Rate[13]	35	37
Individuals Claiming Retaliation/ Seeking Whistleblower Protection	53	88
Individuals Provided Office of Special Counsel Contact Information	50	81
Individuals Provided Merit Systems Protection Board Contact Information	24	47
Individuals Provided Office of Resolution Management Contact Information	80	139

Statistical Highlights

Reports and Work Products	Apr-Sept	FY
Reports Issued		
Audits and Evaluations	24	47
Benefits Inspections	16	16
National Healthcare Reviews	8	13
Hotline Healthcare Inspections	49	62
Clinical Assessment Program Reviews	20	30
Administrative Investigations	4	5
Preaward Contract Reviews	56	95
Postaward Contract Reviews	9	24
Claim Reviews	0	1
Subtotal	**186**	**293**
Work Products		
Administrative Investigation Advisories	7	14
Administrative Investigation Closures	0	0
Audit Work Products	1	2
Healthcare Closures	0	0
Subtotal	**8**	16
Total Reports and Work Products	**194**	**309**

Healthcare Inspections Activities	Apr-Sept	FY
Clinical Consultations	**9**	**15**

1. The 6-month operating cost for the Office of Healthcare Inspections ($12.1 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.
2. This figure is calculated by dividing Total Dollar Impact by Cost of OIG Operations.
3. All investigative data reported and analyzed was collected via OIG's case management system. Please note that OIG does not publish or issue investigative reports related to criminal investigations.
4. Does not include Fugitive Felon arrests by OIG or other agencies.
5. Figure is a result of referrals made to prosecutorial authorities prior to and during the current reporting period.
6 and 7. Due to the timing of the release of the new reporting requirements, OIG was unable to track the number of persons referred for criminal prosecution as the organization has historically tracked cases. However, OIG has modified its tracking process to ensure the number of persons referred is provided in future reporting periods.
8. Includes administrative investigations opened.
9. Includes administrative investigations closed. This total also includes cases which opened in previous FYs.
10. During this reporting period, OIG published 17 administrative summaries of investigation in response to allegations regarding patient wait times received since April 2014. These are listed in Appendix A.
11, 12, & 13. Includes cases which opened in previous FYs.

Glossary

ACOS	Acting Chief of Staff
AFR	Agency Financial Report
AMHIU	Acute Mental Health Inpatient Unit
ATR	Achilles tendon rupture
AUSH	Acting Under Secretary for Health
BBP	bloodborne pathogens
BCVAMC	Battle Creek VA Medical Center
BURC	Blood Usage Review Committee
CAP	Clinical Assessment Program
CAR	Combat Action Ribbon
CBO	Chief Business Office
CBOC	community based outpatient clinic
CFO	Chief Financial Officer
CHAMPVA	Civilian Health and Medical Program of VA
CHIP	Comprehensive Healthcare Inspection Program
Choice	Veterans Choice Program
CIC	Care in the Community
CID	Criminal Investigation Division
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CLC	community living center
CNH	Community Nursing Home
CO	contracting officer
COS	Chief of Surgery
CPAC	Consolidated Patient Account Centers
CSP	compounded sterile product
CT	computed tomography
DATA Act	*Digital Accountability and Transparency Act of 2014*
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DIN-PACS	Digital Imaging Network-Picture Archival Communication System

DoD	Department of Defense
DOL	Department of Labor
DT	dashboard tool
DWHP	Designated Women's Health Provider
EHR	electronic health records
EAM	emergency airway management
EAR	employee assessment review
ED	emergency department
EMG	electromyography
EMS	emergency medical services
EOC	environment of care
EP	End Product
EPM	enterprise portfolio management
FAA	Federal Aviation Administration
FAR	Federal Acquisition Regulation
FBI	Federal Bureau Investigation
FDA	Food and Drug Administration
FHA	Federal Housing Administration
FHCC	Federal Health Care Center
FISMA	*Federal Information Security Modernization Act*
FPDS	Federal Procurement Data System
FPPE	Focused Professional Practice Evaluation
FSS	Federal Supply Schedule
FTE	full-time employee
FY	fiscal year
GLAC	Great Lakes Acquisition Center
H/HHA	Homemaker and/or Home Health Aide
HBPC	Home Based Primary Care
HCPS	Health Care Claims Processing System
HCS	Health Care System
HHS	Health and Human Services
HOR	hybrid operating room
HT	Home Telehealth
HUD	Housing and Urban Development

HUD/ VASH	Housing and Urban Development Veterans Affairs Support Housing
ICU	intensive care unit
IED	Improvised Explosive Device
IG	Inspector General
IPEC	Inpatient Evaluation Center
IPERA	*Improper Payments Elimination and Recovery Act*
IRS	Internal Revenue Service
IT	information technology
IU	Individual Unemployability
JHU	John Hopkins University
LOS	lengths of stay
LVN	licensed vocational nurses
LWOP	Leave Without Pay
MH	mental health
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
MHTC	Mental Health Treatment Coordinator
MRI	magnetic resonance imaging
MS&C	medical support and compliance
NCA	National Cemetery Administration
NCHCS	Northern California Health Care System
NCO	Network Contracting Office
NECC	New England Compounding Center
NFS	Nutrition and Food Service
NVCC	Non-VA Care Coordination
NWQ	National Work Queue
OAE	Office of Audits and Evaluations
OALC	Office of Acquisitions, Logistics, and Construction
OCR	Office of Contract Review
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHRA	Office of Human Resources and Administration
OI	Office of Investigations
OIG	Office of Inspector General
OIT	Office of Information and Technology
OM	Office of Management
OMA	Office of Management and Administration
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
ORT	opioid risk tool
OSI	Opioid Safety Initiative
OSP	Office of Operations, Security, and Preparedness
P&LO	Procurement and Logistics Office
PBM	Pharmacy Benefit Managers
PBS	patient business service
PCP	Primary Care Physician
PCPM	Purchase Card Program Manager
PCT	PTSD Clinical Team
PDMP	prescription drug monitoring program
PII	personally identifiable information
PIV	Personal Identity Verification
PMRS	Physical Medicine and Rehabilitation Services
PODS	Prescription Opioid Documentation and Surveillance
PRMC	Peterson Regional Medical Center
PSAS	Prosthetic and Sensory Aids Service
PTSD	post-traumatic stress disorder
RN	registered nurse
SAC	Special Agreement Check
SBA	Small Business Administration
SC	service-connected
SDVOSB	Service-Disabled Veteran-Owned Small Business

SIC	Security and Investigations Center
SORCC	Southern Oregon Rehabilitation Center and Clinics
SSA	Social Security Administration
SSN	Social Security Number
STVHCS	South Texas Veterans Health Care System
TAVR	transcatheter aortic valve replacement
TCU	Transitional Care Unit
UCC	Urgent Care Clinic
UDS	urine drug screening
USMS	US Marshals Service
USP	United States Pharmacopeia
USPS	US Postal Service
VACC	VA Community Care
VALU	VA Learning University
VAMC	VA Medical Center
VANIHCS	VA Northern Indiana Health Care System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VHA CC	VHA Office of Community Care
VISN	Veterans Integrated Service Network
VRAP	Veterans Retraining Assistance Program
VSC	Veterans Service Center
VSO	Veterans Service Organization

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Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by Public Law (P.L.) 95-452, *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.	Statistical Highlights 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, for which no establishment comment was returned within 60 days of providing the report to the establishment, and for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations.	Other Significant OIG Activities Appendix B
§ 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
§ 5 (a) (17) statisical tables showing the total number of investigative reports issued, the total number of persons referred to the Department of Justice for criminal prosecution, the total number of persons referred to State and local prosecuting authorities for criminal prosecution, the total number of indictments and criminal informations that resulted from any prior referral to prosecuting authorities, and a description of the metrics used for developing the data for the statistical tables.	Statistical Highlights

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Reporting Requirements	Section(s)
§ 5 (a) (19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including a detailed description of the facts and circumstances of the investigation as well as the status and disposition of the matter.	Office of Investigations
§ 5 (a) (20) a detailed description of any instance of whistleblower retaliation.	Other Significant OIG Activities
§ 5 (a) (21) a detailed description of any attempt by the establishment to interfere with the independence of the OIG.	Other Significant OIG Activities
§ 5 (a) (22) detailed descriptions of the particular circumstances of each inspection, evaluation, and audit or investigation involving a senior Government employee that is closed and was not disclosed to the public.	Office of Investigations

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) 2017, VA is operating under a $180 billion budget, with over 382,000 employees serving an estimated 20 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.

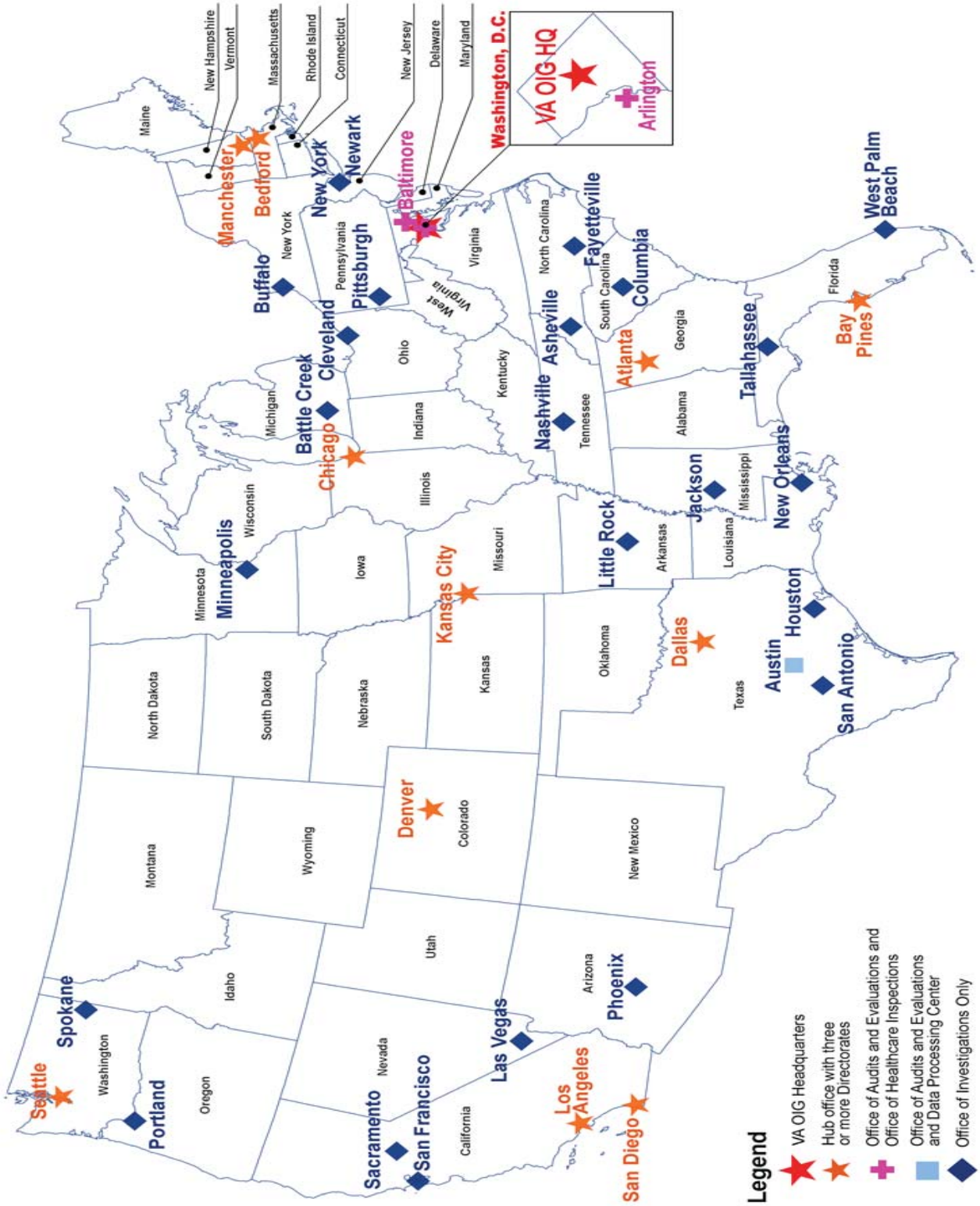
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

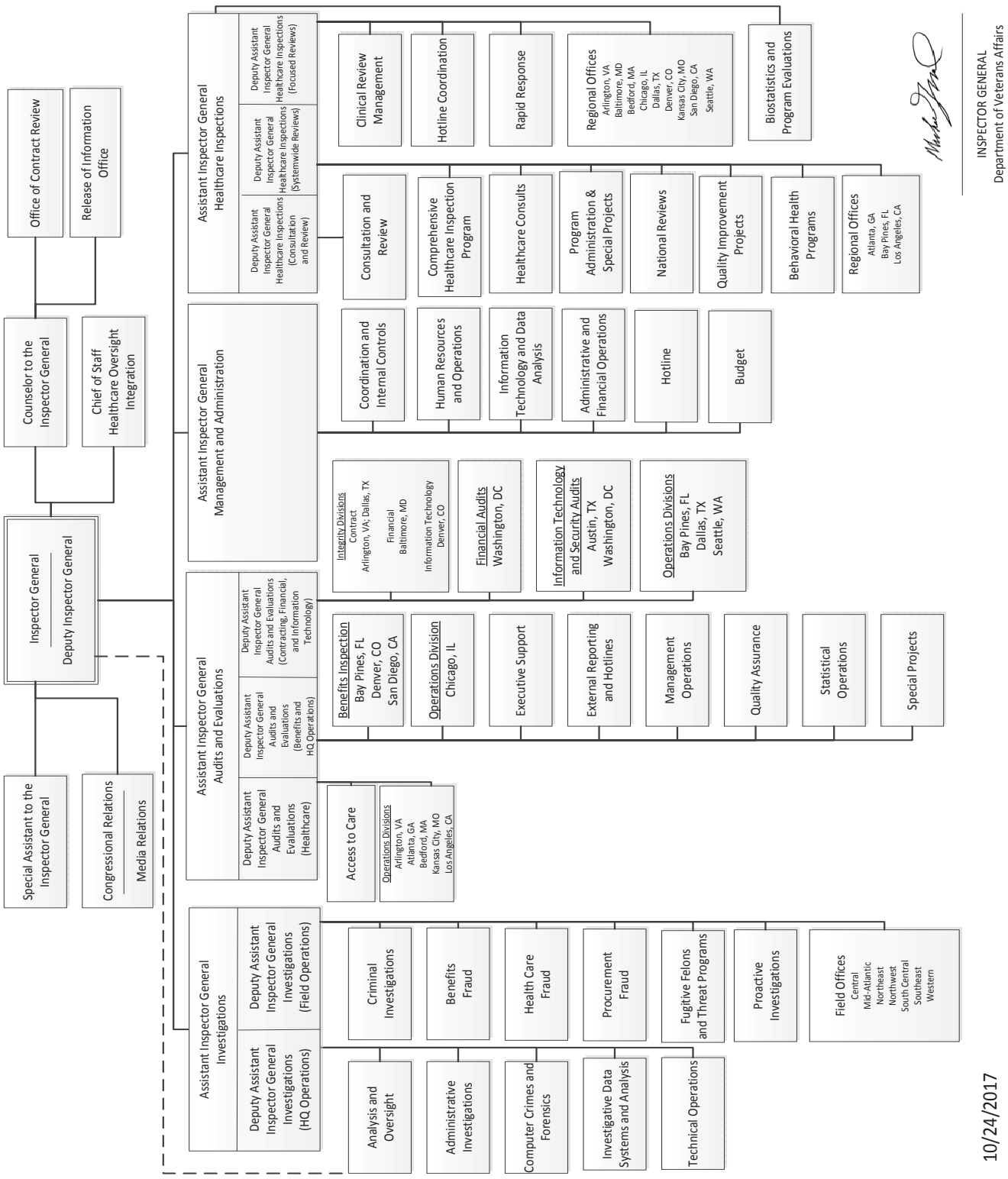
The Office of Inspector General's (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, and investigations. OIG was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, 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 808 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 2017 funding for OIG operations provides $159.6 million from ongoing appropriations. 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, 49 Hotline healthcare inspections, and 20 Clinical Assessment Program (CAP) reviews to evaluate the quality of veteran care. All reports issued this reporting period are listed in Appendix A.

Clinical 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 20 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: (1) Quality, Safety, and Value; (2) Environment of Care (EOC); (3) Medication Management: Anticoagulation Therapy; (4) Coordination of Care: Inter-Facility Transfers; (5) Diagnostic Care: Point-of-Care Testing; (6) Moderate Sedation; (7) Community Nursing Home (CNH) Oversight; (8) Management of Disruptive/Violent Behavior; (9) Post-Traumatic Stress Disorder (PTSD) Care; and (10) Mental Health Residential Rehabilitation Treatment Program (MH RRTP). When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of the evaluation of that specific topic. During this reporting period, OIG issued three CAP summary reports, which are highlighted in the National Healthcare Reviews section. It is important to note that OHI has made revisions to its CAP program that went into effect at the start of FY 2018. The CAP will now be referred to as the CHIP, which stands for the Comprehensive Healthcare Inspection Program. Among other changes, OIG has enhanced the program to include a focus on the effectiveness of leadership at individual medical centers and the production of reports that provide more of a narrative. The new CHIP model represents OIG's dedication to continually provide reports of the highest quality.

National Healthcare Reviews

Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care

OIG conducted a healthcare inspection to review opioid prescribing to high-risk veterans receiving VA purchased care. VHA developed two initiatives in 2014 to improve the safety and management of chronic pain in veterans: (1) the Opioid Safety Initiative (OSI), and (2) the enabling of VA providers to participate in state prescription drug monitoring programs (PDMP). The OSI includes specific management guidelines including a prescriber's toolkit and alternative therapeutic approaches to chronic pain. PDMPs are used to track the prescribing and dispensing of controlled substance prescriptions to patients. VA implemented purchased care programs for veterans to access care in the community when necessary, including the Veterans Choice Program (Choice). OIG determined that with the expansion of community partnerships, a significant risk exists for patients prescribed opioid prescriptions outside of VA. Patients with chronic pain and mental illness who receive opioid prescriptions from non-VA clinical settings where opioid prescribing and monitoring guidelines conflict with VA guidelines may be especially at risk. The risk is exacerbated when information about opioid

prescriptions is not shared. Because of challenges related to health information sharing, OIG noted that non-VA providers do not consistently have access to critical health care information regarding veterans they are treating. OIG noted that while the ability to query PDMP databases is available, VA providers would not likely access the PDMP when not prescribing controlled substances. Timely notification of veteran patients receiving non-VA opioid prescriptions would allow more immediate VA provider awareness and action, if action were required. If all routine non-VA opioid prescriptions were submitted directly to VA pharmacies, VA pharmacy staff could alert the VA provider that a non-VA opioid prescription was dispensed. This would also allow the same level of pain management committee oversight by VA of opioid prescriptions prescribed by VA and non-VA providers. OIG recommended the Acting Under Secretary for Health (AUSH): (1) require all participating VA purchased care providers receive and review OSI evidence-based guidelines for prescribing opioids; (2) implement a process to ensure all purchased care consults for non-VA care include a complete up-to-date list of medications and medical history; (3) require non-VA providers to submit opioid prescriptions directly to a VA pharmacy for dispensing and recording in the patient's VA electronic health record (EHR); (4) ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with OSI guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.

Evaluation of Computed Tomography Radiation Monitoring in VHA Facilities

OIG completed a healthcare evaluation of computed tomography (CT) radiation monitoring in VHA facilities. The purpose of the evaluation was to determine whether facilities complied with selected VHA radiation safety requirements. CT combines a series of x-ray images to create cross-sectional images of the body. Sophisticated computers process the data to generate three-dimensional CT images of the inside of the body that can reveal the presence of disease or injury. CT scans are extremely helpful in diagnosing serious injuries to the head, chest, abdomen, spine, and pelvis. CT scans can also pinpoint the size and location of tumors. However, CT scans also contribute significantly to the amount of total patient radiation exposure and could result in the development of future cancers. For this reason, clinicians should eliminate avoidable exposure. OIG conducted this review at 56 VHA medical facilities during CAP reviews performed across the country from April 1, 2015, through March 31, 2016. OIG noted high compliance in multiple areas, for example: facilities had designated Radiation Safety Officers; clinicians documented radiation doses as required by facility policy; and CT technologists were certified, received selected training, and had dosimetry monitoring. However, OIG identified a system weakness in which medical physicists did not consistently inspect CT scanners after repairs or modifications that affected the dose or image quality prior to returning the scanners to clinical service.

Evaluation of Compounded Sterile Product Practices in VHA Facilities

OIG completed a healthcare inspection of compounded sterile product (CSP) practices in VHA facilities. The review determined whether facilities complied with selected requirements for the safe preparation of CSPs. CSPs are pharmaceutical preparations made or modified in a controlled sterile environment. OIG conducted this review at 25 VHA medical facilities during CAP reviews performed across the country from October 1, 2015, through March 31, 2016. OIG noted high compliance in several areas, including that facilities had adequate policies and provided safe conditions for CSP preparation; that staff documented sampling for contamination in required areas and took actions when they identified positive cultures; and that when facilities used non-VA sources for CSPs, the sources were appropriately registered.

Evaluation of Suicide Prevention Programs in VHA Facilities

OIG completed an evaluation of Suicide Prevention programs in VHA facilities in order to assess facility compliance with selected VHA guidelines for suicide prevention programs. OIG conducted this review at 28 VHA medical facilities during CAP reviews performed across the country from October 1, 2015, through March 31, 2016. OIG found that most facilities had a process for responding to referrals from the Veterans Crisis Line (VCL) and a process to follow up on high-risk patients who missed appointments. Additionally,

when patients died from suicide, facilities generally created issue briefs and when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, OIG identified system weaknesses in outreach activities; suicide prevention safety plan completion, content, and distribution; flagging records of high risk inpatients and notifying the Suicide Coordinator of the admission; evaluating high-risk inpatients during the 30 days after discharge; reviewing flagged high-risk outpatients every 90 days; and clinicians completing suicide risk management training within 90 days of hire.

Review of VHA Care and Privacy Standards for Women Veterans

OIG conducted a Congressionally-requested review to evaluate VHA provisions of care for women veterans, both general and gender-specific, proficiencies of Designated Women's Health Providers (DWHP), and VHA facilities' compliance to privacy standards for women veterans. OIG found that 82.5 percent and 17.5 percent of gender-specific care visits for women veterans were performed at VA and non-VA facilities, respectively, during FY 2014. OIG identified that as of September 2, 2015, there were 2,294 DWHP representing the equivalent of 1,864.7 full-time employees (FTEs). OIG found that 39.8 percent of those FTEs practiced at a VA medical facility, while 60.2 percent practiced in a VA community based outpatient clinic (CBOC) setting. Among these DWHPs, 1,236 (53.9 percent) were shown to have women veteran populations of less than 10 percent of their total patient panel. OIG found that 547 of the 1,236 providers (44.3 percent) had documented proficiencies. OIG noted that VHA has identified those providers with a low percentage of women veterans, but OIG could not verify that the provided documentation satisfied the proficiency requirements for all of these providers. During FY 2014, OIG found that 20.4 percent of the 93 CBOCs evaluated did not meet specific VHA requirements for protecting the privacy of women veterans. OIG noted slight improvement in FY 2015; 14.3 percent of the 56 CBOCs evaluated did not meet the same VHA requirements for women veterans' privacy.

Review of VHA's "Our Doctors" Website Accuracy

OIG conducted a review in response to a letter from 10 current or former members of Congress requesting investigation of inaccurate information that was posted on the VHA "Our Doctors" website. OIG's review found that VHA had not clearly defined the processes involved in uploads of information to the "Our Doctors" website, had not required adequate validation prior to posting information to the website, and had not defined a frequency of updates that would identify normal changes occurring in providers' credentials over time. In addition, processes did not allow for facility level corrections. The result was that some inaccurate information was posted on the "Our Doctors" website. When brought to their attention, VHA facilities reviewed the information and initiated corrective action plans. Although VHA has issued some clarification and a disclaimer, further definitions and clarification are needed. Oversight processes need to be implemented at facility, network, and national levels. OIG identified two system weaknesses and recommended that the AUSH ensure that VHA develops and implements a policy defining the purpose, responsibilities, and requirements for ensuring current credentials information on the "Our Doctors" website and develops and implements an oversight process for accuracy of the information posted on the "Our Doctors" website.

Overview of VA Suicide Prevention Efforts and Data Collection

At the request of Senator Bill Nelson, OIG conducted a healthcare review to address questions regarding VA suicide prevention efforts and suicide data collection: (1) How do you know if VA's suicide prevention programs are working and what percent of veterans who die by suicide have been under the care of VHA; (2) Are data on suicides turned over to mental health (MH) providers in real time; (3) What risk factors associated with higher veteran suicides are being explored in-depth, and by whom; and (4) What ways can be identified to gather more reliable suicide data. OIG found that VHA tracked suicide rates of veterans and other VHA users by matching suicide deaths from the National Death Index; State-based reporting and Suicide Prevention Applications Network initiatives may not have included the full population of veteran suicides; and the VA/Department of Defense (DoD) Suicide Data Repository was developed. OIG found that real time data was not available to MH

providers in all states; VHA implemented a predictive analytics risk model; and non-VA researchers analyzed military service members' social media posts for MH status changes/suicidal ideation to determine suicide risk factors. OIG also found that the Veterans Integrated Service Network (VISN) 2 Center of Excellence and VISN 19 Mental Illness Research, Education and Clinical Center had over 20 suicide prevention research studies and projects; reliability of suicide data was contingent on usage of clear, standardized terminology; training was critical for persons responsible for completing the medical portion of the death certificate; and VHA and DoD Suicide Prevention program staff were developing a sharing agreement to establish a routine method to transfer data. This OIG review was informational and had no recommendations.

OIG Determination of VHA Occupational Staffing Shortages FY 2017

OIG conducted its fourth determination of VHA occupations with the largest staffing shortages as required by Section 301 of P.L. 113-146, *Veterans Access, Choice, and Accountability Act of 2014*. OIG determined that the largest critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, and Medical Technologist. OIG's analysis of the staffing gains and losses for this year's report shows that for critical need occupations, a significant percentage of the total gains continue to be offset by staff losses. At the time of the writing of this report, VHA still does not have operational staffing models that comprehensively cover critical need occupations. In the absence of facility-specific staffing targets or an operational staffing model, determining whether facilities are making meaningful progress in filling critical staffing shortages is challenging. VHA chartered a work group to consider ways to reduce regrettable losses. The work group's report focused on the need for additional studies to determine causative and other factors related to regrettable losses. The work group reported issuing a follow-up report in September 2017. In an effort to better understand staffing processes and identify staffing barriers, OIG conducted a survey of 141 VHA facilities in May 2017. OIG received a request from Senator Thom Tillis to evaluate staffing requirements and demand for select non-physician professionals. OIG included questions in the survey related to those professionals (optometrists, pharmacists, and medical technicians). OIG made four recommendations to the AUSH.

Hotline Healthcare Inspections

Management of MH Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

OIG conducted a healthcare inspection to assess allegations from Senators Tammy Baldwin and Ron Johnson in December 2015 and June 2016 concerning program policies and procedures, staffing, and quality of care in the MH RRTP and Acute Mental Health Inpatient Unit (AMHIU) at the Clement J. Zablocki VA Medical Center (facility) Milwaukee, WI. OIG substantiated staff did not consistently follow MH RRTP patient safety policies. Staff did not consistently conduct or document rounds, maintain physical presence and engagement on the units, or conduct contraband checks. OIG substantiated MH RRTP staffing was inadequate and facility leaders had not assigned a dedicated MH RRTP psychiatrist. OIG did not substantiate that a patient was given a higher than indicated buprenorphine/naloxone dose. The patient's provider prescribed a dosage of buprenorphine/naloxone that was within suggested ranges for the patient's phase of treatment. OIG focused the review of AMHIU safety and security on visitation procedures. OIG substantiated that in Spring 2016, the unit did not have a visitation policy and staff did not consistently check visitors for contraband. OIG could not determine a failure to conduct contraband checks led to an attempted suicide or a patient having a syringe in his room. OIG substantiated an Administrative Investigation Board was conducted and 16 recommendations were issued. One recommendation addressed enhancing MH RRTP safety and security. OIG found increased police presence and measures to limit access to the MH RRTP during a second site visit in August 2016. OIG did not substantiate a patient was denied admission to an MH RRTP program. The patient was discharged due to his failure to comply with policies. OIG found that a Mental Health Treatment Coordinator (MHTC) was not identified in this patient's EHR. OIG was

unable to identify assigned MHTCs for six of seven other patients reviewed. OIG determined facility aftercare programs were available during day, evening, and weekend hours. Six of the reviewed patients who required post discharge follow-up care appointments received appointments; however, not all attended the appointments. OIG recommended that the Facility Director ensure MH RRTP local policies are consistent with VHA's MH RRTP Handbook, MH RRTP leaders and staff adhere to the policies, managers monitor compliance, the MH RRTP has adequate resources, the AMHIU visitation policy is fully implemented, MHTCs are assigned to MH patients, and communication and coordination is enhanced across MH clinical areas.

Alleged Inadequate MH Care, Iowa City VA Health Care System, Iowa City, Iowa

OIG conducted a healthcare inspection of the Iowa City VA Health Care System (system), Iowa City, IA, MH unit admission policies and practices. OIG received review requests from five Members of Congress. The requests were to: (1) examine the facts and circumstances surrounding a patient who was reportedly denied inpatient MH admission; (2) assess whether the patient received appropriate MH care; and (3) conduct a review of the admission policy and practice for inpatient MH. OIG found that the patient requested inpatient MH admission and was not admitted. The psychiatrist made efforts to re-engage the patient after he abruptly left an appointment and followed appropriate medical decision-making practices based on the information available at the time. The patient had access to and participated in extensive MH services appropriate for his diagnoses and needs. OIG identified system shortcomings including adherence to VHA policies on no-shows, treatment planning/communication, and the use of principal MH providers (the system uses the title of "MH Treatment Coordinator" for designated principal MH providers). OIG also identified information during our review that, if known to VHA providers, may have altered the course of care. OIG found system MH admission practices were in alignment with VHA and system policies, including a plan for care when system MH beds were unavailable. Although VHA requirements for review were met, the reviews were limited in scope to the EHR and interviews with clinicians and next of kin. As a result, information relevant to the case was missed. OIG also noted opportunities for the system to proactively plan for the management of communications in similar future cases.

Peer Review for Quality Management Concerns, Huntington VA Medical Center, Huntington, West Virginia

OIG conducted a healthcare inspection of the peer review process for quality management at the Huntington VA Medical Center (facility), Huntington, WV. OIG identified concerns while conducting a CAP review of the facility, which included an evaluation of Peer Review Committee activities. OIG found that in the cases evaluated that were referred for peer review, peer reviewers did not consistently address and document a comprehensive exploration of possible event causes. OIG also found (1) incomplete Peer Review Committee oversight of initial peer reviews; (2) an inappropriate but otherwise qualified individual conducted initial peer reviews; (3) that an individual was uncomfortable about conducting a peer review; and (4) that a peer reviewer conducting an initial review lacked qualifications required of a peer relative to the episode of care under review. OIG made six recommendations for improvement of the facility's peer review process.

Interim Summary Report on Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC

On March 21, 2017, a confidential complainant forwarded to OIG documents describing equipment and supply issues at the Washington DC VA Medical Center (the Medical Center) sufficient to potentially compromise patient safety. OIG promptly reviewed the documentation. On March 29, 2017, OIG deployed a Rapid Response Team to assess the allegations. OIG's team conducted interviews, collected documents, and conducted a physical inspection of the Medical Center's satellite storage areas on March 29–30, 2017. The team returned for an additional site visit on April 4–6, 2017, and was on-site for a third inspection at the time of this report's publication. OIG has preliminarily identified a number of serious and troubling deficiencies at the Medical Center that place patients at unnecessary risk. Although OIG has not identified at this time any adverse patient

outcomes, OIG found other issues. At least some of these issues have been known to VHA senior management for some time without effective remediation. Although OIG's work is continuing, OIG believed it appropriate to publish this Interim Summary Report given the exigent nature of the issues OIG has preliminarily identified and the lack of confidence in VHA adequately and timely fixing the root causes of these issues. OIG also included recommendations for immediate implementation.

