Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 79 | October 1, 2017 – March 31, 2018

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 honored and privileged to submit this Semiannual Report (SAR) to Congress on the Department of Veterans Affairs (VA) Office of Inspector General (OIG) activities and accomplishments for October 1, 2017, through March 31, 2018. This has been and continues to be a challenging time for VA. With a number of permanent Department leadership positions unfilled at the time of this message, the OIG will remain keenly focused on our mission to improve the programs and operations of VA through independent and effective oversight. In pursuing this mission, the OIG recognizes that success is dependent on the efforts of the many dedicated and committed VA employees who work on behalf of veterans every day.

A significant portion of our oversight work is captured in the more than 150 reports we have published in the past six months. OIG reports reflect the accurate, fair, objective, and thorough work that results from our audits, inspections, reviews, and investigations. To make our reports as meaningful as possible, we not only report the facts, but also the root causes of any issues and who may be accountable. We are also seeking to improve the timeliness of products. OIG reports make significant recommendations to help VA advance the programs, services, and benefits provided to veterans.

During this SAR period, the OIG has placed a greater emphasis on leveraging the expertise of staff from across all OIG directorates and offices. One example of how this level of collaboration has been beneficial was the March 2018 report, *Critical Deficiencies at the Washington DC VA Medical Center*. Following an interim report we issued in April 2017, this final report detailed how failures in leadership at the DC VA Medical Center allowed pervasive problems to persist for years that put patients at unnecessary risk for harm and resulted in the mismanagement of taxpayer dollars. The report made 40 recommendations that were accepted by VA.

VA has reported a number of actions to improve services at the DC VA Medical Center in response to the OIG report, including new leadership and other personnel for key medical center positions. VA has also announced its intention to take further steps, including addressing a backlog of prosthetics consults, as well as implementing plans to resolve supply shortages, sterile processing of instrument delays, and unsecured storage areas. Beyond the specific facility changes, VA has stated it would put processes in place to correct and prevent similar problems in other VA facilities, including unannounced audits, VA-wide staffing reviews, reorganized logistics to centralize accountability, and greater oversight of medical center performance within VA's Central Office that entails reforms at the VA regional network level. OIG staff will continue to monitor both the facility-level and systems-wide changes to help ensure implementation is sustained. It is this type of work that our office will continue to pursue—work that can make the greatest positive impact on programs, services, and benefits for veterans and their families across the nation.

In this reporting period, our office identified more than $1.6 billion in monetary impact for a return on investment of $25 for every dollar spent on oversight. The OIG Hotline received more than 16,000 contacts that have helped us identify wrongdoing, waste, abuse, and inefficiencies or deficiencies in VA programs and activities. Our investigators opened 333 investigations and closed 338. Collectively, the OIG's work resulted in 853 administrative sanctions and corrective actions.

I am very appreciative of the outstanding and hard work by OIG staff during this SAR period. They made a real difference in the lives of veterans and their families in a manner consistent with our mission, vision, and values. Their work also promoted the appropriate and efficient use of taxpayer monies. I would also like to recognize the support we received from Congress, VA staff, the Veterans Service Organizations, and other stakeholders. This support was instrumental to our efforts and will continue to advance our oversight work.

MICHAEL J. MISSAL

Inspector General

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VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

The Department of Veterans Affairs (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.

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 their country.

While most Americans recognize VA as a government agency, few realize that it is the second largest federal employer. For fiscal year (FY) 2018, VA is operating under a $188.7 billion budget, with over 379,000 employees serving an estimated 20 million 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. It also operates the nation's largest integrated healthcare system.

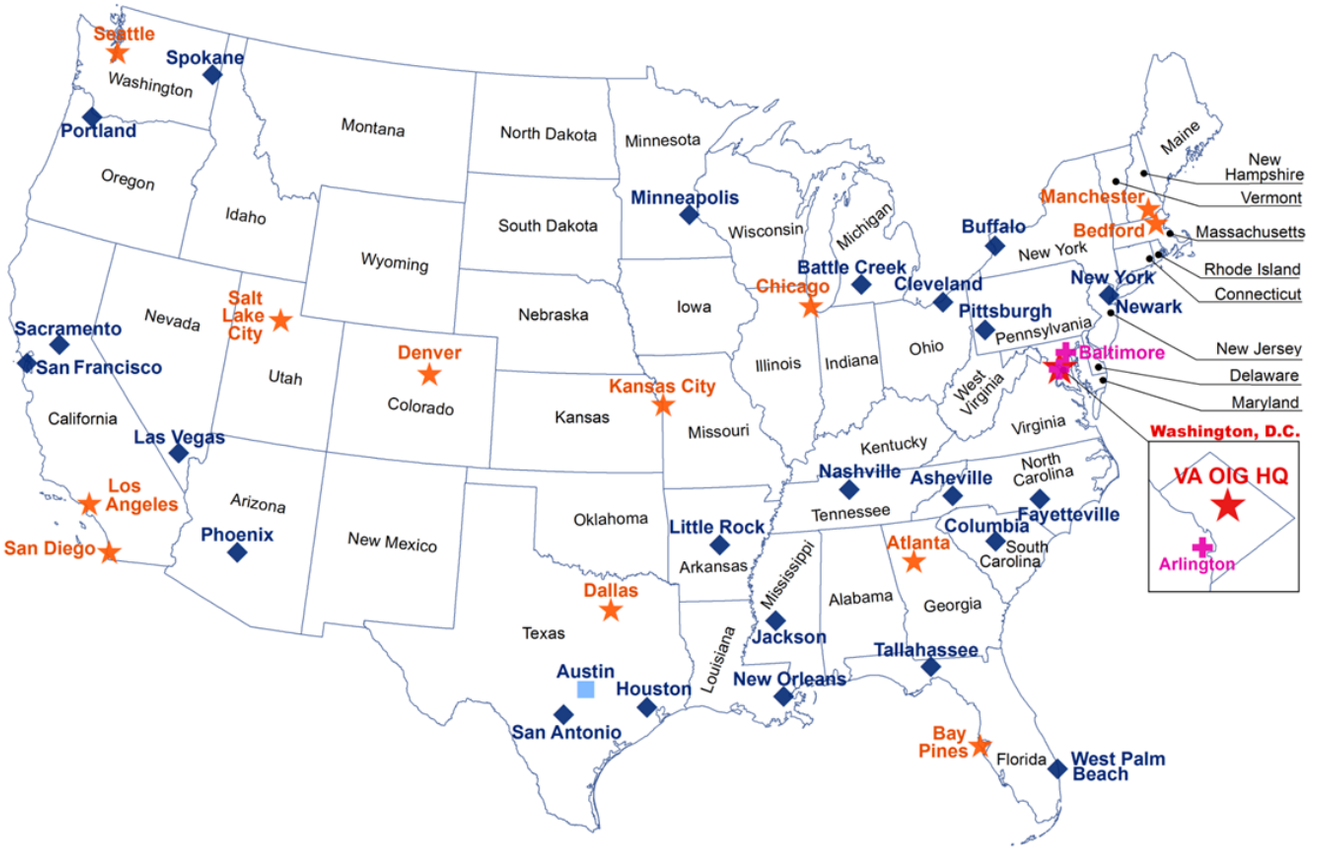
For more information, visit the VA home page at www.va.gov.

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. Although the VA OIG was administratively established on January 1, 1978, its role as an independent agency was formalized and clarified just 10 months later by the *Inspector General Act.* That act states that the Inspector General (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 and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements. In addition, the *Veterans Benefits and Services Act of 1988* charged the OIG with overseeing the quality of VA health care. Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

The OIG has 855 appropriations-funded staff positions organized into four primary directorates: the Offices of Investigations, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG Hotline). In addition, the OIG has integrated into its framework the Office of Contract Review (OCR), which is overseen by the Office of Counselor to the Inspector General, and a new Office of Special Reviews for significant projects not covered by other directorates, as well as offices for congressional, media, and legal affairs. The FY 2018 funding for OIG operations provides $164 million from ongoing appropriations. In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. For more information, visit www.va.gov/oig.

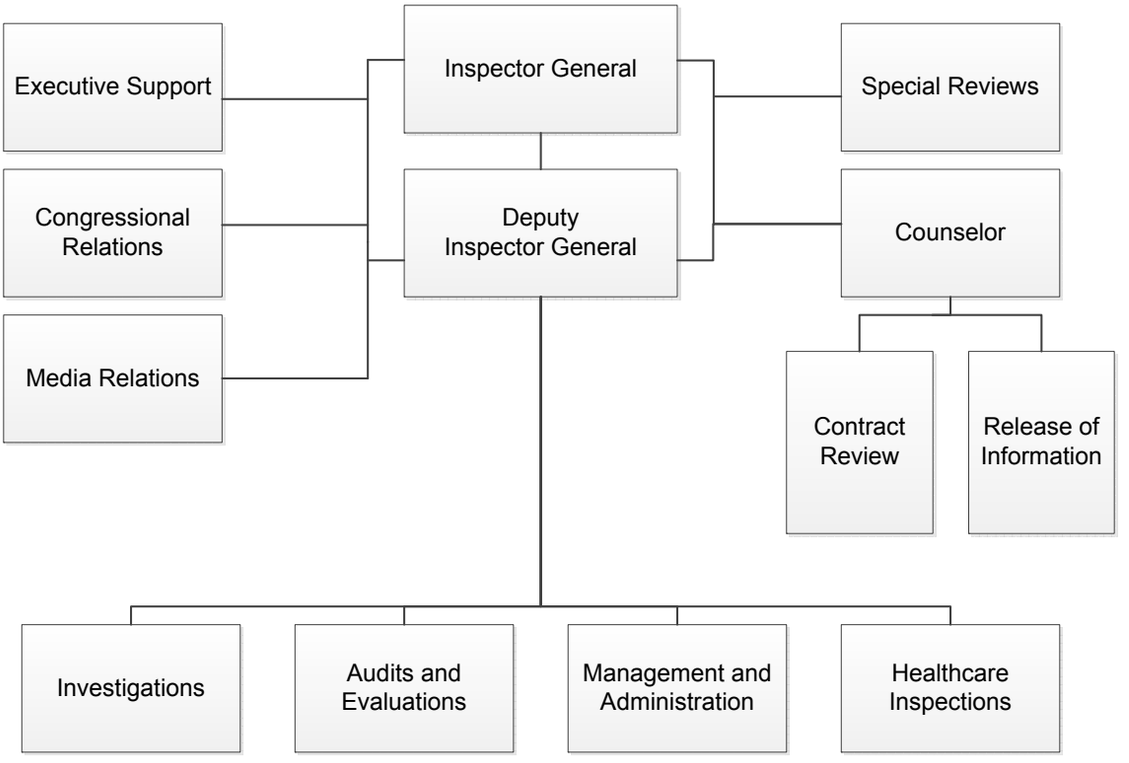
OIG Field Offices Map



Legend

- ★ VA OIG Headquarters
- ★ Hub office with three or more Directorates
- ✚ Office of Audits and Evaluations and Office of Healthcare Inspections
- ■ Office of Audits and Evaluations and Data Processing Center
- ◆ Office of Investigations Only

OIG Organizational Chart



4/23/2018

INSPECTOR GENERAL
Department of Veterans Affairs

Highlights of VA OIG Activities

Pursuant to the *Inspector General Act of 1978* (Public Law (P.L.) 95-452, as amended), this Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the reporting period October 1, 2017–March 31, 2018. Highlighted below are some of the activities conducted during this period by the OIG's offices and their impact, followed by some statistical tables that summarize key performance measures. The report then features examples of each office's high-impact publications and activities. This information is supplemented by appendixes that detail such information as the monetary impact of OIG products by title; savings, cost avoidance, and dollar recoveries of contract reviews; the dollar value of recommendations for audits, evaluations, and reviews; and the status of VA's implementation of recommendations.

Office of Healthcare Inspections

The Office of Healthcare Inspections (OHI) has continued to focus on problems that affect key healthcare functions within VHA, including a new approach to examining staffing gaps. OHI has surveyed each facility's leadership team and requested a site-specific ranking of the most critical clinical and non-clinical positions. The locally generated data will be integrated into an annual staffing report to support a more meaningful and targeted approach to attracting and hiring those specialties and skill sets needed by each local veteran population. The reported rankings can inform facility, Veterans Integrated Service Network (VISN), and VHA leaders' decision making on issues such as hiring in-house staff or purchasing care in the community.

In this SAR period, OHI has maintained a strong focus on leadership and accountability. As the publication section demonstrates, this emphasis on oversight and responsibility is included in all OHI reports—from the 31 Comprehensive Health Inspection Program (CHIP) reports of VA facilities and systems published this reporting period to the thorough examination completed for the Washington DC VA Medical Center (VAMC) that scrutinized how failures in leadership contributed to persistent problems. To ensure that OHI remains responsive to emerging and critical issues that affect patient care and the effective use of resources, the directorate is using a two-prong approach: (1) a top-down strategy that engages its national review team to take on such issues as opioids, traumatic brain injury (TBI), and behavioral health treatment that can result in sweeping VHA changes; and (2) a bottom-up approach that gleans information from healthcare inspections, rapid response team efforts, OIG Hotline complaints, and other sources to inform OHI's work on developing problems and critical needs affecting veterans and their care providers.

Office of Audits and Evaluations

The OIG Office of Audits and Evaluations (OAE) performs audits, reviews, and inspections to help ensure that veterans receive the medical care and benefits to which they are entitled. In FY 2018, OAE continued its reorganizing efforts to more closely align with the VA structure, to develop subject matter expertise within each major VA functional area and effectively identify risk areas, and to improve the quality and timeliness of OAE reports. This reorganization also enables OAE to more effectively and promptly respond to congressional requests and OIG Hotline complaints. For example, OAE's subject matter experts made significant contributions by identifying critical deficiencies in such areas as supply chain inventory management, prime vendor surgical contracts, and financial governance and accountability at the Washington DC VAMC in a joint

project with OHI and other OIG offices that was initiated by a confidential complaint. The OAE is well positioned to both meet the demands of planned work and respond to nascent issues.

During this reporting period, OAE identified an estimated $957 million in potential monetary benefits. To continue performing impactful audits and reviews, OAE is developing initiatives to focus on the areas of highest risk. In FY 2018, OAE began developing a database that will include an assessment of risks regarding the safety of veterans and employees, fiscal management, and compliance with federal law and VA policy. To further enhance strategic planning efforts, OAE developed an audit proposal tool to help compile and prioritize potential audit work, identify areas of importance, and develop a balanced portfolio of work across VA.

Office of Investigations

To enhance the OIG's oversight capabilities, the Office of Investigations (OI) recently expanded its forensic auditor program to support investigative field efforts; created an Investigative Development Division to identify and investigate complex fraud cases related to construction, acquisition/procurement, community care, and grants and education; increased cooperation with VHA's Disruptive Behavior Committee to more effectively address threats against VA employees and facilities; developed a streamlined process for field agents to electronically submit investigative field activity reports; and provided staff training on such issues as confidential sources, qui tam actions, and education benefits and loan guarantee fraud.

OI is also working with the Office of Accountability and Whistleblower Protection to triage and evaluate referrals to OIG investigators. Other proactive efforts include the initiative for field agents to submit investigation ideas based on their experiences and observations of emergent issues. To date, this system has generated 190 referrals and 42 investigations nationwide.

Office of Management and Administration

The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency, and to support the OIG's overall mission and goals. In the last six months, OMA enhanced OIG's oversight capacity by spearheading efforts to recruit top talent and support the workforce. For example, in early December 2017, OMA launched a company page for the OIG on LinkedIn, a large and well-known professional networking site with over 400 million users worldwide. The OIG already has more than 1,100 followers and is actively using LinkedIn to advertise key vacancies. Further, OMA took steps to support the professional development of OIG's workforce by launching a group mentorship program that pairs trained mentors with more junior staff and by initiating an organizational needs analysis to systemically evaluate training and developmental needs. These types of efforts, in conjunction with OIG leaders' commitment to supporting the workforce, contributed to the OIG's placement within the top quartile for Best Places to Work in the Federal Government for agency subcomponents by the Partnership for Public Service.

In addition, OMA enhanced customer services for external and internal stakeholders in multiple ways. With respect to external stakeholders, OMA took steps to more clearly communicate information with individuals who contact OIG's Hotline, which receives, screens, and takes action in response to complaints regarding VA. In particular, in October 2017, OMA began sending customized responses to complainants who contact OIG's Hotline with concerns that are outside the agency's jurisdiction.

Those responses are intended to provide helpful suggestions for other opportunities for redress. Regarding internal stakeholders, OMA established a shared governance structure for several essential administrative functions, including budget formulation and execution. Through a series of recurring meetings and dashboards, OMA has helped to ensure that the OIG's budget requests accurately reflect the resources that the OIG needs to meet its oversight mission and that plans with budgetary implications are continually revisited and effectively implemented.

Office of Counselor to the Inspector General

The Office of the Counselor continued to provide legal support to all components of the OIG. For example, the attorneys supported the OMA in establishing a more robust in-house employee relations function. They also have continued to represent the OIG in employment-related litigation, including matters involving former OIG personnel. The Office of the Counselor added three new attorneys during this six-month period to provide expert advice and guidance in key oversight areas. One of the attorneys is principally focused on supporting the OHI in reviewing Hotline complaints and carrying out inspections. Two attorneys have been selected from within the Office of the Counselor to launch an Office of Special Reviews and have been replaced with new hires. In addition to supporting audits and investigations, these new attorneys bring expertise in employment litigation and government contracting, respectively. The attorneys worked closely with OI on a number of qui tam matters and helped the OIG recognize significant recoveries for VA. They played substantive roles in the investigations underlying the *Critical Deficiencies at the Washington DC VA Medical Center* and *VA Secretary and Delegation Travel to Europe* reports. Finally, the Office of Information Release continued to make substantial contributions to OIG's work this period, reviewing over 500 requests for agency records from the public and other government agencies, in addition to reviewing all OIG reports before publication for compliance with *The Privacy Act of 1974* and other disclosure laws.

Office of Contract Review

OCR conducts preaward and postaward reviews of significant VA proposals and contracts, and other projects concerning contracting matters as appropriate. The majority of the reviews relate to contracts awarded by VA under the Federal Supply Schedule program, construction contracts, and sole-source contracts with affiliated institutions for physician services. These reviews assist VA in achieving the best prices during negotiations, resulting in cost savings to the government and ensuring contractors comply with all contract terms and conditions. The office also ensures pharmaceutical manufacturers' compliance with the pricing provisions contained in the *Veterans Health Care Act of 1992* and provides support to the Department of Justice in litigation and investigations involving VA contracts, such as qui tam lawsuits.

During this reporting period, OCR has added three new positions to form a new Special Projects team. The work of the Special Projects team will be published, as opposed to OCR's current work that is reported only to VA due to the proprietary and confidential data involved in contracts and procurements. The new team will integrate the work of OCR's existing groups and will focus on systemic issues identified by OIG staff conducting reviews. Examples include pharmaceutical pricing policies and practices, payments and funding to VA's affiliated institutions, and fair and reasonable pricing

determinations. The Special Projects team will also undertake in-depth reviews of significant issues in VA contracting identified through the OIG Hotline and other sources.

Office of Special Reviews

The Office of Special Reviews was established in January 2018 to increase the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single existing OIG directorate or office. It is led by an executive director and a deputy director, who are in the process of staffing the office with professionals with a broad array of expertise. This office will undertake projects assigned to it by the IG and Deputy IG and will also work collaboratively with the other directorates to review topics and issues of interest that span multiple offices, such as community care for veterans. Several projects are currently underway and this new directorate is expected to begin issuing reports later in 2018.

Office of Congressional Relations

The OIG actively engages Congress on critical issues facing veterans. During this reporting period, the IG testified before the Senate Appropriations' Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on the OIG report, *Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*. The hearing examined VA's recent efforts to monitor veterans prescribed opioids by both VA healthcare providers and by community care providers paid by VA. The hearing included a discussion of VA's efforts to reduce doses and increase assessments. The IG also participated in the House Veterans Affairs' Committee roundtable discussion on the Government Accountability Office's (GAO) High Risk List and efforts VA must take to address both GAO and OIG recommendations.

