U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Semiannual Report to Congress

Issue 84 | April 1–September 30, 2020

In remembrance of all veterans and VA employees lost to COVID-19.

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

VISION

To perform audits, inspections, investigations, and reviews that improve the efficiency, effectiveness, and integrity of the Department of Veterans Affairs' programs and services.

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

- identify and prioritize work that will have the greatest impact on the lives of veterans, their families and caregivers, and on VA resources and operations;
- prevent and address fraud and other crimes, waste, and abuse, as well as advance efforts to hold responsible individuals accountable;
- help ensure eligible veterans and other beneficiaries receive prompt and high-quality health care, services, and benefits by issuing accurate, timely, and objective reports; and
- make meaningful data- and evidence-driven recommendations that enhance VA programs or operations and promote the appropriate use of taxpayer dollars.

VALUES

- Protect individuals who allege wrongdoing and treat them with respect and dignity
- Promote diversity, inclusion, and equal opportunities within the OIG and a climate that attracts and retains the highest-quality staff
- Meet the highest standards of integrity, professionalism, and accountability
- Safeguard the OIG's independence and maintain transparency
- Honor veterans and all those who serve them by continually striving for excellence

A MESSAGE FROM THE INSPECTOR GENERAL

As I write this message, more than 200,000 people have died in the United States from COVID-19—more than 3,400 veterans according to the Department of Veterans Affairs (VA). Countless more have been battling the virus, taking a toll on families, loved ones, and colleagues. All of us at the VA Office of Inspector General (OIG) express our deep gratitude to the many VA employees who have been working tirelessly during these tremendously difficult times to serve veterans, their families and caregivers, and in many cases members of their local communities, often at significant risk and great personal sacrifice.

The need for effective oversight during these challenging times has never been greater. I am immensely proud of the activities and accomplishments of the OIG staff that are reflected in this Semiannual Report to Congress for April 1 through September 30, 2020. Despite the many hurdles presented by conducting oversight during a pandemic, OIG personnel worked at an impressive pace and focused on issues with the greatest potential impact on veterans, their families and caregivers, VA personnel, and taxpayers. Given the current conditions, it was necessary for our office to expand its priorities, as reflected in the number of reports that assessed how COVID-19 has affected VA's programs and operations.

In this reporting period, our office published reports related to the Veterans Health Administration's responses and preparedness for ongoing demands (building on a prior report regarding COVID-19 screening), VA's cancellations and medical appointment management during the pandemic, alleged staff exposure to COVID-19 at a medical facility, and start dates for veterans' benefits affected by date-stamps of claims received by mail when offices had been generally closed. The additional COVID-19-related funding from Congress was integral to our efforts to pivot to COVID-19-related work. OIG staff also ensured that oversight on important issues unrelated to the pandemic continued at full force. In addition, the OIG's special agents achieved noteworthy results in a number of criminal investigations, including a guilty plea for one count of manslaughter against a former VA pathologist at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, who worked while under the influence of drugs, and a guilty plea for seven counts of second-degree murder against a former nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

COVID-19 has required greater adaptability and perseverance by OIG personnel to identify alternatives to on-site inspections and other oversight measures that reduce the risk for COVID-19 exposure. Staff curtailed on-site travel by conducting virtual site visits whenever possible and worked to minimize the time required of senior VA leaders and key personnel responsible for critical pandemic responses. Non-COVID-19 report releases were also limited during March through June 22, 2020, in recognition of VA's need to focus on the initial pandemic response.

The OIG's oversight work is detailed in the 182 publications issued for the second half of fiscal year 2020. Examples of ongoing, significant work focuses on VA's multibillion-dollar electronic health record modernization efforts, mental health services, and the Veterans Benefits Administration's quality assurance review program for disability compensation benefits. The OIG has also expanded data collection, analysis, and modeling to inform its ongoing oversight activities by, for example, assessing mortality and patient flow at VA community living centers and acute care hospitals, as well as systems for monitoring the COVID-19 outbreak, appointment cancellations and rescheduling, emergency and

A MESSAGE FROM THE INSPECTOR GENERAL

urgent care activity, and appointment wait times. In this six-month period, the OIG identified more than $3.1 billion in monetary impact for a return on investment of $34 for every dollar spent on oversight. The OIG hotline received and triaged 14,605 contacts with information on potential wrongdoing and concerns with VA programs and activities. Investigators opened 172 investigations and closed 232, with efforts leading to 73 arrests. Collectively, the OIG's work also resulted in 741 administrative sanctions and corrective actions.

I am honored to have worked alongside the outstanding and dedicated OIG staff during this reporting period. And I am grateful to the members of Congress, VA staff, the veterans service organizations, and the veteran community for their continued support that is instrumental to our oversight efforts.

MICHAEL J. MISSAL
Inspector General

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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) 2020, VA is operating under a $240.3 billion budget, with over 415,000 employees serving an estimated 19.2 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 meaningful independent oversight of VA.

HISTORY AND STATUTORY AUTHORITY

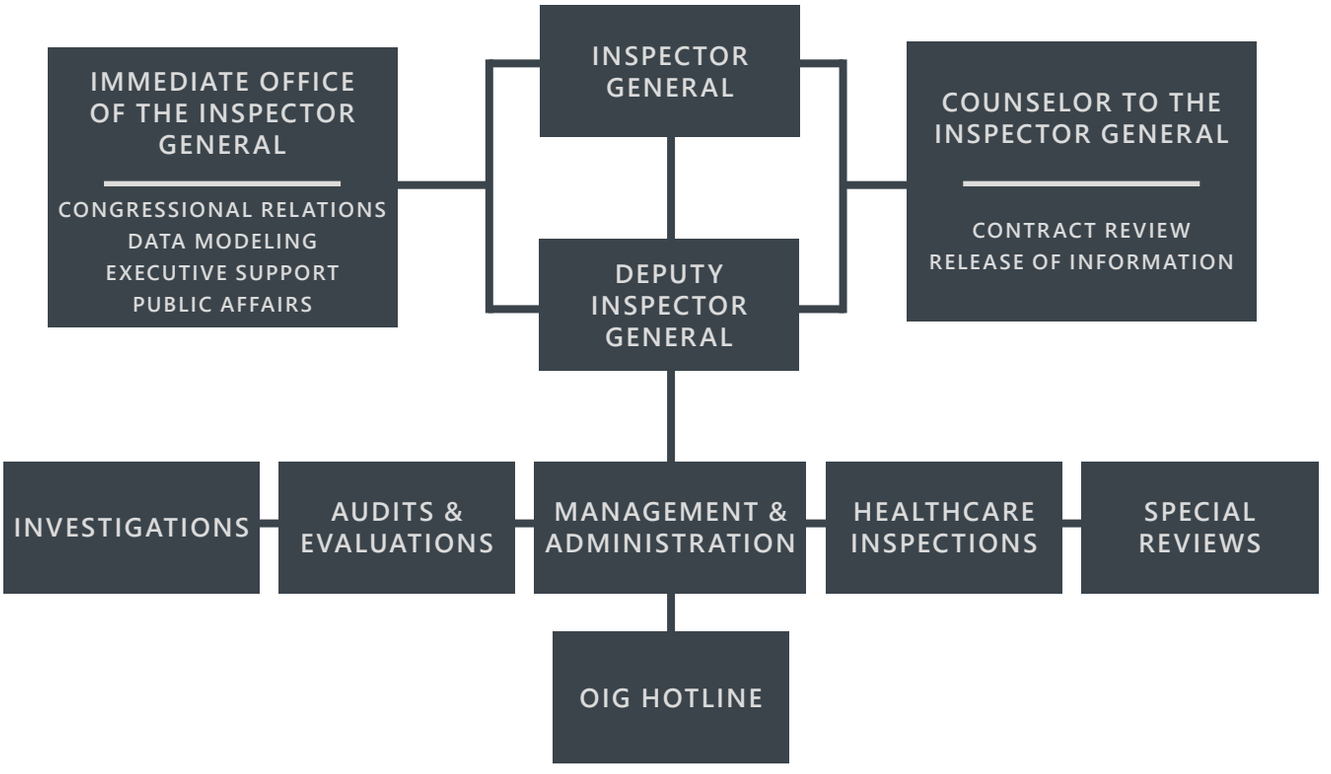
The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) [Public Law (P.L.) 95-452, as amended]. This Act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies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

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has over 1,015 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, data modeling, and executive support, as well as an Office of the Counselor to the Inspector General. The FY 2020 funding for OIG operations provided $210 million from ongoing appropriations. Congress appropriated an additional $12.5 million in supplemental funds to support OIG's COVID-19-specific work.

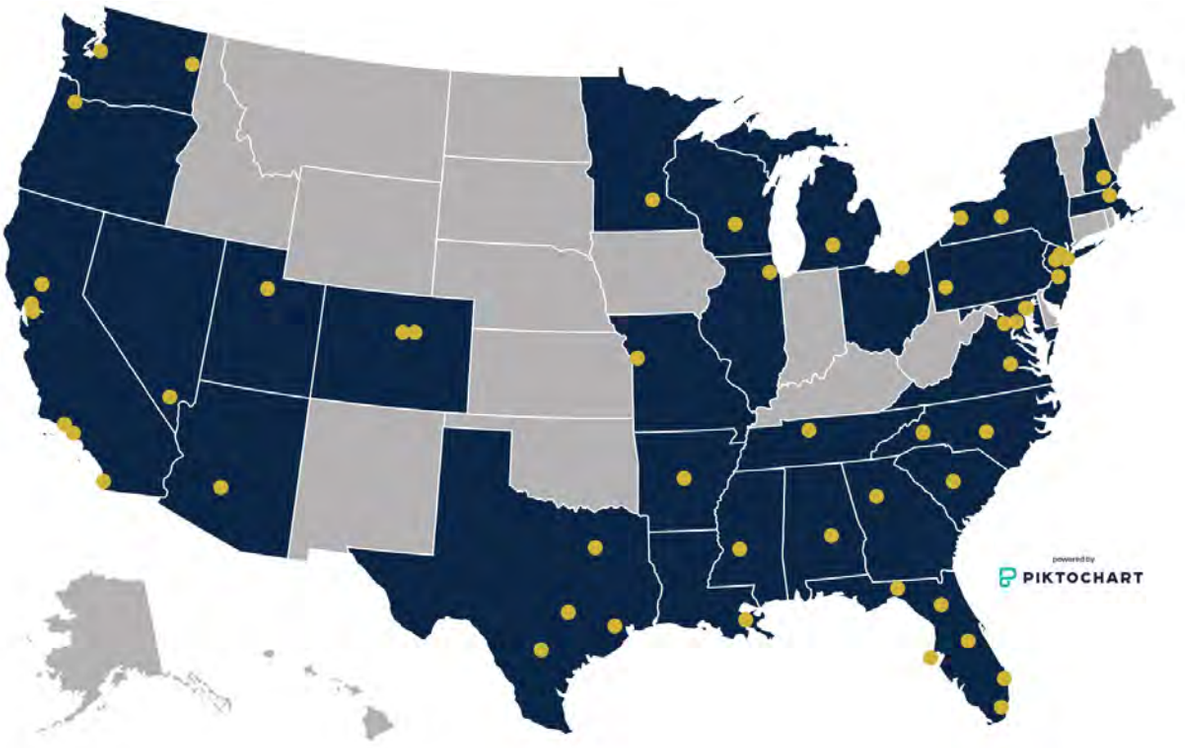
In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff 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



ORGANIZATION PROFILE

OIG FIELD OFFICES MAP



Arlington, VA	Decatur, GA	Martinez, CA	Richmond, VA
Asheville, NC	Denver, CO	Miami, FL	Sacramento, CA
Atlanta, GA	Fayetteville, NC	Middleton, WI	Salt Lake City, UT
Aurora, CO	Fort Snelling, MN	Montgomery, AL	San Antonio, TX
Austin, TX	Gainesville, FL	Nashville, TN	San Diego, CA
Baltimore, MD	Hines, IL	New Orleans, LA	Seattle, WA
Battle Creek, MI	Houston TX	New York, NY	Spokane, WA
Bay Pines, FL	Jackson, MS	Newark, NJ	Tallahassee, FL
Bedford, MA	Kansas City, MO	North Little Rock, AR	Trenton, NJ
Buffalo, NY	Las Vegas, NV	Oakland, CA	Washington, DC
Canandaigua, NY	Long Beach, CA	Orlando, FL	West Palm Beach, FL
Cleveland, OH	Los Angeles, CA	Phoenix, AZ	
Columbia, SC	Lyons, NJ	Pittsburgh, PA	
Dallas, TX	Manchester, NH	Portland, OR	

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, and media inquiries, and has major responsibilities for data modeling 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, as well as a data modeling group that specializes in advanced analytics, information integration, and data visualization. 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 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 THE 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, systems, and networks. Field staff participate in

Comprehensive Healthcare Inspection Program site visits focusing on leadership, quality management, and adherence to requirements and standards for patient care provision. Facility results are aggregated into a summary report 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 potential crimes and civil violations of law involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters including health care, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The office is staffed by special agents with full law enforcement authority, forensic auditors, and other specialized staff. Agents and staff use data analytics, cyber-tools, covert operations, and other strategies to detect and address conduct that poses a threat to or has harmed VA personnel, operations, and the veterans or other beneficiaries VA serves. Through criminal prosecutions and civil monetary recoveries, OIG's investigations promote integrity, patient safety, efficiency, and accountability within VA.

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. Concerns 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.

THE OFFICE OF SPECIAL REVIEWS

This office increases 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. Staffed 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 of interest to multiple offices. This office also conducts administrative investigations.

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the IG Act, this Semiannual Report to Congress presents the OIG's accomplishments during the reporting period April 1–September 30, 2020. 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 highly effective publications and priorities. This information is supplemented by appendixes that detail 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 OIG reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

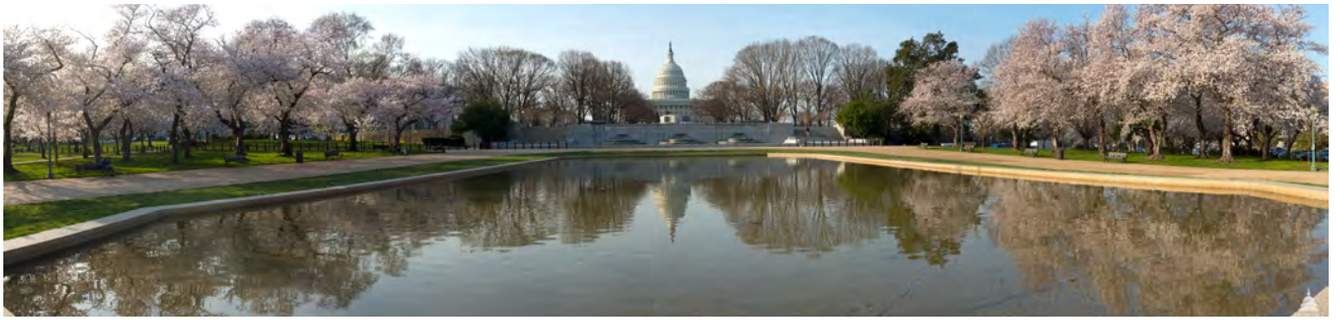
This office is staffed by the Inspector General and Deputy Inspector General's executive support personnel, including oversight report dissemination and recommendation follow-up. It also includes personnel focused on congressional relations, data modeling, and public affairs.

CONGRESSIONAL RELATIONS

The VA OIG actively engages with Congress on critical issues affecting VA programs and operations. During the reporting period, the Inspector General and OIG personnel conducted 65 briefings with congressional members and their staff. Some of the OIG oversight work and recommendations for improvements discussed included

- Reviews of VA's actions related to COVID-19 preparedness and responses;
- An investigation that led to a guilty plea on seven counts for murder in the second degree and one count of assault with intent to commit murder by a former VA employee of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia;
- Several reports evaluating VBA's quality assurance program; and
- The results of comprehensive healthcare inspections of Veterans Integrated Service Networks (VISNs) 12 and 15.

OIG congressional relations staff also fielded 65 inquiries from congressional staff related to constituent matters for review or referral.



HIGHLIGHTED ACTIVITIES AND FINDINGS

DATA MODELING

The Data Modeling Group applies advanced analytics, data visualization, and information synthesis techniques to support proactive oversight of VA programs and operations. During this reporting period, the Data Modeling Group has had 45 ongoing projects, created 16 new internal data reports and made enhancements to several others. The new reports included a focus on COVID-19's impact, procurement of goods and services, documented dates of beneficiaries' deaths, health and benefit claims processing, and healthcare staffing turnover. Other Data Modeling Group efforts included the following:

- Created the first dynamic early warning systems to assess mortality and resident flow at VA community living centers (formerly known as nursing homes) and has provided VHA leadership access to the systems during the pandemic. Similar systems were created for VA acute care hospitals.
- Launched systems for monitoring appointment cancellation and rescheduling, emergency and urgent care activity, and appointment wait times to help OIG directorates evaluate the risks of patients falling through the cracks and delaying access to needed care.
- Established a repository of death records and incorporated it in projects that assess purchased care and services, medical device procurement, and benefit claims processing to identify VA data deficiencies that, if addressed, could result in significant monetary benefits for VA.
- Developed a monitoring tool using data from VA's crisis line to examine contacts, referrals to VHA facilities, post-referral actions, and suicide prevention coordinator workload and staffing. The tool also includes COVID-19-related content that helped inform VHA strategies to continuously support veterans who may be in crisis.
- Enhanced systems to monitor pandemic hotspots in the United States, VA COVID-19 testing and diagnoses, cases treated at VA healthcare facilities, and prescribing and purchasing of medications for treating COVID-19 infections. These systems offer insights into VA's responses to the pandemic and barriers that may hamper VA's rollout of important initiatives.

PUBLIC AFFAIRS

The OIG is committed to transparency and to providing accurate and timely information to Congress, veterans and their families, the media, veterans service organizations, VA leaders and staff, and the public. Communications staff disseminate information on reports, news releases, public statements, and congressional testimony to the OIG's many stakeholders. During this reporting period, internal communications and staff engagement efforts were also ramped up in unprecedented ways to ensure oversight was continuing as efficiently and effectively as possible during the pandemic. Staff also produced three town halls for OIG-wide distribution, including those that align with VA and OIG shared goals to improve diversity and inclusion. Staff continue to leverage video tools, including producing a COVID-19 fraud webinar, and leveraging technology to maintain outreach, such as virtual meetings between the IG and Deputy IG and veterans service organizations. These meetings provided valuable insights into COVID-19-related issues and other matters for potential oversight.

Other outreach relied on the OIG's continued use of social media and traditional notification services:

- LinkedIn page grew to more than 32,000 followers

- Twitter reached more than 5,500 followers with more than 160,000 impressions
- Email delivery system notified more than 50,000 subscribers

Communications staff continue to work with U.S. Attorneys' Offices and other law enforcement partners on press releases and routinely respond to media requests for information on the OIG's investigations, inspections, reviews, and audits. The OIG's work was featured in hundreds of media accounts during the reporting period including the New York Times, Wall Street Journal, Washington Post, Military Times, Stars and Stripes, and other media outlets. Among the issues covered were the OIG's reports on VA's COVID-19 responses and preparedness, as well as criminal cases in the national spotlight such as a former nursing assistant pleading guilty to seven counts of second-degree murder in the deaths of seven veterans and one count of assault with intent to commit murder involving the death of an eighth veteran at a Clarksburg, West Virginia, medical facility.

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations (OAE) examines how effectively VA complies with federal laws and its own guidance (such as policies, procedures, manuals) in structuring and implementing programs that are likely to have a significant impact on veterans, their families, and caregivers. One measure of this office's success are the positive outcomes resulting from the recommendations published in its audit and review reports. In the past six months, with over 111 recommendations from 29 reports, the office has helped spur significant improvements in VA's programs and processes and identified almost $832 million in potential monetary benefits. These reports cover the broad spectrum of the department's operations to include veterans' access to health care, the delivery of their benefits, as well as the behind-the-scenes infrastructure supporting these important programs—systems that manage such operations as VA's finances, acquisition processing, supply chains, and information networks.

For example, VA's Office of Information Technology created a plan responsive to OIG recommendations that focuses on ways to reduce the risk of duplicative, wasteful, or poorly conceived information technology (IT) acquisitions. In the processing and delivery of disability benefits, OAE reports have also helped VBA to strengthen claims processing and help ensure veterans receive the full benefit payments to which they are entitled. As for construction projects, OAE's latest facilities report highlighted the need for medical staff and engineering teams to better coordinate, prioritize, and respond to work orders to minimize the impact of construction on patient care and services.

OAE's commitment to increase positive outcomes for the veteran community, VA personnel, and taxpayers drives the reports and recommendations published in this reporting period.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) is staffed by 34 employees that conduct preaward and postaward reviews of vendors' proposals and contracts in order to help VA obtain the best pricing on products and services. The 51 preaward reviews issued this reporting period yielded potential cost savings of about $183 million. Fifteen postaward reviews recovered $18.6 million in contract overcharges. Also, 10 claim reports were issued identifying $3 million in potential cost savings.

In addition, OCR's Special Projects team issued three reports during this review period, one of which found that VA awarded 227 contracts with a total value of $278.5 million without the required OIG preaward review for contracts above $500,000, which represents 63 percent of the contracts during the five-year review period. Contracting officers awarded contracts just below the review threshold and used a series of extended interim contracts to circumvent the review requirements. VA did not consider the monetary value of extending the contract periods when determining the value of the proposals and repeatedly used interim contracts to procure healthcare services without the required OIG preaward review. Additionally, contracting officers did not consistently document that the negotiated price was fair and reasonable, as required. The second report provided an overview of OCR's 19 Federal Supply Schedule pharmaceutical proposal reviews (preaward reviews) completed during FY 2019. The OIG determined that commercial pricing disclosures were not reliable for negotiations for 14 of the 19 proposals and recommended that VA obtain revised disclosures before awarding the contracts. The OIG's lower Federal Supply Schedule pricing recommendations collectively reflected more than $1 billion in estimated cost savings to VA. The third report summarized OCR's 27 sole-source healthcare resource proposal reviews (preaward reviews) completed during FY 2019. OCR's recommendations that would allow VA to access lower pricing reflected approximately $198 million in cost savings to VA.

