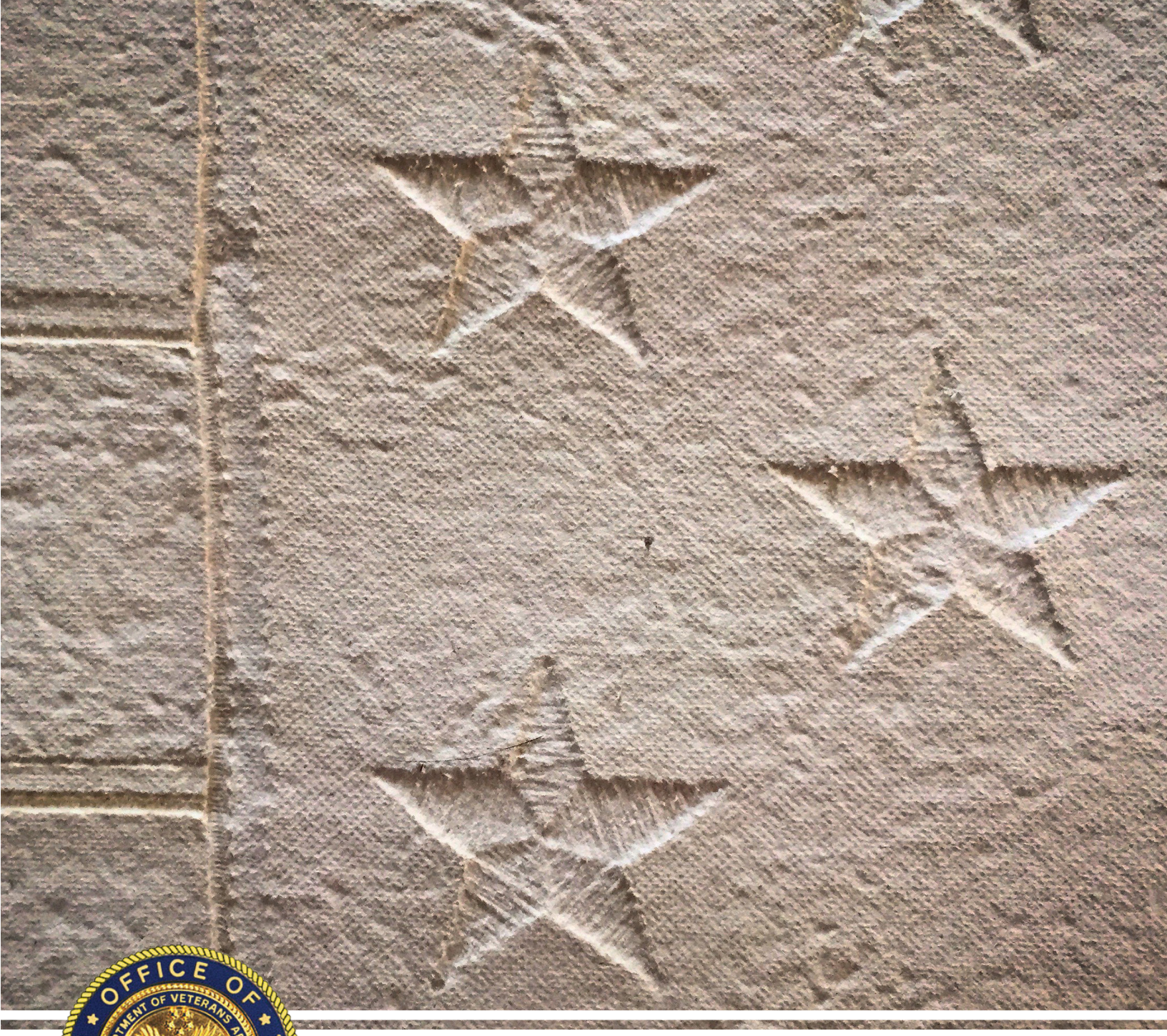


U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT TO CONGRESS

Issue 82 | April 1 – September 30, 2019

U.S. Department of Veterans Affairs
Office of Inspector General

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, reviews, and investigations.

VISION

To be recognized as an independent and fair voice for veterans and their families that makes meaningful improvements to VA programs and services, while being responsive to the concerns of veterans service organizations, Congress, VA employees, and the public.

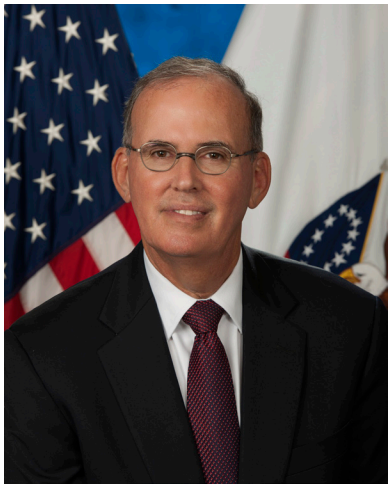
To achieve this vision, the Office of Inspector General (OIG) will

- Make meaningful recommendations that enhance VA programs and operations, as well as prevent and address fraud, waste, and abuse;
- Identify opportunities to promote economy, efficiency, and effectiveness throughout VA and help ensure taxpayer dollars are appropriately spent;
- Safeguard the OIG's independence, consistent with governing laws and policy;
- Identify impactful issues proactively and strategically;
- Produce reports that meet quality standards, including being accurate, timely, proportionate, objective, and thorough;
- Act with transparency by promptly releasing reports that are not otherwise prohibited from disclosure;
- Promote accountability of VA employees; and
- Treat whistleblowers and others who provide information with respect and dignity, including protecting the identities of individuals who wish to remain anonymous.

VALUES

- Meet the highest standards of professionalism, character, and integrity and accept responsibility for actions.
- Maintain a collaborative and engaging work environment that attracts, develops, and retains the highest quality staff.
- Promote diversity, individual perspectives and expertise, and equal opportunity throughout the OIG.
- Honor veterans and the individuals who serve them by continually striving for excellence.

A MESSAGE FROM THE INSPECTOR GENERAL



I am pleased and honored to submit this 82nd *Semiannual Report to Congress* highlighting the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) from April 1 through September 30, 2019. This report's cover depicts a memorial flag created by the Combat Paper project, which helps transform participants' military uniforms into handmade paper. This flag conveys the sense of "vacancy" that some service members feel when shedding their uniforms and transitioning to veteran life, as well as the loss felt for those who never returned.[1] We owe all transitioning and long-standing veterans and their beneficiaries timely access to quality VA programs and services. To that end, the OIG honors veterans, their families, and caregivers by identifying fraud, waste, and abuse related to VA, while recommending continuous improvements to its programs, services, benefits, and health care.

The OIG work conducted in the last six months often focused on three critical areas:

Deficiencies with the Greatest Potential Impact on Veterans

The OIG triaged more than 16,348 Hotline contacts, many reporting alleged wrongdoing, to prioritize those involving actual or potential harm to veterans and their families, the exploitation of vulnerable groups, and system and program breakdowns that delay or deny large numbers of eligible recipients access to the benefits, services, and health care they deserve. Significant work examined areas such as improper denial or rejection of veterans' non-VA emergency care expenses; veterans' paying home loan funding fees from which they were exempt; inappropriate processing of specific types of benefit claims (including more than half of spine disorder claims); inadequate care, safeguards, and discharge planning for individuals with mental health problems; falsification of patients' test results in their electronic health records; and multiple forms of fraud and other crimes.

Root Cause Identification

OIG staff are committed not only to investigating complaints, but to identifying root causes of problems to identify what may be larger-scale, underlying deficiencies. The OIG's identification of root causes provides VA with a road map for meaningful and sustained change. For example, the OIG's sixth report on staffing deficiencies within VA medical facilities revealed that some gaps in clinical and nonclinical positions persist, in part, because of the lack of a comprehensive staffing model that would facilitate meaningful hiring, retention, recruitment, and resource allocation decision-making. It also highlighted difficulties in attracting and retaining medical center directors due to perceived job insecurity, high-profile consequences for facility problems, and noncompetitive salaries.

Accountability

In the most egregious cases the OIG encounters, there are often individuals who have shirked their oversight responsibilities or delayed reporting misconduct, often resulting in harm to veterans. In many cases, the harm would have been avoided or mitigated by either earlier reporting when wrongdoing was suspected, or more careful oversight and decisive action when confirmed. These themes emerge from the more than 137 oversight reports issued in this second half of fiscal year 2019. In this six-month

[1] For more information, see www.combatpaper.org/objects-sculptures.

A MESSAGE FROM THE INSPECTOR GENERAL

period, the OIG also identified more than $1.8 billion in monetary impact for a return on investment of $24 for every dollar spent on oversight. Investigators opened 228 investigations and closed 223. Collectively, the OIG's work resulted in 334 administrative sanctions and corrective actions.

The OIG's mission of effective oversight is all the more critical in the year ahead when VA is executing its largest budget in history and implementing initiatives of massive scope, including the VA MISSION Act of 2018, which will change the face of community-based care; and the development of an integrated electronic health record system costing billions of dollars. VA is also working to keep pace with changes in the veteran population, such as increases in the number of women, those reaching advanced age, and service members whose exposure to toxic materials or whose sustained injuries require specialized responses.

The OIG appreciates the opportunity to work with dedicated professionals within VA, Congress, veterans service organizations, and its many other stakeholders to help address these challenges while improving the health and welfare of millions of veterans and their families nationwide.

MICHAEL J. MISSAL

Inspector General

CONTENTS

A Message from the Inspector General	i
Organization Profile	iv
Highlighted Activities and Findings	1
Statistical Performance	8
Results from the Office of Audits and Evaluations	13
Results from the Office of Contract Review	24
Results from the Office of Healthcare Inspections	26
Results from the Office of Investigations	39
Results from the Office of Management and Administration	55
Congressional Relations and Public Affairs	58
Other Reporting Requirements	60
Awards and Recognition	63
Appendix A: Reports Issued During the Reporting Period	64
Appendix B: Unimplemented Reports and Recommendations	77
Appendix C: Reporting Requirements	110

ORGANIZATION PROFILE

THE DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) oversees VA's three administrations. The Veterans Health Administration (VHA) provides healthcare services, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration 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.

VA is the second-largest federal employer. For fiscal year (FY) 2019, VA is operating under a $201.1 billion budget, with over 400,000 employees serving an estimated 19.6 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 www.va.gov.

THE OFFICE OF INSPECTOR GENERAL

MISSION

The mission of the VA OIG is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, reviews, and investigations.

HISTORY AND STATUTORY AUTHORITY

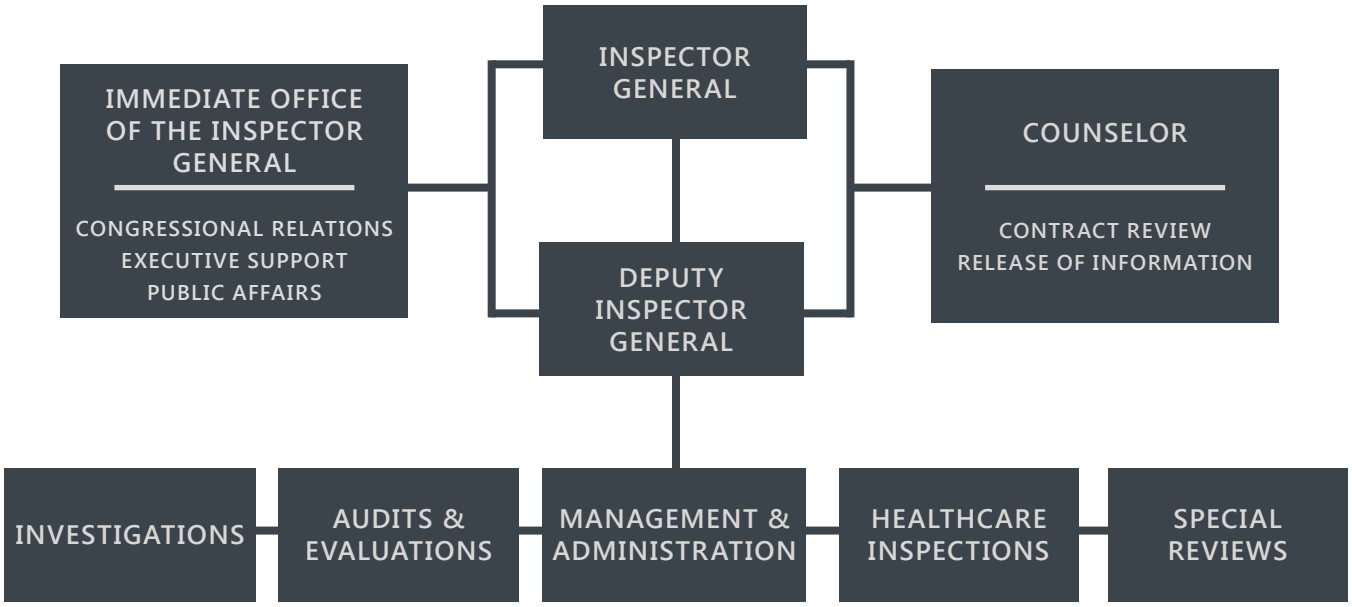
The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) [Public Law (P.L.) 95-452, as amended]. This act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies 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 Inspector General 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 with the Department. In addition, the Veterans Benefits and Services Act of 1988 (P.L. 100-322) 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 make the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

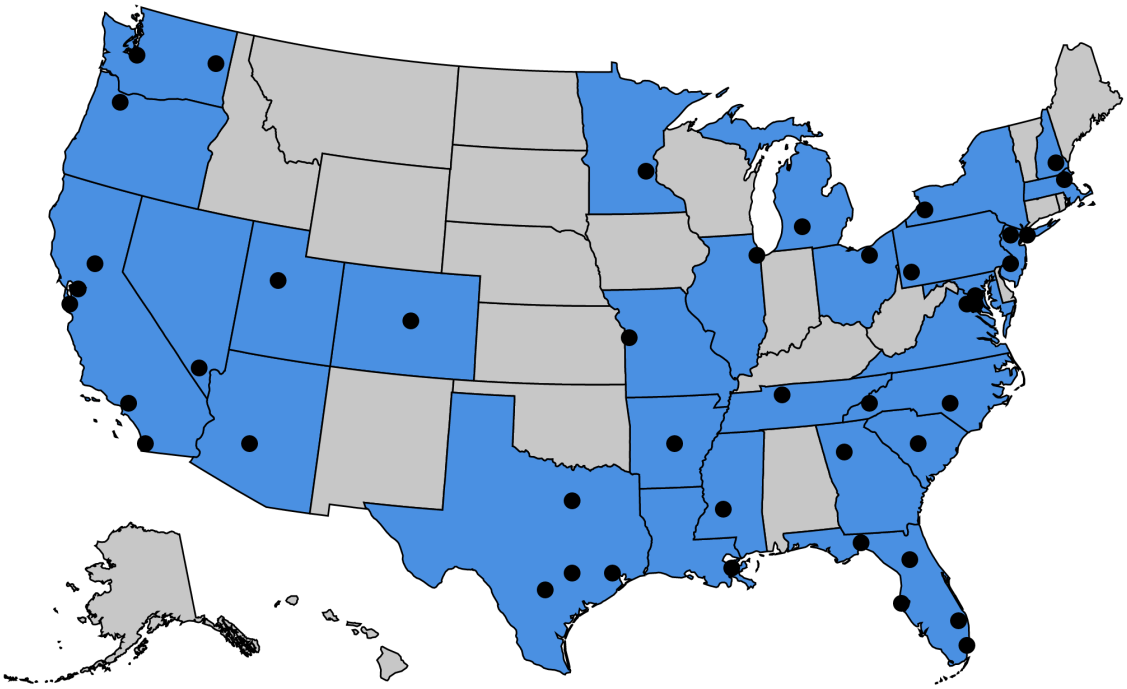
The VA OIG has almost 1,000 staff organized into six primary directorates: the Offices of Audits and Evaluations, Contract Review (which is overseen by the Office of the Counselor to the Inspector General), Healthcare Inspections, Investigations, Management and Administration (including the OIG Hotline), and Special Reviews. The OIG also has an office for congressional relations, public affairs, and executive support, as well as an Office of the Counselor to the Inspector General. The FY 2019 funding for OIG operations provided $192 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 ORGANIZATIONAL CHART



MAP OF OIG FIELD OFFICE LOCATIONS



ARLINGTON, VA	COLUMBIA, SC	MANCHESTER, NH	SACRAMENTO, CA
ASHEVILLE, NC	DALLAS, TX	MIAMI, FL	SALT LAKE CITY, UT
ATLANTA, GA	DENVER, CO	MINNEAPOLIS, MN	SAN ANTONIO, TX
AUSTIN, TX	FAYETTEVILLE, NC	NASHVILLE, TN	SAN DIEGO, CA
BALTIMORE, MD	GAINESVILLE, FL	NEW ORLEANS, LA	SAN FRANCISCO, CA
BATTLE CREEK, MI	HOUSTON, TX	NEW YORK, NY	SEATTLE, WA
BAY PINES, FL	JACKSON, MS	NEWARK, NJ	SPOKANE, WA
BEDFORD, MA	KANSAS CITY, MO	OAKLAND, CA	TALLAHASSEE, FL
BUFFALO, NY	LAS VEGAS, NV	PHOENIX, AZ	TRENTON, NJ
CHICAGO, IL	LITTLE ROCK, AR	PITTSBURGH, PA	WASHINGTON, DC
CLEVELAND, OH	LOS ANGELES, CA	PORTLAND, OR	WEST PALM BEACH, FL

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The office serves as the central coordination point for all executive correspondence, congressional testimony, media inquiries, and stakeholder engagement. The Inspector General and Deputy Inspector General provide leadership and set the strategic direction for a nationwide staff of auditors, investigators, inspectors, attorneys, healthcare professionals, and support personnel who conduct independent oversight of the second-largest agency in the federal government. The office includes congressional relations and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed.

THE OFFICE OF AUDITS AND EVALUATIONS

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Staff are involved in evaluating such diverse areas as healthcare inventory and financial systems, administration of benefits, resource utilization, acquisitions, construction, and information security. This work addresses VA program results; economy and efficiency; controls; fraud indicators; and compliance with legal mandates, policies, and other guidance. Staff also identify opportunities to enhance VA operations and veteran care and support.

THE OFFICE OF CONTRACT REVIEW

Under the supervision of the Counselor to the Inspector General, the office provides preaward, postaward, and other pricing reviews of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward reviews provide VA contracting officers with assistance and information needed to negotiate fair and reasonable prices, and to protect the interests of veterans and taxpayers. Postaward reviews assess compliance with contract terms and conditions and help recover identified overcharges.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The counselor's office provides independent legal advice to OIG leaders and is involved in all aspects of office operations. OIG attorneys provide legal support for investigations, audits, and inspections; work with OIG investigators in developing *qui tam* and False Claims Act matters; represent the OIG in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. The counselor's office also oversees the work of the Release of Information Office and the Office of Contract Review.

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections

prompted by OIG Hotline complaints, congressional requests, and other leads. The office also performs inspections of individual medical facilities and systems. Field staff participate in Comprehensive Healthcare Inspection Program (CHIP) site visits focusing on leadership, quality management, and adherence to requirements and standards for patient care provision and documentation. Facility results are aggregated into summary reports that identify national trends. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

THE OFFICE OF INVESTIGATIONS

This office investigates crimes and other violations of law involving VA programs and operations by employees and nonemployees. Criminal and civil investigations focus on issues such as benefits and procurement fraud (including Service-Disabled Veteran-Owned Small Business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems. Staff have also released reports in response to allegations of serious violations of policies and procedures by high-ranking VA leaders such as misuse of government resources and official time, preferential treatment, abuse of authority, nepotism, and travel irregularities.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

Staff provide comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, information technology, and data services to the organization. The office also oversees the OIG Hotline, which receives, screens, and refers all allegations and complaints for additional action. Cases are accepted on a select basis, prioritizing those having the most potential risk to veterans, VA programs, and operations, or for which the OIG may be the only avenue of redress. In addition, through report follow-up, the office helps to ensure that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

THE OFFICE OF SPECIAL REVIEWS

This office was created 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 OIG directorate or office. It is led by an executive director and a deputy director, who have staffed the office with professionals possessing a broad array of expertise. This office undertakes projects assigned to it by the Inspector General and Deputy Inspector General and also works collaboratively with the other directorates to review topics and issues of interest that span multiple offices. This office conducts administrative investigations of senior officials as well.

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the Inspector General Act of 1978, this Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the reporting period April 1 – September 30, 2019. Highlighted below are some of the activities conducted during this period by the VA OIG's offices and their impact, followed by statistical tables that summarize key performance measures. Subsequent sections of the report then feature examples of each office's high-impact publications and activities. This information is supplemented by appendixes that detail such information as titles of OIG publications released; the monetary impact of OIG products including savings, cost avoidance, and dollar recoveries; the status of VA's implementation of recommendations; and reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

This office consists of the Inspector General and Deputy Inspector General's executive support staff, as well as congressional relations and public affairs personnel.

CONGRESSIONAL RELATIONS

The VA OIG actively works with Congress on issues affecting VA programs and operations. During this reporting period, the OIG testified at 11 hearings on topics that include the following:

- VA processing of benefit claims for military sexual trauma
- Implementation of the Forever GI Bill (enhancing education opportunities for veterans, service members, families, and survivors)
- OIG's process for tracking recommendations to VA for improvement
- Management of VA's emergency medical supply cache
- Washington, DC VA Medical Center deficiencies
- VA staffing challenges, particularly how shortages within medical facilities can impact patients' access to quality care
- Additional concerns with information technology and other VA initiatives[1]

The VA OIG also submitted a statement for the record for a hearing on the VA's Caregiver Program that highlighted implementation challenges and program operations concerns that need to be addressed prior to the program's expansion. The Inspector General and OIG personnel had 63 briefings with congressional members and their staff during this period. These included prerelease briefings on OIG reports that addressed deficiencies in routine clinical evaluations in VA health facilities, opioid prescribing practices, and VBA benefit claims processing. OIG congressional relations staff fielded more than 140 requests related to constituent casework for review or referral as well.

[1] All OIG statements to Congress can be found at www.va.gov/oig/publications/statements. See also Table 9 on pages 58–59.

HIGHLIGHTED ACTIVITIES AND FINDINGS

PUBLIC AFFAIRS

The OIG is committed to providing accurate and timely information to veterans and their families, the media, veterans service organizations, VA staff and leaders, and the public. During this reporting period, the OIG issued two news releases regarding ongoing investigations in West Virginia at the Louis A. Johnson VA Medical Center in Clarksburg and the Beckley VA Medical Center. The U.S. Department of Justice recognized the OIG for its work on criminal investigations in 52 news releases issued by prosecutors across the nation. The OIG responded to more than 100 queries from journalists. The OIG also produced five podcasts that provide context and perspectives on the OIG's oversight work. In addition, it maintained an active presence on social media, with more than 150,000 impressions on Twitter alone. Staff also engaged both internal and external stakeholders to ensure the transparency of OIG work.

THE OFFICE OF AUDITS AND EVALUATIONS

The OIG Office of Audits and Evaluations (OAE) conducts audits, reviews, and inspections to help ensure that veterans receive the timely medical care and benefits to which they are entitled. During this reporting period, OAE identified an estimated $1.2 billion in potential monetary benefits. OAE's efforts continue to focus on oversight of specific, high-risk areas within VA. This proactive identification of areas of vulnerability within VA should help improve program management, delivery of care and benefits to veterans, and ensure that taxpayer dollars are well spent. This reporting period, OAE reports identified issues in key areas where VA struggles to manage its responsibilities, such as inappropriately denying and rejecting non-VA emergency care claims, the lack of reimbursement of home loan fees to exempt veterans, and the management of leases for facilities to expand veteran health care. The impact of OAE reports was evidenced by extensive media coverage that stimulated national discussions of veterans' issues. They also prompted policy and practice changes, as well as congressional action, during the review period, including these:

- VBA implemented a special focused review of all previously denied military sexual trauma claims since October 2016 to correct the types of errors identified in an OIG report. Following the launch of a training initiative, VBA created a panel to improve claims processing.
- An OIG report helped stimulate legislation to send refunds to veterans who were improperly charged home loan funding fees from which they were exempt.
- VBA issued guidance, developed training, and conducted a special focused review of cases involving Lou Gehrig's disease claims (ALS)—an aggressive disease that has been correlated with military service. In May 2019, VBA directed all such claims be handled by a specialist.
- The OIG report on inappropriately denied and rejected non-VA emergency care claims sparked a bipartisan, bicameral letter signed by more than 30 members of Congress demanding that VA promptly fix its errors.

OAE also continues to build its expertise in areas key to making practical and applicable recommendations in audit reports, which in this reporting period included enhancing staff specialization in information technology.

THE OFFICE OF CONTRACT REVIEW

The 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 OCR's reviews relate to contracts awarded by VA under the Federal Supply Schedule (FSS) program, for minor construction projects, and on a sole-source basis to affiliated medical schools for physician services. These reviews assist VA in achieving the best prices during negotiations, resulting in cost savings to the government, and in ensuring contractors comply with all contract terms and conditions. The office also evaluates pharmaceutical manufacturers' compliance with the pricing provisions contained in the Veterans Health Care Act of 1992 (P.L. 102-585) and provides support to the Department of Justice in litigation and investigations involving VA contracts, such as *qui tam* and false claims actions. During this reporting period, OCR made recommendations for lower pricing with potential cost savings of nearly $304 million over the term of the proposed contract and identified more than $23 million in contract overcharges. OCR's new special projects team has completed its first review and expects to publish the report early in the next fiscal year.

During this review period, OCR also published a synopsis of all pharmaceutical preaward reports issued to contracting officers in FY 2018.[2] OCR determined that commercial pricing disclosures were not reliable for negotiations for 16 of the 22 proposals and recommended VA obtain revised disclosures prior to contract award. OCR's lower FSS pricing recommendations collectively reflected more than $515 million in estimated cost savings to VA, nearly 75 percent of which were sustained. The 22 proposals included 2,040 offered drug items.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The Counselor's Office (CO) continues to provide legal support to all components of the OIG and look for new ways to serve the needs of the organization. During the review period, the CO provided the following services:

- Legal support to the Office of Healthcare Inspections in reviewing complaints involving nearly every aspect of healthcare delivery throughout VA. To better serve that office, the CO added an attorney with significant experience in a state Attorney General's office prosecuting administrative actions against medical professionals. The CO also provided legal support on several healthcare inspections reviewing patient suicides, and assisted staff on the inspection of pathology processing delays at the Memphis VA Medical Center. Most notably, the CO provided legal counsel to a team of healthcare inspectors (as well as criminal investigators) reviewing deficient care provided by a pathologist at a VA facility in Arkansas, which resulted in significant harm to patients.

[2] *A Synopsis of OIG Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2018*, Report No. 19-07113-223, September 19, 2019.

- Case law updates and refresher training required by the Council of Inspectors General on Integrity and Efficiency, and the review of more than 175 subpoenas issued in ongoing criminal and civil investigations.
- Significant legal support to the Office of Audits and Evaluations as staff examined VA's Decision Ready Claims Program. The review found that the program was hindered by ineffective planning and expended appropriated funds in apparent violation of the Antideficiency Act. The CO also provided substantial assistance on an audit of VA's use of state prescription drug monitoring programs.

The CO also initiated a monthly program to better engage with OIG employees and provide a forum for employees to raise questions or issues for discussion, and continued to coordinate with the U.S. Office of Special Counsel and VA's oversight offices on matters of shared concern.

The CO's Office of Information Release represented the OIG in establishing data use agreements with several other federal offices of inspector general to aid in ongoing criminal investigations. It also reviewed more than 500 requests from the public and other government agencies for agency records, in addition to reviewing all OIG reports before publication for compliance with the Privacy Act of 1974 (P.L. 93-579) and other disclosure laws. The Office of Information Release also revised and published a System of Records Notice (SORN) for each of the three VA OIG systems of records, which had last been revised in 2008. This publication in the Federal Register is required by the Privacy Act for any new or substantially changed system. These revised SORNs notified Congress and the public of changes to the system location and system manager; clarified terms that might cause unnecessary litigation; and reflected changes to OIG practices and organization, as well as amendments to the IG Act.