The Inspector General and OIG staff had 50 briefings with Members and staff during this six-month period. These included prerelease briefings regarding the OIG report on the VA Secretary's travel to Europe and an assessment of VA protocols for TBI Compensation and Pension Examinations. OIG staff also addressed requests for information following publications on topics ranging from wait times for healthcare appointments to mental health treatment plans to VA contracting issues. Staff conducted outreach on OIG's new oversight product, CHIP reviews, including briefing many offices on individual VA medical center results. OIG staff fielded over 140 requests related to constituent casework for OIG review or referral.

Statistical Highlights

Table 1. Monetary Impact and Return on Investment

Type of Monetary Impact	6-Month Amount (in Millions)
Better Use of Funds	$865.8
Fines, Penalties, Restitution, and Civil Judgments	$15.4
Fugitive Felon Program	$144.2
Savings and Cost Avoidance	$557.9
Questioned Costs	$91.2
Dollar Recoveries	$12.9
Total Dollar Impact	$1,687.4
Cost of OIG Operations[1]	$68.2
Return on Investment[2]	**25:1**

[1] The six-month operating cost for OHI ($13.8 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] The return on investment is calculated by dividing Total Dollar Impact by Cost of OIG Operations.

Table 2. Reports and Work Products

Types of Reports Issued	6-Month Total
Audits and Evaluations	30
National Healthcare Reviews	2
Hotline Healthcare Inspections	17
Comprehensive Healthcare Inspection Program Reviews	31
Administrative Investigations	4
Preaward Contract Reviews	44
Postaward Contract Reviews	21
Claim Reviews	2
Subtotal	**151**
Other Work Products Issued	
Administrative Investigation Advisories	3
Administrative Investigation Closures	0
Administrative Summaries of Investigation	1
Audit Work Products	0
Healthcare Closures	0
Subtotal	**4**
Total Reports and Work Products	**155**

Table 3. Investigative Activities

Type of Activities[1]	6-Month Total
Arrests[2]	150
Fugitive Felon Arrests	7
Fugitive Felon Arrests Made by Other Agencies with OIG Assistance	5
Indictments[3]	106
Indictments and Informations Resulting from Prior Referrals to Authorities	61
Criminal Complaints	45
Convictions	115
Pretrial Diversions and Deferred Prosecutions	11
Case Referrals to Department of Justice for Criminal Prosecution[4]	224
Cases Accepted	58
Cases Declined	92
Cases Pending	74
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	46
Cases Accepted	33
Cases Declined	5
Cases Pending	8
Administrative Investigations Opened	10
Administrative Investigations Closed	7
Administrative Sanctions and Corrective Actions	142
Cases Opened[6]	333
Cases Closed[7]	338

[1] All investigative data reported and analyzed were collected via OIG's case management system. Please note that the OIG does not publish or issue investigative reports related to criminal investigations.
[2] Total arrests do not include Fugitive Felon arrests by OIG or other agencies.
[3] Indictments are a result of referrals made to prosecutorial authorities prior to the current reporting period.
[4] The VA OIG does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.
[5] The VA OIG does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.
[6] Cases opened includes administrative investigations.
[7] Cases closed includes administrative investigations. This total also includes cases opened in previous FYs.

Table 4. Hotline Activities

Type of Activities	6-Month Total
Contacts	16,320
Cases Opened (internal and external)	1,368
Cases Closed (external only)*	1,295
Administrative Sanctions and Corrective Actions*	711
Substantiation Percentage Rate*	41
Individuals Claiming Retaliation/Seeking Whistleblower Protection	52
Individuals Provided Office of Special Counsel Contact Information	59
Individuals Provided Merit Systems Protection Board Contact Information	29
Individuals Provided Office of Resolution Management Contact Information	143

* The totals for these activities include cases that opened in previous FYs.

Table 5. Other Office of Healthcare Inspections Activities

Type of Activities	6-Month Total
Clinical Consultations	6

Office of Healthcare Inspections Reports

Overview

OHI published two national healthcare reviews and 17 inspection reports responsive to OIG Hotline complaints on topics that are related to VHA operations and the access to and quality of care provided patients. The office also published 31 CHIP reports. Listings of all report recommendations for corrective action made during the reporting period are detailed on the OIG's dashboard at www.va.gov/oig. The dashboard allows users to track both the status and monetary impact of report recommendations published since October 2012.

High-Impact Reports

Highlighted below are three OHI reports that focused on issues and recommendations that can have significant impact on VA and the veterans it services.

Critical Deficiencies at the Washington DC VA Medical Center

This report is the result of an OIG inspection of the VAMC in Washington, D.C. (DC VAMC) that began in March 2017 after receiving a confidential complaint. The OIG released an interim report on April 12, 2017, identifying risks to patients and VA assets. This final report provided findings in four areas: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. The OIG found that critical deficiencies at the DC VAMC were pervasive and persistent—often spanning many years—but were not successfully remediated by leaders at multiple levels within VA. These deficiencies impacted core medical center functions that healthcare providers need to effectively provide quality care. The report details the DC VAMC's failures in ensuring supplies and equipment reached patient care areas when needed, processing and sterilizing instruments, managing and securing assets, maintaining cleanliness, providing timely prosthetic devices, properly reporting and analyzing patient safety events, and receiving the staffing and leadership needed for sustainable change. The OIG did not find evidence of adverse clinical outcomes, a condition that is largely attributable to front-line care providers who were committed to providing the best possible care by borrowing supplies, improvising, or personally ensuring patients received what they needed. The OIG made 40 recommendations and VA concurred with each one. VA also provided detailed action plans on how the recommendations are going to be implemented and identified the progress they have already made. This report is meant to not only improve conditions at the DC VAMC, but also to serve as a roadmap for other VA medical facilities and to improve integrated reviews and oversight by VISNs and VA central offices.

National Review – Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations

The OIG assessed all identified 2015 initial TBI Compensation and Pension (C&P) Examinations to determine if the examiners met certain VA stipulations. The OIG conducted the review in response to a legislative mandate and it was expanded at the request of Representatives Tim Walz (MN) and Mike Coffman (CO) to inform the House Committee on Veterans' Affairs about whether qualified care providers are conducting TBI C&P examinations. Also, as directed by Congress, the OIG reviewed a veteran's case and related complaint to the Montana Board of Psychologists to help inform the review.

The OIG found that among the 13,301 contractor examinations and 17,778 examinations performed by VHA staff, VA practice was generally consistent with stipulations related to the specialty and training of providers. The OIG determined, however, that the training curriculum requirements for conducting

examinations lacked rigor. In addition, the documentation of TBI C&P examination findings was insufficient to identify the basis for the assessment of findings of cognitive impairment or residuals (the symptoms and affected bodily functions) of TBI.

The OIG recommended that VA develop a plan to (1) ensure personnel performing TBI C&P examinations have comprehensive training on the evaluation of TBI, including the assessment and evaluation of cognitive disorders; (2) develop requirements for documenting the TBI C&P examination process, including the basis for determinations; and (3) consider whether disability ratings should be provided to veterans with claims arising from cognitive issues based on their clinical signs and symptoms, rather than primarily on the diagnoses or causes of their cognitive deficits.

Healthcare Inspection – Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor Healthcare System, Ann Arbor, Michigan

This report addressed the type of systems that must be in place to protect the lives of patients in VA facilities. This report evaluated the circumstances that led to the failure to resuscitate a patient with full-code resuscitation status who died at the VA Ann Arbor Healthcare System. The OIG found that a nurse caring for the patient incorrectly informed staff members that the patient had a Do Not Attempt Resuscitation order. This erroneous status was relayed to staff who responded as part of the Rapid Response Team. Resuscitation was not initiated, and the patient died. It is not clear whether resuscitation efforts would have been successful if employed at the time. VA staff caring for patients must be aware of resuscitation status, but in this case, inadequate safety measures were in place. The system's policies were inconsistent in identifying the staff responsible for determining a patient's resuscitation status prior to initiating resuscitative efforts. Do Not Attempt Resuscitation orders were not linked to the Clinical Warnings, Allergies, and Directives tab in patients' electronic health records. There was a misperception among physician staff that all patients on a telemetry unit were monitored via telemetry (continuous monitoring of heart rate and rhythm from a remote location), regardless of whether a telemetry order had been entered. Also, electronic health record documentation did not comply with requirements for resident supervision, medical decision making, and resident physician-to-attending physician discussion of care during an emergency situation. The OIG made six recommendations that were accepted by VA.

Additional National Review and Hotline Inspections

National Review: Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities

The OIG completed an assessment of how VHA facilities manage disruptive and violent behavior. It conducted this review at 29 VHA medical facilities from October 1, 2016, through March 31, 2017. While the OIG noted high compliance in multiple areas, some matters were noted as needing improvement, including establishing a required Employee Threat Assessment Team at each facility and the need for facilities to notify patients when Patient Record Flags are placed in electronic health records.

Healthcare Inspection – Opioid Agonist Treatment Program Concerns at VA Maryland Health Care System

The inspection of the VA Maryland Health Care System in Baltimore addressed allegations that the Opioid Agonist Treatment Program (OATP) lacked treatment planning and monthly counseling quality controls and, as a result, caused patient deaths. The OIG substantiated that the OATP lacked effective quality controls to ensure patients consistently received treatment planning and monthly counseling, due in part to a lack of staff supervision. However, the inspection team could not substantiate that these

missing measures resulted in patient deaths. In addition, the inspection revealed the lack of a clear monitoring policy over cardiac risk management and quality controls by the OATP Medical Director.

Healthcare Inspection – Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices at Oklahoma City VA Health Care System

This report was written in response to a congressional request for the OIG to evaluate the system's clinical, supervisory, and administrative practices. The OIG found that the root cause for many of these issues was poor and unstable leadership at a number of levels, most notably in the director position. New leadership was installed in May 2016. The OIG made 24 recommendations related to multiple program areas, processes, and operations that needed improvement across the Health Care System.

Healthcare Inspection – Administrative and Clinical Concerns at Central California VA Health Care System

The Central California VA Health Care System inspection in Fresno, California, addressed congressional concerns and anonymous complaints regarding allegations related to patient length of stay, poor inpatient flow, and nursing staffing shortages in the emergency department. Prior to conducting the inspection, the OIG requested system leaders address the allegations and provide improvement plans. Upon follow-up, the OIG found that the system failed to implement all the action plans and determined an inspection was warranted. Specifically, the system did not establish written protocols that included a process for transferring patients boarded in the emergency department to available VA and non-VA facilities or Community Living Centers (CLC) when acute inpatient beds were unavailable. The OIG made eight recommendations related to boarded patients in the emergency department.

Healthcare Inspection – Mental Health Care Concerns at Atlantic County Community Based Outpatient Clinic in Northfield, New Jersey

This inspection at the Atlantic County Community Based Outpatient Clinic addressed concerns from several members of Congress about limited patient access to mental health care. Specifically, there was concern that one patient's lack of access to timely mental health care may have contributed to suicide. The OIG identified several failures to provide the patient timely mental health care. Additional findings related to staff's nonadherence to scheduling instructions, lack of supervision in managing walk-in patients, and other care coordination issues.

Healthcare Inspection – Unexpected Death of a Patient: Alleged Methadone Overdose at Grand Junction VA Health Care System in Colorado

This inspection was initiated in response to allegations that a patient died of an accidental methadone overdose two days after receiving a prescription for methadone at the Grand Junction VA Health Care System. Although the OIG was unable to determine that the methadone contributed to or was the cause of the patient's death, the OIG found that the system lacked a process to ensure prescribers were aware of, or considered, VHA directives, policies, and guidance related to safe prescribing practices for methadone when treating chronic pain.

Healthcare Inspection – Alleged Women's Health Care Issues at Gulf Coast Veterans Health Care System in Biloxi, Mississippi

The inspection at the VA Gulf Coast Veterans Health Care System addressed allegations regarding women's healthcare services. The OIG made six recommendations, one of which related to ensuring

that providers consistently follow VHA cervical cancer screening guidelines so as not to subject women veterans to unnecessary screening procedures.

Healthcare Inspection – Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility

This report assessed the merit of allegations regarding a patient's mental health care management. The inspection findings related to staff misconceptions regarding residential rehabilitation treatment program admission criteria, but also generally poor communication practices among managing providers.

Healthcare Inspection – Delays in Processing Release of Information Requests at Bay Pines VA Healthcare System in Florida

This inspection at the C.W. Bill Young VAMC assessed allegations regarding a backlog of Release of Information (ROI) requests. The OIG substantiated the ROI backlog, but did not identify patient harm attributable to delays. The OIG made eight recommendations to improve processes for tracking and monitoring requests for patient health information as well as address staffing issues that contributed to the backlog.

Healthcare Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic in Georgia

The inspection at the Fort Benning VA Clinic located at the U.S. Army Garrison in Georgia addressed clinical practice and security concerns. The OIG substantiated several findings, including that the primary care provider did not follow up on prostate-specific antigen results, which delayed a patient's prostate cancer diagnosis and treatment. Although some of the site security-related allegations were substantiated, the OIG determined that U.S. Army Garrison police responded to calls and that panic alarms were not required in the clinic.

Healthcare Inspection – Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center in Columbus, Ohio

This OIG healthcare inspection assessed concerns about possible abuse, neglect, or financial exploitation of veterans residing in certain medical foster homes (MFHs) under the purview of the Chalmers P. Wylie VA Ambulatory Care Center. The OIG did not substantiate allegations that the veterans included in the review were at imminent risk for abuse, neglect, or financial exploitation. However, after determining these MFHs were in violation of VHA policy on state licensure requirements, the facility revoked VA's approval for all of these MFHs.

Healthcare Inspection – Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System

The inspection at the VA Connecticut Healthcare System, West Haven Campus, addressed allegations about a failure in notifying a patient of prostate-specific antigen results and that the lack of notification allowed prostate cancer to metastasize. The OIG did not substantiate the allegation but recommended that the facility director ensure providers follow VHA policy related to patient notification of test results.

Healthcare Inspection – Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley Veterans' Hospital in Tampa, Florida

The inspection of Haley's Cove CLC at the James A. Haley Veterans Hospital assessed allegations regarding patient safety and poor quality of care. The OIG conducted an unannounced inspection in February 2017 and found that the CLC units were clean, odor free, and well-maintained. However, the OIG inspected 46 CLC rooms and found that fall precautions were not consistently implemented and the facility did not have the recommended registered nurse staffing mix.

Healthcare Inspection – Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic, VA Palo Alto Health Care System in California

The OIG healthcare inspection addressed allegations that patients experienced extended wait times for primary care appointments and that funds intended to maintain and improve primary care services were misused. The OIG substantiated that patients experienced extended wait times for primary care appointments due, in part, to staff shortages. Allegations regarding the misuse of clinic funding, however, were not substantiated.

Healthcare Inspection – Mismanagement of Resuscitation and Other Concerns at the Buffalo VA Medical Center in New York

This inspection assessed the management of an attempted patient resuscitation and actions taken by facility leaders subsequent to a patient's death. Findings supported that the attempted resuscitation was mismanaged in that some staff were acting outside their scopes of practice and failed to initiate potentially life-saving interventions. The OIG identified concerns related to the facility's leadership, including a timely review of the event, removal of involved staff from direct patient care, and submission of an issue brief to the VISN.

Healthcare Inspection – Inadequate Intensivist Coverage and Surgery Service Concerns, Gulf Coast Veterans Healthcare System, Biloxi, Mississippi

This inspection evaluated allegations of inadequate staffing of intensivists (physicians who are specialists in the care of critically ill patients) and other Surgery Service concerns at the VA Gulf Coast Healthcare System (System). The OIG substantiated the System did not have full-time intensivist coverage during part of FY 2017. However, the System had taken actions to mitigate patient risk during times that an intensivist was not available, including granting core critical care privileges for hospitalists (physicians who are specialists in the care of patients in the hospital) and diverting admissions for patients possibly needing intensive care unit (ICU) services. The OIG recommended the VISN Director provide oversight of ICU and Surgery Service-related operations until conditions are resolved, and that the System Director follow through on incomplete actions and address improper health record documentation by two providers.

Comprehensive Healthcare Inspection Program Reports

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. The reviews are performed approximately every three years for each facility. There were 31 medical centers and healthcare systems reviewed in the six-month reporting period (see Appendix A for a full listing). The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus included the following:

1. Leadership and Organizational Risks
2. Credentialing and Privileging
3. Quality, Safety, and Value
4. Environment of Care
5. Medication Management
6. Coordination of Care
7. Mental Health Care
8. Long-Term Care
9. Women's Health
10. High-Risk Processes

Office of Audits and Evaluations Reports

Overview

The OAE published 30 reports during this SAR period. These include a focus on issues that have tremendous impact on veterans' health and benefits, management of VA resources and taxpayer dollars, and the effective operations of VA programs and services. As with other OIG published reports, the OAE recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on monetary impact and the implementation status of report recommendations published since October 2012. Figure 1 depicts OAE staff assignments by oversight areas to include health care, contracts and construction, information technology, benefits, financial management, and headquarters/support for the SAR period.

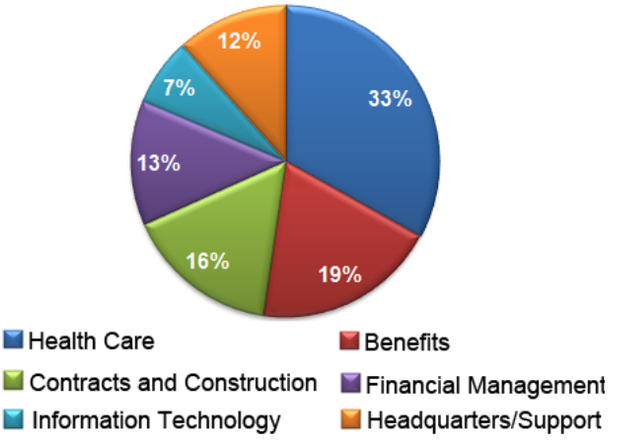


Figure 1. OAE Staff Assignments by Oversight Area

High-Impact Reports

The following three publications provide examples related to the mismanagement of resources for the provision of primary care to veterans, the oversight of high-risk programs such as the payments related to the Veterans Choice Program (Choice) that provides community care, and claims processing actions at pension management centers.

Audit of VHA's Management of Primary Care Panels

Veterans are assigned a primary care provider to ensure easy access to providers familiar with their needs. The group of veterans assigned to a provider is called a primary care panel. In evaluating whether VHA effectively managed these panels, the OIG determined that VHA did not ensure compliance with recommended panel sizes or require facilities to explain why they deviated from those recommendations. The OIG concluded that smaller panel sizes can have several negative ramifications. For example, they result in an over-expenditure by VA on salaries and other costs for providers who are paid but not functioning at full capacity. The OIG determined that six of seven medical facilities had 13–30 percent fewer veterans than the number VHA recommended in the primary care panels. This equated to an estimated $169 million in underutilized provider salaries in FY 2015. When extrapolated, the monetary impact would be about $843 million over five years if OIG recommendations to strengthen primary care panel management are not implemented. VA concurred with OIG recommendations to ensure facilities either set panel sizes at VHA's model goals or justify deviations. Also, VHA did not track the wait time from the date of enrollment to the date of scheduling the first patient appointments. As a result, VHA's recorded wait times did not accurately reflect the wait experienced by the population of veterans the OIG reviewed. VHA's recorded wait time incorrectly showed about eight percent of newly enrolled veterans in the first seven months of FY 2015 waited more than 30 days. However, when including the time between the date a veteran enrolled for care until the date the facility scheduled the appointment, the OIG determined that about 53 percent of the veterans experienced wait times exceeding 30 days. OIG recommendations to establish standardized new enrollee scheduling procedures that properly track wait times were accepted.

Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System

The Choice program entitles veterans to seek medical care outside VA medical facilities when warranted and has been identified by the OIG as a high-risk program. In FY 2018, OAE provided additional oversight of Choice programs and reviewed payments processed through VA's Fee Basis Claims System from November 2014 through September 2016. Under the Choice contract, VA makes payments to Third Party Administrators (TPAs) to process claims and pay Choice medical providers. This audit helps fulfill the congressional requirement for the OIG to report on the accuracy and timeliness of VA payments for medical care provided under that program. The OIG sampled 2 million Choice claims during that time period. The OIG determined that because of weak internal controls over the payment process an estimated 224,000 Choice claims were paid in error with $39 million in overpayments by VA to TPAs. In addition, 1 million claims were processed in excess of the 30-day Prompt Payment Standard. The OIG determined weak internal controls over the payment process contributed to these errors. For example, the VHA's Office of Community Care did not establish clear written policies for Choice claim payments, ensure quality information was available to payment staff, use an information system that could adequately address overpayment of medical claims, establish monitoring activities to determine if payment controls worked, or accurately estimate staffing needs for claims processing. VHA concurred with the OIG recommendations and agreed that a full review of Choice payments and recovery of all identified overpayments is essential.