Follow-Up Review of Management of MH Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine

OIG conducted a healthcare inspection at the request of Senators Susan M. Collins and Angus S. King, Jr., and Representatives Chellie Pingree and Bruce Poliquin to follow up on recommendations made in the original report, *Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine (Report No. 14-05158-377, June 17, 2015).* The purpose of the follow-up inspection was to evaluate the VA Maine Healthcare System's progress in implementing action plans in response to the report to ensure that the consult package is used when referring patient for MH care; MH consults are reviewed and closed in accordance with VHA policy; and VHA appointment schedule guidance is followed, including the use of the electronic wait list. OIG found the system implemented and sustained corrective actions to improve consult package use for patients referred for MH services and the consult review and closure processes were consistent with VHA policy. OIG found the system was noncompliant with the requirement to make direct contact with patients when scheduling MH appointments. At the time of the follow-up review in 2016, system staff was unable to schedule MH appointments for service-connected (SC) veterans timely and no longer needed to use the electronic wait list; therefore, OIG was unable to determine if staff responsible for scheduling MH appointments utilized the electronic wait list correctly. Although not part of the original recommendations OIG was evaluating, OIG found documentation of initial and annual scheduling competencies for medical support assistants responsible for scheduling was missing or incomplete. OIG recommended the System Director ensure: (1) that MH schedulers consistently make direct contact with patients prior to scheduling appointments and that compliance is monitored for a minimum of three months and (2) training and competencies are documented, complete, and up to date for all staff responsible for scheduling MH appointments.

CNH Program Safety Concerns, VA Northern California Healthcare System, Mather, California

At the request of Congressman John Garamendi, OIG conducted an inspection to assess allegations concerning patient safety in the CNH Program at the VA Northern California Healthcare System (HCS), Mather, CA. OIG substantiated that a patient was admitted to a locked CNH Alzheimer care center and the complainant was told he was being held against his will. However, OIG determined the patient's placement was appropriate because a facility psychiatrist deemed the patient lacked decision-making capacity regarding his living situation and demonstrated an inability to safely and independently live in the community. OIG also substantiated a delay in the patient receiving hearing aids with mitigating circumstances, but did not substantiate a patient was given opioid medications against his wishes or was denied physical therapy. However, OIG identified a delay in the patient obtaining prosthesis care and confusion about the provision of his MH care. OIG concluded communication and collaboration between facility and CNH staff needed improvement. OIG did not substantiate facility staff did not report an alleged financial abuse to Adult Protective Services; however, the reporting was not completed timely. OIG substantiated Non-VA Care Coordination (NVCC) consult authorization delays for services. For the reviewed consults, the approval was timely; however, on average, NVCC staff took an additional 24 days before faxing the authorization approval to the CNH. OIG determined program staff needed to monitor the NVCC process and NVCC staff needed to timely fax authorizations to the CNH. OIG did not substantiate facility consult service delays. CNH patients generally received the requested services within 30 days. OIG substantiated program registered nurses (RNs) or social workers did

not consistently comply with the required monthly or quarterly patient visits in CNH facilities and determined regular visits would have provided program staff opportunities to identify and resolve CNH patient-specific issues.

EOC and Other Quality Concerns, Cincinnati VA Medical Center, Cincinnati, Ohio

OIG conducted an inspection at the request of Senator Sherrod Brown to assess allegations concerning the EOC, emergency airway management (EAM) of patients, and clinical practice by a former Acting Chief of Staff (ACOS) at the Cincinnati VA Medical Center (VAMC), Cincinnati, OH. OIG was asked to determine whether clean and dirty materials were stored together in the same location after an OIG 2015 recommendation to store clean and dirty materials separately; reduced availability of EAM providers may have led to a "close call" [delayed intubation of a patient]; and whether deficiencies regarding the former ACOS professional clinical practice had been identified by the facility during peer reviews or ongoing professional practice evaluations (OPPEs). OIG substantiated that clean and dirty patient care equipment items were stored together in the Community Living Center (CLC) following closure of an OIG recommendation made during a review of the facility in October 2014 (*CAP Review of the Cincinnati VA Medical Center, Cincinnati, Ohio, Report No. 14-04215-99, February 4, 2015*). OIG did not substantiate a reduction in availability of facility providers for EAM or a delay in the intubation of a patient. OIG did not substantiate reported deficiencies in the clinical practice of the former ACOS.

Consult Management Concerns, VA Greater Los Angeles HCS, Los Angeles, California

OIG conducted an inspection at the request of former Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, to determine the validity of the allegation that 74 deceased patients had open consults at the VA Greater Los Angeles HCS, Los Angeles, CA. OIG identified 225 deceased patients who had 371 open or pending consults at the time of their deaths or had discontinued consults after their deaths. Of the 225 patients, OIG found 117 patients with 158 consults who experienced delays in obtaining requested consults. OIG substantiated that 43 percent (158 of 371) of consults were not timely because providers and scheduling staff did not consistently follow consult policy or procedures. OIG did not substantiate the allegation that patients experienced serious or severe impact with long-term consequences or organ dysfunctions or that patients died as a result of delayed consults. However, OIG identified two patients who experienced minor or intermediate clinical impacts. OIG found that providers entered incorrect inpatient/outpatient setting and/or urgency for 14 percent (52 of 371) of the reviewed consults. While not an allegation, OIG observed deficiencies in consult management practices contributing to the delays. Of the 158 delayed consults, OIG noted that facility staff did not: (1) timely act on clinical consult requests, (2) close completed consults or discontinue duplicate requests or consults no longer indicated, or (3) monitor the electronic wait list for Homemaker and/or Home Health Aide (H/HHA) services.

Alleged Patient Deaths and Management Deficiencies in Home Based Primary Care, Beckley VAMC, Beckley, West Virginia

At the request of former Congressman Nick J. Rahall, OIG assessed the merit of allegations made by a complainant regarding patient deaths and management deficiencies in the Home Based Primary Care (HBPC) program at the Beckley VAMC, Beckley, WV. OIG substantiated that from 2007 through 2012, 25 of 40 patients died while awaiting admission to HBPC. However, OIG did not find that these patient deaths were associated with a delay in admission to HBPC, as the patients continued to receive care from other health care providers prior to their deaths. OIG found that from 2008 through July 2012, HBPC staff kept an unapproved wait list in violation of VHA policy. OIG did not substantiate that HBPC patient scheduling, wait times, and backlogs were mismanaged. OIG found that, other than the wait list issue, HBPC program managers substantially complied with VHA and facility policies. OIG substantiated that an HBPC provider changed a patient's diagnosis by adding a diabetes diagnosis to the patient's problem list. However, OIG could not determine that the change was

made to obtain prosthetic shoes for the patient. OIG did not substantiate that HBPC providers inappropriately prescribed antibiotics or that providers overprescribed opioids or changed patients' diagnoses in order to prescribe opioids.

Patient Care Concerns at the CLC, Hampton VAMC, Hampton, Virginia

OIG conducted a review at Senator Mark Warner's request to assess complaints about the delivery of care at the CLC, Hampton VAMC, Hampton, VA. OIG substantiated that CLC staff did not consistently have competency validation completed for the care of residents (a term commonly used for patients in a CLC) with suprapubic catheters, failed to carry out some physician orders for catheter irrigation, and did not consistently document checks for well-being and skin assessments. However, OIG did not substantiate that CLC staff failed to weigh residents, take vital signs, offer morning care, or address residents' dining assistance needs; that CLC staff made residents wait for care; that weekend staff were not keeping the same routines for the residents; or that residents were not informed of special events. OIG substantiated that in the past, residents had to go to the facility barbershop to be shaved and also found that resident call lights could be turned off at the nurses' desk. In response, biomedical staff reconfigured the system so that a call light could only be shut off at a resident's bedside. OIG could not substantiate that CLC staff left medications at a resident's bedside and later tried to give the resident another dose that was still sitting at his bedside or that CLC staff were not routinely cleaning or sanitizing durable medical equipment. OIG substantiated that procedures were not followed and an appropriate mattress was not obtained in a timely manner.

Alleged Pathology and Laboratory Medicine Service Quality of Care Issues, Wilmington, VAMC, Wilmington, Delaware

OIG evaluated allegations that a pathologist misread oncology test results, did not complete pathology tests timely, inappropriately sent some tests outside the facility on a fee for service basis, and altered pathology reports from alternate VHA and non-VHA laboratories to make it appear as though he performed the tests at the facility laboratory. OIG could not substantiate that the pathologist misread oncology tests. However, OIG reviewed EHR data and found that the pathologist replaced preliminary pathology results with final results; therefore, initial test results were not available for comparison to final test results or to the facility's data. OIG interviewed oncology staff who could not recall any instances of misread tests. OIG substantiated that the pathologist did not always have pathology test results available to ordering providers within required timeframes and had, with facility leadership approval, sent specimens to Fee Basis vendors for processing. OIG did not substantiate that the pathologist altered reports of pathology tests. However, OIG discovered inconsistent documentation identifying non-VHA pathologists on final pathology reports and incomplete documentation for specimens sent to alternate VHA and non-VHA laboratories. OIG found that the pathologist utilized a non-VHA laboratory to process pathology tests without a required VHA contractual arrangement and inappropriately revised a facility laboratory standard operating procedure. In addition, oversight services and committees did not consistently report accurate statistical and performance information to facility leadership and did not complete and monitor internal review action plans and OPPEs using current facility performance data.

Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans HCS, Little Rock, Arkansas

OIG assessed allegations about a surgical patient's care at the Central Arkansas Veterans HCS, John L. McClellan Memorial Veterans Hospital, Little Rock, AR. OIG did not substantiate that physicians failed to examine the patient every day or EHR documentation contained daily assessments. OIG also did not substantiate that the patient was in bilateral wrist restraints continuously for over 30 days or that nursing staff did not follow physician orders regarding the patient's activity level. EHR documentation showed that restraints were used but removed periodically and that nurses increased the patient's activity level when ordered to do so. The system's restraint policy did not require notification of system leaders of duration of medical restraint

use. OIG did not substantiate that the use of restraints caused a full thickness tissue loss or that staff failed to address an issue with the patient's foot and ankle. However, staff did not consistently follow the system's policy regarding wound care documentation. OIG substantiated that a request for a transfer was denied but did not substantiate that the denial was inappropriate. Services the patient needed were not available at the second hospital. OIG could not substantiate that nursing staff were making bets on how much medication they could give another patient to keep him quiet. The patient had a history of alcohol use, but the EHR did not contain documentation that the surgical team offered preoperative detoxification. It is unknown, however, if the patient would have agreed to the offer.

Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon

OIG reviewed allegations regarding program mismanagement and other concerns at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. The complainant alleged that HBPC, the Transitional Care Unit (TCU), the Non-Institutional Purchased Care program, specifically, the H/HHA, and the Housing and Urban Development Veterans Affairs Supported Housing (HUD/VASH) program were mismanaged and lacked appropriate oversight. In addition, the complainant alleged that services such as occupational therapy, physical therapy, case management, discharge planning, and MH were unavailable; services were denied to patients as a result of other patients receiving services inappropriately; TCU patients' lengths of stay (LOS) were based on need for reimbursement rather than clinical criteria; H/HHA service hours were inflated; patients were harmed at the SORCC; and training and educational resources were unavailable for staff. OIG initially substantiated that H/HHA and HUD/VASH programs lacked appropriate oversight as the Community Care Oversight Committee (H/HHA oversight) and the HUD/VASH program committee did not have required attendance or documentation of relevant program issues as described in VHA and SORCC policy. However, based on updated information received in 2016, OIG noted new committee leadership, required attendance, and discussion of relevant program issues. OIG did not substantiate the other allegations. OIG found the HBPC program and the TCU complied with selected VHA requirements; oversight committees were in place; members attended meetings; and action items were identified, addressed, and resolved. OIG reviewed selected services and found the patients OIG reviewed had received required services. OIG did not receive or identify the names of any patients who were denied services. OIG identified and reviewed the EHRs of 11 TCU patients whose LOS were over 90 days. OIG found the LOS were appropriate based on the inability of the patients to be fully successful in the traditional SORCC setting or in the community. OIG did not find an inflation of care needs without clinical justification for H/HHA patients. We found various educational resources were available to staff and that management supported necessary clinical training.

Nutrition and Food Service EOC Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois

OIG responded to a request in May 2016 from then-Senator Mark Kirk and then-Congresswoman Tammy Duckworth to assess Nutrition and Food Service (NFS) EOC concerns at the Edward Hines, Jr. VA Hospital, Hines, IL. OIG substantiated the persistent presence of cockroaches in and around NFS areas. During OIG's unannounced site visit on May 10, 2016, OIG found dead cockroaches on glue traps dispersed throughout the facility's main kitchen. OIG observed conditions favorable to pest infestation. OIG substantiated that several patients received food trays with cockroaches on them. OIG reviewed email correspondence between MH staff to NFS managers from March 11, 2011, through December 28, 2015, and a MH report dated March 13, 2014, that reported six complaints from patients that cockroaches were present on food trays delivered from the facility's main kitchen to the MH unit via a transportation cart. OIG substantiated that leadership had knowledge of unsanitary food service conditions (cockroaches) in the NFS kitchen but had not successfully resolved the problem. The facility leadership relied on its pest control program and did not take additional action to control the problem. OIG determined that between March 2011 and September 2016, 10 different individuals have been assigned to the Director's position. The facility did not have a permanent Director which may have contributed

to the failure to readily resolve persistent pest issues. Additionally, EOC inspection reports for at least the previous two years did not document the presence of cockroaches, and facility leadership may have considered the cockroaches on patient trays intermittent. NFS staff informed us that understaffing contributed to the presence of cockroaches in the facility's main kitchen.

Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles HCS, Los Angeles, California

OIG evaluated allegations related to patient deaths from drug overdose, inappropriate opioid prescribing practices, and improper consult management at the VA Greater Los Angeles HCS, Los Angeles, CA. We did not substantiate that seven patients died from drug overdoses during an 8-month period at the New Directions housing facility. The complainant did not provide names of the seven patients; therefore, we reviewed the EHRs of six patients who the system reported as having died after moving into New Directions from September 2013 through August 2014. The coroner determined that one of the six patients died from multiple drug intoxication. The drugs listed on the toxicology report had not been ordered by system providers. OIG did not substantiate that system psychiatrists prescribed inordinate amounts of opioids without oversight. OIG obtained data showing the system had a lower percentage of patients on larger amounts of opioids than the national average. OIG substantiated that cardiology consults were canceled or discontinued by non-physician staff members. However, this was an acceptable practice under certain circumstances. Of the 49 consults OIG reviewed that were canceled or discontinued by non-physician cardiology staff, five were inappropriately canceled or discontinued. OIG did not find documented evidence in the EHRs of patient harm in these five patients; however, patients can be put at increased risk of harm when consults are inappropriately canceled or discontinued.

Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada HCS, Las Vegas, Nevada

OIG assessed the merit of allegations regarding delays in the evaluation and care of a patient with lung cancer at the VA Southern Nevada HCS, Las Vegas, NV, in 2014. OIG substantiated a delay of approximately 6 months occurred in the evaluation of the patient's pleural effusion and delays occurred in the diagnosis and treatment of the patient's lung cancer. In conjunction with the delay in evaluation, the patient was not timely notified of test results. OIG identified several contributing factors, including lack of follow-up related to a non-VA provider's lung biopsy recommendation. OIG did not substantiate a Primary Care Physician (PCP) failed to perform a physical examination during an appointment, but substantiated delays in obtaining NVCC authorizations. OIG identified several contributing factors to the delays: (1) NVCC staff inconsistently applied the requirement for system providers to see the patient for services offered at the system before an NVCC consult was approved; (2) NVCC staff failed to process the request according to the requesting provider's urgency; (3) Emergency Department (ED) providers failed to follow the NVCC consult request process; and (4) NVCC staff did not appear to be knowledgeable of covered services. OIG substantiated inadequate medication management due to delays in filling medications ordered by non-VA care providers and problems with delivery of medications. OIG did not substantiate a lack of continuity of care due to changes in the patient's PCP and did not find disruptions in the patient's care due to the changes. However, OIG found inconsistencies with the system's peer review process.

Alleged Unsafe Blood Transfusion Practices, Battle Creek VAMC, Battle Creek, Michigan

OIG responded to allegations received in 2014 about unsafe blood transfusion practices at the Battle Creek VAMC (BCVAMC) in Battle Creek, MI. The complainant alleged that a patient experienced an adverse reaction because of a BCVAMC hospitalist's unsafe transfusion practices. OIG substantiated that a BCVAMC hospitalist engaged in unsafe packed red blood cell transfusion practices, which resulted in a patient's adverse reaction. The patient's pre-transfusion medical issues indicated that the hospitalist should have reassessed the need to

transfuse three units of packed red blood cells and monitored the patient's clinical status, including hemoglobin levels, more closely. The increase in blood volume from three units of packed red blood cells contributed to the patient experiencing a potentially life threatening adverse reaction due to circulatory overload. A lack of guidance in the BCVAMC policy, which did not support recommended standards issued by the American Association of Blood Banks for single unit transfusions, likely contributed to the hospitalist's unsafe transfusion practices. Although not directly related to this patient's case, unit staff identified communication barriers that may have affected professional clinical collaboration. BCVAMC policy requires providers to report blood transfusion related adverse reactions to the Blood Usage Review Committee (BURC) to help prevent similar adverse reactions from occurring in the future. Providers did not report this patient's adverse reaction, and the BURC did not analyze the circumstances surrounding the event. The committee Transfusion Officer was the physician ordering and supervising the majority of transfusions, presenting a potential conflict of interest between committee responsibilities and professional responsibilities. OIG also found that the Peer Review Committee did not follow VHA policy regarding documentation of committee recommendations for actions and follow-up by supervisors.

Opioid Management Practice Concerns, John J. Pershing VAMC, Poplar Bluff, Missouri

OIG conducted an inspection to evaluate allegations regarding opioid management practices at the John J. Pershing VAMC, Poplar Bluff, MO. The summarized allegations included the following: (1) Long-term opioid therapy for pain was poorly managed for certain patients; (2) Opioid prescriptions were written for patients without documentation of an opioid risk stratification tool, such as the opioid risk tool (ORT); (3) Some providers did not consistently use urine drug screening (UDS), order confirmatory tests to evaluate for diversion, or further evaluate UDS results that were suggestive of urine tampering; (4) Opioid pain care agreements, including signed informed consents, were not consistently completed prior to initiating long-term opioid therapy for pain. OIG substantiated poor management of long-term opioid pain therapy for 10 patients. OIG found documentation for the condition requiring opioid therapy, but did not find risk evaluation when clinically significant changes to a patient's health status occurred. OIG also found that a provider lacked knowledge of safe and effective methods for tapering patients' opioids. In addition, OIG substantiated that opioid prescriptions were written for patients without documentation of an opioid risk stratification tool such as ORT. VHA's OSI provides guidelines to develop tools to identify high-risk patients. Using the ORT helps a provider risk stratify patients for initiating or continuing opioid therapy, and the ORT can help guide providers in determining the frequency of obtaining UDS for patients on long-term opioid therapy for pain. OIG substantiated that some providers did not consistently use UDS, order confirmatory tests to evaluate for diversion, or further evaluate UDS results that were suggestive of urine tampering for the patients reviewed. OIG substantiated that some patients did not have signed informed consents prior to initiating long-term opioid therapy for pain.

Sterile Compounding Environment and Practices, Overton Brooks VAMC, Shreveport, Louisiana

OIG inspected the Overton Brooks VAMC, Shreveport, LA, to determine whether deficient conditions in the compounding pharmacy placed patients at risk. OIG confirmed the facility did not comply with key elements of United States Pharmacopeia (USP) <797> (which outlines safe sterile compounding requirements and practices) as initially identified in October 2016 by the Louisiana Board of Pharmacy. The Board's findings included a lack of proper cleaning of the compounding rooms and incomplete air and surface testing and certification in compounding areas. During the site visit, OIG found continuing noncompliance with USP <797> requirements. Specifically, OIG found that: (1) Cleaning logs from September 2016 through January 27, 2017, reflected four days with no evidence of appropriate cleaning and mopping of floors; (2) Only 18 percent of applicable employees had all required training and competency documentation; (3) Air and surface testing and certification had not been completed as required. Pharmacy managers did not report the Louisiana Board of Pharmacy's findings to appropriate leaders or committees. Facility leaders learned of the Board's reports after OIG's unannounced site

visit. In February 2017, Food and Drug Administration (FDA) investigators conducted an extensive review of the facility's compliance with FDA guidance on CSPs. Facility and VISN leaders implemented interim measures to ensure patient safety that included: (1) Sending chemotherapy CSP orders to the Alexandria, LA, VAMC for compounding; (2) Outsourcing routine compounding to a local pharmacy; (3) Limiting CSP activities to immediate use. Facility and VISN officials also implemented an action plan to correct the identified USP <797> deficiencies before re-opening the onsite pharmacy compounding areas. OIG reviewed the EHRs of hospitalized patients who were administered CSP and diagnosed with selected types of infections subsequent to the CSP administration starting in FY 2016 through January 6, 2017. OIG did not identify any patients who developed infections after intravenous infusions or injections of compounded medications.

Alleged Misdiagnosis and Delay in Treatment, Providence VAMC, Providence, Rhode Island

OIG conducted a health care inspection to evaluate allegations that a provider at the Providence, RI, VAMC misdiagnosed a patient's Achilles tendon rupture (ATR) in 2014, leading to a delay in treatment and further injury. OIG substantiated that, on two occasions, an ED provider did not respond to a patient's complaint that he may have an ATR and misdiagnosed him with a sprained ankle. OIG substantiated that the sprained ankle misdiagnosis caused a 16-day delay in treatment of the ATR. OIG could not substantiate that the misdiagnosis, delay in treatment for the ATR, and the treatment prescribed for a sprained ankle versus an ATR in the ED worsened the injury. However, a delay in ATR diagnosis or treatment may result in a worse outcome. Providers utilize a combination of ATR-specific clinical assessments and tests to diagnose and determine the extent of an ATR. However, because the ED provider did not document the proper assessments, which would have provided a clinical baseline of the ATR, OIG could not discern whether the injury became worse during the 16 days the patient was treated for a sprained ankle. In addition to the 16-day delay, OIG identified other timeframes when different treatments affecting optimal outcomes could have occurred. The initial assessment occurred three days after injury. The patient was given options for conservative or surgical treatments within four weeks of injury and pursued conservative treatment. The patient had complaints of persistent pain after six months of conservative treatment and subsequently decided to undergo Achilles tendon surgery. OIG could not determine the extent to which the 3-day delay in seeking treatment, the 16-day delay in diagnosis, and/or the 6-month delay by the patient's initial choice of non-operative treatment contributed to unfavorable healing. OIG found a peer review was done, but documentation of the peer review process was incomplete. OIG identified that the Chief of Emergency Medicine did not follow up on the patient's complaint about his first ED visit.

Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VAMC, Detroit, Michigan

OIG conducted a health care inspection regarding alleged surgical service mismanagement and quality of care issues at the John D. Dingell VAMC, Detroit, MI. OIG substantiated that the Surgical Service ACOS had negative interactions with operating room (OR) staff; however, this did not result in adverse patient outcomes. OIG did not substantiate that the ACOS had unprofessional behavior unaddressed by leadership. OIG substantiated that the ACOS reduced general surgeons' access to surgical cases and OR time. The ACOS performed most of the general surgery cases; however, the Chief of Staff supported the ACOS' actions. OIG substantiated that the ACOS altered the daily surgical schedule over a 2-year timeframe (2013–2015) to accommodate his elective cases, which resulted in patient delays for previously scheduled cases and patient complaints. The facility developed a policy to minimize disruption in the surgical schedule; however, the new policy was not consistently followed. OIG substantiated that the ACOS did not adhere to VHA and facility policy regarding certain aspects of the supervision of surgical residents including correct documentation of the ACOS' presence during surgeries, communication of a designated back-up surgeon when absent from the OR, and ensuring completion of post-operative notes. OIG substantiated that the ACOS performed elective colonoscopy procedures in the OR. These procedures increased OR utilization time, but the practice did not violate VHA or facility policy. OIG did not substantiate that performing these procedures in the OR diluted

morbidity and mortality data. OIG did not substantiate that the ACOS performed colonoscopy examinations without the appropriate equipment available or that the ACOS exercised poor clinical decision-making that resulted in negative outcomes for many patients, including patient deaths. However, OIG reviewed 53 cases with quality of care concerns and found three instances where clinical judgement may have affected patients' adverse outcomes. OIG also found that a requested autopsy was not done and facility staff did not fully comply with VHA peer review requirements.

Alleged Urology Consult Scheduling Delays, Cincinnati VAMC, Cincinnati, Ohio

OIG conducted a healthcare inspection in response to a complainant's concerns regarding delays in the scheduling of urology outpatient consults at the Cincinnati, OH, VAMC. Specific allegations included the following: (1) The Urology Section scheduler retired and was not replaced for 7 months; 2) The new scheduler was floated from the Urology Section to work in other locations; (3) The new scheduler was not fully trained for the position; (4) As of July 10, 2015, about 160 veterans were still awaiting an initial appointment even though their providers had requested urology outpatient consult services as early as May 2015. OIG substantiated that after the Urology Section scheduler retired, a new scheduler was not assigned to the Urology Section until seven months later. However, other schedulers filled the gaps in coverage. While OIG substantiated the new Urology Section scheduler was required to work in other locations, OIG found the scheduler worked the majority of his/her time in the Urology Section. OIG did not substantiate the scheduler was not fully trained for his/her duties when assigned to the Urology Section. OIG substantiated as of July 6, 2015, that 166 Urology Section outpatient consults remained in pending or active status. However, while 85 (52 percent) were pending or active for more than 30 days, 81 (48 percent) of the consults were not over 30 days old and by August 31, 2015, that number was reduced to 11. To assess patient outcomes related to scheduling delays, OIG reviewed the EHR of 39 patients who had outpatient urology consults requested between January 1–August 31, 2015, that remained in a pending or active status for greater than 30 days and who had inpatient hospital stays before August 31, 2015. OIG did not find evidence that delays in outpatient urology consult appointment scheduling contributed to patients' hospital admissions within the timeframe of the review. OIG found from January 11 through May 23, 2016, the scheduling improvements noted in August 2015 were maintained, with no more than eight urology outpatient consults in a pending or active status. A review of outstanding consults in June 2016 confirmed that problems with delays in consult scheduling had not recurred.

Non-VA Colonoscopy Follow-Up Concerns, Southeast Louisiana Veterans HCS, New Orleans, Louisiana

OIG conducted an inspection to assess allegations regarding the management of follow-up care for patients who had colonoscopies from 2006 through 2012 via NVCC at the Southeast Louisiana Veterans HCS, New Orleans, LA. Specific allegations were: (1) System leadership failed to provide appropriate follow-up for roughly 16,000 to 18,000 patients who received colonoscopies through NVCC; (2) System leadership failed to notify patients who had been potentially harmed; (3) System clinicians did not timely receive and review the results of colonoscopies completed for seven patients through NVCC referrals; (4) The System Director knew of the issue and did nothing. At the time of the inspection, system managers had completed a review of the patients and taken action. OIG chose to examine the adequacy of the system's review. OIG could not substantiate system leaders failed to provide appropriate follow-up for patients as we determined system managers did not reliably identify all potentially affected patients. OIG identified patients who had developed colorectal cancer and were not on the system's list. OIG also found system leaders did not take appropriate steps to ensure the validity of case reviews of identified patients. OIG did not substantiate system managers failed to notify a patient who had suffered harm. OIG substantiated the system did not timely receive results for two of seven identified patients who underwent NVCC colonoscopy procedures but did not substantiate the System Director knew of the issue and did nothing about it. While developing a more flexible clinical reminder for colorectal cancer screening, system leaders discovered delays in scheduling the procedure when recommended. The System Director became

aware of this and initiated a protected quality review for patients. After OIG's review, the system generated a report reflecting evidence of their 2014 colonoscopy lookback and confirmed 12,964 patient colonoscopy reports were reviewed and clinical reminders were updated to reflect the appropriate return timeframe for procedures performed from September 1, 2005 to December 30, 2013.

Alleged Unreported Surgical Incidents and Deaths, VA Caribbean HCS, San Juan, Puerto Rico

OIG conducted a health care inspection in 2016 in response to complaints concerning the VA Caribbean HCS, San Juan, PR. An anonymous complainant alleged surgical incidents and deaths were unreported because of a conflict of interest between a quality management employee and a senior leader. During interviews, OIG did not find evidence of a conflict of interest. Therefore, OIG reviewed the validity of the allegation regarding the reporting of surgical incidents and deaths. OIG did not substantiate surgical incidents or deaths were unreported. OIG compared information regarding surgical deaths extracted from the corporate data warehouse with the facility morbidity and mortality committee minutes and found the data to be congruent with information in patients' EHR. OIG distributed a bilingual survey (English and Spanish) to 128 VA Caribbean HCS Quality Management, OR, and Post-Operative Care Unit staff as well as surgeons. OIG asked the following survey questions: (1) "Do you have any concerns about the reporting of incidents in surgery?" and (2) "Are incidents in surgery being reported as required?" OIG had an 11 percent response rate to the survey, with no employees reporting concerns regarding incidents in surgery. Surgical service staff completed a Critical Incident Tracking Notification report when incidents occurred, including deaths in the OR, incorrect surgeries (wrong patient, wrong procedure, wrong side/site, wrong implant), retained surgical items, OR fires, and OR burns. This information was aggregated and included in the quarterly National Surgery Office report and reconciled with records from the National Patient Safety Office. OIG found the facility had an electronic system for reporting incidents. The facility Patient Safety Improvement Program described a "culture of safety," which includes identification and reporting of incidents, review of incidents to determine underlying causes, and implementation of changes to reduce the likelihood of recurrence.

Dermatology Clinic Staffing and Other Concerns at the Dayton VAMC

OIG conducted a CAP review at the Dayton VAMC, Dayton, OH. Prior to the site visit, OIG administered a survey regarding patient safety and quality of care known as the Employee Assessment Review (EAR). An EAR respondent reported in the 3rd and 4th quarters of FY 2012 and during FYs 2013–2014 that: (1) Patient Business Service (PBS) schedulers assigned on a temporary basis to cover the Dermatology Clinic were not adequately trained in its specific scheduling practices; therefore, appointments were not consistently scheduled in accordance with preferred dates; (2) PBS schedulers did not return calls to patients in a timely manner; (3) Dermatology appointments were not scheduled timely; (4) One of 20 patients with scheduling delays had a clinically significant adverse outcome as a result. In this case, deficient conditions dated back several years and had since been corrected by facility managers. Therefore, OIG summarized the allegations, described the conditions that existed at the time of the allegations, and outlined the sequence of events in FYs 2012–2014 while focusing on facility corrective actions. OIG also performed a look-back of patients diagnosed with new melanomas or other skin cancers from FY 2013 through 3rd quarter FY 2016 and provided a status of Dermatology Clinic-related operations as of 4th quarter FY 2016. In 2012, the Dermatology Clinic lost its permanently assigned PBS scheduler. PBS schedulers had to cover the Dermatology Clinic and other specialty care clinics during FYs 2012–2014 (and in the 1st and 2nd quarters of FY 2015). The Chief of Dermatology Service regularly reported the staffing challenges to leadership. Documentation showed clinical and administrative managers attempted to work together to improve clinic access and timeliness. While OIG substantiated specific instances of inadequate scheduling practices, poor follow-up to patient telephone calls, and delayed appointments during the time PBS schedulers covered the Dermatology Clinic, OIG did not substantiate systemic deficiencies in those areas. While OIG substantiated scheduling delays, OIG did not substantiate

patients experienced clinically significant adverse outcomes in the cases provided by the survey respondent or in our look-back of patients diagnosed with new melanomas or other skin cancers.

Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA HCS, Amarillo, Texas

OIG conducted a healthcare inspection at the request of Congressman Mac Thornberry to assess the validity of allegations concerning inadequate staffing, quality of care, and administrative deficiencies. OIG substantiated that nurse staffing at the facility has not been optimal for several years, but OIG could not substantiate that inadequate nurse staffing resulted in the death of three patients, an increase in patient falls, or an increase in pressure ulcers. OIG did not substantiate that the facility closed inpatient beds. OIG found that the facility diverted patients to non-VA facilities in accordance with its diversion policy. However, facility staff failed to document notification of local Emergency Medical Services (EMS) about the diversion status, and facility leaders did not review diversion data quarterly or provide evidence of performance monitoring. OIG did not substantiate that low physician staffing was the basis for facility managers' decision to redirect certain EMS patients. OIG found that facility managers appropriately coordinated with local EMS to divert heart attack and stroke patients to non-VA facilities better equipped to manage such patients. OIG did not substantiate that patients' diagnoses of Chronic Obstructive Pulmonary Disease were inappropriately changed to other diagnoses. OIG did not substantiate that physician transfer orders were overridden by the Chief Nurse Executive. OIG did not substantiate that MH social workers failed to make required weekly visits for three high-intensity patients. OIG also did not substantiate that in October 2013, a patient called the VCL, requesting an appointment but still had not been seen at the facility by January 2014. OIG substantiated that the Gastrointestinal Endoscopy clinic had a procedure backlog due to a month long construction project in the endoscopy suite. As of October 2016, OIG noted that only 8 of 721 procedures were not completed within the time frame specified by the facility. OIG substantiated that the facility no longer performed complex surgeries. OIG could not substantiate that patients were referred to private hospitals for surgeries at their own expense. OIG recommended that the Facility Director: (1) Continue efforts to recruit and hire for nursing staff vacancies and ensure that until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs; and (2) Ensure members consistently attend Pressure Ulcer Committee meetings and document efficacy data on specific treatments, information on new treatment modalities, and action items, to include documentation of follow-up taken regarding action items.

Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA HCS, Muskogee, Oklahoma

OIG conducted a healthcare inspection in response to Senator James Inhofe's request to evaluate a range of clinical, staffing, and administrative practices at the Eastern Oklahoma VA HCS (System), Muskogee, OK. OIG evaluated nine areas and practices. Several of the System's key leadership positions have been in flux in the past few years. The current System Director entered on duty June 12, 2016. OIG could not determine the impact of leadership vacancies and short-term coverage; however, OIG noted a decline in multiple quality measures from FY 2015 to FY 2016. OIG found the System did not consistently provide the necessary monitoring and oversight to ensure that selected patient care processes were safe and effective. Deficient processes included provider-specific privileging, peer review, and institutional disclosure. The System had difficulty recruiting and retaining employees. The System used tele-medicine and contracted services to meet patient care needs when in-house specialty care was not readily available. The System largely met access metrics for primary care and MH; however, about 30 percent of new patient specialty care SC appointments were pending greater than 30 days as of the 2nd quarter of FY 2016. The System did not meet call center performance targets as of quarter 1 of FY 2016. The System has not consistently met Care in the Community (CIC) timeliness goals. OIG found that clinical providers consistently documented patients' relevant histories and presenting problems, treatment plans, follow-up, and medication reconciliation; however, improved documentation of abnormal lab test notification and follow-up was needed. The System also needed to improve its ranking in the MH Domain (performance)

measure. OIG found that the ED was generally meeting performance targets. OIG inspected patient care areas at the Muskogee main healthcare facility and three CBOCs. OIG identified compliance deficiencies related to oversight committee minutes and selected privacy, safety, security, and cleanliness requirements. OIG made 19 recommendations focusing on leadership stability and performance improvement activities; the meeting minutes of Quality, Safety, and Value subordinate committees, clinical privileging, severity assessment code scoring, peer review activities, institutional disclosure; recruitment and hiring; SC and MH access and call center responsiveness; follow-up of CIC improvement actions; notification and follow-up of abnormal lab results, consult completion timeliness, and MH-related quality measure improvements; ED discharges; and EOC-related compliance and improvements.

Alleged Access Delays and Surgery Service Concerns, VA Roseburg HCS, Roseburg, Oregon

At Representative Peter A. DeFazio's request, OIG conducted a healthcare inspection of the VA Roseburg HCS (system), Roseburg, OR, to assess allegations regarding access delays, surgery service quality of care concerns in 2014, and complaints that the Chief of Surgery (COS) performed colonoscopies in an unsafe manner. OIG substantiated access delays in some surgery and gastroenterology service areas; however, system leaders had implemented actions to reduce wait times. OIG did not substantiate surgeons were unable to maintain surgical skills; surgeons could be detailed to other facilities to perform procedures not done at the system. OIG did not substantiate that surgeries were performed without intensive care unit (ICU) back up. OIG did not substantiate a surgeon COS performed colonoscopies unsafely, but found he practiced in an outdated manner. Soon after arriving at the system, gastroenterology staff voiced concerns about the COS's competency although he had performed colonoscopies at another VHA facility. The COS underwent proctoring. Four physician proctors concluded the COS met or exceeded expectations. OIG reviewed the COS's system cases. OIG found no complications such as over sedation, bleeding, perforation, or missed cancers. However, OIG found his documentation often did not include data such as polyp size or quality of bowel preparation. OIG also found the COS fulgurated (burnt) polyps, a practice that has fallen out of favor, and that he made recommendations for surveillance colonoscopies without waiting for pathology results. OIG identified one patient for whom the COS took timely follow-up action on the biopsy results but did not inform the patient of a cancer diagnosis for 15 days. The COS stopped performing colonoscopies at the system. While OIG did not identify system patients with poor outcomes, OIG was concerned that the COS's system documentation may have implications for the colonoscopies he performed at a prior VA facility. OIG found that VHA's Colorectal Cancer Screening directive does not require documentation of many of the established quality indicators for monitoring the practice of providers who perform colonoscopies. OIG recommended the AUSH perform a quality review of the COS's colonoscopies performed in a prior VHA facility, revise VHA's Colorectal Cancer Screening directive to include standardized documentation of quality indicators, and consider adding photodocumentation of cecal intubation and withdrawal time to the Focused Professional Practice Evaluation (FPPE)/OPPE criteria. OIG recommended that the System Director ensure patient notification of diagnostic test results according to required time frames.

Quality of Care Concerns at Two VISN 23 Facilities and a Veterans Readjustment Counseling Center

OIG conducted an inspection at the October 2014 request of Congressman Timothy J. Walz to assess quality of care concerns at the St. Cloud and Minneapolis HCSs (St Cloud, Minneapolis) and the St. Paul Veterans Readjustment Counseling Center (Vet Center). OIG substantiated St. Cloud managers notified patients through a letter rather than individual contact when MH services provided by a non-VA PTSD clinic were stopped in 2009. St. Cloud staff did not individually contact patients prior to terminating or transferring patients. Some veterans did not seek or receive MH services from VA. Also, OIG substantiated Minneapolis managers notified patients through a letter rather than individual contact when MH services provided by a non-VA PTSD clinic were stopped in 2014. However, the decision was rescinded approximately three months after sending the letters and prior to the decision's effectiveness date. OIG could not substantiate when the Vet Center contract

for non-VA PTSD care was terminated in 2014, that a Vet Center staff member misled the vendor regarding termination. OIG did not find documentation that Vet Center staff successfully contacted all affected patients to arrange transfer back to the Vet Center or VA MH services. In addition, OIG did not substantiate a Minneapolis patient's colonoscopy was untimely scheduled. OIG substantiated a Minneapolis patient's x-ray of his foot was not scheduled timely but did not identify adverse effects related to the delay. OIG substantiated test results were not communicated timely to a Minneapolis patient. OIG did not find documentation that the patient experienced adverse effects due to the delay. OIG also substantiated a provider did not document consideration of a potentially significant adverse medication interaction when a patient's medications were changed. However, the patient's EHR did not contain documentation that the patient experienced adverse drug interactions. Minneapolis managers identified opportunities for improvement to ensure medication reconciliation was done consistently. OIG recommended: (1) the St. Cloud Director ensure adequate processes for termination or transfer when non-VA MH services are discontinued and identify patients whose non-VA PTSD services were terminated, determine if the patients were offered and received MH treatment, and take action as appropriate; (2) the Minneapolis Director ensure compliance with VHA scheduling and communication of test results policies; and (3) the Chief of Vet Center Services review the patients whose non-VA PTSD services were terminated, determine if the patients were offered and received MH services, and take action as appropriate.

Quality of Care and Other Concerns, Robert J. Dole VAMC, Wichita, Kansas

OIG conducted a healthcare inspection at the Robert J. Dole VAMC (facility) in Wichita, KS, in response to a July 15, 2015 request from former Congressmen Tim Huelskamp and Mike Pompeo to review mortality rates for patients transferred to the ICU and other quality of care concerns. VA Inpatient Evaluation Center (IPEC) is a program that measures and reports VHA facilities' quarterly mortality data. OIG found that the mortality rate for patients transferred from the inpatient medical/surgical unit to the ICU was not higher than other similar VA hospitals at the time of the congressional inquiry in 2015. During one quarter in 2014, OIG found the facility did not meet national VHA mortality rate benchmarks. OIG found that facility leaders were notified about the IPEC data and consulted with VHA level program offices about practices and processes. During our July 21, 2015 unannounced site visit, OIG found one nocturnist physician working and did not observe doctors playing video games. Anesthesiology and surgery staff were required to return to the facility during off-hours within a specific timeframe if an urgent patient care need arose; however, for other attending physicians, we found that facility policy was not well-defined. OIG reviewed 28 ICU patients' quality of care and did not find evidence of inadequate or inattentive care. During the first two quarters of FY 2015, facility staff transferred 4 patients out of 668 ICU admissions to community hospitals. OIG found transfers were justified because facility medical services were unavailable. However, OIG found system deficiencies in VHA and facility policy compliance and identified a nocturnist coverage concern. Facility staff reported that the ED provider would leave the ED to perform intubations when mid-level providers, who could not perform emergency intubation, worked as nocturnists. OIG confirmed this practice when OIG reviewed one of the EHRs, which documented the ED provider performed an intubation outside of the ED. OIG recommended that the Facility Director implement recommendations from previous event-related reviews, strengthen Hospice/Palliative Care processes, assign Palliative Care Consult Team staff, assess the need to define the required timeframe for attending physicians to return to the facility, comply with facility policy for clinicians who perform EAM, comply with VHA policies on ED coverage, and use qualified physician nocturnists.

Choice Dermatology Delays, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

OIG conducted a healthcare inspection of alleged inefficiencies in processing Choice dermatology consults that resulted in delays and duplicative procedures at the Captain James A. Lovell Federal Health Care Center (FHCC), North Chicago, IL. The specific allegations were: (1) A patient was referred to Choice and underwent a "redundant and unnecessary biopsy"; (2) A patient was referred to Choice and experienced a delay in obtaining

a procedure; (3) A patient was inappropriately referred for Choice care; and (4) Patients who were referred for Choice dermatology care, including those with skin cancers, experienced delays. OIG substantiated that a patient underwent a duplicate biopsy. The FHCC dermatologist biopsied the patient's lesion and ordered a non-VA care consult for Mohs surgery. OIG found that fee department staff provided pathology results from the original biopsy to the Choice third-party administrator. However, the Choice dermatologist did not receive the patient's VA EHR information, including the patient's pathology results, from the Choice third-party administrator. The Choice dermatologist repeated the biopsy to confirm the cancer diagnosis before completing Mohs surgery. OIG substantiated that a patient experienced a delay in obtaining Mohs surgery because the Choice dermatologist did not initially receive a readable copy of the patient's pathology results. OIG found that although fee department staff provided a readable pathology results copy to the Choice third-party administrator, the faxed versions sent to the Choice dermatologist were faint and difficult to read. Although OIG substantiated that fee department staff initially offered a patient care through Choice, which was appropriate, OIG found that the patient ultimately received care through traditional non-VA care. OIG substantiated apparent delays among Choice dermatology consults. For consults ordered from March 1, 2015 through February 29, 2016, OIG found 569 of 613 patients (92.8 percent) with Choice dermatology consults appeared to have experienced delays. Several factors contributed to apparent delays, including fee department staff not taking timely action. OIG did not find patients who were clinically impacted by delays. OIG also noted that the apparent delays persisted through at least September 30, 2016. OIG recommended that the FHCC Director ensure that fee department staff take timely action: (1) when providers order non-VA care and Choice dermatology consults; and (2) to complete, cancel, or discontinue non-VA care and Choice dermatology consults.

Magnetic Resonance Imaging Patient Safety Screening, Central Alabama VA HCS, Montgomery, Alabama

OIG conducted a healthcare inspection to assess whether safety screenings were performed and documented prior to magnetic resonance imaging (MRI) at the Central Alabama Veterans HCS (System), Montgomery, AL. The system has an agreement with a DoD clinic, Lyster Army Health Clinic (Lyster), for MRI services. Lyster staff do not have access to VA EHRs and system staff do not have access to Lyster EHRs. A powerful magnetic field around MRI scanners creates safety risks. Safety screening is critical to alert staff of patients' electronic, mechanical, or magnetic implants. VHA requires pre-MRI initial and secondary safety screenings. OIG did not find a VHA or system policy addressing documentation requirements of MRI safety screening forms completed at non-VA facilities. OIG reviewed 158 of 2,753 MRI orders (6 percent) completed at the system or at Lyster from September 22, 2014 through September 22, 2015, to assess documentation of initial and secondary safety screenings. In September 2015, the system took steps to ensure that staff completed initial safety screening forms when the MRI was ordered for patients receiving MRIs at Lyster. OIG found 17 patients who received MRIs at Lyster without initial safety screenings. However, Lyster staff had completed and documented the secondary safety screenings in the Lyster EHRs, and completed the MRIs. OIG reviewed the 158 patients for secondary screenings. Secondary safety screening forms were not available in VHA EHRs but were in the Lyster EHRs; copies of the completed forms would be made available upon request. To evaluate safety screening documentation after September 2015, OIG reviewed 50 of 475 MRI orders (10.5 percent) placed in July 2016; 10 of the 50 were excluded. OIG found that the remaining MRI orders included the initial safety screening in the VHA EHR.

Follow-Up Review Access to Urology Service, Phoenix VA HCS, Phoenix, Arizona

OIG conducted a healthcare inspection to follow up on concerns regarding access to care in the urology service at the Phoenix VA HCS (system) in Phoenix, AZ. OIG limited our inspection to determining whether a delay in care was associated with adverse patient impact. During OIG's 2014 review of system scheduling practices and wait times, OIG reported that large numbers of patients referred for urological evaluation and/or treatment experienced significant delays. The delays involved obtaining an appointment, scheduling follow-up, and/or

receiving authorizations for non-VA urology care (see: *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Phoenix, Arizona; [Report No. 14-02603-267, August 26, 2014]*). OIG's OHI opened an expanded review focusing on access to urology care at the system. An interim report, *Review of Phoenix VA Health Care System's Urology Department Phoenix, Arizona; (Report No. 14-00875-112, January 28, 2015*), detailed the findings regarding incomplete documentation for 759 urology patients and the potential impact on care. In *Review of Access to Urology Service at the Phoenix VA Health Care System, Phoenix, Arizona; (Report No. 14-00875-03, October 15, 2015)*, OIG found a significant urology staffing shortage, inconsistent non-VA urology provider documentation of patient care, and untimely care to patients needing urological services. OIG committed to reviewing the records and management of the 759 patients once VHA provided us with the necessary documentation. This report details these findings. OIG determined that 148 (20 percent) of the 759 patients experienced delays in getting new evaluations or follow-up appointments. When a delay was identified, OIG assessed the impact of that delay on the patient's care. From a clinical standpoint, OIG found that none of the patients were adversely impacted by a delay in care.

Quality of Care Concerns in Thoracic Surgery, Bay Pines VA HCS, Bay Pines, Florida

OIG conducted a healthcare inspection in response to allegations from anonymous complainant(s) regarding the quality of care provided by a thoracic surgeon at the Bay Pines VA HCS (system), Bay Pines, FL. OIG did not substantiate that the thoracic surgeon was incompetent. However, OIG identified a deficiency in the system's process for evaluating surgeons' competency. Contrary to VA policy, the criteria used in FPPEs were not privilege-specific and inadequate to fully assess a provider's skills. An August 2016 Deputy Under Secretary for Health for Operations and Management memorandum specified that as of August 2017, a provider with similar training and privileges should conduct OPPE. The surgeon's OPPE that OIG reviewed had been completed prior to the August 2016 memorandum and was done by an administrative psychiatrist. OIG did not substantiate that the surgeon had a high rate of complications. OIG did not identify specific quality of care concerns in the surgeon's mortality cases OIG reviewed. The anonymous complainant(s) provided nine specific patient cases. OIG consulted with a thoracic surgeon who did not identify quality of care concerns for the nine patients. OIG also identified six deaths occurring within 30 days of a thoracic surgical procedure. OIG did not identify quality of care concerns with these cases. OIG substantiated that the thoracic surgeon requested the critical care team not care for his patients related to disagreements about fluid management. OIG determined that he had the authority to do so under the system's policy. OIG could not substantiate that surgeons left the system because of quality of care concerns related to the thoracic surgeon, or that the Chief of Staff and/or System Director were aware of concerns regarding the thoracic surgeon's competence yet failed to address them.

Pressure Ulcer Prevention and Management, VA New York Harbor HCS, New York, New York

OIG conducted a healthcare inspection to assess allegations regarding pressure ulcer prevention and management at the Brooklyn and Manhattan campuses of the VA New York Harbor Healthcare System (system), New York, NY. The timeline of events and allegations were: in 2014, a patient developed pressure ulcers following admission to the system, which were not appropriately managed by clinical staff. Initially, OIG's Hotline Division requested that the system conduct a review of the complainant's allegations and submit a response. OIG determined the response to be insufficient. OIG subsequently referred the matter to the VISN for a response and included specific questions for VISN leadership to address. In 2015, another patient developed pressure ulcers, which were not appropriately managed by clinical staff. In April 2016, OIG determined the second response regarding Patient A was insufficient and after reviewing a similar complaint from Patient B, OIG initiated this healthcare inspection. OIG substantiated that Patient A developed pressure ulcers that subsequently worsened following admission, and clinical staff failed to implement timely and appropriate interventions. OIG substantiated that Patient B developed pressure ulcers following admission. However, OIG found that clinical staff timely identified and took steps to address Patient B's pressure ulcer, which healed prior to his initial discharge from the system. OIG noted that clinical staff skin care documentation was incomplete and inconsistent for both Patients A and B. To further evaluate the system's quality of pressure

ulcer documentation, OIG reviewed EHRs of acute care patients with pressure ulcers who were discharged from December 1, 2015 through May 31, 2016, and January 2017. OIG identified noncompliance with requirements for pressure ulcer prevention and management-related documentation. Since the time of our onsite visit in late June 2016, some issues with the quality of pressure ulcer documentation persisted.

Review of Opioid Prescribing Practices, Clement J. Zablocki VAMC, Milwaukee, Wisconsin

OIG conducted an inspection in response to a February 2015 request from Congresswoman Gwen Moore to review prescribing practices related to controlled substances at the Clement J. Zablocki VAMC (facility), Milwaukee, WI. OIG also received an allegation that a provider at the facility had questionable opioid prescribing practices. To review the overall opioid prescribing practices at the facility, OIG evaluated whether facility and VISN leadership complied with specific goals (2, 3, 7, 8, and 9) delineated in the VHA OSI Update. OIG determined the facility met Goal 2 (the number of patients who had an annual UDS increased by nearly twofold from FY 2014 through the second quarter of FY 2015); Goal 8 (complementary and alternative medicine modalities were available), and Goal 9 (a collaborative model to manage opioids and benzodiazepines prescribing had been established). OIG made recommendations related to Goals 3 and 7. OIG substantiated that a provider prescribed opioid medications for some patients in a manner that varied from clinical guidelines and other facility providers. OIG recommended that the VISN Director convene an expert panel knowledgeable in the subspecialties of Pain Medicine and Addiction Medicine to review the subject provider's opioid prescribing practices within the context of the patients whose treatment varied from guidelines and submit a report of findings to the VISN and Facility Directors; ensure the monitoring of patients on Suboxone; and ensure the Pain Committee strengthens processes to improve communication with the facility to ensure information is relayed timely. OIG also recommended that the Facility Director ensure that providers access the PDMP database as required by facility and monitor compliance and that adequate resources are allocated for patient reviews for opioid therapy appropriateness.

Patient Flow, Quality of Care, and Administrative Concerns in the ED, VA Maryland HCS, Baltimore, Maryland

OIG conducted a healthcare inspection to assess allegations made regarding patient flow and quality of care in the ED at the Baltimore VAMC (facility), part of the VA Maryland HCS (system). OIG substantiated patients remained in the ED for more than four hours while waiting for an inpatient bed, and found the median ED LOS for admitted patients, the delay in inpatient admission, and the percentage of patients boarded exceeded VHA targets and thresholds during the period October 2013–December 2016. OIG did not identify patients who were clinically impacted by delays. OIG found that the accuracy of the ED metrics could be compromised when a provider encountered challenges using Emergency Department Integration Software. OIG found that system policy did not include the maximum number of ED boarders as required by VHA. OIG found that staff failed to consistently utilize the Bed Management Solution software. OIG also found that Environmental Management Services staff schedules and cleaning processes were inadequate to support the patient flow process. OIG found that Patient Flow Committee members did not take adequate action to improve patient flow. OIG substantiated the system's capping practice may limit the number of patients the admitting teams can treat and that facility managers had not established alternative processes to improve patient flow. Although OIG substantiated that on a day in 2015, ED patients waited extended times, OIG found no reports of adverse patient events. OIG substantiated that inpatient nurses were sometimes unavailable to receive the handoff report from ED nurses. OIG substantiated that the ED administrative support staffing level was not compliant with the VHA requirement. Further, OIG found that the lack of timely after-hours coverage of computerized tomography scan services contributed to the extended LOS for some ED patients.

Delays in Scheduling Diagnostic Studies and Other Quality of Care Concerns, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

OIG conducted a healthcare inspection at the request of Congressman Mike Coffman to assess allegations received in 2014 regarding delays in scheduling diagnostic studies and other quality of care concerns at the William S. Middleton Memorial Veterans Hospital (facility), Madison, WI. After beginning the review, OIG also received a request from Senator Tammy Baldwin to review the same issues. OIG substantiated delays in scheduling in-house echocardiograms, stress tests, and sleep studies for patients in 2013 and 2015. OIG determined that two patients had an increased risk for sudden cardiac death due to a delay in scheduling an echocardiogram in 2013. After several months delay, both patients underwent echocardiograms followed by surgical procedures to treat their life-threatening conditions. OIG substantiated that a small number of 2013 and 2015 echocardiogram consults were discontinued within 30 days then later resubmitted as new consults without explanatory documentation. OIG could not determine that echocardiogram consults were discontinued within 30 days and resubmitted to appear timely. OIG did not substantiate that facility managers refused to approve non-VA echocardiograms and stress tests as a cost savings decision. OIG reviewed 2013 and 2015 non-VA echocardiogram and stress test consult requests to determine if facility managers refused to approve non-VA care. OIG substantiated that a cardiologist did not sign cardiac catheterization reports timely; however, OIG did not substantiate that untimely signing of cardiac catheterization reports resulted in delayed care for three identified patients. OIG did not substantiate that a cardiologist did not timely review an event monitor tracing strip, which resulted in a patient undergoing an invasive surgical procedure. OIG did not substantiate that pharmacy staff refused to give veterans a 90-day supply of clopidogrel and instead only gave a 30-day supply, and that this contributed to missed doses. OIG did not find evidence that giving three patients a 30-day supply of clopidogrel contributed to missed dosages for those patients.

Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans HCS, Temple, Texas

OIG conducted a healthcare inspection in response to complaints regarding consults at the Central Texas Veterans HCS (system), Temple, TX. The complainant provided 14 examples of patients at the Olin E. Teague Veterans' Medical Center (facility) for whom he/she believed Physical Medicine and Rehabilitation Services (PMRS) consults were not scheduled timely and appointments were delayed as a result. OIG substantiated the allegation that 12 of the 14 patients experienced delays in scheduling consult appointments and in receiving care. Although patients experienced delays in PMRS consults, primary care teams continued to manage patients. OIG found the problem of delayed consult appointments was a systemic problem within PMRS. Some of the facility's PMRS consult procedures did not comply with system policy and could have contributed to the delay in appointment scheduling. Multiple provider and managerial positions were filled by temporary personnel, and an absence of a fully staffed department affected the functioning of the service and contributed to the delays. Facility managers were aware of these problems and attempted to correct them by forming a Consult Management Committee to review consult data and by requesting another VHA facility review PMRS. Although facility managers provided Advanced Medical Support Assistants who scheduled appointments with additional scheduling training, they continued to be confused about scheduling procedures and did not meet scheduling competency evaluation requirements. OIG recommended that the Facility Director ensure that: (a) consult clinical reviews and appointment scheduling for patients are conducted in compliance with VHA directives and policies, (b) PMRS have sufficient staffing to arrange for timely consults and appointments within the service, and (c) facility staff who schedule PMRS patient appointments receive annual scheduling competencies to ensure understanding of the correct process for compliance with VHA directives and staff are monitored for compliance.

Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VAMC, Tomah, Wisconsin

OIG conducted a healthcare inspection at the request of Senators Tammy Baldwin, Chuck Grassley, and Ron Johnson and Representatives Ron Kind and Timothy Walz to assess improper dental infection control practices and administrative action taken by VHA at the Tomah VAMC, (facility) Tomah, WI. These practices potentially exposed 592 veterans to bloodborne pathogens (BBP), including human immunodeficiency virus and hepatitis B and C viruses. Facility leadership were unaware of the improper infection control practices until October 2016, when acting supervisor Dentist B reported to the Chief of Staff that Dentist A (hired in October 2015) used a non-VA unsterile bur during a dental procedure. Two factors that contributed to facility leaders not being aware of Dentist A's improper infection control practices sooner were: (1) failure of staff, despite safety and infection-control training, to report Dentist A's breach of infection control practices, and (2) advance notification and other issues associated with Dental Clinic inspections. OIG determined that the facility, VISN 12, and VHA took appropriate follow-up actions and responded timely to patients' potential exposure to BBP. The facility removed the non-VA unsterile bur from the operatory, reported the incident to Human Resources, briefed VISN 12 leadership, and directed Dentist A to leave the clinic. Dentist A subsequently submitted a letter of resignation. The Deputy Under Secretary for Health for Operations and Management convened a clinical episode response team to identify steps to take in response to the potential exposure of patients to BBP which included identifying, testing, and treating patients. Facility leaders made timely large-scale disclosure to 592 patients and flagged patient EHRs as needed to alert primary care physicians to discuss follow-up.

Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VAMC, Manchester, New Hampshire

OIG conducted a healthcare inspection to evaluate stroke care at the Manchester VAMC (facility), Manchester, NH pursuant to an April 2015 request of Congresswoman Ann McLane Kuster. The request was in response to a Federal court ruling that the facility failed to adequately diagnose and treat a stroke patient when he presented to the Urgent Care Clinic (UCC) in 2010. The purpose of the review was to determine whether system issues may have led to poor care of the patient and to evaluate changes that the facility may have made in response to this incident. OIG found that the patient should have been transferred to another facility with the capability to perform a complete diagnostic workup and care for stroke patients (acute care facility) and should not have received any diagnostic evaluations at the facility. OIG found deficiencies with facility's Peer Review process. Discussion of the specifics of the deficiencies is prohibited by 38 U.S.C. §5705. To determine compliance with VHA and facility policy and assess whether the system issues from 2010 remain today, OIG reviewed the records of 23 patients who presented to the UCC with a presumptive stroke between June 2014 and May 2015. UCC providers did not always transfer patients prior to conducting a diagnostic test and did not always designate the patient's primary care provider as a co-signer of the UCC discharge summary. When UCC providers transferred patients with a presumptive stroke to an acute care facility, they did not consistently observe facility managers' expectations to transfer patients to a non-VA acute care hospital, approximately 2.5 miles away (closest acute care hospital). During a follow-up site visit in February 2016, OIG found that facility managers made system and procedural changes in the UCC.

Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at CBOCs at the Amarillo VA HCS, Amarillo, Texas

OIG conducted a healthcare inspection at the July 2014 request of Congressman Mac Thornberry to assess allegations at the Amarillo VA HCS (facility), Amarillo, TX, concerning provision of care at the Childress, TX, and Clovis, NM, CBOCs; nursing supervision at the Childress, TX, CBOC; and scheduling issues at the Lubbock, TX, CBOC. OIG substantiated that from November 2012 through November 2014, the Clovis and Childress CBOCs had more than 100 patients who had not been seen for more than one year. However, OIG did not find a requirement that patients be seen yearly. OIG did not substantiate that in March 2016, the Childress

CBOC had: (1) inadequate space to provide care and ensure privacy, or (2) did not provide comprehensive care or the same level primary care that was provided at the facility. Services not available on-site were offered via other mechanisms. OIG substantiated that in January 2015, RNs and licensed vocational nurses (LVNs) performed clerical duties because the facility did not assign clerical staff to CBOCs. However, this was not a violation of VHA policy. OIG did not substantiate that in January 2015, nurses at the Childress CBOC lacked supervisory nursing oversight. Nursing staff were supervised and able to contact supervisors by phone and email. OIG substantiated that LVNs may have exceeded their scope of practice. After the 2015 visit, facility staff instituted a new process to provide patients access to an RN and/or a provider by phone when an RN or provider was not available on-site. OIG did not substantiate that in August 2014, Lubbock CBOC staff lacked training in scheduling patient appointments and/or destroyed documents and kept paper wait lists.

Quality of Care and Other Concerns, Captain James A. Lovell FHCC, North Chicago, Illinois

OIG conducted a healthcare inspection to assess allegations made by confidential complainants regarding quality of care and other concerns at the Captain James A. Lovell FHCC, North Chicago, IL. OIG substantiated the HBPC program's Joint Commission accreditation status was "threatened" after a March 2015 FHCC accreditation survey; however, in August 2015, the Joint Commission determined the program complied with accreditation standards. OIG substantiated a CLC patient who fell had an inaccurately low Morse Fall Scale assignment and incomplete Morse Fall Scale Notes. OIG substantiated that CLC patient falls increased during FY 2014; however, facility leadership recognized the issue and completed an action plan, which led to a decrease in patient falls in FY 2015. OIG substantiated the ED was left unattended by a qualified physician when ED physicians left the ED to perform emergency airway management in other FHCC care areas. OIG substantiated the ED did not have clerical staff support on weekends and most weekdays during the dayshift; however, this did not conflict with VHA policy and did not negatively affect delivery of patient care. OIG did not substantiate the ED LOS for admitted patients was long or that ED transfer rates were high. OIG substantiated nurses did not consistently follow proper hand-hygiene practices. OIG substantiated PCPs referred Navy recruits to the ED for non-emergent care needs; however, OIG determined the practice was permitted to ensure recruits were ready for deployment. OIG did not substantiate FHCC staff mishandled the suicides of two individuals. OIG did not substantiate the medical/surgical unit LOS was long. OIG did not substantiate the Associate Director of Inpatient Services lacked the required education and experience to qualify for the position.

Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of RN Staffing Concerns, Southern Arizona VA HCS, Tucson, Arizona

OIG conducted a healthcare inspection at the request of Senator John McCain, Senator Jeff Flake, Congresswoman Martha McSally, former Congresswoman Ann Kirkpatrick, and Congressman Raúl M. Grijalva to assess the merits of allegations regarding patients' delayed access to primary care and contaminated reusable medical equipment at the Southern Arizona VA HCS (system), Tucson, AZ. OIG also followed up on RN staffing concerns identified in the FY 2014 EAR survey. OIG substantiated that the number of primary care patient appointments taking 30 days or more to schedule from FY 2015 to FY 2016 had increased. OIG also found an increase in the number of new and established patients waiting more than 30 days from the preferred date to the appointment date. OIG determined that primary care wait times were affected by complex scheduling templates containing different appointment types and provider vacancies. System leaders increased physician recruitment by offering financial incentives to attract providers to a rural clinic. While OIG substantiated that reusable medical equipment (endoscopes) were contaminated and reused on two patients, OIG did not substantiate it was due to reduced staffing. OIG found this was a process issue. System staff notified the patients, who were tested, and OIG found no related adverse patient outcomes. System managers modified the process and trained staff. OIG found that since FY 2014, RN staffing improved in the inpatient medical/surgical and MH units, the CLC, the special procedures unit, and the ED.

Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto HCS, Palo Alto, California

OIG conducted a healthcare inspection to assess allegations of delays in patients receiving transcatheter aortic valve replacement (TAVR) procedures at the VA Palo Alto HCS (system) due to VHA policy requirements. OIG received complaints alleging: Patient A's TAVR was delayed; VHA's requirement that TAVR procedures occur in a hybrid operating room (HOR) is too stringent and not the community standard; patients were "affected" by the HOR requirement for the TAVR procedure; the system requested and was denied a waiver of the HOR requirement for TAVR procedures; HOR construction delays prevented system TAVR program implementation; and to avoid delays in patient care, the system enrolled patients in research studies so they could undergo TAVR procedures. OIG did not substantiate Patient A experienced a delay in obtaining the TAVR procedure. Once Patient A was recommended for a TAVR, the procedure was completed within a timeframe consistent with his medical needs. OIG substantiated VHA requires TAVR procedures be performed in a HOR. VHA reviewed best practices and obtained expert consensus to establish this requirement. OIG substantiated patients were affected by VHA's requirement that TAVR procedures be performed in a HOR as the system did not have a HOR and was unable to perform non-research TAVR procedures. However, OIG found the system referred patients for care. OIG substantiated that construction on a TAVR HOR was not completed on the projected date and affected the system's program. Patients obtained the TAVR procedure through other services during that time. OIG substantiated that system providers enrolled patients in TAVR procedure research studies. OIG was unable to determine if by doing so, they avoided delays in care. OIG identified lapses in the documentation necessary to maintain accurate records including communication and continuity of care. OIG made one recommendation.