THE OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) remains focused on issues that affect the provision and access of quality health care to veterans. In this SAR period, OHI examined a variety of concerns, including Veterans Health Administration (VHA) staffing shortages, community care, credentialing and privileging of providers, mental health care, and health care for women veterans—complemented by the CHIP routine reviews of VHA facilities that assessed some of the same areas as well as other critical matters, such as leadership engagement and responsiveness to staff and veterans. In its sixth review of critical staffing shortages, OHI found that VHA needs to implement staffing models that incorporate predictive data on veteran demand for health care and address long-standing recruitment and retention challenges for both clinical and nonclinical positions. Current and prior OHI staffing reports also identified deficiencies that warranted additional work conducted in this reporting period, including closer examination of the expansion of care in the community. Ensuring that all individuals are competent who provide care to veterans is imperative. OHI has completed work in response to allegations of inappropriate or incomplete credentialing and privileging of care providers. Without

national-level change to the oversight and standardization of credentialing and privileging, veterans are at risk of receiving care from providers who are not appropriately licensed and are inadequately skilled or trained.

Veterans with complex mental health needs must be served by providers trained to diagnose and provide appropriate treatment. Yet OHI completed a review of VA facilities' use of clinical pharmacists in mental health outpatient care settings and found patients with complex needs were at risk of not receiving the diagnostic and management attention of independent care providers with the necessary training and skills.

During the reporting period, OHI also hosted a roundtable discussion with representatives from seven national veteran service organizations to better understand the needs of women veterans. OHI is committed to supporting this growing population and the need to access primary and gender-specific specialty care in a safe and highly coordinated setting, such as addressing the challenges women veterans face when seeking treatment for substance use disorders.

THE OFFICE OF INVESTIGATIONS

The Office of Investigations (OI) addresses crimes involving VA programs and operations by employees and nonemployees. OIG criminal investigation's staff continue to focus on impactful issues that include healthcare fraud, benefits and procurement fraud (including Service-Disabled Veteran-Owned Small Business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems. Criminal and civil investigations yielded millions of dollars in recoveries for VA and resulted in significant judicial and administrative actions.

With a continued emphasis on VA healthcare fraud, OI has created a healthcare fraud leadership position to oversee and coordinate initiatives among other VA OIG directorates and OI's Investigative Development Division, internal desk officers, and external law enforcement agencies. OI also reorganized and streamlined its divisions by integrating the technical operations, cyber investigations, and computer and forensics lab staff. This is meant to achieve greater collaboration and efficiency.

OI continued coordinating with data analytics specialists to identify patterns of fraud in education and community care to detect vulnerabilities within these programs. OI used data analytics provided by Booz Allen Hamilton and the Investigative Development Division on detecting other types of fraud as well. In addition, OI assigned a desk officer to track data on fiduciary fraud cases, with plans to hire additional investigative analysts to support complex investigations nationwide. OI has also continued to use regional proactive working groups to help detect high-risk program areas that are susceptible

to high-impact fraud. These working groups and the Investigative Development Division coordinate closely to ensure that emerging criminal enterprises and important investigations receive appropriate attention and resources. To assist in those and other efforts, OI's forensic auditor program has been expanded to 12 personnel embedded with criminal investigators in various OIG offices.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

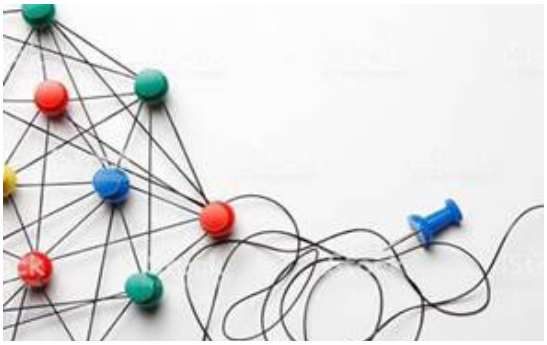
The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency, and to support the OIG's overall mission and goals. In the last six months, OMA had a major role in overseeing execution of the OIG's largest budget to date—$192 million—and in completing the most significant hiring surge in OIG history. To that end, in FY 2019, OMA posted more than 400 vacancies, hired and efficiently onboarded over 200 external applicants, and promoted or reassigned nearly 75 OIG employees. OMA also substantially increased the OIG's capacity to accommodate additional staff by successfully completing two major office moves (Denver and Kansas City) and timely executing renovations at the OIG headquarters in Washington, DC, as well as establishing two new offices in Minneapolis and Trenton.

OMA also continued to have a central role in enhancing the OIG's predictive analytics and data modeling program. OMA has pursued data-sharing agreements, including a recently signed data-use agreement with the Department of Health and Human Services' OIG, to obtain critical data for the ongoing efforts to detect and deter healthcare fraud. OMA also continued partnerships with cross-directorate subject matter experts, as well as staff from the National Technical Information System and joint venture partners, to conduct thorough analyses of VA programs to identify fraud, waste, and abuse. This work generated leads and produced self-service tools for oversight projects, with resulting ongoing work by various directorate staff expected to be completed in the next year.

In addition, OMA is responsible for overseeing the OIG Hotline. During FY 2019, OMA expanded the number of staff who support that function. The increased staffing allows the OIG to more quickly review and respond to the more than 32,000 complaints that are received annually. OMA has also enhanced the systems supporting the Hotline function to help staff process complaints faster and to share information across the organization more effectively.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews (OSR) is conducting work on a number of allegations concerning VA programs, operations, and staff that are not within the scope of another single directorate. OSR is continuing to build its staff and capacity as it conducts multiple ongoing complex reviews. This office undertakes projects assigned to it by the Inspector General and Deputy Inspector General and also works collaboratively with the other directorates to review topics and issues of interest that span multiple offices. Among the efforts currently underway is a review of the implementation and operation of VA's Office of Accountability and Whistleblower Protection that will be released in October 2019.



STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE REPORTING PERIOD

161 REPORTS AND PUBLICATIONS

131 ARRESTS

91 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

11 CONGRESSIONAL TESTIMONIES

914* ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS

16,348 HOTLINE CONTACTS

$24:1 RETURN ON INVESTMENT

661 RECOMMENDATIONS TO VA

$1,810,459,014 MONETARY IMPACT

5 PODCASTS

* Hotline and Investigations included

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR 2019
Better Use of Funds	$161,900,000	$34,263,584	$196,163,584
Dollar Recoveries	$76,410,034	$28,121,022	$104,531,056
Fines, Penalties, Restitution, and Civil Judgments	$159,446,428	$40,713,881	$200,160,309
Fugitive Felon Program	$59,100,000	$110,700,000	$169,800,000
Savings and Cost Avoidance	$340,055,334	$1,305,415,696	$1,645,471,030
Questioned Costs	$1,013,547,218	$2,336,300,000	$3,349,847,218
Total Dollar Impact	**$1,810,459,014**	**$3,855,514,183**	**$5,665,973,197**
Cost of OIG Operations[1]	$76,553,821	$78,384,000	$154,937,821
Return on Investment[2]	**$24:1**	**$49:1**	**$37:1**

1. The six-month operating cost for OHI ($19.4 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.

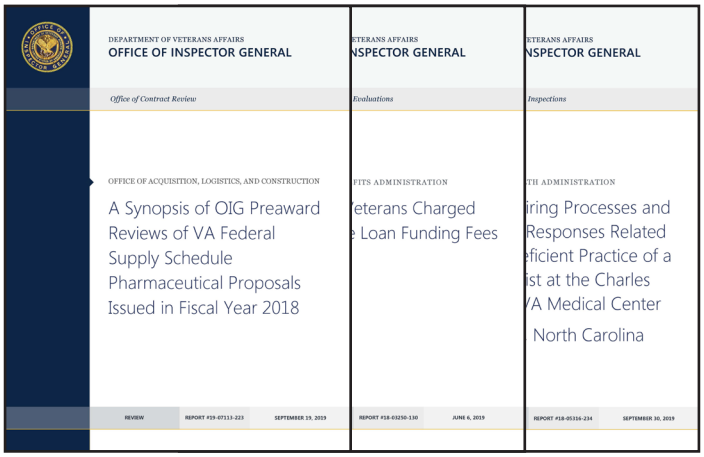


TABLE 2: REPORTS AND OTHER PUBLICATIONS

REPORT TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR 2019
Administrative Investigations	1	5	6
Audits and Reviews	28	11	39
Claim Reviews	4	0	4
Comprehensive Healthcare Inspections	12	19	31
Hotline Healthcare Inspections	29	11	40
National Healthcare Reviews	4	1	5
Postaward Reviews	23	18	41
Preaward Reviews	35	35	70
Roll-Up Reviews	1	0	1
Subtotal	**137**	**100**	**237**
OTHER PUBLICATION TYPE	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR 2019**
Administrative Summaries of Investigation	0	1	1
Congressional Testimony	11	2	13
Issue Statements	0	1	1
Major Management Challenges	0	1	1
Monthly Highlights	6	6	12
Peer Reviews Conducted of other Offices of Inspector General	0	1	1
Podcasts	5	11	16
Press Releases	2	1	3
Subtotal	**24**	**24**	**48**
Total	**161**	**124**	**285**

FOR MORE INFORMATION

View the OIG's Report Recommendation Dashboard at www.va.gov/oig to track VA's progress in implementing OIG's report recommendations.

TABLE 3: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[1]	THIS PERIOD	LAST PERIOD	FISCAL YEAR 2019
Arrests[2]	131	101	**232**
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	1	13	**14**
Indictments[3]	116	84	**200**
Indictments and Informations Resulting from Prior Referrals to Authorities	183	113	**296**
Criminal Complaints	23	25	**48**
Convictions	86	88	**174**
Pretrial Diversions and Deferred Prosecutions	5	9	**14**
Case Referrals to Department of Justice for Criminal Prosecution[4]	175	169	**344**
Cases Accepted	72	66	**138**
Cases Declined	72	65	**137**
Cases Pending	31	38	**69**
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	31	34	**65**
Cases Accepted	19	19	**38**
Cases Declined	6	8	**14**
Cases Pending	6	7	**13**
Administrative Sanctions and Corrective Actions	334	245	**579**
Cases Opened	228	238	**466**
Cases Closed[6]	223	297	**520**

1. Pursuant to §5(a)(18) of the IG Act, all investigative data reported and analyzed were collected via the OIG's case management system. Although the IG Act, under §5(a)(17), requires federal inspectors general to list the total number of investigative reports issued during the reporting period, the VA OIG does not publish or issue investigative reports related to criminal investigations. Reports of noncriminal investigations are disclosed in Table 2. Summaries of arrests and other subsequent actions in selected criminal cases are summarized in the OIG's Monthly Highlights publication, available at www.va.gov/oig/publications/monthly-highlights.asp.

2. Total arrests include five apprehensions of fugitive felons by VA OIG agents. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

3. Indictments may result from referrals made to prosecutorial authorities prior to the current reporting period.

4. The IG Act, under §5(a)(17), requires federal inspectors general to report the "total number of persons" referred to federal authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

5. The IG Act also requires federal inspectors general to report the total number of persons referred to state and local authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

6. This total also includes cases opened in previous fiscal years.

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR 2019
Contacts	16,348	15,669	**32,017**
Cases Opened	702	841	**1,543**
Cases Closed	702	834	**1,536**
Administrative Sanctions and Corrective Actions*	580	545	**1,125**
Substantiation of Allegations Percentage Rate	39%	38%	**39%**
Individuals Claiming Retaliation/Seeking Whistleblower Protection	23	36	**59**
Individuals Provided Office of Special Counsel Contact Information	43	81	**124**
Individuals Provided Merit Systems Protection Board Contact Information	43	9	**52**
Individuals Provided Office of Resolution Management Contact Information	101	145	**246**

* The totals for these activities include cases opened in previous fiscal years.

TABLE 5: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR 2019
Clinical Consultations to Other VA OIG Offices	6	4	**10**
Hotline Referrals Reviewed	1,964	1,773	**3,737**

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

OAE published 28 reports during this SAR reporting period. These focus on issues that have a meaningful impact on veterans' health and benefits, management of VA resources and taxpayer dollars, and the effective operations of VA programs and services. The list of all OAE report recommendations for corrective action made during the reporting period can be tracked on OIG's dashboard at www.va.gov/oig. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

28
REPORTS

124
RECOMMENDATIONS

$1.18B
MONETARY BENEFITS

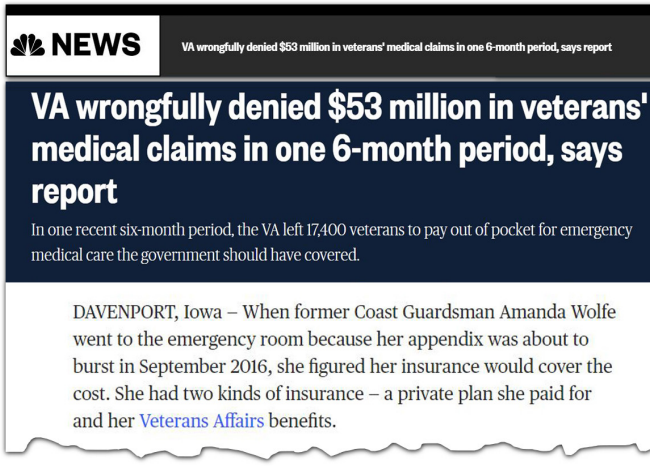
FEATURED PUBLICATIONS

The three publications that follow provide examples of the type of work OAE conducts that focuses on identifying problems and making recommendations that can have a meaningful effect on VA and the veterans it serves. These reports address inappropriate denials and rejections of non-VA emergency care claims, incorrect charges to exempt veterans for VA home loan funding fees, and the failure to promptly and effectively manage major medical leases.

NON-VA EMERGENCY CARE CLAIMS INAPPROPRIATELY DENIED AND REJECTED

The VA OIG conducted this congressionally requested audit to determine whether processors of non-VA emergency care claims inappropriately denied or rejected the claims, and, if so, whether the cause was pressure to meet production standards. The OIG conducted an accuracy review of claims for emergency medical care obtained outside of VA and found that 31 percent of denied or rejected non-VA emergency care claims—with an estimated billed amount of $716 million—were inappropriately processed in the six-month review period, creating the risk of undue financial burden to an estimated 60,800 veterans. Some of those denied and rejected claims should have been approved.

The OIG estimated from its sample that about 17,400 veterans—with bills totaling approximately $53.3 million—were negatively affected. The remaining processing errors created a risk that the claimants did not receive sufficient information to re-attempt claim approval and payment. The OIG concluded there was a significant risk that some errors identified in this audit resulted from pressure to meet production targets, insufficient quality assurance of claims processing accuracy, and incentives associated with meeting production targets. The OIG made 11 recommendations that included addressing the culture of prioritizing claims productivity over accuracy, improving performance evaluation


NEWS VA wrongfully denied $53 million in veterans' medical claims in one 6-month period, says report

VA wrongfully denied $53 million in veterans' medical claims in one 6-month period, says report

In one recent six-month period, the VA left 17,400 veterans to pay out of pocket for emergency medical care the government should have covered.

DAVENPORT, Iowa – When former Coast Guardsman Amanda Wolfe went to the emergency room because her appendix was about to burst in September 2016, she figured her insurance would cover the cost. She had two kinds of insurance – a private plan she paid for and her Veterans Affairs benefits.

standards and review processes, tying incentives to all performance standards rather than just production quantity, reevaluating inappropriately processed claims, and improving communications about claim status.

As a result, VA's Office of Community Care is taking corrective actions on improperly denied claims. That office has also revised and standardized all claim denial and rejection reasons and is fully revising standard operating procedures and developing additional tools to assist staff with making accurate decisions. Weekly quality and accuracy reviews have been added covering rejected and denied claims to raise nationwide awareness and discussion of internal controls needed to prevent future errors.

EXEMPT VETERANS CHARGED VA HOME LOAN FUNDING FEES


MilitaryTimes News Pentagon & Congress Veterans Military Honor

VA refunds $400 million in mistaken home loan fees

By: Leo Shane III October 8

Privatized military homes are shown at Kirtland Air Force Base in New Mexico in April 2019. (Airman 1st Class Alexandria Crawford/Air Force)

Veterans Affairs officials have paid out more than $400 million in refunds of home loan funding fees in the wake of an inspector general's report that tens of thousands of veterans were improperly tagged with extra costs when applying for the loans.

This review gained national media and congressional attention for its examination of whether VBA had adequate controls to ensure exempt veterans did not pay VA home loan funding fees and to refund fees previously charged to exempt veterans. Veterans entitled to receive VA disability compensation do not have to pay funding fees for VA home loans. However, the OIG review team estimated that VA charged about 72,900 exempt veterans about $286.4 million in funding fees between 2012 and 2017. Also, VBA's Loan Guaranty Service managers who oversee VA's home loan guaranty program were aware since October 2014 that thousands of exempt veterans may have been charged funding fees. The team estimated VA had not yet given about $189 million in funding fee refunds to about 53,200 exempt veterans. The OIG recommended the Under Secretary for Benefits makes certain the Loan Guaranty Service identifies exempt veterans who were charged funding fees to issue refunds and conducts ongoing reviews. The OIG also recommended Loan Guaranty Service managers create a plan to minimize and detect inappropriate funding fee charges by updating veteran exemption status in real time, and consistently documenting and verifying that lenders promptly apply funding fee refunds to veterans' loan balances. VBA agreed to implement a plan to issue refunds to exempt veterans identified by this review who were charged funding fees, reporting that approximately $415 million in funding fee refunds have been arriving in veterans' accounts via direct deposit since August. Remaining recommendations will be closed as sufficient documentation of completion is submitted by VBA.

MANAGEMENT OF MAJOR MEDICAL LEASES NEEDS IMPROVEMENT

The OIG conducted this audit to follow up on previous reviews of VA's capital asset programs, which have identified areas of improvement for both major and minor construction projects, and to determine whether VA effectively managed the procurement and awarding of major medical leases under the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). The audit revealed that VA major medical leases authorized by VACAA are approximately 22 months behind schedule on average. The management structure of the lease acquisition process spans multiple lines of authority and requires many decisions to execute a lease contract. As a result, lease acquisitions are often slowed when project managers are confronted with conflicting opinions from different management groups.

VA has taken some steps to improve the major lease acquisition process, including simplifying the solicitation documentation to better align with General Services Administration practices and changing VA's mission-critical building standards for leases to better align with similar private sector facilities. However, several of the recommendations remain unaddressed. The OIG recommended VA ensure adequate funds are available to routinely conduct planning activities such as developing requests for lease proposals while waiting for congressional authorization; reconsider centralizing major medical lease acquisition funding activities; make certain adequate resources are available to deliver leases on schedule; ensure that the prospectus cost estimates provided to Congress are accurate; establish clear lines of authority for critical lease acquisition decisions; and adhere to appropriate security measure requirements by performing Interagency Security Committee risk evaluations prior to solicitation. Implementing these recommendations should result in faster and more cost-efficient acquisition of major medical leases.

VETERANS HEALTH ADMINISTRATION PUBLICATIONS

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

EXPENDABLE INVENTORY MANAGEMENT SYSTEM: OVERSIGHT OF MIGRATION FROM CATAMARAN TO THE GENERIC INVENTORY PACKAGE

The audit staff assessed VHA's oversight of VA medical centers' migration from the Catamaran inventory management system to the Generic Inventory Package and to determine if the medical centers accurately managed expendable supply inventories critical to patient care. The audit found that VA medical centers encountered challenges as part of the migration and significant discrepancies existed in inventory data for expendable medical supplies. Also, inventory monitoring and management were lacking. Some of the deficiencies stemmed from the failure to provide oversight of the migration. The OIG also identified other factors, including inaccurate or nonexistent inventory management practices. Recommendations included implementing controls to annotate supply item distribution, strengthening inventory documentation procedures, implementing controls to ensure storage access procedures are posted and supply item logs are complete, making certain barcode labels are affixed at item storage locations, strengthening procedures for the quality control review process, and updating quality control review documentation.

IMPROPER CODING AND UNNECESSARY OVERTIME AT THE CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM

The OIG received allegations that a psychologist in the Central Texas Veterans Health Care System entered duplicate billing codes for group therapy sessions and received improper overtime pay. The audit substantiated that the psychologist improperly coded appointments and received about $7,700 for clinic time not spent providing direct patient care as well as more than 243 hours in unnecessary overtime pay. The OIG expanded the review to cover other psychologists in the system and found that they also entered improper codes. Coding errors occurred because the chief of psychology and the chief of health information management failed to provide proper oversight. The OIG recommended the health care system director ensure all psychologists receive medical coding training and stronger oversight, improve review of overtime hours, ensure facility hours are used to provide

direct patient care, and confirm psychologists follow VHA's scheduling policies and use approved systems.

ALLEGED UNAPPROVED ACQUISITION OF A ROBOTIC SURGICAL SYSTEM FOR THE W.G. (BILL) HEFNER VA MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

A November 2017 anonymous complaint alleged the W.G. Hefner VA Medical Center located in Salisbury, North Carolina, purchased a robotic surgical system for about $2.3 million without adequate planning and approval. The complainant further alleged the purchase was made using "leftover" funds without approval, and that the purchase was unnecessary because the building was unsuitable and the medical center already had a similar, unused system purchased in 2012. The OIG substantiated that staff were permitted to order the new robotic surgical equipment using year-end spending without proper review and approval. This occurred due to an ineffective capital investment review process and weak internal controls over the ordering process within Veterans Integrated Service Network (VISN) 6. The OIG did not substantiate the purchase was unnecessary but did recommend clarifying approval requirements and ensuring the capital investment board meets annually to review requests in a timely manner.

STAFFING AND VACANCY REPORTING UNDER THE MISSION ACT OF 2018

Because VA has experienced chronic healthcare professional shortages since at least 2015, the VA MISSION Act of 2018 requires annual reporting on steps taken to achieve full staffing and the additional funds needed to achieve that level. The law also requires VA to publicly release quarterly staffing and vacancy data. OIG's legislatively mandated review found VA partially complied with the law's requirements, reporting personnel and time-to-hire data as prescribed. But VA's initial reporting of staff vacancies and employee gains and losses was not transparent enough to allow stakeholders to track VA's progress toward full staffing. VA also did not follow specifications for reporting gains and losses by quarter. The OIG recommended the Assistant Secretary for Human Resources and Administration ensure that staffing and vacancy data are reported as required, disclose limitations in the data, maintain historical data publicly, and update the methodology.

PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS: TIMELY DISCHARGES, BUT OVERSIGHT NEEDS IMPROVEMENT

The OIG audited the Program of Comprehensive Assistance for Family Caregivers to determine whether VHA discharged veterans and their caregivers from the program and subsequently canceled caregiver stipends in a timely manner following a caregiver death or veteran death, incarceration, or hospitalization. The OIG found VHA timely discharged veterans and caregivers, except in about six percent of cases, causing it to pay at least $356,000 in improper and questionable stipends. If controls are not improved, VHA could pay an estimated $583,000 over five years. The OIG also substantiated that a caregiver was improperly paid approximately $71,000 because a caregiver support coordinator did not initiate prompt action to discharge the veteran and cancel the stipend. The OIG recommended establishing regular processes to match enrolled veteran and caregiver records against VA death, incarceration, and hospitalization data; outlining veteran and caregiver responsibilities for death notifications; and clarifying program guidance.

HEALTH INFORMATION MANAGEMENT MEDICAL DOCUMENTATION BACKLOG

VHA medical facilities must accurately and promptly scan and enter medical documents into patients' records to ensure proper care, particularly when using both VA and non-VA care providers. The OIG found that limited monitoring and oversight of scanning activities created backlogs that put the continuity of patient care at risk. The audit team calculated that VHA medical facilities had a cumulative backlog of approximately 5.15 miles of stacked paper compiled of at least 597,000 individual electronic files dating back to October 2016. This occurred in part because staff did not promptly scan and enter documents into electronic health records and did not always perform appropriate reviews to ensure the quality and legibility of scans. The OIG also found staffing shortages contributed to backlogs. In response, VHA has directed VISNs and medical facilities to assign someone to oversee remediation of the scanning backlogs, and directed a national stand-down in July to reduce the backlogs.

STATE PRESCRIPTION DRUG MONITORING PROGRAMS NEED INCREASED USE AND OVERSIGHT

This audit examined whether VA clinicians used state-operated prescription drug monitoring program (PDMP) databases to manage care for patients prescribed opioids. These databases track prescriptions issued by both VA and non-VA prescribers to reduce the risk of overdose, misuse, and complications. The OIG estimated clinicians did not annually check PDMP databases for 73 percent of the 779,000 VA patients prescribed opioids, and an estimated 19 percent of VA patients were at risk because clinicians were unaware of other prescriptions. VHA's controls and policy communications were ineffective. VHA policy did not address significant developments or increased risks. The OIG found inadequate national VHA oversight led to insufficient local monitoring at medical facilities because VHA officials did not always prioritize database queries. The OIG made eight recommendations on strengthening VA's policies and ensuring leaders and clinicians understand and comply with those policies. VHA has convened a work group to examine possible technological solutions.

CONSTRUCTION PROJECT MANAGEMENT AT THE RALPH H. JOHNSON VA MEDICAL CENTER IN CHARLESTON, SOUTH CAROLINA

The OIG audit team reviewed four allegations of potential mismanagement of construction projects at the Ralph H. Johnson VA Medical Center. The OIG substantiated two of the allegations—that construction for some nonrecurring maintenance projects took years to begin after contract awards, resulting in increased costs of at least $441,000, and that engineers had planned to spend about $74,000 to create separate drawings from a single rendering completed for a project. Regarding the first allegation, the OIG recommended a reporting process be established if construction is not planned to start within 150 days after contract awards. The OIG made no recommendations on the improper spending of $74,000 because the separate drawings were never made. The OIG did not substantiate allegations that construction items were inappropriately removed from the solicitation on the intensive care unit project to reduce the contract price, or that a construction project was inappropriately classified.

EQUIPMENT AND SUPPLY MISMANAGEMENT AT THE HAMPTON VA MEDICAL CENTER, VIRGINIA

The OIG received allegations of mismanagement of equipment and supplies resulting in wasted funds and canceled operating room procedures at the Hampton VA Medical Center in Virginia. According to the complaint, these deficiencies were identified in quality control reviews but never addressed by facility leaders. Allegations included unused equipment not being inventoried, poor

inventory practices, and operating room cancellations because supplies were unavailable. The OIG did not substantiate that operations were canceled or that excessive funds were spent on overnight deliveries. However, equipment valued at about $1.8 million was found not inventoried in an unmarked storage room and warehouse basement. The OIG also found that staff ordered too many supplies and partially substantiated that the facility did not have an effective inventory system. These deficiencies had not been addressed since their identification in 2017 and 2018 quality control reviews. Several recommendations were made for improving inventory management.

VETERANS BENEFITS ADMINISTRATION PUBLICATIONS

The OIG performs audits and evaluations of veterans' benefits programs to identify ways in which program operations and services can be improved. Staff examine the effectiveness and accuracy of benefits delivery to veterans, eligible family members, and caregivers.

DEFERRALS IN THE VETERANS BENEFITS MANAGEMENT SYSTEM

A deferral allows VBA employees to return a claim for benefits to an earlier phase in the claims process for correction or additional action. This review focused on whether VBA staff properly created deferrals for disability compensation claims in its web-based electronic program and resolved the deferrals in a timely manner. Unwarranted deferrals can result in needless examination costs, delayed processing, unnecessary rework, and improper guidance to claims processors. Within the three-month OIG review period, an estimated 23,200 unwarranted deferrals occurred. This was due to local and national oversight failing to assess deferral accuracy; claims processors lacking feedback and accountability; guidance being unclear; and limitations affecting the Veterans Benefits Management System. Because, generally, VBA claims processors did resolve sampled deferrals timely, OIG recommendations focused on improving local and national oversight, creating internal documentation controls, and updating deferral guidance and system specifications to provide more space for documentation.

DECISION READY CLAIMS PROGRAM HINDERED BY INEFFECTIVE PLANNING

The OIG conducted this review to determine whether VBA effectively planned and implemented the Decision Ready Claims (DRC) program. The program intended to streamline the processing of veterans' claims applications by allowing veterans to work with a representative who assists in gathering evidence. VBA developed the program with a goal to complete claims within 30 days. The OIG found that VBA did not effectively plan the DRC program or properly engage veterans service organizations in program development. By September 2018, VBA had completed only 1,803 claims— less than 1 percent of the 25 percent of the total compensation claims workload that was anticipated at implementation. Furthermore, VBA contravened the plain language of federal statutes and regulations by obligating and expending funds before receiving veterans' claims. VBA ended the DRC program in February 2019. The OIG recommended the Under Secretary for Benefits work with the Secretary and Chief Financial Officer to determine whether Antideficiency Act violations occurred, and if so, to take necessary actions.