Review of VBA's Claims Processing Actions at Pension Management Centers

Pension Management Centers (PMCs) provide benefits and services to some of the most vulnerable veterans and survivors, in part, because it is based on financial need. Three PMCs (St. Paul, Philadelphia, and Milwaukee) process pension claims. This review focused on rating decisions that impacted original pension claims and claims processing actions related to Medicaid-covered nursing homes. The OIG found St. Paul PMC staff failed to order general medical examinations to support veterans' pension claims—denying 88 percent of those requiring rating decisions in 2015. St. Paul management and staff misinterpreted VBA's guidance on requesting general medical examinations to support pension claims, and VBA lacked oversight for identifying inconsistent rating practices among PMCs. A VA general medical examination may provide the medical evidence necessary to assess disabilities that prevent gainful employment. Therefore, it is important that PMC staff ensure medical documentation is considered when reviewing pension claims. Consequently, absent the medical examination, claims processed by the St. Paul PMC were more likely to be denied when compared to the other two PMCs. The OIG recommended that VBA clarify guidance and provide training on ordering general medical examinations to support original pension claims, review denied pension claims to determine whether examinations were required, and implement a plan to ensure rating consistency. Also, the OIG found that claims processors at the PMCs delayed and inaccurately processed pension benefits reduction cases when beneficiaries resided in Medicaid-covered nursing care facilities because of the lack of training, performance measures, and workload prioritization for Medicaid cases. Delays and inaccuracies found in 1,900 of 2,800 Medicaid benefits reduction cases completed in 2015 resulted in an estimated $6.9 million in improper benefits payments. If the PMCs continue to delay and inaccurately process these adjustments, VBA will pay approximately $34.5 million in improper benefits from calendar years 2016 through 2020. Accordingly, the OIG also recommended that VBA prioritize benefit reduction actions and develop workload performance measures for these cases associated with Medicaid-covered nursing homes.

Additional Veterans Health Administration Audits and Evaluations Reports

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

Audit of Medical Support Assistant Workforce Management at the Phoenix VA Health Care System

In response to a congressional request to evaluate the effectiveness of the Phoenix VA Health Care System's (PVAHCS) management of its outpatient Medical Support Assistant (MSA) workforce, the OIG examined two allegations of MSA mismanagement. Although those two were unsubstantiated, the OIG determined the PVAHCS needs to ensure its outpatient MSA operations align with clinical operational needs. PVAHCS's Health Administration Service was unable to account for the number and clinical location of almost 60 percent of its MSAs. The Office of Personnel Management's hiring model allows agencies 80 days to fill a vacancy and VA's metric allows 60 days. While the PVAHCS did not maintain adequate documentation on time used to fill vacancies, the OIG concluded that the PVAHCS generally did not meet these metrics. Additional findings included newly hired MSAs were not put on performance plans within the required 60 days and all available data was not used to improve MSA retention.

Review of Potential Purchase Card Misuse at Veterans Integrated Service Network 15

In response to a request from the former Chairman of the House Committee on Veterans' Affairs for a review, the OIG concluded that VISN 15 purchase cardholders did not exceed the micro-purchase threshold or split purchases on a contract for restroom supplies. After the contract expired, however, purchase cardholders made 18 split purchases valued at approximately $73,000 when placing Federal Supply Schedule orders to buy restroom supplies from the same vendor that had performed the expired contract. These split purchases resulted in unauthorized commitments and improper payments because cardholders continued to act as if they were operating under the contract. Although the orders were similar to those allowable under the expired contract, they were considered split purchases under the Federal Acquisition Regulation because they were no longer governed by the contract.

Audit of Alleged Beneficiary Travel Processing Irregularities at the VA Medical Center in Phoenix, Arizona

In response to a Hotline complaint, the OIG reviewed allegations that the Carl T. Hayden VAMC did not consistently process beneficiary travel mileage claims. The allegation that VAMC staff improperly reimbursed beneficiaries more than once for the same travel was not substantiated. The OIG did observe, however, that the medical center did not have written procedures directing staff when automated controls alerted them of potential duplicate claims and payments. Although not a widespread problem, some VAMC staff violated policy in approving beneficiary travel mileage claims using post office boxes as beneficiaries' departure addresses instead of physical addresses because the VAMC lacked a local quality review program. VAMC staff also unnecessarily reimbursed most beneficiary travel in cash, rather than by electronic fund transfer.

Review of Excessive Procurement Costs at the Rural Outreach Clinic, Laughlin, Nevada

At the request of former U.S. Senator Harry Reid, the OIG reviewed allegations of excessive rent and remodeling costs, lack of radiology services, and inadequate handicap accessibility at the Master Chief Petty Officer Jesse Dean VA Clinic. The OIG found that VA paid excessive lease costs for the clinic when it awarded a 10-year contract at a rate higher than the established fair rental value (FRV).

Additionally, VA paid for improvement costs for the clinic that were the lessor's responsibility. The contract file had no documents to explain or justify the lease's higher rate, nor was there evidence of any reviews having occurred prior to awarding the lease. As a result, VA may pay as much as 41 percent above FRV over the 10-year lease. The OIG did not substantiate other allegations related to remodeling costs, radiology services, or clinic accessibility.

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15

This audit assessed the reliability of wait time data and evaluated whether VISN 15 provided timely access to health care within its medical facilities and through Choice, and whether they appropriately managed consults. The OIG estimated that new patients waited an average of about 18 days, and 18 percent of the appointments for new patients at VISN 15 facilities had wait times longer than 30 days. This was higher than the estimated 10 percent that the VHA electronic scheduling system showed. Staff did not correctly record clinically indicated dates for about 38 percent of the new patient appointments, which understated wait times by about 15 days. Inaccurate wait time data resulted in veterans not being identified as eligible for Choice. With respect to veterans in VISN 15 who received care through Choice, the OIG estimated that the overall average wait time was 32 days. The audit estimated that 41 percent of the appointments had wait times longer than 30 days, and those veterans waited an average of 58 days. Also, the OIG's Office of Healthcare Inspections identified clinical concerns with six patients, and determined that one patient likely had an adverse outcome as a result of a delay in care. The OIG made 11 recommendations.

Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs

At the request of U.S. Senator Johnny Isakson, the OIG assessed the timeliness of power wheelchair and scooter repairs at the Atlanta VA Health Care System. The OIG used a 30-day benchmark to assess timeliness because Prosthetic and Sensory Aids Service did not have a timeliness standard for the completion of repairs. The OIG confirmed that VISN 7 medical facilities, including the Atlanta VA Health Care System, did not ensure the timely completion of repairs. As a result, the OIG projected 380 veterans in VISN 7 experienced delays in the completion of approximately 480 repairs in FY 2016 and waited an average of 69 days for repair completion. These delays occurred because VISN 7 prosthetic service managers lacked policies for ensuring VA medical facility staff promptly input repair requests and prosthetic service purchasing staff adequately monitored repairs and held vendors accountable for timely repairs. Although the OIG could not confirm that the delayed repairs financially impacted veterans, some veterans experienced related physical hardships.

Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post-Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System

In response to allegations raised by several U.S. Senators and U.S. Representatives regarding the VA Eastern Colorado Health Care System (ECHCS), the OIG initiated a review and substantiated that the ECHCS staff improperly used unofficial wait lists for group therapies and the Post-Traumatic Stress Disorder Clinic Team (PCT) staff did not timely process consults, resulting in inaccurate wait times and lack of assurance that staff scheduled all requests. PCT staff inaccurately recorded dates for calculating wait times for an estimated 91 percent of consults that resulted in care, and improperly closed an estimated 40 consults without adequate documentation of scheduling efforts. As a result, veterans experienced underreported delays by an estimated 50 days for initial treatment. The OIG did not substantiate PCT staff falsified the veteran's medical records. The ECHCS Director concurred with all OIG recommendations and provided corrective action plans.

Review of Alleged Irregularities with the Health Eligibility Center's 365-Day Response Letters to Individuals with Pending Health Care Enrollment Records

The OIG evaluated allegations that the Health Eligibility Center (HEC) sent letters to veterans requesting verification of military service when there was only missing financial information needed, and vice versa. The OIG also evaluated allegations that the VHA planned to declare more than 500,000 healthcare applications incomplete or abandoned at the end of March 2017, thereby deleting the records from the enrollment system. The OIG did not substantiate the allegation that VHA sent individuals with pending records the incorrect letter. The OIG independently traced and verified that the printer proofs for each batch of form letters printed and mailed by the vendor matched the letters sent to the veteran by HEC's contracting officer. The content for both outreach form letter types was appropriate and complied with statutory requirements. The OIG also did not identify evidence that VHA has or planned to prematurely close or delete pending enrollment records prior to the required retention period. Staff conducting day-to-day enrollment activities could not remove or delete these records. Overall, the OIG did not substantiate either allegation and therefore made no recommendations for improvement.

Review of Selected Construction Projects at Oklahoma City VA Health Care System

The OIG reviewed potential mismanagement in the planning and oversight of two construction projects at the Oklahoma City VA Health Care System (OKCVAHCS). The surgical unit and operating room (OR) projects were scheduled for completion in February 2015 and September 2016, respectively, for about $18 million. The OIG concluded VISN 16 and OKCVAHCS officials mismanaged both projects. As of January 2018, the surgical unit project was about 60–65 percent complete, yet the construction contractor had been paid about 93 percent of the allocated construction funds. Inadequate oversight by OKCVAHCS officials contributed to widespread workmanship deficiencies. The decision by these officials to prematurely start the OR project resulted in conflicts between contractors working simultaneously in overlapping space. As a result, the OR project was suspended pending completion of the surgical unit project resulting in delay costs. In May 2017, a VA Administrative Investigative Board reported that an *Antideficiency Act* violation occurred because OKCVAHCS staff removed an elevator from the surgical project and added it to the OR project in an effort to keep the surgical project classified as "minor construction." The OIG recommended sealing surgical construction areas, implementing procedures to strengthen oversight, and considering administrative action for key responsible officials.

Audit of the Personnel Suitability Program

The OIG evaluated controls over the adjudication of background investigations at VA medical facilities and found VA did not effectively manage the personnel suitability program to ensure investigations were completed for facility staff and estimated that about 6,200 required investigations were not initiated. Adjudicators had not been reviewing investigations in a timely manner and suitability staff were not maintaining the required official personnel records. The OIG also found VA could not independently attest to the status of suitability determinations and could not rely on human resources investigation data because the fields necessary to track investigations to conclusion were missing or incomplete. The OIG recommendations focused on improving oversight, monitoring and reporting, data collection and integrity, quality reviews, workload analyses, and other measures to ensure investigations are properly initiated and adjudicated.

Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

The OIG reviewed an allegation that VA officials did not comply with contract requirements and did not follow Occupational Safety and Health Administration (OSHA) requirements, creating an imminent danger. The OIG did not substantiate that VA staff or equipment was used to move excavated soil during the installation of a Full Facility Standby Generator at the medical center. However, the OIG substantiated the allegation that VA officials provided inadequate assurance of contractor compliance with OSHA requirements at the excavation site. The construction safety officer did not follow VA policy on the frequency of safety inspections and did not effectively implement the periodic safety inspections. The Chief of the Engineering Service did not ensure the contracting officer's representative had the experience to provide oversight of the excavation. VA officials terminated the contract after paying nearly $5 million. An estimated additional $17.5 million will be spent to fix problems that arose for total expected costs of $22.5 million.

Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System

The OIG assessed the effectiveness of the Oklahoma City VA Health Care System's (Health Care System) oversight of its disbursement agreement and time and attendance for part-time physicians. The OIG found that managers did not monitor resident participation to ensure they were performing VA work as scheduled or that part-time physicians met their employment obligations. The Health Care System lacked required local policies and procedures for resident educational activity record keeping, did not adequately monitor resident participation in educational activities, and did not reconcile activity records with invoices submitted to the affiliated medical school. Former Health Care System directors also did not appoint a team to conduct required periodic audits of the disbursement agreement and so lacked adequate documentation to substantiate its reimbursement payments for residents. There was no assurance the Health Care System received all of the resident services that it paid for. Because it did not reconcile payments made to part-time physicians on adjustable work schedules with actual work performance, it made approximately $507,000 in improper payments.

Review of Research Service Equipment and Facility Management at the Eastern Colorado Health Care System

In response to a congressional request, the OIG investigated allegations of widespread equipment mismanagement at the research laboratories of the ECHCS in Denver, Colorado. The OIG substantiated allegations about ECHCS Logistics and Research Services' mismanagement of research equipment, materials, and specimens. Its research facilities, chemicals, and veterans' personally identifiable information were also inadequately secured. The monetary waste on equipment due to VA staff mismanagement was uncertain, as the majority of the equipment sampled was near or beyond its useful life span and likely had little to no residual monetary value. The OIG noted the ECHCS Medical Center Director implemented an action plan that included processing the existing unrequired and abandoned equipment. The OIG did not identify anything inappropriate with the transfer of VA research equipment to the University of Colorado.

Veterans Benefits Administration Audits and Evaluations Reports

The OIG performs audits and evaluations of veterans' benefits programs, focusing on the effectiveness of benefits delivery to veterans, dependents, and survivors to identify ways in which program operations and services can be improved.

Audit of the National Pension Call Center

The OIG conducted this audit to determine whether the National Pension Call Center (NPCC) is providing timely and quality assistance to veterans and their families. The OIG found VBA management needed to improve the NPCC's oversight of quality reviews and training. NPCC supervisors did not review or take corrective actions for calls evaluated by quality-review specialists. VBA management lacked reasonable assurance that the NPCC's hours of operation provided sufficient availability for pension recipients to speak with agents. Also, the Philadelphia VA Regional Office (VARO) staff mailed documentation that included personally identifiable information to incorrect addresses. VBA managers did not analyze the available call data to determine the number of calls that go unanswered after the close of NPCC's business day. Based on the OIG's recommendations, the concurring Acting Under Secretary for Benefits provided an implementation action plan.

Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia

The OIG received an anonymous allegation that Veterans Service Center staff at the Roanoke VARO combined appeals to lower the pending inventory and achieve production goals by entering incorrect data into VA's electronic system. The OIG substantiated the allegation that Roanoke VARO appeals management and staff entered incorrect appeals data and prematurely closed appeal records. In some cases with more than one pending appeal, an appeals team member instructed appeals managers and staff to close newer appeals, which were marked as withdrawn by the appellant absent any evidence of a withdrawal. Any pending appeal issues were merged into the oldest appeal record with both records noting the merger of issues. Therefore, the reported statistics for the number of pending and completed appeals were inaccurate, giving a false impression that the appeals inventory decreased, and the associated timeliness measurements were unreliable.

Audit of Vocational Rehabilitation and Employment Program Subsistence Allowance Payments

The OIG found that VBA's management of the Vocational Rehabilitation and Employment (VR&E) program ensured that accurate and timely subsistence allowance payments were made to eligible veterans. In a sample of 120 subsistence allowance payments disbursed in November 2016, the OIG identified only four errors of overpayments and underpayments at two of the four VA regional offices visited. The four errors stemmed from a failure to update files and constituted a 3.3 percent incidence of error. The cumulative monetary impact to VA was $12,532 for the duration of the errors for the four cases involved. Because of the relatively small monetary impact reflected in the errors identified, the OIG made no recommendations.

Review of Timeliness of the Appeals Process

The OIG conducted this review to determine whether opportunities continued to exist for VBA staff to improve the timeliness of appeals processing. The OIG found that VBA staff did not always timely process the benefit appeals workload. Generally, periods of inactivity occurred because (1) VBA senior leaders prioritized the rating claims backlog over other workload and did not dedicate sufficient

resources to timely address appeals; (2) VBA had an ineffective procedure for notifying VA Regional Offices when they were required to process Board of Veterans Appeals grants; (3) some appeals were prematurely closed because VBA staff failed to update, or incorrectly updated, the electronic system and relied on an automated function to close some appeals; and (4) VBA staff failed to follow the Board's remand instructions due to inattention to detail and ineffective oversight. In some cases, delays caused by VBA resulted in appellants waiting years to receive favorable decisions and compensation. Delaying decisions also resulted in some appellants paying more of their benefits to accredited attorneys and agents, and some appellants died before receiving final decisions on their appeals. Processing errors also resulted in loss of control of some appeals, misrepresented VA's reported statistics, and caused unnecessary delays.

Other Audits and Evaluations Reports

The OIG performs audits of administrative support functions and financial management operations, focusing on the adequacy of VA systems in providing managers information needed to efficiently and effectively oversee 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.

In addition, the OIG performs audits of information technology (IT) and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and protecting veterans and VA employees, facilities, and information. OIG audit reports present VA with constructive recommendations 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.

Audit of VA's Financial Statements for FYs 2017 and 2016

This audit is an annual legislative requirement. The OIG contracted with the independent public accounting firm Clifton Larson Allen LLP (CLA) to audit VA's financial statements for the prescribed period. CLA provided an unmodified opinion on VA's financial statements for FYs 2017 and 2016. With respect to internal controls, CLA identified six material weaknesses: (1) compensation, pension, burial, and education actuarial estimates; (2) community care obligations, reconciliations, and accrued expenses; (3) financial reporting; (4) loan guarantee liability; (5) Chief Financial Officer organizational structure; and (6) information technology security controls. CLA further identified the following significant deficiencies: procurement, undelivered orders, accrued expenses, and reconciliations. The report also covers areas of noncompliance and needed improvements. CLA made recommendations for addressing each of the material weaknesses and significant deficiencies.

Review of VA's Reimbursements to the Treasury Judgment Fund

The Committee on Appropriations requested the OIG review VA's reimbursement to the Treasury's Judgment Fund relating to the payment of contractors for major medical construction projects to settle contract dispute claims. The OIG found VA did not reimburse the Judgment Fund in accordance with Title 31 CFR §256.40. From October 1, 2011, through September 30, 2016, the Department of the Treasury paid 23 claims related to 10 major medical facility construction projects totaling $247,748,686. VA has been delinquent in reimbursing the Judgment Fund because VA has not been requesting sufficient funding for the reimbursement of *Contract Disputes Act of 1978* claims. Accordingly, VA

has maintained significant liabilities not covered by budgetary resources. In response to the OIG's recommendations, the Acting Assistant Secretary for Management reported VA will update its policy to reflect all requirements.

Review of Alleged Mismanagement of the Real Time Location System Project

The OIG received an allegation that VA management failed to comply with VA policy and guidance when it deployed Real Time Location System (RTLS) assets without appropriate project oversight and without meeting VA information security requirements. The review found that the RTLS Project Management Office did not follow guidance from VA's Technology Acquisition Center to use an incremental project management approach and did not follow VA's project implementation policy requiring the use of the Project Management Accountability System for all acquisitions and delivery of RTLS assets. Additionally, the OIG found that RTLS assets were connected to the VA network without proper testing and approval of system security controls in accordance with VA's risk management framework. As a result, VA's internal network faced unnecessary risks from these untested RTLS security controls.

Audit of VHA's Use of Appropriations to Develop a System Enhancement and Mobile Health Applications

The OIG conducted this audit to determine whether VA used non-IT systems appropriations to finance IT development costs. The OIG found in this report that the VHA Chief Business Office misused approximately $3.1 million of Medical Support and Compliance (MS&C) appropriations when they funded the Debt Management Center's development of the Veterans Health Information Systems and Technology Architecture system enhancement. MS&C appropriations are only authorized for necessary expenses in the administration of medical, hospital, nursing home, domiciliary, construction, supply, and research activities—not IT development. As a result of the OIG's work, in June 2016, the Office of Management reimbursed the VHA the approximately $3.1 million inappropriately used. The OIG also found that VHA used the MS&C, Medical Services, and IT Systems appropriations to finance five mobile health application development contracts. VHA's improper use of multiple appropriations for the same purpose resulted from a lack of updated financial policies on funding mobile health application development. As a result, VHA lacked consistency and transparency in the execution of its appropriations.