As previously mentioned, OCR has been organizationally aligned under the OIG's Office of the Counselor to the Inspector General. Beginning in FY 2021, OCR will be integrated into OAE. The goal of this realignment is to fully leverage the expertise of OCR staff in the contracting and acquisition arenas that fall within OAE's oversight portfolio.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The Counselor's office continues to provide legal support and guidance to all components of the OIG to advance the organization's accuracy and effectiveness in conducting oversight work in service to veterans. During this reporting period, the Counselor's office performed the following activities:

- Worked with the Office of Investigations (OI) to restructure the OIG's qui tam program, including streamlining initial claims assessments and coordinating with the U.S. Department of Justice on decisions to intervene. Coordinated with the VA Office of General Counsel to complete civil settlements in False Claims Act cases yielding approximately $20.4 million during this review period. Prepared case law updates and developed refresher training for investigators required by the Council of the Inspectors General on Integrity and Efficiency (CIGIE), and reviewed more than 140 subpoenas issued in criminal and civil investigations

- Provided advice to OIG management on implementing the Families First Coronavirus Response Act and, in order to promote more effective oversight, briefed employees and managers on a variety of legal issues such as the legal authorities of inspectors general, government ethics, merit systems processes, and Equal Employment Opportunity and whistleblower rights and responsibilities.
- Advised the Office of Healthcare Inspections (OHI) in its review of complaints involving healthcare delivery throughout VA including reports on VHA's COVID-19 response and ongoing preparedness, patient suicide, medical staffing, surrogate decision making, improving VA and community care health information exchanges, deficiencies in pharmacy services and pathology practices, and inadequate emergency care and physician misconduct at a VA medical center.
- Provided guidance to auditors on a wide range of projects, including on reports relating to proper approvals for canine research and internal controls and oversight at VA-funded non-profit research corporations. Assisted the Office of Special Reviews (OSR) with several investigations, including a report on a former VA Assistant Secretary improperly steering a $5 million contract to benefit individuals with whom he had a personal relationship, and a report on a VA attorney who illegally represented parties in government matters.
- Responded to several litigation matters, including those involving the Privacy Act of 1974 and Federal Tort Claims Act, working closely with U.S. Attorneys' Offices in federal court proceedings.
- Through its Office of Information Release, continued to review all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and processed and responded to more than 500 requests from the public and other government agencies for OIG records.

THE OFFICE OF HEALTHCARE INSPECTIONS

OHI remains committed to focusing on leadership and organizational risks affecting personnel on the frontlines of VA care and the impact these deficiencies have on the provision of quality health care to veterans and a culture of safety within VA facilities. OHI is also focused on the challenges associated with caring for veterans with COVID-19, as well as maintaining care for veterans seeking routine or other needed care during the pandemic. For example, in addition to publications released during this reporting period related to pandemic operations, OHI continued to work on issues as wide-ranging as mental healthcare staffing, the care for rural veteran populations, and VISN and facility leaders' responsiveness.

The pandemic has clearly highlighted the need for healthcare systems to develop emergency plans that ensure patient and staff safety can be prioritized along

with quality healthcare delivery during times of crisis. Appropriately, VHA experienced a massive uptick in the use of virtual care modalities like telehealth. Recently published OHI reports highlight the successes and barriers facilities faced in implementing and expanding telehealth. OHI's work also highlighted multiple other work-arounds and best practices some facilities established during the pandemic for facilities facing similar challenges to explore. While leveraging the experience and skills of OHI clinical staff to conduct real-time and technical reviews, several OHI physicians have also collaborated with leaders in the larger inspector general community as members of the Pandemic Response and Accountability Subcommittee on Healthcare.

Among its priorities, OHI has focused on the following:

- Using its dedicated team of mental healthcare clinicians to assess veterans' access to and quality of mental health care to highlight opportunities for VHA to improve those services and ensure care is provided by compassionate and appropriately trained clinicians.
- Positioning OHI's Comprehensive Healthcare Inspection Program teams to assess VHA's suicide prevention and long-term opioid therapy programs concurrently.
- Continuing to evaluate the effectiveness of military sexual trauma coordinators and the availability of critical services for supporting veterans in need of specialized and integrated care related to their trauma experience.

Every aspect of health care has been affected by the stress of the pandemic, as reported by the experiences of VHA staff and patients. The challenges associated with care delivery under these dynamic and tremendously difficult conditions not only demand innovative and thoughtful healthcare delivery solutions, but also consistent and practical oversight. OHI is committed to supporting veterans by providing such oversight and ultimately advancing high quality healthcare delivery.

THE OFFICE OF INVESTIGATIONS

OI staff investigate an extensive range of potential criminal activity—from drug offenses and various types of fraud, to crimes of violence and threats to information systems and VA personnel. During the COVID-19 pandemic, investigators have been particularly vigilant to allegations of procurement fraud, theft, and other activities that put VA personnel, patients, and resources at risk. In this reporting period, investigators' efforts resulted in 73 arrests. Criminal and civil investigations yielded millions of dollars in recoveries for VA and resulted in significant judicial and administrative actions.

OI continues to focus on high-impact investigations with support from the Health Care Fraud Division, Investigative Development Division (IDD), and OI's investigative regions. These investigations involve working closely with other law enforcement entities and with the U.S. Department of Justice in order to successfully address criminal and civil violations related to high-value VA program areas.

During the ongoing COVID-19 pandemic, OI has initiated a number of significant investigations involving the fraudulent sale of personal protective equipment to VA including face masks, test kits, and ventilators. These investigations involved cooperation among OI offices and external partners to achieve successful outcomes. OI staff continued using data analytics specialists to identify patterns of fraud in education and procurement to detect vulnerabilities within these programs. OI also continued to use regional Proactive Working Groups to help detect program areas susceptible to fraud. These working groups, the IDD, and the Health Care Fraud Division coordinate closely to ensure that emerging criminal enterprises and important investigations receive appropriate attention and resources. To advance these efforts, OI's Forensic Audit Division program maintains its commitment to provide nationwide support to significant agency investigations.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration (OMA) strives to provide comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency, and to support the OIG's overall mission. In this reporting period, OMA had a major role in overseeing execution of the OIG's largest budget to date—$210 million in ongoing appropriations—which was increased by an additional $12.5 million in supplemental funding to support COVID-19-specific work.

OMA took the lead in coordinating the OIG's response to the pandemic through proactive measures to protect the health, safety, and overall well-being of all employees. Measures implemented during the review period include

- Issuing updated guidance on human resources flexibilities and procedures to help prevent the spread of the virus within the office;
- Contracting for just-in-time cleaning for offices in which people have been exposed to the virus;
- Purchasing and distributing cleaning supplies and personal protective equipment to staff across the country; and
- Enhancing communication with staff through increased emails, town hall meetings, and the development of a dedicated COVID-19 internal website with resources and guidance.

Additionally, OMA is evaluating workplace changes necessitated by COVID-19 by entering into an intra-agency agreement with the U.S. General Services Administration to explore space utilization optimization.

OMA has also been working to modernize and enhance support functions to sustain OIG's steady growth. Examples of initiatives that were implemented during the review period include

- Rolling out a virtual onboarding process, which enables the OIG to continue to hire new employees while minimizing face-to-face interactions and supporting social distancing recommendations;
- Converting to a paperless performance management system to streamline processes and

ensuring performance plans strategically align with agencywide standards and the OIG mission;

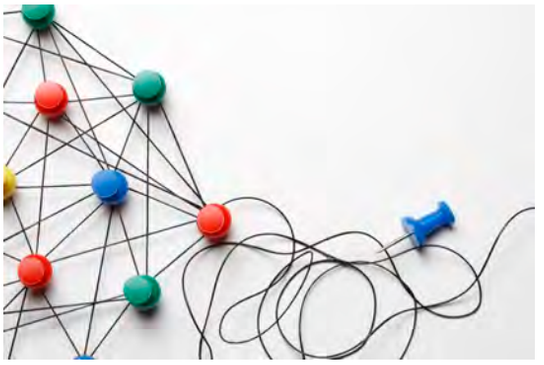
- Enhancing the customer service experience for those who contact the OIG's hotline by continuing to increase the number of semicustom responses delivered in response to complaints that do not result in an OIG review;
- Collaborating with cross-directorate stakeholders to continue to leverage data to proactively identify new areas for impactful oversight and to create and refine user-friendly, self-service dashboards to empower all OIG staff with the just-in-time information they need for their work; and
- Leveraging data and reporting tools to create dashboards to support internal business practices, including a tool that displays budget status information for senior staff and directorate budget liaisons.

OMA's ongoing recruitment and retention efforts have supported the growth of the OIG to over 1,015 onboard employees. During FY 2020, OMA posted more than 200 vacancies, hired and efficiently onboarded over 115 external applicants, and promoted or reassigned nearly 120 OIG employees. Additionally, OMA administers the OIG's staff retention initiatives, including the student loan repayment program and informal recognition awards, and responds promptly to needs identified by staff help to ensure that the OIG maintains an engaging work environment that attracts, develops, and retains the highest quality staff.

THE OFFICE OF SPECIAL REVIEWS

OSR focuses on significant incidents and administrative investigations, particularly involving senior VA officials. The office collaborates with other directorates to address complex issues of concern. Staff work on multiple review projects and administrative investigations pertaining to VA programs, operations, and personnel misconduct. With increases in staff, OSR is now supported by a robust team of investigative attorneys, administrative investigators, criminal investigators, forensic auditors, and senior analysts.

In this reporting period, the office published eight reports relating to the misuse of government resources and abuse of positions by senior VA officials. In particular, the office focused resources on investigating significant ethical lapses by senior VA officials, which resulted in the publication of two important reports: *Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration* and *Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel*. Of note, VA removed an Office of General Counsel attorney from federal service in response to the latter investigation.



OSR was also notified in September that its report on *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017* would receive the CIGIE annual award for exemplary public service,

one of just six inspector general reports to receive comparable CIGIE recognition this year. Leveraging expertise across the OIG, the OSR-led team is being recognized for demonstrating significant value to Congress through its work to improve VA processes and strengthen whistleblower protections.

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STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE FISCAL YEAR

336 PUBLICATIONS

215 ARRESTS

202 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

8 CONGRESSIONAL TESTIMONIES

1,575 ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS*

29,352 HOTLINE CONTACTS

$23:1 RETURN ON INVESTMENT

1,653 RECOMMENDATIONS TO VA

$4,005,712,413 MONETARY IMPACT

15 PODCASTS

*Hotline and Investigations included

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Better Use of Funds	$507,200,000	$484,740,219	$991,940,219
Recoveries	$23,074,372	$13,038,421	$36,112,793
Fines, Penalties, Restitution, and Civil Judgments	$54,266,568	$87,718,300*	$141,984,868
Fugitive Felon Program	$200,000,000	$83,500,000	$283,500,000
Savings and Cost Avoidance	$2,022,573,975	$92,980,909	$2,115,554,884
Questioned Costs	$329,751,900	$106,867,749*	$436,619,649
Total Dollar Impact	**$3,136,866,815**	**$868,845,598***	**$4,005,712,413**
Cost of OIG Operations[1]	$93,133,968	$83,201,589	$176,335,557
Return on Investment[2]	**$34:1**	**$10:1**	**$23:1**

* Corrected figures

1. The six-month operating cost for OHI ($24.3 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.

STATISTICAL PERFORMANCE

TABLE 2: PUBLICATIONS

REPORT TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Administrative Investigations	8	1	9
Audits and Reviews	28	19	47
Claim Reviews	10	2	12
Comprehensive Healthcare Inspections	20	34	54
Hotline Healthcare Inspections	29	17	46
National Healthcare Reviews	4	3	7
Postaward Reviews	15	23	38
Preaward Reviews	51	31	82
Special Reviews	0	1	1
Subtotal	**165**	**131**	**296**
ALTERNATIVE WORK PRODUCTS	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Issue Statements	0	0	0
Management Advisory Memoranda	1	0	1
Subtotal	**1**	**0**	**1**
OTHER PUBLICATION TYPE	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Budget Request	1	0	1
Congressional Testimonies	0	8	8
Major Management Challenges	1	0	1
Monthly Highlights	6	6	12
Peer Reviews Completed of other OIGs	0	0	0
Podcasts	7	8	15
Press Releases	1	1	2
Subtotal	**16**	**23**	**39**
Total	**182**	**154**	**336**

TABLE 3: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	5	6	11
Hotline Referrals Reviewed	2,564	2,101	4,665

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	14,605	14,747	29,352
Cases Opened	718	895	1,613
Cases Closed	706	686	1,392
Administrative Sanctions and Corrective Actions*	548	531	1,079
Substantiation of Allegations Percentage Rate	35%	36%	36%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	18	15	33
Individuals Provided Office of Special Counsel Contact Information	37	38	75
Individuals Provided Merit Systems Protection Board Contact Information	22	48	70
Individuals Provided Office of Resolution Management Contact Information	62	93	155

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

TABLE 5: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[1]	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests[2]	73	142	215
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	2	12	14
Indictments[3]	66	111	177
Indictments and Informations Resulting from Prior Referrals to Authorities	27	76	103
Criminal Complaints	27	28	55
Convictions	65	118	183
Pretrial Diversions and Deferred Prosecutions	5	14	19
Case Referrals to Department of Justice for Criminal Prosecution[4]	144	158	302
Cases Accepted	55	64	119
Cases Declined	47	70	117
Cases Pending	42	24	66
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	19	29	48
Cases Accepted	15	15	30
Cases Declined	2	6	8
Cases Pending	2	8	10
Administrative Sanctions and Corrective Actions	193	303	496
Cases Opened	172	208	380
Cases Closed[6]	232	239	471

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 three 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.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

OAE had 29 publications during this 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/recommendation-dashboard.asp. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

29
PUBLICATIONS

111
RECOMMENDATIONS

$832M
MONETARY BENEFITS

FEATURED PUBLICATIONS

As part of OAE's mission to oversee specific, high-risk areas within VA, this reporting period OAE focused on programs providing veterans with timely medical care and benefits and the infrastructure supporting VA's operations. OAE's oversight of compensation benefits resulted in a series of four nationwide reviews related to various components of VBA's quality assurance review program for disability compensation benefits. Each report detailed issues of monitoring and oversight within the individual programs. In total, the four reports resulted in 18 recommendations. Due to these reviews, VBA is making immediate changes and improvements to its oversight of the delivery of disability compensation benefits.

OAE's review of the use of overtime in the Office of Community Care describes how overtime was used, whether overtime helped reduce the claims backlog, and whether claims processors and nurses abused overtime. OAE concluded that supervisors did not monitor claims processing production that occurred during overtime to ensure staff reduced the claims backlog, and the use of overtime presented a high risk for fraud and abuse.

OAE also examined the infrastructure-readiness supporting the electronic health records modernization initiative, starting with the system's initially scheduled deployment. OAE found the lack of important upgrades jeopardized deployment of the new system and increased risks of delays to the overall schedule. Shoring up the weakness in VA's program infrastructure will better ensure patients have access to the care they need.

VBA'S QUALITY ASSURANCE PROGRAM FOR COMPENSATION CLAIMS PROCESSING: A FOUR-REPORT SERIES

Because accurate and consistent decisions on disability compensation claims are vital to ensuring eligible veterans receive their benefits, OAE conducted four nationwide reviews related to various components of VBA's quality assurance review program for disability compensation benefits. Each report detailed issues of monitoring and oversight within the individual programs. OAE examined

whether VBA processed disability benefits claims uniformly and found that VBA did not ensure all claims processors participated in required consistency studies or that staff followed up on study results to ensure improvements were made.

Overall, VBA lacked strong processes for sharing and monitoring claims results. The agency could also capitalize on information it already collects to help close knowledge gaps and improve the consistency of claims decisions. OAE's four reports resulted in a total of 18 recommendations to the under secretary for benefits.[1] VBA concurred, or concurred in principle, with all recommendations and provided acceptable action plans. As a result, VBA is making immediate changes and improvements to its oversight of the delivery of disability compensation benefits. The OIG also plans to publish a summary report detailing systemic issues related to VBA's quality assurance program on a whole.

OVERTIME USE IN THE OFFICE OF COMMUNITY CARE TO PROCESS NON-VA CARE CLAIMS NOT EFFECTIVELY MONITORED

VA's Office of Community Care intended to use overtime to reduce a backlog of non-VA care claims. This backlog had been increasing since at least October 2016. The OIG examined how the overtime was used, the effect on claims backlog reduction, and whether claims processors and nurses abused overtime. The OIG found neither Office of Community Care nor its Payment Operations and Management (POM) directorate established a policy requiring employees to use overtime exclusively to process those claims or detailed appropriate uses for overtime. Officials did not implement controls to ensure employees used overtime primarily to reduce the claims backlog. A data review of a sample of 45 POM employees found the employees were paid an estimated $11.6 million for overtime hours for which there was no evidence of claims-related activity in the Fee Basis Claims System in FYs 2017 and 2018, representing almost half of the total overtime paid. Significantly, 16 of the 45 employees each received more than $10,000 in overtime for hours during which there was no claims-related activity. The audit team referred those cases to the OIG's Office of Investigations. There must be effective controls in place to monitor use of overtime. The OIG found that during the scope of this audit, such controls did not exist or were ineffective. Supervisors also did not effectively manage productivity during overtime hours, creating a high risk for fraud and abuse. The OIG recommended the under secretary for health review overtime activities for certain POM employees to determine whether disciplinary or other corrective action is warranted, ensure supervisors have the tools to effectively monitor overtime productivity to reduce the risk of abuse, clarify nurse productivity standards and requirements, and implement controls on the appropriate use of overtime.

DEFICIENCIES IN INFRASTRUCTURE READINESS FOR DEPLOYING VA'S NEW ELECTRONIC HEALTH RECORD SYSTEM

VA faces tremendous challenges modernizing its electronic health records system and connecting it to a similarly implemented Department of Defense (DoD) system to create a comprehensive, lifetime health record for service members. The OIG examined whether infrastructure-readiness

[1] VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide,* 19-07062-255, September 29, 2020; VA OIG, *Site Visit Program Can Do More to Improve Nationwide Claims Processing*, 19-07062-230, September 18, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, 19-07054-174, July 22, 2020; VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies,* 19-07059-169, July 22, 2020.

activities were on schedule to support the modernization initiative, starting with the system's initially scheduled deployment on March 28, 2020, at the Mann-Grandstaff VA Medical Center (VAMC) in Spokane, Washington. The OIG found that critical physical and information technology infrastructure upgrades had not been completed at Mann-Grandstaff and associated facilities six months before the specified system deployment date, as guidance suggested. Even as recently as January 8, 2020, some infrastructure updates had yet to be completed, jeopardizing the then planned March 28 deployment. In April 2020, VA postponed going live without specifying a new date. The lack of important upgrades jeopardizes VA's ability to properly deploy the new system and increases risks of delays to the overall schedule. Some needed infrastructure upgrades were not projected to be completed until months after going live. Infrastructure upgrades were not completed at Mann-Grandstaff on time primarily because VA had not completed initial comprehensive site assessments, developed specifications for infrastructure with appropriate monitoring mechanisms, and lacked adequate staffing. VA committed to the March 28 date without having the necessary information on the state of the medical center's infrastructure. The OIG also found security vulnerabilities with some of the physical infrastructure at the Mann-Grandstaff VAMC. Damage to that infrastructure from unauthorized access could lead to loss of connectivity. The OIG made eight recommendations, including establishing an infrastructure-readiness schedule for future deployment sites that incorporates lessons learned from DoD's experience and ensures projected milestones are realistic and achievable. The OIG also recommended ensuring the physical security of electronic health records infrastructure.

PUBLICATIONS ON HEALTHCARE ACCESS AND ADMINISTRATION

OIG audits and evaluations focus on the effectiveness of VA programs providing healthcare delivery for veterans. Reports on these programs identify opportunities for VA leaders to improve the processes, procedures, and policies needed to better manage these operations. The constructive recommendations are meant to support patients' timely access to high-quality healthcare services.

IMPROVED OVERSIGHT OF SURGICAL SUPPORT ELEMENTS WOULD ENHANCE OPERATING ROOM EFFICIENCY AND CARE

The OIG determined that VHA did not consistently use data from its National Surgery Office to improve operating room efficiency. Problems persisted for at least two years at less efficient facilities because regional and facility leaders did not monitor them and follow up on the root causes. At more efficient VHA facilities, surgical workgroups focused on operating room efficiency in addition to surgical outcomes. The audit team estimated that, under non-pandemic conditions, greater regional and facility oversight of surgical support elements would reduce surgical cancellations by 8,600 over five years, save approximately $30 million, and improve services for about 7,200 patients. Surgical support elements include clinical service staff, sterile processing and logistics services, and environmental and resource management. VHA concurred with the OIG's six recommendations in areas such as oversight, assessment and sharing of efficiency data, and clarifying performance measures.

APPOINTMENT MANAGEMENT DURING THE COVID-19 PANDEMIC

VHA protected patients and employees from COVID-19 by canceling face-to-face appointments that were not urgent and converting some to virtual appointments. The OIG assessed the status of

these canceled appointments and VHA's strategies for managing them. The OIG found that about five million appointments (68 percent) canceled from March 15 through May 1, 2020, had evidence of follow-up or other tracking, but about 2.3 million appointments (32 percent) did not. The review team also determined that medical facilities did not consistently follow VHA's guidance on annotating canceled appointments, and on leaving consults open so that medical providers could reschedule them. In addition, the team noted that canceling appointments in batches could mask the instances where patients were not contacted for rescheduling. The OIG made three recommendations to VHA on rescheduling strategy and oversight, monitoring progress on cancellation follow-up, and taking appropriate follow-up action on canceled or discontinued consults.

THE VETERANS HEALTH ADMINISTRATION DID NOT GET SECRETARY'S APPROVAL BEFORE USING CANINES FOR MEDICAL RESEARCH

Five members of Congress requested that the OIG review the VHA's canine research approval process. Congress recently mandated that the VA Secretary directly approve the use of appropriated funds for canine research. VHA conducted eight studies without the Secretary's direct approval, resulting in the unauthorized use of approximately $400,000 in appropriated funds. There also was no formal procedure to obtain and document the Secretary's approval. Unclear communication, inadequate recordkeeping, and inaccurate recording and verification of approval decisions contributed to VHA's noncompliance. Providing unsupported and potentially inaccurate information could undermine public trust in VA and detract attention from its important mission of supporting a wide range of authorized research on veterans' health. The OIG recommended the under secretary for health establish an approval process for canine research, ensure approval is documented, prevent appropriated funds from being spent without approval, and report to Congress on recent funds spent without the Secretary's approval.