INADEQUATE OVERSIGHT OF CONTRACTED DISABILITY EXAM CANCELLATIONS

Responding to a Hotline complaint, the OIG reviewed whether a VA-contracted disability medical exam provider—Medical Support Los Angeles—had the capacity to complete scheduled exams, and whether VBA staff were canceling exams initially scheduled with the provider and rescheduling them through other contractors. The OIG expanded the review to determine whether there was adequate nationwide

oversight of contracted disability exam cancellations. The findings included that Medical Support Los Angeles failed to establish an adequate network of exam providers and, in December 2017, VBA began canceling exams scheduled with the contractor. More than 8,700 exams were canceled and rescheduled by March 2018. The OIG determined in its nationwide examination of contractors that additional VBA oversight was needed to address information systems' limitations, staffing shortages, and some VBA contracting officer's representatives' lack of required qualifications.

ACCURACY OF CLAIMS DECISIONS INVOLVING CONDITIONS OF THE SPINE

Spinal conditions account for two of VA's top 10 service-connected disabilities, totaling some 1.5 million cases. The OIG conducted this review after determining such claims have a higher risk of errors that could keep veterans from receiving proper benefits. The OIG estimated VBA incorrectly processed more than half of the 62,500 claims decided in the first six months of 2018, accounting for at least $5.9 million in either over- or underpayments. The OIG found these incorrectly decided claims resulted from VBA's inadequate process for ensuring accurate and complete evaluation. The OIG recommended the Under Secretary for Benefits instruct VBA to update its disability rating process to establish objective criteria for spine-related conditions and improve internal controls to help ensure the accuracy and consistency of claims decisions. The Under Secretary for Benefits concurred with the recommendations and provided acceptable action plans.

BOSTON, MASSACHUSETTS, VARO SUPERVISOR INCORRECTLY PROCESSED WORK ITEMS

This review considered whether a supervisor at the VA regional office in Boston, Massachusetts, incorrectly processed system-generated messages known as "work items" that may have affected recipients' benefits. The OIG found the supervisor incorrectly cancelled 33 of 55 work items, and improperly cleared another nine work items from the electronic record. The incorrect and improper actions led to VA making about $117,300 in improper payments to veterans or other beneficiaries and delaying about $8,600 in payments. The supervisor said he did not intentionally process the work items incorrectly; the errors were the result of working too quickly and misunderstanding procedures. The OIG recommended the Boston regional office director immediately review and correct all cases the supervisor incorrectly processed that are likely to result in adjustments to recipients' benefits and ensure quality controls for supervisors' work. Administrative action was also taken by VA.

LOS ANGELES VOCATIONAL REHABILITATION AND EMPLOYMENT PROGRAM GENERALLY MET REQUIREMENTS AFTER HIRING ADDITIONAL STAFF

Acting on a congressional request, the OIG reviewed the Vocational Rehabilitation and Employment program at the VA regional office in Los Angeles, California. The program helps veterans with service-connected disabilities prepare for, find, and maintain suitable employment. The OIG found that the program generally complied with VA requirements, criteria, or goals for staffing, making required veteran contacts, meeting rehabilitation outcomes, and reimbursing veterans for supplies, and the program approval percentage was comparable to the national program for the past four years. Despite staffing shortages, the program generally demonstrated progress toward placing veterans on track to gainful employment. The OIG team determined employees made the appropriate number of veteran contacts according to program requirements. The OIG also determined the program processed veterans' reimbursement requests for academic supplies accurately. Therefore, the OIG made no recommendations for improvement.

WORKLOAD MANAGEMENT CHALLENGES IDENTIFIED AT THE SALT LAKE CITY, UTAH, FIDUCIARY HUB

The OIG determined that the Salt Lake City, Utah, Fiduciary Hub had hundreds of annual accounting reports overdue for review, along with a significant number of tasks associated with incoming mail requiring action. There were more than 3,000 pending action mail tasks as of February 2019. The fiduciary hub's workload management plan did not specify how to prioritize action mail tasks and did not require review and resolution of duplicate tasks. The OIG did not substantiate an allegation that fiduciary hub managers hid pending accounting reports to make it seem the work was completed more quickly. The report recommendations included that the fiduciary hub workload management plan contain timeliness goals for action mail tasks and require a routine review of duplicate tasks. The director should also ensure managers measure performance and monitor adherence to those goals.

OVERSIGHT AND RESOLUTION OF HOME LOAN DEFAULTS

This audit examined whether the Loan Guaranty Service provided required oversight of the default resolution process for VA-guaranteed home loans. The Loan Guaranty Service monitors loan servicers and intervenes as needed to ensure delinquent VA home loan borrowers have all available alternatives to foreclosure. The OIG found the Loan Guaranty Service did not always provide enough oversight to ensure borrowers received needed assistance. An estimated 14 percent of loans had at least one oversight deficiency. The audit team and the Loan Guaranty Service also identified potential loan servicing risks to borrowers in disaster areas. The OIG recommended to VA implementing controls to identify and address unreported monthly loan statuses, making certain loan servicers report when loss mitigation letters are sent and cite them for infractions, ensuring key loan servicer performance statistics are generated, and developing a formal tier-ranking system for servicers.

FOR MORE INFORMATION

View the OIG's Report Recommendations Dashboard at www.va.gov/oig **to track VA's progress in implementing OIG recommendations.**

FINANCIAL MANAGEMENT AND INFORMATION TECHNOLOGY PUBLICATIONS

Audits of VA administrative support functions and financial management operations focus on the adequacy of systems in providing managers with information needed to efficiently and effectively oversee and safeguard VA assets and resources. OIG oversight work satisfies the Chief Financial Officers Act of 1990 (P.L. 101-576) 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 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 is also statutorily required to review VA's compliance with the Federal Information Security Modernization Act of 2014 (P.L. 113-283) as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit.

VA'S COMPLIANCE WITH THE IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT FOR FISCAL YEAR 2018

The OIG conducted this review to determine whether VA complied with the Improper Payments Elimination and Recovery Act of 2010 (IPERA) for FY 2018. IPERA requires federal agencies to review and identify programs and activities that may be susceptible to significant improper payments. IPERA requires federal inspectors general to review their agencies for compliance. In FY 2018, VA reported improper payment estimates totaling $14.73 billion. VA did not satisfy two of the six IPERA requirements. First, VA did not meet improper payment reduction targets for eight programs and activities. Second, it did not report a gross improper payment rate of less than 10 percent for seven programs and activities that had improper payment estimates in its FY 2018 Agency Financial Report. The OIG recommended taking steps to achieve reduction targets for three programs and kept five previous recommendations open.

VA'S ADMINISTRATION OF THE TRANSFORMATION TWENTY-ONE TOTAL TECHNOLOGY NEXT GENERATION CONTRACT

Between March and August 2016, VA's Technology Acquisition Center (TAC) awarded the Transformation Twenty-One Total Technology Next Generation contract for IT services. The contract has a total maximum value of $22.3 billion. The OIG conducted this audit to determine whether task orders issued under the contract were administered according to federal and VA acquisition regulations, as well as VA national and local policies and procedures. The OIG also examined whether the TAC performed task order award and modification procedures according to applicable regulations and policies and performed actions that reasonably ensured contractors could successfully complete contract requirements. While the OIG identified no violations of federal and VA acquisition regulations, the audit team found oversight weaknesses that could place IT systems and hundreds of millions of taxpayer dollars at unnecessary risk. The OIG made seven recommendations to mitigate the control deficiencies, such as improving procedures that contracting officer's representatives and TAC contracting officers should perform.

ANNUAL RISK ASSESSMENT OF VA'S CHARGE CARD PROGRAM

The OIG conducted an annual risk assessment of VA's charge card program, evaluating the transactions for the three types of charge card business lines—purchase cards (including convenience checks), travel cards, and fleet cards—for FY 2018. The OIG determined that the purchase card program remains at medium risk of illegal, improper, or erroneous purchases. Data mining of purchase card transactions identified potential misuse of the cards. Also, OIG investigations, audits, and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation and VA policies and procedures. The OIG's assessment also found that VA's Travel Card Program and Fleet Card Program both remain at low risk for illegal, improper, or erroneous purchases. The risk assessment team assigned a low risk level to both programs primarily because data mining showed a low percentage of potential duplicate and split purchases.

VA'S IMPLEMENTATION OF THE VETERANS INFORMATION SYSTEMS AND TECHNOLOGY ARCHITECTURE SCHEDULING ENHANCEMENT PROJECT NEAR COMPLETION

This audit examined whether the Office of Information and Technology and VHA effectively managed the implementation of VA's Veterans Information Systems and Technology Architecture (VistA) Scheduling Enhancement (VSE) project. VSE was intended to be an interim solution to VA's outdated

medical appointment scheduling system. The OIG found the VSE management team did not ensure scheduling enhancements were adequately developed and met users' needs. VA has since decided to use a stand-alone scheduling component within the electronic health records system being developed by the Cerner Corporation as a permanent solution. According to a December 2018 report to Congress, the first standalone scheduling component is planned for deployment in 2020.

SECURITY AND ACCESS CONTROLS FOR THE BENEFICIARY FIDUCIARY FIELD SYSTEM NEED IMPROVEMENT

The OIG conducted this audit to determine if the Beneficiary Fiduciary Field System (BFFS), the IT system for VA's Fiduciary Program, could maintain data integrity and safeguard protected information. The OIG found the BFFS lacked enough controls to ensure privacy of sensitive data and prevent fraud and misuse. VA inappropriately set the security risk level for the BFFS at moderate instead of high because risk managers did not follow established standards or consider whether stored information was sufficiently protected. The OIG also found more than 1,600 BFFS users had access to records not needed for their duties. Finally, the OIG found duties in the report submission process were not fully separated, potentially allowing sensitive information to be changed without approval or documentation. The OIG recommended reevaluating the security risk level for the BFFS, improving controls over access, fully enabling audit logs, and improving separation of duties.

PROBLEMS WERE IDENTIFIED ON ONE REGIONAL PROCUREMENT OFFICE CENTRAL AMBULANCE SERVICE CONTRACT

OIG staff reviewed 18 sole-source contracts awarded in FY 2017 by VHA Regional Procurement Office (RPO) Central with a total value of about $77 million to determine whether the proper justification had been filed and approval obtained. The OIG found that a contracting officer did not obtain the required approval for a service contract worth about $2.2 million because he did not understand the procedures. The same contracting officer also unnecessarily limited competition on the contract by failing to plan for the procurement in advance. The new sole-source contract was awarded based on compelling urgency, even though RPO Central officials knew for several years that the existing contract would expire, requiring a new competition. The OIG recommended VHA ensure awareness of approval procedures for sole-source contracts and that adequate time is allotted for soliciting and awarding recurring services competitively.

SOLE-SOURCE SERVICE CONTRACTING AT REGIONAL PROCUREMENT OFFICE WEST NEEDS IMPROVEMENT

A review of 15 sole-source contracts, valued at about $19 million and awarded in FY 2017 by VHA Regional Procurement Office (RPO) West, focused on whether they were properly justified and approved. The OIG found that this was not done for five contracts worth about $6 million. This occurred because RPO West contracting officers did not follow the required approval process and misunderstood who was the proper approval authority. As a result, the costs of those contracts were not completely justified. The OIG recommended the executive director of VHA procurement ensures awareness of approval procedures and the requirement to prepare a written justification for sole-source contracts; establishes procedures to help make certain the appropriate authority approves all sole-source contracts; and reviews the actions of contracting personnel involved in the cited contracts to determine whether administrative actions are warranted.

SOLE-SOURCE SERVICE CONTRACTING AT REGIONAL PROCUREMENT OFFICE EAST NEEDS IMPROVEMENT

The OIG reviewed 20 sole-source contracts awarded by VHA's Regional Procurement Office East totaling $41.4 million to determine if proper justification and approval were obtained. The audit team found contracting officers did not receive the required approval before awarding 10 contracts worth about $14.2 million. Officials did not follow the proper process, did not receive the correct guidance, and misinterpreted regulations. Contracting officers also unnecessarily limited competition on four recurring contracts worth about $8.5 million. They knew that the existing contracts would expire but did not sufficiently plan for fair and open competition. The OIG recommended VHA ensure personnel's awareness of approval procedures for sole-source contracts and make certain adequate time is allotted for soliciting and awarding recurring services competitively. The OIG also recommended the director review the actions of contracting personnel involved in the cited contracts to determine whether administrative actions are warranted.

RESULTS FROM THE OFFICE OF CONTRACT REVIEW

OVERVIEW

As mentioned previously, the Office of Contract review resumed publishing public reports. Due to the sensitive commercial information contained in contract reviews, information shared with VA on individual contracts cannot be publicly released. To promote transparency, this first roll-up report provides a synopsis of preaward reviews of pharmaceutical proposals that the OIG conducted during FY 2018. This report is meant to provide VA and its stakeholders general information regarding the findings of the OIG's preaward reviews and demonstrates their importance and value. It does not contain any formal recommendations for VA response. Highlighting key data and summarizing findings from the most recent fiscal year's nearly two dozen preaward reviews will provide VA leaders with additional perspective on how its contracting personnel can make the most effective use of VA resources. Examples of other FY 2019 activities conducted by this office follow.

$304M
POTENTIAL COST SAVINGS

$23M
DOLLAR RECOVERIES

PREAWARD REVIEWS

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Thirty-five preaward reviews identified over $300 million in potential cost savings during this reporting period.

In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included 16 healthcare provider proposals, accounting for approximately $43 million of the identified potential savings.

TABLE 6. PREAWARD REVIEWS

PERIOD	PREAWARD REVIEWS	POTENTIAL COST SAVINGS
October 1, 2018–March 31, 2019	35	$1,264,232,273
April 1–September 30, 2019	35	$300,937,079
Total	**70**	**$1,565,169,352**

POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the Veterans Health Care Act of 1992 (P.L. 102-585) for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over $23 million, including approximately $4.9 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 23 postaward reviews performed, 11 involved voluntary disclosures. In 10 of the

11 voluntary disclosure reviews, the OIG identified additional funds due. VA recouped 100 percent of recommended recoveries for postaward contract reviews.

TABLE 7. POSTAWARD REVIEWS

PERIOD	POSTAWARD REVIEWS	DOLLAR RECOVERIES
October 1, 2018–March 31, 2019	18	$22,066,032
April 1–September 30, 2019	23	$23,381,176
Total	**41**	**$45,447,208**

CLAIM REVIEWS

The OIG assists 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 four claims and determined that approximately $2.7 million of claimed costs were unsupported and should be disallowed.

TABLE 8. CLAIM REVIEWS

PERIOD	CLAIM REVIEWS	POTENTIAL COST SAVINGS
October 1, 2018–March 31, 2019	0	$0
April 1–September 30, 2019	4	$2,716,676
Total	**4**	**$2,716,676**

ROLL-UP REVIEW

A SYNOPSIS OF OIG PREAWARD REVIEWS OF VA FEDERAL SUPPLY SCHEDULE PHARMACEUTICAL PROPOSALS ISSUED IN FISCAL YEAR 2018

The federal government spends more than $11 billion annually on pharmaceuticals through VA's Federal Supply Schedule (FSS) contracting program. This report provides a synopsis of 22 FSS reviews conducted by the OIG during FY 2018 of pharmaceutical proposals prior to VA awarding the contracts (preaward reviews). This report summarizes the OIG's findings for the 22 FSS proposals, which included 2,040 offered drug items, and identifies the monetary benefit to VA without disclosing any sensitive commercial information. The OIG determined that commercial pricing disclosures were not reliable for negotiations for 16 of the 22 proposals and recommended VA obtain revised disclosures prior to contract awards. The OIG's FSS lower pricing recommendations collectively reflected more than $515 million in estimated cost savings to VA, nearly 75 percent of which were sustained. The OIG's preaward reviews demonstrate the importance of having reliable information for negotiations and determining fair and reasonable pricing.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, OHI published four national healthcare reviews and 29 inspection reports responsive to OIG Hotline complaints on topics that are related to Veterans Health Administration (VHA) operations and patients' access to quality care. They addressed a broad range of issues such as failures in credentialing and privileging care providers, clearly defining and overseeing the role of clinical pharmacists engaged in outpatient mental health care, and taking adequate measures to reduce suicide in VA facilities. The office also published 12 Comprehensive Healthcare Inspection Program (CHIP) reports, which resulted from unannounced OIG inspections of VA facilities' key clinical and administrative processes that are associated with promoting positive healthcare outcomes for veterans. As with other OIG published reports, the OHI recommendations for corrective action are detailed at www.va.gov/oig. Dashboard users can track the status of report recommendations published since October 2012.

45
PUBLICATIONS

1,964
HOTLINE REFERRALS REVIEWED

6
IN-DEPTH CLINICAL CONSULTATIONS

FEATURED PUBLICATIONS

Highlighted below are three OHI reports that focus on issues and recommendations in areas vulnerable to quality of care concerns that can have significant impact on VA and the veterans it serves.

FACILITY HIRING PROCESSES AND LEADERS' REPONSES RELATED TO THE DEFICIENT PRACTICE OF A RADIOLOGIST AT THE CHARLES GEORGE VA MEDICAL CENTER IN ASHEVILLE, NORTH CAROLINA

The OIG conducted a healthcare inspection to evaluate concerns regarding deficiencies identified in the practice of a fee-basis radiologist, and the facility's oversight of the radiologist's performance during the six-month tenure in 2014. Facility leaders did not complete the credentialing and privileging of the radiologist as required. Specifically, the references used to approve the radiologist's request for privileges did not include a reference from peers and the most recent employer. Facility managers also did not provide adequate oversight of the radiologist and did not complete a timely and focused professional performance evaluation. Prompt administrative action was not taken in response to inaccurate interpretations of radiology imaging and clinical documentation. Facility managers and leaders failed to complete the radiologist's Exit Memorandum, required by VHA to comply with state licensing board reporting requirements, during the mandatory reporting period of seven days after the employee's separation from the facility. They also failed to report the results of a 100-percent clinical review of the radiologist's imaging reports to the facility professional standards board until August 2018—three years after the assigned target date.

The patient safety manager was not notified during the case reviews, nor after the results were issued. Facility leaders failed to submit an issue brief to the Veterans Integrated Service Network (VISN), as is required for significant clinical incidents negatively affecting patients. On January 25, 2019, the

facility director issued notices to eight state licensing boards citing that the radiologist failed to meet generally accepted standards of clinical practice. Two disclosures were made to patients. The OIG made four recommendations related to credentialing and privileging requirements, state licensing board reporting, disclosures of adverse events, and potential administrative actions.

REVIEW OF MENTAL HEALTH CLINICAL PHARMACISTS IN VETERANS HEALTH ADMINISTRATION FACILITIES

This healthcare inspection assessed VHA facilities' use of clinical pharmacists who work under a scope of practice in a mental health outpatient care setting. After reviewing relevant policies and conducting interviews, the OIG found that mental health clinical pharmacists' (MHCPs') independence levels were not clearly identified by staff or facilities' bylaws. Guidance provided conflicting instructions regarding requirements for collaborating agreements and lacked provisions for oversight by specific physicians. Facilities' scopes of practice were inconsistent in describing delegated duties that were specific to mental health. VHA policy was insufficient to ensure that the chief of mental health reviews and endorses MHCPs' scopes of practice. Referral processes were also not clear or standardized regarding how diagnoses were conveyed to MHCPs, or whether involvement of a licensed independent practitioner with prescribing authority was considered in determining the appropriateness of patients' referrals. VHA policy does not require a defined process to consider a patient's clinical complexity, and policies lacked instructions for MHCPs on when or how to refer patients to a higher level of care. The OIG made nine recommendations related to autonomy, collaborating agreements, engaging with licensed independent practitioners with prescribing authority, scopes of practice, and referrals.

PATIENT SUICIDE ON A LOCKED MENTAL HEALTH UNIT AT THE WEST PALM BEACH VA MEDICAL CENTER IN FLORIDA

In response to a notification that a hospitalized patient died by suicide and a subsequent request from House Veterans Affairs Committee Chairman Mark Takano to review the matter, the OIG examined the circumstances of the death. Inpatient death by suicide is an event that is largely preventable. The OIG determined the patient received reasonable care during admission. The patient was appropriately screened for suicide risk, provided medication management, placed on close observation status, and given ongoing assessments, interventions, and a discharge plan. However, the facility failed to abate identified safety hazards on the unit. Patient safety cameras were nonoperational, and policy regarding 15-minute patient safety rounds lacked clear guidance and expectations for staff. The facility did not meet VHA requirements for staffing an Interdisciplinary Safety Inspection Team or training staff regarding the Mental Health Environment of Care Checklist (MHEOCC). The OIG found a lack of oversight by both the VHA MHEOCC Work Group and VISN 8. The OIG also found facility leaders lacked awareness and failed to educate themselves on patient safety requirements regarding the mental health unit. While the OIG team determined the facility responded promptly and was in the process of implementing improvement actions, facility leaders and managers only started to respond aggressively to long-standing deficient conditions after a completed suicide. The OIG made 11 recommendations related to leaders' responsibilities regarding mental health, the environment of care, and patient safety; MHEOCC training; risk mitigation; facility policy regarding patient safety and law enforcement cameras on the locked mental health unit; 15-minute safety rounding policy; and staff training.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

NATIONAL HEALTHCARE REVIEWS

National healthcare reviews focus on VHA programs, activities, or functions from a systemwide perspective. Such reviews may be used to provide factual and analytical information, monitor compliance with established criteria and standards, measure performance, assess the efficiency and effectiveness of programs and operations, or identify and share best practices within VHA facilities. National reviews may be mandated or requested by Congress or initiated by the OIG.

FOR MORE INFORMATION

View the OIG's Report Recommendations Dashboard at www.va.gov/oig **to track VA's progress in implementing OIG recommendations.**

FOLLOW-UP REVIEW OF THE VETERANS CRISIS LINE IN CANANDAIGUA, NEW YORK; ATLANTA, GEORGIA; AND TOPEKA, KANSAS

OIG staff followed up on areas of concern identified in two previous healthcare inspection reports of the Veterans Crisis Line (VCL), published in 2016 and 2017. The OIG found that the VCL sustained corrective actions taken to address prior identified issues regarding governance structure and oversight, operations, and quality management. The VCL was realigned under the Office of Mental Health and Suicide Prevention, hired a permanent director, and remained under a directive that formalized operations. Operations processes also were improved. The use of backup centers decreased while their oversight advanced. The VCL addressed previously identified staffing and training deficiencies. VCL also sustained actions related to previous concerns about quality management leadership training, policies, and processes. During the follow-up review, OIG staff found that the VCL did need to analyze and address issues affecting rescue efforts, with one new recommendation for improving location determinations of veterans who call and need rescue.

NATIONAL REVIEW OF HOSPICE AND PALLIATIVE CARE AT THE VETERANS HEALTH ADMINISTRATION

The OIG evaluated how Hospice and Palliative Care (HPC) services are used at VHA by examining the electronic health records of patients who were newly diagnosed with malignant cancer, and to determine whether there was a formal HPC consult or informal HPC-related discussion with a care provider. The OIG staff also assessed whether completed HPC consults were linked to required stop codes (standardized codes to identify the work group providing a clinical service) used to measure HPC workload. The OIG determined that just more than 10 percent of reviewed malignant cancer patients had a formal HPC consult or related interaction (such as a conversation) without designating there was an HPC consult or linking to a stop code. Subsequently, the OIG found that 78.5 percent of consults were appropriately linked to an HPC stop code and 21.5 percent were not. Overall, the OIG found that patients were receiving HPC consults or having related conversations but the HPC workload was not consistently tracked. The OIG made one recommendation to the Under Secretary for Health to ensure the development and implementation of a consistent and standardized approach for HPC documentation, consult management, and coding.

OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES, FY 2019

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and non-clinical Veterans Health Administration occupations having the largest occupational

staffing shortages at each VA medical facility. In this sixth staffing report, OHI evaluated facility leader-identified severe occupational staffing shortages and explored the impact of medical center director vacancies. Ninety-six percent of facilities identified at least one occupation as having a severe shortage. The most frequently cited shortages were in the Medical Officer and Nurse occupations. Human Resources Management was the most commonly cited non-clinical occupation with a severe staffing shortage. Since 2015, over 46 facilities annually saw at least one change in medical center directors. The OIG made two recommendations to the Under Secretary for Health related to previous recommendations and causes of severe occupational staffing shortages.

HEALTHCARE INSPECTION PUBLICATIONS

Healthcare inspections assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. These inspections typically focus on allegations of serious harm to one or more patients, major lapses in accepted standards of patient care, deficiencies that pose a significant risk to patient safety or quality of care, or major VHA systems issues. They may also evaluate the design, implementation, or results of VHA's operations, programs, or policies.

REVIEW OF DELAYS IN CLINICAL CONSULT PROCESSING AT THE VA BOSTON HEALTHCARE SYSTEM IN MASSACHUSETTS

The review of a sample of discontinued consults (requests for referral) from the VA Boston Healthcare System revealed that none were processed inappropriately as initially alleged. The OIG verified that facility leaders and managers monitored and analyzed consult data, communicated with service leaders about identified concerns, implemented clinical and administrative processes for performance improvement, and monitored the results. VISN leaders provided oversight for tracking access to care and managing consults (drawing on monthly reports provided by the facility) and other performance measures. They also conducted monthly management meetings with facility leaders to review access to care and consult processing concerns. The OIG concluded that facility leaders were also actively engaged and had effective performance improvement and consult management processes in place. Therefore, the OIG made no recommendations.

QUALITY AND COORDINATION OF A PATIENT'S CARE AT THE VA EASTERN COLORADO HEALTH CARE SYSTEM IN DENVER, COLORADO

The OIG substantiated that care providers at the VA Eastern Colorado Health Care System failed to complete a patient's evaluation, including medication reconciliation, which may have contributed to the patient's declining health and hindered care. Care providers also failed to appropriately treat the patient's underlying condition, recognize signs of illness, and identify an infection source, which could have been factors in the patient's death. Although discharge and care options were discussed with the competent patient, providers may not have talked about care with the patient's family. There were also failures in communicating care options to mitigate the patient's suffering. The OIG found that podiatry clinic scheduling was inconsistent, wound care clinic consults were incomplete, geriatric care coordination was deficient and likely contributed to worsening patient wounds, and podiatry resident supervision was not documented as required. The OIG made eight recommendations to address identified deficiencies.

STAFFING, QUALITY OF CARE, SUPPLIES, AND CARE COORDINATION CONCERNS AT THE VA LOMA LINDA HEALTHCARE SYSTEM IN CALIFORNIA

A healthcare inspection team evaluated allegations related to nurse staffing concerns and inadequate supplies. The OIG did not substantiate that deaths that occurred in the Emergency Department (ED) were related to insufficient nurse staffing. The OIG was unable to determine if high patient-nurse ratios caused unsafe working conditions and could not correlate them with adverse events. The system had taken actions to make supplies and linen more available. Quality of care concerns were noted, however, for five patients who stayed in the ED more than four hours after a decision was made to admit. Other concerns included the coordination of care with another VA medical center and a faulty ED surveillance camera. The OIG made 10 recommendations related to ED data collection, ED patient flow and levels of care, coordination of care, root cause analyses, and a review of two patients with injuries after falls.

ORTHOPEDIC SURGERY DEPARTMENT AND OTHER CONCERNS AT THE CARL T. HAYDEN VA MEDICAL CENTER IN PHOENIX, ARIZONA

The OIG evaluated aspects of the Orthopedic Surgery Department, including the care of specific patients, use of physician assistants (PAs), clinical privileging, and leaders' responsiveness. The OIG substantiated care concerns related to two patients and that orthopedic surgeons were not consistently responsive to requests from PAs for assistance. The team confirmed fee surgeons (non-VA contracted surgeons) were used but did not find this problematic. The OIG did not substantiate allegations that orthopedic surgeons ignored critical patients or that facility leaders were unresponsive to concerns related to the Orthopedic Service. The OIG did determine operating room and anesthesia operations were inefficient. The facility was also not consistently compliant with VHA requirements regarding core privileges, ongoing professional practice evaluations, and PA policy and scopes of practice. Twelve recommendations were made related to two patients' care; PA practice; and orthopedic department communications, process efficiencies, and privileging.