Review of Alleged Funding and Security Issues of the Veterans Services Adaptable Network at VA Medical Center, Orlando, Florida

The OIG received an allegation that Veterans Service Adaptable Network (VSAN) development efforts were not coordinated with the Office of Information and Technology (OI&T) and that project funding was inappropriately coming from medical services appropriations rather than IT funding. An OIG review of a Hotline complaint found that the development of VSAN at the Orlando VAMC was not coordinated with OI&T. Specifically, the Orlando VAMC and OI&T did not perform a security risk assessment or implement security controls to segregate VSAN from VA's network. The OIG did not substantiate that the Orlando VAMC inappropriately used $5.2 million in medical appropriations funds to purchase IT hardware, software, and installation services in support of the VSAN system as alleged.

Audit of Interior Design and Furnishings Contract Mismanagement by the Network Contracting Office 21

This audit was in response to a Hotline allegation regarding the Network Contracting Office (NCO) 21's award of a $3.3 million contract to the Contract Office Group, Inc. (COG) to provide interior design services and furnishings to renovate a Sacramento VA Medical Center campus building. The audit determined that a former NCO 21 contracting officer did not ensure adequate competition as required. The contract with COG also violated the rule mandating that a fiscal year's appropriations only be obligated to meet a bona fide need arising in (or before) the fiscal year for which the appropriation was made. Performance under the contract exceeded authority limitations when it continued past the contract's original performance end date. As a result, VA was exposed to the risk of making payments for services and goods using funds that could have been deobligated and reallocated. Also, VA missed opportunities to reallocate $1.1 million of unspent funds.

Independent Review of VA's FY 2017 Detailed Accounting Submission to the Office of National Drug Control Policy

As required by a January 18, 2013, Office of National Drug Control Policy (ONDCP) Circular, the OIG must review the FY 2017 Detailed Accounting Submission by VA to the ONDCP. The OIG reviewed VA management's assertions concerning VA's drug control methodology, application of the methodology, reprogrammings or transfers, and fund control notices. With the exception of the effects, if any, of material weaknesses or significant deficiencies that the OIG previously identified in the *Audit of VA's Financial Statements for Fiscal Years 2017 and 2016*, the OIG's review did not identify anything that caused reviewers to believe management's assertions included in VA's submission were not fairly stated in all material respects consistent with the criteria set forth in the circular. This report is one of two OIG products that examine VA's reporting requirements to ONDCP.

Independent Review of VA's FY 2017 Performance Summary Report to the Office of National Drug Control Policy

The OIG is also required to review VA's FY 2017 Performance Summary Report to the ONDCP. According to the specified criteria and requirements, the OIG reviewed whether VA has a system to accurately capture performance information and properly apply it to generate the performance data provided in the summary report. The OIG did not identify anything that caused reviewers to believe VA lacked a system to accurately capture performance information or that the system was not properly applied to generate the performance data reported. This report is the second of two OIG publications that examine VA's reporting requirements to ONDCP.

Review of Alleged Unsecured Patient Database at the VA Long Beach Healthcare System

The OIG substantiated allegations that an unauthorized Microsoft Access database was developed by VA Long Beach Healthcare System Spinal Cord Injury (SCI) employees to capture patient demographics and to provide a repository for all SCI Centers to track patient data at VA. The OIG team found multiple instances of databases that hosted unsecured veteran sensitive personal information (SPI) including on a server outside of VA's protected network environment in violation of VA policy. OIG recommendations focused on compliance with VA's Privacy Program and information security requirements for all veteran sensitive data collected and suggested the Executive Director for the National Spinal Cord Injury Program Office discontinue storing SPI in unauthorized Microsoft Access databases. The OIG also

recommended that Field Security Services and VA's Privacy Service implement improved procedures to identify unauthorized uses of SPI and take appropriate corrective actions.

Audit of VA's Compliance with the Digital Accountability and Transparency Act

The OIG contracted with an independent public accounting firm for a performance audit of VA's compliance with the *Digital Accountability and Transparency Act of 2014* (DATA Act). The contractor reported that VA did not fully comply with the DATA Act due to weaknesses in VA's existing financial management systems and internal controls related to source systems, data management, and data reporting processes. As a result, VA did not submit complete, timely, quality, and accurate financial and award data to USASpending.gov for the second quarter of FY 2017. The contractor recommended that VA continue its system modernization efforts and coordinate with VA's shared service provider to ensure DATA Act requirements will be met. The contractor made 21 recommendations for improving VA's compliance with the DATA Act.

Office of Investigations Activities

Overview

The Office of Investigations (OI) focuses on a wide range of cases that can have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 370,000 employees; offenses by VA employees and non-employees affecting the Department's programs and operations, as well as allegations of serious violations of policies and procedures by high-ranking VA staff.

High-Impact Cases and Reports

The cases highlighted below illustrate OI's emphasis on cases that ensure benefits and services meant for veterans are being received by the individuals for whom they were intended; result in monetary recoveries for VA that can be reinvested in programs, services, and benefits; address fraud, waste, and abuse by VA employees in positions of trust; and give some measure of relief to victims of crime.

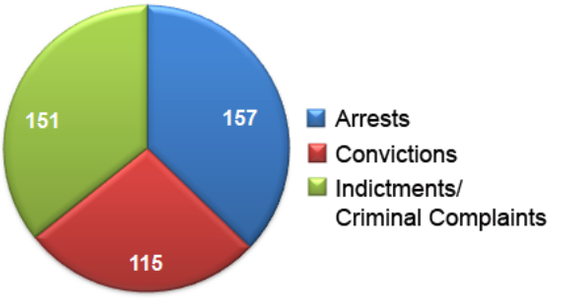


Figure 2. OI Prosecutive Statistics

Criminal Cases

Service-Disabled Veteran-Owned Small Business Fraud

A joint investigation involving the VA OIG, Small Business Administration (SBA) OIG, Defense Criminal Investigative Services, Department of Labor OIG, and Federal Bureau of Investigation (FBI) revealed that five defendants were owners of and/or officers in multiple companies classified and operated as small businesses. The companies, at one point, benefitted from the SBA 8(a) set-aside program's Service-Disabled Veteran-Owned Small Business (SDVOSB) program. The investigation revealed that from February 2003 until October 2014, the defendants conspired with one another and other individuals to defraud the government of over $140 million in contract payments for a profit of approximately $24 million. The VA-specific contracts were worth about $7.9 million. One of the defendants died prior to plea negotiations; two defendants pled guilty to conspiracy to commit wire fraud and were sentenced; one pled guilty to conspiracy to defraud the government with respect to improper claims and was sentenced; and the last of the five defendants pled guilty to false official writings and is awaiting sentencing for claiming to own 100 percent of a minority and woman-owned small business company, when the defendant in fact had one-third ownership.

West Los Angeles, California, VAMC Bribery Investigation

A West Los Angeles VAMC contracting officer was charged with lying to VA OIG agents and filing a false tax return after admitting he accepted approximately $286,250 in cash bribes from a VA contractor. The contractor entered into a sharing agreement with VA for parking services for the medical center, which required the contractor to pay 60 percent of gross parking revenue to VA. Between 2003 and 2016, the contractor allegedly defrauded VA of approximately $12.1 million, not including unreported cash revenue and funds owed to VA for 2017. The investigation resulted in charges that the contractor bribed the contracting officer to commit fraud. The contractor was arrested in November 2017 and remains in custody with a trial date scheduled for June 12, 2018. The VA contracting officer pled guilty and is awaiting sentencing.

Education Benefits Fraud Investigation

A VA OIG, FBI, and Department of Education OIG investigation revealed that between 2011 and 2013, a university and a private company defrauded VA and veterans. As part of the conspiracy, the defendants prepared and submitted an application to VA stating that their courses were developed, taught, and administered by the university faculty. The private company began aggressively marketing the courses to veterans who were eligible to receive Post-9/11 G.I. Bill benefits. Veterans were enrolled in an online program. The program was actually an unapproved correspondence course developed and administered by an unapproved third-party school. Neither the private company nor the third-party subcontractor was ever disclosed to the government, and neither was eligible to receive Post-9/11 G.I. Bill benefit program funds. The former owner of the private company, a former senior-level director of that company, and a former dean of the college have pled guilty to conspiracy to commit wire fraud and agreed to pay total restitution of $24 million. The former dean paid a forfeiture of $73,055 prior to her guilty plea, and the former director agreed to a forfeiture of $426,547. The former owner of the private company pled to a prison term of five years and forfeited proceeds of the crime, including $702,073 in cash, artwork, and stocks. Civil and criminal negotiations are ongoing with the university and current employees.

Drug Diversion from Veterans' Accounts

An OIG and VA Police Service investigation revealed that for over six months a Bradenton, Florida, VA Community Based Outpatient Clinic employee changed the addresses of 19 veterans in VA's Computerized Patient Record System (CPRS) to her own address. The defendant then called VA's Consolidated Mail Outpatient Pharmacy and ordered refills of the veterans' tramadol prescriptions utilizing the veterans' Social Security numbers and prescription numbers. After receiving the shipments of tramadol, the defendant changed the veterans' addresses in CPRS back to their correct address. The defendant diverted 28 shipments of tramadol, totaling 4,020 individual pills. She resigned from VA pursuant to this investigation, entered a guilty plea to one count of Obtaining Possession of a Controlled Substance by Misrepresentation, Fraud, Forgery, Deception, or Subterfuge and was sentenced to four years' probation.

Administrative Investigation

VA Secretary and Delegation Travel to Europe

The OIG received an anonymous complaint alleging that then-Secretary of Veterans Affairs David Shulkin and other senior leaders misused VA funds by taking an official July 2017 trip to Europe for more personal than official activities. Secretary Shulkin traveled with a group that included senior VA leaders, his wife, and a six-member security detail. The 11-day trip included two extensive travel days and three-and-a-half days of official events—with a cost to VA of at least $122,334. The VA delegation had a day-and-a-half of meetings with Danish veterans' healthcare officials and experts in Copenhagen and attended the Ministerial Summit on Veterans' Affairs in London. Secretary Shulkin stated that he also worked on VA matters when there were no official functions. The group's schedule, however, included significant time for preplanned tourist activities.

After a thorough investigation, OIG's findings included (1) the Chief of Staff's alteration of an email and misrepresentations to ethics officials caused Secretary Shulkin's wife to be approved as an "invitational traveler," which authorized VA to pay her travel costs (although only airfare was claimed); (2) Secretary Shulkin improperly accepted a gift of Wimbledon tickets and related hospitality; (3) a VA employee's time was misused as a personal travel concierge to plan tourist activities exceeding that necessary for security arrangements; and (4) travelers' documentation was inadequate to determine the trip's full costs

to VA. The OIG did not assess the value of the trip to VA or determine whether the Europe travel, as conducted, was "essential" per VA policy. The OIG's five recommendations were accepted by VA to ensure reimbursement by the travelers of all unallowable expenses incurred; redress any VA employee misconduct; and retrain VA personnel on ethics and travel policy matters.

Veterans Health Administration Investigations

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this SAR period, OI opened 152 cases; made 70 arrests; obtained nearly $725,000 in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved over $1.9 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The case summaries that follow provide a representative sample of the type of VHA investigations conducted during this period.

OI values the work of other federal, state, and local agencies engaged in the listed multi-agency investigations, including the following:

- Air Force Office of Special Investigations
- Army Criminal Investigation Command
- Defense Criminal Investigative Service
- Department of Agriculture OIG
- Department of Education OIG
- Department of Energy OIG
- Health and Human Services OIG
- Department of Homeland Security (DHS)
- Department of Housing and Urban Development OIG
- Department of Labor (DOL) OIG
- Drug Enforcement Administration
- Federal Drug Administration (FDA) Office of Criminal Investigations (OCI)
- Federal Bureau of Investigation (FBI)
- Federal Deposit Insurance Corporation OIG
- General Services Administration OIG
- Internal Revenue Service (IRS) Criminal Investigation
- Leavenworth County (Kansas) Sheriff's Office
- Missouri Attorney General – Medicaid Fraud Control Unit
- Naval Criminal Investigative Service
- Postal Service OIG
- Small Business Administration (SBA) OIG
- Social Security Administration (SSA) OIG
- State of Ohio OIG
- VA Police Service

Tomah, Wisconsin, VAMC Peer Support Specialist Convicted of Sexual Exploitation

An investigation determined that a Tomah VAMC peer support specialist texted inappropriate pictures, groped, and had sexual relations in his office with female veteran patients. The defendant pled no contest and was convicted of sexual exploitation by a therapist and misdemeanor charges of fourth degree sexual assault and lewd behavior–exposure. The former employee was sentenced to 24 months' probation for the misdemeanor charges, while the felony charge will be dismissed pursuant to the successful completion of a three-year diversion agreement requiring the defendant to be engaged in therapy, have no contact with victims, comply with conditions of probation, and not work in any capacity in mental health or substance abuse treatment.

Former Martinsburg, West Virginia, Chief of Staff Pled Guilty to Drug Diversion

An OIG and VA Police Service investigation revealed that the defendant diverted and used approximately 5,225 micrograms of fentanyl by improperly using patient information to access Omnicell (medication dispensing) machines.

Former Leavenworth, Kansas, VAMC Physician Assistant Sentenced for Sexual Battery

A former Leavenworth VAMC physician assistant was sentenced to 187 months' incarceration, 36 months' supervisory probation, and was ordered to register as a sex offender for life after being convicted at trial of aggravated criminal sodomy, aggravated sexual battery, and sexual battery. An OIG and Leavenworth County Sheriff's Office investigation revealed 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 (OEF/OIF) 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.

Four Subjects Arrested for Drug Distribution at Bedford, Massachusetts, VAMC

OIG and Drug Enforcement Administration agents arrested four subjects and executed two search warrants related to illegal drug distribution at the Bedford VAMC. A fifth defendant remains a fugitive from justice. The investigation determined that two veterans allegedly distributed crack cocaine from their apartments, located at the medical center, to veterans in VA substance abuse treatment programs. Further investigation identified the veterans' crack cocaine source as two known Boston, Massachusetts, gang members. In addition, the investigation developed evidence that an unrelated former VAMC employee was selling morphine and hydromorphone at the medical center.

Two Former Little Rock, Arkansas, VAMC Employees Sentenced for Conspiracy to Possess with Intent to Distribute Oxycodone

An OIG investigation revealed that two VAMC employees who worked at the Little Rock VAMC were involved in drug diversion from the medical center. After pleading guilty, the first defendant was sentenced to 30 months' incarceration, three years' supervised release, and was ordered to pay restitution of $22,000. The second defendant, who also pled guilty, was sentenced to 48 months' incarceration, three years' supervised release, and was ordered to pay restitution of $77,722.

Former Orlando, Florida, VAMC Registered Nurse Sentenced for Drug Diversion

An OIG and VA Police Service investigation revealed that for approximately six months a former Orlando, Florida, VAMC registered nurse diverted 467 vials of fentanyl. The defendant was sentenced to two years' probation. The defendant had tested positive for fentanyl and marijuana and subsequently resigned from VA. The Florida Department of Health is in the process of revoking the defendant's nursing license.

Former Denver, Colorado, VAMC Nurse Pled Guilty to Drug Diversion

A former Denver, Colorado, VAMC contract nurse pled guilty to tampering with a consumer product and obtaining a controlled substance by deceit or subterfuge. An investigation by the OIG and the FDA OCI revealed that the defendant diverted approximately 20 syringes of hydromorphone while at the VAMC and tampered with two vials of fentanyl while working at a non-VA hospital.

Former Cincinnati, Ohio, VAMC Acting Chief of Staff Found Guilty at Trial of Illegal Distribution of a Controlled Substance

An OIG investigation revealed that the defendant prescribed controlled substances to a former VISN director's wife, who is not a veteran. The former VA physician's Drug Enforcement Administration license was restricted to federal official duties only and was voluntarily surrendered by the defendant during the investigation.

Former VA Vendor Pled Guilty to Blackmail

A former VA vendor pled guilty to one count of blackmail. A joint OIG and Federal Deposit Insurance Corporation OIG investigation revealed that from February 2014 to April 2015, a former St. Louis, Missouri, VAMC supervisor issued purchase card payments of about $451,800 to this defendant and two other vendors for unnecessary maintenance work. The three vendors kicked back a total of approximately $136,500 in cash payments to the former supervisor. As part of the plea agreement, the vendor admitted he accepted money to not disclose the violation of federal law. This particular vendor received an estimated $181,600 in purchase card payments and kicked back an estimated $56,250 to the former VAMC supervisor. The two other vendors and the former VAMC supervisor previously pled guilty and were sentenced.

Former Sunrise, Florida, VA Community Outpatient Nurse Sentenced for Drug Diversion

A former Sunrise VA community outpatient clinic nurse was sentenced to mental health and substance abuse treatment and two years' probation after pleading guilty to obtaining possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. An OIG investigation revealed that the defendant diverted two opioids—fentanyl and Versed—by substituting saline solution during gastrointestinal procedures.

Non-VA Care (Community-Based Care) Chiropractor Pled Guilty to Theft from a Healthcare Program

A community care chiropractor paid by VA pled guilty to one count of theft from a healthcare program. An investigation by the OIG resulted in charges that allege the defendant submitted over $220,000 in claims for chiropractic treatments provided to a single veteran during a one-year period.

Veterans Benefits Administration Investigations

VBA implements a number of programs for eligible veterans and family members, including education, insurance, and monetary benefits, as well as VA guaranteed home loans. Investigations routinely concentrate on benefits provided to ineligible individuals. With respect to home loans, the OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. The OIG also investigates allegations of fraud committed by VA-appointed 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, the Death Match project was streamlined to improve accountability and efficiency. Field personnel, to include investigative assistants and special agents, teamed with headquarters personnel to process and work cases resulting in

the arrest of 24 individuals, recoveries of $2.5 million, and a projected five-year savings to VA estimated at $14.6 million.

OI opened 114 investigations involving the fraudulent receipt of VA monetary benefits including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 70 arrests. OI obtained over $10.4 million in court-ordered fines, restitution, penalties, and civil judgements; achieved over $18.7 million in savings, efficiencies, and cost avoidance; and recovered more than $3.7 million. The case summaries that follow provide a representative sample of the type of VBA investigations conducted during this reporting period.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 27 months' incarceration, three years' probation, and was ordered to pay $434,594 in restitution after being found guilty at trial of healthcare fraud and false statements relating to healthcare matters. An OIG investigation revealed that the defendant misrepresented the extent and severity of his disabilities by claiming the loss of use of both feet when the defendant is capable of walking unassisted.

Veteran Convicted of Compensation Fraud

A veteran who was also a former sheriff's deputy was found guilty at trial of theft of government funds and making false statements. An OIG investigation revealed that the defendant, who claimed he was blind and unable to see beyond five feet, was quite functional and engaged in many activities that he claimed he was unable to perform. The loss to VA is $311,215 and the loss to the Social Security Administration (SSA) is $376,200.

Former VA Fiduciary Sentenced for Misappropriation

A former VA fiduciary was sentenced to four years' incarceration, three years' probation, and was ordered to pay restitution of $1,079,857 ($252,992 to VA) after pleading guilty to wire fraud, misappropriation by a federal fiduciary, and preparing fraudulent tax returns. A multi-agency investigation revealed that from 2007 to 2012, the defendant served as a VA fiduciary for eight disabled veterans. The investigation further determined that the defendant embezzled VA-issued funds and used the money for personal expenses, to include his own mortgage.

Veteran and Wife Pled Guilty to VA Compensation Fraud

A veteran pled guilty to conspiracy to commit an offense against the United States and his wife pled guilty to aiding and abetting in the theft of government funds. A VA OIG and SSA OIG investigation resulted in charges that the veteran exaggerated his injuries sustained while serving. After receiving surgery and treatment, the veteran improved, but falsely claimed his condition worsened and he was unable to walk, resulting in the veteran being awarded service-connected disability benefits for the loss of use of both feet and 100 percent posttraumatic stress disorder (PTSD) status. The veteran received such services and benefits as housing adaptation, home health care, and education benefits for his children. Additionally, his wife falsified Social Security documents that resulted in the veteran obtaining additional government benefits. The loss to the government is approximately $837,000, including approximately $594,000 to VA. The veteran was sentenced to two years' imprisonment and ordered to pay restitution of approximately $612,750 to VA and $233,400 to SSA. The veteran's spouse was sentenced to eight months' imprisonment and ordered to pay restitution of approximately $233,400 to SSA.