VA SHOULD EXAMINE OPTIONS TO EXPAND RETAIL PHARMACY DRUG DISCOUNTS

The OIG estimated that VA could have saved about $69 million of the $181 million that Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) paid for retail pharmacy claims in FY 2018 if CHAMPVA qualified for federal price discounts. Federal law allows VA to receive at least a 24 percent discount on direct prescription drug purchases for its facilities. However, VA pays the higher contracted average wholesale price for prescription drugs when purchased through retail pharmacies. VA could save about $345.1 million over the next five years if CHAMPVA could buy drugs through retail pharmacies at the same discounted prices as VA pharmacies. Other VA programs could also save money if this authority was expanded to include them. The OIG recommended the under secretary for health determine how VA could require that drug manufacturers provide the discounted prices and pursue related statutory or other changes needed.

IMPROVEMENTS NEEDED TO REDUCE AGING INFRASTRUCTURE RISKS AT NORTHPORT VA MEDICAL CENTER IN NEW YORK

The OIG assessed the merits of a hotline complaint it received in March 2019 regarding building conditions and patient safety at the Northport VA Medical Center in New York. The complaint alleged that medical center managers did not take adequate action to maintain the center's buildings. According to the complaint, the delivery system for steam heat failed and caused damage that contaminated employee and patient areas with asbestos, lead paint, and other debris. The review team determined that damage occurred in building 65 of the medical center and that four rooms were closed for repairs between February and October 2019. The room closures did not affect patient care

because other space was available. The OIG made three recommendations to the VISN 2 director that focused on implementing the master plan to reduce the medical center's footprint and on work orders for recurring and preventive maintenance.

INDEPENDENT REVIEW OF VA'S SPECIAL DISABILITIES CAPACITY REPORTS FOR FISCAL YEARS 2017 AND 2018

The OIG conducted an independent review of VA's reports on special disabilities capacity for FYs 2017 and 2018. These annual reports document VA's capacity to meet the specialized treatment and rehabilitative needs of disabled veterans. VA is required to submit the reports to Congress, and the OIG is required to report to Congress on report accuracy. The OIG found nothing that caused it to believe the capacity reports were not fairly stated and accurate in all material respects, with exceptions noted in the OIG report. The OIG believes VA can no longer meet the requirement to compare current capacity to 1996 levels because of changes in areas such as diagnoses and information technology. However, the OIG also believes Congress can better assess VA's capacity by requiring reports annually or more frequently, and by considering the extent to which VA can meet disabled veterans' needs for health care and services.

Visit the OIG's Recommendation Dashboard at www.va.gov/oig/recommendation-dashboard.asp to track VA's progress in implementing OIG recommendations.

PUBLICATIONS ON BENEFITS DELIVERY AND ADMINISTRATION

The OIG performs audits and evaluations of VA's veterans' benefits programs. Through published reports, the OIG identifies potential risks to benefit program operations and services. Staff examine the effectiveness, timeliness, and accuracy of benefits delivery to veterans, eligible family members, and caregivers.

DATE OF RECEIPT OF CLAIMS AND MAIL PROCESSING DURING THE COVID-19 NATIONAL STATE OF EMERGENCY

The OIG reviewed VBA's processing of mail and benefit claims during the COVID-19 pandemic. The review team found VBA staff continued to process mail received at VA facilities but did not properly apply new guidance related to date of receipt for an estimated 98 percent of about 3,200 claims established from April 7 through April 20, 2020. The date of receipt may be used to determine when veterans become entitled to benefit payments. Veterans could be underpaid if a date of receipt is incorrect. VBA concurred with the OIG's recommendations to (1) ensure VBA staff understand date of receipt guidance for claims received during the pandemic and implement those actions; (2) make certain that claims received and completed from March 1, 2020, had the correct date of entitlement; and (3) evaluate existing guidance for recording the date of receipt for claims without a postmark.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

THE VETERANS BENEFITS ADMINISTRATION INADEQUATELY SUPPORTED PERMANENT AND TOTAL DISABILITY DECISIONS

VBA manages VA's disability compensation program. The OIG examined whether VBA staff cited adequate medical evidence to support decisions involving veterans' permanent and total (P&T) disability status. The OIG found that 61 percent of the decisions sampled did not cite adequate medical evidence, and about 15,100 veterans received P&T status without this evidence. As a result, VA may have improperly paid an estimated $38 million in dental, medical, and education benefits for P&T veterans and dependents between October 1, 2017, and December 31, 2019, and may pay more than $84 million for these benefits over the next five years. The OIG recommended VBA update P&T status procedures for consistency with relevant statute, revise procedures to ensure staff supports P&T status decisions by citing evidence, revise the title and language used in the decisions for clarity, and provide training to staff on updated procedures.

ACCURACY OF DISABILITY BENEFIT EVALUATIONS FOR VETERANS' SERVICE-CONNECTED HEART DISEASES

The OIG examined whether VBA decision makers accurately completed disability evaluations for veterans' service-connected heart disease. The OIG estimated that decision makers incorrectly evaluated about 12 percent of claims for heart disease between November 1, 2018, and April 30, 2019. Of those, about 870 resulted in improper payments totaling at least $5.6 million. The OIG determined that the disability benefits questionnaire format prompted inappropriate evaluations of veterans' heart conditions. VBA decision makers did not consistently ask for the clarification they needed to accurately determine disability. The OIG made three recommendations for improving the handling of disability benefits questionnaires for heart diseases to ensure they are properly filled out and the information is unambiguous and consistent.

CONTROLS APPEAR TO HAVE ADDRESSED PRIOR OVERPAYMENTS OF POST-9/11 GI BILL MONTHLY HOUSING ALLOWANCE

The OIG analyzed 10 years of Post-9/11 GI Bill monthly student housing allowance data and identified potential overpayments. VBA made substantial overpayments to 16 students, totaling $961,000, as a result of control deficiencies that allowed some payments to continue beyond required limits. The number of individual overpayments was minimal, as more than two million students were enrolled in classes using Post-9/11 GI Bill benefits during the review period. VBA's Education Service has added controls that appear to have been effective in reducing the risk of overpayments, as no similar overpayments were identified since the last control was implemented in June 2017. The OIG did not make any recommendations because VBA's existing and planned controls appeared to address the errors found in this review but encouraged additional measures, such as monthly student certifications, to further reduce the risk of future long-term overpayments.

DISABILITY COMPENSATION BENEFIT ADJUSTMENTS FOR HOSPITALIZATION NEED IMPROVEMENT

This audit examined whether veterans received accurate compensation when hospitalized by VA for more than 21 days for service-connected disabilities. These veterans are entitled to receive temporary increases in benefits. VBA employees process increases using hospital admission and discharge reports. The OIG estimated VA regional office employees did not adjust or incorrectly adjusted disability compensation benefits in about 2,500 of the 5,800 cases eligible for adjustments, creating an estimated

$8 million in improper payments in calendar year 2018. Errors occurred because employees did not generate required reports and maintain report logs, and managers provided ineffective oversight. Employees processing adjustments lacked proficiency because they handled such cases infrequently and lacked training to maintain their knowledge. The OIG made six recommendations to the under secretary for benefits, including ensuring proper admission and discharge reporting, as well as making certain that employees receive refresher training when needed.

PUBLICATIONS ON MANAGEMENT OF FINANCIAL OPERATIONS AND SYSTEMS

Audits and reviews of VA's administrative support functions and financial management operations focus on the adequacy of infrastructure to provide program managers and leaders with the information needed to be good stewards of the funds entrusted to them by efficiently and effectively overseeing and safeguarding 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.

LACK OF ADEQUATE CONTROLS FOR CHOICE PAYMENTS PROCESSED THROUGH THE PLEXIS CLAIMS MANAGER SYSTEM

The OIG examined whether the VA Office of Community Care accurately reimbursed millions of dollars to third-party administrators for payments made to community healthcare providers under the Veterans Choice Program for services to veterans during the audit period. The audit team found the office reimbursed third-party administrators at rates higher than what was typical for similar medical services in a given geographic area. The office could have saved approximately $132.1 million during the period audited if it reimbursed third-party administrators at verifiable usual and customary rates, as required by the contract. Additionally, the office did not fully implement prior OIG recommendations to develop effective payment and internal control processes for the Choice program. As a result, the office made about $73 million in overpayments to third-party administrators for medical services provided under the program. The OIG made eight recommendations in this report to address these issues.

FINANCIAL CONTROLS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS: IDAHO VETERANS RESEARCH AND EDUCATION FOUNDATION

The OIG investigated whether the former executive director of the Idaho Veterans Research and Education Foundation, a VA-affiliated nonprofit, improperly raised her pay and misused the nonprofit's credit card. It also assessed controls and oversight regarding the nonprofit's expenditures and VA payments. Findings confirm the former director did receive an unapproved salary increase and used the credit card for personal purchases. She pleaded guilty to federal program theft, paid about $44,300 in restitution, and was sentenced to five years' probation. The current executive director also received a questionable salary increase. Finally, VA improperly paid about $50,600 to the nonprofit due in part to insufficient oversight. Recommendations to the medical center director included determining whether administrative action should be taken against the current executive director, ensuring the nonprofit requires two or more officials oversee salary changes and better controls credit card use, and establishing procedures for proper invoice review and oversight.

FINANCIAL MANAGEMENT PRACTICES CAN BE IMPROVED TO PROMOTE THE EFFICIENT USE OF FINANCIAL RESOURCES

The purpose of this OIG audit was to review whether VHA established adequate financial management practices at the VA Southeast Network (VISN 7) and the VA Great Lakes Health Care System (VISN 12) to promote the efficient use of financial resources. The audit team found that VHA's financial management practices did not include financial controls, such as performance indicators, to readily assess whether its regional networks and medical centers were using their funds cost effectively. The OIG made three recommendations to VHA that included establishing key performance indicators that align with medical center operations and can be used to assess the efficient use of operating funds, specifying the office responsible for establishing financial controls at networks and medical centers, and requiring establishment and publication of organizational charts identifying the appropriate financial management reporting lines of authority and developing familiarization training on those lines of authority at the appropriate levels.

POTENTIAL PAYMENT ERRORS MADE BY VETERAN READINESS AND EMPLOYMENT SERVICE

The OIG issued a management advisory memorandum to VBA to request that VBA examine potential overpayments by the Vocational Rehabilitation and Employment Program. The payments to schools covered veterans' tuition. The OIG analyzed data on 1.8 million tuition payments and determined that the program potentially made 360 errors in payments from January 1, 2014, through December 30, 2019, totaling more than $554,000 in overpayments. The overpayments ranged from $18 to $237,762 and averaged $1,542. The errors appeared to have resulted from program staff transposing numbers or adding one or more digits to the invoice amounts. In alerting VBA, the OIG did not determine if the program corrected or recovered the overpayments. Given the small percentage of errors, the OIG did not initiate an audit or investigation. Instead, the OIG has provided the potential errors to VBA to examine and take any actions, including recovering overpayments, as appropriate.

FINANCIAL CONTROLS AND PAYMENTS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS: MIDDLE TENNESSEE RESEARCH INSTITUTE

The OIG evaluated the merits of a complaint alleging that the Middle Tennessee Research Institute (MTRI) overbilled the Nashville, Tennessee, VA Medical Center by at least $342,000. MTRI is a VA-affiliated nonprofit corporation and the bills were for Intergovernmental Personnel Act agreement reimbursements from 2014 through 2017. The OIG did not substantiate the May 2018 allegation. However, the audit team determined that both the medical center and MTRI made payments that lacked proper supporting documentation. The medical center made about $720,000 in such payments to MTRI from January 2014 through April 2018, and MTRI made about $337,000 in such payments from January 2017 through June 2018. The OIG recommended that the VA Tennessee Valley Healthcare System director ensure the appropriate staff (1) establish procedures for verifying the supporting documentation for expenditures, (2) confirm that services or goods were received, and (3) periodically review invoices that were authorized for payment.

FINANCIAL CONTROLS AND PAYMENTS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS: NORTHERN CALIFORNIA INSTITUTE FOR RESEARCH AND EDUCATION

The OIG evaluated a complaint alleging the former executive director of the VA-affiliated Northern California Institute for Research and Education spent about $740,000 on a project without review by the board of directors. The OIG also examined whether San Francisco VA Medical Center officials

adequately controlled and oversaw VA payments to the institute. The audit team found the board was aware of project costs to expand or relocate some or all of the medical center research and clinical activities. As a result, the OIG did not substantiate the allegation. However, the nonprofit's board did not ensure its activities and expenditures complied with restrictions in federal law and VHA policy that limited its purpose to supporting VA-approved research and education. The OIG found that the institute's directors did not ensure activities and expenditures complied with these restrictions and that medical center officials could not be sure payments to the institute were valid or accurate. The OIG made two recommendations to the medical center director concerning confirmation of the receipt of services or goods prior to approving payment and periodic reviews of invoices authorized for payment.

FY 2019 RISK ASSESSMENT OF VA'S CHARGE CARD PROGRAM

The OIG conducted an annual risk assessment of VA's charge card program by evaluating the three types of charge cards—purchase cards (including convenience checks), travel cards, and fleet cards—for transactions during FY 2019. Among its findings, 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 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 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 COMPLIANCE WITH THE IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT FOR FISCAL YEAR 2019

The OIG reviewed whether VA complied with Improper Payments Elimination and Recovery Act of 2010 requirements for FY 2019. VA did not comply because it did not satisfy two of the six requirements. VA did not meet annual reduction targets for a program considered at risk for improper payments and did not report a gross improper payment rate of less than 10 percent for six programs and activities. The OIG also determined VHA understated a program estimate because of insufficient documentation that services were received, and recommended VHA implement appropriate testing procedures. Four programs and activities were noncompliant for five consecutive fiscal years and two activities were noncompliant for three years. VA must submit compliance plans to Congress for them. VA satisfied the additional reporting requirements for two high-priority programs and another program with a monetary loss of more than $100 million as reported in FY 2018.

PUBLICATIONS ON MANAGEMENT OF INFORMATION TECHNOLOGY AND SECURITY

OIG audits and reviews VA's information technology (IT) systems and security operations. This work ensures the policies focusing on the adequacy of managing and protecting veterans and VA employees, facilities, and information are in place and fully implemented. 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 POLICE INFORMATION MANAGEMENT SYSTEM NEEDS IMPROVEMENT

VA has worked to improve its police program governance in response to a December 2018 OIG report that found overall weaknesses. This audit examined whether VA's police information systems have provided the information needed to further advance governance of police operations in its medical facilities. The OIG found VA did not have an effective strategy to update its police information system. Persistent weaknesses included inadequate planning that stalled new system implementation, limited officers' access to information, and created incompatible parallel systems. As a result, VA employees could not get law enforcement information needed to do their jobs. Information security controls were also lacking, putting individuals' sensitive personal information at risk. The OIG recommended VA consider the Law Enforcement Training Center's role in overseeing police records management, a working group to evaluate whether the updated system meets police needs, and a strategy to fully implement the system or its replacement.

VA IMPROVED THE TRANSPARENCY OF MANDATORY STAFFING AND VACANCY DATA

The OIG assessed reporting of staffing and vacancy data on the VA website. The VA MISSION Act of 2018 requires VA to publicly release this information quarterly. The review team found VA partially complied with Section 505 of the act by reporting time to hire data using a 100-day target instead of the Office of Personnel Management's required 80-day target. However, VA implemented sufficient corrective actions to close three of the five recommendations from the OIG's June 2019 report on this topic. VA also improved transparency and usefulness of its data by posting all quarterly staffing and vacancy publications on its public website, as well as summaries and additional context. The OIG recommended the assistant secretary for human resources and administration ensure time to hire data are reported as required and confer with the Office of General Counsel to ensure that changes in reporting methodology adhere to the Act.

PUBLICATIONS ON ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT

OIG audits and reviews VA's acquisition processes and oversight operations. These reports provide insight into the challenges of a large, decentralized purchasing system, through which a variety of offices play significant roles. Compliance with the Federal Acquisition Regulation (as well as title 48 C.F.R.) and VA's internal acquisition regulations ensures VA staff and veterans receive the best and most timely supplies and services VA staff and veterans receive the best and most timely supplies and services. The recommendations in these reports present VA with insightful and constructive means to improve the acquisition and procurement processes.

THE VETERANS HEALTH ADMINISTRATION'S GOVERNANCE OF ROBOTIC SURGICAL SYSTEM INVESTMENTS NEEDS IMPROVEMENT

This audit examined whether VHA adequately governs its purchase and use of robotic surgical systems, which cost between $1.5 million and $2.2 million each. The findings included that VHA did

not consistently support its acquisition of robotic surgical systems as required. Between June 2013 and September 2018, 13 of 45 systems had incomplete information to support a justification, and 10 systems had no documented evidence of VHA approval. This occurred because VHA did not adequately manage the internal process for submitting and reviewing applications to acquire the systems. VHA also lacked comprehensive data on robotic surgeries because medical facility staff recorded procedures inconsistently. Its National Surgery Office reported about 2,300 fewer procedures than the robotic systems manufacturer had tracked. The OIG made five recommendations, to which VHA concurred, to improve the governance of robotic surgical systems.

VA'S IMPLEMENTATION OF THE FITARA CHIEF INFORMATION OFFICER AUTHORITY ENHANCEMENTS

The OIG examined whether VA implemented key elements of Section 831 of the Federal Information Technology Acquisition Reform Act (FITARA) on Chief Information Officer Authority Enhancements. Specifically, the audit team evaluated whether VA met requirements involving the role of the VA chief information officer during FY 2018. These included the chief information officer role in (1) reviewing and approving all information technology (IT) asset and service acquisitions across the VA enterprise and (2) planning, programming, budgeting, and executing functions for IT, including governance, oversight, and reporting. The team found that VA did not meet these FITARA requirements and identified several causes, such as policies and processes that limit the chief information officer's ability to review IT investments. The OIG made 10 recommendations to help VA meet FITARA requirements. The recommendations focus on IT governance and oversight processes, acquisition processes, internal controls, policies and procedures, and training programs.

RESULTS FROM THE OFFICE OF CONTRACT REVIEW

OVERVIEW

The Office of Contract Review (OCR) provides VA's Office of Acquisition, Logistics, and Construction with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for Office of Acquisition, Logistics, and Construction contracting activities and conducts healthcare preaward review for VHA. OCR issued 76 reports during this reporting period including three public reports. The majority of reports completed by OCR are released only to the contracting officer because of proprietary and privacy information contained in the reports. The information that follows provides an overview of OCR's performance.

PREAWARD REVIEWS

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. 51 preaward reviews identified over $183 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 21 healthcare provider proposals, accounting for approximately $58 million of the identified potential savings.

51
PREAWARD REVIEWS

$183M
POTENTIAL COST SAVINGS

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 $18 million, including approximately $11 million related to compliance with the Veterans Health Care Act's 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 15 postaward reviews performed, seven involved voluntary disclosures. In five of the seven voluntary disclosure reviews, OCR identified additional funds due. VA recouped 100 percent of the recommended recoveries for postaward contract reviews.

15
POSTAWARD REVIEWS

$18M
DOLLAR RECOVERIES

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, OCR reviewed 10 claims and determined that $3.4 million of claimed costs were unsupported and should be disallowed.

PUBLICATIONS

SUMMARY OF FY 2019 PREAWARD REVIEWS OF HEALTHCARE RESOURCES PROPOSALS FROM AFFILIATES

VA spends millions of taxpayer dollars annually on healthcare resources procured without competition from affiliated institutions. This report provides a summary of the OIG's 27 reviews of healthcare resource proposals in FY 2019 before VA awarded the contracts (preaward reviews). Preaward reviews are used by contracting officers to negotiate fair and reasonable prices. Due to the sensitive commercial proprietary information included in the proposals, reports issued to VA to help obtain the best pricing are not published. This report, however, summarizes the OIG's findings for the 27 healthcare resource proposals and identifies the monetary benefit to VA without disclosing any sensitive commercial information. The OIG's lower pricing recommendations collectively reflected approximately $198 million in estimated cost savings to VA. More than $26 million has been sustained by VA. The 27 proposals included 77,701 annual hours of physician services and services priced per procedure and ordered as needed.

A SYNOPSIS OF PREAWARD REVIEWS OF VA FEDERAL SUPPLY SCHEDULE PHARMACEUTICAL PROPOSALS ISSUED IN FY 2019

VA and other government agencies spend billions of taxpayer dollars annually through VA's Federal Supply Schedule (FSS) contracting program. This report summarizes the OIG's 19 FSS reviews of pharmaceutical proposals before VA awarded the contracts (preaward reviews) during FY 2019. Due to the sensitive commercial proprietary information included in the FSS proposals, reports issued to VA are not published. This report presents the OIG's findings for the 19 FSS proposals and identifies the monetary benefit to VA without disclosing sensitive commercial information. The OIG determined that commercial pricing disclosures were not reliable for negotiations for 14 of the 19 proposals and recommended VA obtain revised disclosures before awarding the contracts. The OIG's FSS lower pricing recommendations collectively reflected more than $1 billion in estimated cost savings to VA. Nearly $203 million has been sustained by VA as of May 8, 2020. The 19 proposals included 862 drug items.