Review of PTSD Consult Management, Battle Creek VAMC, Battle Creek, Michigan

OIG conducted a healthcare inspection to assess allegations made regarding the management of outpatient PTSD consults by the PTSD Clinical Team (PCT) at Battle Creek VAMC (facility). Specifically, the complainant alleged: (1) Between May and July 2016, consults were improperly designated as complete although a PCT provider had not evaluated the patient; (2) A MH provider used computer-based and written psychological testing as a substitution for evaluations; and (3) Staff psychologists were unproductive. OIG substantiated that some PCT consults were improperly identified as completed between May 1 and July 30, 2016. OIG substantiated that four of the five identified patients had PCT consults inappropriately designated as complete roughly between May 1 and July 30, 2016. In Spring 2016, PCT managers changed their assessment process to include multiple clinic visits rather than a single one. The change caused confusion relating to when a consult was considered complete. OIG reviewed the care of all patients who received a PCT consult between January 1 and March 31, 2016, before the process change, and between May 1 and July 30, 2016, after the process change. OIG found 37 of the 111 (33 percent) consults were marked as completed prior to the assessment process with a provider. However, OIG did not find any of the patients suffered adverse clinical impact. OIG confirmed that PCT managers decided to return the PCT consult process to its previous operation prior to our site visit in August 2016. In that the consult scheduling process was corrected and OIG found no adverse impact to patients, OIG made no recommendations. Also, OIG did not substantiate an MH provider used computer-based and written psychological testing as a substitution for an evaluation or that psychologists had nonproductive work hours during the new scheduling process. As a result, OIG made no recommendations.

Opioid Purchases, VA Northern Indiana HCS, Marion, Indiana

OIG conducted an inspection to evaluate the merit of a concern submitted by the Drug Enforcement Administration (DEA) regarding the Marion Division of the VA Northern Indiana HCS (VANIHCS). The DEA reported a large opioid purchase increase by the VANIHCS Marion Division in FY 2015 when compared to FY 2014 and to local Marion non-VA hospitals. OIG suspended the inspection. OIG decided to suspend the review because the Marion Division pharmacy purchases medications for patients in the Marion catchment area and for VANIHCS's four CBOCs, and OIG determined that comparing the Marion Division pharmacy

purchases to a local hospital's pharmacy purchases was not an equal comparison to the population size or type served. Additionally, regulatory changes occurred in October 2014 that re-categorized hydrocodone from a Schedule III to a Schedule II drug that required the Marion Division pharmacy to begin purchasing and dispensing hydrocodone, which patients had previously obtained via mail order from a Consolidated Mail Outpatient Pharmacy. Therefore, it would be expected that the Marion Division pharmacy would be purchasing and dispensing larger numbers of opioid medications. The DEA did not have evidence of specific patient harm regarding opioid prescribing practices at the Marion Division, and our preliminary onsite interviews at the Marion Division did not reveal evidence of patient harm or drug diversion. OIG suspended our inspection after determining there was a rationale for the increase in purchases of hydrocodone at the Marion Division. OIG made no recommendations.

Primary Care Access, Scheduling, and Consult Management Concerns, Erie VAMC, Erie, Pennsylvania

OIG conducted a healthcare inspection to evaluate primary care access, scheduling, and consult management concerns at the Erie VAMC (facility). OIG conducted a survey in advance of a December 2014 CAP review. Anonymous survey respondents alleged that: (a) PCPs were assigned too many patients, resulting in access issues, (b) Patient appointments were scheduled and later "cancelled by patient" without patients' knowledge, and (c) NVCC and inter-facility transfer consults were delayed. OIG substantiated that in March 2015, some PCPs were assigned more than the maximum number of patients specified under VHA procedures and local policy. Eleven of 22 providers (50 percent) had adjusted panel sizes outside the expected panel size range. Further, 12 of 22 providers (54.5 percent) had adjusted panel sizes outside the expected panel size range specified in facility policy. The facility attributed the panel sizes to challenges related to provider turnover and recruiting and retaining qualified PCPs at least in part because of the competitiveness of salaries. Since the onsite visit, facility leaders implemented a number of strategies to enhance recruitment and retention leading to some improvement in PCP panel size. At the end of FY 2016, 10 of 22 providers (45.5 percent) and 11 of 22 providers (50 percent) had adjusted panel sizes outside the expected ranges specified in VHA and facility policies, respectively. OIG did not substantiate that patients had limited access to primary care appointments. OIG found appointment wait times based on preferred date were relatively short, on average, both at the time of our onsite visit in March 2015 and at the end of FY 2016. OIG could not substantiate patient appointments were scheduled and subsequently "cancelled by patient," without patients' knowledge. Because the allegation was vague and lacked additional information such as specific patient appointments, staff involved, or time period, OIG was unable to fully address the anonymous survey respondent's specific concern. OIG substantiated inter-facility transfer and NVCC consult delays occurred in FY 2015, due at least in part to another VA medical facility leader's decision to decline certain transfer requests in an effort to address wait times concerns at the other facility. Facility leaders initiated multiple actions to address those delays which led to improved consult timeliness in FY 2016. Further, OIG did not identify patients who were clinically impacted by delays.

Non-VA Care Consult Program Concerns, Charles George VAMC, Asheville, North Carolina

OIG conducted an inspection in 2016 to assess concerns made regarding the clinical and administrative systems and practices within the non-VA care program at the Charles George VAMC (facility). In 2015, OIG conducted a survey in advance of a CAP review and multiple respondents raised concerns about the non-VA care program. OIG did not find that non-VA care consult staff inappropriately discontinued or cancelled consults. Based on the random sample of 147 non-VA care consults, OIG found that staff discontinued or cancelled 33 consults. Of the 33 consults, OIG found 32 (97 percent) had appropriate reasoning documented within the consult. OIG did not find that the facility's non-VA care program lacked clinical oversight. OIG found that approving officials reviewed and documented approval for the 147 randomly sampled consults. OIG found that telephone calls to the non-VA care program went unanswered. Beginning in October 2015, non-VA care leadership changed and then implemented a reorganization. In addition, the non-VA care program increased the number of phone lines,

implemented teams, clarified roles and responsibilities, and increased staffing. With these efforts, the facility's telephone metrics improved by the end of March 2016. OIG found apparent delays in processing non-VA care consults in FY 2015 and FY 2016. OIG focused our findings on the results from our review of the non-VA care consults ordered in FY 2016. OIG found apparent delays for 3,294 of 6,800 patients (48.4 percent) with at least one non-VA care consult. OIG reviewed the 863 EHRs of patients who experienced either a hospital admission or death following an apparent delay. OIG did not identify that the delays in care clinically impacted the patients reviewed. OIG made no recommendations.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, reviews, and inspections of VA programs, functions, and facilities. This work addresses the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, veterans' eligibility for benefits and benefits administration, resource utilization, financial and contract management, forensic auditing, fraud prevention, and information security. During the reporting period, OAE published 24 audits and evaluations of VA programs and operations, and published one additional work product. 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.

Audit of the Health Care Enrollment Program at Medical Facilities

OIG evaluated controls over the health care enrollment program administered at VA medical facilities and determined if enrollment actions were processed timely and supported by required documentation. OIG found that VHA did not provide effective governance necessary to ensure oversight and control over the health care enrollment program at medical facilities. Specifically, VHA required medical facilities to establish procedures for processing enrollment applications without implementing effective processes to monitor those activities. Only 38 of 106 VA medical facilities sampled had local enrollment policies. Medical facilities that did have guidance were permitted to adopt practices that were inconsistent with national policies. Conflicts between local practices and national policies occurred because VHA lacked appropriate guidance, oversight, and monitoring to ensure a standardized enrollment process. Formal training was also not provided to eligibility and enrollment staff at VA medical facilities. OIG also found that data systems did not have the capability to identify new enrollment applications or provide the basis for independent testing of timeliness or supporting documentation. Based on a statistical sample, OIG projected that only 197,000 of 427,000 enrollment records in the universe represented FY 2015 applications for enrollment. Further, OIG could not make conclusions related to timeliness or supporting documentation. This occurred because VHA did not adequately monitor program effectiveness or ensure that accurate data were available for program transparency. OIG recommended VHA develop standardized national policy and procedures, implement national oversight, and provide mandatory and standardized training for the health care enrollment program at VA medical facilities. OIG also recommended VHA implement a plan to correct the data integrity issues necessary to improve the accuracy and timeliness of health care enrollment data.

Audit of Consolidated Patient Account Centers To Prevent Improper Billings for SC Conditions

In March 2015, OIG received an allegation that VHA Consolidated Patient Account Centers (CPACs) inappropriately billed veterans and third-party payers for treatment of SC conditions and used an automated system designed to bill by default. OIG assessed whether CPAC controls ensured veterans and third-party payers were not billed for treatment of SC conditions. OIG substantiated the allegation that CPACs improperly billed veterans and third-party payers and used an automated system that billed by default. Of about

15.4 million bills VHA issued during FY 2015, OIG estimated approximately 1.7 million (11 percent) were improper bills for treatment of SC conditions. Of the 1.7 million bills, approximately 623,000 were sent to veterans and approximately 1.0 million were sent to third-party payers. This occurred because CPACs did not provide billing staff access to Veterans Benefits Management System (VBMS), establish procedures to review prescriptions, conduct comprehensive quality assurance reviews of SC determinations, or provide consistent training to VA medical facility staff. OIG estimated that VHA improperly issued bills totaling about $15 million to veterans and approximately $295.6 million to third-party payers for treatment of SC conditions. OIG also estimated VHA inappropriately collected approximately $13.9 million from veterans and at least $13 million from third party payers for the improper bills. OIG recommended the Under Secretary for Health statistically sample bills of SC veterans and assess other means to identify and refund erroneous bills. OIG also recommended the Under Secretary ensure CPAC billing staff receive read-only access to VBMS, review prescriptions for service connection, revise quality assurance reviews, monitor changes, and provide training for medical providers. The Under Secretary for Health concurred or concurred in principle with our recommendations and provided action plans. OIG considered the plans acceptable and will follow up on their implementation.

Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities

OIG's Hotline received an allegation in October 2014 that VA was paying full price for physician services to a non-VA care provider rather than paying lower contract rates, resulting in overpayments of provider claims for non-VA care. OIG substantiated the allegation that, contrary to Government regulations, VHA Florida claims processing centers did not reimburse a non-VA care provider based on the applicable Medicare rates, when appropriate. OIG determined that VHA payments exceeded Medicare rates in 52 of the 55 examples provided by the complainant, of which 44 (valued at $27,010) were related to specific physician administered drugs. The associated overpayments totaled $28,295. Based on these results, OIG expanded the review to all payments made by Florida VA facilities from October 1, 2012 through March 31, 2016 for these types of services. For this time period, the review of 73,124 payments to non-VA care providers for physician-administered drugs identified 26,178 overpayments (35.8 percent), totaling approximately $17.2 million, and ranging from $.01 to $47,943.40. Of this $17.2 million, VHA overpaid approximately $6.9 million (40.2 percent) to the provider identified in the allegation. These overpayments occurred because VHA did not use Medicare rates for physician administered drugs, as published by the Centers for Medicare & Medicaid Services. These funds could have been more effectively spent on veteran care. VHA stated that they would provide OIG with documentation to support completion of the action plans.

Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3

In May 2015, Congresswoman Kathleen Rice and Congressman Mike Coffman requested OIG review allegations that a supervisor at a VA facility in Bronx, NY, made unauthorized commitments by splitting prosthetic purchases in increments below $25,000 in FYs 2011 and 2012. Congresswoman Rice asked OIG to assess VA's claim that related procurement records were destroyed during Hurricane Sandy in October 2012. OIG did not substantiate that the Purchase Card Program Manager (PCPM) made unauthorized commitments by splitting prosthetic purchases but did determine that Network Contracting Office (NCO) 3 and the PCPM erroneously reported approximately $54.4 million of prosthetic purchases in Federal Procurement Data Systems (FPDS) during FYs 2011 and 2012. This erroneous reporting included the alleged split purchases under review. The PCPM erroneously reported contract purchases because NCO 3 was not meeting a performance metric that measured acquisitions on contracts. This occurred because the NCO 3 Contract Manager did not provide oversight or ensure implementation of the required segregation of duties for FPDS reporting. The erroneous reporting of prosthetic purchases was eventually removed from FPDS in 2013. OIG did identify 11 unauthorized commitments totaling approximately $457,000 for prosthetic purchases that exceeded the warrants of the

purchasers. The facility was unable to provide documentation of compliance with VA policies showing that these payments had been made by purchase cardholders in accordance with their warrant authority. The unauthorized commitments must now be ratified. OIG did not substantiate VA's claim that procurement records for prosthetic purchases at NCO 3 were destroyed during Hurricane Sandy. All the prosthetic procurement files had been stored on the 14th floor of the medical center and were not in an area affected by the hurricane.

Review of Alleged Mismanagement of VHA's Patient Transportation Service Contract for the Jesse Brown VAMC, Chicago, Illinois

In March 2015, OIG received an allegation of mismanagement of the patient transportation service contract for the Jesse Brown VAMC, which resulted in a waste of funds. OIG substantiated the allegation of contract mismanagement. Specifically, the Great Lakes Acquisition Center (GLAC) Contracting Officer (CO) did not adequately validate performance requirements to determine the required quantity of transportation trips. The CO did not adequately determine price reasonableness or fully fund the contract prior to obligating the Government. Finally, the CO did not document required contract information in VA's Electronic Contract Management System. This occurred because the GLAC CO did not ensure required reviews were performed for the awarded contract and for four modifications that either funded or extended the contract, increasing its value from roughly $885,000 to more than $6 million. Also, VA did not solicit competition to ensure fair and reasonable pricing. As a result, VA lacks assurance that the amount paid was the best value to the Government. In addition, VA potentially violated the P.L. 97-258, *Antideficiency Act* if funds were not available at the time VA incurred obligations for the services performed. The AUSH provided a plan for corrective action. OIG considered the plan acceptable and will follow up on its implementation.

Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VAMC, Dublin, Georgia

OIG conducted this review in response to allegations that Dublin VAMC purchase cardholders split purchases and made duplicate payments to Ryland Contracting Inc. and Sterilizer Technical Specialists. OIG substantiated the allegation that VAMC Dublin cardholders in Engineering Service made unauthorized commitments by splitting purchases and exceeding micro purchase limits. Of 130 sampled purchases made from October 2012 through March 2015, 23 were split purchases that avoided the $3,000 limit for supplies and 14 were purchases that exceeded the $2,500 limit for services. This was not prevented because approving officials did not adequately monitor cardholders to ensure compliance with VA policy. As a result, of 5,100 purchase card transactions totaling roughly $7.1 million, we estimated approximately 100 transactions totaling about $240,000 (3.4 percent) were unauthorized commitments and improper payments. OIG did not substantiate the allegation that cardholders made duplicate payments to Ryland Contracting Inc. and Sterilizer Technical Specialists. However, OIG found cardholders inappropriately made 91 micro purchases for services received from these vendors without establishing contracts. This was not prevented because approving officials did not adequately review cardholder transactions to identify service purchases exceeding VHA's $5,000 threshold for establishing contracts during a FY. As a result, cardholders purchased and received services totaling approximately $218,000 that avoided Federal competition requirements.

Review of Alleged Misuse of Resources by VHA's Strategic Investment Management, Business Architecture Division

OIG received an anonymous Hotline complaint in February 2015 stating that the VHA Strategic Investment Management, Business Architecture Division misused Government funds when it purchased Troux Technologies' Architect software. The complainant also stated that VA already had project management and architecture tools available; therefore, the purchase of this software was a duplication of existing software functionality. OIG conducted this review to determine the merits of the allegations. OIG did not substantiate the allegation that VHA acquired Troux Technologies' Architect software. However, VHA procured other Troux

Enterprise Portfolio Management (EPM) tools, including Troux Navigate for a report-creation capability and Troux Insight as a business analysis engine. OIG did not substantiate the allegation that the purchase of other Troux services was a duplication of existing VA project management and architecture software functionality. At the time of the allegation, VHA was developing EPM capabilities through a contract with Troux Technologies, Inc. Prior to awarding the contract to Troux Technologies, Inc., VHA conducted a review of business activities and identified functionality gaps for portfolio management. VHA's "Alternatives Analysis Review" provided several possible vendor solutions to address the gaps, one of which was Troux EPM software. The analysis identified weaknesses within VA existing systems inventory and noted that the current toolset could not provide portfolio management functionality without extensive modification. OIG conducted a review of VA's systems inventory and found no EPM capability that met VHA's requirements. OIG did not substantiate the allegations.

Audit of Alleged Inappropriate Scheduling of Electromyography Consults at the Memphis VAMC

At the request of former Chairman of the House of Representatives Committee on Veterans' Affairs, OIG reviewed an allegation of inappropriate scheduling for 143 VA Electromyography (EMG) consults at the Memphis VAMC. Additionally, the Office of Special Counsel provided similar allegations stating the intent was to disguise wait times. OIG substantiated that Memphis VAMC staff did not follow appropriate procedures when they discontinued the 143 EMG consults. OIG did not substantiate that EMG staff discontinued these consults to disguise wait times. The Assistant Chief of the Business Office made the decision to discontinue these consults and authorize Choice consults. This circumvented established procedures where EMG staff should have first scheduled the veteran and placed them on the Choice List if the wait time was greater than 30 days out. This circumvention of procedures occurred because the Assistant Chief thought bypassing the required scheduling process would save time and effort, and veterans would receive more timely care through Choice. The result was that patients who did not desire Choice care risked not being scheduled. The VAMC ultimately created new VA consults for 21 veterans who opted not to use Choice. In reviewing the allegations, OIG determined that Memphis VAMC did not provide care within 30 days to veterans for six consults still waiting for care. The delays resulted from insufficient staffing resources in the EMG Clinic and Business Office. On average, the veterans who received their EMG appointment waited an average of 198 days to receive care.

Review of Alleged Delay of Care and Scheduling Issues at the VAMC in West Palm Beach, Florida

VA OIG received two separate anonymous complaints in October 2014 and February 2015 alleging delay of care and potential manipulation of wait-time statistics at the VAMC in West Palm Beach, FL. The first complaint alleged that the VAMC and its outlying clinics were using patient cancellations to manipulate wait times. This complaint also contained allegations pertaining to unrelated human resources matters that included promotion and hiring decisions, which OIG did not review. The second anonymous complaint alleged that canceled cardiology appointments delayed cardiology patient care. The VAMC had a higher than average rate of clinic-canceled cardiology appointments with some patients experiencing multiple cancellations. Clinic scheduling staff canceled approximately 15 percent of cardiology appointments scheduled from October 1, 2014 through February 26, 2016. The VA national average for clinic-canceled cardiology appointments for the same period was 11 percent. These canceled appointments resulted in delayed care for many veterans, with at least 971 veterans incurring multiple cancellations. Scheduling staff incorrectly recorded wait times when rescheduling appointments. These issues occurred because the VAMC did not fully staff the cardiology clinic due to unexpected staff departures and challenges in recruiting cardiologists and because facility scheduler training and supervision were inadequate. Moreover, supervisors did not complete required scheduler audits, which inhibited the detection of scheduling errors. As a result, the VAMC understated patient wait times, delayed patient care, and did not offer eligible patients care through Choice. OIG recommended the Director fill cardiology vacancies, provide effective training to schedulers, and perform required scheduling

audits. The VAMC Director concurred with the report recommendations and provided appropriate action plans. OIG did not substantiate the allegation that VAMC scheduling staff manipulated wait times by scheduling appointments within wait-time goals, improperly marking them canceled by patient, and then rescheduling the appointments in the future.

Audit of Imaging Service Scheduling Practices at the South Texas Veterans HCS

OIG conducted this audit at the request of Congressman Mike Coffman in response to an allegation that the South Texas Veterans HCS (STVHCS) had about 20,000 past due pending radiology orders. To address the allegation, OIG evaluated if STVHCS had past due radiology orders that required action and adversely affected patients' quality of care. OIG substantiated the allegation that STVHCS Imaging Service had a significant number of past due radiology orders, although fewer than alleged by the complainant. OIG identified 17,790 potentially past due pending orders with a clinically indicated date before January 1, 2016. OIG projected that as of January 5, 2016, STVHCS had 5,500 patients with 7,200 pending past due orders that were not completed or not scheduled for timely completion. Additionally, OIG estimated STVHCS had as many as 9,500 pending orders that should have been canceled. This occurred because STVHCS Imaging Service lacked an effective manual hard copy radiology exam scheduling process, a means of ensuring pending orders were canceled when no longer needed, and procedures to address delays and prevent duplicate orders. The STVHCS Imaging Service's inability to provide patients with timely radiological care adversely affected the quality of care provided to some patients. OHI's clinical reviews confirmed that delays had minor clinical impacts on 14 patients and an intermediate clinical impact on one patient. OIG recommended the STVHCS Director address STVHCS's current pending radiology order inventory and strengthen radiology exam scheduling, management, and monitoring controls to prevent future delayed exams. In response to this audit, STVHCS reported it had reduced its pending radiology inventory to only 366 orders as of April 19, 2017. The STVHCS Director concurred with OIG's recommendations and provided an action plan to address these recommendations. OIG will monitor the planned actions and follow up on implementation.

Review of Alleged Continued Misuse of VA Funds To Develop the Health Care Claims Processing System

OIG evaluated the merits of two confidential Hotline allegations received after we published the *Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System (Report No. 14-00730-126, March 2, 2015).* The complainants alleged that the Chief Business Office (CBO) continued to spend about $11 million of medical support and compliance (MS&C) appropriations on Health Care Claims Processing System (HCPS) development from August through September 2014, despite being told by OIG during an April 2014 meeting of OIG, CBO, and the Financial Services Center that they should have used the Information Technology (IT) Systems appropriation. OIG confirmed that CBO spent MS&C funds to support HCPS during OIG's previous review, conducted from March through December 2014. This was prior to OIG's official notification to VA in December 2014 that a potential *Antideficiency Act* violation had occurred. OIG confirmed that OIG personnel informed the former Deputy Chief Business Officer of the potential violation of appropriations law at an April 2014 meeting. However, CBO staff did not alter their spending patterns after learning of the potential violation. In addition, OIG did not formally notify the former Interim Under Secretary for Health of the potential violation until the draft report was issued in December 2014. The VA Secretary reported the violation of the *Antideficiency Act* as required by Section 1351 of Title 31, United States Code. Therefore, OIG made no recommendations in the report.

Review of Alleged Payment Issues at Kerrville VA Hospital, Kerrville, Texas

OIG received a complaint from a veteran alleging that the Peterson Regional Medical Center (PRMC) in Kerrville, TX, canceled his sleep study appointment because VA owed PRMC more than $2 million and PRMC was no longer accepting VA referrals for non-VA care as a result. There was insufficient evidence to

substantiate the allegation that PRMC canceled the veteran's scheduled sleep study because of non-payment by VA or that PRMC limited other veterans' access to care. While PRMC continued to accept patients through the non-VA care program, OIG discovered that PRMC improperly informed the veteran that he might be responsible for payment if VA did not pay. OIG recommended the Director of the STVHCS should instruct PRMC to stop advising veterans that they could be liable for pre-authorized non-VA care. The Director of the STVHCS concurred with our findings and recommendation and stated that STVHCS would implement the recommendation. OIG will monitor STVHCS' progress and follow up on the implementation of the recommendation until the proposed action is completed.

Review of Alleged Use of Wrong VA Funds To Purchase IT Equipment

In November 2015, Congress referred to OIG an allegation that VISN 23 may have misused medical funding when procuring IT equipment and that purchase orders and contracts appeared to bundle IT hardware and software together with medical equipment while classifying them exclusively as medical equipment. OIG sought to determine whether appropriate funds were used and procedures were followed for 30 purchase orders and associated contracts. OIG did not substantiate the allegation and determined the 30 orders (about $57.9 million) and contracts were for IT hardware, software, and services dedicated to patient care. OIG found all 30 purchase orders were appropriately funded with medical appropriations but that VISN 23 improperly funded one purchase for patient WiFi and cable television services (about $245,000) by using the wrong type of medical appropriation. VISN 23 used MS&C funds instead of Medical Services funds because VA's Office of Information Technology (OIT) guidance on what VISN 23 was allowed to fund with IT appropriations was outdated, unclear, and incomplete. The Office of General Counsel's (OGC) determination that funding patient WiFi using Medical Services funds was acceptable was not communicated to VHA's Chief Financial Officer (CFO). OIG recommended the VISN 23 Director consult with OGC and take corrective actions and also ensure that appropriate funds are used for future IT procurements following the most recent VA policy and OGC guidance. The Director should work with the CFO to determine if an *Antideficiency Act* violation occurred and take appropriate action. OIG recommended the Acting Assistant Secretary for OIT update the 2016 IT/Non-IT Policy to address the dissemination of decisions and issues that may be systemic across VA. The Director concurred with Recommendations 1 and 2 and reported corrective actions were completed. OIG will close them once documentation is received. The Acting Assistant Secretary concurred with Recommendation 3. The corrective action plan is acceptable and OIG will follow up on its implementation.

Audit of Purchase Card Use To Procure Prosthetics

OIG reviewed allegations VHA inappropriately used Government purchase cards to procure commonly used prosthetics, instead of establishing contracts to leverage VHA's purchasing power, and failed to ensure fair and reasonable prices. Furthermore, VHA allegedly did not report purchases in FPDS. OIG substantiated the allegation that for some prosthetic purchases above the micro-purchase limit, VHA did not leverage its purchasing power by establishing contracts and did not ensure fair and reasonable prices. This occurred because VHA controls did not ensure the Prosthetic and Sensory Aids Service (PSAS) sufficiently analyzed prosthetic purchases to identify commonly used prosthetics and the Procurement and Logistics Office (P&LO) did not adequately monitor NCO procurement practices to ensure contracts were established. OIG estimated VHA may have paid higher prices for an estimated $256.7 million in prosthetics purchases during FY 2015 by not establishing contracts. OIG did not substantiate the allegation that VHA failed to report prosthetic procurements in FPDS. However, OIG determined VA medical facility staff improperly procured prosthetics above the micro-purchase limit without authority. OIG estimated VHA made improper payments and unauthorized commitments totaling about $520.7 million in FY 2015. If VHA staff does not ensure P&LO and PSAS implement our recommendations and newly established controls, they increase risks for improper payments and unauthorized commitments totaling about $2.6 billion over a five-year period. OIG recommended the AUSH take additional actions to identify all commonly used prosthetics

offering opportunities for leveraging VHA's purchasing power and pursue appropriate contracts. OIG also recommended the AUSH review FYs 2015 and 2016 prosthetics transactions to identify unauthorized commitments for ratification, conduct annual reviews, and consider holding cardholders and their approving officials accountable for unauthorized commitments, as appropriate.

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.

Review of Alleged Removal of Workload Controls at the VA Regional Office in San Juan, Puerto Rico

In August 2015, the OIG Hotline received complaints alleging San Juan VA Regional Office (VARO) staff were improperly removing workload controls for claims from VBA's workload management system. The End Product (EP) system is VBA's primary electronic workload monitoring and management tool and claims identified as EP 930 require additional processing, which may not have been properly performed before the removal of the claims from the system. OIG substantiated the allegation. Specifically, claims processors inaccurately removed 6 of the 30 cases OIG sampled, improperly terminating these veterans' claims without appropriate review and processing. One error delayed paying a veteran about $23,000 in benefits by more than 3 years and the remaining five errors had the potential to affect veteran benefits. OIG also confirmed that processing of this workload was a recurring challenge for Veterans Service Center (VSC) management. Because VSC management did not ensure staff followed plans to process this workload, the inventory continued to increase.

Review of Alleged Failure of the National Work Queue To Perform in Production

In November 2015, OIG received an anonymous Hotline complaint alleging that the VA National Work Queue (NWQ) did not perform in a production environment because VA did not test the system to specification. In addition, the complaint claimed that the VBMS Release 9.1 deployment prevented the processing of 4,000 disability claims. OIG did not substantiate that NWQ failed to perform in a production environment. At the time of the allegation, NWQ was still in testing and was not processing claims. Moreover, OIG noted that seven of eight VARO pilot sites reported that NWQ functionality worked when they first started using it to process disability claims in February 2016. One site reported that claims did not automatically route from NWQ into employee queues on the first day. OIG determined that VA tested NWQ functionality to specification. OIG reviewed applicable VBMS development artifacts that supported NWQ functionality to include system deployment requirements, configuration control records, test plans, and test cases. From February through June 2016, OIG noted that the average time for the actual NWQ claims distributions was 1 hour and 57 minutes; better than the 4-hour performance standard. OIG did not find that NWQ functionality had a negative effect upon disability claims processing. Specifically, OIG noted that none of the eight pilot sites reported lost disability claims resulting from the NWQ implementation. At the time of the allegation, NWQ was not yet used to process claims. OIG did not find that VBMS Release 9.1 had a significant adverse effect on claims processing, such as preventing the processing of 4,000 disability claims. Accordingly, OIG made no recommendations for improvements.

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 VSC 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 16 reports during this reporting period related to claims processing, management controls, data integrity, and public contact. In addition to its regular inspection protocol reviews, the Benefits Inspections divisions completed one review on May 24, 2017, regarding the Alleged Removal of Workload Controls at the San Juan, Puerto Rico VARO.

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 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. 113-283, *Federal Information Security Modernization Act of 2014* (FISMA), as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit.

Review of Unauthorized System Interconnection at the VARO in Wichita, Kansas

The OIG Hotline Division received an allegation that an unauthorized system interconnection existed between a Veterans Service Organization (VSO) network and the Wichita, KS, VARO. More specifically, the allegation stated that a system interconnection existed without a required Interconnection Security Agreement in place to define applicable information security requirements. The complaint also stated that the system interconnection was not disclosed to OIG during a recent FISMA audit. OIG substantiated the allegation that an unauthorized system interconnection existed between the Wichita VARO and the Kansas Commission on Veterans Affairs network. OIG also substantiated the allegation that the system interconnection was not disclosed to OIG because the OIT staff did not believe the connection constituted a formal system interconnection according to VA policy. The unauthorized system interconnection occurred because OIT technical staff did not have the technical knowledge or exercise due diligence to identify the system interconnection in accordance with VA policy; OIT technical staff did not follow VA's change management procedures for reviewing and approving significant network and system changes; and the Wichita VARO did not have a formal process in place for managing VSO system change requests that may adversely affect VA's network environment. As a result, the unauthorized system interconnection violated VA policy and the computers used by VSO representatives were inappropriately allowed to use client software to establish simultaneous network connections between VA's and the VSO's networks. OIG recommended the Assistant Secretary for OIT, in conjunction with the Wichita VARO Facility Director, ensure that the network interconnection with the Kansas Commission on Veterans Affairs is

brought into compliance with VA information security requirements. The Principal Deputy Under Secretary for Benefits and the Acting Assistant Secretary for OIT concurred with OIG's findings and recommendations. OIG will follow up on the implementation of corrective actions.

Review of Alleged Mismanagement of VA's Human Resources and Administration Contract Funds

In September 2015, OIG received an allegation that the Office of Human Resources and Administration's (OHRA) VA Learning University (VALU) management authorized vendor payment for a dashboard tool (DT) before receiving the deliverable. In addition, the complainant alleged OHRA provided a competitive advantage to a vendor by helping the vendor develop a performance work statement for a future contract to maintain the DT. The DT is a web-based interface designed to organize and manage OHRA and VALU program data, such as performance metrics and training outcomes. OIG substantiated the allegation that VALU management authorized final payment in April 2015 for the DT that had not been delivered. OIG determined VALU did not accept the DT because it did not have the capability to operate the tool. Authorizing final payment before delivery did not allow VA to determine whether the DT conformed to applicable contract quality requirements. The former Dean of VALU did not assign responsibility for identifying and procuring a hosting solution to any individual or office. Additionally, the former Dean did not take timely action to obtain roughly $3,200 in funding to purchase a hosting solution. As a result, OHRA was unable to use its estimated $3.7 million investment in the DT. As of March 2017, OHRA had not purchased a hosting solution on which to operate the DT, and it remained in the possession of the vendor. OIG did not substantiate the allegation that OHRA provided a competitive advantage to a vendor for a future contract to maintain the DT. OIG found OHRA officials drafted a performance work statement for a DT maintenance contract. An Office of Acquisition Operations CO appropriately refused to approve the performance work statement as it was determined the contract was unnecessary because VALU officials could not demonstrate they were in possession of the DT.