Veteran and Spouse Sentenced for VA Compensation Fraud

A veteran was sentenced to 36 months' incarceration and three years' probation, and his spouse was sentenced to three years' probation. Both defendants were also ordered to pay restitution of $1,237,427 ($922,137 to VA and $315,290 to the Department of Labor). The veteran previously pled guilty to wire fraud and his spouse previously pled guilty to misprision of a felony, which requires the knowledge of and concealment of a felony. The investigation revealed that the veteran, who was rated 100 percent disabled and received special monthly compensation for the loss of use of both feet and major depressive disorder, was able to ambulate and carry out daily tasks with a clear ability to use both of his feet.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 21 months' incarceration and three years' supervised release, and was ordered to pay restitution of $201,521 after pleading guilty to wire fraud. An OIG investigation revealed that the defendant fraudulently claimed to VA that he was unable to walk and was confined to a wheelchair. The investigation revealed that the defendant did not use a wheelchair or any other assistive device except during VA appointments. Additionally, VA determined that the defendant also lied about having PTSD and that he was overpaid an additional $200,000 in PTSD benefits that have been ordered to be reimbursed to VA. The investigation also prevented the veteran from using a recently awarded $67,000 adaptive housing grant.

Former VA Field Examiner Indicted for Wire Fraud, Theft of Public Money, and False Statements

OIG investigators found that the defendant allegedly drafted a Last Will and Testament for an incompetent veteran and listed himself as the sole beneficiary of the veteran's financial assets, valued at approximately $680,000. The defendant resigned from employment with VA in lieu of termination. The defendant was 100 percent service-connected due to claims he submitted to VA alleging he could not work as a result of mental health issues. A subsequent investigation revealed that during that period, he was actually working full time. A VA Regional Office review revealed that the defendant should have never received a 100 percent rating. A $142,000 overpayment resulted from the defendant's alleged false statements and misrepresentations.

Board Members Indicted for Fiduciary Fraud

Four members from the board of directors of a professional fiduciary company were arrested after being indicted for aggravated identity theft, fiduciary misappropriation, mail fraud, and money laundering. Criminal forfeiture was also ordered for two vehicles and five properties. A multi-agency investigation including the VA OIG resulted in charges that allege that 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 annual statements. The loss is $2.7 million.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to nine months' home detention, five years' probation, and was ordered to pay $583,485 in restitution to VA after pleading guilty to the theft of government funds. An OIG investigation revealed that the defendant falsified the extent of his vision-related disability for over 20 years and subsequently received a 100 percent service-connected rating for blindness in both eyes.

In reality, the defendant had an extensive driving history, visual acuity of 20/40 during his last Florida vision test, and 20/25 and 20/40 visual acuity recorded from a private optometrist.

VA Beneficiary and Husband Indicted for Conspiracy and Theft of Government Property

An OIG investigation resulted in charges that allege the beneficiary, with assistance from her husband, fraudulently led VA to believe she was so severely disabled that VA granted her special monthly compensation benefits for the loss of the use of both feet. The investigation identified the VA beneficiary had little to no limitations, and that she received no assistance from her husband. The loss to VA is over $942,000.

Veteran Sentenced for VA Compensation Fraud

In 2005, VA granted individual unemployability benefits to the defendant after he fraudulently claimed to be too disabled to work. The investigation further determined that the defendant owned and operated his own business and lied to VA about his employment status. The veteran was sentenced to five years' probation and ordered to complete 500 hours of community service after pleading guilty to one count of theft of government funds. The defendant was also ordered to pay restitution to VA of over $486,000 for disability, dependent education, and other benefits.

Former Philadelphia, Pennsylvania, VARO Employee and his Father-in-Law Charged in Wire Fraud Scheme

An OIG investigation resulted in charges that allege a former VA employee used his position to release fraudulent VA pension award money to multiple co-schemers in exchange for kickbacks. The employee was arrested after being indicted for wire fraud and aggravated identity theft. In addition, the veteran's father-in-law was arrested after being charged with wire fraud and aiding and abetting. Additional individuals have been charged under seal. The loss to VA is over $421,000.

Other Investigations

OI investigates a diverse 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. OIG also investigates 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 alone, OI opened 41 cases and made 10 arrests. These investigations resulted in over $4.2 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $101,000 in savings, efficiencies, and cost avoidance.

Construction Company Owners Enter into Agreement with Government

A multi-agency investigation revealed that a construction company's owners created an SDVOSB using a service-disabled veteran to act as a "pass through" for their company, which then allowed it to compete for SDVOSB set-aside contracts. As a result, the SDVOSB was awarded 21 set-aside contracts totaling over $21 million, all of which were subcontracted directly to or through the preexisting construction company. The construction company and its owners have agreed to pay the United States $3 million to resolve allegations that they violated the *False Claims Act* by taking advantage of federal contracting opportunities reserved for SDVOSBs.

Computer Training Center Owner Sentenced for Theft

An OIG and DOL investigation revealed that a computer training center owner stole over $2.8 million from a program designed to help older, unemployed veterans receive training and find employment. The defendant logged on to the application system more than 100 times and certified that she was the actual veteran applying for benefits, supplied false employment status information, and provided false attendance information. The defendant also allowed veterans to attend less than required training hours, stop prior to completion, and in many cases never attend training. The defendant was sentenced to 24 months' incarceration and three years' supervised release after pleading guilty to theft of government funds. Under the plea agreement, the defendant consented to a forfeiture judgment of $1.27 million and agreed to pay restitution of $2.8 million.

Founder/Majority Owner of Insys Therapeutics Inc. Arrested for Racketeer Influenced and Corrupt Organizations Conspiracy, Conspiracy to Commit Mail and Wire Fraud, and Conspiracy to Violate the Anti-Kickback Law

A multi-agency investigation resulted in charges that the defendant led a nationwide conspiracy to profit by using bribes and fraud to cause the illegal distribution of Subsys, a fentanyl spray intended for cancer patients experiencing breakthrough pain. A superseding indictment charges former Insys executives and managers with conspiring to bribe private practitioners in various states to prescribe Subsys. In exchange for bribes and kickbacks, the practitioners allegedly wrote a large number of prescriptions for patients, most of whom were not diagnosed with cancer. The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) paid the company approximately $3.3 million for Subsys.

Naturalized U.S. Citizen Pled Guilty to Bulk Cash Smuggling in Connection with an e-Benefits Redirection Scheme

An OIG and Department of Homeland Security investigation resulted in the defendant's arrest as she attempted to leave the United States. A Customs and Border Patrol examination of her checked baggage resulted in the discovery of $94,000 concealed in Vaseline containers and additional funds discovered in her carry-on luggage. The investigation determined that the seized funds were the proceeds of redirected monthly benefit payments of VA and SSA beneficiaries and Jamaican lottery scam victims. Per the plea agreement, the defendant agreed to forfeit the total $102,848 in seized funds.

Workers' Compensation Clinic Owner Charged with Healthcare Fraud, Wire Fraud, and Aggravated Identity Theft

A multi-agency investigation resulted in charges that since October 2012, the defendant submitted false and fraudulent claims and requests for payment for services not rendered to multiple federal agencies. The defendant also allegedly used the name and physical therapy license number of another person without his/her knowledge in an effort to further the fraud scheme. The overall loss to the government is approximately $7.5 million, to include a loss to VA of approximately $400,000.

Veteran Indicted for Child Pornography

A veteran was indicted and arrested on federal charges for receipt of a visual depiction of a minor engaging in sexually explicit conduct and possession of child pornography. An investigation resulted in charges that allege the defendant utilized a VA network to access a Google account containing child pornography while residing at the Big Spring, Texas, VAMC. The defendant subsequently admitted to possessing and viewing child pornography. This investigation was initiated following a tip from the National Center for Missing and Exploited Children.

Former Youngstown, Ohio, VA Community Based Outpatient Clinic Employee Sentenced for Child Sexual Activity

A former Youngstown VA Community Based Outpatient Clinic employee was sentenced to 53 months' incarceration and 10 years' supervised release. An OIG, Ohio Internet Crimes Against Children Task Force, and Homeland Security Investigations joint effort 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.

Construction Company Owner Indicted for Major Fraud against the United States

An OIG and FBI investigation resulted in charges that allege the defendant falsely claimed to VA that the construction company had paid its bond premium and was entitled to reimbursement under the Federal Acquisition Regulations. The defendant sent correspondence to VA seeking reimbursement for a bond premium of $532,000 and made false claims concerning the bond premium payment to the surety, including documents that purported to be copies of canceled checks indicating full payment of the bond premium. The construction company received approximately $3.7 million before walking off the job site and VA terminated the contract for default.

Pharmacist Pled Guilty to Conspiracy

A pharmacist, the first of numerous defendants, pled guilty to conspiracy to defraud the United States. A multi-agency investigation revealed that four compounding pharmacy companies falsely billed CHAMPVA, TRICARE, and other healthcare benefit programs for compounded pharmaceuticals. From January 2012 to May 2015, the defendant dispensed prescriptions for high-yield compounded medications to beneficiaries of these and other healthcare benefit programs for medications not necessary and induced by kickback payments. As a result, the healthcare benefit programs were falsely billed by this company approximately $192 million for high-yield compounded medications. CHAMPVA was billed over $5 million and reimbursed this particular pharmacy $4.7 million in claims. Of that amount, VA was falsely billed $1,732,000.

Welding School Owner Pled Guilty to Wire Fraud Conspiracy and Making and Subscribing a False Tax Return

An investigation by the OIG and IRS CID revealed the defendant 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 for by VA. Enrolled veterans rarely, if ever, received instruction from school employees. Many enrolled veterans visited the school only to sign-in to create the appearance that they were attending the required number of hours. The owner hired a recruiter who enrolled at least 20 veterans at the school. These veterans were told they would not have to attend classes, but could still receive their monthly VA housing allowance. To date, VA has paid over $1.4 million to the school in tuition and over $1.1 million to veteran enrollees in housing allowances, book costs, and supply stipends.

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

A business owner, who provided financing to several service-disabled veteran-owned small businesses and minority-owned businesses, was sentenced to 24 months' incarceration and three years' supervised release after pleading guilty to conspiracy. The defendant's business was also sentenced to five years' probation and was ordered to pay a $500,000 fine. In addition, a service-disabled veteran was sentenced

to three years' probation after pleading guilty to charges of having knowledge of a felony, but failing to report the act to authorities. A multi-agency investigation revealed that over $350 million in set-aside construction contracts were fraudulently obtained after several subjects conspired in creating companies for the sole purpose of obtaining set-aside government contracts. The subjects provided false information to VA and the SBA by concealing that the companies were not controlled by veterans, service-disabled veterans, minorities, or women.

Political Consulting Business Owner Pled Guilty to Conspiracy to Commit Fraud against the United States

A multi-agency investigation revealed that the owner of a political consulting business was part of a conspiracy to unjustly enrich himself and others through a nonprofit organization that contracted with VA to provide substance abuse counseling and housing services for veterans. The owner and others unlawfully used the nonprofit's funds for political contributions, excessive lobbying, political advocacy, and paid themselves through a system of kickbacks that disguised the nature and source of the payments. The conspirators caused the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through "political outreach" that violated both law and public policy. The defendant allegedly negotiated $264,000 in kickback payments to the executives of the nonprofit organization. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, to include $1.7 million contributed by VA.

Non-Veteran Business Owner Charged with Wire Fraud and Money Laundering

This multi-agency investigation resulted in charges that allege the defendant falsely represented his construction company to be a qualified SDVOSB. As a result, the business received $16.5 million in SDVOSB set-aside contracts, to include $1.9 million in VA contracts that the business was not entitled to receive. The defendant is alleged to have used his father-in-law's rating to obtain SDVOSB status and set-aside contracts for the company and then passed the contracts on to his own business.

Defendant Pled Guilty for Service-Disabled Veteran-Owned Small Business Fraud

The last of four defendants pled guilty to false official writings for claiming to own 100 percent of her company when she only owned a third. This 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 individuals to defraud the United States and its agencies of over $140 million in contract payments from 8(a) and SDVOSB contracts for a profit of approximately $24 million. The VA contracts, which included American Recovery and Reinvestment Act Funds, were worth approximately $7.9 million.

Former NECC Supervisory Pharmacist Sentenced in Connection with the 2012 Nationwide Fungal Meningitis Outbreak

The former supervisory pharmacist of the New England Compounding Center (NECC) was convicted at trial of 77 counts that included 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 record-breaking fungal meningitis outbreak, the largest public health crisis caused by a pharmaceutical drug in U.S. history. The outbreak killed 64 and caused infections in 793 patients. The defendant was sentenced to eight years' incarceration, two years' probation, and forfeiture and restitution

of an amount that will be determined at a later date. This multi-agency investigation revealed that the defendant deliberately violated safety regulations when he ran NECC's clean room operations. The investigation additionally revealed that NECC, under the defendant's supervision, improperly sterilized medication, conducted inadequate sterility testing, mislabeled drugs, and skipped routine cleaning of the clean room. Although no known VA patients died or became ill as a result of receiving an NECC product, VA purchased approximately $516,000 of NECC products that were allegedly produced in unsanitary conditions and in an unsafe manner.

Former Advanced BioHealing, Inc. Federal Sales and Marketing Director Sentenced for Conspiracy to Commit Healthcare Fraud

The former federal sales and marketing director for Advanced BioHealing, Inc. (ABH) was sentenced to three years' probation and a $5,000 fine after pleading guilty to felony conspiracy to commit healthcare fraud. The defendant provided gifts to VA physicians initially for speaking engagements, but expanded their roles so that some clinicians were functioning as de facto sales representatives. The investigation determined that ABH sales representatives provided cash, all-expense paid trips, concert tickets, and expensive meals to VA clinicians in exchange for promoting the company's product within VA. The ABH sales to VA during the time the gratuities were paid to VA clinicians were approximately $147 million.

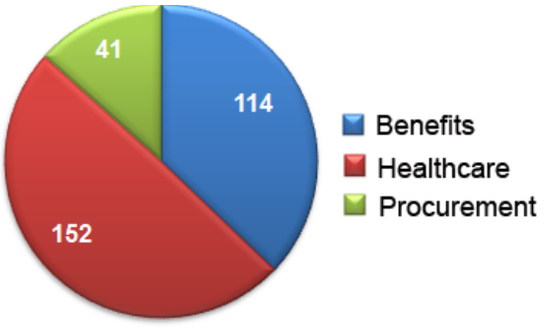


Figure 3. OI Investigations Opened During Reporting Period

Construction Company Owners Pled Guilty to Conspiracy to Commit Wire Fraud

An OIG-led investigation, with assistance from the Government Services Administration OIG, revealed the two defendants used another defendant's service-disabled veteran status to create a "pass-through" company for the purpose of obtaining 20 set-aside SDVOSB and Veteran-Owned Small Business (VOSB) contracts in the sum of $13.8 million. The work was then subcontracted to a non-SDVOSB, which was owned by the other non-veteran defendant. The SDV owner maintained full-time work as a government employee and did not control the day-to-day management, daily operation, or long-term decision making of the SDVOSB. Sentencing is pending for two defendants who previously pled guilty in connection with this investigation.

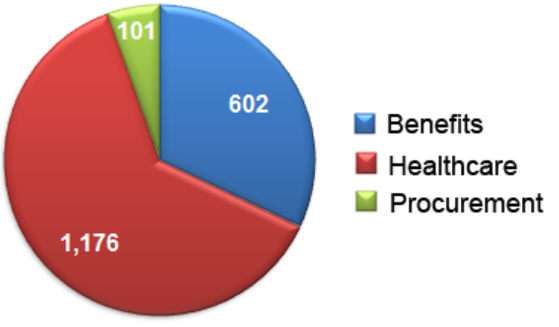


Figure 4. OI Referrals Opened During Reporting Period

Two Subjects Arrested for OWCP Fraud

Two subjects were charged relating to their involvement with a pharmacy that provided prescription medication to patients participating in DOL's Office of Workers' Compensation Program (OWCP). Two of the subjects have been arrested and an arrest warrant was filed for a third subject who is now considered an international fugitive. This multi-agency investigation resulted in charges that allege the defendants were unlawfully billing multiple federal agencies for prescription medication through the DOL OWCP in return for kickbacks from the clinic's owner. Overall, the defendants were responsible for billing OWCP for $23.3 million in claims for prescription medication obtained through illegal kickback payments, and were paid at least $11.6 million from DOL. The loss to VA is approximately $650,000.

Assaults and Threats Made against VA Employees

During this reporting period, OI initiated 30 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 22 individuals. Investigations resulted in over $313,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Involuntarily Committed for Making Threats to Las Vegas, Nevada, VAMC

A veteran was involuntarily committed for mental health treatment at the Las Vegas VAMC after threatening to shoot armed guards and anyone wearing a white coat at the medical center. The veteran stated that he wanted to create as much publicity as possible by shooting VA employees with the intent of encouraging other veterans to do the same and also threatened violence if approached by law enforcement. The veteran was detained at his residence and agreed to a consent search that resulted in the seizure of a .45 caliber handgun and ammunition.

Veteran Sentenced for Assault of Federal Officer

A veteran was sentenced to 15 years' incarceration and three years' supervised release after being found guilty at trial of assault on a federal officer. An OIG investigation revealed that the defendant intentionally used his vehicle to strike a uniformed VA police officer while departing the Montgomery, Alabama, VARO. The VA police officer was medically retired because of the injuries sustained from this incident.

Veteran Arrested for Threatening to Assault and Murder a Federal Official

An OIG investigation revealed that between 2015 and 2017 the defendant allegedly made several threats to assault and murder VA employees and contractors at the Tampa, Florida, VAMC. Specifically, the defendant threatened to cut the heads off VA employees, threatened to "blow up" VA, and claimed he could get away with murder because of his VA disability rating.

Veteran Arrested and Indicted for Threatening to Assault, Kidnap, and Murder an Employee of the United States

An OIG investigation resulted in charges that the defendant made numerous threatening statements towards a VA doctor during 880 calls that he made over a weekend to Senator John McCain's office; the Tucson, Arizona, VAMC; and the White House.

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, 75.3 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 89,046 investigative leads being referred to law enforcement agencies. Over 2,607 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified $1.45 billion in estimated overpayments with cost avoidance of approximately $1.84 billion. During this reporting period, OI identified $144.2 million in estimated overpayments on benefit terminations.

Administrative Investigations

The OIG's Administrative Investigations Division independently reviews allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress and the Department. During this reporting period, the OIG opened 10 administrative investigations and closed seven. The work resulted in the issuance of four reports, which are listed in Appendix A. The first report, *VA Secretary and Delegation Travel to Europe,* was previously highlighted and the remaining three are described below. Recommendations for corrective action resulting from these reports can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on the status and monetary impact of report recommendations published since October 2012.

The Division also conveys advisory memoranda to the Department when warranted by information gathered in the course of an investigation, but where findings do not give rise to formal report recommendations. During this reporting period, the Division issued three advisory memorandums, which are listed in Appendix A and available on the OIG's website at www.va.gov/oig.

Improper Relocation Allowance and Market Pay, Veterans Health Administration, Washington, DC

The OIG Administrative Investigations Division responded to an allegation that a former Senior Medical Advisor and a former VA employee misused VA travel funds. The OIG did not substantiate that allegation, but during the investigation, the OIG found that the former Senior Medical Advisor was improperly paid $19,800 for Temporary Quarters Subsistence Expenses in connection with a Permanent Change of Station move that he did not execute. The OIG also found that his annual salary was increased to make his salary competitive with the Washington, DC, metro area. Because he did not relocate, this resulted in salary overpayments of over $55,000. The OIG recommended VA issue bills of collection to the employee to reimburse VA.

Administrative Investigation – Improper Locality Pay, Office of the General Counsel, Pacific District South, Phoenix, Arizona

The OIG Administrative Investigations Division investigated an allegation that a former Deputy Counsel in the Office of the General Counsel improperly received the higher locality pay for Los Angeles, California, while living and working in Phoenix, Arizona. The OIG found the employee received about $6,500 in improper locality pay and recommended that VA issue the former employee a bill of collection to reimburse VA.

Conflict of Interest, Nepotism, and False Statements within the VA Office of General Counsel, Washington, DC

An allegation was made that the Chief Counsel of the Procurement Law Group within the Office of General Counsel (OGC) actively and openly solicited other OGC employees to hire his wife, who was later given a position. The OIG substantiated that the Chief Counsel had a conflict of interest and engaged in nepotism when he used his position to advocate for the employment of his wife and helped establish a position for her within an OGC group he managed. The OIG also substantiated that the Chief Counsel improperly shared VA sensitive information with his wife while she was being vetted for the VA position, and he and his wife made false statements when questioned about it during their respective interviews. The OIG referred the conflict of interest and false statement matters to the U.S. Attorney's Office, which declined prosecution. The OIG recommended that VA take appropriate administrative and corrective actions.