RESULTS FROM THE OFFICE OF CONTRACT REVIEW

VA'S NONCOMPLIANCE WITH PREAWARD REVIEW REQUIREMENTS FOR SOLE-SOURCE PROPOSALS FOR HEALTHCARE SERVICES

VA spends millions of dollars annually on sole-source healthcare resource contracts with affiliated educational institutions. This review examined whether VA complied with the requirement to obtain an OIG preaward review of these contract proposals from affiliates and the potential monetary impact of identified noncompliance. Preaward reviews generally provide VA with pricing recommendations based on the affiliate's actual expenses for providing services and are used by VA contracting officers to negotiate fair and reasonable prices for the government and taxpayers. Of the contracts that met the $500,000-plus threshold during the review period, VA awarded 63 percent without the required OIG preaward review. Contract files and other sources revealed contracting officers awarded and extended interim contracts using methods to circumvent the review requirements. Contracting officers also did not consistently document that the negotiated price was fair and reasonable, as required by regulation and policy. The OIG made three recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, the Office of Healthcare Inspections (OHI) published four national healthcare reviews and 29 inspection reports responsive to OIG hotline complaints on topics that are related to VHA operations and the access to and quality of care provided to patients. They addressed a broad range of topics such as mental health care, pharmacy deficiencies, care coordination, community living centers, and leadership. The office also published 20 Comprehensive Healthcare Inspection Program 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/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

53
PUBLICATIONS

2,564
HOTLINE REFERRALS REVIEWED

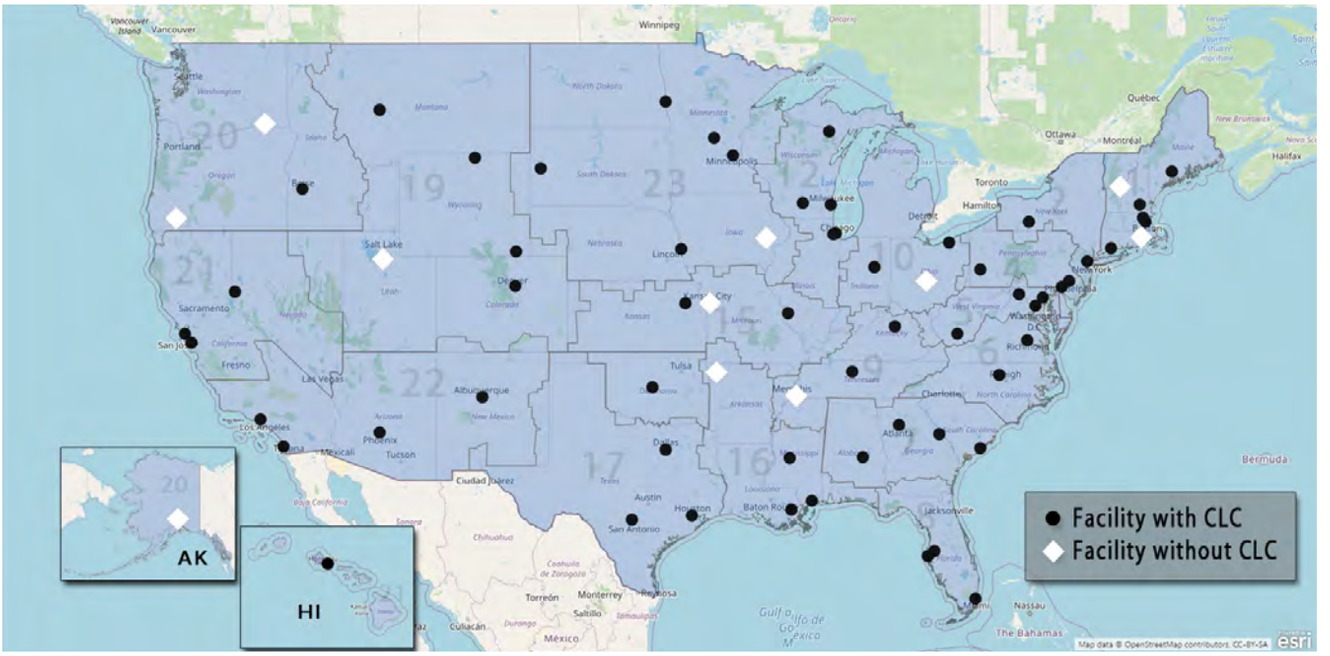
5
IN-DEPTH CLINICAL CONSULTATIONS

FEATURED PUBLICATIONS

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

REVIEW OF VETERANS HEALTH ADMINISTRATION'S COVID-19 RESPONSE AND CONTINUED PANDEMIC READINESS

On March 26, 2020, the OIG published its first COVID-19-focused report, *OIG Inspection of Veterans Health Administration's COVID-19 Screening and Pandemic Readiness*. In that report, the OIG evaluated how VHA was preparing facilities to meet anticipated rising demands. This second report outlined VHA's continued response to the pandemic and provides VHA leaders' descriptions of the evolving challenges they faced in caring for veterans and nonveteran patients as well. The OIG engaged leaders from 70 selected facilities in discussions about patient-care services provided from March 11, 2020, through June 15, 2020. The discussions covered the management of urgent and emergent care, the adequacy of equipment and supplies, testing capabilities, community living center (nursing home) admissions and discharges, testing protocols, and the engagement of community healthcare partners. Discussions also detailed VISN leaders' involvement in, and overall support of, facility operations. Finally, the OIG provided VHA leaders the opportunity to comment on plans to manage anticipated COVID-19 surges. Overall, this report highlighted a multitude of actions taken by VHA, VISN, and facility leaders to maintain operations during a national emergency. With the uncertainty of timing and magnitude of possible recurrent outbreaks, this review presented strategies that various facilities put into place over the past several months that will hopefully promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.



Map of VISNs (regions outlined in gray and numbered) as well as VHA facilities and community living centers virtually interviewed from June 15 through June 23, 2020.

INADEQUATE EMERGENCY DEPARTMENT CARE AND PHYSICIAN MISCONDUCT AT THE WASHINGTON DC VA MEDICAL CENTER

The OIG conducted an inspection at the Washington DC VA Medical Center (facility) to assess care provided to a patient six days prior to death by suicide and an allegation that an emergency department physician made a statement to the effect of "[the patient] can go shoot [themself]. I do not care." The OIG substantiated that the patient died by suicide six days after presenting to the emergency department with suicidal ideation and staff failed to complete required suicide prevention planning. During the 12-hour episode of care, the patient navigated two transitions between the emergency department and outpatient mental health clinic and saw seven providers. Lack of collaboration between providers, hand-off process deficiencies, and providers' failure to read the outpatient psychiatrist's notes led to a compromised understanding of the patient's medical needs and a failure to enact the outpatient psychiatrist's recommended treatment plan. The OIG substantiated that an emergency department physician made a statement to the effect of "[the patient] can go shoot [themself]. I do not care," which could be considered misconduct and patient abuse. Facility and contracted staff failed to report the behavior and did not receive required annual abuse and neglect policy education. The emergency department physician had a history of verbal misconduct. Despite facility leaders' awareness by late spring 2019 of the emergency department physician's inappropriate statement regarding the patient and prior pattern of misconduct, facility leaders did not conduct a formal fact-finding or administrative investigation as required by VA. The suicide prevention coordinator failed to complete the required suicide behavior report and the emergency department did not meet Veteran Health Administration's requirements for a safe and secure mental health evaluation area. The OIG made one recommendation to the VISN director and 10 recommendations to the facility director.

COMPREHENSIVE HEALTHCARE INSPECTION OF THE VA ST. LOUIS HEALTH CARE SYSTEM IN MISSOURI

This OIG Comprehensive Healthcare Inspection Program report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA St. Louis Health Care System and multiple outpatient clinics in Illinois and Missouri. The inspection covers key clinical and administrative processes that are associated with promoting quality care. For this inspection, the areas of focus were Leadership and Organizational Risks; Quality, Safety, and Value; Medical Staff Privileging; Environment of Care; Medication Management: Long-Term Opioid Therapy for Pain; Mental Health: Suicide Prevention Program; Care Coordination: Life-Sustaining Treatment Decisions; Women's Health: Comprehensive Care; and High-Risk Processes: Reusable Medical Equipment. The executive leadership team had worked together for over two years. Survey results indicated that employees were generally satisfied. However, patient survey results were often lower than the corresponding VHA averages, indicating multiple opportunities for system leaders to improve satisfaction. The OIG identified the lack of a permanent pain director as an area of vulnerability for the healthcare system. Executive leaders were able to speak knowledgeably about performance improvement actions taken during the previous 12 months, employee satisfaction, and patient experiences. The OIG issued 20 recommendations for improvement.

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.

REVIEW OF HIGHLY RURAL COMMUNITY-BASED OUTPATIENT CLINICS' LIMITED ACCESS TO SELECT SPECIALTY CARE

The OIG reviewed the accessibility of dermatology, orthopedics, and urology specialty care for patients in 17 community-based outpatient clinics classified as highly rural from March 1, 2018 (or from the date the community-based outpatient clinic became highly rural), through February 28, 2019. The OIG identified that sites mostly used referrals to their parent facility and community care specialty providers. Sites rarely used telehealth, inter-facility consults, and eConsults. The OIG made four recommendations to the under secretary for health to assess specialty care needs, ensure VHA Site Tracking System validation, ensure the maintenance of accurate information on VA websites, and assess whether highly rural community-based outpatient clinics located in non-VA health care centers fully utilized resources in the colocated facilities. After VHA implemented its COVID-19 Response Plan, four of the 17 highly rural community-based outpatient clinics closed and 13 listed pre-pandemic operations on their websites.

IMPROVING VA AND SELECT COMMUNITY CARE HEALTH INFORMATION EXCHANGES

The OIG reviewed how VA facilities and community providers used health information exchanges in their respective communities to share information and coordinate care for veterans enrolled at VA

facilities and identify any barriers that may be preventing optimum exchange of healthcare information. VA shares information with the community through two methods, VA Exchange and VA Direct. The OIG conducted a survey and interviewed VHA facilities with complexity levels of 2 or 3, for a total of 48 sites. Additionally, the OIG interviewed staff from the offices of Veterans Health Information Exchange, Information Technology, Community Care, Rural Health, two state health information exchanges, and Cerner. The most commonly cited challenges included training, the need for more community partners, use of contract community coordinators, and technology. The OIG made four recommendations.

OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and nonclinical occupations experiencing staffing shortages within VHA. In this seventh staffing report, the OIG evaluated severe occupational staffing shortages and compared this information to the previous two years. The OIG surveyed medical center directors and found 95 percent of facilities identified one or more severe occupational staffing shortages. Medical officer and nurse were the most frequently cited shortages. Within the medical officer occupational series, psychiatry was the most frequently identified clinical severe staffing shortage. Custodial worker was the most frequently identified nonclinical severe staffing shortage. Since FY 2018, the overall number of severe occupational staffing shortages decreased from 3,068 to 2,430 in FY 2020. Similarly, the number of occupations reported by at least 20 percent of facilities decreased from 30 to 17. The OIG made no recommendations.

HEALTHCARE INSPECTIONS

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 ACCESS TO CARE AND CAPABILITIES DURING VA'S TRANSITION TO A NEW ELECTRONIC HEALTH RECORD SYSTEM AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON

This review examined the first facility to transition to VA's new EHR to determine how the new EHR's capabilities could affect patients' access to care. The deficiencies identified in this report confirmed to VA leadership that the implementation of the Cerner Electronic Health Record should be delayed until FY 2021. Facility leaders lacked written guidance on handling an anticipated 30 percent drop in productivity that could affect patients' access to care. Although primary care access was addressed, understaffing (48.5 of 108 staff needed for EHR support) and a backlog of 21,155 community care referrals remained in January 2020. Staff needed to enact 84 mitigations for 62 moderate or high-risk systems to address gaps at the go-live date. Workarounds for VA's removal of an online prescription refill process and going live with fewer capabilities present risks to patient safety. The OIG made four

recommendations regarding productivity and capabilities to VA leaders, with two recommendations on facility support and two recommendations to the facility's director related to community care referrals and timely medication refills.

MANIPULATION OF RADIOLOGY REPORTS AND LEADERSHIP FAILURES IN THE MEDICAL IMAGING SERVICE AT THE CLEMENT J. ZABLOCKI VA MEDICAL CENTER IN MILWAUKEE, WISCONSIN

This inspection reviewed a radiologist's alleged errors with treatment delays and misleading addenda placement, leaders' tolerance of this practice, and leaders' response to an OIG query. The radiology manager manipulated an EHR by deleting a radiologist's interpretation. Facility leaders failed to manage ongoing interpersonal conflicts within the radiology service. The OIG did not substantiate the radiologist added addenda to cover errors causing treatment delays that contributed to patients' adverse clinical outcomes. However, the OIG determined leaders failed to conduct a thorough, impartial oversight review. The OIG made eight recommendations, including two under secretary for health recommendations regarding new EHR addenda formatting and a manager's imaging report deletion; two VISN director recommendations regarding image archiving and communication system practices as well as OIG Hotline case referral oversight; and four facility director recommendations regarding an erroneous imaging study correction, radiology service oversight and management, radiology service's workplace culture, and workplace intimidation training and employees' reporting process.

RADIOLOGY CONCERNS AT THE VA ILLIANA HEALTH CARE SYSTEM IN DANVILLE, ILLINOIS

This inspection assessed facility leaders' response to a radiologist's four alleged errors. The OIG determined that care for one of the four patients met institutional disclosure criteria. Facility leaders conducted two expanded reviews of the radiologist with VISN and National Teleradiology Program assistance. The OIG concluded the Radiology Service lacked early detection and identification processes for radiologic errors, and the radiology service chief inadequately assessed the radiologist's performance. The OIG made six recommendations: one to the under secretary for health regarding radiologists' professional practice evaluation guidelines; one to the VISN director regarding continued oversight of the facility's response to National Teleradiology Program findings; and four to the facility director regarding disclosures to patients or families, Radiology Service improvements in quality assurance and performance plans, radiologist competency reviews based on VA's National Guidelines for Radiology Professional Competency, and further evaluation of National Teleradiology Program final findings.

CRITICAL CARE UNIT STAFFING AND QUALITY OF CARE DEFICIENCIES AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

The OIG assessed allegations that inadequate nurse staffing resulted in the development of pressure ulcers, inadequate cardiac and respiratory care, and medication management failures. Lack of consistent documentation prevented the OIG from determining whether nurse staffing contributed to many of the alleged conditions. Noncompliant practices and other deficits were identified that contributed to care management challenges and increased risk for poor clinical outcomes. Facility and tele-intensive care unit (tele-ICU) staff did not immediately recognize and respond to a life-threatening arrhythmia, which may have contributed to a patient's death. Other OIG-identified deficits related to the facility's pressure injury program, respiratory care, and medication management. Recommendations were made related to compliance with VHA and local requirements for pressure injury prevention and management including nursing documentation. Other recommendations focused on tele-ICU and cardiac monitoring,

the respiratory care for a specific patient, processes for securing sitters, and nursing staff assignment practices.

DELAYS IN DIAGNOSIS AND TREATMENT AND CONCERNS OF MEDICAL MANAGEMENT AND TRANSFER OF PATIENTS AT THE FAYETTEVILLE VA MEDICAL CENTER IN NORTH CAROLINA

The OIG assessed the diagnostic delay and treatment of one patient's (Patient A) leukemia, a second patient's (Patient B) admission, inter-facility transfer processes, and facility responses to both patients' deaths. A primary care provider failed to act on Patient A's abnormal laboratory results and pathologists' recommendations. The OIG was unable to determine whether a delay in diagnosing and treating Patient A's leukemia occurred. A hospitalist failed to initiate the emergency transfer protocol, which delayed Patient A's transfer. Staff response to an emergency medical service's call delayed Patient B's inter-facility transfer. Patient B died, but the OIG was unable to determine whether the delay was a factor. The facility's policy did not reflect available treatment capabilities. Leaders did not conduct comprehensive analyses of the deaths. The OIG made 12 recommendations regarding abnormal laboratory results, community care processes, emergency patient treatment and transfer policy updates, facility responses to the events, and providers' evaluations.

Visit the OIG's Recommendation Dashboard at www.va.gov/oig/recommendation-dashboard.asp to track VA's progress in implementing OIG recommendations.

DEATH OF A PATIENT, DEFICIENCIES IN DOMICILIARY SAFETY AND SECURITY, AND INADEQUATE CONTRACTUAL AGREEMENT AT THE VA NORTHEAST OHIO HEALTHCARE SYSTEM IN CLEVELAND

This healthcare inspection of the facility's domiciliary assessed alleged deficiencies in the care of a patient who died. The team also examined safety and security measures and nurse staffing. In response to a congressional request, the OIG evaluated whether Volunteers of America (VOA) met contractual requirements for providing nonclinical staffing and food and cleaning services. The OIG did not substantiate that emergency department staff failed to properly assess the patient; however, no provider ordered an electrocardiogram as recommended by VHA prior to initiating methadone. VOA staff were found to have improperly completed health and safety sheets. The OIG determined nurse staffing was not unsafe and core clinical staffing met or exceeded requirements. VOA substantially met its contractual obligations. Two recommendations were made to the VA Office of Asset Enterprise Management director related to contract modifications, and three were made to the facility director related to electrocardiograms, institutional disclosure, and safety rounds.

COORDINATION OF CARE AND EMPLOYEE SATISFACTION CONCERNS AT THE COMMUNITY LIVING CENTER, LOCH RAVEN VA MEDICAL CENTER, IN BALTIMORE, MARYLAND

This inspection evaluated allegations at the community living center involving managers' interactions with staff and inadequacies with staffing, laboratory, medication delivery, and environmental temperature regulation. Additional concerns involved employee dissatisfaction and critical laboratory result notifications. Although allegations regarding manager interactions with staff were not substantiated, leaders acknowledged persistent dissatisfaction could impact resident care. The community living center maintained adequate nurse and provider staffing. Laboratory specimen handling led to inaccurate potassium results and unnecessary treatments, and laboratory staff failed

to investigate and resolve the cause. Also, providers were inconsistently notified of critical laboratory results. The lack of an on-site pharmacy likely contributed to medication delivery delays. However, during the inspection, the System Director announced plans for an on-site pharmacy. The OIG did not substantiate additional allegations of an inability to regulate environmental temperatures as staff provided timely responses to periodic temperature issues. The OIG made five recommendations regarding employee satisfaction, laboratory processes, and medication delivery.

DEFICIENCIES IN NURSING CARE AND MANAGEMENT IN THE COMMUNITY LIVING CENTER AT THE COATESVILLE VA MEDICAL CENTER IN PENNSYLVANIA

An inspection was initiated regarding deficiencies in the community living center at the Coatesville VA Medical Center. The OIG substantiated the allegation that a nurse left medication in a patient's room. The OIG found deficiencies, which included inconsistent documentation of compliance with medication order instructions, pain assessments, and pain management plans; fall prevention and post-fall assessments; fall prevention measures; nursing wound prevention processes; and inconsistent use of the fall prevention measure of answering call bells. The OIG identified other findings not specifically related to the allegations, including the failure to follow the approval procedure for a new hourly rounding form, ineffective implementation of a new nurse rounding procedure, incomplete fact-finding reviews, inconsistent facility committee documentation, and inoperable safety equipment. One possible contributing factor for the identified deficiencies was an outdated policy that did not follow staffing methodology requirements. The OIG made nine recommendations related to documentation, procedural compliance, and ensuring operational safety equipment for transfers.

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=63.

DEFICIENCIES IN VIRTUAL PHARMACY SERVICES IN THE CARE OF A PATIENT

The OIG evaluated concerns related to a Virtual Pharmacy Services (VPS) pharmacist's discontinuation of one of two antidepressant medications for a Minneapolis VA Health Care System patient who died by suicide six weeks later. The OIG found that the pharmacist did not access the patient's electronic health record or notify the psychiatrist when discontinuing the medication. The OIG was unable to determine whether the discontinuation of the antidepressant medication contributed directly to the patient's death; however, possible worsening of the underlying depressive illness may have been a contributing factor. Other findings included that VPS pharmacists were unable to fully perform the duties as described in their functional statement and the 95 prescriptions-per-hour productivity target may be unreasonable. Also, pharmacy benefits management leaders failed to monitor VPS prescription processing accuracy and outline program management and quality assurance objectives and processes. The OIG made five recommendations to the under secretary for health.

DEFICIENCIES IN EVALUATION, DOCUMENTATION, AND CARE COORDINATION FOR A BARIATRIC SURGERY PATIENT AT THE VA PITTSBURGH HEALTHCARE SYSTEM IN PENNSYLVANIA

This inspection assessed allegations of inadequate preoperative evaluations and the management of postoperative care for a patient approved for bariatric surgery at the VA Pittsburgh Healthcare System. The OIG did not substantiate that the patient was inappropriately or inadequately evaluated and

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=65.

approved for bariatric surgery. The lack of three preoperative tests did not affect surgical outcome. The OIG substantiated that the Managing Overweight and/or Obesity for Veterans Everywhere coordinator overstated the patient's mental health treatment and did not correct the documentation error after discovering it. The OIG noted that the lack of formal communication could have contributed to the incomplete preoperative evaluation. The patient was sufficiently monitored following surgery but completed suicide despite consistent postoperative care. The OIG made six recommendations regarding development and review of policy and procedure for bariatric surgery evaluations, communication, and staff education on documentation requirements.

ANESTHESIA PROVIDER PRACTICE CONCERNS AT THE W.G. (BILL) HEFNER VA MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

A healthcare inspection was conducted to evaluate an anesthesia provider's practice. Unsafe practices were not identified after review of nine identified patient electronic health records. Initial hiring process deficiencies were noted related to the provider's reporting, and the facility's verification, of previous employment. The provider did not accurately document a prior discharge, and the facility credentialing and privileging staff did not complete required timely verifications. Additionally, the provider's personnel file was missing proficiency reports. Facility staff did not consistently follow VHA policy to report patient safety events and quality of care concerns, affecting facility leaders' ability to respond and take appropriate action. One recommendation, made to the under secretary for health, addressed physician applicants' listing of contracting companies. Other recommendations made to the facility related to credentialing and privileging checks, annual proficiency reports, reporting to the Professional Standards Board, and training related to patient safety reporting.

INADEQUATE CARE BY A CLINICAL PHARMACY SPECIALIST AND A PRIMARY CARE PROVIDER AT THE TENNESSEE VALLEY HEALTHCARE SYSTEM IN NASHVILLE

This healthcare inspection evaluated an allegation that a clinical pharmacy specialist (CPS) failed to act on a patient's abnormal test results, resulting in the patient going undiagnosed and untreated for pancreatic cancer for three months. Findings included that a primary care provider failed to acknowledge or assess the patient's unintentional weight loss during an annual physical; the CPS failed to act on a patient's abnormal test results, including communicating the results to the patient; and VHA's current electronic health record lacks a process to ensure that test results are communicated and acted upon by ordering providers. Facility policies and practices supported CPSs collaborating with primary care providers when patients' conditions changed; however, an opportunity for collaboration was missed in this instance. The OIG made two recommendations related to reviewing the patient's episode of care and ensuring staff are aware of and follow the VHA directive regarding communication of test results.