Review of Alleged Mismanagement of VA's Personal Identity Verification Processes

OIG conducted this review to determine the merits of allegations involving the mismanagement of the Personal Identity Verification (PIV) Program and related systems. In June 2015, OIG received a Hotline complaint alleging VA's Security and Investigations Center (SIC) was inappropriately permitting the issuance of PIV cards and VA network system access to individuals without completed background investigations or adjudicated fingerprints. SIC personnel process and adjudicate background investigations for all moderate and high-risk public trust and national security positions for Federal employees within VA. They also process all levels of investigation for contractors performing jobs and functions for VA. OIG did not find instances where VA's SIC was inappropriately authorizing the issuance of PIV cards and allowing VA network system access to individuals without a completed Special Agreement Check (SAC) and a scheduled background investigation as required by VA policy. OIG reviewed VA local policies and procedures as they related to PIV card authorizations. To evaluate business processes and compliance with VA policies, OIG selected 32 cases to sample from VA's Security Manager system of record. The 32 cases included 25 individuals chosen randomly, 6 personnel from SIC management, and 1 individual named in the complaint as having received a PIV card without meeting VA policy requirements. OIG observed SIC personnel accessing each of these cases in the system of record and reviewing the electronic records, SAC, background investigation dates, and any relevant comments associated with each case. OIG found each case reviewed met VA policy requirements for PIV card authorization. As a result, OIG concluded that SIC personnel appropriately authorized the issuance of PIV cards in accordance with VA policy. OIG did not substantiate the allegations of SIC's mismanagement of the PIV Program and related systems. Additionally, OIG did not find any instances of improper processing of selected cases.

Review of Alleged Inappropriate Contract Actions Related to VA's Lease of a Digital Imaging Network-Picture Archival Communication System

In June 2015, OIG received an allegation regarding the procurement strategy used by VA under DoD Digital Imaging Network-Picture Archival Communication System (DIN-PACS) contract. The complainant alleged that VA did not perform a proper business case analysis of its procurement strategy of leasing versus purchasing DIN-PACS. The complainant further alleged technical evaluations were manipulated, excessive amounts of equipment were purchased, and an award was made at a cost 30 percent higher than recommended by the CO. OIG reviewed the VISN 1 DIN-PACS lease and found that VA did not adequately evaluate the advantages or disadvantages of leasing versus purchasing DIN-PACS. Furthermore, VA did not comply with the Federal Acquisition Regulation (FAR) and DoD contract, as required by the contract terms, to determine that prices were fair and reasonable once it elected to use the DoD contract to lease the DIN-PACS. This occurred because VA's CO misinterpreted an internal directive and did not fully comply with FAR Part 7.4, which requires a lease versus purchase analysis. The CO did not ensure the acquisition team fully complied with the FAR to conduct this analysis even after receiving advice from VA's General Counsel. In addition, VA lacked documented evidence of a formal contract oversight review as required by VA's Integrated Oversight Process. As a result, the decision of VA's CO to lease DIN-PAC systems at an estimated value of $9 million could lead to the wasteful spending of taxpayer dollars. OIG did not substantiate that VA manipulated technical evaluations, purchased excessive amounts of equipment, or made an award 30 percent higher than recommended. OIG considers their corrective action plans acceptable and will follow up on the implementation.

Review of Alleged Adverse Effect on Patient Care Due to Removal of a Computer-Assisted Survey Instrument

In September 2015, OIG received an allegation that OIT removed the Prescription Opioid Documentation and Surveillance (PODS) application from a VA server at the Northern California HCS (NCHCS) Pain Management Clinic. The complainant alleged the removal was potentially harmful to veterans who were put at increased risk of accidental overdose. OIG substantiated the allegation that OIT removed PODS. PODS used medical and MH questionnaires to obtain patient information from patients prior to face-to-face evaluations with clinicians. According to the NCHCS Chief of Staff, PODS was "not a standard of care." In addition, clinicians told us PODS was not necessary for prescribing and tracking opioids. Clinicians reported they clinically evaluated and assessed patients' to determine the required level of monitoring and long-term opioid therapy. Because PODS was not needed to meet an appropriate standard of care, and clinicians reported they could provide requisite care without PODS, OIG concluded its removal did not put veterans at increased risk of accidental overdose. Although not part of the allegation, OIG found OIT failed to protect the integrity of VA's enterprise and the security of the information it stored by allowing PODS' use. PODS was started as a research project in 2006. After the research ended in 2012, clinicians continued to use PODS until it was removed in July 2015. However, PODS was an unsupported Class III software that did not meet system requirements, which created an unnecessary risk that veterans' sensitive information could be accessed. These security concerns existed because OIT Region 1 staff failed to follow their standard operating procedures for the assessment and removal of Class III software.

Federal Information Security Modernization Act Compliance

In compliance with FISMA, the FY 2016 audit determines the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. OIG contracted with an independent accounting firm to perform this audit. VA has made progress developing policies and procedures but still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted,

this FISMA audit continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems. Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, databases, and server platforms VA-wide. Further, VA has not remediated approximately 9,500 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its information security posture. As a result, the FY 2016 Consolidated Financial Statement audit concluded that a material weakness still exists in connection with VA's information security program.

Improper Payments Elimination and Recovery Act Compliance

OIG determined whether VA complied with the P.L. 111-204, *Improper Payments Elimination and Recovery Act* (IPERA) for FY 2016. VA reported improper payment estimates totaling approximately $5.5 billion in its FY 2016 Agency Financial Report (AFR). As allowed by Office of Management and Budget (OMB) guidance, VA reported improper payment data based on the previous FY activity. VA did not comply with two of six requirements that constitute compliance according to OMB. VA did not report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was published in the FY 2016 AFR. Two VA programs, VA Community Care (VACC) and Purchased Long Term Services and Support, exceeded 10 percent. Also, VA did not meet annual reduction targets for the following six programs: VACC, Purchased Long Term Services and Support, Beneficiary Travel, Civilian Health and Medical Program of the VA (CHAMPVA), State Home Per Diem Grants, and Supplies and Materials. VA met four of the six IPERA requirements for FY 2016 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. Although VA published improper payment estimates as required, OIG determined estimates for the Supplies and Materials Program and the Post 9/11 G.I. Bill Program were not reliable because of weaknesses in sample evaluation procedures. OIG also identified further improvements VA could make in estimating improper payments for two programs and in reducing improper payments for another program that resulted from a program design issue.

Digital Accountability and Transparency Act Compliance

OIG contracted with an independent public accounting firm to perform a review of VA's readiness to implement P.L. 113-101, *Digital Accountability and Transparency Act of 2014* (DATA Act). The contractor reported that VA's outdated systems and their limitations would prevent VA's full compliance with the DATA Act. Specifically, implementing guidance for the DATA Act requires that agencies submit three different data files in May 2017 that will be linked with four other data files from Government-wide systems for publication on USAspending.gov. At the time of the accounting firm's review, VA reported that of the three files, it would be able to submit one, would be challenged by some aspects of the second, and would not be able to submit the third, with one possible exception. As such, VA would not be able to fully comply with the DATA Act and implementing guidance by May 2017. The contractor made 17 recommendations for improving VA's implementation of the DATA Act.

Office of Investigations

Veterans Health Administration Investigations

The Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OI opened 126 cases; made 80 arrests; obtained over $2.9 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $2.1 million in savings, efficiencies, and cost avoidance; and recovered over $273,000.

During this reporting period, OI opened 26 investigations related to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 20 individuals were arrested for various crimes related to drug diversion. These investigations resulted in over $20,000 in court ordered payment of fines, restitution, penalties, and civil judgments and nearly $892,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OI initiated 19 investigations related to the fraudulent receipt of health benefits, which resulted in 10 arrests for various related crimes. These investigations resulted in approximately $792,000 in fines, restitution, penalties, and civil judgments; and over $287,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OI 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. OI opened 2 investigative cases and made 4 arrests related to beneficiary travel fraud. The investigations resulted in nearly $18,000 in court ordered payment of fines, restitution, penalties, and civil judgments and $2,400 in savings, efficiencies, cost avoidance, and dollar recoveries.

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 OI work in this area, 9 individuals were arrested which resulted in approximately $779,000 in court ordered payments of fines, restitution, penalties, and civil judgements; and nearly $230,000 achieved 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 VA Vendor Pleads Guilty to Blackmail

A joint VA OIG and Federal Deposit Insurance Corporation OIG investigation revealed that from April 2014 to April 2015 the defendant received purchase card payments of $125,549 for unnecessary maintenance work. During this time, the defendant kicked back an estimated $39,000 to a former St. Louis, MO, VA supervisor and an estimated $20,800 to his step-father, who at the time was also a VA employee. This investigation is ongoing and there is an anticipated loss to VA of $451,853.

Former Leavenworth, Kansas, VAMC Physician Assistant Convicted of Aggravated Criminal Sodomy, Aggravated Sexual Battery, and Sexual Battery

An OIG and Leavenworth County Sheriff's Office investigation resulted in charges that the defendant committed sexual assaults during physical examinations. The defendant served as a primary care provider for the Operation Enduring Freedom/Operation Iraqi Freedom Section that included 750 to 1,000 patients. During the investigation, the defendant confessed to over-prescribing narcotic medication as well as exceeding standard

examination practices by administering unnecessary and excessive genital examinations to multiple male patients.

Former Muskogee, Oklahoma, VAMC Psychiatrist Pleads Guilty To Tampering with a Witness/Victim

An OIG investigation revealed that the defendant engaged in a long-term inappropriate sexual relationship with a psychiatric patient while serving as a staff psychiatrist at the medical center. During the investigation, the defendant attempted to coerce and intimidate the victim to lie to investigators as to the nature of their relationship. The State of Oklahoma Board of Medical Licensure and Supervision initiated the process to revoke the defendant's medical license.

Veteran Sentenced for Sexual Abuse of an Incapable Victim

A veteran was sentenced to 100 months' incarceration, lifetime probation, and was ordered to participate in a sex offender and drug treatment program after pleading guilty to the sexual abuse of an incapable victim. An OIG investigation revealed that while the defendant and victim were both inpatients at the Lexington, KY, VAMC, the defendant sexually assaulted the female victim. The defendant waited until the victim received "sleeping medications" and then went into her room and sexually assaulted the victim on several occasions.

Veteran Arrested for Burglary, Willful Cruelty to an Elder/Dependent Adult, and Sexual Battery

An OIG and local police investigation resulted in charges that allege that the defendant sexually assaulted a spinal cord injury patient while visiting the patient at the San Diego, CA, VAMC. The defendant is a registered sex offender and was remanded to custody.

Youngstown, Ohio, VA CBOC Employee Pleads Guilty to Intent to Engage in Illicit Sexual Conduct with a Minor

A Youngstown, OH, VA CBOC employee pled guilty to transportation of minors, travel with intent to engage in illicit sexual conduct. An OIG, Ohio Internet Crimes Against Children Task Force, and Homeland Security Investigations investigation revealed that the defendant used electronic devices with internet connectivity, including his VA-issued computer, to entice an underage female to engage in sexual activity, and then traveled interstate to engage in illicit sexual activity with a 15-year-old girl.

Minneapolis, Minnesota, VAMC Medical Instrument Technician Charged with Indecent Exposure

An OIG investigation resulted in charges alleging that the defendant exposed himself to two different female co-workers on multiple occasions.

Seattle, Washington, VAMC Employee Sentenced for Weapon Possession

A Seattle, WA, VAMC employee was sentenced to 42 months' incarceration after pleading guilty to weapon possession charges. An OIG, Bureau of Alcohol, Tobacco, Firearms and Explosives, and VA Police Service investigation revealed that the defendant, a previously convicted felon, threatened VA coworkers, possessed methamphetamine and a loaded firearm on VA premises, and possessed a sawed-off shotgun and controlled substances at his residence. Evidence in the case was developed during an undercover operation and from the execution of search warrants conducted of the defendant's vehicle and residence.

Northport, New York, VAMC Employee Sentenced for Larceny

A Northport, NY, VAMC employee and former American Federation of Government Employees president was sentenced to 280 hours' community service and 3 years' probation after pleading guilty to petit larceny. The

defendant also made full restitution to the union prior to sentencing. An OIG, Department of Labor (DOL) Office of Labor Management Standards, and Attorney General's Office investigation revealed that the defendant embezzled approximately $45,000 from the union's bank account and used the funds for personal expenditures.

Non-Veteran Indicted for Theft in Connection with Health Care and Demands Against the United States

A non-veteran was indicted for theft in connection with health care and demands against the United States. An OIG and local sheriff's office investigation resulted in charges that the defendant allegedly enrolled at the Minneapolis, MN, VAMC using a fraudulent DD-214 (Certificate of Release or Discharge from Active Duty) and obtained over $100,000 in health care benefits. In addition, the defendant allegedly submitted the fraudulent DD-214 to VBA, obtained a 30 percent disability rating, and subsequently received over $25,000 in disability compensation benefits.

Non-Veteran Sentenced for "Stolen Valor"

A non-veteran was sentenced to 18 months' incarceration and was ordered to pay VA restitution of $130,122. An OIG investigation revealed that the defendant obtained medical care from the Cincinnati, OH, VAMC as well as VA grant benefits by submitting falsified documents claiming to be a Marine Corps veteran.

Former Martinsburg, West Virginia, Chief of Staff Arrested for Drug Diversion

The former Martinsburg, WV, Chief of Staff was arrested after being indicted for acquiring fentanyl by misrepresentation, fraud, deception, and subterfuge. The indictment, which was the result of an OIG and VA Police Service investigation, alleged that the defendant acquired fentanyl by fraudulently entering patient information into the facility's Omnicell medication dispensers.

Former Columbia, Missouri, VAMC Nurse Sentenced for Drug Diversion

A former Columbia, MO, VAMC licensed practical nurse was sentenced to 5 years' supervised probation, 5 years' incarceration (suspended), and was ordered to pay restitution and court costs of $331 after pleading guilty to receiving stolen property. An OIG investigation revealed that for approximately 6 months the defendant diverted for personal use anywhere between 342 to 456 controlled substances from the medical center.

Former Alexandria, Louisiana, VAMC Nurse Arrested for Drug Diversion

A former Alexandria, LA, VAMC licensed practical nurse, who was assigned to the CLC, was arrested for theft of Schedule II narcotics. An OIG investigation resulted in charges alleging that the defendant stole narcotic medications, specifically oxycodone and hydrocodone, by obtaining the medications and then failing to dispense them to patients.

Sunrise, Florida, CBOC Nurse Arrested for Drug Diversion

A Sunrise, FL, VA CBOC nurse was indicted and arrested for obtaining possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. An OIG investigation resulted in charges after the defendant tested positive for drugs, recorded inaccurate patient vital signs, generated fictitious patients, and diverted Fentanyl during gastrointestinal procedures. The defendant admitted to the drug diversion.

Fresno, California, VAMC Nurse Arrested for Drug Diversion

An OIG investigation resulted in charges that allege that a VAMC nurse diverted Fentanyl from a veteran in hospice care.

Orlando, Florida, VAMC Nurse Arrested for Drug Diversion

An Orlando, FL, VAMC nurse was indicted and arrested for obtaining possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. An OIG investigation resulted in charges that allege

for over 6 months the defendant diverted 467 vials of fentanyl. The defendant also tested positive for fentanyl and marijuana subsequent to a facility-administered drug test.

Former San Juan, Puerto Rico, VAMC Pharmacy Procurement Technician Arrested for Drug Theft

An OIG investigation resulted in charges that allege that the defendant used her position to order and subsequently steal large quantities of insulin, with a market value of $6.75 million, from the medical center. The actual loss to VA is $762,234.

Former Lebanon, Pennsylvania, Licensed Practical Nurse Pleads Guilty to Acquiring a Controlled Substance by Fraud

A former Lebanon, PA, licensed practical nurse pled guilty to acquiring a controlled substance by fraud. During an OIG and VA Police Service investigation, the defendant admitted that she diverted hydromorphone, oxycodone, and morphine while working in the medical center's hospice unit.

Cincinnati, Ohio, VAMC Physician Indicted for Drug Distribution Without a License

A physician, who was also the former acting COS at the Cincinnati, OH, VAMC, was indicted for drug distribution without a license. An OIG investigation resulted in the defendant being charged with issuing three controlled substance prescriptions for the former VISN Director's wife, a non-veteran, using her DEA license that was restricted to Federal official duties only.

Former Spokane, Washington, VAMC Nurse Indicted on Drug Charges

A former Spokane, WA, VAMC nurse was indicted for acquiring and obtaining a controlled substance by fraud, misrepresentation, deception, and subterfuge. An OIG investigation resulted in the defendant being charged with fraudulently obtaining prescriptions of the controlled substance phentermine using VA prescription forms containing forged signatures of VA physicians.

Non-Veteran Sentenced for Drug Distribution

A non-veteran was sentenced to 14 months' incarceration and 36 months' supervised release after pleading guilty to conspiracy to distribute and possess with intent to distribute cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and DEA New York Organized Crime Drug Enforcement Strike Force investigation identified the defendant as a supplier of narcotics to a criminal enterprise that mailed six U.S. Postal Service (USPS) parcels, each containing one to two kilograms of cocaine, from Puerto Rico to the Bronx, NY, VAMC. Six defendants have been charged, including two former VA employees. To date, five of the defendants have pled guilty.

Veteran Pleads Guilty to "Doctor Shopping"

A veteran pled guilty to deception to obtain a dangerous drug and possession of a dangerous drug (with a prior drug conviction specification). An OIG investigation revealed that the defendant obtained opioids from VA and his non-VA medical provider from 2014 to 2016, resulting in the defendant receiving approximately 1,260 tablets by deception. The defendant admitted to distributing some of the controlled substances he obtained to other individuals.

Veteran Pleads Guilty to Drug Trafficking

A veteran pled guilty to drug trafficking, drug possession, and deception to obtain a dangerous drug. The defendant was admitted to a drug treatment program in lieu of conviction. An OIG investigation revealed that the defendant sold his VA-prescribed medication to another veteran receiving treatment at the Cleveland, OH, VAMC domiciliary. On a daily basis, the defendant received two doses of Suboxone from VA, one he would take while the other was hidden and later sold to other veterans.

Veteran Sentenced for VA Travel Benefit Fraud

A veteran was sentenced to 12 months' incarceration, 3 years' supervised release, and was ordered to pay $142,474 to VA in restitution after pleading guilty to theft of Government funds. An OIG and VA Police Service investigation determined that the defendant made more than 700 false claims to the San Francisco, CA, VAMC in order to receive more beneficiary travel pay. The defendant claimed to drive more than 500 miles a day to the medical center, 4 to 5 days per week for several years. In actuality, the defendant was living in a mobile recreational vehicle trailer much closer to the facility.

Veteran Indicted for Theft of Government Funds and False Statements

A veteran was indicted for theft of Government funds and false statements. An OIG and VA Police Service investigation resulted in the defendant being charged with submitting fraudulent travel vouchers to the Martinsburg, WV, VAMC. For nearly 5 years, the defendant is alleged to have claimed an address 123 miles from the medical center, when in reality, he resided in HUD/VASH provided housing five miles from the facility. The loss to VA is approximately $30,000.

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 48 investigations, which resulted in 31 arrests and $3.7 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,745 possible cases with over 4,388 investigative cases opened. Investigations have resulted in the actual recovery of $109 million, with an additional $36 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $227 million. To date, there have been 854 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OI opened 162 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 75 arrests for these types of investigations. OI obtained over $16.3 million in court ordered payment of fines, restitution, penalties, and civil judgements; achieved over $67.7 million in savings, efficiencies, and cost avoidance; and recovered more than $1.5 million.

Two Co-Owners of Fiduciary Company Arrested on Multiple Charges

The two co-owners of a professional fiduciary company were arrested after being indicted for conspiracy, fraud, theft, and money laundering. A VA OIG, Federal Bureau of Investigations (FBI), Internal Revenue Service (IRS), Social Security Administration (SSA) OIG, and U.S. Marshals Service (USMS) investigation resulted in charges that allege the defendants embezzled more than $4 million from their special needs clients to support lavish lifestyles for themselves and their families. The defendants allegedly submitted 34 fraudulent annual VA

Fiduciary Statement of Accounts and also created and submitted approximately 700 fraudulent bank statements in support of the fraudulent annual statements. Agents enforced a Federal court order that authorized the USMS's Complex Assets Unit to assume control of the business operations. The court order appointed the USMS as the receiver and monitor of the business, to include all financial accounts. The order authorizes the USMS to operate the business to ensure that its assets are not improperly spent or removed and that the interests of VA and SSA beneficiaries are protected. The loss to VA is $2.7 million.

Former VA Fiduciary Pleads Guilty to Misappropriation and Other Charges

A former VA fiduciary pled guilty to wire fraud, misappropriation by a fiduciary, and preparing fraudulent tax returns. As part of the plea agreement, the defendant also agreed to pay restitution. An OIG, FBI, and IRS Criminal Investigation Division (CID) investigation determined that from 2007 to 2012, the defendant, who served as VA fiduciary for eight disabled veterans, embezzled more than $250,000 in VA-issued benefits from the veterans' accounts. Some of the VA funds were used for personal mortgage payments.

Former VA Fiduciary and Husband Ordered To Pay Restitution

A former VA fiduciary and her husband received the final order of restitution/penalty judgement following sentencing. A multi-agency investigation revealed that the defendants co-owned a residential care facility and were assigned as the fiduciary for a mentally disabled veteran. The veteran received a $209,235 retroactive benefit check from VA, which the defendants were supposed to deposit into a resident trust account. Instead, the defendants deposited the check into their business account and utilized the funds for personal gain to include purchasing three vehicles for their family. The former VA fiduciary was convicted at trial, which resulted in her spouse pleading guilty to the same charges of financial exploitation of a disabled person, Medicaid fraud, and income tax fraud. The defendants were ordered to jointly pay $143,273 in restitution and $10,352 in tax fraud penalties. Also, each defendant was independently ordered to pay an additional $5.3 million in Medicaid fraud penalties.

Veteran's Sister Sentenced for Theft of Government Funds

The sister of a veteran, appointed as her brother's fiduciary, was sentenced to 3 years' probation after pleading guilty to theft of Government funds. The defendant also repaid $215,512. An OIG investigation revealed that the defendant was responsible for more than $200,000 belonging to her brother and subsequently withdrew more than $95,000 to pay off her loans and purchase a new BMW. The defendant also initially failed to transfer the remaining funds to a professional fiduciary appointed as her replacement.

VA-Appointed Fiduciary Arrested for Wire Fraud and Misappropriation

A VA-appointed fiduciary was arrested after being indicted for wire fraud and misappropriation. An OIG and FBI investigation resulted in charges that the defendant allegedly misappropriated over $100,000 of her brother's VA compensation benefits.

Veteran's Spouse Indicted for Theft of Government Funds and False Statements

The spouse of a disabled veteran, who was also the veteran's fiduciary, was indicted for theft of Government funds and false statements. The defendant left the veteran and moved in with another man in South Carolina after allegedly claiming to be living with and caring for her veteran husband in North Carolina. The defendant also used a fraudulent power of attorney to obtain a VA guaranteed loan in the veteran's name for a house in South Carolina. The power, water, and other utilities supporting the veteran's home in North Carolina were subsequently disconnected and the abandoned veteran, who had been terminally ill for some time, was found deceased in his North Carolina home. After the veteran's death, the defendant allegedly claimed that she lived with the veteran continuously until his death and filed for and received Dependency and Indemnity Compensation (DIC) benefits. The loss to VA is approximately $40,000 and the misappropriated amount taken

from the veteran prior to his death is approximately $8,000. The investigation identified the VA loan fraud before VA suffered any loss.

Former VA Fiduciary Arrested for Embezzling Funds

A former VA fiduciary was arrested for embezzling VA, Social Security, and personal funds intended for her mother. An OIG, SSA OIG, and local police investigation resulted in the defendant being charged with stealing $53,000 in VA beneficiary payments, $34,000 in Social Security payments, and $10,000 in personal funds. The fiduciary also allegedly failed to pay $28,000 in nursing home care for her mother.

VA-Appointed Fiduciary Sentenced for Theft of Government Funds

A VA-appointed fiduciary was sentenced to 5 years' probation and was ordered to pay VA restitution of $47,720 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant misused funds intended for her veteran brother by using the funds to pay personal church tithes, her own mortgage, and various other expenses.

Former VA Fiduciary Pleads Guilty to Misappropriation by a Fiduciary

A former VA fiduciary pled guilty to misappropriation by a fiduciary after admitting to misappropriating approximately $44,000 from two different veterans. An OIG investigation revealed that the defendant transferred approximately $17,903 of VA funds to a corporate credit card in her name and used the card to pay for charges at restaurants, florists, jewelers, grocery stores, hospitals, and furniture stores. The card was not used for the benefit of the veterans.

VA-Appointed Fiduciary Charged With Larceny

A VA-appointed fiduciary, the former girlfriend of a disabled veteran, was charged with larceny by a single scheme. An OIG investigation resulted in the fiduciary being charged with misusing approximately $14,547 of VA compensation funds intended for the disabled veteran. The investigation was initiated when the veteran, who had been abandoned by the fiduciary, was found by his VA social worker in his apartment where he was unable to care for himself or pay his bills. The fiduciary used the veteran's funds to make personal purchases to include tattoos, car repairs, and hotel rooms.

Veteran and Wife Indicted for Conspiracy and Theft of Government Funds

A veteran and his wife were indicted for conspiracy and theft of Government funds. A VA OIG and SSA OIG investigation resulted in charges that the two defendants filed fraudulent claims alleging that the veteran was unable to care for himself as a result of injuries received during combat operations in Iraq. The veteran claimed the loss of use of both feet from a spinal cord injury he sustained as a result of an improvised explosive device (IED). The total fraud loss is approximately $900,000, to include a loss to VA of approximately $600,000.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for theft of Government funds and false statements. An OIG investigation resulted in charges that allege that while in receipt of VA compensation benefits for blindness, the defendant held a valid driver's license, drove regularly, volunteered and traveled to work on church construction sites overseas, and volunteered at local prisons. For over 16 years, the defendant had been informing VA physicians that he was blind. The loss to VA is $538,480.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 9 months' incarceration, 3 years' supervised release, and was ordered to pay VA $394,800 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with claiming blindness in order to fraudulently collect VA compensation benefits for over 15 years. During the time that the defendant told VA physicians that she was

almost completely blind, she obtained driver's licenses with no vision restrictions in three states. The defendant was also observed driving on numerous occasions, to include a daily commute of 40 miles to and from work.

Veteran Sentenced for Wire Fraud

A veteran was sentenced to 3 years' incarceration and was ordered to pay restitution of $646,000 after pleading guilty to wire fraud. A multi-agency investigation revealed that the veteran and his sister provided false medical documentation to VA, SSA, and other agencies in order to fraudulently obtain caregiver support, VA compensation, and other benefits. The investigation determined that the veteran also submitted fraudulent documents to the Army in order to obtain a Purple Heart and Combat Infantry Badge, which he then used as a basis for his benefits. The Army subsequently stripped the veteran of the awards. The loss to VA is $343,000.

Veteran Sentenced for "Stolen Valor"

A veteran was sentenced to 21 months' incarceration and was ordered to pay VA restitution of $322,654 after pleading guilty to wire fraud and "Stolen Valor." An OIG and FBI investigation revealed that the defendant falsely claimed that he was awarded a Combat Action Ribbon (CAR) along with two Purple Heart medals after being injured by an IED while serving in Iraq. As a result of his claims, the defendant fraudulently obtained VA compensation benefits, in addition to receiving a mortgage-free house from the Military Warrior Support Foundation. The investigation further revealed that while the defendant did serve in the US Marine Corps, he was not awarded a CAR or Purple Heart medals. Also, the defendant was not injured by an IED explosion and did not engage in combat.

Veteran Sentenced for Theft of Government Funds and False Statements

A veteran was sentenced to 6 months' incarceration, 3 years' supervised release, and was ordered to pay $303,995 in restitution after being found guilty at trial of theft of Government funds and false statements. A VA OIG, SSA, and Health and Human Services (HHS) OIG investigation revealed that the defendant fraudulently applied for and received VA, SSA, and HHS disability benefits by claiming loss of use of her right hand, when in actuality, the defendant had full use of both hands. During the investigation, the defendant also provided false statements to VHA and SSA medical staff regarding the extent of her disabilities.

Veteran Found Guilty of VA Compensation Fraud

A veteran was found guilty at trial of health care fraud and false statements relating to a health care matter. An OIG investigation revealed that the defendant, who was rated 100 percent disabled and received special monthly compensation for loss of use of both feet, was able to mow his lawn and walk up and down his driveway without any assistance. Additionally, the defendant received adaptive housing and various prosthetics devices to assist with his alleged disability. The loss to VA is approximately $300,000.

Veteran Arrested for VA Compensation Fraud

A veteran was arrested after being indicted for theft of Government funds. An OIG investigation resulted in charges that allege that while the defendant was in receipt of VA benefits for losing the use of both feet, he was able to walk without any assistance and was also able to walk while carrying large, heavy objects. During the investigation, the defendant was never observed using any form of assistive walking device outside of VA property. The loss to VA is $263,786.

Veteran Arrested for VA Compensation Fraud

A veteran was arrested for theft of Government funds. An OIG investigation resulted in the defendant being charged with fraudulently claiming a neurological disorder that allegedly led to the partial paralysis of her legs and left arm. The defendant claimed she could not walk for long distances, drive a vehicle, or provide basic care for herself. The investigation revealed that the defendant maintained a very physically active lifestyle, to include

running several miles a day, participating in daily vigorous exercise classes at her gym, and mowing her yard. The loss to VA is approximately $190,000.

Veteran and Family Members Indicted for Fraud

A veteran and his wife, along with his mother and father, were indicted for health care fraud, wire fraud, false statements, and principals. An OIG investigation resulted in charges that allege the veteran owned and operated various companies while claiming to be unemployed due to his SC disabilities. The veteran is also alleged to have been gainfully employed while in receipt of VA Individual Unemployability (IU) compensation benefits and to have obtained multiple Government set-aside contracts, most with VA, while being 100 percent SC for PTSD. The veteran's wife, mother, and father submitted fraudulent claims to VA on the veteran's behalf and were instrumental in the alleged fraud scheme. The veteran was also certified as a private pilot and as an aircraft mechanic dating back to 2013 and obtained both certifications only days after claiming to VA multiple alleged disabilities, including PTSD. The veteran failed to report those disabilities to the Federal Aviation Administration (FAA) and was subsequently indicted for falsification of FAA records. The loss to VA is approximately $175,000.

Veteran Arrested for Theft of Government Funds

An OIG investigation resulted in charges that allege the defendant fraudulently received compensation benefits for loss of the use of both feet. The defendant claimed to VA and OIG agents that he could not walk or even stand for more than a few seconds without falling. The defendant was observed and recorded walking, driving, climbing ladders, mowing his lawn, and engaging in other physical activities. The loss to VA is approximately $157,000.

Veteran Arrested for VA Compensation Fraud

A veteran was indicted and arrested for false statements on a loan application, theft of Government funds, wire fraud, and engaging in monetary transactions in property derived from specified unlawful activity. The veteran's girlfriend was indicted and arrested for false statements on a loan application. An OIG and U.S. Secret Service investigation resulted in charges that allege the defendants engaged in a scheme to defraud VA by having the veteran report to VA that he was unable to maintain substantially gainful employment as a result of his SC disabilities. The veteran subsequently received VA IU benefits from 2009 to 2017. The investigation further revealed that the veteran did maintain substantially gainful employment during most, if not all, of the time he was receiving IU benefits. The veteran's girlfriend admitted that she took steps to assist the veteran in concealing his employment from VA. It is also alleged that from approximately 2009 to 2015, while the veteran was a co-owner of a Virginia-based company, he stole over $300,000 that should have been used to pay contractors and vendors who worked on a Dallas, TX, construction project. The loss to VA is approximately $134,000.