Closed Senior Government Employee Criminal Investigations Not Disclosed to the Public

When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. Those previously undisclosed investigations of senior government officials that were closed or referred out after allegations were not substantiated follow for this reporting period:

Office of Acquisition, Logistics, and Construction Supervisory Program Manager Alleged Misconduct

On January 30, 2018, the OIG received information regarding a potential conflict of interest involving a supervisory program manager at the VA Acquisition Academy in Frederick, Maryland. No criminal conflict of interest was identified regarding the employee's involvement with a company; however, the OIG did identify potential telework agreement and time and attendance violations. That matter was referred to VA for further review.

Former Acting Under Secretary for Benefits Alleged Misconduct

A contracting officer at the Strategic Acquisition Center in Frederick, Maryland alleged that during initial reviews of proposals submitted in response to a contract solicitation pertaining to the Transition Assistance Program (TAP), the government discovered that the former Acting Under Secretary for Benefits had been proposed as "Key Personnel and Senior Advisory Board Lead" as a subcontractor employee with a company. The contracting officer conducted a fact-finding investigation, which determined that the proposed approach by the prime contractor would put the former employee in a position to violate the "cooling off" prohibitions prescribed under 18 USC § 207 and cause an Organizational Conflict of Interest. The prime contractor was then excluded from competition. It was also alleged that the former employee contacted VA employees in the Office of the Under Secretary for Benefits to try to get information on the contract. It was determined that the former employee sought and received guidance from the OGC prior to the submission of the TAP proposal by the prime contractor. This investigation did not substantiate the allegations and was closed on October 26, 2017.

Former VHA National Program Director of Orthotics and Prosthetics Services Alleged Misconduct

A confidential complainant reported a former VHA National Program Director of Orthotics and Prosthetics Services potentially received financial gain as a result of their position with VA. While employed with VA from January 2010 until September 2016, the former employee was responsible for coding, pricing, and providing guidance on which prosthetics and orthotics should be purchased by VA through their involvement with the Centers for Medicare and Medicaid Services' (CMS) and VA Prosthetic and Sensory Aids Services coding groups. The complainant alleged that in or around 2013, the former employee was removed from the CMS coding group after a potential conflict of interest was identified due to the former employee's ownership of a company. The investigation did not substantiate any criminal activity committed by the former employee. The OIG closed this case on October 11, 2017.

James Lovell Federal Health Care Center Chief of Medicine Alleged Misconduct

The OIG received a referral stating the administration at the James Lovell Federal Health Care Center (FHCC) identified that the Chief of Medicine failed to disclose approximately $270,000 in income received from pharmaceutical companies between August 2013 and December 2014, as was required on his Confidential Financial Disclosure (CFD) report completed October 30, 2014. It was also alleged that

the employee submitted false documents in a 2016 Pay for Performance package, including a curriculum vitae in which the employee fraudulently claimed positions held at Rosalind Franklin University of Medicine and Science, and falsified sign-in sheets as evidence of having conducted staff meetings. The OIG closed the investigation on March 1, 2018, and it was not referred to a prosecutor or VA for administrative consideration because the allegations were not substantiated.

Office of Management and Administration Activities

Overview

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations, including the Hotline for reporting fraud, waste, abuse, and other misconduct. The Coordination and Internal Controls Division coordinates training for more than 800 employees to ensure personnel have the skills and expertise to effectively conduct their work. It oversees the internal controls program and proper records management. The Human Resources and Operations Division works to recruit and retain qualified and committed staff, conducts critical follow-up of OIG report recommendations to VA, prepares and disseminates published reports, and develops policies and procedures, among its many support functions. Data Analysis staff manage access to information requests, help identify fraud-related activities and support OIG comprehensive initiatives, including, for example, a recent proactive review of VA's prosthetics supply processes. The Administrative and Financial Operations Division oversees such areas as employee travel, logistical coordination, purchase card coordination, and space and property management. Finally, the Budget Division provides a broad range of budgetary formulation and execution services to include making certain the OIG properly targets and executes its spending plans to the greatest effect. Together, these divisions ensure the efficiency and effectiveness of activities OIG-wide to best serve veterans and their families.

Oversight Activities

OMA provides comprehensive services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support. In addition to providing essential support services to advance the OIG's overall mission and goals, OMA has noteworthy oversight responsibilities related to the operation of the Hotline Division. The Hotline receives, screens, and takes action in response to complaints regarding VA programs and services. Hotline staff also oversee the Whistleblower Protection Program, which was established to ensure that federal employees, job seekers, contractors, and grantees who disclose allegations of serious wrongdoing or gross mismanagement are free from fear of reprisal for their disclosures.

During this reporting period, the Hotline Division accomplished the following:

- Received and screened 16,320 contacts from complainants, including VA employees, veterans, and the public
- Referred 1,263 cases to applicable VA offices after determining that allegations pertained to higher-risk topics and merited review by the OIG, however insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 998 non-case referrals to appropriate VA offices after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 1,295 cases for which nearly 41 percent of allegations were substantiated, over 700 administrative sanctions and corrective actions were taken, and nearly $1.7 million in monetary benefits were achieved
- Responded to more than 153 requests for record reviews from VA staff offices

Examples of Hotline Cases

Disability Benefits Fraud

OIG's Hotline referred a case to VA concerning allegations that a veteran was fraudulently receiving special compensation and disability benefits. VA substantiated that the veteran received, but was not entitled to, 100 percent service-connection benefits, an automobile allowance, special adaptive housing, and dependent education assistance. The loss to VA for compensation alone exceeded $90,000.

Misuse of Service-Disabled Veteran-Owned Small Business Status

After receiving allegations that a business fraudulently claimed to be owned by a service-disabled veteran to maintain status as a SDVOSB, OIG's Hotline referred the case to VA for review. VA substantiated that the veteran was no longer associated with the business and subsequently removed the company from Vendor Information Pages, thus preventing the business from being awarded further SDVOSB contracts that should only be awarded to eligible service-disabled veterans.

Deficiencies in Home Based Primary Care Suicide Prevention

In response to allegations that the VAMC in Fayetteville, Arkansas, was failing to meet external peer review program (EPRP) standards for Home Based Primary Care (HBPC), OIG's Hotline referred the case to VA for review. VA subsequently identified that the HBPC program did not have a Standard Operating Procedure (SOP) for Suicide Risk Assessment, and therefore suicide-related screening and risk assessments were being completed using inconsistent processes. Following the review, HBPC leaders outlined an action plan to develop and implement an SOP in accordance with the relevant handbook and to direct the VAMC's suicide prevention coordinator to educate HBPC staff regarding the use of suicide risk assessment tools.

Benefits Fraud

OIG's Hotline referred a case to VA concerning allegations that a veteran was receiving disability benefits at the 100 percent rate and caregiver support, even though he was able to work as a mechanic and address all of his activities of daily living. After revisiting this veteran's level of function, VA determined that his rating should be reduced to 70 percent and terminated his entitlement to dependent education assistance.

Problems with Veterans Choice

After receiving allegations that staff at the Central Western Massachusetts VAMC were not uploading veterans' information into the VA third-party administrator's portal, a required step so that the veterans may be placed on the Veterans Choice List to receive care in the community, OIG's Hotline referred the case to VA. The department substantiated the allegations and implemented corrective actions to help ensure that veterans were able to expeditiously opt-in for care through the Veterans Choice Program.

Office of Contract Review Activities

Overview

The Office of Contract Review provides VA's Office of Acquisition, Logistics, and Construction (OALC) with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for OALC contracting activities. The OIG completed 67 reviews in this reporting period and the tables that follow provide an overview of the Office of Contract Review's performance.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Forty-four preaward reviews identified nearly $533 million in potential cost savings during this reporting period.

In addition to Federal Supply Schedule and Architect/Engineer Services proposals, preaward reviews during this reporting period included 16 healthcare provider proposals, accounting for approximately $27.8 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2017–March 31, 2018	44	$532,881,003

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 nearly $9.1 million, including approximately $4.5 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 21 postaward reviews performed, 15 involved voluntary disclosures. In 14 of the 15 voluntary disclosure reviews, the OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2017–March 31, 2018	21	$9,057,782

Claim Reviews

The 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, the OIG reviewed two claims and determined that approximately $2.2 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2017–March 31, 2018	2	$2,201,806

Other Significant OIG Activities

Inspector General Act Reporting Requirements Not Elsewhere Reported

Peer and Qualitative Assessment Reviews

P.L. 111-203, *Restoring American Financial Stability Act of 2010*, requires OIGs to report the results of any peer review conducted of its audit operation by another OIG during the reporting period or to identify the date of the last peer review conducted by another OIG, in addition to any outstanding recommendations that have not been fully implemented. The 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, the VA OIG received a rating of pass. No peer reviews were conducted of VA OIG's audit operation during this reporting period.

The Act also requires OIGs to report the results of any peer review they 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. The 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, the OIG did not issue any reports meeting these requirements.

OIG Reviews of Proposed Legislation and Regulations

The 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, the OIG reviewed 126 proposals and made six comments.

Refusals to Provide Information or Assistance

P.L. 95-452, *Inspector General Act of 1978*, as amended, authorizes the OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the 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. The OIG is required to provide a summary of instances when such information or assistance is refused and reports no such instances occurring during this reporting period.

Attempts by the Establishment to Interfere with the Independence of the OIG

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

Instances of Whistleblower Retaliation

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

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

P.L. 95-452, *Inspector General Act of 1978*, as amended, requires the OIG to provide a summary of each report issued before the commencement of the reporting period for which no management decision had been made by the end of the current reporting period and for which VA did not provide substantive comments within 60 days of receipt of the draft report. In each case, there were no instances to report. As part of the report production process, the OIG transmits its draft report to VA for review, comment, and concurrence to implement recommendations. The OIG's goal is to receive substantive feedback from the Department within 30 days of transmitting the draft report.

Employee Recognition of Military Personnel

OIG Employees Currently Serving or Returning from Active Military Duty

The Inspector General and staff extend their thanks to OIG employees listed below who are on or have returned from active military duty:

- Felix Beltran, a Criminal Investigator in Washington, DC, was activated by the U.S. Army in March 2018.
- Brian Celatka, a Resident Agent in Charge in Nashville, Tennessee, was activated by the Tennessee Air National Guard in February 2018.
- Matthew Clark, an Auditor in Dallas, Texas, was activated by the U.S. Army in October 2017.
- Wessley Dumas, a Criminal Investigator in Little Rock, Arkansas, was activated by the U.S. Army in May 2017.
- Dana Epperson, a Criminal Investigator in Seattle, Washington, was activated by the Washington Army National Guard in February 2018.
- John Moore, a Program Specialist at OIG Headquarters, was activated by the U.S. Army National Guard in March 2013.
- Christopher Sizemore, an Auditor in Bay Pines, Florida, was activated by the Department of the Air Force National Guard in March 2018.
- Ricardo Wallace-Jimenez, a Criminal Investigator in Spokane, Washington, was activated by the U.S. Army National Guard in March 2017 and returned to the OIG in January 2018.

Appendix A: Reports and Work Products Issued during Reporting Period

All OIG recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on monetary impact and the implementation status of report recommendations published since October 2012.

Table 1. List of Reports Issued by the Office of Audits and Evaluations

Report Information	Better Use of Funds	Questioned Costs
Review of Potential Misuse of Purchase Cards at Veterans Integrated Service Network 15 *Issued 10/26/2017 | Report Number 15-05519-377*		$73,000
Review of Claims Processing Actions at Pension Management Centers *Issued 11/1/2017 | Report Number 15-04156-352*		$41,400,000
Audit of the National Pension Call Center *Issued 11/1/2017 | Report Number 16-03922-392*		
Audit of VA's Compliance With the DATA Act *Issued 11/8/2017 | Report Number 17-02811-21*		
Audit of VA's Financial Statements for Fiscal Years 2017 and 2016 *Issued 11/15/2017 | Report Number 17-01219-24*		
Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post-Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System *Issued 11/16/2017 | Report Number 17-00414-376*		
Review of VA's Reimbursements to the Treasury Judgment Fund *Issued 11/28/2017 | Report Number 17-00833-05*		
Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia *Issued 12/5/2017 | Report Number 17-00397-364*		
Audit of Management of Primary Care Panels *Issued 12/6/2017 | Report Number 15-03364-380*	$843,000,000	
Audit of Alleged Beneficiary Travel Processing Irregularities at the VA Medical Center in Phoenix, Arizona *Issued 12/14/2017 | Report Number 16-00471-10*		
Review of Alleged Mismanagement of the Real Time Location System Project *Issued 12/19/2017 | Report Number 15-05447-383*		
Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System *Issued 12/21/2017 | Report Number 15-03036-47*		$39,000,000

Report Information	Better Use of Funds	Questioned Costs
Audit of Medical Support Assistant Workforce Management at the Phoenix VA Health Care System *Issued 1/9/2018 | Report Number 16-00928-391*		
Audit of VHA's Use of Appropriations to Develop a System Enhancement and Mobile Health Applications *Issued 1/17/2018 | Report Number 15-01005-18*		
Review of Alleged Funding Security Issues of the Veterans Services Adaptable Network at VA Medical Center Orlando, FL *Issued 1/31/2018 | Report Number 15-03059-384*		
Review of Excessive Procurement Costs at the Rural Outreach Clinic, Laughlin, Nevada *Issued 2/8/2018 | Report Number 16-02695-51*	$290,009	
Audit of Interior Design and Furnishing Contract Mismanagement by the Network Contracting Office 21 *Issued 3/6/2018 | Report Number 16-00409-64*		$3,300,000
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*		
Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs *Issued 3/14/2018 | Report Number 16-04655-70*		
Audit of Vocational Rehabilitation and Employment Program Subsistence Allowance Payments *Issued 3/15/2018 | Report Number 16-05121-110*		
Review of Selected Construction Projects at Oklahoma City VA Health Care System *Issued 3/22/2018 | Report Number 17-00253-102*		
Review of Alleged Irregularities with the Health Eligibility Center's 365-Day Response Letters to Individuals with Pending Health Care Enrollment Records *Issued 3/22/2018 | Report Number 17-02123-109*		
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*		
Independent Review of VA's FY 2017 Performance Summary Report to the Office of National Drug Control Policy *Issued 3/26/2018 | Report Number 18-00835-146*		
Independent Review of VA's FY 2017 Detailed Accounting Submission to the Office of National Drug Control Policy *Issued 3/26/2018 | Report Number 18-00836-147*		

Report Information	Better Use of Funds	Questioned Costs
Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma *Issued 3/27/2018 | Report Number 15-04678-114*	$22,540,470	
Review of Alleged Unsecured Patient Database at the VA Long Beach Healthcare System *Issued 3/28/2018 | Report Number 15-04745-48*		
Review of Timeliness of the Appeals Process *Issued 3/28/2018 | Report Number 16-01750-79*		
Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System *Issued 3/28/2018 | Report Number 17-00253-93*		$7,400,000
Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System *Issued 3/29/2018 | Report Number 16-02742-77*		
Total Monetary Impact	**$865,830,479**	**$91,173,000**

Table 2. List of Reports Issued by the Office of Healthcare Inspections

Comprehensive Healthcare Inspection Program Reviews
James J. Peters VA Medical Center, Bronx, New York *Issued 11/29/2017 | Report Number 17-01751-25*
Long Beach VA Healthcare System, Long Beach, California *Issued 11/29/2017 | Report Number 17-01739-31*
Bath VA Medical Center, Bath, New York *Issued 12/7/2017 | Report Number 17-01752-32*
Eastern Kansas Health Care System, Topeka, Kansas *Issued 12/7/2017 | Report Number 17-01850-38*
John D. Dingell VA Medical Center, Detroit, Michigan *Issued 12/21/2017 | Report Number 17-01849-42*
New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 1/4/2018 | Report Number 17-01741-58*
South Texas Veterans Health Care System, San Antonio, Texas *Issued 1/8/2018 | Report Number 17-01852-59*
Minneapolis VA Health Care System, Minneapolis, Minnesota *Issued 1/11/2018 | Report Number 17-01755-61*
Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Issued 1/11/2018 | Report Issued 17-01740-62*
Grand Junction Veterans Health Care System, Grand Junction, Colorado *Issued 1/18/2018 | Report Number 17-01744-69*

Comprehensive Healthcare Inspection Program Reviews
Huntington VA Medical Center, Huntington, West Virginia *Issued 1/31/2018 | Report Number 17-01760-85*
Alexandria VA Health Care System, Pineville, Louisiana *Issued 2/1/2018 | Report Number 17-01853-89*
Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania *Issued 2/1/2018 | Report Number 17-01855-81*
West Texas VA Health Care System, Big Spring, Texas *Issued 2/5/2018 | Report Number 17-01742-90*
Robert J. Dole VA Medical Center, Wichita, Kansas *Issued 2/6/2018 | Report Number 17-01748-82*
Central Alabama Veterans Health Care System, Montgomery, Alabama *Issued 2/6/2018 | Report Number 17-01851-72*
New York Harbor VA Healthcare System, New York, New York *Issued 2/7/2018 | Report Number 17-01762-88*
Black Hills VA Health Care System, Fort Meade, South Dakota *Issued 2/8/2018 | Report Number 17-01745-96*
Miami VA Healthcare System, Miami, Florida *Issued 2/13/2018 | Report Number 17-01756-86*
Northern California VA Health Care System, Mather, California *Issued 2/15/2018 | Report Number 17-01750-97*
Hampton VA Medical Center, Hampton, Virginia *Issued 2/28/2018 | Report Number 17-01758-104*
Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 3/1/2018 | Report Number 17-01746-116*
Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 3/14/2018 | Report Number 17-01854-115*
Providence VA Medical Center, Providence, Rhode Island *Issued 3/21/2018 | Report Number 17-01761-129*
Nebraska-Western Iowa Health Care System, Omaha, Nebraska *Issued 3/26/2018 | Report Number 17-05402-137*
Tennessee Valley Healthcare System, Nashville, Tennessee *Issued 3/27/2018 | Report Number 17-01764-143*
Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 3/28/2018 | Report Number 17-01856-135*
Illiana VA Health Care System, Danville, Illinois *Issued 3/28/2018 | Report Number 17-05424-142*
Martinsburg VA Medical Center, Martinsburg, West Virginia *Issued 3/29/2018 | Report Number 17-05409-140*
Samuel S. Stratton VA Medical Center, Albany, New York *Issued 3/29/2018 | Report Number 17-05407-141*

Comprehensive Healthcare Inspection Program Reviews
North Texas VA Health Care System, Dallas, Texas *Issued 3/29/2018 | Report Number 17-05404-149*
National Healthcare Reviews
Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities *Issued 1/30/2018 | Report Number 17-04460-84*
Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations *Issued 2/27/2018 | Report Number 15-01580-108*
Hotline Healthcare Inspections
Opioid Agonist Treatment Program Concerns VA Maryland Health Care System Baltimore, Maryland *Issued 10/19/2017 | Report Number 16-01091-06*
Administrative and Clinical Concerns, Central California VA Health Care System, Fresno, California *Issued 11/2/2017 | Report Number 16-00352-12*
Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma *Issued 11/2/2017 | Report Number 16-02676-13*
Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor Healthcare System, Ann Arbor, Michigan *Issued 11/7/2017 | Report Number 17-01208-07*
Mental Health Care Concerns, Atlantic County Community Based Outpatient Clinic, Northfield, New Jersey *Issued 11/15/2017 | Report Number 16-03519-28*
Unexpected Death of a Patient: Alleged Methadone Overdose, Grand Junction VA Health Care System, Grand Junction, Colorado *Issued 11/30/2017 | Report Number 16-04208-30*
Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility *Issued 1/4/2018 | Report Number 16-03576-53*
Alleged Women's Health Care Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 1/4/2018 | Report Number 16-03705-60*
Delays in Processing Release of Information Requests Bay Pines VA Healthcare System, Bay Pines, Florida *Issued 1/17/2018 | Report Number 16-02864-71*
Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic, Fort Benning, Georgia *Issued 1/30/2018 | Report Number 16-03405-80*
Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio *Issued 2/13/2018 | Report Number 17-03860-100*
Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System, West Haven, Connecticut *Issued 2/27/2018 | Report Number 17-02678-107*