SAFETY CONCERNS WHEN PROVIDING CARE IN THE COMMUNITY AT THE VA SOUTHERN NEVADA HEALTHCARE SYSTEM IN NORTH LAS VEGAS

Following a referral from the U.S. Office of Special Counsel, the OIG evaluated allegations that facility leaders responded inadequately after a patient attacked and later threatened a social worker. The OIG substantiated managers failed to timely respond after the social worker reported an assault during a home visit and did not address the social worker's health needs after the assault. The social worker was not informed by a supervisor of a subsequent threat until two weeks after facility leaders became aware of the threat. Additional issues included disruptive behavior flag placement, VA police participation deficiencies in Disruptive Behavior Committees, and staffing in the facility Housing and

Urban Development Veterans Affairs Supporting Housing (HUD-VASH) program. The OIG made six recommendations related to off-campus patient disruptive behavior incidents, work-related emotional or mental health injury, timely notification of threats, patient record flags, Disruptive Behavior Committee, and HUD-VASH staffing and training.

CONSULT DELAYS AT THE ATLANTA VA HEALTH CARE SYSTEM IN DECATUR, GEORGIA

The OIG conducted an inspection and substantiated that three patients experienced delays in non-VA community care consult (NVCC) scheduling. However, the delays did not result in increased risk of or adverse clinical outcomes for the three patients. The OIG performed an expanded review of 221 consults and found delays. Two of the 221 patients had an increased risk of an adverse clinical outcome; however, both patients received care, and neither experienced an adverse clinical outcome. The other patients reviewed did not have increased risks of or adverse clinical outcomes related to consult delays. The facility also had a backlog of open NVCC consults with contributory factors that included deficiencies in consult processing, scheduling, and timeliness; scheduling audits; and consult procedures. The OIG made six recommendations to the facility director related to NVCC consult management, hiring, and training of staff; patient case reviews; and NVCC policy.

ALLEGED DEFICIENCIES WITHIN THE CARDIAC TELEMETRY MONITORING SERVICE AT THE NASHVILLE VA MEDICAL CENTER IN TENNESSEE

This inspection evaluated alleged deficiencies related to cardiac telemetry monitoring services including policies, staffing, and communication. The OIG did not substantiate outdated telemetry policies, staffing shortages, inadequate training, or inappropriate treatment of patients with "do not resuscitate" orders. Isolated communication issues between telemetry technicians and telemetry patient nurses related to the location and movement of telemetry patients in the hospital were identified. However, an electronic patient tracking system was available in an emergency. In 2018, facility leaders identified other communication issues. The OIG reviewed facility leaders' actions and noted overall improvement. The rapid response team policy and staff practice regarding the initiation of a rapid response team call did not always align, which is important to mitigate system vulnerabilities. The OIG made one recommendation to the Tennessee Valley Healthcare System director to ensure consistency between the system's policy and actual practice for initiating a rapid response team call.

FACILITY OVERSIGHT AND LEADERS' RESPONSES RELATED TO THE DEFICIENT PRACTICE OF A PATHOLOGIST AT THE HUNTER HOLMES MCGUIRE VA MEDICAL CENTER IN RICHMOND, VIRGINIA

The OIG initiated an inspection to evaluate facility leaders' oversight and response to misdiagnoses by a pathologist. The Pathology and Laboratory Medicine chief (chief) performed quality reviews, identified a misdiagnosis, and conducted comprehensive reviews that identified additional misdiagnoses. Facility leaders suspended, and then terminated, the pathologist. The pathologist appealed to the VHA Disciplinary Appeals Board and was subsequently reinstated. The chief reviewed the misdiagnoses, completed supplemental reports, and notified providers. The OIG found no documentation that providers informed three patients of their misdiagnoses. One patient experienced an adverse clinical outcome with no documented disclosures. Staff and leaders did not report the misdiagnoses as adverse events. Quarterly retrospective reviews of all pathology reports exceeded requirements, but the chief did not consistently review 10 percent of each pathologist's cases. Leaders did not follow mandated privileging processes and were unaware of state licensing board reporting requirements. The OIG made 10 recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

FOCUSED PERFORMANCE REVIEW OF SELECT METRICS AT THE IOANNIS A. LOUGARIS VA MEDICAL CENTER IN RENO, NEVADA

The OIG conducted a review to identify and evaluate declining performance as reflected in the facility's Strategic Analytics for Improvement and Learning data. The OIG focused on the facility's performance in six quality domains—Access, Performance Measures, Mental Health, Emergency Department Throughput, Patient Experience, and Employee Satisfaction, as well as leaders' awareness of and response to the negative trending. The OIG did not find evidence of large-scale system or process deficits such as a dysfunctional organizational or communication structure. In relation to the six quality domains, the OIG found staffing and pay issues, as well as inefficient processes, that may have contributed to some of the selected performance measure declines. One recommendation was made to the facility director to ensure that mechanisms to report and follow up on performance deficits were well defined and disseminated to staff, and that monitors were in place to confirm functionality.

ALLEGED DEFICIENCIES IN PHARMACY SERVICE PROCEDURES AT THE LOUIS A. JOHNSON VA MEDICAL CENTER IN CLARKSBURG, WEST VIRGINIA

This healthcare inspection reviewed deficiencies in pharmacist orientation and training, intravenous (IV) admixture compounding, and staff's annual competencies. Allegations of pharmacy management's noncompliance with controlled substance policies were also reviewed. The OIG did not substantiate deficiencies in pharmacist orientation and training or a lack of pharmacist oversight in IV admixtures. The staff's annual competencies were current; however, the orientation checklists and competencies lacked a tracking mechanism. Pharmacy managers complied with VHA's controlled substance directive. Facility leaders reported a suspected controlled substance diversion incident to the VA police and the OIG, but not to the required VHA email group. On one occasion, testosterone was not added to inventory records or secured. The OIG made three recommendations related to developing a tracking process for orientation and competencies of pharmacy staff, ensuring facility leaders are trained on current drug diversion reporting requirements, and conducting a review of the testosterone misplacement.

SURROGATE DECISION-MAKER, CLINICAL, AND PATIENT RIGHTS DEFICIENCIES AT THE ROBLEY REX VA MEDICAL CENTER IN LOUISVILLE, KENTUCKY

The OIG substantiated an allegation that providers permitted a patient's neighbor, who had no legal authority, to make medical decisions for the patient. The patient had a three-week hospitalization that was marked by repeated episodes of confusion and agitation, was transferred to hospice care, and died five days later. Facility staff did not take the required steps to identify and confirm the eligibility of the patient's surrogate, such as reviewing other VA records, due to staff's varied understanding of the procedures and requirements. The OIG noted additional clinical and patient rights deficiencies and reviewed the facility leaders' evaluation of the deficiencies in the patient's care. The OIG made 15 recommendations to the facility director focusing on the patient's decision-making capacity, surrogate identification, medical assessments, medication management, a review of the patient's hospice admission, patients' rights, and quality management processes.

INADEQUATE INPATIENT PSYCHIATRY STAFFING AND NONCOMPLIANCE WITH INPATIENT MENTAL HEALTH LEVELS OF CARE AT THE VA CENTRAL WESTERN MASSACHUSETTS HEALTHCARE SYSTEM IN LEEDS

The inspection was conducted, in response to a referral from Senator Elizabeth Warren and a complaint, to assess mental health staffing, lengths of stay, medical assessments, prescribing practices, nurse staffing methodology, health programming, and facility levels of care. Inpatient psychiatry staffing was below expected levels but did not contribute to increased lengths of stay. The OIG was unable to determine if medical provider staffing was inadequate. All required utilization management reviews were not completed. The OIG did not substantiate that patients remained on the acute inpatient mental health unit to treat medical issues or inappropriate prescribing practices. Nurse staffing methodology was not completed and required health programming was not occurring. Facility leaders failed to convert sustained treatment and rehabilitation and posttraumatic stress disorder beds to acute or residential beds. Recommendations were made related to staffing, utilization management reviews, medical assessments, nurse staffing methodology, programming, and levels of care.

ALLEGED DEFICIENCIES IN THE MANAGEMENT OF STAFF EXPOSURE TO A PATIENT WITH COVID-19 AT THE VA PORTLAND HEALTH CARE SYSTEM IN OREGON

This healthcare inspection evaluated the management of staff exposure to a patient with COVID-19. This was the facility's first patient diagnosed with COVID-19. The OIG did not substantiate that emergency department staff failed to notify imaging department staff before transferring a patient with COVID-19, that supervisors failed to promptly notify staff about exposure to a patient with COVID-19, or that leaders failed to take appropriate action following staff exposure to a patient with COVID-19. The OIG identified some missteps in the facility's processes when responding to staff exposure, which affected the accuracy of exposure risk assessments and monitoring for some exposed staff. While missteps were noted, the facility made timely efforts to identify exposed staff and respond according to Centers for Disease Control and Prevention guidance. The OIG made five recommendations to the facility director related to communicating infection control precautions, managing staff exposed to high-consequence infections, and implementing a detailed staff exposure management processes in facility policies.

DEFICIENCIES IN CARE, CARE COORDINATION, AND FACILITY RESPONSE TO A PATIENT WHO DIED BY SUICIDE AT THE MEMPHIS VA MEDICAL CENTER IN TENNESSEE

This healthcare inspection evaluated whether a patient received the care needed at the Memphis VA Medical Center. The patient died by suicide the day following a visit to the emergency department. The OIG substantiated that the patient presented to the emergency department seeking treatment for insomnia and psychiatric medication refills. After an evaluation and negative suicide screening, the patient was discharged with instructions to go to the outpatient mental health clinic immediately for medication management. The OIG found no documentation that the patient registered or received treatment in the clinic. The patient received mental health care through the community. The OIG found deficiencies in care coordination with facility community care staff, community care providers, and the third-party administrator. Authorizations for community care treatment were not timely, resulting in the patient's inability to receive several medication refills. The OIG made 16 recommendations to the facility director.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

MISMANAGEMENT OF EMERGENCY DEPARTMENT CARE OF A PATIENT WITH ACUTE CORONARY SYNDROME AT THE ROBERT J. DOLE VA MEDICAL CENTER IN WICHITA, KANSAS

The healthcare inspection assessed allegations that coordination and quality of care issues contributed to the delay of an interfacility transfer resulting in a patient death shortly after transfer from the facility to a community hospital. The OIG substantiated that coordination and quality of care issues in the management of a patient who presented to the emergency department with acute coronary syndrome symptoms contributed to the patient's death. The emergency department physician mismanaged the patient's care by failing to initiate a timely interfacility transfer to a hospital capable of providing percutaneous coronary intervention (PCI). The failure to transfer the patient for PCI within 30 minutes of arrival limited the patient's chances for the best possible outcome. The OIG made one recommendation to the VISN related to peer review and nine recommendations to the facility director related to staff training, interfacility transfers, policy updates, committee oversight, and institutional disclosure.

PHARMACY PROCESS CONCERNS AND IMPROPER STAFF COMMUNICATION AT THE HUNTER HOLMES MCGUIRE VA MEDICAL CENTER IN RICHMOND, VIRGINIA

This inspection assessed allegations related to the prior authorization drug request process. The required consult template included limited space and prescribers did not always know about an option to document supplemental information. The relationship between Pharmacy and Therapeutics Committee leaders and the mental health representative was problematic and noncollaborative. The prior authorization drug request process did not delay treatment; however, a mental health prescriber may have contributed to one patient not receiving medications. Facility leaders did not effectively resolve unprofessional communications between Mental Health and Pharmacy Services staff. A pharmacist canceled medication orders without communicating with a patient; however, the requesting prescriber was required to notify the patient. Pharmacists did not cancel medication orders without communicating with the requesting prescriber or deny a large number of requests. The OIG made five recommendations regarding prescriber education, effective treatment plans, review of electronic health records and email, and workplace relationships.

DEFICIENCIES IN PROVIDER OVERSIGHT AND PRIVILEGING PROCESSES AT THE CARL VINSON VA MEDICAL CENTER IN DUBLIN, GEORGIA

The OIG evaluated facility leaders' response to a report that a urologist had physical impairments. Leaders failed to adequately oversee the urologist's performance by not formally evaluating reported impairments. Management reviews were conducted, but processes were flawed. Privileging process failures delayed removing the urologist's privilege to perform open procedures, and the urologist was not properly informed of active privileges. Facility leaders were noncompliant with VHA directives regarding reporting physicians to the National Practitioner Data Bank and state licensing boards. Frequent personnel changes in leadership positions affected oversight, privileging, and reporting processes. Poor communication regarding the urologist, a lack of knowledge of position responsibilities, and inexperienced support staff contributed to noncompliance. The OIG previously identified deficiencies in focused professional practice evaluations and National Practitioner Data Bank reporting; therefore, recommendations were not made regarding these issues. The OIG made six recommendations to VISN 7 and facility directors.

NURSE STAFFING, PATIENT SAFETY, AND ENVIRONMENT OF CARE CONCERNS AT THE COMMUNITY LIVING CENTER WITHIN THE SAN FRANCISCO VA HEALTH CARE SYSTEM IN CALIFORNIA

This inspection assessed allegations related to staffing shortages, adverse events, environment of care, infection control, a registry agency's provision of staff, and registry staff's inability to document care. Facility leaders failed to address community living center staffing shortages yet maintained a high resident census, reduced the number of operating beds without VHA authorization, used inaccurate staffing targets, and relied on inconsistently supplied registry staff. The facility did not further analyze an event with a higher potential for an adverse clinical outcome. Registry staff could not document in electronic health records. Twenty-four-hour Environmental Management Service support was not consistently available or easily contacted. Staff did not meet hand-hygiene compliance. The community living center had flying insects. Managers followed identified quarantine processes. The OIG made 10 recommendations regarding staffing methodology, operating beds, staff retention and recruitment, adverse events, registry staff electronic health record access, pest control, hand hygiene, and contract performance.

DEFICIENCIES IN PHARMACY AND NURSING PROCESSES AT THE SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM IN NEW ORLEANS

The OIG conducted a healthcare inspection to evaluate concerns that failure to follow pharmacy and nursing policies and procedures may have contributed to the death of a patient. The OIG determined that pharmacy staff failed to comply with a facility policy's intent by sending an unaffixed IV norepinephrine label to the intensive care unit. Subsequently, an intensive care unit nurse failed to follow policy when they placed the incorrect IV norepinephrine label on the IV fentanyl without first verifying the patient and medication information. Intensive care unit nursing staff also failed to follow infusion rate orders, assess the medication effectiveness, and did not completely document their actions and findings. Additional concerns the OIG identified included unsecured IV controlled substances and the facility's failure to conduct a thorough review of the medication error. The OIG made eight recommendations.

DEFICIENCIES IN CARE AND EXCESSIVE USE OF RESTRAINTS FOR A PATIENT WHO DIED AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

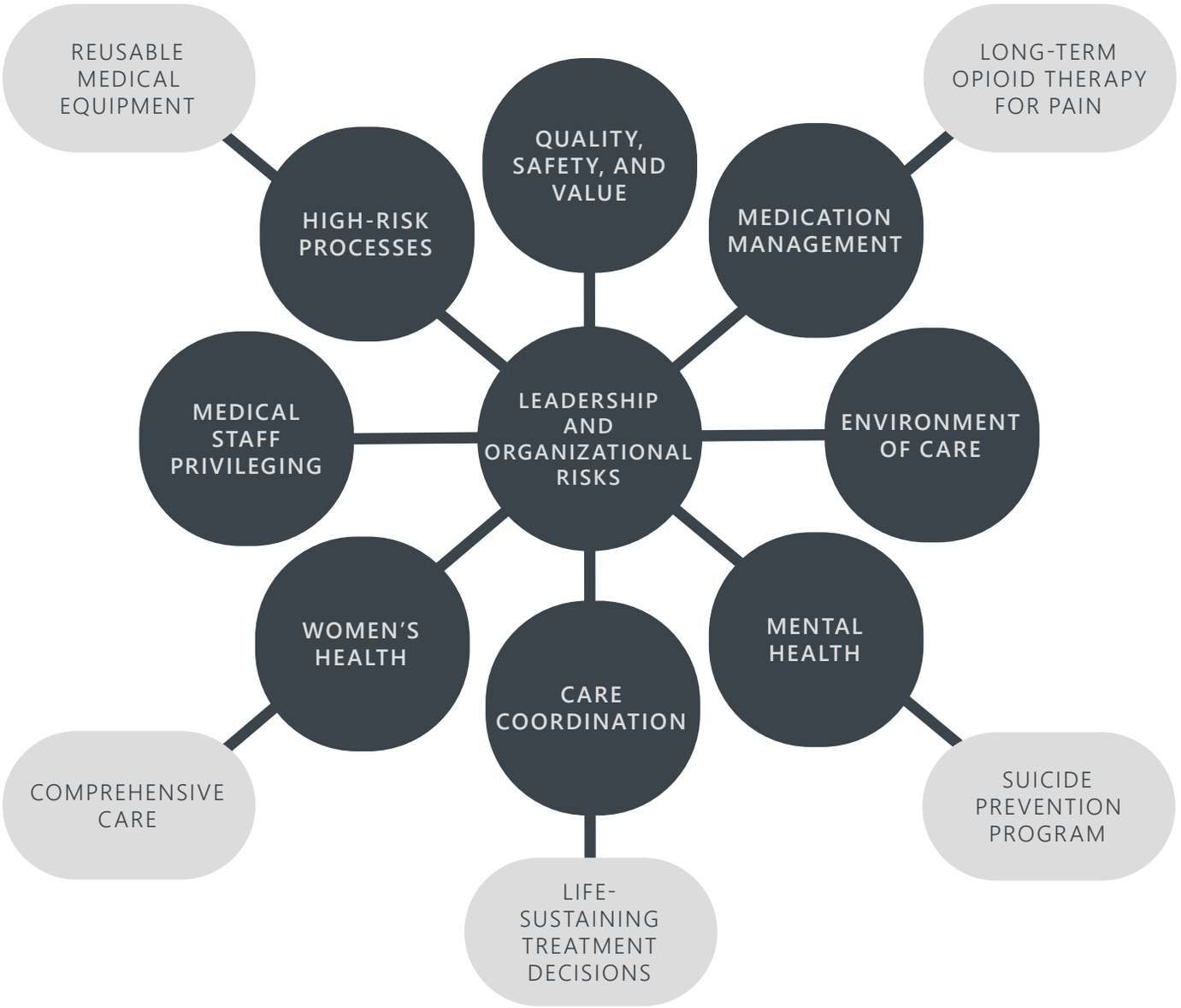
This inspection evaluated allegations related to the care provided to a patient who died at the facility and an allegation of inadequate psychiatric provider coverage. The OIG did not substantiate that the patient died due to overmedication, because the cause of death was pulmonary thromboemboli. Given that the patient was restrained for approximately 71 hours, the staff's failure to effectively address the patient's deep vein thrombosis prophylaxis needs contributed to the patient's death. Facility leaders and staff failed to comply with Georgia State law involuntary commitment process requirements. The lack of mental health provider involvement likely contributed to the patient's death. The Downtown Division lacked adequate psychiatric providers. The OIG concluded that the Disruptive Behavior Committee failed to provide input that may have contributed to a mismanagement of the patient's mental health treatment needs. The OIG made 18 recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTIONS

Comprehensive healthcare inspections 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 20 comprehensive healthcare inspections, which are listed in appendix A. Comprehensive healthcare inspections 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 18 medical centers and healthcare systems and two 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 415,000 employees; and offenses affecting the Department's programs and operations.

73
ARRESTS

65
CONVICTIONS

$2.1B
MONETARY BENEFITS

FEATURED INVESTIGATIONS

The investigations 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 CLARKSBURG, WEST VIRGINIA, VA MEDICAL CENTER NURSING ASSISTANT PLEADS GUILTY TO SECOND-DEGREE MURDER AND ASSAULT WITH INTENT TO COMMIT MURDER

A former nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, pleaded guilty in the Northern District of West Virginia to seven counts of second-degree murder and one count of assault with intent to commit murder. An investigation by the VA OIG and the Federal Bureau of Investigation (FBI), which received assistance from the West Virginia State Police and the Greater Harrison County Drug and Violent Crimes Task Force, revealed that the defendant administered insulin to several patients under her care with the intent to cause their deaths. In her role as a nursing assistant, the defendant was not qualified or authorized to administer any medication to patients, including insulin. As a result of her actions, several patients died of hypoglycemia.

DEFENDANT ARRESTED IN CONNECTION WITH AN ALLEGED MULTIMILLION DOLLAR COVID-19 SCAM

A defendant was arrested after being charged in the District of Columbia with wire fraud in connection with an alleged COVID-19 scam. An investigation by the VA OIG and Homeland Security Investigations resulted in charges alleging the defendant made a series of fraudulent misrepresentations in an attempt to secure orders from VA for 125 million face masks and other personal protective equipment that would have totaled over $750 million. The defendant allegedly promised that he could obtain millions of genuine 3M masks from domestic factories when he knew that fulfilling the orders would not be possible. The defendant also allegedly made similar false representations in an effort to enter into other fraudulent agreements to sell personal protective equipment to state governments.

FORMER VETERANS HEALTH ADMINISTRATION EMPLOYEE SENTENCED IN CONNECTION WITH FRAUD SCHEME

A former VHA Office of Community Care benefits advisor was sentenced in the District of Colorado to 192 months' imprisonment and three years' supervised release and was also ordered to pay restitution of $18,777,135 to VA. Following an eight-day trial, the defendant was previously found guilty by a federal jury of conflict of interest, healthcare fraud, conspiracy, soliciting an illegal gratuity, receiving an illegal gratuity, unlawful monetary transactions, and money laundering. An investigation by the VA OIG, FBI, and Internal Revenue Service Criminal Investigation (IRS-CI) resulted in charges that the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives in exchange for kickbacks. As a result of these referrals, VA paid the home health agencies approximately $19 million.

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 reporting period, OI opened 70 cases; made 40 arrests; obtained nearly $27 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved over $5.3 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.

Cases Involving Patient Harm

FORMER FAYETTEVILLE, ARKANSAS, VA MEDICAL CENTER CHIEF OF PATHOLOGY PLEADS GUILTY TO INVOLUNTARY MANSLAUGHTER AND MAIL FRAUD

A former Chief of Pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, pleaded guilty in the Western District of Arkansas to involuntary manslaughter and mail fraud. A VA OIG investigation revealed the defendant misdiagnosed thousands of VA patients while under the influence of a potent substance that causes a lengthy intoxication period but no hangover and is undetectable using routine drug and alcohol testing methods. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency.

FORMER BECKLEY, WEST VIRGINIA, VA MEDICAL CENTER DOCTOR PLEADS GUILTY TO CIVIL RIGHTS OFFENSE

A former Beckley, West Virginia, VA Medical Center doctor specializing in Osteopathic Manipulation Therapy pleaded guilty in the Southern District of West Virginia to the deprivation of rights under the color of law (civil rights). A VA OIG, FBI, and VA Police Service investigation revealed that the defendant sexually abused three patients who sought chronic pain treatment during examinations at the facility.