Widow Sentenced for VA Compensation Fraud

The widow of a deceased veteran was sentenced to 18 months' incarceration, 12 months' probation, and was ordered to pay restitution of $242,844 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to inform VA and TRICARE that she remarried in 2004 and subsequently continued to receive benefits from both agencies until 2015. The loss to VA is $131,340.

Veteran Pleads Guilty to VA Pension Fraud

A veteran pled guilty to wire fraud. An OIG investigation revealed that the defendant was receiving a special VA pension since 2001 because of his claim that he was unable to walk. The investigation further revealed that the defendant was able to walk and drive with no apparent difficulty. In order to continue the fraud, the defendant attended a VA medical examination in a wheelchair and stated that he hadn't walked or driven in over 10 years. The loss to VA is in excess of $370,000.

Veteran Sentenced for VA Pension Fraud

A veteran was sentenced to 9 months' incarceration and was ordered to pay VA restitution of $205,534 after pleading guilty to theft of Government funds and Social Security fraud. A VA OIG and SSA OIG investigation revealed that the defendant was issued a Social Security Number (SSN) in 1969, which he used to enlist in the military, and then in 1984 the defendant obtained a second SSN. In 2005 the defendant used his first SSN to apply for VA pension benefits claiming he was disabled and that he did not have any sources of income. However, from 2005 to 2012, the defendant worked under his second SSN and in October 2012 began receiving Social Security Disability benefits. The defendant failed to report any of his employment income to VA.

Veteran Sentenced for Conspiracy to Defraud the United States

A veteran was sentenced to 36 months' probation and was ordered to pay VA restitution of $70,123 after pleading guilty to conspiracy to defraud the United States. An OIG investigation revealed that from June 2009 to January 2017, the veteran collected $65,509 in VA "special monthly pension" benefits by falsely claiming that he was blind. Also, the veteran's wife was sentenced to 12 months' probation after pleading guilty to misprision of a felony. She assisted the veteran in appearing to be blind by guiding him throughout his VA appointments. The veteran also improperly received prosthetic devices valued at $4,614. The investigation revealed that the veteran was able to maintain a driver's license, drive, and perform other daily activities without assistance.

Veteran Sentenced for "Stolen Valor"

A veteran was sentenced to 51 months' incarceration and ordered to pay VA restitution of $2,289 after pleading guilty to unlawfully exhibiting a military discharge certificate, theft of Government funds, false statements, and attempt to obstruct an official proceeding. An OIG investigation revealed that the defendant submitted a false DD-214 to VA on multiple occasions claiming that he was a Navy Seal and had received Purple Heart and Bronze Star medals. The defendant also failed to disclose sources of income that would have eliminated his VA pension benefit.

Husband and Wife Indicted for Theft and Gross Neglect of a Corpse

A husband and wife were indicted for theft, gross neglect of a corpse, and failure to report the knowledge of a death. A veteran, who was not related to the defendants, resided at their residence for 6 years before he died in November 2016. The defendants failed to report the veteran's death to the local authorities and subsequently stole the veteran's VA and SSA benefits while the veteran's corpse decomposed inside their home.

Daughter-in-Law of Deceased Veteran Arrested for Larceny

The daughter-in-law of a deceased veteran was arrested for larceny by conversion. An OIG investigation resulted in the defendant being charged with allegedly stealing VA benefits that were direct deposited after the veteran's death. The loss to VA is $191,119.

Sons of Deceased VA Beneficiaries Sentenced for Theft of Government Funds

The son of a deceased VA beneficiary was sentenced to 2 years' probation, 6 months' home confinement, and 30 hours' community service after pleading guilty to theft of Government funds. The defendant previously paid full restitution of $188,406 to VA. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into his deceased mother's bank account after her death in June 2003.

In a separate case, the son of a deceased VA beneficiary was sentenced to 3 years' probation and was ordered to pay VA restitution of $126,821 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in November 2004.

In another case, the son of a deceased VA beneficiary was sentenced to 2 years' probation and was ordered to pay a $3,000 fine and $108,690 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited into his deceased mother's account after her death in June 2009. The defendant stole most of the funds by forging his deceased mother's signature on personal checks.

In addition, the son of another deceased VA beneficiary was sentenced to 24 months' probation and was ordered to pay VA restitution of $87,445 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in October 2008.

Daughters of Deceased Beneficiaries Sentenced for Theft of Government Funds

The daughter of a deceased VA and SSA beneficiary was sentenced to 5 years' probation and was ordered to pay VA $262,163 and SSA $247,617 in restitution after pleading guilty to theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated VA and SSA benefit checks that were issued after her mother's death in October 1988.

In a separate case, the daughter of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay VA $194,807 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in January 1998.

In another case, the daughter of a deceased VA beneficiary was sentenced to 3 years' probation and was ordered to pay VA restitution of $179,466 after pleading guilty to theft of Government funds. A VA OIG and Treasury OIG investigation revealed that the defendant stole DIC benefits that were direct-deposited after her mother's death in July 1999. The defendant admitted to forging VA documents and using the VA funds for personal expenses.

In addition, the daughter of another deceased VA beneficiary was sentenced to 4 months' incarceration, 4 months' home confinement, and 5 years' probation and was ordered to pay VA restitution of $147,557 after pleading guilty to theft of Government funds. An OIG and FBI joint effort revealed that the defendant stole, endorsed, and negotiated VA benefit checks issued after her mother's death in August 1997. The defendant used the funds for personal expenses.

Also, the daughter of a deceased VA beneficiary was sentenced to 15 months' incarceration and was ordered to pay VA $99,006 in restitution after pleading guilty to 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 December 2009. The defendant submitted falsified documents and made phone calls to VA pretending to be her deceased mother in order to continue receiving VA benefit payments. The defendant also changed mailing addresses and bank accounts multiple times in order to avoid detection.

Finally, the daughter of a deceased VA beneficiary was sentenced to 3 years' probation after being found guilty at trial of theft of Government funds. The defendant made full restitution of $101,459 prior to sentencing. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death.

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 approximately $182,000 in VA benefits that were direct deposited

after his mother's death in December 1995. The defendant wrote checks payable to himself and forged his deceased mother's signature.

Assisted Living Facility Owner Sentenced for Theft of Government Funds

The president and owner of an assisted living facility was sentenced to 3 days' incarceration, 3 years' probation, and was ordered to pay $145,176 in restitution. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks, through the facility's business account, that were issued after a veteran's death in March 2009.

Granddaughters of Deceased VA Beneficiaries Sentenced for Theft of Government Funds

The granddaughter of a deceased VA beneficiary was sentenced to 6 months' home confinement, 5 years' probation, and was ordered to pay VA restitution of $91,373 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her grandmother's death in November 2009. The loss to VA is $118,717.

The granddaughter of another deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay VA restitution of $103,318 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her grandmother's death in January 2010 and then used the funds for personal use.

Son of Deceased VA Beneficiary Sentenced for Making a False Statement

The son of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay VA restitution of $97,660 after pleading guilty to making a false statement. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in May 2008. The defendant also admitted to forging and submitting a VA marital status questionnaire in order to make it appear that his mother was still alive.

Son-in-Law of Deceased VA Beneficiary Charged With Theft of Government Funds

The son-in-law of a deceased VA beneficiary was charged with theft of Government funds. An OIG investigation resulted in the defendant being charged with receiving, forging, and negotiating approximately 67 VA benefit checks after his mother-in-law's death in January 2006. The loss to VA is $91,500.

Wife of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The wife of a deceased VA beneficiary was sentenced to 3 years' probation and was ordered to pay $81,493 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA pension benefits that were direct deposited into a joint account after her husband's death in April 2007. The defendant knew she was not entitled to the benefits and used the funds for personal expenses.

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

The niece of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole $118,672 in VA funds after her aunt's death. The defendant also forged VA marital status questionnaires to ensure the continuation of VA payments.

Nephew of a Deceased VA Beneficiary Arrested for Theft of Government Funds and Social Security Fraud

The nephew of a deceased VA beneficiary was arrested for theft of Government funds and Social Security fraud by concealment. A VA OIG, SSA OIG, and Office of Personnel Management (OPM) OIG investigation resulted in the defendant being charged with stealing his aunt's VA, SSA, and OPM benefits that were direct deposited to a joint account after her death. The loss to the Government was $363,924, to include a loss to VA of $209,274.

Other Investigations

OI investigates a wide array of criminal offenses in addition to those listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography; 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 56 cases and made 5 arrests. These investigations resulted in over $20.2 million in court ordered payment of fines, restitution, penalties, and civil judgments; over $2.5 million in savings, efficiencies, cost avoidance; and nearly $20,000 in dollar recoveries.

Mortgage Company Agrees To Pay Federal Government

A mortgage company and its subsidiaries have agreed to pay the United States $74,453,802 to resolve allegations that they violated the P.L. 97-258, *False Claims Act* by knowingly originating and underwriting mortgage loans insured, guaranteed, and purchased by Government programs that did not meet applicable requirements. A VA OIG, Housing and Urban Development (HUD) OIG, and Federal Housing Administration (FHA) OIG investigation resolved allegations that the mortgage company failed to comply with certain VA, Fannie Mae, Freddie Mac, and FHA origination, underwriting, and quality control requirements. The VA portion of the settlement is $6,464,000.

Trucking School Coordinator Pleads Guilty to Wire Fraud

The former student coordinator of a trucking school pled guilty to wire fraud for his part in enrolling at least 108 veterans who allegedly never attended or received training at the school. As part of the plea agreement, the defendant agreed to pay up to $4.3 million in criminal restitution. A nationwide OIG, FBI, and Department of Justice OIG investigation resulted in charges that alleged between 2011 and 2015 the defendant, the school's president, the school's former vice president, and veterans conspired to defraud VA of over $4.3 million. The involved veterans included Federal and State correctional officers, Federal employees, and a local police officer. The school received inflated, unearned tuition and fees ranging from between $5,000 and $13,000 per course, while the veterans received basic housing allowance and a books and supplies stipend totaling over $2,000 per month.

Defendants Plead Guilty to Health Care Fraud

As part of a National Health Care Fraud Takedown, two defendants pled guilty to Federal health care fraud violations. As part of the plea agreement, one defendant agreed to pay restitution of at least $34.2 million. A multi-agency investigation revealed that the defendants caused the mailing of compounded medications to unsuspecting patients throughout the United States. The defendants then caused the submission of false billings to TRICARE, CHAMPVA, other Federal insurance programs, and private insurance companies in order to receive a reimbursement. The compounded medications were of questionable, if any, medical value and in most instances physicians who prescribed the compounded medication never met the patient. The defendants caused a loss to the U.S. Government of at least $62.9 million, to include a loss to VA of $208,274. The defendants were among hundreds of defendants charged nationwide in cases that allege false billings of approximately $1.3 billion.

Company Owner Sentenced for Conspiracy to Commit Mail Fraud

The owner of three companies, who contracted with various Government agencies, was sentenced to 60 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $1,176,168 after pleading guilty to 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 $48,953 VA contract, through FedBid.com. The companies then arranged for victim-vendors to provide the goods to the Government. To induce the victim-vendors to provide the goods and extend credit to the companies, the

defendant made fraudulent representations regarding his companies' creditworthiness and association with the Government. As part of the conspiracy, the defendant falsely promised to pay the victim-vendors for the goods and then subsequently failed to pay more than 40 victim-vendors over $1 million for goods provided to various Government agencies.

Seven Defendants Sentenced for Health Care Fraud

Seven defendants pled guilty to various health care fraud related charges and were subsequently sentenced to a combined 295 months' incarceration, 168 months' supervised release, and were ordered to forfeit $66,704,316 in proceeds obtained by defrauding multiple Federal Government and private insurance programs. A VA OIG, Defense Criminal Investigative Service, Office of Personnel Management, FDA, Army Criminal Investigation Command, and USPS OIG investigation revealed that the defendants submitted false claims to the DoD TRICARE health care program, CHAMPVA, other Federal insurance programs, and private insurance companies for compounded prescriptions. The compounded prescriptions were fraudulently dispensed without a physician's authorization; were never dispensed; were returned; or were dispensed to TRICARE, CHAMPVA, and privately insured recipients without FDA approval.

Veteran Charged with Wire Fraud Conspiracy

An OIG and IRS-CID investigation resulted in charges that allege the defendant and the owners of a welding school provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. Allegedly, the enrolled veterans rarely, if ever, received instruction from employees at the school. The defendant, who enrolled in three courses at the school, admitted that he did not receive any instruction during his period of enrollment and instead visited the school only to sign-in to create the appearance that he was attending the required number of hours. Also, the school owners are alleged to have hired the defendant to recruit additional veteran students. The defendant stated that he recruited approximately 20 veterans to enroll at the school and informed those veterans that they would not have to attend classes but could still receive their housing allowance. To date, VA has paid more than $1.4 million to the school in tuition and more than $1.1 million to veteran enrollees in housing allowances, books, and supply stipends.

Computer School Owner Pleads Guilty to Theft of Government Funds

The owner and operator of a computer school pled guilty to theft of Government funds. As part of the plea agreement, the defendant agreed to pay $2.83 million in criminal restitution, including $1.27 million in forfeiture. A VA OIG and DOL OIG investigation revealed that between April 2013 and June 2014, the defendant logged onto the VA/DOL portal and enrolled approximately 182 veterans to attend her school using Veterans Retraining Assistance Program (VRAP) educational benefits. The vast majority of these veterans were either not eligible for VRAP and/or were not actually attending the classes. Additionally, the defendant certified the veterans for up to 12 months for a class that was only approved for 14 weeks. The defendant also charged the veterans $750 per month to allow them to continue to collect monthly benefits.

Accountant Pleads Guilty to False Statements

The accountant for a Service-Disabled Veteran-Owned Small Business (SDVOSB) pled guilty to false statements after a multi-agency investigation revealed over $350 million in set-aside (Veteran-owned, minority-owned, woman-owned) construction contracts were fraudulently obtained. The investigation revealed that several subjects conspired in creating companies for the sole purpose of obtaining set-aside Government contracts, all while providing false information to VA and the Small Business Administration (SBA) in order to qualify for the contracts and concealing the fact that the companies were not controlled by veterans, service-disabled veterans, minorities, or women.

Two Defendants Plead Guilty to Conspiracy To Commit Wire Fraud

A multi-agency investigation revealed that the defendants were owners of and/or officers in multiple companies, all being classified and operated as small businesses. All companies were, at one point, operated under the SBA 8(a) program or the VA SDVOSB program. The investigation further revealed that beginning in February 2003 and continuing until October 2014, the defendants conspired with one another and other persons to defraud the United States and its agencies of more than $140 million in contract payments from 8(a) and SDVOSB contracts for a profit of approximately $24 million. The VA contracts included P.L. 111-5, *American Recovery and Reinvestment Act* Funds and were worth approximately $7.9 million.

Veteran and Non-Veteran Indicted for SDVOSB Fraud

A veteran and a non-veteran business owner, as well as their respective companies, were indicted on multiple charges to include conspiracy, major fraud against the United States, wire fraud, and false statements. An OIG investigation resulted in charges that allege the defendants participated in a conspiracy to defraud the Government by forming a joint venture and falsely representing that the joint venture and another company qualified as a SDVOSB. The defendants fraudulently obtained approximately $11 million in VA funded SDVOSB set-aside construction contracts or task orders. Four separate Federal search warrants executed at various business locations yielded vital documents and information supporting the indictment.

Government Contractor Agrees To Pay VA

A Government contractor and its owners entered into a civil settlement agreement with the Government to pay $335,000 in response to allegations that they took advantage of Federal contracting opportunities reserved for SDVOSBs. A VA OIG and SBA OIG investigation revealed that the contractor structured its dealings with an SDVOSB so as to relegate it to the role of a "pass through." To further the scheme, the contractor submitted a bid to VA in the veteran's name, but after being awarded the contract as an SDVOSB, the contractor subcontracted all of the work to a third party. When paid, one of the contractor's employees, who was also a signatory on the SDVOSB's bank account, transferred all of the VA funds to the contractor's bank account.

Four Subjects Plead Guilty to Conspiracy To Commit Health Care Fraud

The defendants were involved in creating a fraud scheme in which Cockerell Dermatopathy billed TRICARE and CHAMPVA approximately $5 million for unnecessary lab testing. The overall scheme involved allegations of kickbacks to doctors and patients who received compound medication and lab testing through a compound pharmacy and Cockerell Dermatopathy. The estimated loss to VA is $547,000.

Home Health Care Provider Sentenced for Health Care Fraud and Conspiracy

The owner of a Northeast Ohio home health care provider was sentenced to 120 months' incarceration, and her son was sentenced to 87 months' incarceration after being convicted at trial of health care fraud and conspiracy to commit health care fraud. Both defendants were also ordered to pay $8.16 million in restitution, including $429,603 to VA. A former nurse manager was sentenced to 18 months' incarceration and a former billing clerk was sentenced to 8 months' home confinement after previously pleading guilty to conspiracy to commit health care fraud. The former nurse manager was also ordered to pay $1.13 million in restitution, including $250,072 to VA, and the billing clerk was ordered to pay $318,786 in restitution, including $250,072 to VA. A multi-agency health care fraud task force investigation revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information and stolen identities on every annual provider agreement submitted and approved by the Cleveland, OH, VAMC. Five defendants were originally charged, one of whom died and two who previously pled guilty.

VA Fee-Basis Physician Pleads Guilty to Health Care Fraud

A physician pleaded guilty to health care fraud and has agreed to pay VA restitution of $238,230. The defendant also entered into a civil settlement agreement with the Government and agreed to pay more than

$476,000 to resolve the Government's claims under P.L. 97-258, *False Claims Act*. A VA OIG, HHS OIG, and FBI investigation revealed that on more than 350 occasions between 2011 and 2015, the physician submitted documentation to VA claiming to have performed procedures that he had not actually performed.

Chiropractor Sentenced for Theft of Government Funds

A chiropractor was sentenced to 2 months' home detention and 5 years' probation and was ordered to pay VA their share of $39,155 in restitution, along with two other defendants, after pleading guilty to theft of Government funds. An OIG investigation revealed that a VA contractor subcontracted with a clinic to provide VA disability examinations for local veterans. The examinations were performed in violation of the primary contract with VA, which required that the examinations be conducted by a licensed and credentialed provider who had a clear and unrestricted license and was not excluded from participating in Federal health care programs. The investigation revealed that a total of 209 subcontractor examinations were submitted for 53 veterans by an unlicensed person using another doctor's name and license without permission.

Health Care Company Agrees to Reimburse VA

A contracted health care company agreed to reimburse VA $260,179 related to overcharging for MH care treatment visits. An OIG investigation revealed that the company overbilled VA by improperly coding veterans' care as a "vesting visit" when the care provided fell below the contractually defined level. The improper coding allowed the company to charge VA an increased monthly capitated rate. The company has further agreed to a continued review by VA of enrollment numbers at the affected facilities.

Former Insys Therapeutics Manager Pleads Guilty to Conspiracy to Commit Wire Fraud

A former Insys Therapeutics, Inc. manager pled guilty to conspiracy to commit wire fraud. A multi-agency investigation determined that Insys created a reimbursement center for the purpose of obtaining prior authorizations for Subsys, their fentanyl-based pain medication. The reimbursement center then used a variety of fraudulent reimbursement schemes to obtain payment authorization from insurers and Pharmacy Benefit Managers (PBMs). These schemes were used to defraud insurers and PBMs who were reluctant to approve payment for Subsys when it was prescribed off-label. The defendant was the manager for Insys' reimbursement services and directly supervised reimbursement center employees. CHAMPVA paid Insys approximately $3.31 million for Subsys.

Defendants Sentenced in Construction Bond Scheme

A defendant was sentenced to 10 years' incarceration and was ordered to pay restitution of $3.98 million. Another defendant was sentenced to 4 years' incarceration and was ordered to pay restitution of $3.98 million. Both defendants were found guilty at trial of major fraud against the United States. A VA OIG, HUD OIG, United States Postal Inspection Service, and North Carolina Department of Insurance investigation revealed that the defendants participated in a fraudulent interstate construction bond scheme involving multiple federal agencies that had been occurring for several years. The total dollar amount of the bonds written during the fraudulent scheme was calculated at $113 million. Seven defendants either pled guilty or were found guilty at trial as a result of this investigation.

Defendants Sentenced for Workers' Compensation Fraud

Two defendants were sentenced after being found guilty at trial of conspiracy, health care fraud, wire fraud, and money laundering relating to their ownership and operation of multiple workers' compensation clinics throughout the United States. The first defendant was sentenced to 25 years' incarceration, 3 years' probation, and was ordered to pay restitution of $13,365,525. The second defendant was sentenced to 10 years' incarceration, 3 years' probation, and was ordered to pay restitution of $14,537,548. A third defendant is still awaiting sentencing. A multi-agency investigation resulted in the defendants being charged with conspiring since January 2011 to unlawfully bill multiple Federal agencies for false and fraudulent claims and for services

not rendered. The investigation also revealed that in July 2013, shortly after the execution of a Federal search warrant on the business, two of the defendants laundered $700,000 in an attempt to conceal the money's location from law enforcement.

Health Care Company President and Company Sentenced for Defrauding VA

The former president of a health care company was sentenced to 2 years' probation and the company was sentenced to 5 years' probation, with both being responsible for paying VA restitution of over $200,000 and a $500,000 fine. The company was also required to create an ethics and compliance program. An OIG and FDA investigation revealed that the defendants produced bariatric beds, a Class II medical device, at unregistered facilities for sale and lease to VA. As a result of receiving the defective and unusable bariatric beds, a new VA nursing facility was unable to open on time.

New England Compounding Center Owner Sentenced in Connection With 2012 Nationwide Fungal Meningitis Outbreak

The owner and head pharmacist of the New England Compounding Center (NECC) was sentenced to 9 years' incarceration, 3 years' probation, and was assessed a penalty of $5,700. The amount of forfeiture and restitution will be determined at a later date. The defendant was previously convicted at trial of racketeering, racketeering conspiracy, mail fraud, and introduction of misbranded drugs into interstate commerce with the intent to defraud and mislead in connection with a 2012 nationwide fungal meningitis outbreak. An OIG, FDA Office of Criminal Investigations, FBI, Defense Criminal Investigative Service, and United States Postal Inspection Service investigation revealed that the defendant directed and authorized the shipping of contaminated methylprednisolone acetate to NECC customers nationwide. In addition, the defendant authorized the shipping of drugs before test results confirming their sterility were returned, never notified customers of nonsterile results, and shipped compounded drugs with expired ingredients. Furthermore, certain batches of drugs were manufactured, in part, by an unlicensed pharmacy technician at NECC. The defendant also repeatedly took steps to shield NECC's operations from regulatory oversight by the FDA by claiming to be a pharmacy dispensing drugs pursuant to valid, patient-specific prescriptions. The investigation further revealed that VA purchased approximately $500,000 worth of various pharmaceutical products from NECC. The Government contended that all products compounded and sold to NECC customers, including VA, were made in an unsafe manner and under unsanitary conditions.

Former Kansas City, Missouri, Physician Sentenced for Health Care Fraud

A former Kansas City, MO, physician was sentenced to 15 months' incarceration, 3 years' probation, and was ordered to pay $39,155 in restitution after pleading guilty to health care fraud. An OIG investigation revealed that the former physician, who lost his license due to his involvement in an earlier fraud scheme, was employed as a medical consultant at a Kansas City, MO, clinic that was subcontracted by a VA contractor to provide VA disability examinations for local veterans. The examinations were performed in violation of the prime contractor's contract with VA, which required that the examinations be conducted by a licensed and credentialed provider, who has a clear and unrestricted license, and who has not been excluded from participating in Federal health care programs. The investigation revealed that a total of 209 examinations were submitted for 53 veterans utilizing another doctor's name and license without his permission.

Jamaican Nationals Arrested for Wire Fraud and Conspiracy to Commit Wire Fraud

To date, eight subjects have been arrested and seven have been sentenced to a combined 336 months' incarceration, 216 months' of supervised release, and 36 months' probation. The seven who were sentenced have also been ordered to pay $2,164,783 in restitution. Two additional subjects have been indicted and are currently fugitives. An investigation conducted by VA OIG, Homeland Security Investigations, United States Postal

Inspection Service, and SSA OIG in the Miami, FL, area resulted in the discovery of some of the defendants in Jamaica redirecting the monthly benefit payments of veterans and Social Security recipients. Subsequently, pre-paid credit cards containing the benefit payments were mailed to the other defendants in the Miami, FL, area where the funds were removed, a portion kept, and the remainder sent back to Jamaica. This Florida-based investigation began as a proactive, nationwide effort to combat the growing problem of veterans' benefits redirections. It is estimated that approximately $7 million in VA benefits have been redirected nationwide since 2015.

Veteran Sentenced for Child Pornography

A veteran was sentenced to 9 years' incarceration after pleading guilty to illegal use of a minor in nudity-oriented material or performance, pandering sexually oriented material involving a minor, and possessing criminal tools, with a forfeiture specification. An OIG and Ohio Adult Parole Authority investigation revealed that the defendant, while on post-release control through the state of Ohio for a previous rape conviction, viewed child pornography in the computer lab at the Cleveland, OH, VAMC domiciliary as well as on personal electronic devices.

Veteran Indicted for Access with Intent to View Child Pornography

An OIG investigation resulted in charges that allege the defendant, while residing as an inpatient at the Hampton, VA, VAMC domiciliary, used a computer belonging to his roommate to access and download child pornography.

Veteran Residing at VA CLC Arrested for Failure to Register as a Sex Offender

A veteran residing at The Big Spring, TX, VAMC CLC was arrested for failure to register as a sex offender. OIG, Homeland Security Investigations, and the Texas Department of Public Safety initiated this investigation on a tip from the National Center for Missing and Exploited Children. Allegations included that the defendant used a VA network to access a Google account containing child pornography. The defendant subsequently admitted to possessing and viewing child pornography. Additional Federal charges are pending based on the final number of images identified as a result of this investigation.

Veteran Sentenced for VA Home Loan Fraud

A veteran was sentenced to 3 years' probation and was ordered to pay $46,103 in restitution to HUD. A VA OIG and HUD OIG investigation revealed that the defendant obtained a $190,000 VA guaranteed home loan while he was receiving housing payments from a Section 8 tenant who occupied his home. This is a violation of VA's loan occupancy requirement. The defendant and his tenant conspired to conceal the defendant's true residency and submitted false certifications to the county housing authority.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 66 months' incarceration and was ordered to pay $85,000 in restitution after previously being convicted at trial of aggravated identity theft, access device fraud, conspiracy to commit identity theft, and conspiracy to commit access device fraud. A VA OIG and Federal Housing Finance Authority OIG investigation revealed that the defendant obtained the personally identifiable information (PII) of dozens of VA employees from a former VA employee. The defendant then used the PII of the VA employees and of Freddie Mac pension plan participants to run credit reports, to open credit accounts, to make fraudulent purchases at high-end retailers, and to pay for plastic surgery in Miami, FL.

Subject Indicted for Identity Theft and Larceny

A subject was arrested for identity theft and larceny. A VA OIG, SSA OIG, and County District Attorney's Office investigation resulted in charges that allege that the defendant used the identity of a veteran to receive medical care and medications from the New York, NY, VAMC. The defendant also applied for VA compensation and

pension benefits using the veteran's identity, but was denied. The defendant did obtain SSA and local welfare benefits using the veteran's identifiers. The loss to VA is $26,578.

Non-Veteran Sentenced for Identity Theft

A non-veteran was sentenced to 39 months' incarceration, 3 years' supervised release, and was ordered to pay VA restitution of $68,655 and attend MH and sex offender treatment. An OIG investigation revealed that following release from prison, the defendant assumed the identity of a veteran, failed to register as a sex offender, and subsequently began receiving medical treatment and other benefits from the West Palm Beach, FL, VAMC. The defendant has multiple prior convictions for various sexual assaults.

Non-Veterans Arrested for Identity Theft Charges

Two Tampa, FL, non-veterans were arrested for theft of Government property, access device fraud, aggravated identity theft, and conspiracy. An OIG, IRS CID, and Tampa Police Department investigation revealed that the defendants illegally obtained numerous VAMC records, used at least 20 veterans' PII from the records, filed fraudulent tax returns, and opened lines of credit in the victims' names. The defendants obtained approximately $561,000 from the fraud.

Non-Veteran Arrested for Identity Theft

A non-veteran was arrested for false statements. An OIG investigation resulted in charges that the defendant allegedly assumed the identity of a 100 percent service-connected veteran, who was his estranged half-brother, and began receiving medical treatment and narcotics from the Cincinnati, OH, VAMC. The defendant also used the assumed identity to obtain narcotics from other local hospitals in the southern OH area. The loss to VA is $20,669.

Undocumented Immigrant Sentenced for Identity Theft

An undocumented immigrant was sentenced to 60 days' incarceration, 48 months' probation, and was ordered to pay restitution of $35,662 after pleading guilty to forgery and taking the identity of another. A VA OIG and SSA OIG investigation revealed that the defendant stole the identity of a deceased veteran approximately 20 years ago and used the identity to obtain SSA benefits in 2012 and VA benefits in 2016.

Non-Veteran Sentenced for Robbery

A non-veteran was sentenced to 84 months' incarceration and 5 years' supervised probation after pleading guilty to robbery of a post office located at the Perry Point, MD, VAMC. An OIG and United States Postal Inspection Service investigation revealed that the defendant and a second subject stole U.S. currency and more than 60 blank postal money orders during the robbery. The money orders were subsequently negotiated for $19,340.

Assaults and Threats Made Against VA Employees

During this reporting period, OI initiated 19 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 13 individuals. Investigations resulted in nearly $1,700 in court ordered payment of fines, restitution, penalties, and civil judgments and over $118,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Arrested for Assault of a Stockton, California, VA Community Based Outpatient Clinic Employee

An OIG investigation resulted in charges that allege the defendant, after being asked to leave the Stockton clinic where he exhibited disruptive behavior, returned with a bicycle chain and lock wrapped around his hand and shoved a clinic employee against a door.

Veteran Sentenced for Making Threats to Albany, New York, VAMC Staff

A veteran was sentenced to 1 year of incarceration (time served) and 3 years' supervised release after pleading guilty to transmitting in interstate commerce a communication that threatens to injure another. An OIG investigation revealed that the defendant threatened to shoot and kill people at the Albany, NY, VAMC that resulted in a facility-wide lockdown. In a separate and unrelated case, the defendant was previously charged and sentenced in 2015 for making similar threats regarding another VAMC.

Veteran Sentenced After Making Threats to Long Beach, California, VAMC Staff

A veteran was sentenced to 460 days' incarceration and 3 years' probation after pleading guilty to obtaining an assault rifle as a prohibited person. An OIG investigation revealed that the defendant threatened to kill his VA physician, the physician's family, and three VA Police Service officers at the Long Beach, CA, VAMC. The defendant made the threats because he wanted specific medications.

Veteran Arrested for Emailing Threats to Palo Alto, California, VAMC Employees

A veteran was arrested after emailing threats to several Palo Alto, CA, VAMC employees. An OIG investigation revealed that the defendant was a member of the U.S. Special Operations Command and served on a Navy SEAL team. The defendant has a history of making threats to VA employees.

Veteran Arrested for Harassment

A veteran was arrested on a bench warrant for failure to comply with his sentencing after a harassment conviction. An OIG, VA Police Service, and U.S. Capitol Police investigation revealed that the defendant made thousands of repetitive, harassing, and vulgar phone calls to various VA offices throughout the country since 2014, to include several VARO directors and the Office of the VA Secretary. The veteran also made similar calls to several Congressional offices. The veteran was also issued two additional citations by the VA Police Service for disorderly conduct for repeated harassing phone calls to the local VA Suicide Prevention Coordinator and the VCL. These repeated calls, over 200 on one day, severely hampered the VCL's ability to assist veterans who were actually in need of assistance. The defendant is also pending similar charges in State court. The defendant was arrested by OIG and convicted on similar harassment charges in 2011.

Veteran Pleads Guilty To Creating a Disturbance at Jacksonville, Florida, Outpatient Clinic

An OIG investigation revealed that the defendant entered the Jacksonville, FL, outpatient clinic and created a disturbance that obstructed the performance of a VA patient advocate. Afterwards, the defendant called the VA VCL and threatened to shoot and kill the VA patient advocate as well as his VA physician. During the defendant's arrest, a pistol was recovered from his person, and two additional firearms were recovered from his apartment.