Hotline Healthcare Inspections
Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley VA Hospital, Tampa, Florida *Issued 3/1/2018 | Report Number 17-01491-112*
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*
Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic, VA Palo Alto Health Care System, Palo Alto, California *Issued 3/8/2018 | Report Number 17-02686-125*
Mismanagement of a Resuscitation and Other Concerns, Buffalo VA Medical Center, Buffalo, New York *Issued 3/12/2018 | Report Number 17-01485-128*
Inadequate Intensivist Coverage and Surgery Service Concerns, VA Gulf Coast Healthcare System, Biloxi, Mississippi *Issued 3/29/2018 | Report Number 17-03399-150*

Table 3. List of Reports and Work Products Issued by the Office of Investigations

Administrative Investigations
Improper Relocation Allowance and Market Pay, Veterans Health Administration, Washington, DC *Issued 1/2/2018 | Report Number 16-02552-49*
Improper Locality Pay, Office of the General Counsel, Phoenix, Arizona *Issued 1/2/2018 | Report Number 17-02375-50*
VA Secretary and Delegation Travel to Europe *Issued 2/14/2018 | Report Number 17-05909-106*
Conflict of Interest, Nepotism, and False Statements within the VA Office of General Counsel *Issued 3/29/2018 | Report Number 17-03324-123*
Administrative Summaries of Investigation
Wait Time Investigation, Fayetteville, NC, VAMC *Issued 11/8/2017 | Report Number 14-02890-378*
Administrative Investigation Advisories
Alleged Misuse of Official Time, VA Long Beach Healthcare System, Long Beach, CA *Issued 11/8/2017 | Report Number 17-03557-19*
Conflict of Interest, Veterans Health Administration, Washington, DC *Issued 3/12/2018 | Report Number 17-05308-122*
Alleged Misuse of Travel Funds, Office of the Secretary, Center for Strategic Partnerships, Washington, DC *Issued 3/19/2018 | Report Number 17-03268-87*

Table 4. List of Preaward Reviews by the Office of Contract Review

Report Information	Savings and Cost Avoidance
Review of Proposal Submitted Under a Solicitation *Issued 10/10/2017 | Report Number 17-05339-01*	$44,981
Review of Proposal Submitted Under a Solicitation *Issued 10/13/2017 | Report Number 17-05640-03*	$6,278,806
Review of Proposal Submitted Under a Solicitation *Issued 10/13/2017 | Report Number 17-05340-04*	$116,563
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 10/17/2017 | Report Number 17-03905-02*	$353,952,920
Review of Proposal Submitted Under a Solicitation *Issued 10/17/2017 | Report Number 18-00041-08*	$2,468,710
Review of Proposal Submitted Under a Solicitation *Issued 10/20/2017 | Report Number 17-05433-09*	$4,615,152
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 10/26/2017 | Report Number 17-02809-16*	$3,818,222
Review of Proposal Submitted Under a Solicitation *Issued 10/30/2017 | Report Number 18-00404-15*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/1/2017 | Report Number 17-04584-14*	$14,925,958
Review of Proposal Submitted Under a Solicitation *Issued 11/1/2017 | Report Number 18-00170-17*	$5,242,840
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/6/2017 | Report Number 17-04604-22*	$27,615,216
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/8/2017 | Report Number 17-04303-20*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/8/2017 | Report Number 17-05477-23*	
Review of Proposal Submitted Under a Solicitation *Issued 11/21/2017 | Report Number 18-00903-35*	$22,430
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/22/2017 | Report Number 17-04764-34*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/28/2017 | Report Number 17-05590-39*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 12/5/2017 | Report Number 17-01525-40*	
Review of Proposal Submitted Under a Solicitation *Issued 12/5/2017 | Report Number 18-01010-43*	$2,282,303

Report Information	Savings and Cost Avoidance
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 12/6/2017 | Report Number 16-05311-46*	$5,477,136
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 12/19/2017 | Report Number 17-03626-56*	
Review of Proposal Submitted Under a Solicitation *Issued 12/19/2017 | Report Number 18-00445-54*	$1,054,805
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 12/21/2017 | Report Number 18-00517-57*	$45,750,393
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 1/3/2018 | Report Number 17-04385-65*	$395,779
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 1/4/2018 | Report Number 18-00398-68*	$71,892
Review of Proposal Submitted Under a Solicitation *Issued 1/5/2018 | Report Number 18-01349-66*	$1,015,995
Review of Proposal Submitted Under a Solicitation *Issued 1/5/2018 | Report Number 18-01030-67*	$958,818
Review of Proposal Submitted Under a Solicitation *Issued 1/10/2018 | Report Number 17-05934-73*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 1/11/2018 | Report Number 17-05263-74*	$3,060,380
Review of Proposal Submitted Under a Solicitation *Issued 1/16/2018 | Report Number 18-01384-76*	$8,993
Review of Contract Extension Proposal and Request for Modification – Product Additions, Submitted Under a Federal Supply Schedule Contract *Issued 1/24/2018 | Report Number 18-00012-91*	$59,510
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 1/25/2018 | Report Number 17-05915-83*	$35
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 1/29/2018 | Report Number 17-05154-92*	$466,912
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 2/1/2018 | Report Number 17-04769-94*	$37,149,340
Review of Proposal Submitted Under a Solicitation *Issued 2/6/2018 | Report Number 18-01745-101*	$968,816
Review of Change Order Proposal Submitted under a VA Contract *Issued 2/21/2018 | Report Number 17-04789-111*	$115,668

Report Information	Savings and Cost Avoidance
Review of Request for Modification – Product Additions – Submitted Under a Federal Supply Schedule Contract *Issued 2/26/2018 | Report Number 18-01402-118*	$379,540
Review of Contract Extension Proposal and Request for Modification – Product Additions, Submitted Under a Federal Supply Schedule Contract *Issued 2/26/2018 | Report Number 17-05665-119*	
Review of Proposal Submitted Under a Solicitation *Issued 2/26/2018 | Report Number 17-05933-120*	
Review of Request for Modification for Product Addition Submitted Under a Federal Supply Schedule Contract *Issued 2/27/2018 | Report Number 18-00070-124*	
Review of Request for Modification – Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 2/28/2018 | Report Number 17-05635-126*	$216,525
Review of Proposal Submitted Under a Solicitation *Issued 3/5/2018 | Report Number 18-02362-127*	$2,012,023
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 3/8/2018 | Report Number 18-00511-131*	$8,237,131
Review of Proposal Submitted Under a Solicitation *Issued 3/22/2018 | Report Number 18-02360-145*	$700,830
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 3/22/2018 | Report Number 18-01495-148*	$3,396,381
Total Monetary Impact	**$532,881,003**

Table 5. List of Postaward Reviews by the Office of Contract Review

Report Information	Dollar Recoveries
Review of Voluntary Disclosure of Public Law Pricing Errors Under Federal Supply Schedule Contract *Issued 10/20/2017 | Report Number 17-05557-11*	$23,061
Review of Voluntary Disclosure Submitted Under a Federal Supply Schedule Contracts *Issued 11/8/2017 | Report Number 17-03444-26*	$3,756,008
Review of Voluntary Disclosure of Price Reductions Under a Federal Supply Schedule Contract *Issued 11/9/2017 | Report Number 17-02214-17*	$5,726
Review of Voluntary Disclosures and Refund Offer Under a Federal Supply Schedule Contract *Issued 11/15/2017 | Report Number 16-00452-29*	$287,900
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 11/21/2017 | Report Number 17-00534-36*	$130,708

Report Information	Dollar Recoveries
Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contracts *Issued 11/21/2017 | Report Number 17-00856-37*	$964,155
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 12/6/2017 | Report Number 18-00171-45*	$8,933
Follow-Up Review of Compliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract *Issued 12/14/2017 | Report Number 18-00065-44*	$6,289
Review of Voluntary Disclosure of Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 12/18/2017 | Report Number 17-03166-55*	$8,514
Review of Voluntary Disclosure Under a Federal Supply Schedule Contract *Issued 12/28/2017 | Report Number 16-00827-63*	$52,429
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 1/29/2018 | Report Number 17-05641-95*	$12,567
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 1/30/2018 | Report Number 16-00058-99*	$1,051,873
Review of Voluntary Disclosure of Public Law 102-585 Section 603 Pricing Errors Under a Federal Supply Schedule Contract *Issued 2/1/2018 | Report Number 16-01549-52*	$513,163
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 2/12/2018 | Report Number 17-05411-103*	$913,104
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 2/21/2018 | Report Number 17-04049-113*	$265,193
Review of Shipping Charges Billed Under a VA Contract *Issued 3/12/2018 | Report Number 18-02889-132*	$106,185
Review of Shipping Charges Billed Under Federal Supply Schedule Contract *Issued 3/12/2018 | Report Number 18-02892-133*	$18,039
Review of Shipping Charges Billed Under Federal Supply Schedule Contract *Issued 3/12/2018 | Report Number 18-02891-134*	$57,256
Review of Voluntary Disclosure of Public Law Pricing Errors Under Federal Supply Schedule Contracts *Issued 3/22/2018 | Report Number 17-05820-121*	$143,261
Settlement Agreement Under a Federal Supply Service Contract *Issued 3/22/2018 | Report Number 18-03152-144*	$683,850

Report Information	Dollar Recoveries
Review of Voluntary Disclosure of Public Law Pricing Errors Under Federal Supply Schedule Contracts *Issued 3/26/2018 | Report Number 17-05431-98*	$49,568
Total Monetary Impact	**$9,057,782**

Table 6. List of Claim Reviews by the Office of Contract Review

Report Information	Savings and Cost Avoidance
Review of Certified Claim Under a VA Contract *Issued 1/11/2018 | Report Number 16-02259-75*	$399,296
Review of Termination Settlement Proposal and Certified Claim Under a VA Contract *Issued 2/13/2018 | Report Number 17-04789-111*	$1,802,510
Total Monetary Impact	**$2,201,806**

Table 7. Total Potential Monetary Benefits of Reports Issued

Report Type	Better Use of Funds	Questioned Costs	Savings and Cost Avoidance	Dollar Recoveries
Audits and Reviews	$865,830,479	$91,173,000		
Preaward Reviews			$532,881,003	
Postaward Reviews				$9,057,782
Claim Reviews			$2,201,806	
Subtotals	**$865,830,479**	**$91,173,000**	**$535,082,809**	**$9,057,782**
Total	**$1,501,144,070**			

Table 8. 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	5	$91,173,000
Total inventory this period	**5**	**$91,173,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	5	$91,173,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**5**	**$91,173,000**
Total carried over to next period	**0**	**$0**

Table 9. Resolution Status of Reports with Recommended Funds to Be Put to Better Use by Management

Resolution Status	Number	Dollar Value
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	3	$865,830,479
Total inventory this period	**3**	**$865,830,479**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	3	$865,830,479
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**3**	**$865,830,479**
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.

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, the OIG is required to identify the matter in each *Semiannual Report to Congress* until final action on the management decision is completed.

Tables 1 and 2, respectively, identify the number of open OIG reports and recommendations with results sorted by action office. Table 3 provides a list of the reports and recommendations that have been open less than one year. Table 4, in contrast, identifies the reports and recommendations that remain open for more than one year. All figures in the tables are current as of March 31, 2018. OIG recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on monetary impact and the implementation status of report recommendations published since October 2012.

Table 1. Number of Unimplemented OIG Reports by VA Office

Table 1 identifies the number of open OIG reports with results sorted by action office. As of March 31, 2018, there are 156 total open reports. However, seven reports are counted twice in Table 1 because they have actions at more than one office.

VA Action Office	Open More Than 1 Year	Open Less Than 1 Year	Total Open
Veterans Health Administration	18	105	123
Veterans Benefits Administration	10	10	20
National Cemetery Administration	1	0	1
Office of Acquisition, Logistics, and Construction	0	1	1
Office of Management (OM)	1	2	3
Office of Information and Technology	3	2	5
Office of Human Resources and Administration	1	1	2
Office of Operations, Security, and Preparedness (OSP)	1	1	2
Office of General Counsel	1	3	4
Office of the Secretary (OSVA)	0	2	2
Totals	**36**	**127**	**163**

Table 2. Number of Unimplemented OIG Recommendations by VA Office

Table 2 identifies the number of open OIG recommendations with results sorted by action office. As of March 31, 2018, there are 802 total open recommendations. However, eight recommendations are counted twice in Table 2 because they have actions at more than one office.

VA Action Office	Open More Than 1 Year	Open Less Than 1 Year	Total Open
Veterans Health Administration	39	675	714
Veterans Benefits Administration	14	19	33
National Cemetery Administration	2	0	2
Office of Acquisition, Logistics, and Construction	0	1	1
Office of Management (OM)	1	22	23
Office of Information and Technology	3	5	8
Office of Human Resources and Administration	4	1	5
Office of Operations, Security, and Preparedness (OSP)	1	8	9
Office of General Counsel	1	4	5
Office of the Secretary (OSVA)	0	10	10
Totals	**65**	**745**	**810**

Table 3. Unimplemented OIG Reports and Recommendations Less Than One Year Old

Table 3 identifies the 122 reports and 738 recommendations that, as of March 31, 2018, have been open less than one year. The total monetary benefit attached to these reports is $957,113,470.