INPATIENT MENTAL HEALTH CLINICAL OPERATIONS CONCERNS AT THE PHOENIX VA HEALTH CARE SYSTEM IN ARIZONA

The OIG substantiated allegations that inpatient mental health unit staff did not consistently follow the facility's patient safety observer policy for one-to-one care or have required training. However, healthcare inspectors were unable to determine whether a patient was improperly restrained because a seclusion room was unavailable or whether nurse staffing was adequate to meet patient care needs. While one room was closed temporarily, both seclusion rooms were available in 2018. Staffing data used to determine nursing hours needed after the unit was partitioned in 2018 were not complete. The OIG noted a lack of cleanliness, patients not wearing personal clothes, and a noncompliant patient advocacy program. Seven recommendations were made related to documentation issues, the patient safety observer policy, staffing methodology, training, environment of care, and the patient advocacy program.

ALLEGED COMPLICATIONS ASSOCIATED WITH PHOTOTHERAPY AT THE GULF COAST VETERANS HEALTH CARE SYSTEM IN BILOXI, MISSISSIPPI

A healthcare inspection was conducted to assess the care of a patient who was mistakenly treated at the facility with phototherapy for bed bugs. Two days later, the patient was hospitalized for first-degree (outer layer of skin) and second-degree (deeper layers of skin) burns. Although phototherapy is not indicated for the treatment of patients with bed bugs, a dermatology clinic registered nurse provided

that therapy without a care provider's assessment and order. System staff improperly attributed the need for multiple actions to the facility's Integrated Pest Management policy that guides environmental actions. As a result of the patient's resulting injuries, facility leaders initiated a fact-finding review, but the review's charge letter was unclear regarding its confidential or nonconfidential status. Seven recommendations were made to improve the dermatology clinic nurse practice requirements, the facility's pest management policy, and the completion of actions recommended by an internal review.

REVIEW OF ENVIRONMENT OF CARE, INFECTION CONTROL PRACTICES, PROVIDER AVAILABILITY, AND LEADERSHIP AT THE VA LOMA LINDA HEALTHCARE SYSTEM IN CALIFORNIA

Congressmen Pete Aguilar and Mark Takano requested OIG examination of a series of concerns regarding the environment of care (EOC), infection control (including Legionella), care provider availability, leadership responsiveness, and the dental clinic at the VA Loma Linda Healthcare System. The facility had inconsistent levels of cleanliness and repair. Staff also lacked bloodborne pathogen and cleaning training. The OIG found water temperatures that would not deter the growth of Legionella and inconsistent notification of water testing results. The Sterile Processing Services' storage room was not consistently within temperature and humidity parameters. The facility's healthcare-associated infection rates underperformed VHA's national averages. Additionally, facility leaders' corrective actions to address EOC concerns were not effective. Inpatient provider availability was limited and there were mental health staff vacancy challenges. The OIG substantiated the dental clinic was not routinely cleaned, but no determination was made that there was biohazard exposure. The OIG made 14 recommendations regarding EOC, infection control, Legionella inhibition, training, staffing, and documentation.

ALLEGED DEFICIENCIES IN OUT-OF-OPERATING ROOM AIRWAY MANAGEMENT PROCESSES AT THE COLMERY-O'NEIL VA MEDICAL CENTER WITHIN THE VA EASTERN KANSAS HEALTH CARE SYSTEM

This healthcare inspection addressed care and process issues concerning an Emergency Department patient and examined out-of-operating room airway management processes (OOORAM) at the medical center in Topeka, Kansas. The OIG substantiated that an Emergency Department patient suffered minor airway trauma and a provider did not document failed intubation attempts. The OIG did not substantiate that the patient was inadequately sedated prior to intubation. The facility was not, however, in compliance with tracking competency assessments for OOORAM providers. The OIG team noted that leaders addressed OOORAM issues when they became aware of deficiencies and were working to implement new processes. The team also identified that providers' credentialing information was not consistently uploaded into a database and committee minutes lacked discussions related to resuscitative events, data analysis, and proposed improvements. Seven recommendations addressed improving areas such as OOORAM documentation, review of OOORAM policy, and training and competency.

DELAY IN DIAGNOSIS AND SUBSEQUENT SUICIDE AT A VETERANS INTEGRATED SERVICE NETWORK 15 MEDICAL FACILITY

In response to allegations of a delay in the diagnosis of a patient's cancer at a VISN 15 medical facility, the OIG conducted this healthcare inspection. In summer 2016, a patient had abnormal imaging results indicating possible cancer. The patient's primary care providers did not evaluate or confirm the cancer diagnosis until spring 2018. The patient completed suicide prior to treatment. The OIG identified deficiencies in the coordination of the patient's care among multiple providers, including care provider

consistency, arrangements for patient care when a provider is unavailable, and notifications to providers and the patient of imaging study abnormalities. These deficiencies contributed to the patient's delayed diagnosis. Additionally, VHA policy requires a retrospective review to conduct a root cause analysis when certain events occur. However, facility leaders conducted a proactive risk assessment of the patient's care instead of the required root cause analysis. The OIG made 11 recommendations for corrective action.

EPISODES OF NON-ADHERENCE TO PRIVACY AND SECURITY POLICIES AT THE TIBOR RUBIN VA MEDICAL CENTER IN LONG BEACH, CALIFORNIA

The OIG conducted an inspection to evaluate episodes of possible patient information privacy and security breaches. After a VA computer update, a medical diagnostic device no longer interfaced with VA patients' electronic health records. A facility provider used his personal laptop to work around the interface issue and stored information contrary to VA and VHA privacy and security policies. Although the facility mitigated some privacy concerns, the facility had additional issues with staff text messages, unencrypted email, and use of unapproved devices. These issues were not addressed by VA or facility policy. The OIG concluded that patients' sensitive personal information was at risk for disclosure to outside sources. Additionally, facility staff used prohibited logbooks to track patient information and test equipment. The OIG made six recommendations related to communication and education, disclosure of protected patient information, VA policy review, and logbooks.

FACTORS CONTRIBUTING TO THE DEATH OF A VENTILATOR-DEPENDENT PATIENT AT THE VA SAN DIEGO HEALTHCARE SYSTEM IN CALIFORNIA

The OIG evaluated factors that may have contributed to the death of a ventilator-dependent patient on the spinal cord injury (SCI) unit and the facility's response. The OIG determined that the facility did not implement risk mitigation strategies for use of the in-line Passy-Muir® Valve (speaking valve) on ventilated patients. Specifically, the facility did not have policies for using the speaking valve, monitoring and documenting ventilator and alarm settings while engaging the speaking valve, or using anti-disconnect devices. Staff failed to report ventilator tubing disconnections, and SCI leaders failed to follow the standard operating procedure for clinical alarm management. The OIG made five recommendations related to policy and training for use of the speaking valve on the SCI unit and the anti-disconnect device, potential issuance of a National Patient Safety Advisory, reporting of patient safety issues, and reviews of clinical alarms according to facility policies.

CONCERNS RELATED TO AN INPATIENT'S RESPONSE TO OXYCODONE AND FACILITY ACTIONS AT THE BALTIMORE VA MEDICAL CENTER, MARYLAND

The OIG conducted a healthcare inspection to evaluate concerns related to a patient's response to oxycodone at the facility and assessed management actions taken at the facility after that event. Providers ordered oxycodone consistent with manufacturer recommendations; however, the patient experienced symptoms of oxycodone overdose. After administration of naloxone, the patient's symptoms immediately improved, indicating the patient did have a response to the oxycodone. Facility managers did not consider conducting an internal quality review or outside reporting following the event. A clinical disclosure, though warranted, was not documented. The facility director did not ensure compliance with the medical center's peer review policy. In addition, the Surgical Work Group did not meet monthly, and meeting minutes lacked discussion of required data. The OIG made six recommendations related to resident supervision, reporting adverse drug events, clinical disclosures, peer reviews, and the Surgical Work Group.

CONCERNS WITH ACCESS AND DELAYS IN OUTPATIENT MENTAL HEALTH CARE AT THE NEW MEXICO VA HEALTH CARE SYSTEM IN ALBUQUERQUE, NEW MEXICO

This healthcare inspection revealed that patients' access to outpatient mental health appointments was limited, and appointment delays occurred. Contributing factors included underutilization of non-VA and telemental health care, staffing shortages, staff hiring delays, hiring practices, disproportionate care provider productivity, and deficient training and supervision of scheduling staff. The OIG found issues with the facility's no-show policy and staff follow-up with no-show patients. The facility had an incomplete administrative investigative board review and action plan, and some consults were marked complete without documentation that patients were evaluated and/or seen as requested by the consult. The OIG made 12 recommendations related to electronic wait lists, outpatient mental health appointments, non-VA and telemental health care, appointment scheduling delays, staff shortages, hiring practices, policy compliance, administrative investigation board review processes, and the consult completion process.

ALLEGED INADEQUATE RESPONSE TO A MISSING PATIENT AND SAFETY CONCERNS AT THE BAY PINES VA HEALTHCARE SYSTEM, FLORIDA

Allegations were made to the OIG of an inadequate response to a Code Orange (an emergency code designation for at-risk missing and wandering patients) and safety concerns related to a missing patient. A staff physician determined the patient was at risk. Staff activated a Code Orange; however, due to staff error, the Code Orange was activated for the wrong patient. The error was corrected two hours later. The patient was located and returned to the facility five days later. Following the event, unit leaders initiated measures to ensure accurate patient identification before a Code Orange is called. Staff received training on missing and wandering patients and Code Orange visual aids. VA police also began conducting annual drills. The OIG also found that the facility's incident report did not address the misidentified patient, and the fact-finding did not engage all staff involved. The OIG made three recommendations related to patient identification practices and missing patient documentation.

ALLEGED INTERFERENCE AND FAILURE TO COMPLY WITH THE PAIN MANAGEMENT DIRECTIVE AND THE OPIOID SAFETY INITIATIVE AT THE VA NORTHERN INDIANA HEALTH CARE SYSTEM IN FORT WAYNE, INDIANA

The OIG determined that the chief of staff interfered with primary care providers' prescribing practices at the system. The system did not follow all requirements in VHA's pain management directive and met six of the nine goals in VHA's Opioid Safety Initiative. Not all providers used the required risk assessment tools for patients on long-term opioid therapy. The OIG made one recommendation to the VISN 10 director related to the ethics of a system leader interfering with the opioid prescribing practices of primary care providers and 11 recommendations to the system director related to the Pain Management Committee and the team, pain assessments, annual evaluation of compliance with the Pain Management Strategy, tertiary pain rehabilitation programs, stepped care education and training, opioid risk assessment tools, veteran requests to change providers, prescription drug monitoring program reports, and opioid and benzodiazepine tapering protocols.

LEADERSHIP, CLINICAL, AND ADMINISTRATIVE CONCERNS AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

A healthcare inspection was conducted to assess allegations of multiple quality of care and leadership failures at the facility. Many of the allegations were largely unfounded; however, the OIG identified

several concerns including clinical staff members who did not feel supported by the leadership team. Poor nursing morale was attributed to inadequate nurse staffing levels and accountability. Communication and understanding of certain facility policies were inadequate. Deficits were identified related to nurse competency assessments and the facility's response to a 2018 sentinel event. The OIG-identified security lapses, unavailability of some laboratory services, and unclear patient transfer policies potentially placed emergency department patients at risk. Also, communication related to a connecting bridge between the facility and an adjacent healthcare institution was a confusing and contentious problem for staff. The OIG made 27 recommendations involving communication, hiring processes, nurse staffing and competencies, policy development and communication, provider privileges, and emergency department security.

DEFICIENCIES IN DISCHARGE PLANNING FOR A MENTAL HEALTH INPATIENT WHO TRANSITIONED TO THE JUDICIAL SYSTEM FROM A VETERANS INTEGRATED SERVICE NETWORK 4 MEDICAL FACILITY

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=50.

The OIG conducted an inspection at a VISN 4 medical facility to assess the discharge of a patient from an inpatient mental health unit and transfer to a federal detention center where the patient died. The associate medical examiner identified the cause of death as hypertensive and atherosclerotic cardiovascular disease (plaque buildup in arteries) and the manner as natural. Additional OIG concerns included the facility staff's discharge planning processes, compliance with voluntary and involuntary admission policies, use of available guidance regarding the patient's legal and psychiatric status, and patient record flag management. The OIG made 10 recommendations regarding inclusion of families in mental health treatment and discharge planning; assessment of decision-making capacity and voluntary admission status; documentation of a patient's surrogate; complete diagnostic summaries to receiving providers; assignment of a mental health treatment coordinator; release of information processes; voluntary and involuntary admission processes; and access to consultative resources.

FACILITY LEADERS' OVERSIGHT AND QUALITY MANAGEMENT PROCESSES AT THE GULF COAST VA HEALTH CARE SYSTEM IN BILOXI, MISSISSIPPI

A thoracic surgeon allegedly provided poor quality of care to five patients. The surgeon no longer worked in the health care system. The facility had validated quality of care concerns for two of five patients and took appropriate action. Prior to hiring the surgeon, facility leaders were aware of licensure and malpractice issues, including the relinquishing of a state medical license. The OIG found that facility leaders were deficient in granting and then continuing the surgeon's clinical privileges and made errors during the surgeon's removal process that prevented reporting to the National Practitioner Data Bank and delayed reporting to state licensing boards.

PATHOLOGY PROCESSING DELAYS AT THE MEMPHIS VA MEDICAL CENTER IN TENNESSEE

The OIG evaluated allegations that surgical pathology specimen processing delays in the pathology and laboratory medicine service (P&LMS) resulted in harm and possibly death to multiple patients. The OIG found that none of the reviewed patients with delays experienced adverse clinical outcomes and that turnaround times improved for surgical pathology specimens processed onsite. However, P&LMS quality management program action plans were not fully implemented. Also, approximately 39 percent of P&LMS positions were vacant, and pathologist staffing shortages contributed to inconsistent surgical

pathology quality assurance and prolonged specimen turnaround times. In addition, the OIG found deficiencies in P&LMS staff initial training and annual competency documentation. Facility leaders did not conceal deficiencies but submitted a delayed and incomplete issue brief to VISN leaders.

ALLEGED DELAY IN SURGICAL CARE, LACK OF RESIDENT OVERSIGHT, AND IMPROPER PHYSICIAN PAY AT EDWARD HINES, JR. VA HOSPITAL IN HINES, ILLINOIS

Allegations were made of a delay in surgical care, lack of resident oversight, and improper physician pay. The OIG substantiated a delay of approximately three hours occurred in performing an appendectomy. However, the patient received appropriate preoperative care, and there was no evidence of an adverse outcome related to the delay. The delay was due to another patient requiring surgery more urgently and poor communication. The facility's practice for scheduling surgeries did not address communication among key staff. The OIG did not substantiate the appendectomy was delayed because of inadequate resident oversight. As to physician pay, because of a lack of a verification process to determine if surgeons' timecards matched actual hours worked, it could not be determined if surgeons were unavailable or working at other institutions while being paid by VA as alleged.

ALLEGED DEFICIENCIES IN MENTAL HEALTH CARE PRIOR TO A DEATH BY SUICIDE AT THE VA SAN DIEGO HEALTHCARE SYSTEM IN CALIFORNIA

A healthcare inspection was conducted to determine if staff failed to provide mental health care to a patient who sought care and subsequently died by suicide. The OIG did not substantiate that the system failed to provide mental health care when the patient sought help. The OIG found that the suicide risk assessment of the patient was adequate and complied with requirements. The system also complied with resident supervision policies. However, the OIG team identified deficits in the decision-making process to deactivate the patient's High Risk for Suicide Patient Record Flag and found that VHA did not clearly delineate flag deactivation requirements. Deficiencies in the medication-reconciliation process were also found.

MISMANAGEMENT OF A RESUSCITATION AND OTHER CONCERNS AT THE GULF COAST VETERANS HEALTH CARE SYSTEM IN BILOXI, MISSISSIPPI

This healthcare inspection evaluated the care of a patient who died in a behavioral health unit. The OIG team found that the unit's registered nurses (RNs) did not fulfill their position responsibilities or ensure accurate electronic health record documentation. Also, unit staff did not initiate appropriate resuscitation efforts after finding the patient unresponsive, but the OIG was unable to determine whether initiating full resuscitation efforts would have been successful if employed at the time the patient was found unresponsive. The OIG also found an RN inappropriately determined the patient's death; there was inconsistent tracking of RN basic life support training; emergency department providers did not document handoff to the admitting behavioral health provider; and an emergency cart was unlocked and contained an expired item. The OIG also found that staff did not document resuscitation measures on required forms and the designated committee did not review the event.

QUALITY OF CARE AND PATIENT SAFETY CONCERNS ON THE ACUTE BEHAVIORAL HEALTH UNIT AT THE CORPORAL MICHAEL J. CRESCENZ VA MEDICAL CENTER IN PHILADELPHIA, PENNSYLVANIA

The OIG identified quality of care deficiencies that may have contributed to a patient's death during an acute behavioral health unit admission. These included involved staff and providers not intervening, not

communicating with each other, or not adding team members as additional signers in the electronic health record when documenting signs consistent with oversedation. Also, some providers were not monitoring for electrocardiogram changes or drug-drug interactions. The facility did not comply with VHA requirements for issue briefs, root cause analyses, and peer reviews. The acute behavioral health unit staff also did not follow the facility's observation policy. Leaders noted equipment deficiencies and staff training needs related to medical emergency responses. Facility care providers did not adhere to policies requiring discussion, documentation, and a patient-signed informed consent prior to initiating methadone treatment. The OIG made nine recommendations.

ALLEGED CARE DELAYS AND INADEQUATE INSTRUMENT PRECLEANING AT THE NEW MEXICO VA HEALTH CARE SYSTEM IN ALBUQUERQUE

A healthcare inspection team assessed allegations regarding patient care concerns in the facility's departments of ophthalmology and gastroenterology (GI). The OIG found the ophthalmology department failed to meet VHA consult (referral) management scheduling expectations. Authorizations of non-VA care consults for comprehensive eye appointments were delayed. Significant delays in access to outpatient GI care and a lack of monitoring for consult performance deficiencies were also identified. GI providers did not consistently communicate test results to patients per facility policy or arrange for other practitioners to take over their patients' care when they were unavailable. The timeliness of GI providers' test result notifications to patients was not monitored. The OIG did not substantiate that patients underwent procedures with improperly cleaned endoscopes. The OIG made 13 recommendations related to improving non-VA care appeals, consult management, eye appointments and surgery timeliness, test result issues, and precleaning of endoscopic instruments.

LEADERSHIP FAILURES RELATED TO TRAINING, PERFORMANCE, AND PRODUCTIVITY DEFICITS OF A PROVIDER AT A VETERANS INTEGRATED SERVICE NETWORK 10 MEDICAL FACILITY

The OIG reviewed concerns provided by the U.S. Office of Special Counsel regarding an ophthalmologist at a VISN 10 medical facility. The OIG found credentialing and privileging activities were deficient, including primary source verification from foreign educational institutions and reference checks attesting to the surgeon's suitability to perform procedures. The ophthalmologist was hired regardless. The ophthalmologist lacked VHA-required training for cataract surgery and laser procedures, did not meet surgical productivity requirements, and did not consistently demonstrate surgical skills necessary to assure good patient outcomes. Once the surgeon's deficits were identified, facility leaders were slow to respond. Despite ongoing concerns, the chief of staff endorsed the surgeon's reappointment as the facility's sole ophthalmologist. The surgeon's employment was subsequently terminated. The OIG made five recommendations related to credentialing and privileging, professional practice evaluations, management of performance deficits, and the chief of staff's actions.

ALLEGED POOR QUALITY OF CANCER CARE AT THE VA CARIBBEAN HEALTHCARE SYSTEM, SAN JUAN, PUERTO RICO

This inspection was conducted in response to an allegation of poor quality of cancer care to a community living center patient, and to follow up on the adequacy and implementation status of an action plan at the VA Caribbean Healthcare System. The OIG substantiated staff inadequately monitored the patient. The action plan at issue did not address all prior findings of deficiencies. During the inspection, the OIG found instructions provided to interrater reviewers were not identical. The OIG made one recommendation to the VISN 8 director related to clear and consistent instructions for concurrent management reviews and six recommendations to the facility director related to

chemotherapy patient monitoring, care coordination agreements, communication of patient status changes, patient care plan accuracy, primary care provider training on prostate cancer patient management, and addressing the findings of non-facility reviewers.

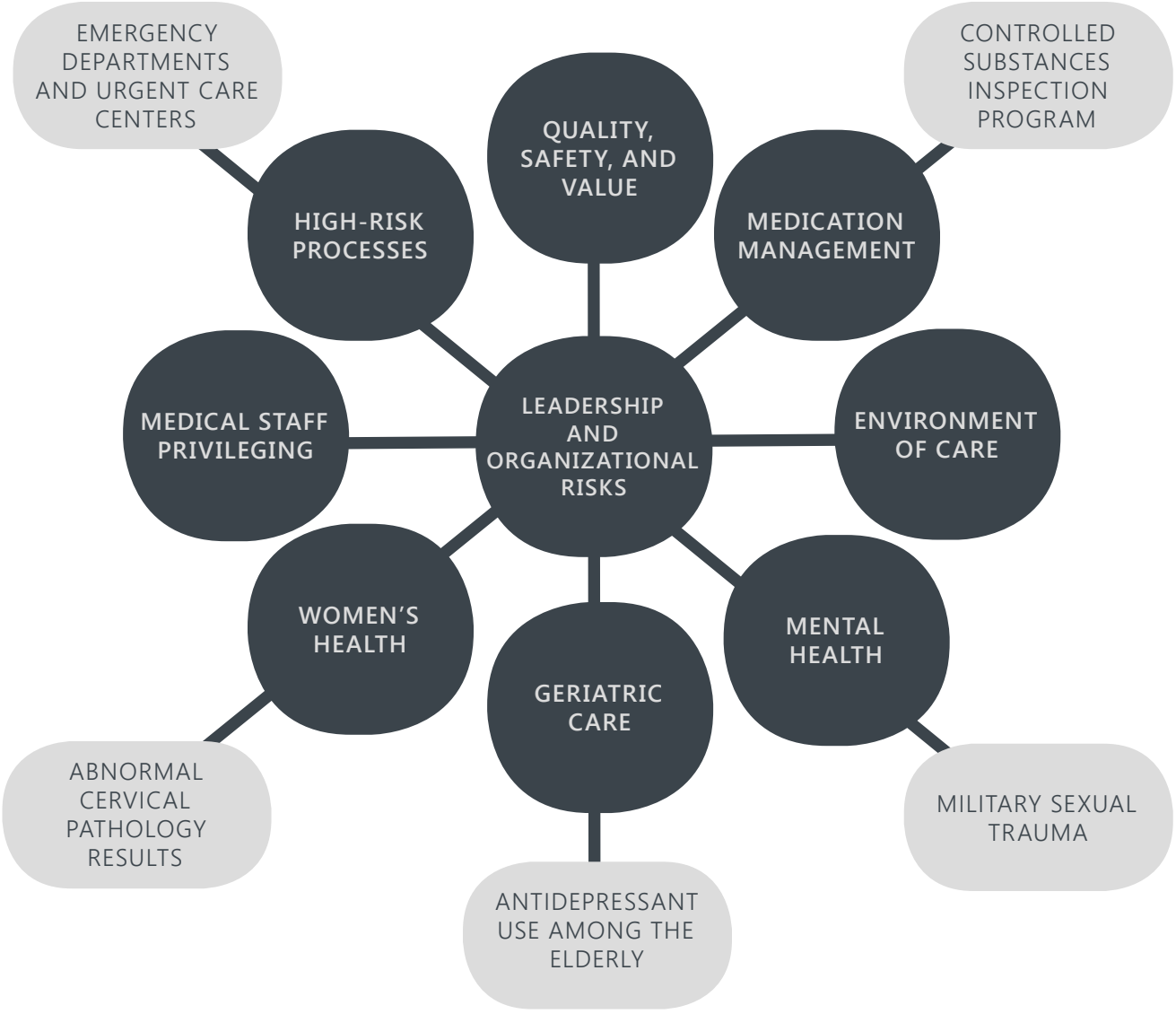
EMERGENCY DEPARTMENT CARE OF INTOXICATED PATIENTS AND THOSE WITH MENTAL HEALTH CONDITIONS AT THE LOUIS STOKES CLEVELAND VA MEDICAL CENTER IN OHIO

An inspection team evaluated whether some patients who presented with mental health-related issues to the facility's Emergency Department were adequately assessed prior to transfer to the facility's Psychiatric Observation and Assessment Center (PAOC), as failure to do so put patients at risk. The OIG substantiated the allegation; however, the conditions generally occurred prior to August 2018 and complied with then-facility policy. The facility changed its policy to require all patients presenting with intoxication or an acute mental health condition to be medically screened in the Emergency Department before transfer to the PAOC. A review of 205 relevant patient encounters in early 2019 found the facility was complying with the new policy related to medical screening examinations and notes. No evidence of adverse clinical outcomes related to patients receiving care in the PAOC was found. The OIG made one recommendation related to medical screening examinations prior to transfer to the PAOC.

COMPREHENSIVE HEALTHCARE INSPECTIONS

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. During the reporting period, the OIG issued 12 CHIP reports, which are listed in Appendix A. CHIP reviews are performed approximately every three years for each facility. 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 are depicted in the illustration on the next page. There were 19 medical centers and healthcare systems and three VISNs reviewed in the six-month reporting period.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS



RESULTS FROM THE OFFICE OF INVESTIGATIONS

OVERVIEW

The Office of Investigations (OI) focuses on a wide range of criminal and civil cases that 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 400,000 employees; and offenses affecting the Department's programs and operations.

131
ARRESTS

86
CONVICTIONS

$249M
MONETARY BENEFITS

FEATURED INVESTIGATIONS

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.

FORMER FAYETTEVILLE, ARKANSAS, VA MEDICAL CENTER CHIEF OF PATHOLOGY INDICTED FOR INVOLUNTARY MANSLAUGHTER

A former chief of pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was indicted in the Western District of Arkansas on 31 counts including involuntary manslaughter, wire fraud, mail fraud, and making false statements pertaining to healthcare matters. A VA OIG investigation resulted in charges alleging that the defendant misdiagnosed thousands of VA patients while under the influence of a substance that provides the effects of alcohol but is not tested for during conventional drug and alcohol testing. The indictment also alleged that the defendant circumvented contractually obligated drug and alcohol testing. Some patients were told they had cancer when the tests actually indicated otherwise, were misdiagnosed resulting in improper treatments, or had cancer that was missed entirely. The pathologist covered up at least two of his misdiagnoses by faking a peer's concurrence with the findings. He is detained while awaiting trial.

FORMER SACRAMENTO, CALIFORNIA, VA MEDICAL CENTER CHIEF OF PODIATRY AND PROSTHETICS VENDOR CONVICTED OF HEALTHCARE FRAUD AND CONSPIRACY

The former chief of podiatry at the Sacramento, California, VA Medical Center and a prosthetics vendor were found guilty of healthcare fraud and conspiracy following a two-week trial in the Eastern District of California. A VA OIG, Homeland Security Investigations, and VA Police Service investigation revealed that between March 2008 and February 2015, the former chief and the vendor engaged in a scheme that involved billing VA for custom prescription footwear containing carbon graphite plates but instead provided veterans with inferior footwear containing preinstalled components. In addition, the former chief, the vendor, and a former employee of the vendor who separately pleaded guilty in December 2016 made materially false statements to VA regarding the manufacturing location of the shoes while applying for a national contract worth over $11 million per year. The loss to VA is approximately $2.16 million.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

TWO DEFENDANTS PLED GUILTY FOR THEIR ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

An investigation revealed a veteran defendant participated in a pass-through scheme in which he falsely claimed to control the service-disabled veteran-owned small business (SDVOSB) construction company, when in fact it was owned and operated by his nonveteran coconspirator. The nonveteran defendant submitted false invoices, past performance questionnaires, and references on behalf of the company to perpetuate the conspiracy. VA awarded $118 million in set-aside contracts to the company. When the company grew too large to compete for small business contracts, the nonveteran defendant used the minority status of the veteran defendant to set up a second 8(a) certified company. The second 8(a) company was awarded an additional $11 million in set-aside contracts. The veteran owner of the SDVOSB pled guilty in the Western District of Missouri to making a false statement related to the award of $350 million in set-aside government contracts. A nonveteran owner of the same SDVOSB pled guilty to conspiracy to commit wire fraud. The investigation was conducted by the VA OIG, Department of Labor (DOL) OIG, General Services Administration OIG (GSA OIG), Internal Revenue Service Criminal Investigation (IRS-CI), Small Business Administration (SBA) OIG, Department of Agriculture OIG, DOL Employee Benefits Security Administration, Army Criminal Investigation Command, and U.S. Secret Service.