Veteran Sentenced for Making Threats to VA Physician

A veteran was sentenced to 6 months' home detention, 4 years' probation, 100 hours' community service, and was ordered to participate in a drug/MH treatment program. An OIG investigation revealed that the defendant threatened to kill his VA physician due to the doctor's refusal to prescribe additional Oxycodone. As a result of the veteran's threats, a VA CBOC was temporarily placed on "lock down," adversely impacting patient care.

Former St. Louis, Missouri, VAMC Employee Arrested for Interstate Violation of a Protection Order

An OIG investigation resulted in charges that allege the defendant made threats to another VA employee via text message stating that she was going to kill people at the St. Louis, MO, VAMC. The recipient of the threat subsequently obtained a protection order against the defendant. The investigation revealed that the defendant also later traveled interstate to engage in conduct that was against the protection order.

Fugitive Felons Arrested with OIG Assistance

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 72.3 million felony warrants have been received from the National Crime Information Center and participating states resulting in 84,519 investigative leads being referred to law enforcement agencies. Over 2,595 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OI has identified $1.39 billion in estimated overpayments with an estimated cost avoidance of $1.75 billion. During this reporting period, OI opened three and closed four fugitive felon investigations, identifying $115 million in estimated overpayments. OI investigative work resulted in the arrest of 1 fugitive felon and at least 14 additional arrests were made by other law enforcement agencies.

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 Congress and the Department. During this reporting period, OIG opened 10 administrative investigations and closed 12 administrative investigations. The work resulted in the issuance of four reports. These reports are listed in Appendix A.

The Administrative Investigations Division also 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 six advisory memorandums.

Misuse of Official Time and Failure to Properly Supervise, Oklahoma City VA HCS

OIG's Administrative Investigations Division found that a former employee of the Oklahoma City VA HCS worked at Johns Hopkins University (JHU) during his VA duty hours, and a former Associate Chief of Staff for Research improperly approved the former employee's pay for the time he was absent from VA. Between April 2014 and September 2016, the former employee teleworked without authorization for 157 hours, collected dual compensation from VA and JHU for 1,374 hours, and misused his official time when he received VA pay for 441 hours while traveling and giving lectures during his VA duty hours that were not VA sponsored. The former Associate Chief of Staff failed in his supervisory responsibilities by not being aware of the former employee's attendance, yet certifying the employee's subsidiary timecards and VA's electronic time and attendance system for hours the employee was not present at the facility and/or did not work. The dual compensation matter was referred to the Western District of Oklahoma United States Attorney's Office. They reviewed the evidence, declined to prosecute, and advised OIG to proceed with it administratively. The former employee's use of unauthorized telework, misuse of official time, dual compensation, and falsely claimed hours created a cost to VA of $102,542.

Conflicting Interests and Misuse of Government Equipment, Overton Brooks VAMC, Shreveport, Louisiana

OIG's Administrative Investigations Division found that an Assistant Chief and an Operations Manager engaged in conflicting interests when they received wages, salaries, and/or profits from educational institutions that operated for profit and misused Government equipment in support of their outside employment activities. OIG did not substantiate that a Supervisory Medical Support Assistant and the Operations Manager improperly accumulated compensatory time due to the Chief of MH Services failing to properly manage them or that a Staff Psychologist improperly accumulated overtime.

Failure to Follow VA Policy, VAMC, Washington, DC

OIG's Administrative Investigations Division found that Mr. Brian Hawkins, Director, VAMC, Washington, DC, violated VA policy when he sent VA sensitive personnel information from his VA-assigned email account to his and his spouse's private email accounts. Mr. Hawkins confirmed that he used his VA-assigned email account to send VA sensitive information to his spouse on a number of occasions. When issued a subpoena instructing him to produce these communications, he refused to produce those sent to his spouse's private email account claiming they were protected under spousal privilege. VA policy states that VA email is for official use only, and there is no expectation of privacy or confidentiality. It does not contain any communication exclusions, privileged or otherwise. OIG also found that Mr. Hawkins convened an Administrative Investigation Board to investigate improper monetary awards and other allegations listed in a complaint letter sent to VA's Secretary. OIG received a subsequent allegation that Mr. Hawkins attempted to impede that Board, and after OIG communicated with VA Officials and OGC, the convening authority for the Board was transferred to the VA Capital Health Care Network Director.

Improper Approval and Use of Leave, VAMC, Chillicothe, Ohio

OIG's Administrative Investigations Division found that Ms. Wendy Hepker, Director, VAMC, Chillicothe, OH, violated VA policy when she allowed Dr. Suzanne Johnston to go on extended leave without pay (LWOP) knowing that Dr. Johnston was not going to return to duty. While Ms. Hepker approved the extended LWOP, it did not absolve Dr. Deborah Meesig, VAMC Chief of Staff, of the responsibility for recommending the unwarranted LWOP in the first instance. Ms. Hepker's approval of Dr. Johnston's extended LWOP was intended for Dr. Johnston's personal benefit to allow her to relocate and to reach her minimum retirement age so that she could retire from VA. In total, Dr. Johnston was absent from the VAMC for 438 calendar days prior to her retirement. In addition, Dr. Johnston misused 60 days of sick leave when she used it for unauthorized purposes during her extended absence. She used her annual leave and sick leave in combination with LWOP to avoid losing service credit and to maintain her Federal health insurance while on extended absence. VA's leave policy states that sick leave is used when the employee is incapacitated for the performance of their duties due to personal illness, disease, injury; for necessary medical, dental or optical examination or treatment; or when caring for a sick family member of the employee. For the first 6 months of Dr. Johnston's absence, Ms. Hepker was unaware that she used sick leave in combination with LWOP, but once she learned of it, she took no action to stop it and approved her to use the balance of her sick leave. Dr. Johnston's misuse of sick leave cost VA more than $47,600.

Closed Senior Government Employee Investigations Not Disclosed to the Public

OIG often reviews allegations and conducts administrative and criminal investigations concerning high-ranking senior officials. However, if allegations in these investigations are unsubstantiated, or if investigations are referred to another office such as Office of Special Counsel, OIG may close these investigations and take no action. Below is a list detailing those investigations of senior Government officials that were closed and not disclosed to the public during the reporting period.

Martinsburg, West Virginia VAMC Chief of Staff Misconduct

A joint investigation with VA Police Service determined that between September 8, 2016 and March 27, 2017, the Chief of Staff at the Martinsburg VAMC removed 26,600 micro grams of Fentanyl from the facility's Omnicell dispensers. Of this total amount, a discrepancy of 5,225 micro grams/140 milliliters could not be accounted for. The Chief of Staff's VA employment was terminated effective June 1, 2017, and a Federal grand jury returned an indictment that charged him with 15 felony counts of Acquiring Fentanyl by Misrepresentation, Fraud, Deception, and Subterfuge, in violation of Title 21, U.S.C. § 843(a)(3) and (d). Judicial proceedings are ongoing.

Washington, DC VAMC Assistant Director Misconduct

OIG investigated allegations of abuse of power and retaliation as well as allegations of a hostile work environment; racism; and fraud, waste, and abuse by the Assistant Director of the Washington, DC VAMC. The investigation did not disclose any evidence of criminal conduct, and this matter was not referred to the Department of Justice.

Washington, DC VAMC Former Acting Associate Director Misconduct

OIG investigated allegations of contract fraud against the former Acting Associate Director of the Washington, DC VAMC. The investigation determined the subject was involved with several Administrative Investigative Board investigations involving unauthorized commitments while employed with VA. These unauthorized commitments were addressed via VA procedures and policies. The subject resigned their employment with VA in July 2017. Based on the disciplinary actions taken by VA, lack of identifiable criminal intent, and the subject's resignation, no further investigation was conducted regarding the aforementioned allegation of misconduct. This case was not referred to the Department of Justice.

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.

Human Resources and Operations Division

The HR and 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 HR 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 20,204 contacts. Each contact to the Hotline is reviewed initially by OIG staff. Of these contacts, 919 became external Hotline cases, while an additional 736 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 1,021 external cases, substantiating allegations 35 percent of the time. External Hotline cases also resulted in 760 administrative sanctions and corrective actions and $1.5 million in monetary benefits. In addition, the Hotline responded to more than 665 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.

Patient Abuse at the Richmond VAMC

A complainant alleged that nursing staff in the poly-trauma unit of the Richmond VAMC were abusive to patients on the ward. The facility reviewed the complaint and found that in one instance staff improperly used a gait belt on a patient when the seat belt on a wheel chair was discovered to be broken. The broken belt was replaced soon after the incident and within two weeks the staff was retrained on the proper use of gait belts. The facility also substantiated that a member of the staff caused bruising and bleeding to a patient's hand when he was being transferred out of his bed against his will. The facility is working with the Labor Relations Management Office on appropriate discipline for the employee.

Bat Infestation at the Dwight D. Eisenhower VAMC

A provider at the Dwight D. Eisenhower VAMC, Leavenworth, Kansas, reported that for the past two years there had been bats on the surgical floor, to include the recovery room, bathroom, scrub sink, and sterile instrument room, an area within the sterile OR environment. Upon review, the facility confirmed the allegations and took immediate steps to remedy the problem.

Unpaid Fee-Basis Bills

A Florida health care provider reported that the Gainesville VAMC had 100 non-fee basis claims, totaling $350,000, which had not been paid. Upon review the VHA Office of Community Care (VHA CC) confirmed that some of the claims had been improperly rejected while others had been denied because of errors by either or both the facility and provider. As a result, the VHA CC re-opened incorrectly rejected claims and processed them for payment while it requested corrected information from the provider on others.

DIC Fraud

The widow of a deceased veteran was reported to be drawing DIC benefits since 1998 despite having remarried. The Milwaukee VARO notified the widow of the allegation and provided a 60-day window in which to respond. Based on the information received, the VARO terminated the benefit effective back to March 1, 2008, which was the date of the widow's remarriage. They also created an overpayment of $132,730.

Care Issues at the Hampton VAMC CLC

An anonymous complainant reported numerous problems at the Hampton CLC. The problems were in a number of areas and related to staffing, patient care, and equipment availability/maintenance. Upon review, the facility substantiated or partially substantiated all 12 of the specific allegations. This resulted in 18 corrective actions, a comprehensive corrective action plan, and ongoing quarterly CLC improvement meetings.

Office of Contract Review

The Office of Contract Review (OCR) operates to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts for the Office of Acquisitions, Logistics, and Construction (OALC) and VHA. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 65 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. Fifty-six preaward reviews identified approximately $5.7 billion in potential cost savings during this reporting period. A single preaward report accounted for $5.3 billion of the $5.7 billion in potential cost savings. This unusually large and significant recommended cost savings related to a proposal to supply drugs used to treat chronic hepatitis C infection. Our recommendation was based on our determination that the manufacturer was offering a lower price to another customer in the commercial market. OIG recently learned that VA contracting officials have awarded a contract for the supply of the hepatitis C drugs, but did not achieve or sustain the potential savings recommended by OCR. While the manufacturer is voluntarily providing a temporary price reduction to VA, which was cited by the CO as a factor in the award, there is no guarantee or contractual obligation for the manufacture to continue offering the temporary price reduction to VA. Therefore, there is no basis to predict how long the voluntary price reduction will be offered.

In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included fifteen health care provider proposals, accounting for approximately $29 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2016–March 31, 2017	39	$447,245,411
April 1–September 30, 2017	56	$5,663,306,895
Fiscal Year	95	$6,110,552,306

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 $14 million, including approximately $10.1 million related to the *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 nine postaward reviews performed, six involved voluntary disclosures. In three of the six 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, 2016–March 31, 2017	15	$25,804,128
April 1–September 30, 2017	9	$14,138,950
Fiscal Year	24	$39,943,078

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 did not review any claims.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2016–March 31, 2017	1	$9,894,257
April 1–September 30, 2017	0	$0
Fiscal Year	1	$9,894,257

Other Significant OIG Activities

Congressional Testimony

IG Testifies on VCL at House and Senate Hearings

The Honorable Michael J. Missal testified at two separate hearings on the OIG's recent work related to the operations of VA's VCL. Mr. Missal testified before the Committee on Veterans' Affairs, United States House of Representatives, at an April 4, 2017 hearing titled, "An Assessment of Ongoing Concerns at the Veterans Crisis Line." He also testified about the OIG's VCL work on April 27, 2017 before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, at a hearing on "Preventing Veteran Suicide." Mr. Missal's testimony emphasized that the tragedy of veteran suicide is one of the most significant issues facing VHA. In discussing OIG's two VCL reports—*Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York (Report No. 14-03540-123, February 11, 2016)* and *Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line (Report No. 16-03985-81, March 20, 2017)*—he highlighted numerous deficiencies related to governance, operations, and quality assurance. Mr. Missal emphasized that until VHA fully implements OIG's 23 recommendations, it will continue to face challenges meeting the VCL's critically important mission to provide "suicide prevention and crisis intervention services to veterans, service members, and their family members."

Deputy Assistant Inspector General for OAE Testifies Before the House Committee on Veterans Affairs Subcommittee on Oversight and Investigations on VA Financial Management

Mr. Nick Dahl, Deputy Assistant Inspector General for OAE, testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on the results of the audit of VA's consolidated financial statements and its progress on reducing improper payments. Mr. Dahl focused on the increase in material weaknesses from FY 2015 to FY 2016 and the elevation of a significant deficiency to a material weakness. The new material weaknesses relate to: (1) education benefits accrued liability and (2) actuarial estimates for compensation, pension, and burial benefits. The issue of the relationship between VA's CFO and VHA's CFO was elevated from a significant deficiency. The Subcommittee and the hearing witnesses also discussed the definition of improper payments and efforts to reduce them. Mr. Dahl was accompanied by Ms. Sue Schwendiman, Director, OIG Financial Audits Division.

OIG Senior Physician Testifies at House Field Hearing on VA's Telehealth Program

Thomas Wong, D.O., Senior Physician, OHI, testified at a field hearing in Traverse City, MI, before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, regarding OIG's work on VA's Home Telehealth (HT) program. He discussed OIG's recent healthcare inspection that reviewed allegations related to the documentation of patient enrollment in HT at the John D. Dingell VAMC. OIG's report, *Healthcare Inspection–Documentation of Patient Enrollment Concerns in Home Telehealth, John D. Dingell VAMC, Detroit, Michigan (Report No. 14-00750-143, February 9, 2017)*, found that more than 800 patients were not properly enrolled by program staff into HT; that program staff worked overtime in order to initiate these improper enrollments; and that without use of overtime to initiate these enrollments, the facility and Associate Chief of Nursing Service would not have surpassed the annual performance goal for HT encounters. Dr. Wong's testimony also highlighted opportunities for VA to expand the use of HT, particularly with respect to aiding providers, often in emergency room settings, who diagnose a patient with a very recent cerebral stroke.

Assistant Inspector General's Testimony Highlight Opportunities To Enhace VA'S Suicide Prevention Efforts

John D. Daigh, Jr., M.D., CPA testified before the U.S. Senate's Committee on Veterans' Affairs at a hearing on preventing veteran suicide. Dr. Daigh noted three possible strategies that may lessen the risk that a veteran will attempt or commit suicide. First, he discussed expanding suicide prevention efforts to those veterans who do not receive care through VHA. Second, he suggested enhancing prediction models beyond identifying who is at risk to also determine an actionable timeframe for when a veteran may be at highest risk to attempt suicide. Finally, he indicated that efforts could be increased to improve communication between care providers and family members of at-risk veterans. With regard to the third strategy, Dr. Daigh explained that OIG has reported on the deaths of many veterans with diverse MH issues that often revealed significant communication gaps between care providers and the veteran's family due to privacy and confidentiality laws. By devoting more effort to improving communication through the use of advance directives or other mechanisms, VA could determine if better information flow can reduce veterans' risk of suicide.

False Claims Act Settlements

The Counselor to the IG's Office did not have any financial recoveries related to P.L. 97-258, *False Claims Act* independent of OI for this reporting period.

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. During the last reporting period, the Department of Justice OIG completed a peer review of VA OIG's audit operations, focusing on the system of quality controls that were in effect for the year ending September 30, 2015. As result of this review, on December 30, 2016, VA OIG received a rating of pass.

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 286 proposals and made 16 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.

Attempts by the Establishment To Interfere with the Independence of OIG

P.L. 95-452, *Inspector General Act of 1978*, as amended, also requires OIG to report on instances where VA imposes budget constraints designed to limit OIG capabilities. Additionally, the Act requires OIG to report incidents where VA has resisted OIG oversight or delayed OIG access to information. During this reporting period, OIG reports no such instances.

Instances of Whistleblower Retaliation

P.L. 95-452, *Inspector General Act of 1978*, as amended, requires OIG to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires OIG to detail the consequences imposed by the Department to hold the official accountable. However, OIG's current practice is to forward allegations of whistleblower reprisal to the Office of Special Counsel. As a result, OIG cannot provide information regarding whistleblower retaliation at this time.

Agency Comments Not Received Within 60 Days

As part of the report production process, OIG transmits its draft report to VA for review, comment, and concurrence to implement recommendations. OIG's goal is to receive substantive feedback from the Department within 60 days of transmitting the draft report. During this reporting period, there were no instances of OIG receiving agency comments more than 60 days after draft report transmittal.

Management Decisions and Agency Comments for Reports Issued Before the Reporting Period

P.L. 95-452, *Inspector General Act of 1978*, as amended, mandates OIG to list reports issued before the commencement of the reporting period in which there was no management decision by the end of the current reporting period and where VA did not provide substantive comments within 60 days of receipt of the draft report. In both cases, there were no instances to report.

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.

- Wessley Dumas, a Criminal Investigator in Little Rock, AR, was activated by the U.S. Army in May 2017.
- John Moore, a Program Specialist at OIG Headquarters, was activated by the U.S. Army National Guard in March 2013.
- Ricardo Wallace-Jimenez, a Criminal Investigator in Spokane, WA, returned from active duty from the U.S. Army National Guard in May 2017.
- Dana Epperson, a Criminal Investigator in Seattle, WA, returned from duty from the U.S. Army in May 2017 and was reactivated in July 2017.

2017 Council of the Inspectors General for Integrity and Efficiency Award Recipients

Every year, the Council of the Inspectors General on Integrity and Efficiency (CIGIE) presents awards for outstanding work in the IG community. While the work of all OIGs provides immense value to their agencies, the CIGIE awards offer an opportunity to recognize some of the very best work of IGs as determined by their peers. For FY 2017, VA OIG won eight awards across several categories. Our award winners are the following:

- Award for Excellence, Evaluations – Review of Claims-Related Documents Pending Destruction at VA Regional Offices Team
- Award for Excellence, Evaluations – Review of VBA's Special Monthly Compensation Housebound Benefits Team
- Award for Excellence, Evaluations – Drug Pricing Compliance Team
- Award for Excellence, Audit – Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6 Team
- Award for Excellence, Audit – Audit of VBA's Post 9/11 G.I. Bill Tuition and Fee Payments Team
- Award for Excellence, Multiple Disciplines – Review of Alleged Consult Mismanagement at the Phoenix VA HCS Team
- Award for Excellence, Multiple Disciplines – Evaluation of the VHA VCL Team
- Award for Excellence, Administrative Support – Process Improvement Enhancements to Improve OIG Hotline Coordination and Collaboration Team

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	
4/6/2017 16-00376-133	Review of Unauthorized System Interconnection at the VA Regional Office in Wichita, Kansas			
5/15/2017 16-04416-231	Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2016			
5/24/2017 15-05235-200	Review of Alleged Removal of Workload Controls at the VARO in San Juan, PR			
6/1/2017 16-00327-209	Review of Alleged Mismanagement of VA's Human Resources and Administration Contract Funds	$3,700,000	$3,700,000	
6/5/2017 15-01080-208	Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities			$17,200,000
6/5/2017 15-04365-328	Review of Alleged Mismanagement of VA's Personal Identity Verification Processes			
6/7/2017 15-04351-188	Review of Alleged Inappropriate Contract Actions Related to VA's Lease of a Digital Imaging Network-Picture Archival Communication System			
6/12/2017 15-03678-210	Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3			$457,000
6/21/2017 16-01949-248	VA's Federal Information Security Modernization Act Audit for Fiscal Year 2016			
6/27/2017 15-03357-180	Review of Alleged Mismanagement of VHA's Patient Transportation Service Contract for the Jesse Brown VAMC in Chicago, IL			

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	
6/27/2017 15-01217-249	Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia			$418,000
6/29/2017 15-02586-419	Review of Alleged Misuse of Resources by VHA's Strategic Investment Management, Business Architecture Division			
7/20/2017 16-02468-281	Audit of VHA's Alleged Inappropriate Scheduling of Electromyography Consults at the Memphis VA Medical Center			
8/8/2017 16-02454-250	Review of VA's Readiness To Implement the Digital Accountability and Transparency Act			
8/9/2017 15-02583-256	Review of Alleged Delay of Care and Scheduling Issues at the VAMC in West Palm Beach, FL			
8/9/2017 16-00589-264	Audit of VHA's Consolidated Patient Account Center Controls To Prevent Improper Billings for Service-Connected Conditions			
8/10/2017 16-01401-295	Review of Alleged Failure of the National Work Queue To Perform in Production			
8/14/2017 16-00355-296	Audit of the VHA's Health Care Enrollment Program at Medical Facilities			
8/17/2017 16-00597-279	Audit of VHA's Imaging Service Scheduling Practices in the South Texas Veterans Health Care System			
9/6/2017 15-05020-278	Review of Alleged Continued Misuse of VA Funds To Develop the Health Care Claims Processing System			
9/28/2017 16-02151-320	Review of Alleged Payment Issues at Kerrville VA Hospital Kerrville, Texas			

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	
9/29/2017 16-00753-338	Review of Alleged Use of Wrong VA Funds To Purchase IT Equipment			
9/29/2017 16-00838-348	Review of Alleged Adverse Effect on Patient Care Due to Removal of a Computer-Assisted Survey Instrument			
9/29/2017 15-04929-351	Audit of Purchase Card Use To Procure Prosthetics	$2,600,000,000	$2,600,000,000	$520,700,000
	Total Monetary Impact	**$2,603,700,000**	**$2,603,700,000**	**$538,775,000**

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
06/21/2017	16-04762-232	Inspection of VA Regional Office Boise, Idaho
8/1/2017	17-00962-262	Inspection of the Veterans Service Center Cheyenne, Wyoming
8/3/2017	16-04918-263	Inspection of the VA Regional Office Indianapolis, Indiana
8/3/2017	16-04764-266	Inspection of the VA Regional Office Seattle, Washington
8/10/2017	16-04626-280	Inspection of the VA Regional Office New Orleans, Louisiana
8/10/2017	16-05468-282	Inspection of the VA Regional Office Atlanta, Georgia
8/17/2017	17-00515-299	Inspection of the VA Regional Office Phoenix, Arizona
8/23/2017	17-00394-298	Inspection of the VA Regional Office Louisville, Kentucky
8/24/2017	17-01276-300	Inspection of the VA Regional Office Philadelphia, Pennsylvania
9/5/2017	17-01354-336	Inspection of the VA Regional Office Denver, Colorado
9/6/2017	17-00970-327	Inspection of the VA Regional Office Wilmington, Delaware
9/7/2017	17-02150-340	Inspection of the VA Regional Office St. Louis, Missouri
9/11/2017	17-02079-328	Inspection of the VA Regional Office San Juan, Puerto Rico
9/21/2017	17-02073-317	Inspection of the VA Regional Office, Detroit, Michigan
9/28/2017	17-00266-349	Inspection of the VA Regional Office Winston-Salem, North Carolina
9/29/2017	17-02084-343	Inspection of the VA Regional Office Anchorage, Alaska

Office of Audits and Evaluations | Work Products		
Issue Date	Number	Title
9/12/2017	17-00000-379	Inspector General Memorandum Concerning Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act

Office of Healthcare Inspections | Clinical Assessment Program Reviews		
Issue Date	**Number**	**Facility**
4/13/2017	16-00565-154	Orlando VA Medical Center, Orlando, Florida
4/14/2017	16-00564-170	VA Central Iowa Health Care System, Des Moines, Iowa
4/24/2017	16-00571-207	Lebanon VA Medical Center, Lebanon, Pennsylvania
6/1/2017	16-00581-239	Birmingham VA Medical Center, Birmingham, Alabama
6/8/2017	16-00569-253	Atlanta VA Medical Center, Decatur, Georgia
6/20/2017	16-00556-244	White River Junction VA Medical Center, White River Junction, Vermont
7/13/2017	16-00568-292	Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan
7/17/2017	16-00578-291	El Paso VA Health Care System, El Paso, Texas
7/17/2017	16-00549-302	Aleda E. Lutz VA Medical Center, Saginaw, Michigan
7/19/2017	16-00580-303	Lexington VA Medical Center, Lexington, Kentucky
7/26/2017	16-00573-309	Montana VA Health Care System, Fort Harrison, Montana
7/31/2017	16-00579-293	VA Loma Linda Healthcare System, Loma Linda, California
8/1/2017	16-00576-310	W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
8/7/2017	16-00558-311	Syracuse VA Medical Center, Syracuse, New York
8/7/2017	16-00566-314	Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana
8/15/2017	16-00577-335	VA Northern Indiana Health Care System, Fort Wayne, Indiana
8/15/2017	16-00555-337	James E. Van Zandt VA Medical Center, Altoona, Pennsylvania
9/7/2017	16-00552-341	Michael E. DeBakey VA Medical Center, Houston, Texas
9/20/2017	16-00548-361	Wilmington VA Medical Center, Wilmington, Delaware
9/29/2017	16-00546-388	VA Eastern Colorado Health Care System, Denver, Colorado

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
4/11/2017	16-03920-197	Evaluation of Computed Tomography Radiation Monitoring in Veterans Health Administration Facilities
5/10/2017	16-03807-223	Evaluation of Compounded Sterile Product Practices in Veterans Health Administration Facilities
5/18/2017	16-03808-215	Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities
6/19/2017	15-03303-206	Review of VHA Care and Privacy Standards for Women Veterans
6/23/2017	16-01436-270	Review of VHA's "Our Doctors" Website Accuracy
8/1/2017	17-01846-316	Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care
9/19/2017	16-00349-369	Overview of VA Suicide Prevention Efforts and Data Collection

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
9/27/2017	17-00936-385	OIG Determination of VHA Occupational Staffing Shortages FY 2017

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
4/11/2017	15-00223-196	Peer Review for Quality Management Concerns, Huntington VA Medical Center, Huntington, West Virginia
4/12/2017	17-02644-202	Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington, DC VA Medical Center, Washington, DC
4/20/2017	16-00354-201	Follow-Up Review of Management of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine
5/2/2017	15-01325-205	Community Nursing Home Program Safety Concerns, VA Northern California Healthcare System, Mather, California
5/3/2017	16-02094-219	Environment of Care and Other Quality Concerns, Cincinnati VA Medical Center, Cincinnati, Ohio
5/4/2017	15-04681-228	Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California
5/8/2017	15-00408-204	Alleged Patient Deaths and Management Deficiencies in Home Based Primary Care, Beckley VA Medical Center, Beckley, West Virginia
5/11/2017	15-02009-227	Patient Care Concerns at the Community Living Center, Hampton VA Medical Center, Hampton, Virginia
5/16/2017	14-04524-224	Alleged Pathology and Laboratory Medicine Service Quality of Care Issues, Wilmington, VA Medical Center, Wilmington, Delaware
5/17/2017	15-01653-226	Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
5/17/2017	15-04516-229	Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
5/23/2017	15-01301-242	Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada Health Care System, Las Vegas, NV
5/23/2017	15-01669-246	Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California
5/23/2017	16-03302-252	Nutrition and Food Service Environment of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois
5/25/2017	15-01043-247	Alleged Unsafe Blood Transfusion Practices, Battle Creek VA Medical Center, Battle Creek, Michigan
6/1/2017	16-01077-255	Opioid Management Practice Concerns, John J. Pershing VA Medical Center Poplar Bluff, Missouri
6/15/2017	15-05123-254	Alleged Misdiagnosis and Delay in Treatment, Providence VA Medical Center, Providence, Rhode Island

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
6/15/2017	17-01542-273	Sterile Compounding Environment and Practices, Overton Brooks VA Medical Center, Shreveport, Louisiana
6/19/2017	15-02994-269	Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan
6/21/2017	15-04725-272	Alleged Urology Consult Scheduling Delays, Cincinnati VA Medical Center, Cincinnati, OH
6/26/2017	14-01451-276	Non-VA Colonoscopy Follow-Up Concerns, Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana
6/27/2017	16-03150-277	Alleged Unreported Surgical Incidents and Deaths, VA Caribbean Healthcare System, San Juan, Puerto Rico
6/29/2017	16-01855-288	Dermatology Clinic Staffing and Other Concerns (2012-2014)
7/6/2017	14-03822-289	Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas
7/10/2017	16-02676-297	Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
7/11/2017	15-00506-535	Alleged Access Delays and Surgery Service Concerns, VA Roseburg Healthcare System, Roseburg, Oregon
7/17/2017	15-00509-301	Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center
7/19/2017	15-04641-304	Quality of Care and Other Concerns Robert J. Dole VA Medical Center, Wichita, Kansas
7/27/2017	16-00748-319	Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
8/3/2017	15-05578-294	Administrative Summary Non-VA Care Consult Program Concerns, Charles George VA Medical Center, Asheville, North Carolina
8/3/2017	16-04535-329	Alleged Inadequate Mental Health Care, Iowa City VA Health Care System, Iowa City, Iowa
8/7/2017	16-02551-306	Veterans Choice Program Dermatology Delays, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
8/8/2017	15-01484-321	Administrative Summary - Primary Care Access, Scheduling, and Consult Management Concerns, Erie VA Medical Center, Erie, Pennsylvania
8/14/2017	14-00875-334	Follow-Up Review Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona
8/14/2017	15-02993-339	Magnetic Resonance Imaging Patient Safety Screening, Central Alabama VA Healthcare System, Montgomery, Alabama
8/16/2017	17-00602-342	Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System, Bay Pines, Florida
8/17/2017	16-02160-344	Administrative Summary – Opioid Purchases, VA Northern Indiana Health Care System, Marion, Indiana

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
8/17/2017	16-02998-345	Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York
8/23/2017	15-03418-350	Patient Flow, Quality of Care, and Administrative Concerns in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland
8/29/2017	15-00650-353	Delays in Scheduling Diagnostic Studies and Other Quality of Care Concerns, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
9/5/2017	16-02526-358	Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas
9/7/2017	14-03822-359	Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas
9/7/2017	15-03288-362	Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VA Medical Center, Manchester, New Hampshire
9/7/2017	17-00712-366	Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VA Medical Center, Tomah, Wisconsin
9/19/2017	16-00349-369	Overview of VA Suicide Prevention Efforts and Data Collection
9/20/2017	15-04546-374	Quality of Care and Other Concerns, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
9/26/2017	16-02241-375	Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona
9/28/2017	15-01415-382	Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto Health Care System, Palo Alto, California
9/29/2017	16-04991-387	Administrative Summary – Review of Post-Traumatic Stress Disorder Consult Management, Battle Creek VA Medical Center, Battle Creek, Michigan

Office of Investigations | Administrative Investigations		
Issue Date	**Number**	**Report Title**
6/22/2017	17-00253-267	Administrative Investigation - Misuse of Official Time and Failure to Properly Supervise, Oklahoma City VA Health Care System
7/18/2017	14-03508-275	Administrative Investigation - Conflicting Interests and Misuse of Government Equipment, Overton Brooks VA Medical Center, Shreveport, Louisiana
8/1/2017	15-01119-315	Administrative Investigation - Failure to Follow VA Policy, VA Medical Center, Washington, DC
8/2/2017	15-04374-313	Administrative Investigation - Improper Approval and Use of Leave, VA Medical Center, Chillicothe, Ohio