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Evaluation of Computed Tomography Radiation Monitoring in Veterans Health Administration Facilities *Issued 4/11/2017 | Report Number 16-03920-197*	VHA	1	
Clinical Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, Iowa *Issued 4/14/2017 | Report Number 16-00564-170*	VHA	2, 11, 12, 14, 16	
Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities *Issued 5/18/2017 | Report Number 16-03808-215*	VHA	1-6	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Alleged Unsafe Blood Transfusion Practices, Battle Creek VA Medical Center, Battle Creek, Michigan *Issued 5/25/2017 | Report Number 15-01043-247*	VHA	4	
Review of Alleged Mismanagement of VA's Human Resources and Administration Contract Funds *Issued 6/1/2017 | Report Number 16-00327-209*	OHRA	2	$3,700,000
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	3	
Review of Alleged Inappropriate Contract Actions Related to the Lease of a Digital Imaging Network-Picture Archival Communication System *Issued 6/7/2017 | Report Number 15-04351-188*	OALC	2	
Clinical Assessment Program Review of the Atlanta VA Medical Center, Decatur, Georgia *Issued 6/8/2017 | Report Number 16-00569-253*	VHA	1, 5, 6, 15, 17, 19, 21	
Healthcare Inspection – Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan *Issued 6/19/2017 | Report Number 15-02994-269*	VHA	2, 5	
Clinical Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont *Issued 6/20/2017 | Report Number 16-00556-244*	VHA	3, 8, 11, 12, 19, 23, 24	
Federal Information Security Modernization Act Audit for Fiscal Year 2016 *Issued 6/21/2017 | Report Number 16-01949-248*	VHA	1-31	
Healthcare Inspection – Review of VHA's "Our Doctors" Website Accuracy *Issued 6/23/2017 | Report Number 16-01436-270*	VHA	1, 2	
Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 7/10/2017 | Report Number 16-02676-297*	VHA	7, 12, 13, 17, 18	
Clinical Assessment Program Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan *Issued 7/13/2017 | Report Number 16-00568-292*	VHA	3	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Clinical Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas *Issued 7/17/2017 | Report Number 16-00578-291*	VHA	1	
Healthcare Inspection – Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center *Issued 7/17/2017 | Report Number 15-00509-301*	VHA	1	
Clinical Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan *Issued 7/17/2017 | Report Number 16-00549-302*	VHA	1, 4-11, 13-16	
Administrative Investigation – Conflicting Interests and Misuse of Government Equipment, Overton Brooks VA Medical Center, Shreveport, Louisiana *Issued 7/18/2017 | Report Number 14-03508-275*	OGC	3, 4	
Clinical Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky *Issued 7/19/2017 | Report Number 16-00580-303*	VHA	6, 8-10, 13, 18, 21, 22	
Healthcare Inspection – Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 7/27/2017 | Report Number 16-00748-319*	VHA	1-3, 5	
Clinical Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California *Issued 7/31/2017 | Report Number 16-00579-293*	VHA	16, 20	
Clinical Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina *Issued 8/1/2017 | Report Number 16-00576-310*	VHA	4, 8-10, 12, 13, 23	
Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care *Issued 8/1/2017 | Report Number 17-01846-316*	VHA	4	
Healthcare Inspection – Alleged Inadequate Mental Health Care, Iowa City VA Health Care System, Iowa City, Iowa *Issued 8/3/2017 | Report Number 16-04535-329*	VHA	2	
Clinical Assessment Program Review of the Syracuse VA Medical Center, Syracuse, New York *Issued 8/7/2017 | Report Number 16-00558-311*	VHA	1, 10, 12	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana *Issued 8/7/2017 | Report Number 16-00566-314*	VHA	2, 3, 5, 6, 12, 15, 16, 18	
Review of Alleged Delay of Care and Scheduling Issues at the VA Medical Center in West Palm Beach, Florida *Issued 8/9/2017 | Report Number 15-02583-256*	VHA	3	
Audit of Consolidated Patient Account Center Controls To Prevent Improper Billings for Service-Connected Conditions *Issued 8/9/2017 | Report Number 16-00589-264*	VHA	2-4, 6	
Inspection of the VA Regional Office, New Orleans, Louisiana *Issued 8/10/2017 | Report Number 16-04626-280*	VBA	2	
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	1-5	
Clinical Assessment Program Review of the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania *Issued 8/15/2017 | Report Number 16-00555-337*	VHA	2, 8, 10, 11	
Clinical Assessment Program Review of the VA Northern Indiana Health Care System, Fort Wayne, Indiana *Issued 8/15/2017 | Report Number 16-00577-335*	VHA	2, 5, 6, 11, 13, 17	
Healthcare Inspection – Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York *Issued 8/17/2017 | Report Number 16-02998-345*	VHA	4	
Inspection of the VA Regional Office, Phoenix, Arizona *Issued 8/17/2017 | Report Number 17-00515-299*	VBA	1, 5	
Healthcare Inspection – Review of Opioid Prescribing Practices, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 8/22/2017 | Report Number 15-02156-346*	VHA	2, 5	
Healthcare Inspection – Patient Flow, Quality of Care, and Administrative Concerns in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland *Issued 8/23/2017 | Report Number 15-03418-350*	VHA	1, 2, 6-9, 11	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas *Issued 9/5/2017 | Report Number 16-02526-358*	VHA	2, 3	
Inspection of the VA Regional Office, Denver, Colorado *Issued 9/5/2017 | Report Number 17-01354-336*	VBA	2	
Clinical Assessment Program Review of the Michael E. DeBakey VA Medical Center, Houston, Texas *Issued 9/7/2017 | Report Number 16-00552-341*	VHA	5, 12	
Inspection of the VA Regional Office, San Juan, Puerto Rico *Issued 9/11/2017 | Report Number 17-02079-328*	VBA	2	
Healthcare Inspection – Quality of Care and Other Concerns, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois *Issued 9/20/2017 | Report Number 15-04546-374*	VHA	2, 3	
Clinical Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware *Issued 9/20/2017 | Report Number 16-00548-361*	VHA	3, 11-14, 16, 17	
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 *Issued 9/26/2017 | Report Number 16-02241-375*	VHA	1	
OIG Determination of VHA Occupational Staffing Shortages FY 2017 *Issued 9/27/2017 | Report Number 17-00936-385*	VHA	1-4	
Healthcare Inspection – Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto Health Care System, Palo Alto, California *Issued 9/28/2017 | Report Number 15-01415-382*	VHA	1	
Inspection of the VA Regional Office, Winston-Salem, North Carolina *Issued 9/28/2017 | Report Number 17-00266-349*	VBA	5	
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 9/29/2017 | Report Number 16-00546-388*	VHA	3, 5-9, 15-20, 22, 25, 26	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Opioid Agonist Treatment Program Concerns VA Maryland Health Care System, Baltimore, Maryland *Issued 10/19/2017 | Report Number 16-01091-06*	VHA	1-5	
Review of Potential Misuse of Purchase Cards at Veterans Integrated Service Network 15 *Issued 10/26/2017 | Report Number 15-05519-377*	VHA	1-3	$73,000
Review of Claims Processing Actions at Pension Management Centers *Issued 11/1/2017 | Report Number 15-04156-352*	VBA	2, 3, 6, 7	$41,400,000
Audit of the National Pension Call Center *Issued 11/1/2017 | Report Number 16-03922-392*	VBA	2, 5, 6	
Healthcare Inspection – Administrative and Clinical Concerns, Central California VA Health Care System, Fresno, California *Issued 11/2/2017 | Report Number 16-00352-12*	VHA	1-3, 5	
Healthcare Inspection – Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma *Issued 11/2/2017 | Report Number 16-02676-13*	VHA	1-3, 5, 7, 8, 12-14, 17-19, 21, 23, 24	
Healthcare Inspection – Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor Healthcare System, Ann Arbor, Michigan *Issued 11/7/2017 | Report Number 17-01208-07*	VHA	1-6	
Audit of VA's Compliance With the DATA Act *Issued 11/8/2017 | Report Number 17-02811-21*	OM	1-21	
Healthcare Inspection – Mental Health Care Concerns, Atlantic County Community Based Outpatient Clinic, Northfield, New Jersey *Issued 11/15/2017 | Report Number 16-03519-28*	VHA	1-6	
Review of VA's Reimbursements to the Treasury Judgment Fund *Issued 11/28/2017 | Report Number 17-00833-05*	OM	1	
Comprehensive Healthcare Inspection Program Review of the VA Long Beach Healthcare System, Long Beach, California *Issued 11/29/2017 | Report Number 17-01739-31*	VHA	1-4, 6, 8-11, 13	
Comprehensive Healthcare Inspection Program Review of the James J. Peters VA Medical Center, Bronx, New York *Issued 11/29/2017 | Report Number 17-01751-25*	VHA	1-11, 13-15	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Unexpected Death of a Patient: Alleged Methadone Overdose, Grand Junction VA Health Care System, Grand Junction, Colorado *Issued 11/30/2017 | Report Number 16-04208-30*	VHA	1, 3, 4	
Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia *Issued 12/5/2017 | Report Number 17-00397-364*	VBA	1-2	
Audit of Management of Primary Care Panels *Issued 12/6/2017 | Report Number 15-03364-380*	VHA	1-3	$843,000,000
Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center, Bath, New York *Issued 12/7/2017 | Report Number 17-01752-32*	VHA	1-11	
Comprehensive Healthcare Inspection Program Review of the VA Eastern Kansas Health Care System, Topeka, Kansas *Issued 12/7/2017 | Report Number 17-01850-38*	VHA	1-5	
Audit of Alleged Beneficiary Travel Processing Irregularities at the VA Medical Center in Phoenix, Arizona *Issued 12/14/2017 | Report Number 16-00471-10*	VHA	1-2	
Review of Alleged Mismanagement of the Real Time Location System Project *Issued 12/19/2017 | Report Number 15-05447-383*	VHA OIT	VHA: 1-2 OIT: 1-3	
Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	1-8	$39,000,000
Comprehensive Healthcare Inspection Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan *Issued 12/21/2017 | Report Number 17-01849-42*	VHA	1-10	
Administrative Investigation – Improper Relocation Allowance and Market Pay, Veterans Health Administration, Washington, DC *Issued 1/2/2018 | Report Number 16-02552-49*	VHA	1-3	
Administrative Investigation – Improper Locality Pay, Office of the General Counsel, Phoenix, Arizona *Issued 1/2/2018 | Report Number 17-02375-50*	OGC	2	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility *Issued 1/4/2018 | Report Number 16-03576-53*	VHA	2, 3, 5, 6, 8, 10-12	
Healthcare Inspection – Alleged Women's Health Care Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 1/4/2018 | Report Number 16-03705-60*	VHA	1, 3-6	
Comprehensive Healthcare Inspection Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 1/4/2018 | Report Number 17-01741-58*	VHA	1, 2, 4, 5, 7-13, 15-18, 20	
Comprehensive Healthcare Inspection Program Review of the South Texas Veterans Health Care System, San Antonio, Texas *Issued 1/8/2018 | Report Number 17-01852-59*	VHA	1-3	
Comprehensive Healthcare Inspection Program Review of the Minneapolis VA Health Care System, Minneapolis, Minnesota *Issued 1/11/2018 | Report Number 17-01755-61*	VHA	1-18	
Comprehensive Healthcare Inspection Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Issued 1/11/2018 | Report Number 17-01740-62*	VHA	2-6	
Healthcare Inspection – Delays in Processing Release of Information Requests Bay Pines VA Healthcare System, Bay Pines, Florida *Issued 1/17/2018 | Report Number 16-02864-71*	VHA	2-8	
Comprehensive Healthcare Inspection Program Review of the Grand Junction Veterans Health Care System, Grand Junction, Colorado *Issued 1/18/2018 | Report Number 17-01744-69*	VHA	1-9	
Healthcare Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic, Fort Benning, Georgia *Issued 1/30/2018 | Report Number 16-03405-80*	VHA	1-3, 5, 6	
Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities *Issued 1/30/2018 | Report Number 17-04460-84*	VHA	1-4	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the Huntington VA Medical Center, Huntington, West Virginia *Issued 1/31/2018 | Report Number 17-01760-85*	VHA	2-7	
Comprehensive Healthcare Inspection Program Review of the Alexandria VA Health Care System, Pineville, Louisiana *Issued 2/1/2018 | Report Number 17-01853-89*	VHA	1-9	
Comprehensive Healthcare Inspection Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania *Issued 2/1/2018 | Report Number 17-01855-81*	VHA	1, 3	
Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System, Big Spring, Texas *Issued 2/5/2018 | Report Number 17-01742-90*	VHA	1-4, 8-10	
Comprehensive Healthcare Inspection Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas *Issued 2/6/2018 | Report Number 17-01748-82*	VHA	1-8, 11, 12	
Comprehensive Healthcare Inspection Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama *Issued 2/6/2018 | Report Number 17-01851-72*	VHA	1-7	
Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York *Issued 2/7/2018 | Report Number 17-01762-88*	VHA	1-14	
Review of Excessive Procurement Costs at the Rural Outreach Clinic, Laughlin, Nevada *Issued 2/8/2018 | Report Number 16-02695-51*	VHA	2	
Comprehensive Healthcare Inspection Program Review of the VA Black Hills Health Care System, Fort Meade, South Dakota *Issued 2/8/2018 | Report Number 17-01745-96*	VHA	1-6	
Comprehensive Healthcare Inspection Program Review of the Miami VA Healthcare System, Miami, Florida *Issued 2/13/2018 | Report Number 17-01756-86*	VHA	1-11	
Healthcare Inspection – Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio *Issued 2/13/2018 | Report Number 17-03860-100*	VHA	1	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Administrative Investigation – VA Secretary and Delegation Travel to Europe *Issued 2/14/2018 | Report Number 17-05909-106*	OSVA	1-5	
Comprehensive Healthcare Inspection Program Review of the VA Northern California Health Care System, Mather, California *Issued 2/15/2018 | Report Number 17-01750-97*	VHA	1-13	
Healthcare Inspection – Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations *Issued 2/27/2018 | Report Number 15-01580-108*	VHA VBA	VHA: 1-3 VBA: 1-3	
Healthcare Inspection – Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System, West Haven, Connecticut *Issued 2/27/2018 | Report Number 17-02678-107*	VHA	1	
Comprehensive Healthcare Inspection Program Review of the Hampton VA Medical Center, Hampton, Virginia *Issued 2/28/2018 | Report Number 17-01758-104*	VHA	1-19	
Healthcare Inspection – Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley VA Hospital, Tampa, Florida *Issued 3/1/2018 | Report Number 17-01491-112*	VHA	1, 2, 4	
Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 3/1/2018 | Report Number 17-01746-116*	VHA	1-10	
Audit of Interior Design and Furnishing Contract Mismanagement by the Network Contracting Office 21 *Issued 3/6/2018 | Report Number 16-00409-64*	VHA	3	
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*	VHA	1-40	
Healthcare Inspection – Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic, VA Palo Alto Health Care System, Palo Alto, California *Issued 3/8/2018 | Report Number 17-02686-125*	VHA	2	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Mismanagement of a Resuscitation and Other Concerns, Buffalo VA Medical Center, Buffalo, New York *Issued 3/12/2018 | Report Number 17-01485-128*	OGC VHA	OGC: 1 VHA: 2-9	
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*	VHA	1, 3-10	
Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs *Issued 3/14/2018 | Report Number 16-04655-70*	VHA	1-4	
Comprehensive Healthcare Inspection Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 3/14/2018 | Report Number 17-01854-115*	VHA	1-10	
Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center, Providence, Rhode Island *Issued 3/21/2018 | Report Number 17-01761-129*	VHA	1, 4-12	
Review of Selected Construction Projects at Oklahoma City VA Health Care System *Issued 3/22/2018 | Report Number 17-00253-102*	VHA	1-4	
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	OSP VHA	OSP: 1-5, 9-11 VHA: 5-8, 11	
Comprehensive Healthcare Inspection Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska *Issued 3/26/2018 | Report Number 17-05402-137*	VHA	1-7	
Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma *Issued 3/27/2018 | Report Number 15-04678-114*	VHA	1-3, 5	$22,540,470
Comprehensive Healthcare Inspection Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee *Issued 3/27/2018 | Report Number 17-01764-143*	VHA	1-9, 11-15	
Review of Alleged Unsecured Patient Database at the VA Long Beach Healthcare System *Issued 3/28/2018 | Report Number 15-04745-48*	VHA OIT	VHA: 1-2 OIT: 3-4	
Review of Timeliness of the Appeals Process *Issued 3/28/2018 | Report Number 16-01750-79*	VBA	4	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System *Issued 3/28/2018 | Report Number 17-00253-93*	VHA	4, 7, 10-13	$7,400,000
Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 3/28/2018 | Report Number 17-01856-135*	VHA	1-3, 5-10	
Comprehensive Healthcare Inspection Program Review of the VA Illiana Health Care System, Danville, Illinois *Issued 3/28/2018 | Report Number 17-05424-142*	VHA	1-7	
Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System *Issued 3/29/2018 | Report Number 16-02742-77*	VHA	1-16	
Administrative Investigation of Conflict of Interest, Nepotism, and False Statements within the VA Office of General Counsel *Issued 3/29/2018 | Report Number 17-03324-123*	OSVA	1-5	
Healthcare Inspection – Inadequate Intensivist Coverage and Surgery Service Concerns, VA Gulf Coast Healthcare System, Biloxi, Mississippi *Issued 3/29/2018 | Report Number 17-03399-150*	VHA	1, 2	
Comprehensive Healthcare Inspection Program Review of the VA North Texas Health Care System, Dallas, Texas *Issued 3/29/2018 | Report Number 17-05404-149*	VHA	1-6	
Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York *Issued 3/29/2018 | Report Number 17-05407-141*	VHA	1-10	
Comprehensive Healthcare Inspection Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia *Issued 3/29/2018 | Report Number 17-05409-140*	VHA	1-5	
Totals		**738**	**$957,113,470**

Table 4. Unimplemented OIG Reports and Recommendations More Than One Year Old

Table 4 identifies the 34 reports and 64 recommendations that, as of March 31, 2018, remain open for more than one year. The total monetary benefit attached to these reports is $321,600,000.

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Audit of VA Regional Offices' Appeals Management Processes *Issued 05/30/12 | Report Number 10-03166-75*	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.		
Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC *Issued 09/28/12 | Report Number 12-00375-290*	OM OGC	None
Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel immediately determine what services VOA 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.		
Review of Alleged Delays in VA Contractor Background Investigations *Issued 09/30/12 | Report Number 12-00165-277*	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.		
Review of Alleged Mismanagement at the Eastern Area Fiduciary Hub *Issued 05/28/14 | 13-03018-159*	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.		
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 07/11/14 | Report Number 13-01452-214*	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.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Audit of the Efforts to Effectively Obtain Veterans' Service Treatment Records *Issued 08/28/14 | Report Number 14-00657-261*	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.		
Review of Alleged Data Manipulation and Mismanagement at the VA Regional Office, Philadelphia, Pennsylvania *Issued 04/15/15 | Report Number 14-03651-203*	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.		
Audit of Fiduciary Program's Management of Field Examinations *Issued 06/01/15 | Report Number 14-01883-371*	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.		
Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama *Issued 07/29/15 | Report Number 14-04530-452*	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.		
Audit of the Seismic Safety of VA's Facilities *Issued 11/12/15 | Report Number 14-04756-32*	VHA	None
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.		
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio *Issued 01/13/16 | Report Number 15-05151-81*	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.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Follow-Up Audit of Internal Controls Over Disability Benefits Questionnaires *Issued 02/25/16 | Report Number 14-02384-45*	VBA	None
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.		
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona *Issued 03/09/16 | Report Number 15-05160-161*	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.		
Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Web Site *Issued 04/07/16 | Report Number 15-02781-153*	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		
Review of Claims-Related Documents Pending Destruction at VA Regional Offices *Issued 04/14/16 | Report Number 15-04652-146*	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.		
Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System *Issued 04/26/16 | Report Number 11-00826-261*	VHA	None
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.		
Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System *Issued 04/28/16 | Report Number 15-03802-222*	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.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
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.		
Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 05/11/16 | Report Number 16-00101-300*	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 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.		
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 05/11/16 | Report Number 16-00010-302*	VHA	None
Recommendation 7: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.		
Review of Guidance on Protecting Religious Beliefs *Issued 06/16/16 | Report Number 15-03700-283*	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 3: We recommended the Interim Under Secretary for Memorial Affairs recertify or rescind Directive 3170/1, Ceremonies and Special Events at VA National Cemeteries.		
Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 09/30/16 | Report Number 15-00084-370*	VHA	None
Recommendation 1: We recommended that the Facility Director ensure that recommendations, if any, from other reviews of the surgical program be implemented.		
Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses *Issued 12/6/2016 | Report Number 16-00790-417*	OIT	$7,200,000
Recommendation 1: We recommended the Assistant Secretary for Information and Technology implement a policy to ensure cost-effective utilization of information technology equipment, installed software, and services and ensure coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions.		
Audit of Recruitment, Relocation, and Retention Incentives *Issued 1/5/2017 | Report Number 14-04578-371*	OHRA	$81,400,000
Recommendation 1: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to ensure recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Recommendation 3: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor compliance with its employee certification requirement before relocation incentives are authorized for payment. Recommendation 9: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor facilities' compliance with VA Handbook 5007/46 requirements to initiate debt collection from individuals who did not fulfill their recruitment, relocation, or retention incentive service obligations. Recommendation 10: We recommended the Assistant Secretary for Human Resources and Administration examine the capabilities of the HR Smart personnel system to determine the extent to which it is possible to develop an incentive-specific automated alert that notifies Human Resources personnel when employees have outstanding recruitment, relocation, or retention incentive service obligations.		
Review of the Implementation of the Veterans Choice Program *Issued 1/30/2017 | Report Number 15-04673-333*	VHA	None
Recommendation 2: We recommended the Under Secretary for Health develop accurate forecasts of demand for care purchased in the community. Recommendation 5: We recommended the Under Secretary of Health ensure community providers are paid in a timely manner under the Veterans Choice Program.		
Audit of Automated Burial Payments *Issued 2/8/2017 | Report Number 15-01436-456*	VBA	$28,000,000
Recommendation 2: We recommended the Principal Deputy Under Secretary for Benefits, Performing the Duties of Under Secretary for Benefits, strengthen controls to ensure intended recipients meet entitlement requirements before authorizing automated burial payments.		
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6 *Issued 3/2/2018 | Report Number 16-02618-424*	VHA	None
Recommendation 4: We recommended the Under Secretary for Health implement monitoring controls to ensure the third-party administrators return authorizations after 2 business days for urgent care and 5 business days for routine care if an appointment had not been scheduled. Recommendation 6: We recommended the Under Secretary for Health implement controls to ensure the third party administrators create an appointment for the veteran within 5 business days of receiving an authorization. Recommendation 7: We recommended the Under Secretary for Health to ensure all data required to manage the third party administrator contracts provided by the VA and the third party administrators is complete, accurate, and timely. Recommendation 8: We recommended the Director of Veterans Integrated Service Network 6 ensure services monitor and timely address consults pending greater than 7 days. Recommendation 9: We recommended the Director of Veterans Integrated Service Network 6 identify and implement best practices to timely schedule appointments for consults upon receipt and review by the receiving specialty care clinicians. Recommendation 10: We recommended the Director of Veterans Integrated Service Network 6 establish a mechanism to routinely audit closed consults to ensure they are in accordance with Veterans Health Administration consult business rules, and take corrective actions as needed based on audit results.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Combined Assessment Program Summary Report – Evaluation of Inpatient Flow in Veterans Health Administration Facilities *Issued 3/7/2017 | Report Number 16-03805-20*	VHA	None
Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when resident physicians complete discharge notes or instructions, supervising physicians co-sign the residents' notes.		
Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico *Issued 3/8/2017 | Report Number 16-00551-128*	VHA	None
Recommendation 2: We recommended that facility managers ensure information technology network room doors at the facility and the St. Croix community based outpatient clinic are secured. Recommendation 12: We recommended that providers complete diagnostic evaluations for patients with positive post-traumatic stress disorder screens within 30 days of referral.		
Clinical Assessment Program Review of the Louis Stokes Cleveland VA Medical Center Cleveland, Ohio *Issued 3/13/2017 | Report Number 16-00553-135*	VHA	None
Recommendation 7: We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, and identification of transferring and receiving provider or designee and that facility managers monitor compliance. Recommendation 9: We recommended that for patients transferred out of the facility, sending nurses document transfer assessments/notes and that facility managers monitor compliance. Recommendation 14: We recommended that facility managers ensure all employees receive training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		
Clinical Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona *Issued 3/13/2017 | Report Number 16-00554-148*	VHA	None
Recommendation 7: We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.		
Clinical Assessment Program Review of the VA Portland Health Care System Portland, Oregon *Issued 3/16/2017 | Report Number 16-00547-156*	VHA	Non
Recommendation 13: We recommended that facility managers ensure all employees assigned to high-risk areas receive additional Prevention and Management of Disruptive Behavior training as required within 90 days of hire and that the training is documented in employee training records.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 3/31/2017 | Report Number 15-04976-191*	VHA	None
Recommendation 1: We recommended that the System Director ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.		
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	None
Recommendation 1: We recommended the Under Secretary for Health update patient advocate policies and procedures to ensure they meet current needs.		
Recommendation 2: We recommended the Under Secretary for Health develop procedures to ensure pertinent program information is recorded in a standardized format in the Patient Advocate Tracking System.		
Recommendation 3: We recommended the Under Secretary for Health ensure responsible officials and staff perform patient complaint processing activities in accordance with policies and procedures, such as assuring required program information is recorded and trended at the local and national level.		
Recommendation 4: We recommended the Under Secretary for Health work with the Assistant Secretary for Information and Technology to ensure its Patient Advocate Tracking System meets current program requirements for efficient complaint processing and reporting.		
Recommendation 5: We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.		
Recommendation 7: We recommended the Under Secretary for Health implement mechanisms to ensure that privileges and access rights to the Patient Advocate Tracking System are regularly reviewed and extended based upon specific job duties and the need to know.		
Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016 *Issued 3/31/2017 | Report Number 16-03743-193*	VHA	None
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy.		
Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Utilization Managers complete at least 75 percent of all required reviews and designated Physician Utilization Management Advisors document their review decisions in the Veterans Health Administration's utilization management database.		
Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure Patient Safety Managers enter all patient incidents into the Veterans Health Administration's web-based patient incident database, complete the minimum number of root cause analyses, provide feedback about the root cause analyses findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually.		
Recommendation 5: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure committees and teams consistently implement and evaluate corrective actions from quality, safety, and value activities.		
Total		**$321,600,000**

Appendix C: Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by the *Inspector General Act of 1978* (P.L. 95-452), 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 Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities • Office of Contract Review Activities • Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period.	• Office of Healthcare Inspections Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities
§ 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 Activities
§ 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 Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities
§ 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

Reporting Requirements	Section(s)
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period.	• Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement.	• Appendix A
§ 5 (a) (13) information described under section 804(b) of the *Federal Financial Management Improvement Act of 1996.*	• Office of Audits and Evaluations Reports
§ 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) statistical 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
§ 5 (a) (18) a description of the metrics used for developing the data for the statistical tables under paragraph (17).	• Statistical Highlights
§ 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 Activities
§ 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 Activities

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On the Cover

Statues at the New Jersey Korean War Veterans Memorial in Atlantic City, N.J., July 27, 2017. The New Jersey Korean War Veterans Memorial was created to ensure that future generations remember and honor the pride and dedication of those who served and the freedom they preserved. (New Jersey Department of Military and Veterans Affairs photo by Mark C. Olsen/Released) Reprinted with permission.

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