SELECTED 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 98 cases; made 69 arrests; obtained over $5.1 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved more than $3.6 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period.

FOR MORE INFORMATION

See monthly criminal case summaries at www.va.gov/oig/publications/monthly-highlights **and subscribe to email alerts at** www.va.gov/oig.

Cases Involving Patient Harm[3]

FORMER WATERTOWN, NEW YORK, VA OUTPATIENT CLINIC PHYSICIAN INDICTED ON SEXUAL ABUSE CHARGES

A former VA outpatient clinic physician based in Watertown, New York, was indicted by a Jefferson County Grand Jury for aggravated sexual abuse, sexual abuse, and forcible touching. A VA OIG and New York State Police investigation resulted in charges alleging that the defendant sexually abused numerous active-duty service members while conducting disability evaluation physical examinations as part of their service separation process.

[3] See also the drug diversion cases that follow in which patients' pain management may have been compromised by care professionals' diluting medication prior to their administration in order to redirect drugs for their own purposes. Other crimes that follow also may have negatively affected patient or veterans' health.

FORMER BEDFORD, MASSACHUSETTS, VA MEDICAL CENTER NURSING ASSISTANT PLED GUILTY TO MAKING FALSE STATEMENTS

An investigation conducted by the VA OIG and the Federal Bureau of Investigation (FBI) found that a former VA medical center nursing assistant in Bedford, Massachusetts, made false statements to VA OIG agents when questioned regarding the unattended death of a VA inpatient. When interviewed on two occasions, the defendant told agents that she had conducted her assigned hourly checks throughout the night. When confronted with evidence indicating the checks were not conducted, the defendant admitted to lying to the agents and falsifying the hourly checks record.

Drug Diversion by VA Employees

FORMER PROVIDENCE, RHODE ISLAND, VA MEDICAL CENTER INTENSIVE CARE UNIT NURSE SENTENCED FOR DRUG TAMPERING

A former Providence, Rhode Island, VA Medical Center intensive care unit nurse was sentenced to 24 months' incarceration and 24 months' probation after previously pleading guilty to tampering with prepackaged fentanyl and hydromorphone syringes. A VA OIG, Food and Drug Administration (FDA), and VA Police Service investigation revealed the defendant would withdraw the narcotic, inject saline back into the carpuject (the device used for administering injectable fluid), and put the tampered drug back in the automated medication dispensing machine for distribution to patients.

FORMER BEDFORD, MASSACHUSETTS, VA MEDICAL CENTER HOSPICE NURSE CHARGED WITH DRUG TAMPERING AND DIVERSION

A former Bedford, Massachusetts, VA Medical Center hospice unit nurse was arrested after being criminally charged in the District of Massachusetts with tampering with a consumer product and drug diversion. A VA OIG investigation resulted in charges alleging the defendant used tap water to dilute liquid morphine and subsequently administered the diluted substance to medical center hospice patients. The defendant then ingested the remaining drug to support her addiction. To conceal her drug diversion, the defendant allegedly falsified medical records by reporting that the patients had received more pain medication than they did. After conducting a review of patient records, the medical center identified a patient whose end-of-life comfort appeared to have been negatively impacted by the defendant's actions.

FORMER SHREVEPORT, LOUISIANA, VA MEDICAL CENTER PHARMACIST INDICTED FOR DRUG DIVERSION

A VA OIG and Drug Enforcement Administration (DEA) investigation resulted in charges alleging that the defendant diverted more than 200 controlled substances, including hydrocodone and morphine, from mail order prescription packages. The packages were inside the medical center outpatient pharmacy vault and were intended for veterans living in the local area. In addition, more than 1,600 noncontrolled substances issued to different veterans were seized from the defendant's office. As part of the criminal indictment, the defendant was required to surrender her Louisiana pharmacist license and DEA number.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Drug Distribution at VA Facilities

DEFENDANT SENTENCED FOR DRUG DISTRIBUTION AT THE BEDFORD, MASSACHUSETTS, VA MEDICAL CENTER

A defendant was sentenced in the District of Maine to 60 months' incarceration and 48 months' probation for his role in the distribution of crack cocaine at the Bedford, Massachusetts, VA Medical Center. This judicial action was a result of a year-long VA OIG and DEA investigation that identified five individuals who were working together to distribute drugs to veterans receiving addiction treatment at the medical center. The remaining four defendants were criminally charged, entered guilty pleas, and are awaiting sentencing.

TWO DEFENDANTS ARRESTED FOR DRUG DISTRIBUTION

A former San Diego, California, VA Medical Center inpatient and his girlfriend were arrested in the Superior Court of California on charges of distribution of a controlled substance. A VA OIG and DEA investigation resulted in charges alleging that the defendants provided counterfeit fentanyl pills to an inpatient who was subsequently found deceased in his VA domiciliary room.

TWO DEFENDANTS INDICTED FOR DRUG DISTRIBUTION AT THE CLEVELAND, OHIO, VA MEDICAL CENTER

Two defendants were arrested after being indicted in the Northern District of Ohio for drug distribution resulting in serious bodily injury, conspiracy to distribute heroin and fentanyl, and use of a communications facility to facilitate a felony drug offense. An investigation by the VA OIG and the FBI resulted in charges alleging that the defendants sold a substance containing heroin, fentanyl, carfentanil (one of the most potent synthetic opioids), and acetyl fentanyl (another synthetic opioid) to an inpatient veteran while on the property of the Cleveland, Ohio, VA Medical Center. The veteran allegedly injected the substance directly into her peripherally inserted central catheter (or PICC line, a form of intravenous access), which resulted in a nonfatal overdose.

Public Corruption by VHA Employees

FORMER TEMPLE, TEXAS, VA MEDICAL CENTER MAINTENANCE AND OPERATIONS SUPERVISOR SENTENCED IN THEFT SCHEME

A VA OIG investigation revealed that the former VA Maintenance and Operations supervisor, his wife, and a third-party vendor used the wife's company to steal funds from VA. The former supervisor and his wife provided the third-party vendor with fraudulent invoices from her company for services that were not actually provided to the vendor. The vendor paid the former supervisor, and then fabricated his own set of invoices used to bill VA for goods and services that were never provided. The amount of these invoices equaled the amount the vendor paid to the former supervisor plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The

defendant was sentenced in the Western District of Texas to 12 months' incarceration and 36 months' supervised release, and ordered to pay restitution of $715,000. The loss to VA is approximately $1.1 million.

INDIVIDUAL PLED GUILTY TO PAYING AN ILLEGAL GRATUITY TO A PUBLIC OFFICIAL

An investigation by the VA OIG, FBI, and IRS-CI revealed that from December 2017 through June 2018, an individual provided 18 payments to a VHA Office of Community Care employee totaling more than $1 million. The payments were made in exchange for the VA employee referring the caregivers of seven beneficiaries with spina bifida to the defendant's home health agency, which in turn billed VA for more than $3 million in ineligible home health services. The defendant pled guilty in the District of Colorado to paying an illegal gratuity to a public official, and charges against the VA employee are still pending.

FORMER MEMPHIS, TENNESSEE, VA MEDICAL CENTER POLICE SERVICE SERGEANT ARRESTED FOR CONFLICT OF INTEREST AND WIRE FRAUD

A VA OIG investigation resulted in charges alleging that a former Memphis, Tennessee, VA Medical Center Police Service sergeant created a shell security company, which she then paid for its services for area VA facilities using her government purchase card. The funds from the purchase card were allegedly laundered through an account opened by the defendant with a third-party processor and subsequently deposited into the defendant's personal bank account. The loss to VA is approximately $137,000. The defendant was subsequently arrested for conflict of interest and wire fraud.

Civilian Health and Medical Program Fraud

WIDOW INDICTED FOR DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

The widow of a deceased veteran was indicted in the Southern District of Texas for mail fraud, healthcare fraud, and false statements relating to healthcare matters. A VA OIG investigation resulted in charges alleging that over the course of approximately four years, the defendant submitted counterfeit prescription receipts to VA for reimbursement under VA's Civilian Health and Medical Program (CHAMPVA). The loss to VA is approximately $650,000.

Spinal Bifida Health Care Benefits Program Fraud

SISTER OF SPINA BIFIDA BENEFICIARY INDICTED FOR HEALTHCARE FRAUD

The sister of a now deceased VA spina bifida beneficiary was indicted in the Southern District of West Virginia for healthcare fraud. A VA OIG, Health and Human Services OIG (HHS OIG), and FBI investigation resulted in charges alleging the defendant fraudulently billed VA's Spinal Bifida Health Care Benefits Program by charging eight hours of home health care, seven days a week, at $736 per day. The defendant allegedly spent only a few hours per week with her sister and maintained full-time employment during a portion of the period in which she billed VA for her sister's home health care. During the time frame in which she maintained full-time employment, VA paid $257,914 to the defendant for her sister's care. The defendant also gave the VA spina bifida beneficiary over $30,000 from the money received from VA for home healthcare services. The loss to VA is approximately $470,000.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

SELECTED 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 and caregivers.

OIG's IT and Data Analysis Division, in coordination with OI, conducts an ongoing proactive data Death Match 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 VA OIG investigative field offices for appropriate action. Within this reporting period, field personnel, including investigative assistants and special agents, teamed with headquarters personnel to process and work cases resulting in the arrest of six individuals, recoveries of $1.2 million, and a projected five-year savings to VA estimated at $12.1 million.

OI opened 94 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 38 arrests. OI obtained over $5.1 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $31 million in savings, efficiencies, and cost avoidance; and recovered more than $3.1 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

Education Benefits Fraud

TRUCKING SCHOOL OWNER PLED GUILTY TO WIRE FRAUD

A joint VA OIG, FBI, and Department of Justice (DOJ) OIG investigation revealed that a trucking school owner, school employees, and veteran students conspired to, or had knowledge of, a scheme to fraudulently enroll veterans at the trucking school from 2011 to 2015. Subsequently, the trucking school owner pled guilty in the Central District of California to wire fraud. The loss to VA is approximately $4.2 million.

Compensation Benefits Fraud

VETERAN INDICTED FOR THEFT OF GOVERNMENT FUNDS

A VA OIG investigation resulted in charges alleging that a veteran provided false statements to VA regarding his lack of use of an arm and a leg, which resulted in increased VA compensation benefits of nearly $8,000 per month. The defendant was arrested following an indictment in the Western District of North Carolina for theft of government funds. The loss to VA is approximately $1.3 million.

VETERAN SENTENCED FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was sentenced to 12 months' imprisonment and ordered to pay approximately $1.3 million in restitution to the VA. A VA OIG investigation revealed that since 1969, the veteran lied to VA in order to obtain a 100-percent service-connected disability rating for total blindness despite being able to drive a vehicle, maintain a Colorado driver's license, and ambulate without the assistance of walking aids.

THREE INDIVIDUALS INDICTED FOR COMPENSATION BENEFITS FRAUD SCHEME

Three defendants were indicted in the District of Maryland in connection with a compensation benefits fraud scheme which impacted VA and the Social Security Administration (SSA). One defendant was charged with conspiracy, theft of government property, aggravated identity theft, and SSA fraud. The other two defendants were charged with conspiracy and theft of government property. A VA OIG and SSA OIG investigation resulted in charges alleging the defendants submitted fraudulent documents and misrepresented the severity of their disabilities to obtain VA compensation benefits. It is alleged that one defendant fraudulently received approximately $35,000 in SSA Disability Insurance benefits for her claimed disabilities. The loss to VA is approximately $820,000.

VETERAN CHARGED WITH THEFT OF PUBLIC MONEY

A veteran was indicted in the District of Kansas with theft of public money. A VA OIG and SSA OIG investigation resulted in charges alleging that the defendant misrepresented symptoms of conversion (medically unexplained neurological) disorder and choreiform gait (involuntary movement) disorder to obtain a 100 percent service-connected disability rating, VA Aid and Attendance benefits, and VA Survivors' and Dependents' Educational Assistance. The total estimated loss to the government is over $567,000. Of this amount, the loss to VA is approximately $422,600.

VETERAN SENTENCED FOR COMPENSATION BENEFITS FRAUD

A veteran was sentenced in the Northern District of California to 37 months' imprisonment following an investigation that revealed the defendant repeatedly submitted false claims and information to VA and other federal agencies. Some of the false claims related to the defendant's military service. Consequently, the defendant was awarded a VA disability rating of 100 percent and medically retired from the Federal Bureau of Prisons at age 35. The veteran was ordered to pay approximately $632,400 in restitution to the government. Of this amount, VA will receive approximately $249,500. The VA OIG, Office of Personnel Management (OPM) OIG, DOJ OIG, and SSA OIG conducted the investigation.

VETERAN SENTENCED FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was sentenced in the Northern District of Florida to three years' probation and ordered to pay over $243,000 in restitution to VA. A VA OIG investigation revealed the defendant maintained a full-time position as an auto service manager while receiving Individual Unemployability, a VA benefit reserved for veterans who demonstrate that they cannot work due to their service-connected disability.

Sexual Assault

FORMER CONTRACT PHYSICIAN PLED GUILTY TO SEXUAL ASSAULT

A former contract physician pled guilty in the County of San Diego to the sexual assault of five female patients who were referred to him by VA. A VA OIG and Medical Board of California investigation revealed the defendant engaged in inappropriate acts while conducting Compensation and Pension (C&P) examinations. In support of this investigation, a VA C&P physician determined through an independent review that the defendant conducted examinations that were outside standard practices, to include unnecessary pelvic examinations. As part of the plea, the defendant agreed to a suspended prison sentence of 36 months and probation of 36 months. The defendant was also required to surrender his medical license and register as a sex offender.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Public Corruption by VBA Employees

FORMER VA EMPLOYEE AND CONSTRUCTION CONTRACTOR PLED GUILTY FOR ROLES IN BRIBERY SCHEME

A former VA Specially Adapted Housing grant agent and construction contractor each pled guilty in the Eastern District of North Carolina to conspiracy to commit bribery. A VA OIG investigation revealed that the construction contractor's company, which specialized in making homes more accessible for individuals with disabilities, provided over $20,000 in gratuities to the former VA employee. In exchange, the former VA employee steered construction work orders to the construction contractor's company, which were funded by VA's Specially Adapted Housing grant program and valued at more than $1 million.

Fiduciary Fraud

FORMER VA FIDUCIARY INDICTED FOR THEFT SCHEME

A former VA-appointed fiduciary was indicted for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant stole more than $100,000 in funds that were intended for her veteran father.

Fraud in Connection with Computers

HUNTINGTON, WEST VIRGINIA, VA REGIONAL OFFICE EMPLOYEE PLED GUILTY TO FRAUD IN CONNECTION WITH COMPUTERS

A Huntington, West Virginia, VA Regional Office employee pled guilty in the Southern District of West Virginia to an information (a formal charging document) which charged him with fraud in connection with computers. A VA OIG and FBI investigation revealed that between March 2018 and May 2018, the defendant accessed service-connected medical diagnoses of six veterans without authorization or a legitimate business purpose. One of the victims was a former West Virginia State Senator. The defendant subsequently shared a computer screenshot of that victim's health information via text message with an acquaintance.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. OI 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 32 cases and made 21 arrests. These investigations resulted in nearly $149.2 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as nearly $1.5 million in savings, efficiencies, and cost avoidance.

Service-Disabled Veteran-Owned Small Business Fraud

INDIVIDUAL SENTENCED FOR ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A defendant was sentenced to 51 months' imprisonment and 3 years' supervised release after pleading guilty to wire fraud. A VA OIG, Defense Criminal Investigative Service (DCIS), Air Force Office of Special Investigations, Army Criminal Investigation Command, Department of Energy OIG, Department of Agriculture OIG, and SBA OIG investigation revealed that more than $350 million in construction contracts were fraudulently obtained after several subjects conspired in creating companies for the sole purpose of obtaining set-aside government contracts. Of this amount, more than $26 million was awarded by VA. The subjects provided false qualifying information to VA and the SBA by concealing that the companies were not controlled by veterans, service-disabled veterans, minorities, or women. Eleven associated companies and five defendants were suspended and subsequently debarred from obtaining future government contracts until March 2021. Additional business associates, including a service-disabled veteran, were previously sentenced.

INDIVIDUAL PLED GUILTY FOR ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A nonveteran business owner pled guilty to wire fraud. A VA OIG and FBI investigation revealed the defendant devised a "rent-a-vet" scheme to fraudulently obtain six VA construction projects throughout Ohio and Michigan. Numerous legitimate service-disabled veteran-owned small businesses were passed over as a result of the scheme. The largest contract involved the construction of an outpatient pharmacy in Cleveland, Ohio. The construction was delayed by the defendant's company for at least six months and ultimately completed by another company. The loss to VA is approximately $11.9 million.

CONSTRUCTION COMPANY AND OWNER AGREE TO CIVIL SETTLEMENT

A VA OIG investigation revealed that a large construction company controlled a SDVOSB joint venture that fraudulently obtained $11.9 million in set-aside contracts awarded by VA and the Army Corps of Engineers for VA projects. The construction company and its nonveteran owner entered into a civil settlement with the U.S. Attorney's Office for the Southern District of California under which the company agreed to pay nearly $3.3 million to settle a False Claims Act complaint. The company and the owner were also separately sentenced in the Southern District of California. The owner was sentenced to 18 months' imprisonment, and the company was sentenced to pay over $330,000 in forfeiture.

SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS AGREES TO CIVIL SETTLEMENT

An investigation substantiated that a SDVOSB violated the False Claims Act by selling substandard defective products to the United States that were not in compliance with the contractually required national electric code and structural standards. In support of the VHA's Continuity of Operations Plan, VA acquired approximately 24 Medical Response Support Units from the SDVOSB for $1.4 million. VA subsequently awarded an additional $1.7 million in contractual task orders to the SDVOSB for the maintenance, storage, and transport of the Response Support Units. During their deployment, VA personnel encountered multiple electrical problems; heating, ventilating, and air conditioning issues; and structural defects that limited the Response Support Units' ability to deploy efficiently and consistently. The investigation was conducted by the VA OIG, Army Criminal Investigative Command, GSA OIG, and DCIS. As a result of the joint investigation, the SDVOSB entered into a civil settlement

with the U.S. Attorney's Office for the Southern District of Georgia in which the company agreed to pay $2.4 million to settle False Claims Act allegations.

FORMER SDVOSB OFFICER AGREES TO CIVIL SETTLEMENT

A former SDVOSB construction company officer was accused of allegedly creating the company to act as a pass-through for a non-SDVOSB company so that it could qualify for, and bid on, set-aside contracts. The former officer entered into a civil settlement with the U.S. Attorney's Office for the District of New Jersey under which the individual agreed to pay $2.4 million to the government to resolve the allegations. This settlement is the result of a VA OIG and SBA OIG investigation involving numerous construction contracts at VA facilities in New Jersey and New York. The total value of these VA contracts is approximately $58 million.

Bribery

FORMER PHARMACEUTICAL EXECUTIVES CONVICTED OF RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT CONSPIRACY

The founder and majority owner of the company and four former managers were found guilty of Racketeer Influenced and Corrupt Organizations Act conspiracy following a nine-week trial in the District of Massachusetts. Three other defendants previously pled guilty, including the former chief executive officer and the vice president of sales. Additionally, the company entered into a global resolution in which, among other sanctions, it agreed to pay $225 million in criminal and civil penalties. This case was initiated pursuant to a *qui tam* action filed in the U.S. District Court for the District of Massachusetts. The investigation revealed the pharmaceutical company's upper management led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of a reimbursement center, the defendants also conspired to mislead and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorizations from insurers. CHAMPVA paid the company approximately $3.3 million for this drug. The investigation was conducted by the VA OIG, U.S. Postal Inspection Service (USPIS), U.S. Postal Service (USPS) OIG, DOL OIG, DCIS, OPM OIG, HHS OIG, FDA, FBI, and DEA.

Workers' Compensation Benefits Fraud

DEFENDANT PLED GUILTY TO CONSPIRACY TO COMMIT HEALTHCARE FRAUD

A joint investigation revealed the defendant submitted false claims to DOL's Office of Workers' Compensation Program (OWCP) on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, assigned inaccurate billing codes in an effort to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The defendant conspired with others to perpetuate the fraud for about six years. The loss to VA is approximately $2.9 million. A medical office administrator pled guilty in the Northern District of Texas to conspiracy to commit healthcare fraud. This was a VA OIG, DOJ OIG, DOL OIG, USPS OIG, and IRS-CI investigation.

Compound Pharmacy Fraud

EIGHT INDIVIDUALS CHARGED IN COMPOUND PHARMACY SCHEME

A superseding indictment was filed in the Northern District of Texas against seven defendants for various charges to include conspiracy to commit healthcare fraud, conspiracy to launder money and engage in monetary transactions in criminally derived property, and money laundering in connection with healthcare fraud. One additional subject was indicted for conspiracy to defraud the United States in connection with healthcare fraud. A VA OIG, USPS OIG, and DOL OIG investigation resulted in charges alleging that multiple doctors received kickbacks from a compounding pharmacy's owner and associates. The loss to the federal government is approximately $70 million. Of this amount, the loss to VA is approximately $7.5 million.

FIVE INDIVIDUALS INDICTED IN HEALTHCARE FRAUD SCHEME

Five subjects were indicted in the Northern District of Texas for another healthcare fraud and conspiracy effort to commit healthcare fraud. Three of the subjects subsequently surrendered and one was arrested. A VA OIG, DCIS, OPM OIG, HHS OIG, FBI, and DOL OIG investigation resulted in charges alleging that the defendants participated in multiple fraudulent practices to defraud CHAMPVA and the Department of Defense's TRICARE healthcare program. The scheme included kickbacks, use of unapproved ingredients, and the filling of unauthorized prescriptions. The loss to the federal government is approximately $90 million. Of this amount, the loss to VA is approximately $3.3 million.

THREE INDIVIDUALS PLED GUILTY FOR ROLE IN COMPOUND PHARMACY SCHEME

Three owners/controllers of multiple pharmacies pled guilty to conspiring and engaging in a scheme to defraud the federal government and private healthcare insurance companies for more than $200 million across multiple states. The investigation revealed that the defendants fraudulently formulated, marketed, prescribed, and billed for compound medications produced and dispensed by pharmacies in south Mississippi. CHAMPVA paid fraudulent claims for compound medications to these pharmacies, which totaled approximately $2.4 million. This investigation involved the VA OIG, Mississippi Bureau of Narcotics, DOL OIG, USPIS, HHS OIG, DCIS, IRS-CI, and FBI.

FIVE INDIVIDUALS CHARGED IN KICKBACK SCHEME

Three physicians and five marketers were charged via criminal information (a formal charging document) in the Northern District of Oklahoma with conspiring to pay healthcare kickbacks and healthcare fraud for their participation in a scheme to defraud multiple federal government healthcare insurance programs. An investigation resulted in charges alleging that the defendants participated in a conspiracy to fraudulently bill CHAMPVA, OWCP, Medicare, and TRICARE for compounded medications. The total loss to the federal government is approximately $4.3 million. Of this amount, the loss to VA is approximately $590,000. The VA OIG, DCIS, HHS OIG, FBI, DOL OIG, USPS OIG, and IRS-CI conducted this investigation.

TWO FORMER COMPOUNDING PHARMACY EMPLOYEES CONVICTED OF VIOLATING THE FOOD, DRUG, AND COSMETIC ACT

Two former employees of a compounding pharmacy were found guilty of violating the Food, Drug, and Cosmetic Act after a week-long trial in the District of Massachusetts. A former pharmacist for the compounding pharmacy was sentenced to 30 months' imprisonment and one year of probation,

and another former pharmacist for the same compounding pharmacy was sentenced to a two-year probationary period, which included eight months of home confinement. A former pharmacy technician was also sentenced to two years' probation. A VA OIG, USPIS, FDA OCI, FBI, and DCIS investigation revealed that the defendants routinely dispensed drugs in bulk without valid prescriptions. Specifically, the two defendants signed off on drug orders with obviously fictitious patient names such as "Flash Gordon," "Long John," "Filet of Fish," and "L.L. Bean." The compounding pharmacy was at the center of a 2012 nationwide fungal meningitis outbreak that killed 64 people and caused infections in 793 patients. Although no known VA patients died or became ill from the compounding pharmacy's product, VA purchased approximately $516,000 of products that were produced in an unsafe manner and under unsanitary conditions. With these convictions, a total of 13 defendants, including the pharmacy's part owner, have been convicted of 178 charges to date.

TWO DEFENDANTS INDICTED FOR ROLES IN COMPOUNDING PHARMACY SCHEME

Two defendants were indicted and arrested in the Southern District of Florida for conspiracy to commit wire fraud, mail fraud, aggravated identity theft, conspiracy to pay kickbacks, and payment of healthcare kickbacks. A VA OIG, Army Criminal Investigative Command, DCIS, FDA OCI, and DOL Employee Benefits Security Administration investigation resulted in charges alleging that the defendants submitted false claims for compounded prescriptions to TRICARE, CHAMPVA, and private insurance companies. According to the allegations, the compounded prescriptions were either fraudulently dispensed without a physician's authorization; never dispensed; returned; or dispensed to TRICARE, CHAMPVA, and privately insured recipients without FDA approval. The overall loss to the government is approximately $18.9 million. Of this amount, the loss to VA is approximately $450,800.

Embezzlement

TWO FORMER NONPROFIT EXECUTIVES AND A FORMER ARKANSAS STATE SENATOR INDICTED ON CONSPIRACY CHARGES

Two former executives for a nonprofit organization and a former Arkansas state senator surrendered after being indicted in the Western District of Missouri for conspiracy, theft, bribery, wire and honest services fraud, and aiding and assisting false returns. The investigation resulted in charges alleging that the defendants conspired to unjustly enrich themselves and others through a nonprofit organization that contracted with VA to provide substance abuse counseling and housing services for veterans. As part of the conspiracy, the defendants allegedly unlawfully used the nonprofit's funds for political contributions, excessive lobbying, and political advocacy, and paid themselves through a system of kickbacks that disguised the nature and source of the payments. To increase the supply of funds from which they could embezzle, the defendants allegedly led 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. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, to include $1.7 million contributed by VA. The investigation was conducted by the VA OIG, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Medicaid Fraud Control Unit of the Missouri Attorney General's Office, IRS-CI, HHS OIG, DOL OIG, and FBI.

Workers' Compensation Program Fraud

TWO SUBJECTS INDICTED IN WORKERS' COMPENSATION FRAUD SCHEME

Two subjects were arrested after being indicted in the Northern District of Texas for conspiracy to commit healthcare fraud, payment of illegal remuneration, and identity theft. The investigation resulted in charges alleging that the subjects fraudulently billed DOL's OWCP and purchased the illegally obtained personally identifiable information of government employees to further their fraudulent billing scheme. The loss to the federal government is approximately $6.5 million. Of this amount, the loss to VA is approximately $2.5 million. The VA OIG, Department of Homeland Security OIG, USPS OIG, and DOL OIG conducted the investigation.

Home Healthcare Services Fraud

HOME HEALTHCARE COMPANY OWNER PLED GUILTY IN FRAUD SCHEME

A home healthcare company owner who provided care to veterans as part of VA's Purchased Care program pled guilty to destruction, alteration, or falsification of records as well as healthcare fraud for fraudulently billing VA and Medicare. A VA OIG, FBI, and HHS OIG investigation revealed the defendant and other employees submitted altered therapy notes documenting home healthcare services to VA patients that were never provided by the company but were subsequently paid for by VA. The loss to VA is approximately $868,000.

Fraud

DEFENDANT AGREES TO SETTLE FRAUD ALLEGATIONS

A defendant entered into a settlement agreement with the United States pertaining to his role as a prime vendor on a VA contract. A VA OIG investigation revealed the defendant created fraudulent, improper, and exaggerated travel expenses while working on the VA contract. The defendant agreed to pay $750,000, of which VA will receive $630,000.