FORMER CONTRACT PHYSICIAN AT THE WATERTOWN, NEW YORK, VA OUTPATIENT CLINIC SENTENCED FOR FORCIBLE TOUCHING

A former VA outpatient clinic contract physician based in Watertown, New York, was sentenced in the Superior Court of Jefferson County, New York, to six years' probation with sex offender conditions and ordered to turn over his medical license after previously pleading guilty to forcible touching. A VA OIG and New York State Police investigation revealed that the defendant sexually abused multiple active-duty service members while conducting disability evaluation physical examinations as part of their military service separation process.

Healthcare Fraud

MEDICAL TECHNOLOGY COMPANY PRESIDENT CHARGED WITH SECURITIES FRAUD AND CONSPIRACY TO COMMIT HEALTHCARE FRAUD

The president of a medical technology company was arrested after being charged in the Northern District of California with securities fraud and conspiracy to commit healthcare fraud. A VA OIG, Department of Health and Human Services (HHS) OIG, U.S. Postal Inspection Service, and Defense Criminal Investigative Service (DCIS) investigation resulted in charges alleging the defendant conspired to improperly bill healthcare insurers for approximately $69 million in false and fraudulent claims for allergy and COVID-19 testing. The defendant and others allegedly schemed to manipulate the company's stock price by making false claims concerning the company's ability to provide accurate, fast, and cheap COVID-19 tests in compliance with federal and state regulations. It is further alleged the defendant and others made numerous misrepresentations to potential investors about the COVID-19 tests and used a VA solicitation to further the stock manipulation scheme.

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

OWNERS OF DURABLE MEDICAL EQUIPMENT COMPANIES PLEAD GUILTY TO CONSPIRACY TO COMMIT HEALTHCARE FRAUD

Two owners of numerous durable medical equipment (DME) companies pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. A VA OIG, FBI, IRS-CI, and HHS OIG investigation resulted in charges alleging the defendants placed the DME companies in the names of straw owners, which allowed for the submission of high volumes of illegal DME claims to government healthcare programs including Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The defendants and their coconspirators allegedly purchased thousands of DME doctors' orders for braces from "marketers" who bribed doctors to sign under the guise of telemedicine. In one year, the defendants' companies submitted more than $20 million in illegal DME claims to government healthcare programs. The total loss to VA is approximately $375,000.

NONVETERAN PLEADS GUILTY IN CONNECTION WITH FRAUD SCHEME

A nonveteran pleaded guilty in the Eastern District of Pennsylvania to stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, aiding and abetting straw purchases of firearms, and false statements to SSA. A VA OIG and SSA OIG investigation revealed that from approximately April 2010 to September 2019, the defendant defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits. The defendant falsely claimed to be a decorated veteran, specifically, a U.S. Navy SEAL, a prisoner of war, and a Silver Star recipient. After the defendant was arrested, additional investigation with the Bureau of Alcohol, Tobacco, Firearms, and Explosives revealed that the defendant participated in the straw purchase of two firearms. The loss to VA is over $302,000.

Public Corruption by VHA Employees

PHILADELPHIA, PENNSYLVANIA, VA MEDICAL CENTER CHIEF OF ENVIRONMENTAL MEDICAL SERVICE INDICTED IN CONNECTION WITH BRIBERY SCHEME

The Chief of Environmental Management Service at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania, was indicted in the Eastern District of Pennsylvania for bribery. A VA OIG investigation resulted in charges alleging that this defendant and 16 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach, Florida; Miami, Florida; and Philadelphia, Pennsylvania. The charges allege that VA employees placed supply orders in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts. To date, six defendants have been sentenced to a combined 97 months' confinement, 117 months' supervised release, and restitution of over $3.7 million.

FORMER TRANSPORTATION ASSISTANT AT THE VILLAGES, FLORIDA, VA OUTPATIENT CLINIC PLEADS GUILTY IN CONNECTION WITH FRAUD SCHEME

A former transportation assistant at VA's outpatient clinic in The Villages, Florida, pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud and wire fraud, and solicitation and receipt of a healthcare kickback. A VA OIG investigation revealed that the defendant, who had the authority to award transportation assignments to vendors, created and controlled two companies to whom he steered VA transportation assignments. As a result, VA paid $305,673 to these companies. The defendant also solicited and received approximately $76,789 in kickbacks from two other transportation vendors. The defendant's ex-wife and daughter, who were involved in the fraud scheme, previously pleaded guilty to making false statements and conspiracy to commit healthcare fraud and wire fraud.

VA PUGET SOUND HEALTHCARE SYSTEM EMPLOYEE INDICTED FOR THEFT OF GOVERNMENT PROPERTY

A suspended employee of the VA Puget Sound Healthcare System in Seattle, Washington, was indicted in the Western District of Washington for theft of government property. A VA OIG investigation resulted in charges alleging that the defendant stole several pieces of medical equipment, including ventilators and bronchoscopes, and then sold the items on eBay. The approximate value of the stolen items is $181,000.

FORMER VA POLICE OFFICER IN BAY PINES, FLORIDA, SENTENCED FOR CRIMINAL CIVIL RIGHTS VIOLATION AND MAKING FALSE ENTRIES IN A REPORT

A former VA police officer at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, was sentenced in the Middle District of Florida to 24 months' imprisonment and three years' supervised release. The defendant previously pleaded guilty to depriving an individual of his Fourth Amendment right to a reasonable search and seizure under color of law and knowingly making false entries in a report with the intent to obstruct an investigation within the jurisdiction of a federal agency. A VA OIG and FBI investigation revealed the defendant used excessive force during an unlawful arrest and falsified a police report and two arrest affidavits following the incident.

Fraud against the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

DEFENDANT INDICTED IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

A defendant was indicted in the Northern District of Texas on charges of soliciting and receiving healthcare kickbacks and conspiracy to pay and receive healthcare kickbacks. A multiagency investigation resulted in charges alleging the defendant received over $60 million in kickbacks from a compounding pharmacy for fraudulent prescriptions written by doctors that he recruited. The compounding pharmacy, and their subsidiaries, billed private and government healthcare insurance programs an estimated $700 million. In total, VA's Civilian Health and Medical Program and its Office of Workers' Compensation Program were billed more than $16.8 million. Of this amount, VA paid over $1.9 million. This investigation was conducted by the VA OIG, FBI, DCIS, U.S. Postal Inspection Service, HHS OIG, Office of Personnel Management OIG, Food and Drug Administration Office of Criminal Investigations, IRS-CI, and Drug Enforcement Administration.

TELEMARKETING COMPANY OWNER SENTENCED FOR CONSPIRACY TO COMMIT HEALTHCARE FRAUD

The owner of a telemarketing company was sentenced in the Middle District of Florida to four years' imprisonment, three years' supervised release, and restitution of $3.42 million after previously pleading guilty to conspiracy to commit healthcare fraud. Of this amount, VA will receive $1.71 million. An investigation by the VA OIG, IRS-CI, HHS OIG, and FBI resulted in charges alleging the defendant's company targeted the Medicare-aged population to generate orders for durable medical equipment and cancer genetic testing. It is further alleged that the doctors' orders were approved under the guise of telemedicine; however, no actual telemedicine consults occurred, and orders for durable medical equipment and cancer genetic testing were approved regardless of medical necessity. The signed doctors' orders for durable medical equipment and cancer genetic testing were sold by the defendant to conspirators who submitted claims to government healthcare programs, including CHAMPVA.

DEFENDANT SENTENCED FOR DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

A deceased veteran's widow was sentenced in the Southern District of Texas to one year and one day of imprisonment, three years' probation, and restitution of $642,078 to VA after previously pleading guilty to false statements relating to healthcare matters. A VA OIG investigation revealed that over a period of five years, the defendant fabricated fictitious pharmacy receipts and submitted them to CHAMPVA for reimbursement.

DEFENDANT ARRESTED FOR DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

A defendant was arrested after being charged in the District of New Jersey with conspiracy to violate the Anti-Kickback Statute. A VA OIG, HHS OIG, FBI, and IRS-CI investigation resulted in charges alleging that the defendant participated in a telemarketing scheme to solicit genetic cancer screenings to prospective patients and then used telemedicine doctors to generate prescriptions for these patients regardless of medical necessity. It is alleged that the telemedicine doctors had no relationship with the patients, and that the telemarketers then sold the completed orders to a testing laboratory. Many of the companies participating in the scheme billed VA through CHAMPVA. The total loss to the government exceeds $1 billion. Of this amount, VA's loss from this scheme is approximately $330,000.

TEXAS DOCTOR PLEADS GUILTY TO OBSTRUCTION OF A HEALTHCARE INVESTIGATION

A doctor pleaded guilty in the Eastern District of Arkansas to obstruction of a healthcare investigation. An investigation by the VA OIG, DCIS, HHS OIG, and FBI revealed that the defendant used telemedicine to fraudulently prescribe compounding medication, which resulted in over $5 million paid by government healthcare insurance programs, to include CHAMPVA. The investigation further revealed that the defendant did not speak to many of the patients for whom she wrote prescriptions. The defendant also misled agents during an interview that was conducted in connection with this investigation. The loss to VA is $305,430.

Spina Bifida Health Care Benefits Program Fraud

SISTER OF INDIVIDUAL RECEIVING VA BENEFITS FOR SPINA BIFIDA DIAGNOSIS SENTENCED FOR HEALTHCARE FRAUD

The sister of a deceased woman who received VA benefits for her spina bifida diagnosis was sentenced in the Southern District of West Virginia to 42 months' incarceration, three years' supervised release, and restitution of approximately $289,000 after previously pleading guilty to healthcare fraud. VA provides monetary allowances, vocational training and rehabilitation, and VA-financed health care benefits to certain Korea and Vietnam veterans' birth children who have been diagnosed with spina bifida. A VA OIG, FBI, and HHS OIG investigation revealed that for 18 months the defendant fraudulently billed VA's Spina Bifida Health Care Benefits Program by charging eight hours of home health care, seven days per week, at $736 per day. The defendant 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. The judge imposed a sentencing enhancement for obstruction after finding that the defendant staged an elaborate hoax to fake her own death to avoid federal sentencing. The scheme involved a false report of her fall from a national park overlook, which led to an extensive search effort. The defendant was subsequently found hiding in a closet in her home.

Drug Diversion by VA Employees

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

A former pharmacist at the Overton Brooks VA Medical Center in Shreveport, Louisiana, was sentenced in the Western District of Louisiana to 12 months and one day imprisonment and one year of supervised release. The defendant was previously found guilty at trial of acquiring controlled substances by fraud. A VA OIG investigation resulted in charges alleging the defendant diverted opioid pills from

outpatient prescriptions that were being prepared to be mailed out to veterans. When performing final verifications, the defendant allegedly diverted some pills before sealing the packages and placing them in the outgoing mail.

MUSKOGEE, OKLAHOMA, VA COMMUNITY BASED OUTPATIENT CLINIC PHYSICIAN INDICTED FOR MAIL THEFT AND DIVERSION OF A CONTROLLED SUBSTANCE

A general physician employed at the Ernest Childers VA Outpatient Clinic in Muskogee, Oklahoma, was arrested after being indicted in the Northern District of Oklahoma for mail theft and diversion of a controlled substance. A VA OIG investigation resulted in charges alleging the defendant diverted previously mailed out narcotics that were returned to the facility's mail room as undeliverable, but before they were returned to the pharmacy for disposal.

FORMER CLARKSBURG, WEST VIRGINIA, VA MEDICAL CENTER REGISTERED NURSE PLEADS GUILTY TO DRUG DIVERSION

A former registered nurse at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, pleaded guilty in the Northern District of West Virginia to acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge. A VA OIG and FBI investigation revealed that over a two-month period, the defendant diverted hydromorphone from the facility's Pyxis automated medication management machines for her own personal use on 110 occasions.

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 "Death Match" project to proactively 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 one individual, recoveries of $886,202, and a projected five-year savings to VA estimated at $4.7 million.

OI opened 66 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 25 arrests. OI obtained over $2.4 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $19.5 million in savings, efficiencies, and cost avoidance; and recovered more than $4.1 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

Fiduciary Fraud

DEFENDANT SENTENCED IN CONNECTION WITH FIDUCIARY FRAUD SCHEME

An employee of a former VA-appointed professional fiduciary was sentenced in the District of New Mexico to 71 months' imprisonment, three years' supervised release, and restitution after previously pleading guilty to conspiracy, mail fraud, aggravated identity theft, money laundering, and conspiracy to commit money laundering. A comprehensive order for the restitution, which the defendant will pay jointly and severally with the other three defendants, will be filed after all are sentenced. A VA OIG, SSA OIG, FBI, and IRS-CI investigation revealed that from November 2006 to July 2017, the defendants engaged in a sophisticated financial scheme to use their nonprofit organization to defraud victims of their VA and SSA beneficiary funds. The defendants unlawfully transferred money from their clients' accounts to their own business accounts. The defendants then used funds from these comingled accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately $3.3 million dollars.

Life Insurance Fraud

VETERAN PLEADS GUILTY IN CONNECTION WITH LIFE INSURANCE FRAUD SCHEME

A veteran pleaded guilty in the Southern District of California to wire fraud. An investigation by the VA OIG, Naval Criminal Investigative Service, and FBI resulted in charges alleging that this defendant and at least 16 others, submitted numerous Traumatic Servicemembers Group Life Insurance (TSGLI) claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living to generate payouts of $25,000 to $100,000 per claim. The leader of the scheme allegedly recruited a Navy medical doctor and a Navy nurse to create false medical records and sign the claims. VA supervises the administration of the TSGLI program. The loss to the TSGLI program is approximately $2 million.

Compensation Benefits Fraud

VETERAN SENTENCED IN CONNECTION WITH FRAUD SCHEME

A veteran was sentenced in the District of South Carolina to 15 months' incarceration, three years' supervised release, and restitution of $1,043,150 after previously pleading guilty to conspiracy to commit theft of government funds. A VA OIG proactive investigation revealed that for more than 20 years, the defendant fraudulently received approximately $9,000 per month from VA for the loss of use of his limbs and hearing problems with associated vertigo. This investigation determined that the defendant was able to ambulate without difficulty and did not require the assistance that he claimed to VA was necessary.

VETERAN PLEADS GUILTY IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

A veteran pleaded guilty in in the Middle District of North Carolina to theft of public money. A VA OIG proactive investigation revealed the defendant grossly exaggerated the severity of his service-connected conditions in order to receive more than $8,500 per month in VA compensation benefits. The defendant, who retired from the U.S. Army, subsequently worked as a police officer while being compensated by VA for a multitude of falsified ailments. Video footage showed the veteran playing

basketball, using stairs, and ambulating without any form of assistance. The loss to VA is approximately $1 million. This loss amount consists of a combination of VA benefits including compensation benefits, a Specially Adapted Housing grant, automobile grants, and education benefits. As a result of this investigation, a beachfront condominium, an automobile, a motorized scooter, and cash were seized from the defendant.

VETERAN PLEADS GUILTY TO THEFT OF GOVERNMENT FUNDS

A veteran pleaded guilty in the Middle District of Florida to theft of government funds. A VA OIG and SSA OIG investigation revealed that the defendant made false representations regarding his physical limitations in connection with his application for VA disability compensation benefits. Based upon these false representations, VA found that the defendant was entitled to monthly compensation benefits and other related benefits. The investigation further revealed that the defendant also fraudulently received Social Security Disability Insurance benefits. The total loss to the government is $730,561. Of this amount, the loss to VA is $549,426.

THREE DEFENDANTS CHARGED IN CONNECTION WITH FRAUD SCHEME

Three defendants were charged with racketeering, obtaining funds under false pretenses, and forgery (two in the 18th District Court of Michigan and one in the 27th District). A VA OIG and Michigan Attorney General investigation resulted in charges alleging that the defendants used aliases to obtain or create fraudulent documents, including vital records such as birth certificates, to make it appear as if they were surviving spouses of deceased veterans. These documents were then allegedly used to fraudulently obtain VA Dependency and Indemnity Compensation benefits, VA Survivors Pension benefits, and unclaimed funds from the state of Michigan. The total loss is approximately $470,000, of which the loss to VA is approximately $430,000.

VETERAN AND WIFE INDICTED IN CONNECTION WITH FRAUD SCHEME

A veteran and his wife were indicted in the Western District of Michigan for conspiracy to defraud the government, theft, false statements, and fraudulent claims. A VA OIG investigation resulted in charges alleging the defendants falsely reported to VA that the veteran was unable to walk or use his arms. It is further alleged that when applying for a VA Caregiver Support Program grant, the wife stated that she cared full-time for the veteran when in fact she often left the home while the veteran worked on the family ranch without assistance. The loss to VA is over $264,000.

Theft of Government Funds

FORMER BANK MANAGER PLEADS GUILTY TO THEFT OF GOVERNMENT FUNDS

A former bank manager pleaded guilty in the District of Nevada to theft of government funds. An investigation by the VA OIG and SSA OIG revealed that the defendant used his position as a bank manager to fraudulently obtain VA and SSA benefit payments that were made to two deceased beneficiaries. The defendant used the funds for personal expenses. The total loss is $1,194,672. Of the amount, the loss to VA is $757,985.

DAUGHTER OF DECEASED VA BENEFICIARY SENTENCED FOR THEFT OF GOVERNMENT FUNDS

The daughter of a deceased VA beneficiary was sentenced in the Northern District of California to 36 months' probation and restitution of $286,612 after pleading guilty to theft of government funds. A VA OIG investigation revealed that the defendant stole monthly VA Dependency and Indemnity Compensation payments intended for her mother, who died in September 2002.

DAUGHTER-IN-LAW OF DECEASED VA BENEFICIARY INDICTED FOR THEFT OF GOVERNMENT FUNDS

The daughter-in-law of a deceased VA beneficiary was arrested after being indicted in the District of Arizona for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant stole monthly VA Dependency and Indemnity Compensation payments intended for her mother-in-law, who died in August 2003. The loss to VA is over $232,000.

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 31 cases and made five arrests. These investigations resulted in over $25.3 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $1.8 billion in savings, efficiencies, and cost avoidance.

Service-Disabled Veteran-Owned Small Business (SDVOSB) Fraud

CERTIFIED PUBLIC ACCOUNTANT SENTENCED FOR ROLE IN SDVOSB FRAUD SCHEME

A certified public accountant was sentenced in the Eastern District of Wisconsin to three months' imprisonment; three years' supervised release; 100 hours of community service to a SDVOSB, minority-owned business, or a disadvantaged business enterprise; and a fine of $7,500. The defendant was previously found guilty of conspiracy to commit wire and mail fraud following a jury trial. A multiagency investigation resulted in charges alleging the defendant provided accounting services to the leader of a 12-year fraud scheme, which involved over $260 million in government-funded contracts intended to benefit small businesses including SDVOSBs. The alleged scheme involved the purported operation of three construction companies by "straw" owners who qualified either as a disadvantaged individual or a service-disabled veteran, but who did not actually control the companies. The defendant allegedly advised the scheme's participants to hide their common ownership and affiliations, wrote letters attesting to their independence that were later submitted to the controlling government agencies, and lied to federal investigators when interviewed. This case was investigated by the VA OIG, General Services Administration OIG, Small Business Administration OIG, DCIS, and FBI.

THREE INDIVIDUALS SENTENCED IN CONNECTION WITH SDVOSB FRAUD SCHEME

Two nonveterans and one veteran were sentenced in the District of Massachusetts in connection with an SDVOSB fraud scheme. The two nonveteran defendants were each sentenced to two years' supervised release, forfeiture of $300,000, and a fine of $300,000. The veteran defendant received the same sentence minus the fine. A VA OIG, Army Criminal Investigation Command, and General Services Administration OIG investigation revealed the defendants defrauded VA's SDVOSB program and the Department of Defense's Historically Underutilized Business Zone-certified business program. The defendants used a veteran-owned small business to apply for and receive set-aside contracts and then passed through most of the work to an ineligible business not owned by a veteran. The value of these contracts totaled approximately $10 million for VA and $6.4 million for the Department of Defense.

VETERAN PLEADS GUILTY IN CONNECTION WITH SDVOSB FRAUD SCHEME

A veteran pleaded guilty in the Southern District of Florida to making a false statement. An investigation by the VA OIG and Treasury Inspector General for Tax Administration revealed that the defendant's company held SDVOSB set-aside courier contracts with VA and the IRS while he was incarcerated in a state prison. The defendant continued to certify that he was in control of the day-to-day operation of the company despite not being able to make phone calls to his drivers, correspond with VA contracting officials, or sign contracting documents. The defendant also received VA Individual Unemployability benefits and continually certified to VA that he had not been employed despite owning his own business and holding multiple government contracts. The total loss to VA is approximately $1.2 million.

REWARD FOR REPORT OF SDVOSB FRAUD

The VA OIG presented a reward to a confidential complainant who submitted two separate allegations, which involved fraud against VA's SDVOSB program. VA OIG subsequently conducted investigations revealing that, in both instances, the two unrelated construction companies falsely represented that they were owned and controlled by service-disabled veterans. As a result of these false representations, the two construction companies obtained over $65 million in set-aside contracts from VA. The two construction companies and their principal owners entered into separate civil agreements under which they agreed to pay a total of almost $2.6 million to the federal government.

Cases Resulting in Settlements

BIOPHARMACEUTICAL MANUFACTURER AGREES TO PAY $6.5 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A biopharmaceutical manufacturer entered into a civil agreement with the U.S. Attorney's Office for the District of Minnesota and the Department of Justice Civil Division's Commercial Litigation Branch, under which the company agreed to pay $6.5 million to resolve allegations that it violated the False Claims Act by knowingly submitting false commercial pricing disclosures to VA. A VA OIG investigation resolved allegations that, since at least 2013, the company defrauded the government in the sale of human tissue grafts through the VA Multiple Award Schedule. In particular, it was alleged that the company

submitted false statements and disclosures to VA regarding their commercial pricing practices, which enabled the company to charge inflated prices to VA for their human tissue graft products.