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
4/19/2017	17-02564-211	Review of Proposal Submitted under a Solicitation	$10,972,296
4/19/2017	17-02224-212	Review of Request for Modification under a Federal Supply Schedule Contract	
4/27/2017	17-00804-213	Review of Contract Extension Proposal Submitted under Federal Supply Schedule Contract	$13,402,915
4/27/2017	17-02578-214	Review of Proposal Submitted under a Solicitation	$5,996,719
4/27/2017	17-00737-217	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
5/1/2017	17-02077-221	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$29,164,260
5/1/2017	17-03182-222	Review of Proposal Submitted under a Solicitation	$16,478
5/8/2017	17-03370-233	Review of Commercial Sales Practices Submitted under a Solicitation Number	$103,860
5/8/2017	17-03074-234	Review of Commercial Sales Practices Submitted under a Solicitation Number	$4,373,260
5/8/2017	17-03078-235	Review of Commercial Sales Practices Submitted under a Solicitation Number	$2,491,100
5/8/2017	17-03424-237	Review of Commercial Sales Practices Submitted under a Solicitation Number	
5/8/2017	17-03427-238	Review of Commercial Sales Practices Submitted under a Solicitation Number	
5/9/2017	17-02761-230	Review of Proposal Submitted under a Solicitation	$105,519
5/9/2017	17-03422-240	Review of Commercial Sales Practices Submitted under a Solicitation Number	$598,280
5/10/2017	17-03423-236	Review of Commercial Sales Practices Submitted under a Solicitation Number	$506,303
5/11/2017	17-02106-243	Review of Proposal Submitted under a Solicitation	
5/16/2017	17-02904-245	Review of Proposal Submitted under a Solicitation	
5/17/2017	17-02893-241	Review of Proposal Submitted under a Solicitation	$3,150,394
5/18/2017	17-00041-218	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$5,361,492,540
5/18/2017	17-03070-251	Review of Commercial Sales Practices Submitted under a Solicitation Number	$6,024,200
5/31/2017	17-02635-257	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$59,087,410
5/31/2017	16-04597-259	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$433,188

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
5/31/2017	17-01247-260	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$2,792,289
6/1/2017	17-02902-258	Review of Proposal Submitted under a Solicitation	$1,209,923
6/1/2017	17-02306-265	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$4,259,513
6/5/2017	17-03104-261	Review of Proposal Submitted under a Solicitation	$78,181
6/7/2017	16-05156-271	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$9,073,420
6/16/2017	17-02400-283	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
6/21/2017	17-03473-286	Review of Proposal Submitted under a Solicitation	$485,860
6/21/2017	17-03799-287	Review of Proposal Submitted under a Solicitation	$591,570
6/27/2017	17-02294-290	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$18,150,473
7/14/2017	17-03270-308	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
7/17/2017	17-02089-307	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
7/20/2017	17-04136-312	Review of Proposal Submitted under a Solicitation	$221,503
7/28/2017	17-02287-318	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$23,562,496
7/28/2017	17-03695-322	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$66,768,005
7/28/2017	17-03591-326	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
7/31/2017	17-02289-324	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$314,157
8/1/2017	17-03267-325	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$443,480
8/2/2017	17-04190-330	Review of Proposal Submitted under a Solicitation	$253,725
8/7/2017	17-03103-333	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$1,315,664
8/21/2017	17-04394-347	Review of Request for Modification under a Federal Supply Schedule Contract	
8/24/2017	17-04125-354	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule	
8/28/2017	17-04272-355	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$47,444

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
8/28/2017	17-04864-357	Review of Proposal Submitted under a Solicitation	$1,087,562
8/30/2017	17-03249-356	Review of Proposal Submitted under a Solicitation	
9/1/2017	17-03277-363	Review of Proposal Submitted under Solicitation	$4,151,334
9/6/2017	17-00801-367	Review of Contract Extension Proposal Submitted under Federal Supply Schedule	$4,240,420
9/6/2017	17-04379-371	Review of Federal Supply Schedule Proposal Submitted under Solicitation	$511,940
9/6/2017	17-03443-372	Review of Federal Supply Schedule Proposal Submitted under a Solicitation	
9/6/2017	17-04177-373	Review of Federal Supply Schedule Proposal Submitted under Solicitation	
9/26/2017	17-05338-381	Review of Proposal Submitted under a Solicitation	$361,090
9/26/2017	17-04536-386	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	
9/27/2017	17-04401-365	Review of Federal Supply Schedule Proposal Submitted under a Solicitation	$1,707,337
9/27/2017	17-04273-360	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	
9/28/2017	17-02247-389	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$23,760,787
		Total Monetary Impact	**$5,663,306,895**

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
6/20/2017	16-00470-284	Review of Federal Supply Schedule Contracts	$3,841,735
8/2/2017	16-04105-331	Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract	$420,384
7/13/2017	16-04490-305	Review of Voluntary Disclosure and Refund Offer under Federal Supply Schedule Contract	$3,385,146
7/28/2017	13-00931-323	Follow-up Review of a Federal Supply Schedule Contract	$1,573,469
6/21/2017	17-04098-285	Review of Voluntary Disclosure of Public Law Pricing Errors under Federal Supply Schedule Contract	
9/26/2017	16-01968-370	Review of a Federal Supply Schedule Contract	$83,054
9/28/2017	17-05573-390	Review of Voluntary Disclosure of Public Law Pricing Errors under Federal Supply Schedule Contract	$34,937

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
8/8/2017	17-01517-332	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$234,839
5/2/2017	17-00472-225	Review of Voluntary Disclosure of Price Reductions under Federal Supply Schedule Contracts	$4,565,386
		Total Monetary Impact	**$14,138,950**

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$2,603,700,000	$538,775,000		
Preaward Reviews			$5,663,306,895	
Postaward Reviews				$14,138,950
Claim Reviews				
	$2,603,700,000	**$538,775,000**	**$5,663,306,895**	**$14,138,950**

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	$538,775,000
Total inventory this period	4	$538,775,000
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	4	$538,775,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	4	$538,775,000
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	2	$2,603,700,000
Total inventory this period	2	$2,603,700,000

Table 3: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management

Resolution Status	Number	Dollar Value
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$2,603,700,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	2	$2,603,700,000
Total carried over to next period	**0**	**$0**

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

Office of Investigations | Administrative Summaries of Investigation		
Issue Date	**Number**	**Facility**
5/4/2017	14-02890-93	VA Medical Center, Alexandria, Louisiana
5/4/2017	14-02890-96	VA Medical Center, Tuskegee and Montgomery, Alabama
5/4/2017	14-03368-97	VA Medical Center, Atlanta, Georgia
5/4/2017	14-02890-104	VA Medical Center, Las Vegas, Nevada
5/4/2017	14-02890-110	VA Medical Center, Phoenix, Arizona and Community Based Outpatient Clinic, Gilbert, Arizona
5/4/2017	14-02890-112	VA Medical Center, Montgomery, Alabama
5/4/2017	14-02890-116	VA Medical Center, Washington, DC
5/4/2017	14-02890-126	VA Medical Center, Phoenix, Arizona
5/4/2017	14-02890-127	VA Medical Center, Atlanta, Georgia
5/4/2017	14-02890-129	VA Medical Center, Augusta, Georgia
5/4/2017	14-02890-409	Community Based Outpatient Clinic, West Roxbury, Massachusetts
5/8/2017	14-02890-169	VA Medical Center, Beckley, West Virginia
5/24/2017	14-02890-95	VA Medical Center, Montgomery, Alabama
6/12/2017	14-02890-99	VA Medical Center, Phoenix, Arizona
6/12/2017	15-00986-130	VA Medical Center, Montgomery, Alabama
7/14/2017	14-02890-131	VA Medical Center, Asheville, North Carolina
7/14/2017	14-02890-132	VA Medical Center, Pittsburgh, Pennsylvania

Office of Investigations | Administrative Investigation Advisories		
Issue Date	**Number**	**Advisory Title**
4/18/2017	16-02435-190	Alleged Improper Collection of Funds, Misuse of Government Property, and Preferential Treatment, Buffalo Regional Benefit Office, Buffalo, New York
4/27/2017	16-05353-220	Summary of Report of Internal Investigation
5/4/2017	16-04882-216	Alleged Gross Mismanagement, Department of Veterans Affairs
5/11/2017	16-00932-203	Alleged Misuse of Position, VA Central Office (VACO), Washington, DC
6/22/2017	17-00126-268	Alleged Misuse of Travel and Conference Funds, Veterans Health Administration, Office of Strategic Integration, Washington, DC
6/26/2017	17-01079-274	Alleged Misuse of Government-Owned Vehicle, Office of Acquisition, Logistics, and Construction, Washington, DC
9/14/2017	17-03095-368	Alleged Improper Performance Pay, VHA, Ralph H. Johnson Medical Center, Charleston, South Carolina

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, 2017, there are 153 total open reports and 766 total open recommendations. However, 10 reports and 9 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 116 reports and 682 recommendations that, as of September 30, 2017, have been open less than 1 year. The total monetary benefit attached to the reports open less than 1 year is $3,340,560,000. Table 3, on the other hand, identifies the 37 reports and 84 recommendations that, as of September 30, 2017, 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 the reports open greater than 1 year is $2,954,600,128.

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	18	93	111	33	599	632
Veterans Benefits Administration	12	19	31	27	69	96
National Cemetery Administration	1	0	1	3	0	3
Office of Acquisition, Logistics, and Construction	3	2	5	9	3	12
Office of Management (OM)	2	1	3	4	2	6
Office of Information and Technology	6	3	9	9	3	12
Office of Human Resources and Administration	0	2	2	0	7	7
Office of Operations, Security, and Preparedness (OSP)	1	0	1	1	0	1
Office of General Counsel	1	2	3	3	3	6
Total	**44**	**122**	**166**	**89**	**686**	**775**

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
10/4/2016 15-04672-342	Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System	VHA	1	
11/10/2016 16-03330-91	Administrative Investigation – Conduct Prejudicial to the Government and Misuse of Position in the VA Office of General Counsel, Washington, DC	OGC	1	
12/6/2016 16-00790-417	Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses	OIT	1	$7,200,000
12/15/2016 15-02278-415	Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System	VHA	1	
1/5/2017 14-04578-371	Audit of Recruitment, Relocation, and Retention Incentives	OHRA	6	$162,600,000
1/30/2017 15-03401-76	Review of Alleged Human Resources Delays at the Atlanta VA Medical Center	VHA	3	
1/30/2017 15-04673-333	Review of the Implementation of the Veterans Choice Program	VHA	4	
2/8/2017 15-01436-456	Audit of Automated Burial Payments	VBA	1	$28,000,000
2/9/2017 14-00750-143	Healthcare Inspection – Documentation of Patient Enrollment Concerns in Home Telehealth John D. Dingell VA Medical Center Detroit, Michigan	VHA	1	
2/16/2017 16-00574-151	Clinical Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana	VHA	12	
3/2/2017 16-02618-424	Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6	VHA	9	
3/7/2017 16-03805-20	Combined Assessment Program Summary Report – Evaluation of Inpatient Flow in Veterans Health Administration Facilities	VHA	1	
3/8/2017 16-00551-128	Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico	VHA	7	
3/8/2017 16-00550-145	Clinical Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri	VHA	4	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
3/10/2017 16-00621-175	Healthcare Inspection – Consult Delays and Management Concerns VA Montana Healthcare System Fort Harrison, Montana	VHA	3	
3/13/2017 16-00553-135	Clinical Assessment Program Review of the Louis Stokes Cleveland VA Medical Center Cleveland, Ohio	VHA	8	
3/13/2017 16-00554-148	Clinical Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona	VHA	2	
3/16/2017 16-00547-156	Clinical Assessment Program Review of the VA Portland Health Care System Portland, Oregon	VHA	9	
3/20/2017 16-03985-181	Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line	VHA	13	
3/24/2017 15-03231-319	Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia	VHA	1	$285,000
3/27/2017 16-00575-147	Clinical Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York	VHA	3	
3/31/2017 15-04976-191	Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California	VHA	1	
3/31/2017 15-05379-146	Audit of VHA's Patient Advocacy Program	VHA/OIT	7	
3/31/2017 16-00572-179	Clinical Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah	VHA	8	
3/31/2017 16-03743-193	Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016	VHA	5	
4/11/2017 16-03920-197	Healthcare Inspection – Evaluation of Computed Tomography Radiation Monitoring in Veterans Health Administration Facilities	VHA	1	
4/12/2017 17-02644-202	Interim Summary Report – Healthcare Inspection – Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC	VHA	8	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
4/13/2017 16-00565-154	Clinical Assessment Program Review of the Orlando VA Medical Center, Orlando, Florida	VHA	3	
4/14/2017 16-00564-170	Clinical Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa	VHA	8	
4/20/2017 16-00354-201	Follow-Up Review of Management of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine	VHA	1	
4/24/2017 16-00571-207	Clinical Assessment Program Review of the Lebanon VA Medical Center, Lebanon, Pennsylvania	VHA	6	
5/2/2017 15-01325-205	Healthcare Inspection – Community Nursing Home Program Patient Safety Concerns VA Northern California Health Care System Mather, California	VHA	3	
5/10/2017 16-03807-223	Evaluation of Compounded Sterile Product Practices in Veterans Health Administration Facilities	VFHA	5	
5/15/2017 16-04416-231	Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2016	VHA/ VBA/ OALC/OM	8	
5/18/2017 16-03808-215	Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities	VHA	6	
5/23/2017 16-03302-252	Healthcare Inspection – Nutrition and Food Service Environment of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois	VHA	2	
5/24/2017 15-05235-200	Review of Alleged Removal of Workload Controls at the VARO in San Juan, PR	VBA	2	
5/25/2017 15-01043-247	Healthcare Inspection – Alleged Unsafe Blood Transfusion Practices, Battle Creek VA Medical Center, Battle Creek, Michigan	VHA	2	
6/1/2017 16-00327-209	Review of Alleged Mismanagement of VA's Human Resources and Administration Contract Funds	OHRA	1	$3,700,000
6/1/2017 16-00581-239	Clinical Assessment Program Review of the Birmingham VA Medical Center, Birmingham, Alabama	VHA	7	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
6/1/2017 16-01077-255	Healthcare Inspection – Opioid Management Practice Concerns John J. Pershing VA Medical Center Poplar Bluff, Missouri	VHA	8	
6/5/2017 15-01080-208	Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities	VHA	3	$17,200,000
6/7/2017 15-04351-188	Review of Alleged Inappropriate Contract Actions Related to VA's Lease of a Digital Imaging Network-Picture Archival Communication System	OALC	2	
6/8/2017 16-00569-253	Clinical Assessment Program Review of the Atlanta VA Medical Center Decatur, Georgia	VHA	21	
6/12/2017 15-03678-210	Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3	VHA	1	$457,000
6/15/2017 17-01542-273	Healthcare Inspection – Sterile Compounding Environment and Practices, Overton Brooks VA Medical Center, Shreveport, Louisiana	VHA	1	
6/19/2017 15-02994-269	Healthcare Inspection – Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan	VHA	8	
6/19/2017 15-03303-206	Review of VHA Care and Privacy Standards for Women Veterans	VHA	1	
6/20/2017 16-00556-244	Clinical Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont	VHA	17	
6/21/2017 16-01949-248	Federal Information Security Modernization Act Audit for Fiscal Year 2016	VHA	31	
6/21/2017 16-04762-232	Inspection of VA Regional Office Boise, Idaho	VBA	1	
6/22/2017 17-00253-267	Administrative Investigation – Misuse of Official Time and Failure to Properly Supervise, Oklahoma City VA Health Care System	VHA	2	
6/23/2017 16-01436-270	Healthcare Inspection – Review of VHA's "Our Doctors" Website Accuracy	VHA	2	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
6/27/2017 15-01217-249	Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia	VHA	7	$418,000
6/27/2017 15-03357-180	Review of Alleged Mismanagement of the Patient Transportation Service Contract for Jesse Brown VA Medical Center	VHA	3	
7/6/2017 14-03822-289	Healthcare Inspection – Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas	VHA	2	
7/10/2017 16-02676-297	Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma	VHA	8	
7/11/2017 15-00506-535	Alleged Access Delays and Surgery Service Concerns, VA Roseburg Healthcare System, Roseburg, Oregon	VHA	3	
7/13/2017 16-00568-292	Clinical Assessment Program Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan	VHA	8	
7/17/2017 15-00509-301	Healthcare Inspection – Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center, St. Cloud VA Health Care System, St. Cloud, Minnesota; the Minneapolis VA Health Care System, Minneapolis	VHA	2	
7/17/2017 16-00549-302	Clinical Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan	VHA	16	
7/17/2017 16-00578-291	Clinical Assessment Program Review of the El Paso VA Health Care System El Paso, Texas	VHA	10	
7/18/2017 14-03508-275	Administrative Investigation – Conflicting Interests and Misuse of Government Equipment, Overton Brooks VA Medical Center, Shreveport, Louisiana	VHA/OGC	4	
7/19/2017 15-04641-304	Healthcare Inspection – Quality of Care and Other Concerns Robert J. Dole VA Medical Center, Wichita, Kansas	VHA	1	
7/19/2017 16-00580-303	Clinical Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky	VHA	24	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
7/20/2017 16-02468-281	Audit of Alleged Inappropriate Scheduling of Electromyography Consults at the Memphis VA Medical Center	VHA	2	
7/26/2017 16-00573-309	Clinical Assessment Program Review of the Montana VA Health Care System, Fort Harrison, Montana	VHA	14	
7/27/2017 16-00748-319	Healthcare Inspection – Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin	VHA	5	
7/31/2017 16-00579-293	Clinical Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California	VHA	20	
8/1/2017 15-01119-315	Administrative Investigation – Failure to Follow VA Policy VA Medical Center Washington, DC	VHA	1	
8/1/2017 16-00576-310	Clinical Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina	VHA	26	
8/1/2017 17-00962-262	Inspection of the Veterans Service Center Cheyenne, Wyoming	VBA	2	
8/1/2017 17-01846-316	Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care	VHA	4	
8/2/2017 15-04374-313	Administrative Investigation – Improper Approval and Use of Leave, VA Medical Center, Chillicothe, Ohio	VHA	3	
8/3/2017 16-04535-329	Healthcare Inspection – Alleged Inadequate Mental Health Care, Iowa City VA Health Care System, Iowa City, Iowa	VHA	4	
8/3/2017 16-04764-266	Inspection of the VA Regional Office Seattle, Washington	VBA	3	
8/3/2017 16-04918-263	Inspection of the VA Regional Office Indianapolis, Indiana	VBA	6	
8/7/2017 16-00558-311	Clinical Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York	VHA	11	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
8/7/2017 16-00566-314	Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana	VHA	18	
8/7/2017 16-02551-306	Healthcare Inspection – Veterans Choice Program Dermatology Delays, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois	VHA	2	
8/9/2017 15-02583-256	Review of Alleged Delay of Care and Scheduling Issues at the VAMC in West Palm Beach, FL	VHA	4	
8/9/2017 16-00589-264	Audit of VHA's Consolidated Patient Account Center Controls To Prevent Improper Billings for Service-Connected Conditions	VHA	6	
8/10/2017 15-05468-282	Inspection of the VA Regional Office Atlanta, Georgia	VBA	8	
8/10/2017 16-04626-280	Inspection of the VA Regional Office New Orleans, Louisiana	VBA	5	
8/14/2017 16-00355-296	Audit of the Health Care Enrollment Program at Medical Facilities	VHA	5	
8/15/2017 16-00555-337	Clinical Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, Pennsylvania	VHA	10	
8/15/2017 16-00577-335	Clinical Assessment Program Review of the VA Northern Indiana Health Care System Fort Wayne, Indiana	VHA	18	
8/16/2017 17-00602-342	Healthcare Inspection – Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System, Bay Pines, Florida	VHA	2	
8/17/2017 16-02998-345	Healthcare Inspection – Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York	VHA	5	
8/17/2017 17-00515-299	Inspection of the VA Regional Office Phoenix, Arizona	VBA	6	
8/22/2017 15-02156-346	Healthcare Inspection – Review of Opioid Prescribing Practices, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin	VHA	4	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
8/23/2017 15-03418-350	Healthcare Inspection – Patient Flow, Quality of Care, and Administrative Concerns in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland	VHA	9	
8/23/2017 17-00394-298	Inspection of the VA Regional Office Louisville, Kentucky	VBA	2	
8/24/2017 17-01276-300	Inspection of the VA Regional Office Philadelphia, Pennsylvania	VBA	3	
8/29/2017 15-00650-353	Healthcare Inspection – Delays in Scheduling Diagnostic Studies and Other Quality of Care Concerns, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin	VHA	1	
9/5/2017 16-02526-358	Healthcare Inspection – Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas	VHA	3	
9/5/2017 17-01354-336	Inspection of VA Regional Office Denver, Colorado	VBA	4	
9/6/2017 17-00970-327	Inspection of VA Regional Office Wilmington, Delaware	VBA	3	
9/7/2017 14-03822-359	Healthcare Inspection – Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA Health Care System, Amarillo, Texas	VHA	2	
9/7/2017 15-03288-362	Healthcare Inspection – Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VA Medical Center, Manchester, New Hampshire	VHA	1	
9/7/2017 16-00552-341	Clinical Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas	VHA	12	
9/7/2017 17-00712-366	Healthcare Inspection – Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VA Medical Center, Tomah, Wisconsin	VHA	4	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
9/7/2017 17-02150-340	Inspection of the VA Regional Office St. Louis, Missouri	VBA	6	
9/11/2017 17-02079-328	Inspection of the VA Regional Office San Juan, Puerto Rico	VBA	2	
9/20/2017 15-04546-374	Healthcare Inspection – Quality of Care and Other Concerns, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois	VHA	2	
9/20/2017 16-00548-361	Clinical Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware	VHA	20	
9/21/2017 17-02073-317	Inspection of the VA Regional Office, Detroit, Michigan	VBA	2	
9/26/2017 16-02241-375	Healthcare Inspection – Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona	VHA	1	
9/27/2017 17-00936-385	OIG Determination of VHA Occupational Staffing Shortages FY 2017	VHA	4	
9/28/2017 15-01415-382	Healthcare Inspection – Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto Health Care System, Palo Alto, California	VHA	1	
9/28/2017 16-02151-320	Review of Alleged Payment Issues at Kerrville VA Hospital Kerrville, Texas	VHA	1	
9/28/2017 17-00266-349	Inspection of the VA Regional Office Winston-Salem, North Carolina	VBA	7	
9/29/2017 15-04929-351	Audit of Purchase Card Use To Procure Prosthetics	VHA	5	$3,120,700,000
9/29/2017 16-00546-388	Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado	VHA	26	
9/29/2017 16-00753-338	Review of Alleged Use of Wrong VA Funds To Purchase IT Equipment	VHA/OIT	3	

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

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
9/29/2017 17-02084-343	Inspection of VA Regional Office Anchorage, Alaska	VBA	3	
Total				**$3,340,560,000**

Table 3: 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 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

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

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
09/28/12	**12-01012-298**	***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**	**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.				
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.				
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 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.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
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.*				
01/22/15	**13-03324-85**	**Follow-up Audit of the Information Technology Project Management Accountability System**	**OIT**	**$6,400,000**
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).				
04/15/15	**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. *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.*				
06/01/15	**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.*				

Table 3: 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 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.				
07/29/15	**14-04530-452**	**Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama**	**VHA**	**None**
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.				
09/14/15	**13-00690-455**	**Follow-up Review of VA's Veterans Benefits Management System**	**VBA/OIT**	**$27,000,000**
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.				
09/30/15	**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 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 cardiothoracic 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).*				
11/12/15	**14-04756-32**	**Audit of the Seismic Safety of VA's Facilities**	**VHA/OALC/OM**	**None**
Recommendation 1: We recommended the Principal Executive Director for the Office of Acquisition, Logistics, and Construction establish policy requiring medical facilities to conduct detailed seismic studies for all critical and essential buildings located in high and very high seismic zones that have not already undergone detailed seismic studies.				

Table 3: 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 the Acting Assistant Secretary for Management revise VA Directive 7415 to mandate that enhanced use lease agreements require developers to certify the seismic safety of buildings or to have a plan for mitigating identified seismic deficiencies prior to renewal or execution of new facility use agreements with VA organizations. *Recommendation 9: We recommended the Under Secretary for Health develop policies and procedures requiring VHA medical facilities to develop and test Continuity of Operations Plans, to include documenting the testing performed, in accordance with Federal Continuity Directive 1 requirements.*				
01/12/16	**14-02465-47**	**Audit of VHA's Non-VA Medical Care Obligations**	**VHA**	**$358,000,000**
Recommendation 1: We recommended that the Under Secretary for Health improve cost estimation tools to ensure adequate Non-VA Care cost estimates are produced consistently. *Recommendation 3: We recommended that the Under Secretary for Health update Fee Basis Claims System software to ensure inpatient authorizations can be periodically adjusted when the scope of patient care is fully known.* *Recommendation 4: We recommended that the Under Secretary for Health update Fee Basis Claims System software to allow the system to automatically deobligate unused funds when Non-VA Care staff indicate payments for the authorized services are complete.*				
01/13/16	**15-05151-81**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio**	**VHA**	**None**
Recommendation 5: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA. *Recommendation 7: We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.*				
02/25/16	**14-02384-45**	**Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires**	**VBA**	**None**
Recommendation 1: We recommended the Acting Under Secretary for Benefits evaluate options for electronically capturing and analyzing information contained on completed Disability Benefits Questionnaires and implement the most cost effective option. (Similar to recommendation from 2012 Office of Inspector General audit report.)				

Table 3: 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 Acting Under Secretary for Benefits revise policies and procedures to include steps for obtaining missing public-use Disability Benefits Questionnaires clinician information and verifying clinicians have an active medical license. (Similar to recommendation from 2012 Office of Inspector General audit report.) *Recommendation 9: We recommended the Acting Under Secretary for Benefits establish procedures requiring Veterans Affairs Regional Office staff to receive recurring training on systemic issues identified during analyses of local quality assurance review results related to compliance with Disability Benefits Questionnaires' special issue indicator and clinician information completeness requirements.* *Recommendation 14: We recommended the Acting Under Secretary for Benefits establish procedures requiring Veterans Affairs Regional Office staff to receive recurring training on systemic issues identified during analyses of local quality assurance review results related to public-use Disability Benefits Questionnaires, including unnecessary Veterans Health Administration compensation and pension examinations.*				
03/09/16	**15-05160-161**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona**	**VHA**	**None**
Recommendation 16: We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. *Recommendation 17: We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.*				
04/07/16	**15-02781-153**	**Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act onMyCareer@VA Web Site**	**OIT**	**None**
Recommendation 4: We recommended the Assistant Secretary for Human Resources and Administration correct all Section 508 compliance issues with the MyCareer@VA Web site and seek certification of Section 508 compliance				
04/14/16	**15-04652-146**	**Review of Claims-Related Documents Pending Destruction at VA Regional Offices**	**VBA**	**None**
Recommendation 1: We recommended the Acting Under Secretary for Benefits revise Veterans Benefits Administration's Policy on Management of Veterans' and Other Governmental Paper Records to ensure documents printed from Veterans Benefits Management System are clearly identified.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 2: We recommended the Acting Under Secretary for Benefits revise Veterans Benefits Administration's Policy on Management of Veterans' and Other Governmental Paper Records to include detailed, standardized procedures for the collection and review of material by records management staff at VA Regional Offices. *Recommendation 3: We recommended the Acting Under Secretary for Benefits implement a plan to ensure all claims-related documents receive the mandated levels of review to comply with Veterans Benefits Administration's policy.* *Recommendation 5: We recommended the Acting Under Secretary for Benefits implement a plan to ensure records management staff comply with Veterans Benefits Administration's policy to track all shredding violations they identify.*				
04/21/16	**15-05154-271**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Sheridan VA Healthcare System, Sheridan, Wyoming**	**VHA**	**None**
Recommendation 8: We recommended that clinicians consistently notify patients of their laboratory results within the timeframe required by VHA. *Recommendation 9: We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.*				
04/26/16	**11-00826-261**	**Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System**	**VHA**	**$8,900,000**
Recommendation 1: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review of VA New Jersey Health Care System purchase card transactions from December 2012 through May 2014 and require cardholders to initiate ratification for identified unauthorized commitments. *Recommendation 4: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review of VA New Jersey Health Care System purchase card transactions for building renovations and take corrective action for all identified inappropriate transactions.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
04/28/16	**15-03802-222**	**Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System**	**VBA/OIT**	**None**
Recommendation 2: We recommended the Assistant Secretary for Information and Technology integrate audit logs into the Veterans Benefits Management System based on the requirements provided by the Acting Under Secretary for Benefits. *Recommendation 3: We recommended the Acting Under Secretary for Benefits test the newly integrated audit logs to ensure that the logs capture all potential security violations.*				
05/09/16	**15-02459-260**	**Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard**	**OIT**	**None**
Recommendation 1: We recommended the Assistant Secretary for Information and Technology create read-only access capability for the Project Management Accountability System. *Recommendation 2: We recommended the Assistant Secretary for Information and Technology assess the current level of each user's access to the Project Management Accountability System Dashboard to ensure each user's access is based on the least privilege needed.* *Recommendation 3: We recommended the Assistant Secretary for Information and Technology develop Project Management Accountability System Dashboard access logs.* *Recommendation 4: We recommended the Assistant Secretary for Information and Technology periodically review Project Management Accountability System Dashboard access logs to ensure users have a need for system access.*				
05/11/16	**16-00010-302**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Greater Los Angeles Healthcare System, Los Angeles, California**	**VHA**	**None**
Recommendation 7: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
05/11/16	16-00101-300	Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California	VHA	None
Recommendation 3: We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance. *Recommendation 5: We recommended that senior managers become involved in quality, safety, and value activities.* *Recommendation 17: We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance.* *Recommendation 18: We recommended that the Medical Records Committee provide oversight and coordination of the review of the quality of entries in electronic health records.*				
05/12/16	16-00025-301	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Carl Vinson VA Medical Center, Dublin, Georgia	VHA	None
Recommendation 5: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA. *Recommendation 6: We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.* *Recommendation 7: We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.*				
06/16/16	15-03700-283	Review of VA's Guidance on Protecting Religious Beliefs	VHA/NCA	None
Recommendation 1: We recommended the Interim Under Secretary for Memorial Affairs rescind and replace Chapters 6 and 7 from Manual 40-2, National Cemeteries, Administration, Operation, and Maintenance. *Recommendation 2: We recommended the Interim Under Secretary for Memorial Affairs recertify or rescind Directive 3170/1, Ceremonies and Special Events at VA National Cemeteries.* *Recommendation 3: We recommended the Interim Under Secretary for Memorial Affairs incorporate National Cemetery Administration's three interim guidance documents into directives or handbooks.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
06/23/16	**15-01296-203**	**Community Based Outpatient Clinics Summary Report - Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics**	**VHA**	**None**
Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic staff document the offer of further treatment to patients diagnosed with alcohol dependence and that managers monitor for compliance. *Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that that clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care and that managers monitor for compliance.*				
08/09/16	**16-02729-350**	**Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan**	**VHA**	**None**
Recommendation 2: We recommended the Veterans Integrated Service Network 10 Acting Director ensure the Detroit VA Medical Center develop and implement a plan to use the purchased televisions or make them available to other VA facilities to use.				
09/28/16	**16-00351-453**	**OIG Determination of VHA Occupational Staffing Shortages**	**VHA**	**None**
Recommendation 1: We restated our previous recommendation that the Under Secretary for Health ensure that the Veterans Health Administration develops staffing models for critical need occupations, and we further recommend that the Veterans Health Administration sets forth milestones and a timetable for further critical need occupations' staffing model development, piloting, and implementation. *Recommendation 2: We restated our previous recommendation that the Under Secretary for Health review data on regrettable losses and consider implementing measures to reduce such losses.* *Recommendation 3: We recommended that the Under Secretary for Health consider incorporating data that predicts changes in veteran demand for health care into its staffing model.* *Recommendation 4: We recommended that the Under Secretary for Health assess the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/29/16	15-02707-277	Review of VBA's Special Monthly Compensation Housebound Benefits	VBA	$44,300,000
Recommendation 2: We recommended the then Acting Under Secretary for Benefits conduct a review of all veterans being paid compensation at the housebound rate with a combined evaluation of 90 percent or less and provide certification of completion of the review to the Office of Inspector General.				
09/30/16	14-05118-147	Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments	VBA	$2,270,000,128
Recommendation 2: We recommended the Acting Under Secretary for Benefits develop risk profiles for schools that are prone to certification problems, improper payments, and missed recoupments; and implement a process to periodically review and verify the certification information submitted by these schools. *Recommendation 3: We recommended the Acting Under Secretary for Benefits incorporate improper payment and missed recoupment risk factors into Veterans Benefits Administration's risk-based system for the prioritization and completion of compliance surveys.* *Recommendation 7: We recommended the Acting Under Secretary for Benefits initiate action to recover identified improper payments when collections are deemed appropriate and reasonable.*				
09/30/16	15-00084-370	Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina	VHA	None
Recommendation 1: We recommended that the Facility Director ensure that recommendations, if any, from other reviews of the surgical program be implemented.				
Total				**$2,954,600,128**

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On the Cover

On March 29, 2016, VA conducted hundreds of events in VA facilities across the nation to recognize, honor, and thank U.S. Vietnam veterans and their families for their service and sacrifices as part of the national Vietnam War Commemoration. VA photo courtesy of Gene Russell.

Department of Veterans Affairs

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