False Claims Act Civil Settlement

PHARMACEUTICAL COMPANY AGREES TO SETTLE FALSE CLAIMS ACT ALLEGATIONS

A VA OIG, HHS OIG, and FBI investigation resulted in a pharmaceutical company entering into a civil settlement agreement to pay $52.6 million to the federal government. Of this amount, VA will receive approximately $600,000. This agreement resolved allegations that the defendant violated the False Claims Act by illegally making copayments for Medicare and CHAMPVA patients through independent charitable foundations. The anti-kickback statute prohibits pharmaceutical companies from offering or paying, directly or indirectly, copayments to induce patients to purchase the companies' drugs. Whenever a Medicare or CHAMPVA beneficiary obtains a prescription drug covered by the respective government program, the beneficiary may be required to make a partial payment that may take the form of a copayment, coinsurance, or deductible. This investigation determined that VA spent approximately $3.2 million in purchases for one of the pharmaceutical company's drugs.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

ASSAULTS AND THREATS MADE AGAINST VA EMPLOYEES

During this reporting period, OI initiated 12 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 11 individuals. Investigations resulted in over $360,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Assault Against VA Employees

VETERAN CHARGED IN CONNECTION WITH SHOOTING AT WEST PALM BEACH, FLORIDA, VA MEDICAL CENTER

An investigation conducted by the VA OIG and the FBI resulted in charges that a veteran inflicted non-life-threatening injuries on two VA employees by firing a handgun inside the medical center. While being processed in the facility's emergency room on a psychiatric hold, the defendant opened fire on VA emergency room staff after becoming agitated. Two VA physicians and a veteran subdued the defendant until VA police officers arrived at the scene. The defendant is a convicted felon who was legally prohibited from possessing firearms or ammunition.

Threats Against VA Employees

VETERAN SENTENCED FOR MAKING THREATS AGAINST VA EMPLOYEES AND A CONGRESSWOMAN

A veteran was sentenced in San Mateo Superior Court to 92 months' imprisonment. A VA OIG, VA Police Service, FBI, and San Mateo Police Department investigation determined that the defendant threatened to kill at least five specific VA employees at the Palo Alto and San Francisco VA medical centers in California. The defendant also threatened to "end" U.S. Congresswoman Jackie Speier and kill members of her congressional staff, and repeatedly "threatened to shoot all (derogatory term for African Americans) at the VA with a 1911 [firearm]." During one month, the defendant called various VA facilities in the Northern California area more than 600 times and placed many other threatening calls to Congresswoman Speier's office and the San Francisco District Attorney's Office.

VETERAN SENTENCED FOR MAKING THREATS AGAINST A VA DOCTOR

A veteran was sentenced in the District of Arizona to time served and three years' supervised release after previously pleading guilty to threats to assault, kidnap, or murder an employee of the United States. The defendant served more than 19 months in prison after being arrested in October 2017. A VA OIG investigation revealed the defendant made threatening statements toward a VA doctor during 880 calls over one weekend to Senator John McCain's office; the Tucson, Arizona, VA Medical Center; and the White House.

VETERAN SENTENCED FOR MAKING THREAT AGAINST THE MOUNT VERNON, MISSOURI, VA COMMUNITY-BASED OUTPATIENT CLINIC

A veteran was sentenced in the Western District of Missouri to 12 months' imprisonment and three years' supervised release following a VA OIG and FBI investigation that revealed the defendant made at least one threat by telephone to "blow up" the Mount Vernon, Missouri, VA Community Based Outpatient Clinic, resulting in the evacuation and closure of the clinic.

VETERAN ARRESTED FOR MAKING THREATS TO SEATTLE, WASHINGTON, VA MEDICAL CENTER

A VA OIG investigation resulted in the arrest of a veteran on charges alleging that he made threats toward the medical center and the facility's personnel. During the course of this investigation, the OIG obtained an Extreme Risk Protection Order (ERPO) directed to the defendant. The ERPO required the defendant to surrender all firearms and restricted him from possessing any firearms in the future.

FUGITIVE FELON PROGRAM

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since 2002, 83.5 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 98,335 investigative leads being referred to law enforcement agencies. More than 2,618 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified nearly $1.52 billion in estimated overpayments and cost avoidance of more than $2.03 billion. During this reporting period, OI made two arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of one additional fugitive felon, and identified $59.1 million in estimated overpayments.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES

SUBSTANTIATED ALLEGATIONS OF MISCONDUCT AGAINST SENIOR GOVERNMENT OFFICIALS

Under §5(a)(19) of the IG Act, inspectors general must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) in which allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether (1) the matter was referred to the DOJ, (2) the date of such referral, and (3) if applicable, the date of declination by the DOJ. During this reporting period, OI closed no criminal investigations with substantiated allegations against senior government employees.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES NOT DISCLOSED TO THE PUBLIC

Section 5(a)(22)(B) of the IG Act requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was 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. During this reporting period, there were no instances of previously undisclosed investigations of senior government officials that were closed or referred out after allegations were unsubstantiated.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

ADMINISTRATIVE INVESTIGATIONS

The VA OIG's Administrative Investigations Division independently reviews allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders. This division formerly reported to the OIG's Office of Investigations, but in October 2018 merged with the Office of Special Reviews. The reports discussed in this section were initiated while the division was still a part of the Office of Investigations. Future administrative investigations reports will be featured in the section discussing the results of the Office of Special Reviews.

Under §5(a)(19) of the IG Act, OIGs must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) where allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether the matter was referred to the DOJ, the date of such referral, and, if applicable, the date of declination by the DOJ. Section 5(a)(22)(B) also requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. The OIG publishes all closed administrative investigations, whether or not the allegations were substantiated. This reporting period, the OIG published one administrative investigation, the details of which follow.

ALLEGED IMPROPER RELEASE OF PROCUREMENT INFORMATION

The OIG received allegations that a current VA employee and the employee's spouse, a former (retired) VA employee, improperly released VA procurement information. There was insufficient evidence to substantiate the allegations. The OIG determined that the complainant's information was hearsay and there was no direct evidence. The OIG interviewed the complainant's source and determined that the source's information did not support the allegations raised by the complainant.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

16,348
HOTLINE CONTACTS PROCESSED

471
DATA REQUESTS COMPLETED

241
FOLLOW-UP INQUIRIES MADE

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations. The Human Resources Division works to recruit and retain qualified and committed staff and coordinates centralized training and staff development activities. The Operations Division prepares and disseminates published reports, conducts critical follow-up of OIG report recommendations to VA, and oversees the internal controls program and proper records management. The Information Technology (IT) Division provides nationwide IT support, systems development, and integration. The Space and Facilities Management Division oversees the process of obtaining and appropriately furnishing nationwide office space and property management. The Budget Division provides a broad range of budgetary formulation and execution services as well as a range of financial services, including administration of the employee travel and purchase card program. The Hotline Division receives, screens, and refers OIG mission-related complaints as appropriate. It also analyzes and synthesizes information to inform decisions to accept cases on a select basis regarding issues having the most potential risk to veterans, VA programs, and operations, or for which the OIG may be the only avenue of redress. Finally, the Data Analysis Division manages access to information requests, helps identify fraud-related activities, and supports the OIG's comprehensive oversight initiatives. 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 acts in response to complaints regarding VA programs and services. The Hotline director also serves as the Whistleblower Protection Coordinator. The coordinator is responsible for educating agency employees about prohibitions on retaliation for disclosing serious wrongdoing or gross mismanagement and the rights and remedies against retaliation associated with those disclosures. During this reporting period, the Hotline Division accomplished the following:

- Received and screened 16,348 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 621 cases to and required a written response from applicable VA offices after determining that allegations pertained to higher-risk topics, but where insufficient resources were available for OIG staff to complete a prompt independent review at that time

- Made 631 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 702 cases for which nearly 39 percent of allegations were substantiated, 580 administrative sanctions and corrective actions were taken, and nearly $280,774 in monetary benefits were achieved
- Responded to more than 258 requests for record reviews from VA staff offices
- Issued 47 semi-custom responses to provide other options for redress to individuals who contacted the Hotline with concerns that were outside the OIG's scope, and finalized a contract to significantly increase the volume of semi-custom responses in the future.

FEATURED HOTLINE CASES

Highlighted below are cases opened by the OIG's Hotline that were not included in inspections, audits, investigations, or reviews by other VA OIG directorates.

INADVERTENT DESTRUCTION OF VETERAN'S PRESCRIPTION MEDICATION

The OIG Hotline received an anonymous complaint that on two separate occasions, employees from a Consolidated Mail Order Pharmacy (CMOP) mistakenly sent truckloads of medication intended for patients to the recycling center. The Veterans Integrated Service Network (VISN) reviewed the allegations and determined that on one occasion 1,956 prescriptions were inadvertently sent to the recycling center and could not be retrieved for use. The loss was $39,950. In a second incident 1,708 prescriptions were sent to the recycling center but were retrieved before they were processed. In both cases, all veteran patients were sent their appropriate medications. Additionally, the CMOP took corrective actions to include development of a new standard operating procedure to cover protocols for shipping out drugs to be recycled and new shipment verification procedures.

BETTING IN THE WORK PLACE

Hotline staff received allegations that a pharmacist was running sports betting pools involving other pharmacy employees. Upon review, the medical center determined that the named pharmacist coordinated gambling brackets centered around the 2019 Final Four and the Super Bowl. The buy-ins were between $50 and $100 and the payouts over $1,000. As a result of the investigation, the pharmacy service chief was provided enough information to take appropriate personnel action and the compliance/ethics officer was instructed to send all employees a reminder that betting (pools) on sporting event outcomes in the workplace is prohibited.

MISMANAGEMENT OF AMBULANCE CLAIMS

Following consideration of a complaint, the OIG Hotline referred a case to a VA medical center regarding the alleged mismanagement of 9-1-1 ambulance claims. The complainant alleged that there were several million dollars in pending claims, $50,000 in returned checks over a 12-month period, and 4,000 unverified claims sitting in a drawer. Both the facility chief financial officer and chief of the Veterans Transportation Office investigated the issue and determined the program was mismanaged

and that the issues had been ongoing since 2014. Additionally, they found $35,000 in checks waiting for action and 2,000 unverified claims. As a result of the investigation, the new management team began working all backlogged items, and by May 2019 all accounts were current. Management is currently working with veterans that have since come forward with new issues related to accounts that went to debt collections as a result of the original problem with the program.

MISSING PROVIDER PAYMENTS

A complaint was received from a non-VA provider who had not been paid because HealthNet Federal Services incorrectly processed a payment to an incorrect bank account. The provider had tried, without success, to have HealthNet fix the problem. The OIG Hotline staff sent a case to the Office of Community Care, which worked with HealthNet's financial department to identify the source of the problem and correct it. As a result of the case, the care provider received payments totaling $106,112.

TRANSPLANT PROGRAM DEFICIENCIES

OIG Hotline staff referred a case to VISN 4 regarding an allegation that a veteran who should have been on the kidney transplant list three or four years ago was never placed on the list. The VISN substantiated the allegation and took immediate corrective action regarding the veteran and management of the transplant program at the servicing medical center. The transplant coordinator initiated the referral process and the veteran began prerequisite testing. The Root Cause Analysis team identified three required corrective actions for the program. First, they implemented a requirement that all veterans referred for transplant consideration be placed on the high-risk registry. Second, they mandated a records flag to promptly identify veterans being considered for a transplant. Last, they required that the facility work with the Transplant Center to request utilization of communication consults to notify primary care providers of any recommendations, results, and updates regarding transplant tests or listing status for organ transplant.

VETERAN BENEFIT FRAUD

The OIG received allegations that a veteran was fraudulently receiving additional disability benefits for dependents although he was not related to two of the individuals. A case was sent to the VA Regional Office (VARO) that determined that the veteran was not entitled to benefits for a spouse and step-child. As part of the VARO review, the veteran was afforded due process, but failed to respond with the information requested. Consequently, the VARO removed both individuals from the claim with an effective date of October 1, 2015, initiated an overpayment of $9,481, and has begun recouping the money.

FOR MORE INFORMATION

on the Hotline and how to report fraud, waste, abuse, or mismanagement, visit www.va.gov/oig/hotline.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

TABLE 9. CONGRESSIONAL TESTIMONY

WITNESS	COMMITTEE	TOPIC	DATE
Deputy Inspector General for Audits and Evaluations Brent Arronte with Director of Information Technology and Security Audits Division Michael Bowman	House Committee on Veterans' Affairs, Subcommittee on Technology Modernization	Mapping the Challenges and Progress of The Office of Information and Technology	4/2/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, and Technology Modernization	Examining Ongoing Forever GI Bill Implementation Efforts	5/9/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Health, and Technology Modernization	MISSION Critical: Caring for Our Heroes	5/22/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations	Improving the Department of Veterans Affairs Effectiveness: Responding to Recommendations from Oversight Agencies	5/22/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations	Examining VA's Police Force	6/11/2019
Assistant Inspector General for Audits and Evaluations Larry Reinkemeyer	House Committee on Veterans' Affairs, Subcommittee on Health	Mission Readiness: VA's Emergency Response and Cache Program	6/19/2019
Director, Denver Benefits Inspections Division, Office of Audits and Evaluations Steve Bracci	House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs	Ensuring Access to Disability Benefits for Veteran Survivors of Military Sexual Trauma	6/20/2019

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

WITNESS	COMMITTEE	TOPIC	DATE
Inspector General Michael J. Missal	House Committee on Oversight and Reform, Subcommittee on Government Operations	Ensuring Quality Health Care for Our Veterans	6/20/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations	Learning from Whistleblowers at the Department of Veterans Affairs	7/23/2019
Inspector General Michael J. Missal	House Committee on Veterans' Affairs	Critical Impact: How Barriers to Hiring at VA Affect Patient Care and Access	9/18/2019
Assistant Inspector General for Audits and Evaluations Larry Reinkemeyer	House Committee on Veterans' Affairs, Subcommittee on Technology Modernization	The Future of VA Scheduling: Implementing a Commercial Off-the-Shelf Scheduling Solution	9/26/2019

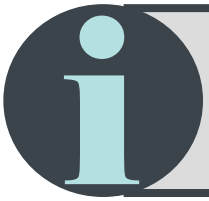
TABLE 10. PRESS RELEASES

TITLE	ISSUE DATE
OIG Statement on Allegations of Potential Wrongdoing Resulting in Patient Deaths at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	8/27/2019
OIG Statement on Allegations of Sexual Assaults at the Beckley VA Medical Center in West Virginia	9/9/2019

TABLE 11. PODCASTS

All podcasts and their transcripts are available at www.va.gov/oig/podcasts/default.asp.

TITLE	ISSUE DATE
VA OIG April 2019 Highlights	4/30/2019
VA OIG June 2019 Highlights	7/29/2019
VA OIG July 2019 Highlights	8/8/2019
Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility	8/29/2019
VA OIG August 2019 Highlights	9/13/2019



STAY CONNECTED

For the latest news and information, follow the OIG on LinkedIn and Twitter, sign up to receive email alerts about new reports and website content, and subscribe to the RSS feeds.

OTHER REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors general are required by §4(a)(2) of the Inspector General Act of 1978 (IG Act) (P.L. 95-452) to review existing and proposed legislation and regulations and make recommendations in the SAR 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 13 legislative or regulatory proposals and made no comments.

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

Under the authority of the IG Act, the VA OIG is authorized to access 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 an OIG in the Act. OIGs are required under §5(a)(5) of the Act to provide a summary of instances when such information or assistance is refused. The VA OIG reports no such instances occurring during this reporting period.

PEER AND QUALITATIVE ASSESSMENT REVIEWS

Under §5(a)(14) and (15) of the IG Act, as amended by the Dodd-Frank Wall Street Reform and Consumer Protection Act (P.L. 111-203), inspectors general must report the results of any peer review conducted of their operations by another office of inspector general during the reporting period or identify the date of the last peer review conducted by another office of inspector general, in addition to any outstanding recommendations that have not been fully implemented. Both the VA OIG's Office of Audits and Evaluations and the Office of Investigations are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by the respective organizations meets the applicable requirements and standards.

The IG Act also requires inspectors general, under §5(a)(16), to report the results of any peer review they conducted of another office of inspector general'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.

MOST RECENT PEER REVIEW CONDUCTED OF THE VA OIG

During this reporting period, the Department of Energy (DOE) 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, 2018. In their review, posted August 28, 2019, DOE OIG found that VA OIG's system of quality controls was suitably designed and that the audit organization complied with this system.

As a result, DOE OIG concluded VA OIG's system of quality controls provides reasonable assurance of audit organizations performing and reporting in conformity with applicable standards in all material respects. Therefore, VA OIG received a rating of pass.

The last Quality Assessment Review (QAR) conducted of VA OIG's Office of Investigations was completed on December 10, 2018. The QAR was completed by NASA OIG and found VA OIG's internal system of safeguards and management procedures for its investigative function to be in compliance with the quality standards established by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) and other applicable guidelines and statutes.

MOST RECENT PEER REVIEW CONDUCTED BY THE VA OIG

The VA OIG completed a peer review of the SSA OIG's audit operation and issued a final report on August 8, 2018, determining that SSA OIG was in compliance with the quality standards established by CIGIE. The VA OIG made no recommendations as a result of this review.

INSTANCES OF WHISTLEBLOWER RETALIATION

Inspectors general are required by §5(a)(20) of the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires inspectors general to detail the consequences imposed by the Department to hold those officials accountable. However, the VA OIG's current practice is to refer individuals making allegations of whistleblower reprisal to either the VA Office of Accountability and Whistleblower Protection or the Office of Special Counsel. As a result, the VA OIG has no information responsive to this requirement to report.

ATTEMPTS TO INTERFERE WITH THE INDEPENDENCE OF THE OFFICE OF INSPECTOR GENERAL

Section 5(21) of the IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information. During this reporting period, there were no such incidents.

CLOSED OFFICE OF INSPECTOR GENERAL WORK NOT DISCLOSED TO THE PUBLIC

The VA OIG is required by §5(a)(22)(A) of the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, and audit conducted by the OIG that is closed and was not disclosed to the public. The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

FALSE CLAIMS ACT SETTLEMENTS

For this reporting period, the Office of Contract Review, independent of the Office of Investigations, issued two settlements under the *qui tam* provisions of the False Claims Act (P. L. 97-258) totaling over $6.5 million in recoveries collected by the Department of Justice on VA's behalf. These settlements are reflected in the Postawards Reviews section of Appendix A.

OTHER REPORTING REQUIREMENTS

GOVERNMENT CONTRACT AUDIT FINDINGS

The IG Act, as amended by the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181), requires each inspector general to submit an appendix on final, completed contract audit reports issued to the contracting activity (agency component) 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 SAR. During this reporting period, the VA OIG did not issue any reports meeting these requirements.

AWARDS AND RECOGNITION

EMPLOYEE RECOGNITION OF MILITARY PERSONNEL

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

- Peter Moore, a Criminal Investigator in Dallas, Texas, was activated by the United States Army in February 2019.
- Christopher Dong, an Attorney in Washington, DC, was activated by the United States Air Force in March 2019.
- Jason Kravetz, a Criminal Investigator in Needham, Massachusetts, returned from duty in April 2019.
- Brian Celatka, a Criminal Investigator in Nashville, Tennessee, was activated by the United States Air Force in April 2019.
- George Kurtzer, an Information Technology Specialist in Hines, Illinois, was activated by the United States Air Force in April 2019.
- Matthew Clark, an Auditor in Dallas, Texas, was activated by the United States Army in July 2019.

2019 COUNCIL OF THE INSPECTORS GENERAL ON INTEGRITY AND EFFICIENCY AWARD RECIPIENTS

VA OIG staff were recognized by CIGIE for these outstanding accomplishments:

- The Audit team that produced the *Review of Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma* was selected for an Award for Excellence in Evaluations.
- The Healthcare team that engaged in the *Review of Pain Management Services in Veterans Health Administration Facilities* also won an Award for Excellence in Evaluations.
- The Investigations team that investigated post-9/11 GI Bill fraud was selected for an Award for Excellence in Investigations.
- The Audit team that produced the *Audit of VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students* was selected for an Award for Excellence in Audit.
- The Audit team engaged in the *Audit of Emergency Cache Program: Ineffective Management Impairs Mission Readiness* also won an Award for Excellence in Audit.
- The Audit team that engaged in the *Audit of Bulk Payments Made Under Patient-Centered Community Care/Veterans Choice Program Contracts* also won an Award for Excellence in Audit.
- A cross-directorate team that worked on the *Review of Two Mental Health Patients Who Died by Suicide, Madison, WI* earned an Award for Excellence in Multiple Disciplines.

For more information and to view other CIGIE award recipients, visit https://ignet.gov/content/awards.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

Federal inspectors general are required to provide information on the reports they publish and any associated monetary impact. Tables A.1 through A.4 provide a listing of VA OIG publications issued this period with results sorted according to the authoring directorate. If applicable, the total dollar value of questioned costs and recommendations that funds be put to better use are identified. Table A.5 summarizes all monetary benefits for OIG reports issued this reporting period. This information is required by §5(a)(6) of the IG Act.

Under §5(a)(8) and (9) of the Act, OIGs must provide statistical tables showing the total number of reports issued during the reporting period with questioned costs or recommendations that funds be put to better use (1) for which no management decision had been made by the commencement of the reporting period, (2) which were issued during the reporting period, (3) for which a management decision was made during the reporting period, and (4) for which no management decision was made by the end of the current reporting period. This information is provided in Tables A.6 and A.7.

Sections 5(a)(10)(A) and (B) of the IG Act require that OIGs 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 VA 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. The reporting requirement under §5(a)(10)(C) is presented in Appendix B.

Federal inspectors general are also required under §5(a)(11) and (12) of the IG Act to provide a description and explanation of the reasons for any significant revised management decision made during the reporting period, as well as information concerning any significant management decisions with which the inspector general is in disagreement.

While VA OIG reports that there were no significant revised management decisions made during the reporting period, there were four significant management decisions (nonconcurrences) in three reports. In the report *Follow-Up Review of the Veterans Crisis Line, Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas*, the Department nonconcurred with OIG Recommendation 1, which required analysis and action to bolster rescue efforts for callers whose location cannot be identified. In the nonconcurrence, the Department asserted that there is no industry standard for the requested analysis but indicated a formal process would be instituted to share information with local dispatch centers in support of locating persons at risk of imminent harm to themselves or others. While the Department nonconcurred with the recommendation based upon the lack of an industry standard, the OIG supports the Department's proposed action plan.

Also, in the report *Decision Ready Claims Program Hindered by Ineffective Planning*, the Department nonconcurred with OIG Recommendation 1, which required the Department to determine if an Antideficiency Act violation occurred and take actions for funds already obligated and expended for medical examinations. The Department contended that OIG may have overlooked a proper interpretation of the Antideficiency Act and the "necessary expense" doctrine. The Department further contended that the OIG misconstrued the VA appropriations statutes at issue. However, the OIG disagreed with this basis for noncurrence as the OIG relied on the plain language of the relevant statutes and regulations, which neither oversimplifies nor is inconsistent with the relevant law regarding claims initiation.

Finally, in the report *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, the Department nonconcurred with OIG Recommendations 2 and 8 related to mental health clinical pharmacists having collaborative practice agreements and establishing guidance regarding the process for mental health clinical pharmacists referring patients to a higher level of mental health care. The Department contended that previously developed mental health care coordination agreements addressed both recommendations as these agreements require that mental health clinical pharmacist specialists collaborate with other licensed healthcare professionals for advanced care beyond their scope of practice and outline the process for referring patients to higher levels of mental health care. However, the OIG stands by its findings and recommendations as these agreements are not sufficient.

TABLE A.1. PUBLICATIONS ISSUED BY THE OFFICE OF AUDITS AND EVALUATIONS

AUDITS AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package *Issued 5/1/2019 | Report Number 17-05246-98*	--	--
Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System *Issued 5/2/2019 | Report Number 18-03159-74*	--	$45,332
Deferrals in the Veterans Benefits Management System *Issued 5/15/2019 | Report Number 18-00215-83*	--	$1,100,000
Decision Ready Claims Program Hindered by Ineffective Planning *Issued 5/21/2019 | Report Number 18-05130-105*	$9,600,000	$972,000
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018 *Issued 6/3/2019 | Report Number 18-05864-127*	--	--
Exempt Veterans Charged VA Home Loan Funding Fees *Issued 6/6/2019 | Report Number 18-03250-130*	--	$352,600,000
Inadequate Oversight of Contracted Disability Exam Cancellations *Issued 6/10/2019 | Report Number 18-04266-115*	--	--
VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract *Issued 6/13/2019 | Report Number 17-04178-46*	--	$37,500,000

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Alleged Unapproved Acquisition of a Robotic Surgical System for the W.G. (Bill) Hefner Veterans Affairs Medical Center, Salisbury, North Carolina *Issued 6/19/2019 | Report Number 18-03260-102*	--	--
Staffing and Vacancy Reporting under the MISSION Act of 2018 *Issued 6/25/2019 | Report Number 19-00266-141*	--	--
Management of Major Medical Leases Needs Improvement *Issued 7/2/2019 | Report Number 17-05859-131*	$152,300,000	--
Annual Risk Assessment of VA's Charge Card Programs *Issued 7/22/2019 | Report Number 19-00223-166*	--	--
Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement *Issued 7/25/2019 | Report Number 18-04924-112*	--	$938,801
Non VA Emergency Care Claims Inappropriately Denied and Rejected *Issued 8/6/2019 | Report Number 18-00469-150*	--	$533,000,000
VA's Implementation of the Veterans Information Systems and Technology Architecture Scheduling Enhancement Project Near Completion *Issued 8/20/2019 | Report Number 16-03597-171*	--	--
Health Information Management Medical Documentation Backlog *Issued 8/21/2019 | Report Number 18-01214-157*	--	--
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/5/2019 | Report Number 18-05663-189*	--	$64,800,000
Security and Access Controls for the Beneficiary Fiduciary Field System Need Improvement *Issued 9/12/2019 | Report Number 18-05258-193*	--	--
Problems Were Identified on One Regional Procurement Office Central Ambulance Service Contract *Issued 9/12/2019 | Report Number 18-01836-183*	--	$2,227,493
Sole-Source Service Contracting at Regional Procurement Office West Needs Improvement *Issued 9/17/2019 | Report Number 18-01836-185*	--	$6,034,026

AUDITS AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Sole-Source Service Contracting at Regional Procurement Office East Needs Improvement *Issued 9/17/209 | Report Number 18-01836-184*	--	$14,245,166
Boston, Massachusetts, VA Regional Office Supervisor Incorrectly Processed Work Items *Issued 9/19/2019 | Report Number 19-07350-192*	--	$84,400
Los Angeles Vocational Rehabilitation and Employment Program Generally Met Requirements After Hiring Additional Staff *Issued 9/23/2019 | Report Number 18-04562-205*	--	--
State Prescription Drug Monitoring Programs Need Increased Use and Oversight *Issued 9/23/2019 | Report Number 18-02830-164*	--	--
Workload Management Challenges Identified at the Salt Lake City, Utah, Fiduciary Hub *Issued 9/25/2019 | Report Number 19-06565-217*	--	--
Construction Project Management at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina *Issued 9/25/2019 | Report Number 18-01944-214*	--	--
Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia *Issued 9/26/2019 | Report Number 19-00260-215*	--	--
Oversight and Resolution of Home Loan Defaults *Issued 9/30/2019 | Report Number 18-03979-204*	--	--
Total	**$161,900,000**	**$1,013,547,218**

TABLE A.2. PUBLICATIONS ISSUED BY THE OFFICE OF CONTRACT REVIEW

OCR preaward reviews of prospective VA contracts and postaward reviews of awarded contracts are submitted only to the Department and are not publicly released. These reports contain nonpublic, confidential, and proprietary data relating to the contractors' business and include trade secret information protected from public release by 18 U.S.C. § 1905. Section 1905 provides for criminal penalties for any government employee or contractor who publicly discloses such protected information. Further, the reports are exempt, in whole or in part, from mandatory public disclosure under subparagraphs (b)(3), (b)(4), and (b)(5) of the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Portions of the reports that pertain to contractor proposals are also protected from disclosure by 41 U.S.C. § 4702 (prohibiting disclosure of contractor proposals under FOIA).