COMPANY AGREES TO PAY $117 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A for-profit holding company that directly or indirectly owned the assets or stock of inpatient and residential psychiatric and behavioral health facilities entered into a civil settlement agreement with the U.S. Attorney's Office for the Eastern District of Pennsylvania to resolve allegations that the company violated the False Claims Act. A VA OIG, DCIS, Office of Personnel Management OIG, and HHS OIG investigation resolved allegations that the company knowingly submitted false claims related to unallowable costs for payment. As part of the settlement, the company agreed to pay $117 million, which included $88.1 million to the federal government and $28.9 million to the Medicaid participating states. From this settlement, VA will receive $5,127,848.

CANCER TREATMENT CENTER AGREES TO PAY $2.3 MILLION TO RESOLVE CIVIL CLAIMS PERTAINING TO PHYSICIAN-ADMINISTERED DRUGS

A non-VA cancer treatment center entered into a civil settlement in the Middle District of Florida under which the entity agreed to return over $2.3 million in overpayments to VA. Although most veterans enrolled in the VA healthcare system receive care in VA-operated medical facilities, VA may also contract with non-VA facilities to provide services that are not readily available from a VA medical facility. The Code of Federal Regulations allows for VA to reimburse non-VA care providers for certain physician-administered drugs in accordance with Medicare pricing schedules. This VA OIG investigation resolved allegations that the cancer treatment center submitted claims to VA that were related to physician-administered drugs but calculated over the applicable Medicare rates. This investigation was based upon a hotline complaint and the findings of a subsequent audit conducted by VA OIG's Office of Audit and Evaluations.

PHARMACEUTICAL MANUFACTURER AGREES TO PAY $678 MILLION TO RESOLVE FALSE CLAIMS ACT AND ANTI-KICKBACK STATUTE ALLEGATIONS

A pharmaceutical manufacturer entered into a civil agreement with the Southern District of New York and the Department of Justice Civil Division's Commercial Litigation Branch, agreeing to pay $678 million to resolve allegations that it violated the False Claims Act and the Anti-Kickback Statute. Of this amount, VA will receive over $1.3 million. A VA OIG, DCIS, FBI, and HHS OIG investigation resolved allegations that between 2002 and 2011, the company operated a nationwide sham speaker program that was established to induce physicians to increase the number of prescriptions they wrote for the company's cardiovascular and diabetes drugs. This kickback scheme included payments to physicians for speaking fees, recreational outings, lavish meals, and expensive alcohol. As a result, federal healthcare programs to include VA paid hundreds of millions of dollars in reimbursements for these tainted prescriptions.

RESIDENTIAL MORTGAGE COMPANY AGREES TO PAY $15 MILLION TO RESOLVE CIVIL ALLEGATIONS

A residential mortgage company entered into a civil agreement with the U.S. Attorney's Office for the Northern District of New York and the Department of Justice Civil Division's Commercial Litigation Branch, under which the company agreed to pay more than $15 million to resolve allegations that it violated the False Claims Act and the Financial Institutions Reform, Recovery, and Enforcement Act

of 1989. The investigation by the VA OIG and Department of Housing and Urban Development OIG resolved allegations that the company knowingly originated and underwrote mortgage loans insured by the Federal Housing Administration, the Department of Housing and Urban Development, and VA that did not meet critical program requirements. In particular, it was alleged that the company knowingly failed to comply with material program rules that require lenders to maintain quality control programs to prevent and correct underwriting deficiencies, self-report any materially deficient loans, and ensure that the underwriting process is free from conflicts of interest. The amount attributed to VA loans is $698,787 in damages and penalties, of which $420,956 will be returned to VA and the remainder to the Department of the Treasury.

Workers' Compensation Program Fraud

MEDICAL OFFICE ADMINISTRATOR SENTENCED FOR ROLE IN WORKERS' COMPENSATION FRAUD SCHEME

A medical office administrator was sentenced in the Northern District of Texas to 18 months' incarceration, two years' supervised release, and restitution of $437,940 to the federal government. VA's portion of the restitution is still being determined. An investigation by the VA OIG, Department of Labor OIG, U.S. Postal Service OIG, Department of Justice OIG, and Army Criminal Investigation Command Major Procurement Fraud Unit resulted in charges alleging the defendant submitted false claims to the Department of Labor's Office of Workers' Compensation Program on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, assigned inaccurate billing codes to increase the practice's Office of Workers' Compensation Program reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The investigation revealed that this defendant and a coconspirator perpetuated the fraud for a period of approximately six years. The loss to VA is approximately $2.9 million.

Compounding Pharmacy Fraud

FORMER PHARMACY OWNER AND HIS WIFE SENTENCTED IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

The former owner of a pharmacy was sentenced in the Southern District of Texas to 10 years' imprisonment and ordered to pay over $12 million in restitution to the federal government. The defendant was previously found guilty at trial of various charges, including conspiracy to pay healthcare kickbacks, conspiracy to commit money laundering, conspiracy to commit healthcare fraud, healthcare fraud, and wire fraud. The defendant's wife, who served as the pharmacy's vice president and previously pleaded guilty to related charges, was also sentenced to three years' probation and restitution of over $950,000. A VA OIG, Department of Homeland Security OIG, DOL OIG, and U.S. Postal Service OIG investigation resulted in charges that the defendants conspired with others to pay kickbacks to physicians in order to induce the physicians to write prescriptions for compounded gels and creams dispensed by their pharmacy. The payments for prescriptions were made by the Department of Labor's Office of Workers' Compensation Programs. Between 2011 and 2016, the defendants billed the federal government over $21 million in compounded gels and creams. The loss to VA is approximately $610,000.

Mail Fraud

CEMETERY CO-OWNER SENTENCED FOR CONSPIRACY TO COMMIT MAIL FRAUD

A co-owner of a cemetery was sentenced in the Middle District of Pennsylvania to 12 months' and one day of imprisonment (to run concurrently with a previously imposed state sentence), two years' supervised release, and joint restitution of approximately $495,000 after previously pleading guilty to conspiracy to commit mail fraud. A VA OIG, Northern York County Regional Police Department, and FBI investigation revealed the defendant and a codefendant defrauded at least 223 customers out of approximately $495,000. Instead of applying customers' monies to prepaid cemetery services and products, the defendants embezzled the money for their own personal gain. VA's National Cemetery Administration provided grave markers for veterans buried at the cemetery, many of which were never found, and the burial sites of several veterans could not be confirmed. The codefendant was previously sentenced to 13 months' imprisonment, two years' supervised release, and joint restitution of approximately $495,000.

THREATS AND ASSAULTS MADE AGAINST VA EMPLOYEES

During this reporting period, OI initiated 15 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 10 individuals. Investigations resulted in over $65,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Threats Against VA Employees

FORMER BUFFALO, NEW YORK, VA REGIONAL OFFICE EMPLOYEE PLEADS GUILTY TO THREATENING FELLOW EMPLOYEE

A former employee of the Buffalo VA Regional Office in New York pleaded guilty in the Western District of New York to intentionally opposing, impeding, intimidating, and interfering with a VA employee. A VA OIG investigation revealed that over a 13-month period, the defendant left several voicemails for a coworker at the regional office in which he threatened to rape and/or kill the employee's family members and to kill the employee.

Assaults Against VA Employees

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

A veteran was sentenced in the Southern District of Florida to 25 years of mental health treatment at a suitable medical facility and three years' supervised release. A VA OIG and FBI investigation revealed that the defendant inflicted non-life-threatening injuries on three VA emergency room employees by firing a handgun inside the West Palm Beach VA Medical Center. If it is determined during his commitment that the defendant no longer needs treatment, he will reappear in federal court where he will be sentenced to a prison term of between 12.5 years and 25 years.

DEFENDANT SENTENCED FOR ASSAULTING VA POLICE OFFICERS AT THE BUFFALO, NEW YORK, VA MEDICAL CENTER

A nonveteran was sentenced in the Western District of New York to six months' imprisonment, one year of supervised release, and 200 hours of community service. A VA OIG and VA Police Service investigation revealed that the defendant drove to the Buffalo, New York, VA Medical Center to confront his girlfriend about a domestic incident while she was working at the facility and a verbal altercation ensued. When VA Police Service officers attempted to intervene, the defendant fought with the officers and head-butted one in the face. Two other officers involved in the incident suffered minor injuries.

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, 89.1 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 103,238 investigative leads being referred to law enforcement agencies. More than 2,641 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 $1.6 billion in estimated overpayments and cost avoidance of more than $2.2 billion. During this reporting period, OI made three arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of two additional fugitive felons, and identified $200 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 Department of Justice, (2) the date of such referral, and (3) if applicable, the date of declination by the Department of Justice. During this reporting period, OI closed one criminal investigation with substantiated allegations against senior government employees.

TIMECARD FRAUD BY A FORMER RADIOLOGIST AT THE VA CONNECTICUT HEALTHCARE SYSTEM IN WEST HAVEN

The OIG received a referral alleging that a radiologist employed by the VA Connecticut Healthcare System in West Haven was committing timecard fraud. The investigation determined that the radiologist improperly received compensation from a private company for reviewing scans during his

scheduled VA tour of duty. The radiologist acknowledged to investigators that he was aware that he was not authorized to receive compensation for outside work performed during VA hours. This case was declined for criminal and civil prosecution by the U.S. Attorney's Office for the District of Connecticut. The radiologist, who retired from VA employment in June 2018, subsequently paid $40,448 to VA as repayment for what he earned from the private company while working during his VA tour of duty.

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, OI closed two criminal investigations with unsubstantiated allegations against a senior government employee.

ALLEGED FALSE STATEMENTS BY A FORMER RADIOLOGIST AT THE COLMERY-O'NEIL VA MEDICAL CENTER IN TOPEKA, KANSAS

The OIG received a referral alleging that a radiologist at the Colmery-O'Neil VA Medical Center in Topeka, Kansas, made false statements to gain employment with VA in April 2015. It was alleged that despite not being eligible to be board certified, the radiologist provided a curriculum vitae during the hiring process, which stated he was scheduled to take the Board Certification Exam in November 2015. The radiologist resigned from VA in November 2015. The investigation determined that the VA Eastern Kansas Healthcare System did not have a requirement to be board certified-eligible, nor did that requirement exist in the hiring announcement. Furthermore, it was determined that the Eastern Kansas Healthcare System credentialed the radiologist prior to verifying all certifications and eligibilities. This matter was not referred to the U.S. Attorney's Office because no criminal conduct was identified.

ALLEGED THEFT OF GOVERNMENT PROPERTY BY A PHYSICIAN AT THE WEST LOS ANGELES VA MEDICAL CENTER IN CALIFORNIA

The OIG received a referral alleging that a Los Angeles, California, VA Medical Center physician was suspected in the theft of a binder containing records and protocols related to research projects, 14 boxes of controlled tissue samples, tissue samples from multiple waxed slides, and keys to the facility's Histology Department. The investigation could not substantiate that the physician was involved in the disappearance in these items. Furthermore, investigators were not able to determine the whereabouts of these items. As a result, this matter was not referred to the U.S. Attorney's Office because the investigation did not substantiate the allegation that the physician engaged in criminal conduct. The investigation identified numerous administrative issues pertaining to the facility's Pathology and Laboratory Medicine Service that were referred to VA OIG's Office of Healthcare Inspections.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

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 oversees the internal controls program, manages the senior executive services program, and ensures 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. In addition, procurement staff have major responsibilities for contracting for goods and services that are essential to OIG operations. 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 with priority given to 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 14,605 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 718 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 757 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 706 cases for which nearly 35 percent of allegations were substantiated, 548 administrative sanctions and corrective actions were taken, and $876,679 in monetary benefits were achieved
- Responded to more than 233 requests for record reviews from VA staff offices
- Issued 3,609 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.

FIDUCIARY FRAUD

A veteran reported fraud in the management of his disability payments, alleging that his previous fiduciary stole $200,000 over a span of about 10 years. The hotline tasked the servicing fiduciary hub to investigate and respond with their findings. The hub determined that the previous fiduciary misused $320,280 of the veteran's funds. As a result, the hub initiated collection action against the previous fiduciary, took action to collect the related surety bond, and notified VA's Office of General Counsel of the issue.

PRIVACY ACT AND HIPAA VIOLATIONS

A veteran reported that another veteran's private information was addressed and sent to him by the Veterans Benefits Administration. He also alleged that their benefits information was commingled and that this had a negative impact on the outcome of his claim. Based on the information provided, the hotline asked the appropriate VA regional office to review the allegations and determine if corrective actions were warranted. The regional office substantiated the allegations and implemented three corrective actions, including issuing a counseling to the responsible employee, instituting mandatory training for regional office staff, and correcting benefit paperwork for both veterans. Additionally, both veterans were offered free credit monitoring.

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

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

FACILITY RENOVATION IMPACT TO HOSPITAL OPERATIONS

A complainant alleged that a five-year-long facility renovation was having a severe negative impact on pathology and lab operations and that $500,000 worth of equipment had been wasted because it was sitting in storage. The hotline referred the case to the medical center to review the allegations and determine their merit. The facility determined that a significant amount of space had been taken out of service due to construction and flooding events. Additionally, they confirmed that multiple labs had either been relocated more than once or condensed despite increased workload. As a result of the case, the facility took steps to acquire a temporary lab-grade trailer for swing space in order to minimize the impact to the department and help expedite the construction effort.

DELAY OF CARE

A veteran submitted a complaint regarding canceled community care and follow-up appointments for multiple orthopedic issues as well as radiology images missing from his record. He claimed that he had been trying to address the issues for over six months with no resolution. At the request of the hotline, the facility reviewed the specifics of the complaint and concluded that the veteran experienced a delay in care. To address the issues identified, all staff received education on proper scheduling and coordination of community care as well as instruction on the proper technique for uploading radiological images to electronic medical records. The response also documented efforts by the facility to ensure that the veteran received the care he needed.

GRANT PER DIEM PROGRAM MISMANAGEMENT

A caller to the hotline reported that several participants in the Alaska Grant and Per Diem Program were not receiving the services that the program was supposed to provide, such as assistance with résumé writing, job searching, skills building, and housing. The complainant also alleged that updates to veterans' files were missing. The hotline referred the case to VHA, which confirmed the allegations. To address the issues, VHA suspended the specific grant and per diem provider pending program changes, and the provider subsequently terminated the responsible case manager. In addition, impacted veterans received revised case management services and all records in question were reviewed and updated accordingly.

ERRONEOUS GRANTING OF DISABILITY BENEFITS

A veterans service officer reported that a veteran he assisted was granted compensation incorrectly and in violation of the statute governing honorable military service. Specifically, he alleged that VA made an administrative determination that the veteran’s service was honorable despite military records to the contrary. The regional office reviewed the complaint and found that a portion of the veteran’s service was not considered honorable and therefore elements of his disability award were incorrect. As a result, the veteran’s final rating and award date were adjusted. However, because VA considered the cause of the erroneous rating to be an administrative error, a debt was not established and the veteran will not be expected to repay the funds.

FEATURED DATA-DRIVEN INITIATIVES

The Data Analysis Division, in collaboration with cross-directorate stakeholders, continues to leverage data to proactively identify new areas for impactful oversight and to create and refine user-friendly, self-service dashboards to empower all OIG staff with the just-in-time information they need for their work. Examples of these data-driven initiatives include the following:

- Providing in-depth analytic support for a growing body of data-driven audits, investigations, and other reviews. Examples of relevant publications from this reporting period include the following:
  - Potential Payment Errors Made by Veteran Readiness and Employment Service
  - VA Should Examine Options to Expand Retail Pharmacy Drug Discounts
  - Controls Appear to Have Addressed Prior Overpayments of Post-9/11 GI Bill Monthly Housing Allowance
- Launching a VA procurement dashboard that allows the OIG to efficiently review VA expenditures, including those related to COVID-19, and lookup detailed company information. This tool has a variety of use cases, including assisting OIG staff to triage incoming hotline complaints and qui tams, and has been well received.
- Creating a self-service VA system access tool. To facilitate OIG employees' ability to efficiently access the systems they need to complete their oversight, the Data Analysis Division developed this tool to synthesize instructions on how to access various VA systems, such as Compensation and Pension Record Interchange, Corporate Data Warehouse, and Invoice Payment Processing System. In addition, the tool automates numerous required steps for the employees and their supervisors and facilitates the tracking of access requests to ensure that they are timely resolved, thereby avoiding delays in oversight activities for which system access is required.
- Continuing to make enhancements to Automated Cluster Analysis Tool for Investigating Education (Auto-CATIE). The original development of Auto-CATIE, a tool that bolsters oversight of the nearly $13 billion educational benefits programs administered by VA, was highlighted in the prior SAR. During this reporting period, the Data Analysis Division incorporated additional risk indicators for educational institutions into the tool by leveraging open source data from the Department of Education. OIG staff continue to use the dashboard to search for specific educational institutions and has generated multiple new preliminary or full investigative cases. This initiative was also recognized with an Award for Excellence in Multiple Disciplines at the 2020 Annual CIGIE Award Ceremony.

RESULTS FROM THE OFFICE OF SPECIAL REVIEWS

OVERVIEW

The Office of Special Reviews (OSR) increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single existing OIG directorate or office. Staffed with professionals possessing a broad array of expertise, OSR undertakes projects assigned to it by the Inspector General and Deputy Inspector General, works collaboratively with the other directorates to review topics and issues of interest that span multiple offices, and conducts administrative investigations. As with other OIG published reports, OSR recommendations for corrective action are detailed at www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

8
PUBLICATIONS

19
RECOMMENDATIONS

$5M
MONETARY BENEFITS

FEATURED PUBLICATIONS

WASTE AND ABUSE BY THE FORMER ASSISTANT SECRETARY FOR HUMAN RESOURCES AND ADMINISTRATION

The OIG substantiated allegations that Peter Shelby, while serving as VA's Assistant Secretary for Human Resources and Administration (HR&A), improperly steered a $5 million contract for the benefit of individuals with whom he had a personal relationship. The OIG determined that VA could not use the contract services, resulting entirely in waste. In February 2018, VA awarded a one-year contract to an SDVOSB that provides leadership development training. The contract also included talent assessment services for evaluating whether to hire or promote candidates. When the contract concluded in August 2019, it became evident that VA had purchased services far in excess of what it could use. VA used only 232 of the 17,000 one-year training licenses it purchased for $3.8 million and VA received no value whatsoever for the talent assessment services because required privacy and security certifications were not obtained. The OIG determined that this waste occurred as a direct result of Mr. Shelby's misuse of his official position by directing his senior staff to arrange for the award of this contract to the SDVOSB on a sole-source basis (i.e., without competition). The OIG determined that although there was statutory authority to contract with SDVOSBs, use of VA's sole source authority in this case was not supported by an adequate justification as required by VA policy and regulation. Mr. Shelby resigned from federal service in July 2018 after learning that he had been recommended for possible removal for reasons unrelated to this contract. The OIG made eight recommendations for process improvements spotlighted by this investigation and for VA to consider whether any administrative action should be taken for certain employees. VA concurred with all eight recommendations.

ATTORNEY MISCONDUCT, INADEQUATE SUPERVISION, AND MISMANAGEMENT IN THE OFFICE OF GENERAL COUNSEL

Following an investigation conducted in response to allegations made to the OIG hotline, OSR substantiated that an Office of General Counsel (OGC) attorney was using VA time and resources to work on matters related to his outside law practice. Moreover, the OIG determined that the attorney represented private clients in U.S. bankruptcy court in cases where the clients owed money to the federal government. This conduct implicated criminal conflict of interest laws, which prohibit federal government employees from representing third parties in cases where the United States is a party or has a direct and substantial interest. The review team discovered that VA's OGC received complaints about the attorney using VA time and resources to engage in his outside law practice as early as 2012. The OIG found that OGC's failure to appropriately supervise or meaningfully investigate the attorney's misconduct allowed it to continue. It was not until the OIG alerted OGC to this review's preliminary findings that the OGC investigated the attorney, which ultimately led to his removal from federal employment in March 2020. The OIG's seven recommendations to the Acting VA General Counsel addressed actions to be considered in light of the attorney's misconduct and OGC officials' prior failures to take prompt appropriate action. These included revision to the OGC's relevant guidance and how OGC identifies and advises its employees who have outside employment. OGC was also asked to consider whether it should implement a supplemental regulation requiring some employees to disclose and obtain prior approval before engaging in outside employment. VA's OGC concurred with all recommendations. This matter was referred to the Department of Justice Criminal Division and declined on November 13, 2019. It was forwarded to the Department of Justice Civil Division and accepted on January 24, 2020.

ADMINISTRATIVE INVESTIGATIONS

OSR evaluates allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders.

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 Department of Justice,, the date of such referral, and, if applicable, the date of declination by the Department of Justice. Section 5(a)(22)(B) of the IG Act 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 eight administrative investigations. Two

were discussed under OSR's featured publications; the details of the remaining six administrative investigations follow.

IMPROPER PAY TO FEE-BASIS PROVIDERS ADEQUATELY ADDRESSED BY VA SAN DIEGO HEALTHCARE SYSTEM IN CALIFORNIA

The OIG investigated allegations that staff at the VA San Diego Healthcare System manipulated the timecards for seven fee-basis medical providers in order to pay these individuals on a salary or wage basis rather than a per-procedure basis. In addition, the allegations contended that a fee-basis care provider was told he would be converted to a full-time employee after working full time as a fee-basis provider for one year. The OIG substantiated that certain fee-basis care providers at the VA San Diego Healthcare System were being paid for their time, rather than on a per-procedure basis, as required by law and VA policy. The OIG did not substantiate that a fee-basis professional had been promised conversion to full-time status. The OIG did not make any recommendations because the medical center took corrective action, including disciplinary action with respect to the supervisor who was accountable for this conduct.

ALLEGED MISCONDUCT BY EMPLOYEES OF THE GREATER LOS ANGELES HEALTHCARE SYSTEM ADDRESSED BY VA

The OIG investigated alleged misconduct by two employees of the VA Greater Los Angeles Healthcare System in California. A complainant alleged that a supervisory health system specialist misused his/her public office for private gain by improperly participating in matters related to a contract maintained by the healthcare system with a vendor whose vice president was the supervisor's significant other and roommate. The supervisor resigned during the investigation, and the OIG removed this allegation from the scope of the investigation. The complainant also alleged that a former medical center director failed to make proper rental payments while residing in the healthcare system's quarters. Although the director underpaid VA by $158, the OIG determined the cause was a coding error and identified no evidence of misconduct on the part of the director. Because corrective action had already been taken by the healthcare system, the OIG made no recommendations.