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS	SAVINGS AND COST AVOIDANCE
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 4/11/2019 | Report Number 19-06448-110*	$7,976,688
Review of a Proposal Submitted under a Solicitation *Issued 4/23/2019 | Report Number 19-07571-116*	$1,823,546
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/23/2019 | Report Number 19-06762-118*	$875,510
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 4/23/2019 | Report Number 19-06028-117*	$1,231,608
Review of a Proposal Submitted under a Solicitation *Issued 5/7/2019 | Report Number 19-07430-124*	$1,041,561
Review of a Proposal Submitted under a Solicitation *Issued 5/16/2019 | Report Number 19-07524-128*	$2,805,530
Review of a Request for Modification Submitted under a Federal Supply Schedule Contract *Issued 5/17/2019 | Report Number 19-05910-133*	--
Review of a Proposal Submitted under a Solicitation *Issued 5/23/2019 | Report Number 19-07989-134*	$2,784,599
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/24/2019 | Report Number 19-07100-136*	$3,529,888
Review of a Proposal Submitted under a Solicitation *Issued 5/30/2019 | Report Number 19-08028-137*	$5,973,261
Review of a Proposal Submitted under a Solicitation *Issued 6/5/2019 | Report Number 19-08183-143*	$3,265,340
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 6/6/2019 | Report Number 19-06805-135*	$264,648
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 6/12/2019 | Report Number 19-07570-149*	--
Review of a Proposal Submitted under a Solicitation *Issued 6/14/2019 | Report Number 19-07996-145*	$2,144,392

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of a Proposal Submitted under a Solicitation *Issued 6/14/2019 | Report Number 19-08122-151*	$6,303,443
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation Number *Issued 7/11/2019 | Report Number 18-06024-169*	$16,171,433
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/18/2019 | Report Number 19-06379-172*	--
Review of a Proposal Submitted under a Solicitation *Issued 7/18/2019 | Report Number 19-08445-174*	$4,282,119
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 7/25/2019 | Report Number 19-08365-181*	$3,438,012
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/25/2019 | Report Number 19-08113-182*	--
Review of a Proposal Submitted under a Solicitation *Issued 8/6/2019 | Report Number 19-08245-188*	$3,098,333
Review of a Proposal Submitted under a Solicitation *Issued 8/16/2019 | Report Number 19-08491-191*	--
Review of a Proposal Submitted under a Solicitation *Issued 8/20/2019 | Report Number 19-08548-197*	$7,350,079
Review of a Proposal Submitted under a Solicitation *Issued 8/20/2019 | Report Number 19-09145-203*	$192,646
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 8/22/2019 | Report Number 19-07494-207*	--
Review of a Proposal Submitted under a Solicitation *Issued 8/26/2019 | Report Number 19-07236-206*	$798,637
Review of a Proposal Submitted under a Solicitation *Issued 8/28/2019 | Report Number 19-09160-208*	$150,176
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 8/28/2019 | Report Number 19-08337-201*	$6,763,592
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 8/30/2019 | Report Number 19-08458-210*	$6,468,581

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/5/2019 | Report Number 19-08821-216*	$209,773,243
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 9/11/2019 | Report Number 19-08687-221*	--
Review of a Proposal Submitted under a Solicitation *Issued 9/13/2019 | Report Number 19-08985-225*	$887,243
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/18/2019 | Report Number 19-09081-226*	--
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/24/2019 | Report Number 19-07875-233*	--
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/26/2019 | Report Number 19-09085-235*	$1,542,971
Total	**$300,937,079**

POSTAWARD REVIEWS	DOLLAR RECOVERIES
Review of Compliance with Public Law 102-585, Section 603, under Federal Supply Schedule Contracts *Issued 4/5/2019 | Report Number 18-01606-104*	$196,415
Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 4/12/2019 | Report Number 18-06097-111*	$248
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 4/12/2019 | Report Number 18-06095-109*	$14,728
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 4/12/2019 | Report Number 18-06098-106*	$362,993
Review of a Federal Supply Schedule Contract *Issued 4/16/2019 | Report Number 19-07320-113*	$14,302

POSTAWARD REVIEWS (CONTINUED)	DOLLAR RECOVERIES
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 4/29/2019 | Report Number 17-02029-120*	$2,315,941
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 5/1/2019 | Report Number 17-01458-123*	$9,384,463
Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 5/14/2019 | Report Number 19-00620-126*	$100,559
Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 5/16/2019 | Report Number 10-03286-132*	$690,528
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 5/30/2019 | Report Number 18-04479-139*	$572,527
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 6/14/2019 | Report Number 19-05844-148*	$105,732
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 6/25/2019 | Report Number 19-05833-147*	$12,724
Settlement Agreement *Issued 6/25/2019 | Report Number 19-06005-156*	$429,701
Review of Voluntary Disclosures and Refund Offers under a Federal Supply Schedule Contract *Issued 6/26/2019 | Report Number 19-06210-160*	$1,324,558
Review of a Voluntary Disclosure under a Federal Supply Schedule Contract *Issued 6/27/2019 | Report Number 19-07028-159*	$112,647
Settlement Agreement *Issued 7/18/2019 | Report Number 19-08849-173*	$6,100,000
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 7/25/2019 | Report Number 14-00004-180*	$157,113
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 8/7/2019 | Report Number 19-08568-190*	$7,971

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)	DOLLAR RECOVERIES
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 8/20/2019 | Report Number 19-05878-202*	$919,661
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 9/4/2019 | Report Number 16-00059-121*	$557,250
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 9/10/2019 | Report Number 19-00621-220*	$1,115
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 9/12/2019 | Report Number 19-06644-219*	--
Review of Contracts *Issued 9/19/2019 | Report Number 19-09430-231*	--
Total	**$23,381,176**

CLAIM REVIEWS	SAVINGS AND COST AVOIDANCE
Review of a Proposal Submitted under a VA Contract *Issued 5/15/2019 | Report Number 19-00385-129*	$838,008
Review of a Certified Claim under a VA Contract *Issued 6/25/2019 | Report Number 19-06924-152*	$73,073
Review of a Proposal Submitted under a VA Contract *Issued 8/26/2019 | Report Number 19-08238-209*	$1,527,378
Review of a Proposal Submitted under a VA Contract *Issued 9/18/2019 | Report Number 19-08242-229*	$278,217
Total	**$2,716,676**

ROLL-UP REVIEW	SAVINGS AND COST AVOIDANCE
A Synopsis of OIG Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2018 *Issued 9/19/2019 | Report Number 19-07113-223*	--
Total	--

TABLE A.3. PUBLICATIONS ISSUED BY THE OFFICE OF HEALTHCARE INSPECTIONS

NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities	6/27/2019	18-00037-154
Follow-Up Review of the Veterans Crisis Line, Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas	7/31/2019	18-03390-178
National Review of Hospice and Palliative Care at the Veterans Health Administration	9/5/2019	17-05251-194
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019	9/30/2019	19-00346-241

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Quality and Coordination of a Patient's Care at the VA Eastern Colorado Health Care System, Denver, Colorado	4/11/2019	18-01455-108
Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts	4/11/2019	17-05504-107
Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California	5/6/2019	17-02186-114
Orthopedic Surgery Department and Other Concerns at the Carl T. Hayden VAMC, Phoenix, Arizona	5/7/2019	18-02493-122
Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona	5/7/2019	17-02629-119
Alleged Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi	6/11/2019	17-03399-140
Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership, VA Loma Linda Healthcare System, California	6/18/2019	18-02405-146
Alleged Deficiencies in Out of Operating Room Airway Management Processes at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas	6/20/2019	18-02765-144
Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility	6/26/2019	19-00022-153
Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility	7/2/2019	18-03576-158
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia	7/11/2019	19-00497-161

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Alleged Interference and Failure to Comply with the Pain Management Directive and the Opioid Safety Initiative at the VA Northern Indiana Health Care System, Fort Wayne, Indiana	7/16/2019	17-05835-165
Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida	7/18/2019	18-04132-163
Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico	7/23/2019	17-05572-170
Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland	7/29/2019	18-05731-176
Factors Contributing to the Death of a Ventilator-Dependent Patient at the VA San Diego Healthcare System, California	7/30/2019	19-06386-179
Episodes of Non-Adherence to Privacy and Security Policies at the Tibor Rubin VA Medical Center, Long Beach, California	7/31/2019	17-03557-177
Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi	8/6/2019	18-00808-186
Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California	8/7/2019	19-00501-175
Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Edward Hines, Jr. VA Hospital, Hines, Illinois	8/8/2019	19-00004-187
Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida	8/22/2019	19-07429-195
Pathology Processing Delays at the Memphis VA Medical Center, Tennessee	8/27/2019	18-02988-198
Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi	8/28/2019	17-03399-200
Quality of Care and Patient Safety Concerns on the Acute Behavioral Health Unit at the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania	9/19/2019	18-00777-224
Alleged Care Delays and Inadequate Instrument Precleaning at the New Mexico VA Health Care System, Albuquerque	9/23/2019	18-03526-230

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility	9/24/2019	19-06429-227
Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico	9/26/2019	18-01879-232
Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions at the Louis Stokes Cleveland VA Medical Center, Ohio	9/27/2019	19-07818-242
Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina	9/30/2019	18-05316-234

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan	5/28/2019	18-04669-125
Edward Hines, Jr. VA Hospital, Hines, Illinois	6/18/2019	18-04676-142
Jesse Brown VA Medical Center, Chicago, Illinois	6/18/2019	18-04673-138
James H. Quillen VA Medical Center, Mountain Home, Tennessee	7/2/2019	18-06508-155
Amarillo VA Health Care System, Texas	7/24/2019	19-00007-168
Cheyenne VA Medical Center, Wyoming	7/24/2019	18-04680-162
Central California VA Health Care System, Fresno, California	8/22/2019	19-00006-191
Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma	9/24/2019	18-06510-222
Sheridan VA Medical Center, Wyoming	9/26/2019	18-04681-228
Tuscaloosa VA Medical Center, Alabama	9/27/2019	19-00057-238
North Florida/South Georgia Veterans Health System, Gainesville, Florida	9/27/2019	19-00010-237
Hunter Holmes McGuire VA Medical Center, Richmond, Virginia	9/27/2019	18-04679-239

TABLE A.4. PUBLICATION ISSUED BY THE OFFICE OF INVESTIGATIONS

INVESTIGATIVE REPORT	ISSUE DATE	REPORT NUMBER
Alleged Improper Release of Procurement Information	5/1/2019	18-02487-95

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.5. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$1,013,547,218
Better Use of Funds	$161,900,000
Savings and Cost Avoidance	$303,653,755
Dollar Recoveries	$23,381,176
Total	**$1,502,482,149**

TABLE A.6. RESOLUTION STATUS OF PUBLICATIONS WITH QUESTIONED COSTS

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no VA management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	12	$1,013,547,218
Total inventory this reporting period	**12**	**$1,013,547,218**
REPORTS WITH VA MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by VA management)	11	$1,012,575,218
Reports with allowed costs (not agreed to by VA management)	1	$972,000
Total management decisions this period	**12**	**$1,013,547,218**
Total carried over to next reporting period	**0**	**$0**

TABLE A.7. RESOLUTION STATUS OF PUBLICATIONS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no VA management decision made by the commencement of the reporting period	0	$0
Reports with recommended funds to be put to better use issued during the reporting period	2	$161,900,000
Total inventory this reporting period	**2**	**$161,900,000**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by VA management)	1	$152,300,000
Reports with allowed costs (not agreed to by VA management)	1	$9,600,000
Total VA management decisions this period	**2**	**$161,900,000**
Total carried over to next reporting period	**0**	**$0**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

The follow-up reporting and tracking of federal inspector general recommendations is required by the Federal Acquisition Streamlining Act of 1994 (P.L. 103-355), as amended by the National Defense Authorization Act of 1996 (P.L. 104-106). The acts require agencies to complete final action on each management decision required with regard to a recommendation in any federal OIG report within 12 months of the report's issuance/publication. If the agency fails to complete final action within the 12-month period, federal inspectors general are required by §5(a)(3) of the IG Act to identify the matter in each Semiannual Report to Congress until final action on the management decision is completed. The tables that follow identify all unimplemented VA OIG reports and recommendations. All data in the tables are current as of September 30, 2019. Real-time information on the status of VA OIG recommendations is available through the OIG's Report Recommendation Dashboard.

FOR MORE INFORMATION

View the OIG's Report Recommendation Dashboard at www.va.gov/oig **to track VA's progress in implementing OIG recommendations.**

TABLE B.1. NUMBER OF UNIMPLEMENTED REPORTS BY VA OFFICE

Table B.1 identifies the number of VA OIG reports with at least one unimplemented recommendation, with results sorted by action office. As of September 30, 2019, there are 143 total open reports, with 49 open more than a year and 94 open less than a year. However, Table B.1 shows a total of 152 open reports, with 53 open more than a year and 99 open less than a year. This is because 9 reports are counted twice in the table, as they have open recommendations at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	38	78	116
Veterans Benefits Administration	8	10	18
Office of Acquisition, Logistics, and Construction	1	2	3
Office of General Counsel	1	0	1
Office of Human Resources and Administration	1	2	3
Office of Information and Technology	1	5	6
Office of Management	2	1	3
Office of Operations, Security, and Preparedness	1	1	2
Totals	**53**	**99**	**152**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

TABLE B.2. NUMBER OF UNIMPLEMENTED RECOMMENDATIONS BY VA OFFICE

Table B.2 identifies the number of open VA OIG recommendations with results sorted by action office. As of September 30, 2019, there are 769 total open recommendations, with 126 open more than a year and 643 open less than a year. However, Table B.2 shows a total of 778 open recommendations, with 131 open more than a year and 647 open less than a year. This is because 9 recommendations are counted twice in the table as they have actions pending at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	80	546	626
Veterans Benefits Administration	16	31	47
Office of Acquisition, Logistics, and Construction	3	13	16
Office of General Counsel	1	0	1
Office of Human Resources and Administration	2	17	19
Office of Information and Technology	1	34	35
Office of Management	22	2	24
Office of Operations, Security, and Preparedness	6	4	10
Totals	**131**	**647**	**778**

TABLE B.3. UNIMPLEMENTED REPORTS AND RECOMMENDATIONS LESS THAN ONE YEAR OLD

Table B.3 identifies the 94 reports and 643 recommendations that, as of September 30, 2019, have been open less than one year. The total monetary benefit attached to these recommendations is $3,509,565,977.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina *Issued 10/16/2018 |* *Report Number 18-01140-312*	VHA	2	--
Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts *Issued 10/23/2018 |* *Report Number 17-05570-06*	VHA	3, 4	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia *Issued 10/24/2018 |* *Report Number 18-01136-313*	VHA	2	--
Alleged Concerns in Sterile Processing Services at the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 10/31/2018 |* *Report Number 17-04593-10*	VHA	1–4, 11, 12	--
Emergency Cache Program: Ineffective Management Impairs Mission Readiness *Issued 10/31/2018 |* *Report Number 18-01496-301*	VHA	1, 2, 4, 5, 7	$34,263,584
Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis *Issued 11/20/2018 |* *Report Number 18-00031-05*	VBA	1, 2	$13,800,000
Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine *Issued 11/28/2018 |* *Report Number 18-01152-14*	VHA	3, 4	--
Comprehensive Healthcare Inspection Program Review of the Central Texas Veterans Health Care System, Temple, Texas *Issued 11/29/2018 |* *Report Number 18-01137-15*	VHA	1–4, 11, 13–16	--
VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students *Issued 12/3/2018 |* *Report Number 16-00862-179*	VBA	1, 2, 4–6	$2,300,000,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Program Review of the VA Southern Nevada Healthcare System, North Las Vegas, Nevada *Issued 12/4/2018 |* *Report Number 18-01145-26*	VHA	4, 8	--
Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida *Issued 12/10/2018 |* *Report Number 17-02163-23*	VHA	2, 3	--
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 |* *Report Number 17-01007-01*	VHA OSP	1–5	--
Comprehensive Healthcare Inspection Program Review of the VA Pittsburgh Healthcare System, Pennsylvania *Issued 12/17/2018 |* *Report Number 18-01154-27*	VHA	4	--
Comprehensive Healthcare Inspection Program Review of the West Palm Beach VA Medical Center, Florida *Issued 12/18/2018 |* *Report Number 18-01159-38*	VHA	4, 5	--
Alleged Delay in Care and Care Coordination at Cheyenne VA Medical Center, Wyoming, and Iowa City VA Health Care System, Iowa *Issued 12/19/2018 |* *Report Number 18-00693-41*	VHA	3	--
Comprehensive Healthcare Inspection Program Review of the Durham VA Medical Center, North Carolina *Issued 12/19/2018 |* *Report Number 18-01146-35*	VHA	1	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Program Review of the Robley Rex VA Medical Center, Louisville, Kentucky *Issued 12/19/2018 |* *Report Number 18-01163-36*	VHA	4–7, 9	--
Comprehensive Healthcare Inspection Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin *Issued 12/20/2018 |* *Report Number 18-01147-47*	VHA	1	--
Comprehensive Healthcare Inspection Program Review of the San Francisco VA Health Care System, California *Issued 12/20/2018 |* *Report Number 18-01153-43*	VHA	3, 4, 5	--
Comprehensive Healthcare Inspection Program Review of the VA New Jersey Health Care System, East Orange, New Jersey *Issued 12/27/2018 |* *Report Number 18-01164-42*	VHA	1–4, 6	--
Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System, Danville, Illinois *Issued 1/16/2019 |* *Report Number 18-02056-54*	VHA	6	--
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 |* *Report Number 17-03499-20*	OHRA	1–12	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center *Issued 1/28/2019* | *Report Number 17-01757-50*	VHA	1, 3, 5–9, 11, 12, 15, 16	--
Medication Management, Dispensing, and Administration Deficiencies at the VA Maryland Health Care System, Perry Point, Maryland *Issued 2/6/2019* | *Report Number 17-05742-66*	VHA	1, 2, 6, 7	--
Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas (VA Eastern Kansas Health Care System) *Issued 3/7/2019* | *Report Number 18-00980-84*	VHA	3	--
Federal Information Security Modernization Act Audit for Fiscal Year 2018 *Issued 3/12/2019* | *Report Number 18-02127-64*	OIT	1–28	--
Review of Hepatitis C Virus Care within the Veterans Health Administration *Issued 3/20/2019* | *Report Number 17-05297-85*	VHA	1, 2	--
Quality and Coordination of a Patient's Care at the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 4/11/2019* | *Report Number 18-01455-108*	VHA	1, 2, 4, 5	--
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package *Issued 5/1/2019* | *Report Number 17-05246-98*	VHA	1–6	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California *Issued 5/6/2019* | *Report Number 17-02186-114*	VHA	1–10	--
Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona *Issued 5/7/2019* | *Report Number 17-02629-119*	VHA	1, 4, 6	--
Orthopedic Surgery Department and Other Concerns at the Carl T. Hayden VAMC, Phoenix, Arizona *Issued 5/7/2019* | *Report Number 18-02493-122*	VHA	1–12	--
Deferrals in the Veterans Benefits Management System *Issued 5/15/20198* | *Report Number 18-00215-83*	VBA	3, 4	--
Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan *Issued 5/28/2019* | *Report Number 18-04669-125*	VHA	1, 2, 4–7, 9	--
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018 *Issued 6/3/2019* | *Report Number 18-05864-127*	VHA	1	--
Exempt Veterans Charged VA Home Loan Funding Fees *Issued 6/6/2019* | *Report Number 18-03250-130*	VBA	1–5	$352,600,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Inadequate Oversight of Contracted Disability Exam Cancellations *Issued 6/10/2019 |* *Report Number 18-04266-115*	VBA	1, 2	--
Alleged Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 6/11/2019 |* *Report Number 17-03399-140*	VHA	1–7	--
VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract *Issued 6/13/2019 |* *Report Number 17-04178-46*	OALC	1–7	$37,500,000
Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership, VA Loma Linda Healthcare System, California *Issued 6/18/2019 |* *Report Number 18-02405-146*	VHA	1–14	--
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, Illinois *Issued 6/18/2019 |* *Report Number 18-04673-138*	VHA	1–11	--
Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital, Hines, Illinois *Issued 6/18/2019 |* *Report Number 18-04676-142*	VHA	1–10	--
Alleged Unapproved Acquisition of a Robotic Surgical System for the Salisbury Veterans Affairs Medical Center, North Carolina *Issued 6/19/2019 |* *Report Number 18-03260-102*	VHA	1–3	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Alleged Deficiencies in Out of Operating Room Airway Management Processes at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas *Issued 6/20/2019 |* *Report Number 18-02765-144*	VHA	1–7	--
Staffing and Vacancy Reporting under the MISSION Act of 2018 *Issued 6/25/2019 |* *Report Number 19-00266-141*	OHRA	1–5	--
Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility *Issued 6/26/2018 |* *Report Number 19-00022-153*	VHA	1–11	--
Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities *Issued 6/27/2019 |* *Report Number 18-00037-154*	VHA	1, 3–7, 9	--
Management of Major Medical Leases Needs Improvement *Issued 7/2/2019 |* *Report Number 17-05859-131*	OALC OM	1–8	$152,300,000
Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility *Issued 7/2/2019 |* *Report Number 18-03576-158*	VHA	1–10	--
Comprehensive Healthcare Inspection of the James H. Quillen VA Medical Center, Mountain Home, Tennessee *Issued 7/2/2019 |* *Report Number 18-06508-155*	VHA	1–5	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 7/11/2019 |* *Report Number 19-00497-161*	VHA	1–27	--
Alleged Interference and Failure to Comply with the Pain Management Directive and the Opioid Safety Initiative at the VA Northern Indiana Health Care System, Fort Wayne, Indiana *Issued 7/16/2019 |* *Report Number 17-05835-165*	VHA	1–6, 8–12	--
Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida *Issued 7/18/2019 |* *Report Number 18-04132-163*	VHA	1–3	--
Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 7/23/2019 |* *Report Number 17-05572-170*	VHA	3–12	--
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming *Issued 7/24/2019 |* *Report Number 18-04680-162*	VHA	1–8, 11–17	--
Comprehensive Healthcare Inspection of the Amarillo VA Health Care System, Texas *Issued 7/24/2019 |* *Report Number 19-00007-168*	VHA	1–19	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement *Issued 7/25/2019 |* *Report Number 18-04924-112*	VHA	1–3	$938,801
Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland *Issued 7/25/2019 |* *Report Number 18-05731-176*	VHA	1–6	--
Factors Contributing to the Death of a Ventilator-Dependent Patient at the VA San Diego Healthcare System, California *Issued 7/30/2019 |* *Report Number 19-06386-179*	VHA	1–5	--
Episodes of Non-Adherence to Privacy and Security Policies at the Tibor Rubin VA Medical Center, Long Beach, California *Issued 7/31/2019 |* *Report Number 17-03557-177*	VHA OIT	1–6	--
Follow-Up Review of the Veterans Crisis Line, Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas *Issued 7/31/2019 |* *Report Number 18-03390-178*	VHA	1	--
Non VA Emergency Care Claims Inappropriately Denied and Rejected *Issued 8/6/2019 |* *Report Number 18-00469-150*	VHA	1–11	$533,000,000
Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 8/6/2019 |* *Report Number 18-00808-186*	VHA	1–9	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California *Issued 8/7/2019 |* *Report Number 19-00501-175*	VHA	1, 2	--
Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Edward Hines, Jr. VA Hospital, Hines, Illinois *Issued 8/8/2019 |* *Report Number 19-00004-187*	VHA	1, 2	--
VA's Implementation of the Veterans Information Systems and Technology Architecture Scheduling Enhancement Project Near Completion *Issued 8/20/2019 |* *Report Number 16-03597-171*	OIT	1	--
Health Information Management Medical Documentation Backlog *Issued 8/21/2019 |* *Report Number 18-01214-157*	VHA	1–9	--
Comprehensive Healthcare Inspection of the Central California VA Health Care System Fresno, California *Issued 8/22/2019 |* *Report Number 19-00006-191*	VHA	1–11	--
Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center *Issued 8/22/2019 |* *Report Number 19-07429-195*	VHA	1–11	--
Pathology Processing Delays at the Memphis VA Medical Center, Tennessee *Issued 8/27/2019 |* *Report Number 18-02988-198*	VHA	1–8	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi *Issued 8/28/2019* | *Report Number 17-03399-200*	VHA	1–19	--
National Review of Hospice and Palliative Care at the Veterans Health Administration *Issued 9/5/2019* | *Report Number 17-05251-194*	VHA	1	--
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/5/2019* | *Report Number 18-05663-189*	VBA	1–5	$64,800,000
Problems Were Identified on One Regional Procurement Office Central Ambulance Service Contract *Issued 9/12/2019* | *Report Number 18-01836-183*	VHA	2	--
Security and Access Controls for the Beneficiary Fiduciary Field System Need Improvement *Issued 9/12/2019* | *Report Number 18-05258-193*	VBA OIT	1–4	--
Sole-Source Service Contracting at Regional Procurement Office East Needs Improvement *Issued 9/17/2019* | *Report Number 18-01836-184*	VHA	2–4	$14,245,166
Sole-Source Service Contracting at Regional Procurement Office West Need Improvement *Issued 9/17/2019* | *Report Number 18-01836-185*	VHA	2	$6,034,026

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Quality of Care and Patient Safety Concerns on the Acute Behavioral Health Unit at the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania *Issued 9/19/2019 |* *Report Number 18-00777-224*	VHA	1–9	--
Boston, Massachusetts, VARO Supervisor Incorrectly Processed Work Items *Issued 9/19/2019 |* *Report Number 19-07350-192*	VBA	1, 3	$84,400
State Prescription Drug Monitoring Programs Need Increased Use and Oversight *Issued 9/23/2019 |* *Report Number 18-02830-164*	VHA OIT	1–8	--
Alleged Care Delays and Inadequate Instrument Precleaning at the New Mexico VA Health Care System, Albuquerque *Issued 9/23/2019 |* *Report Number 18-03526-230*	VHA	1–13	--
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 9/24/2019 |* *Report Number 18-06510-222*	VHA	1–11	--
Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility *Issued 9/24/2019 |* *Report Number 19-06429-227*	VHA	1–5	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico *Issued 9/26/2019* | *Report Number 18-01879-232*	VHA	1–7	--
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming *Issued 9/26/2019* | *Report Number 18-04681-228*	VHA	1–22	--
Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia *Issued 9/26/2019* | *Report Number 19-00260-215*	VHA	1–12	--
Workload Management Challenges Identified at the Salt Lake City, Utah, Fiduciary Hub *Issued 9/25/2019* | *Report Number 19-06565-217*	VBA	2	--
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia *Issued 9/27/2019* | *Report Number 18-04679-239*	VHA	2–19, 21	--
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida *Issued 9/27/2019* | *Report Number 19-00010-237*	VHA	1–28	--
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Alabama *Issued 9/27/2019* | *Report Number 19-00057-238*	VHA	1–14	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions at the Louis Stokes Cleveland VA Medical Center, Ohio *Issued 9/27/2019 |* *Report Number 19-07818-242*	VHA	1	--
Oversight and Resolution of Home Loan Defaults *Issued 9/30/2019 |* *Report Number 18-03979-204*	VBA	1–4	--
Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina *Issued 9/30/2019 |* *Report Number 18-05316-234*	VHA	1–4	--
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019 *Issued 9/30/2019 |* *Report Number 19-00346-241*	VHA	1, 2	--
Total			**$3,509,565,977**

TABLE B.4. UNIMPLEMENTED REPORTS AND RECOMMENDATIONS MORE THAN ONE YEAR OLD

Table B.4 identifies the 49 reports and 126 recommendations that, as of September 30, 2019, remain open for more than one year. The total monetary benefit attached to these reports is $567,900,000.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VA Regional Offices' Appeals Management Processes *Issued 5/30/2012 | Report Number 10-03166-75*	VBA	--
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 9/28/2012 | Report Number 12-00375-290*	OM OGC	--
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.		
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 7/11/2014 | 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.		
Audit of the Seismic Safety of VA's Facilities *Issued 11/12/2015 | Report Number 14-04756-32*	VHA	--
Recommendation 9: We recommended the Under Secretary for Health develop policies and procedures requiring Veterans Health Administration medical facilities to develop and test Continuity of Operations Plans, to include documenting the testing performed, in accordance with Federal Continuity Directive 1 requirements.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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	$77,500,000
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. 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.		
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	--
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.		
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	--
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.		
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	--
Recommendation 3: We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care *Issued 8/1/2017 | Report Number 17-01846-316*	VHA	--
Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with Opioid Safety Initiative guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.		
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	--
Recommendation 2: We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.		
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	--
Recommendation 1: We recommended the Acting Under Secretary for Health develop standardized national policy and procedures for the health care enrollment program at VA medical facilities. Recommendation 4: We recommended the Acting Under Secretary for Health develop and execute a process to distinguish new applications for health care enrollment in VistA from other registration data. Recommendation 5: We recommended the Acting Under Secretary for Health implement a plan to correct current data integrity issues in VistA to improve the accuracy and timeliness of enrollment data.		
OIG Determination of VHA Occupational Staffing Shortages, Fiscal Year 2017 *Issued 9/27/2017 | Report Number 17-00936-385*	VHA	--
Recommendation 1: We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations. Recommendation 3: We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model. Recommendation 4: We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 9/29/2017 | Report Number 16-00546-388*	VHA	--
Recommendation 16: 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, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in transfer documentation and that facility managers monitor compliance.		
Recommendation 25: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		
Audit of VA's Compliance With the DATA Act *Issued 11/8/2017 | Report Number 17-02811-21*	OM	--
Recommendation 1: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue progress with system modernization efforts. Ensure that current and upcoming DATA Act requirements are incorporated so that the detail level requirements for meeting the DATA Act will be made possible as automatic bulk file transmissions going forward.		
Recommendation 2: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer establish milestones to monitor VA's system modernization efforts. Coordination with the shared service provider should continue to incorporate current and upcoming DATA Act requirements to ensure that they will be met going forward.		
Recommendation 3: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer obtain procurement management system and if feasible, grants management system capabilities that are integrated with the financial system as part of VA's transition to a shared service provider.		
Recommendation 4: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer to the extent possible, reduce the amount of journal vouchers to those related to accrual adjustments or one time, unusual transactions. Journal vouchers recorded should contain data elements required for File B such as the program activity. In addition, if possible, automate efforts to combine FMS journal output files with the MinX-based Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) trial balance and resolve variances between the two systems.		
Recommendation 5: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer reduce the extensive use of 1358 obligations, and develop an automated procurement action capturing and reporting mechanism to timely capture all procurement activities greater than $3,500 for the File D1 submission.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS

Recommendation 6: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer prepare the SBR and ensure reconciliation of File A, SF-133s and the SBR prior to File A submission.

Recommendation 7: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue efforts to reduce the number of journal vouchers to those related to accrual adjustments or one time, unusual transactions. Journal vouchers recorded should contain data elements required for File B such as the program activity code and budget object class. In addition, if feasible, automate efforts to combine FMS journal output files with the MinX-based GTAS trial balance and identify and resolve variances between the two systems.

Recommendation 8: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer where feasible, perform validation of MinX journal vouchers as they may contain errors and reside in the ultimate File B submission.

Recommendation 9: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer research and resolve warnings identified by the broker before DATA Act files submission.

Recommendation 10: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure that knowledge of DATA Act processes is not limited to one or a few people, and develop a succession plan to ensure the required expertise and capabilities will continue to remain available before personnel with highly technical and specialized knowledge leave or retire from the agency.

Recommendation 11: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure complete reconciliations between the subsidiary and general ledger systems are performed. Differences should be researched and resolved to improve data accuracy, completeness and quality.

Recommendation 12: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer for all TASes, ensure that amounts can be distinguished between general ledger accounts 4901 and 4902.

Recommendation 13: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure a timely reconciliation process between File A and File B; File B to File C (when applicable); and File B to Files D1 and D2 such that procedures are completed prior to certifying each quarter's submission through the broker. Research and resolve variances identified through reconciliation processes.

Recommendation 14: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer maintain documentation to support the various cost allocation methodologies used for aggregating VHA transactions included in File D2. Ensure File D2 VHA aggregated data includes only the required costs for DATA Act submission. Seek formal confirmation from OMB and Treasury that the direct services VHA is reporting should be included in File D2 as financial assistance awards and the employee payroll and File D1 duplicate contract cost data VHA is reporting should or should not be included in File D2 as financial assistance awards.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 15: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer provide targeted training to address specific issues identified to DATA Act points of contact on USASpending.gov requirements.		
Recommendation 16: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer implement PMO oversight of the reports submitted by VBA and VHA's ARC to ensure completeness, timeliness, quality, and accuracy of the information reported.		
Recommendation 17: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer implement internal controls related to the proper tracking and accounting for intragovernmental transfers as to their trading partner, type, and nature. Produce reliable subsidiary reports with transfer level details to facilitate management's reconciliation and reporting with the trading partner. Any differences between File A and B should be researched and corrected prior to file submission.		
Recommendation 18: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer research and identify the root cause of those transactions with default program activity names and implement corrective actions to address those issues. In addition, implement FMS and MinX JV edit checks to ensure all JVs contain the proper program activity name, program activity code and object class code or the JV will not be accepted by the system. The JV reviewer should ensure all those elements are properly recorded and are consistent with OMB A-11 and the President's Budget to improve the accuracy of the data.		
Recommendation 19: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer assess the impact of the internal control weaknesses reported and develop corrective actions to address data quality issues at the individual or aggregate transaction level.		
Recommendation 20: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure the complete reporting of all required data elements. Establish and develop a process to validate data quality for all DATA Act files on a regular basis prior to file submission.		
Recommendation 21: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue to maintain communication with OMB and Treasury regarding VA's data reporting limitations and progress, and document such communication.		
Audit of VHA's Management of Primary Care Panels *Issued 12/6/2017 | Report Number 15-03364-380*	VHA	--
Recommendation 1: The OIG recommended the Acting Under Secretary for Health establish standardized primary care scheduling processes that provide newly enrolled veterans an opportunity to schedule an appointment at the time of enrollment.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through FBCS *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	$39,000,000
Recommendation 1: We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators, as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.		
Recommendation 2: We recommended the Executive in Charge, Veterans Health Administration, ensure payment processing staff have access to documentation from the Third Party Administrators verifying amounts paid to providers to ensure the Third Party Administrators are not billing VA more than they paid the provider for medical claims.		
Recommendation 3: We recommended the Executive in Charge, Veterans Health Administration, ensure Veterans Health Administration payment staff have access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.		
Recommendation 4: We recommended the Executive in Charge, Veterans Health Administration, ensure the new payment processing systems used for processing medical claims from Third Party Administrators have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.		
Recommendation 5: We recommended the Executive in Charge, Veterans Health Administration, ensure VA performs post-payment audits on a periodic basis to determine if payments made to Third Party Administrators for medical care are accurate.		
Recommendation 6: We recommended the Executive in Charge, Veterans Health Administration, ensure that Office of Community Care staff and members of VA's Office of General Counsel continue to work collaboratively with relevant government authorities to review and determine an appropriate process for reimbursement.		
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	--
Recommendation 6: We recommended that the Facility Director ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.		
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	--
Recommendation 1: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure Facility Directors establish Employee Threat Assessment Teams.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require attendance by VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance.		
Recommendation 4: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.		
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	--
Recommendation 13: The Chief of Staff ensures providers include a review of abnormalities of major organ systems; an airway assessment; and a review of alcohol, tobacco, or substance use or abuse in the history and physical exams and/or pre-sedation assessments and monitors providers' compliance.		
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*	VHA	--
Recommendation 1: The Medical Center Director ensures that necessary supplies, instruments, and equipment are available in patient care areas at the Medical Center when and where they are needed.		
Recommendation 7: The Medical Center Director confirms the full utilization of a VHA-authorized inventory system that contains accurate and reliable information regarding the availability of supplies throughout the Medical Center.		
Recommendation 15: The Medical Center Director verifies that all SPS employees have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties.		
Recommendation 20: The VISN 5 Director ensures the timely completion of hiring actions at the Medical Center until staffing deficiencies in Logistics Service and Sterile Processing Services are fully resolved.		
Recommendation 25: The VISN 5 Director ensures that the Medical Center updates and maintains the Equipment Inventory List (EIL) as required by VA policy and makes certain that the Medical Center Director and Chief Logistics Officer are held accountable for the timely and accurate reporting of the Medical Center EIL.		
Recommendation 31: The Medical Center Director verifies that accurate and complete financial documentation to support medical supply and equipment purchases is readily available in accordance with GAO Standards for Internal Control in the Federal Government.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 33: The Deputy Under Secretary for Health for Operations and Management ensures that the VHA Procurement and Logistics Office conducts regular audits of the logistics services within VHA medical centers to assess compliance with VA and VHA policies pertaining to procurement and logistics, and makes certain that timely and effective remediation occurs in response to all noncompliant conditions identified as a result of those audits.		
Recommendation 39: The VISN 5 Director oversees implementation of recommendations directed to the Medical Center Director.		
Recommendation 40: The Under Secretary for Health verifies the successful implementation of all recommendations contained within this report.		
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*	VHA	--
Recommendation 7: The OIG recommended the Veterans Health Administration Executive in Charge implement controls to ensure Choice medical documentation is received timely in accordance with Choice contracts.		
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	VHA OSP	--
Recommendation 2: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.		
Recommendation 4: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage the background investigation workload.		
Recommendation 5: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Office of the Under Secretary for Health, to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.		
Recommendation 6: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, improve management oversight of the personnel suitability program at VA medical facilities and ensure background investigations are properly initiated and adjudicated nationwide, and internal control mechanisms required by policy are properly implemented.		
Recommendation 8: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.		
Recommendation 9: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 10: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.		
Recommendation 11: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.		
Comprehensive Healthcare Inspection Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee *Issued 3/27/2018 | Report Number 17-01764-143*	VHA	--
Recommendation 4: The Facility Director ensures inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee and monitors compliance.		
Recommendation 5: The Chief of Staff ensures providers consistently document patient or surrogate informed consent and the patient's medical and behavior stability when patients are transferred out of the facility and monitors the providers' compliance.		
Recommendation 6: The Chief of Staff ensures providers countersign the acceptable designees' transfer/progress notes when patients are transferred out of the facility and monitors compliance.		
Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 3/28/2018 | Report Number 17-01856-135*	VHA	--
Recommendation 10: The Chief of Staff ensures that acceptable providers complete diagnostic evaluations for patients with positive post-traumatic stress disorder screens within 30 days of the referral and monitors providers' compliance.		
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	--
Recommendation 3: The Chief of Staff ensures that Ongoing Professional Practice Evaluations include the utilization of service-specific criteria and monitors compliance.		
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	--
Recommendation 6: The Associate Director ensures required team members consistently participate on environment of care rounds and monitors team members' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Healthcare Inspection – Testosterone Replacement Therapy Initiation and Follow-Up Evaluation in VA Male Patients Center, Albany, New York *Issued 4/11/2018 | Report Number 15-03215-154*	VHA	--
Recommendation 1: The Under Secretary for Health ensures that providers establish clinical signs and symptoms consistent with androgen deficiency, prior to testing patients' testosterone level for confirmation in alignment with Veterans Health Administration guidance.		
Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact *Issued 5/2/2018 | Report Number 16-04555-138*	VBA	$9,600,000
Recommendation 3: The OIG recommended the Executive in Charge for Benefits coordinate with the Office of Information Technology, the Office of Management, and the Office of General Counsel to make accounting adjustments to debit the information technology account that should have been used and credit the general operating expense account that was inappropriately used, determine whether Antideficiency Act violations occurred, and report the violations as appropriate.		
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	$34,500,000
Recommendation 5: The OIG recommended the Under Secretary for Health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).		
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017 *Issued 5/15/2018 | Report Number 17-05460-169*	VHA VBA	--
Recommendation 1: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, develops a timeline to reduce improper payments under the 10 percent threshold for the Beneficiary Travel; Communications, Utilities, and Other Rents; Medical Care Contracts and Agreements; Prosthetics; Purchased Long Term Services and Support; Supplies and Materials; and VA Community Care Programs and activities. This is a repeat finding and recommendation for the Purchased Long Term Services and Support and VA Community Care programs from our FY 2015 and 2016 reports. Recommendation 2: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, implements steps to achieve stated reduction targets for the Beneficiary Travel; Civilian Health and Medical Program of the Department of Veterans Affairs; Purchased Long Term Services and Support; Supplies and Materials; and VA Community Care Programs and activities. This is a repeat finding for all five programs from our FY 2016 report. Recommendation 3: The OIG recommended the Executive in Charge, Veterans Benefits Administration, implements steps to achieve reduction targets for the Pension and Post-9/11 GI Bill Programs.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 5: The OIG recommended the Executive in Charge, Veterans Benefits Administration, continue working with the Department of Defense to increase the frequency of drill pay adjustments from annually to monthly. This is a repeat recommendation from our FY 2016 report.		
Recommendation 6: The OIG recommended the Executive in Charge, Veterans Benefits Administration, continue to report statutory barriers preventing complete resolution of drill pay improper payments in future Agency Financial Reports until resolved.		
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY18 *Issued 6/14/2018 | Report Number 18-01693-196*	VHA	--
Recommendation 1: The Under Secretary for Health refines and formalizes VHA's position categorization of individuals (clinical and nonclinical) who are necessary to VHA's mission of delivering health care by looking at various dimensions of each occupation, including staff skill set and function, enabling identification of positions based on the specific role a person would fill.		
Recommendation 2: The Under Secretary for Health ensures the consistent implementation and use of the position categorization approach across all facilities.		
Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Memphis, Tennessee *Issued 6/19/2018 | Report Number 18-00609-185*	VHA	--
Recommendation 8: The Associate Director ensures the Facility managers maintain a safe and clean environment at the Covington North Community Based Outpatient Clinic and monitors compliance.		
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	$100,600,000
Recommendation 1: The Under Secretary for Benefits establishes internal controls sufficient to ensure that a reexamination is necessary prior to employees ordering it, and modifies VBA procedures as appropriate to reflect these improved business processes.		
Recommendation 4: The Under Secretary for Benefits conducts a special focused quality improvement review of cases with unwarranted reexaminations to develop data sufficient to understand and redress the causes of any avoidable errors.		
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*	VHA	--
Recommendation 3: The Principal Deputy Under Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Employee 3.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio *Issued 8/14/2018 | Report Number 18-00619-242*	VHA	--
Recommendation 9: The Chief of Staff ensures providers perform geriatric medical evaluations and monitors compliance.		
Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed *Issued 8/16/2018 | Report Number 17-04003-222*	VHA	--
Recommendation 4: The Executive in Charge, Veterans Health Administration, will establish assessment guidelines that caregiver support coordinators should follow when a veteran's need for care changes.		
Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma *Issued 8/21/2018 | Report Number 17-05248-241*	VBA	--
Recommendation 1: The Under Secretary for Benefits reviews all denied military sexual trauma related claims since the beginning of FY 2017, determines whether all required procedures were followed, takes corrective action based on the results of the review, renders a new decision as appropriate, and reports the results back to the Office of Inspector General.		
Recommendation 3: The Under Secretary for Benefits requires an additional level of review for all denied military sexual trauma related claims and holds the second level reviewers accountable for accuracy.		
Recommendation 4: The Under Secretary for Benefits conducts special focused quality improvement reviews of denied military sexual trauma related claims and takes corrective action as needed.		
Recommendation 5: The Under Secretary for Benefits updates the current training for processing military sexual trauma related claims, monitors the effectiveness of the training, and takes additional actions as necessary.		
Use of Not Otherwise Classified Codes for Prosthetic Limb Components *Issued 8/27/2018 | Report Number 16-01913-223*	VHA	$21,300,000
Recommendation 1: The Executive in Charge, Veterans Health Administration, should review the Prosthetic and Sensory Aids Service Ottobock microprocessor knee instructions (August 2011, March 2013, and August 2013), coordinate with appropriate officials to determine which Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System Level II L codes are appropriate to classify these items for reimbursement, and issue revised guidance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: The Executive in Charge, Veterans Health Administration, should develop and implement effective processes and procedures to monitor the use of Not Otherwise Classified codes and communicate these procedures to the Veterans Integrated Service Networks to ensure compliance with Veterans Health Administration Directive 1045, Healthcare Common Procedure Coding System (HCPCS) List for Prosthetic Limb and/or Custom Orthotic Device Prescription (December 30, 2013) and the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System Level II Coding Procedures. Recommendation 5: The Executive in Charge, Veterans Health Administration, should issue corrected guidance to replace the Prosthetic and Sensory Aids Service Ottobock microprocessor knee instructions (March 2013 and August 2013) and the prosthetic limb contract template issued in August 2014, by coordinating with appropriate officials to develop and implement pricing guidance to ensure VA pays a fair and reasonable price for items classified using a Not Otherwise Classified code.		
Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York *Issued 8/29/2018 | Report Number 17-01770-188*	VHA	--
Recommendation 5: The Facility Director ensures that a process is implemented to track, monitor, and report intraoperative radiofrequency ablation outcomes to Facility and Quality Management leaders.		
Accuracy of Effective Dates for Reduced Evaluations *Issued 8/29/2018 | Report Number 17-05244-226*	VBA	$37,900,000
Recommendation 2: The Under Secretary for Veterans Benefits Administration establish a plan to modify the Veterans Benefits Management System to apply correct effective dates for cases with reduced evaluations for conditions that were no longer service-connected and alert staff when the assigned effective dates are improper. Recommendation 4: The Under Secretary for Veterans Benefits Administration implement a plan to provide refresher training on the proper processing of reduced evaluations to staff who process rating reductions and monitor the effectiveness of that training. Recommendation 6: The Under Secretary for Veterans Benefits Administration implement a plan to conduct periodic reviews for veterans who had evaluations reduced after the first of the month following the final notification letter and before the first of the month following 60 days after the final notification letter, take corrective actions as needed, and provide certification of completion to the Office of Inspector General.		
Bulk Payments Made under Patient-Centered Community Care/ Veterans Choice Program Contracts *Issued 9/6/2018 | Report Number 17-02713-231*	VHA	$35,300,000
Recommendation 2: The Executive in Charge, Office of Under Secretary for Health, ensure that Office of Community Care staff and members of VA's Office of General Counsel continue to work collaboratively with relevant government authorities to review and determine an appropriate process for reimbursement of overpayments by the third-party administrators.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Accuracy of Reported Pending Disability Claims Backlog Statistics *Issued 9/10/2018 | Report Number 16-02103-265*	VBA	--
Recommendation 2: The OIG recommended the Under Secretary for Benefits implement a plan to provide consistent oversight and training of Claims Assistants through national performance and training plans.		
Comprehensive Healthcare Inspection Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 9/11/2018 | Report Number 18-00608-247*	VHA	--
Recommendation 5: The Chief of Staff ensures that clinical managers consistently review Ongoing Professional Practice Evaluation data every six months and monitors compliance.		
Recommendation 6: The Associate Director ensures required team member participate in environment of care rounds and monitors compliance.		
Recommendation 13: T The Chief of Staff ensures that providers complete suicide risk assessments within the required timeframe for patients with positive Posttraumatic Stress Disorder screens and monitors compliance.		
Review of Pain Management Services in Veterans Health Administration Facilities *Issued 9/17/2018 | Report Number 16-00538-282*	VHA	--
Recommendation 3: The Under Secretary for Health evaluates and determines the adequacy of the number of pain specialists at each facility through formalized assessments and takes action as appropriate.		
Recommendation 4: The Under Secretary for Health ensures that VA facilities without pain specialists have formalized designated resources of pain care provided by providers.		
Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 18-01018-281*	VHA	--
Recommendation 2: The Facility Director ensures implementation of root cause analysis actions and provides feedback of results to the reporting individuals or departments and monitors compliance.		
Recommendation 4: The Chief of Staff ensures that Service Chiefs complete and report Focused and Ongoing Professional Practice Evaluations to the Professional Standards Board for determination of provider privileges and monitors the Service Chiefs' compliance.		
Recommendation 5: The Associate Director ensures environment of care rounds are conducted in patient care areas of the Facility at the required frequency and monitors compliance.		
Recommendation 9: The Associate Director ensures the mental health seclusion room flooring provides cushioning.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Alleged Nonacceptance of VA Authorizations by Community Care Providers *Issued 9/20/2018 | Report Number 17-05228-279*	VHA	--
Recommendation 2: The Executive in Charge, Office of the Under Secretary for Health, ensure the Veterans Integrated Service Network 6 Claims Adjudication and Reimbursement office identify and dedicate the appropriate number of staff needed to timely process Non-VA Care medical claims.		
Recommendation 4: The Executive in Charge, Office of the Under Secretary for Health, implement controls to ensure VA staff timely resolve medical claim inquiries from community providers.		
Recommendation 5: The Executive in Charge, Office of the Under Secretary for Health, implement oversight procedures to ensure community care contractors effectively notify community providers when they reject their claims.		
Recommendation 6: The Executive in Charge, Office of the Under Secretary for Health, implement oversight procedures to ensure community care contractors effectively resolve medical claim inquiries from community providers.		
Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware *Issued 9/27/2018 | Report Number 17-03676-307*	VHA	--
Recommendation 7: The Wilmington VA Medical Center Director ensures that the Code Blue members utilize the Code Blue Flow Sheet and that Rapid Response and Code Blue events are documented and presented monthly to the Facility's Health Care Delivery Council.		
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*	VHA OALC	--
Recommendation 1: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System implement a plan that puts the West LA campus in compliance with the West Los Angeles Leasing Act of 2016, the Draft Master Plan, and other federal laws, including reasonable time periods to correct deficiencies noted in this report.		
Recommendation 2: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure all non-VA entities operating on the West LA campus with expired or undocumented land use agreements establish new agreements compliant with the West Los Angeles Leasing Act.		
Recommendation 3: The Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System create a process to allow the Veterans Community Oversight and Engagement Board an opportunity to provide input to the executive leadership on West LA campus land use.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The Principal Executive Director, Office of Acquisition, Logistics, and Construction create documented policies and procedures for out leases and Revocable Licenses to govern their use, management, and pricing to ensure fair value is received and negotiations are documented.		
Recommendation 5: The Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure VA's Capital Asset Inventory accurately reflects all land use agreements six months or longer on West LA campus.		
Total		**$567,900,000**

APPENDIX C: REPORTING REQUIREMENTS

TABLE C.1. REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
§ 4. Duties and responsibilities; report of criminal violations to Attorney General (a) It shall be the duty and responsibility of each Inspector General, with respect to the establishment within which his Office is established—	--
(2) to review existing and proposed legislation and regulations and make recommendations in the semiannual reports concerning the impact of such legislation or regulations on the economy and efficiency in the administration of programs and operations administered or financed by such establishment or the prevention and detection of fraud and abuse in such programs and operations;	Other Reporting Requirements
§ 5. Semiannual reports; transmittal to Congress; availability to public; immediate report on serious or flagrant problems; disclosure of information; definitions (a) Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to—	--
(1) a description of significant problems, abuses, and deficiencies relating to the administration of [VA] programs and operations disclosed during the reporting period;	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations Results from the Office of Management and Administration

REQUIREMENT	SAR SECTION(S)
(2) a description of the recommendations for corrective action made by the Office during the reporting period;	Results from the Office of Audits and Evaluations Results from the Office of Healthcare Inspections Results from the Office of Investigations
(3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed;	Appendix B
(4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted;	Results from the Office of Investigations
(5) a summary of each report made to the VA Secretary concerning instances when information or assistance requested was, in the judgment of the Inspector General, unreasonably refused or not provided;	Other Reporting Requirements
(6) a listing, subdivided according to subject matter, of each audit, inspection, and evaluation report issued during the reporting period and for each report, where applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use;	Appendix A
(7) a summary of each particularly significant report;	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(8) statistical tables showing the total number of audit, inspection, and evaluation reports and the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs), for reports— (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— (i) the dollar value of disallowed costs; and (ii) the dollar value of costs not disallowed; and (D) for which no management decision has been made by the end of the reporting period;	Appendix A
(9) statistical tables showing the total number of audit, inspection, and evaluation reports and the dollar value of recommendations that funds be put to better use by management, for reports— (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— (i) the dollar value of recommendations that were agreed to by management; and (ii) the dollar value of recommendations that were not agreed to by management; and (D) for which no management decision has been made by the end of the reporting period;	Appendix A

REQUIREMENT	SAR SECTION(S)
(10) a summary of each audit, inspection, and evaluation report issued before the commencement of the reporting period— (A) for which no management decision has been made by the end of the reporting period (including the date and title of each such report), an explanation of the reasons such management decision has not been made, and a statement concerning the desired timetable for achieving a management decision on each such report; (B) for which no establishment comment was returned within 60 days of providing the report to the establishment; and (C) for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations;	(10)(A): Appendix A (10)(B): Appendix A (10)(C): Appendix B
(11) a description and explanation of the reasons for any significant revised management decision made during the reporting period;	Appendix A
(12) information concerning any significant management decision with which the Inspector General is in disagreement;	Appendix A
(13) the information described under section 804(b) of the Federal Financial Management Improvement Act of 1996;	Results from the Office of Audits and Evaluations
(14)(A) an appendix containing the results of any peer review conducted by another OIG during the reporting period; or (B) if no peer review was conducted within that reporting period, a statement identifying the date of the last peer review conducted by another OIG;	Other Reporting Requirements
(15) a list of any outstanding recommendations from any peer review conducted by another office of inspector general that have not been fully implemented, including a statement describing the status of the implementation and why implementation is not complete;	Other Reporting Requirements

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(16) a list of any peer reviews conducted by the Inspector General of another office of the inspector general during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review conducted before the reporting period) that remain outstanding or have not been fully implemented;	Other Reporting Requirements
(17) statistical tables showing— (A) the total number of investigative reports issued during the reporting period; (B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period; (C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and (D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;	Statistical Performance
(18) a description of the metrics used for developing the data for the statistical tables under paragraph (17);	Statistical Performance
(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— (A) the facts and circumstances of the investigation; and (B) the status and disposition of the matter, including— (i) if the matter was referred to the Department of Justice, the date of the referral; and (ii) if the Department of Justice declined the referral, the date of the declination;	Results from the Office of Investigations

REQUIREMENT	SAR SECTION(S)
(20)(A) a detailed description of any instance of whistleblower retaliation, including information about the official found to have engaged in retaliation; and (B) what, if any, consequences the establishment actually imposed to hold the official described in subparagraph (A) accountable;	Other Reporting Requirements
(21) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including— (A) with budget constraints designed to limit the capabilities of the Office; and (B) incidents where the establishment has resisted or objected to oversight activities of the Office or restricted or significantly delayed access to information, including the justification of the establishment for such action; and	Other Reporting Requirements
(22) detailed descriptions of the particular circumstances of each— (A) inspection, evaluation, and audit conducted by the Office that is closed and was not disclosed to the public; and (B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.	(22)(A): Other Reporting Requirements and Statistical Performance (22)(B): Other Reporting Requirements

APPENDIX C: REPORTING REQUIREMENTS

DEFINITIONS

As defined in the IG Act:

Questioned cost means a cost that is questioned by the Office because of—

(A) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds;

(B) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or

(C) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable;

Unsupported cost means a cost that is questioned by the Office because the Office found that, at the time of the audit, such cost is not supported by adequate documentation;

Disallowed cost means a questioned cost that management, in a management decision, has sustained or agreed should not be charged to the Government;

Recommendation that funds be put to better use means a recommendation by the Office that funds could be used more efficiently if management of an establishment took actions to implement and complete the recommendation, including—

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

(C) withdrawal of interest subsidy costs on loans or loan guarantees, insurance, or bonds;

(D) costs not incurred by implementing recommended improvements related to the operations of the establishment, a contractor or grantee;

(E) avoidance of unnecessary expenditures noted in preaward reviews of contract or grant agreements; or

(F) any other savings which are specifically identified;

Management decision means the evaluation by the management of an establishment of the findings and recommendations included in an audit report and the issuance of a final decision by management concerning its response to such findings and recommendations, including actions concluded to be necessary;

Final action means—

(A) the completion of all actions that the management of an establishment has concluded, in its management decision, are necessary with respect to the findings and recommendations included in an audit report; and

(B) in the event that the management of an establishment concludes no action is necessary, final action occurs when a management decision has been made; and

Senior government employee means—

(A) an officer or employee in the executive branch (including a special Government employee as defined in section 202 of title 18, United States Code) who occupies a position classified at or above GS–15 of the General Schedule or, in the case of positions not under the General Schedule, for which the rate of basic pay is equal to or greater than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule; and

(B) any commissioned officer in the Armed Forces in pay grades O–6 and above.

THIS PAGE IS INTENTIONALLY BLANK

THIS PAGE IS INTENTIONALLY BLANK

THIS PAGE IS INTENTIONALLY BLANK

Connect with the OIG

CONTACT THE OIG HOTLINE

to report suspected criminal activity or other wrongdoing.

www.va.gov/oig/hotline
Telephone: (800) 488-8244
Fax: (202) 495-5861
VA Inspector General Hotline (53E)
810 Vermont Avenue, NW, Washington, DC 20420

The cover depicts *Burial Flag*, a linen-rag handmade paper sheet created from disassembled military uniforms worn by veterans who participate in Combat Paper—a collaborative veteran-civilian art program. Learn more at www.combatpaper.org.

Photo courtesy of the artist and Army veteran, Drew Cameron, Combat Paper Co-founder.