ALLEGED MISUSE OF OFFICIAL TIME AND POSSIBLE ETHICS VIOLATION BY AN INFORMATION TECHNOLOGY EMPLOYEE

OSR investigated but could not substantiate allegations that an OIT employee misused his government email by sending personal emails during work hours and took advantage of his telework arrangement to handle personal matters during his duty hours. However, the OIG did determine that the employee engaged in conduct that appeared contrary to ethical rules prohibiting the use of public office for private gain by referring staff who were planning conferences for his group to his wife, a sales manager for a hotel chain, and otherwise involving himself in the arrangements made with the hotel chain for those conferences. The OIG made one recommendation relating to a supervisory review of the employee's conduct and consideration of appropriate administrative action, if any. VA concurred with this recommendation.

ALLEGATIONS OF NEPOTISM AT THE MIAMI VA HEALTHCARE SYSTEM IN FLORIDA

In response to allegations made to the OIG hotline, the OIG investigated whether chief nurses within the Miami VA Health Care System violated the federal antinepotism statute by arranging to have their

spouses hired for positions for which the spouses were not qualified. This allegation could not be substantiated. However, the OIG did substantiate an allegation that a specific chief nurse violated the federal antinepotism statue by recommending the chief nurse's spouse for a position at the healthcare system. The chief nurse is a public official and was prohibited from advocating for the employment by the VA of the chief nurse's spouse. The chief nurse advocated for the spouse's employment in an email contrary to the antinepotism statute. The spouse withdrew his/her application without providing an explanation and was not hired by VA. The OIG made one recommendation relating to possible administrative action against the chief nurse.

ALLEGED CONFLICT OF INTEREST BY A VA MEDICAL CENTER CHIEF OF STAFF

The OIG investigated allegations that the chief of staff at a VA medical center engaged in a conflict of interest by performing work for a private company that provides education services and misused his official position by recruiting VA physicians to work for that same company in 2017 and 2018. The OIG did not substantiate either alleged violation. The OIG did, however, identify a related misuse of government resources. The OIG identified email threads exchanged between the chief of staff and the VA physicians in support of the outside business activities associated with the education company. When presented with these emails, the chief of staff apologized and expressed surprise. The two VA physicians indicated they believed (incorrectly) that the use of VA resources to conduct activities related to the company was permissible if it was done outside working hours. The OIG made no recommendations.

MISUSE OF FUNDS, IMPROPER DISPOSAL OF EQUIPMENT, AND DESTRUCTION OF RECORDS

The OIG received allegations of misconduct in the operations of VHA's Consolidated Patient Account Center (CPAC) field offices, which function within the Office of Community Care, and substantiated that (1) CPAC management improperly used government funds to purchase food for CPAC employees in FYs 2015 and 2016, (2) one CPAC violated VA policy for disposing of excess equipment when computer monitors were given to a local school without following established procedures, and (3) some CPAC field offices violated VA policy requiring that destruction of temporary paper records be performed pursuant to a written contract. The OIG made two recommendations with which VA concurred and took prompt corrective action. The OIG considers these recommendations closed. Allegations relating to improper travel, the misuse of funds for the purchase of planners and a wheelchair, and the improper use of purchase cards for armored car services were not substantiated.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

CONGRESSIONAL RELATIONS

During this reporting period, the Inspector General and OIG personnel conducted 65 briefings with congressional members and their staff. OIG congressional relations staff also fielded 65 inquiries from congressional staff related to constituent matters for review or referral.

PRESS RELEASE

All OIG press releases, as well as press releases made by the U.S. Department of Justice regarding VA OIG criminal investigations, are available at www.va.gov/oig/publications/press-releases.asp.

TABLE 6. OIG PRESS RELEASE (APRIL 1–SEPTEMBER 30, 2020)

TITLE	ISSUE DATE
OIG Statement on Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	7/14/2020

PODCASTS

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

TABLE 7. OIG PODCASTS (APRIL 1–SEPTEMBER 30, 2020)

TITLE	ISSUE DATE
VA OIG March 2020 Highlights	4/14/2020
VA OIG April 2020 Highlights	6/18/2020
VA OIG May 2020 Highlights	7/7/2020
Coatesville VA Medical Center: Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center	7/9/2020
VA OIG June 2020 Highlights	8/3/2020
Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania	9/14/2020
VA OIG July 2020 Highlights	9/18/2020

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 three legislative or regulatory proposals and made no comments. The OIG also reviewed 22 internal VA directives and handbooks that guide the work of VA employees and provided six comments.

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

The IG Act authorizes federal inspectors general to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to 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 its 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. The VA OIG's offices of Audits and Evaluations, Contract Review, Healthcare Inspections, Investigations, and Special Reviews 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 these offices 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 REVIEWS CONDUCTED OF THE VA OIG

On February 4, 2020, the HHS OIG initiated a peer review of VA OIG's inspections and evaluations for the calendar year 2019. The HHS OIG, with staff from the OIGs of the Department of Housing and Urban Development, the Department of the Interior, and SBA, issued a final report on June 25, 2020, and concluded that VA OIG's internal policies and procedures addressed the seven covered CIGIE standards

and each of the four reviewed reports complied with CIGIE standards and VA OIG internal policies and procedures.

On December 10, 2018, the NASA OIG completed a peer review of VA OIG's Office of Investigations for the three-year period ending September 2018. The NASA OIG 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 Council of the Inspectors General on Integrity and Efficiency and other applicable guidelines and statutes.

On October 10, 2018, the Department of Energy OIG initiated a peer review of VA OIG's audit operations for the three-year period ending September 2018. The DOE OIG issued a final report on August 28, 2019 and concluded that VA OIG's system of quality controls provides reasonable assurance that the Office of Audits and Evaluations performs its work and reports its findings in conformity with applicable standards in all material respects.

MOST RECENT PEER REVIEWS CONDUCTED BY THE VA OIG

The VA OIG completed no peer reviews of other OIGs during the reporting period. There are no outstanding recommendations that have not been fully implemented from any peer review completed by the VA OIG prior to the reporting period.

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 U.S. 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.

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:

- Matthew Baker, a health systems specialist in Buffalo, New York, was activated by the United States Army in March 2020 and returned from duty in May 2020.
- Katherine Bostick, a health systems specialist in Aurora, Colorado, was activated by the United States Army in March 2020.
- Matthew Clark, an auditor in Dallas, Texas, was activated by the United States Army in July 2019.
- Damian Donahoe, a training management coordinator in Kansas City, Missouri, was activated by the United States Army in January 2020.
- Christopher Dong, an attorney in Washington, DC, was activated by the United States Air Force in March 2019.
- Danielle Head, a procurement analyst in Arlington, Virginia, was activated by the United States Army in October 2019.
- Ricardo Wallace-Jimenez, a criminal investigator in Spokane, Washington, was activated by the United States Army in April 2020.

2020 COUNCIL OF THE INSPECTORS GENERAL ON INTEGRITY AND EFFICIENCY AWARDS

Each year, the Council of the Inspectors General on Integrity and Efficiency (CIGIE) presents awards for outstanding work in the inspector general community. These awards offer an opportunity to recognize some of the very best work throughout the OIG community, as determined by a panel of peers. VA OIG staff were recognized by CIGIE for these outstanding accomplishments:

- The Glenn/Roth Award for Exemplary Service was awarded to the Special Reviews team that produced *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017.*
- An Award for Excellence in Investigations was awarded to Special Agent Kristofor Raper for his efforts in leading one of the most significant homicide investigations in VA OIG history against a former VA pathologist accused of practicing while under the influence, leading to incorrect diagnoses and treatment decisions that resulted in the deaths or serious injury of about 600 veterans.

- An Award for Excellence in Multiple Disciplines was awarded to staff from OIG's Investigations, Audits and Evaluations, and Management and Administration offices for the Automated Cluster Analysis Tool for Investigating Education (Auto-CATIE), which bolstered oversight of VA educational programs.
- An Award for Excellence in Evaluations was awarded to the Healthcare Inspections team responsible for *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*.
- An Award for Excellence in Evaluations was awarded to the Audits and Evaluations team that produced *Exempt Veterans Charged VA Home Loan Funding Fees*.
- An Award for Excellence in Audit was awarded to the Audits and Evaluations team responsible for *Non-VA Emergency Care Claims Inappropriately Denied and Rejected*.

U.S. ATTORNEY'S OFFICE INVESTIGATIVE EXCELLENCE AWARD AND VICTIM SERVICE AWARD

The U.S. Attorney's Office for the District of Massachusetts presented the multiagency Insys Therapeutics investigative team, which included VA OIG Resident Agent-in-Charge Robert Bosken, with an Investigative Excellence Award and a Victim Service Award. The team earned this prestigious award after their successful investigation and prosecution of Insys Therapeutics and former employees for their role in a racketeering conspiracy in connection with bribing medical practitioners to prescribe their drug, called Subsys.

U.S. ATTORNEY'S OFFICE INVESTIGATIVE EXCELLENCE AWARD

The U.S. Attorney's Office for the District of Massachusetts presented a multiagency investigative team, which included Special Agent Jason Kravetz, with an Investigative Excellence Award. The award was in honor of the team's investigation into pharmaceutical companies that violated the False Claims Act by illegally paying the copayments of Medicare and CHAMPVA patients through independent charitable foundations.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

Federal inspectors general are required to provide information on the reports it publishes 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, offices of inspector general 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 offices of inspector general 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 two significant management decisions in two reports with which the Inspector General is in disagreement:

- In the report *Deficiencies in Virtual Pharmacy Services in the Care of a Patient*, the Department nonconcurred with OIG Recommendation 3, but provided an action plan. The Department also nonconcurred with Recommendation 5 related to the establishment of program management and quality assurance objectives for Virtual Pharmacy Services that define the reporting frequency and structure. For this recommendation, the Department contends that they hold the Virtual Pharmacy Services program to the same rigorous quality assurance standards and objectives as facility-based pharmacy programs.
- In the report *Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center in Louisville, Kentucky*, the Department nonconcurred with OIG Recommendation 11 related to developing a mechanism to ensure that patients in behavioral restraints are assessed every 15 minutes as required, and that documentation complies with VHA policy. For this recommendation, the Department believes the findings in the report

underlying this recommendation are incorrect. However, the OIG stands by its findings and recommendations for both reports.

The Department's comments and the VA OIG's responses are available in full in the respective reports on the VA OIG's website.

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

AUDITS AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Independent Review of VA's Special Disabilities Capacity Reports for Fiscal Years 2017 and 2018 *Issued 4/16/2020 | Report Number 19-06382-111*	—	—
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System *Issued 4/27/2020 | Report Number 19-08980-95*	—	—
VA's Compliance with the Improper Payments Elimination and Recovery Act for Fiscal Year 2019 *Issued 5/14/2020 | Report Number 19-09563-142*	—	—
VA Improved the Transparency of Mandatory Staffing and Vacancy Data *Issued 6/3/2020 | Report Number 20-00541-149*	—	—
Improvements Needed to Reduce Aging Infrastructure Risks at Northport VA Medical Center in New York *Issued 6/4/2020 | Report Number 19-07482-91*	—	—
VA's Implementation of the FITARA Chief Information Officer Authority Enhancements *Issued 6/9/2020 | Report Number 18-04800-122*	—	—
Fiscal Year 2019 Risk Assessment of VA's Charge Card Program *Issued 6/10/2020 | Report Number 20-00417-170*	—	—
Disability Compensation Benefit Adjustments for Hospitalization Need Improvement *Issued 6/10/2020 | Report Number 19-06249-94*	—	$40,000,000

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Middle Tennessee Research Institute *Issued 6/16/2020 | Report Number 18-00711-106*	—	$1,900,000
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Northern California Institute for Research and Education *Issued 6/16/2020 | Report Number 18-00711-141*	—	$25,940,000
VA Police Information Management System Needs Improvement *Issued 6/17/2020 | Report Number 19-05798-107*	—	—
Overtime Use in the Office of Community Care to Process Non-VA Care Claims Not Effectively Monitored *Issued 6/23/2020 | Report Number 18-06292-117*	—	—
Controls Appear to Have Addressed Prior Overpayments of Post-9/11 GI Bill Monthly Housing Allowance *Issued 6/23/2020 | Report Number 19-08728-166*	—	—
VA Should Examine Options to Expand Retail Pharmacy Drug Discounts *Issued 6/30/2020 | Report Number 19-07281-105*	$345,100,000	—
The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research *Issued 7/14/2020 | Report Number 19-06451-165*	—	—
Potential Payment Errors Made by Veteran Readiness and Employment Service *Issued 7/21/2020 | Report Number 20-02562-188*	—	—
The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies *Issued 7/22/2020 | Report Number 19-07059-169*	—	—
Deficiencies in the Quality Review Team Program *Issued 7/22/2020 | Report Number 19-07054-174*	—	—
Accuracy of Disability Benefit Evaluations for Veterans' Service-Connected Heart Diseases *Issued 8/5/2020 | Report Number 19-08095-198*	—	$61,800,000

AUDITS AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Site Visit Program Can Do More to Improve Nationwide Claims Processing *Issued 8/18/2020 | Report Number 19-07062-230*	—	—
Appointment Management During the COVID-19 Pandemic *Issued 9/1/2020 | Report Number 20-02794-218*	—	—
Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources *Issued 9/2/2020 | Report Number 18-03800-232*	—	—
The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions *Issued 9/10/2020 | Report Number 19-00227-226*	—	$122,000,000
Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency *Issued 9/17/2020 | Report Number 20-02825-242*	—	—
Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care *Issued 9/17/2020 | Report Number 18-06039-229*	$30,000,000	—
Financial Controls Related to VA-Affiliated Nonprofit Corporations: Idaho Veterans Research and Education Foundation *Issued 9/24/2020 | Report Number 18-00711-251*	—	$112,400
Governance of Robotic Surgical System Investments Needs Improvement *Issued 9/25/2020 | Report Number 19-07103-252*	—	—
Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide *Issued 9/29/2020 | Report Number 19-07062-255*	—	—
Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System *Issued 9/30/2020 | Report Number 19-00226-245*	$132,100,000	$73,000,000
Total	**$507,200,000**	**$324,752,400**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

Office of Contract Review 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).

PREAWARD REVIEWS	SAVINGS AND COST AVOIDANCE
Review of a Proposal Submitted under a Solicitation *Issued 4/2/2020 | Report Number 20-02118-121*	$235,802
Review of a Proposal Submitted under a Solicitation *Issued 4/8/2020 | Report Number 20-02233-125*	$284,845
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/13/2020 | Report Number 20-01525-128*	$9,146,480
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 4/13/2020 | Report Number 20-01164-129*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/15/2020 | Report Number 20-02117-131*	—
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 4/16/2020 | Report Number 20-01347-132*	$1,236,870
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/17/2020 | Report Number 20-00567-126*	$9,476,271
Review of a Proposal Submitted under a Solicitation *Issued 4/21/2020 | Report Number 20-01956-134*	$1,844,868
Review of a Proposal Submitted under a Solicitation *Issued 4/21/2020 | Report Number 20-01095-127*	$18,285,865

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of a Proposal Submitted under a Solicitation *Issued 4/23/2020 | Report Number 20-01672-130*	$1,655,980
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/29/2020 | Report Number 20-00406-140*	$2,645,731
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/1/2020 | Report Number 20-00652-143*	$416,054
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/4/2020 | Report Number 19-08892-145*	—
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 5/4/2020 | Report Number 19-09728-146*	$9,507,376
Review of a Proposal Submitted under a Solicitation *Issued 5/5/2020 | Report Number 20-02406-139*	$617,200
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/5/2020 | Report Number 20-00190-144*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/8/2020 | Report Number 20-01793-150*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/11/2020 | Report Number 19-09547-147*	$11,013,708
Review of a Proposal Submitted under a Solicitation *Issued 5/13/2020 | Report Number 20-01700-154*	$12,848,385
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/15/2020 | Report Number 20-00969-160*	$28,094
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/18/2020 | Report Number 20-01165-162*	—

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 5/20/2020 | Report Number 20-02301-163*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 5/27/2020 | Report Number 20-02075-167*	—
Review of a Proposal Submitted under a Solicitation *Issued 6/10/2020 | Report Number 20-03001-176*	$237,701
Review of a Proposal Submitted under a Solicitation *Issued 6/12/2020 | Report Number 20-02982-179*	$2,379,220
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 6/16/2020 | Report Number 20-01799-184*	$19,994,324
Summary of Fiscal Year 2019 Preaward Reviews of Healthcare Resources Proposals from Affiliates *Issued 6/25/2020 | Report Number 20-00184-153*	—
Review of a Proposal Submitted under a Solicitation *Issued 6/29/2020 | Report Number 20-03040-196*	$137,380
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 6/29/2020 | Report Number 20-02532-197*	—
A Synopsis of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2019 *Issued 6/30/2020 | Report Number 20-00010-151*	—
Review of a Proposal Submitted under a Solicitation *Issued 6/30/2020 | Report Number 20-02870-195*	$1,833,161
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 7/1/2020 | Report Number 20-02704-193*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 7/15/2020 | Report Number 20-02665-213*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 7/20/2020 | Report Number 20-02674-221*	—

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of a Proposal Submitted under a Solicitation *Issued 7/23/2020 | Report Number 20-03068-224*	$110,284
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/23/2020 | Report Number 20-02019-227*	$13,273,320
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/24/2020 | Report Number 20-02390-228*	$94,123
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 8/3/2020 | Report Number 20-03039-234*	$13,800,761
Review of a Proposal Submitted under a Solicitation *Issued 8/11/2020 | Report Number 20-03377-237*	$2,054,053
Review of a Proposal Submitted under a Solicitation *Issued 8/11/2020 | Report Number 20-03458-239*	$4,541,673
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 8/17/2020 | Report Number 20-01632-246*	$944,606
Review of a Proposal Submitted under a Solicitation *Issued 8/18/2020 | Report Number 20-03425-247*	$-348,380
Review of a Proposal Submitted under a Solicitation *Issued 9/8/2020 | Report Number 20-03558-254*	$3,781,537
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/11/2020 | Report Number 20-02604-256*	$31,961,273
Review of a Proposal Submitted under a Solicitation *Issued 9/17/2020 | Report Number 20-03665-263*	$3,657,532
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 9/17/2020 | Report Number 20-03439-264*	$1,458,659
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 9/18/2020 | Report Number 20-03442-260*	—

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 9/22/2020 | Report Number 20-03015-268*	—
Review of a Proposal Submitted under a Solicitation *Issued 9/25/2020 | Report Number 20-04064-276*	$938,753
Review of a Proposal Submitted under a Solicitation *Issued 9/30/2020 | Report Number 20-03916-274*	$189,959
Review of a Proposal Submitted under a Solicitation *Issued 9/30/2020 | Report Number 20-03761-270*	$3,087,573
Total	**$183,371,042**

Note: Numbers may not sum due to rounding.

POSTAWARD REVIEWS	RECOVERIES
Review of Voluntary Disclosure Due to Violations of the Price Reductions Clause under a Federal Supply Schedule Contract *Issued 4/17/2020 | Report Number 19-08585-133*	$61,690
Review of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 5/13/2020 | Report Number 20-01210-152*	$58,638
Review of Compliance with Public Law 102-585 Section 603 and Related Contract Provisions under a Federal Supply Schedule Contract *Issued 5/13/2020 | Report Number 16-02145-155*	$634,942
Review of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 5/18/2020 | Report Number 20-00447-161*	$283,058
Review of a Voluntary Disclosure of Pricing Errors Under a Federal Supply Schedule Contract *Issued 6/3/2020 | Report Number 20-01211-173*	$275,950
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Prior to Award of a Federal Supply Schedule Letter Contract *Issued 6/10/2020 | Report Number 20-01209-177*	$1,879,064
Review of Voluntary Disclosure Due to Violations of the Price Reductions Clause under a Federal Supply Schedule Contract *Issued 6/17/2020 | Report Number 19-08531-187*	$2,777,210

POSTAWARD REVIEWS (CONTINUED)	RECOVERIES
Review of Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts *Issued 7/20/2020 | Report Number 16-01960-219*	$2,591,827
Review of a Voluntary Disclosure for Price Reductions under a Federal Supply Schedule Contract *Issued 8/5/2020 | Report Number 18-03066-235*	$331,866
Review of Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts *Issued 8/19/2020 | Report Number 18-06100-244*	$5,290,853
Review of a Settlement Agreement *Issued 9/1/2020 | Report Number 20-00443-253*	$4,086,731
Review of Voluntary Disclosure Due to Violations of the Price Reductions Clause under a Federal Supply Schedule Contract *Issued 9/15/2020 | Report Number 20-02852-257*	$267,253
Review of a Voluntary Disclosure of Pricing Errors Under a Federal Supply Schedule Contract *Issued 9/25/2020 | Report Number 20-03316-275*	$38,923
Review of Billings under a Federal Supply Schedule Contract and a Blanket Purchase Agreement *Issued 9/29/2020 | Report Number 20-02534-277*	—
VA's Noncompliance with Preaward Review Requirements for Sole-Source Proposals for Healthcare Services *Issued 9/30/2020 | Report Number 18-04150-261*	—
Total	**$18,578,004**

Note: Numbers may not sum due to rounding.

CLAIM REVIEWS	SAVINGS AND COST AVOIDANCE
Review of Subcontractor Termination Settlement Proposal Submitted under a VA Contract *Issued 4/23/2020 | Report Number 20-01070-137*	$-64,202
Review of Termination Settlement Proposal Submitted under a VA Contract *Issued 4/29/2020 | Report Number 20-00986-138*	$1,163,282

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

CLAIM REVIEWS (CONTINUED	SAVINGS AND COST AVOIDANCE
Review of Subcontractor Termination Settlement Proposal Submitted under a VA Contract *Issued 5/5/2020 | Report Number 20-01325-148*	$65,691
Review of Subcontractor Termination Settlement Proposal Submitted under a VA Contract *Issued 5/26/2020 | Report Number 20-01069-164*	$153,762
Review of Subcontractor Termination Settlement Proposal Submitted under a VA Contract *Issued 5/28/2020 | Report Number 20-01067-168*	$28,724
Review of Request for Equitable Adjustment Submitted under a VA Contract *Issued 6/12/2020 | Report Number 20-01809-181*	$689,282
Review of a Certified Claim Submitted under a VA Lease *Issued 8/3/2020 | Report Number 20-02396-231*	$194,742
Review of a Certified Claim Submitted under a VA Lease *Issued 8/3/2020 | Report Number 20-02395-233*	$260,666
Review of Contract Services to a VA Healthcare System *Issued 9/23/2020 | Report Number 20-03908-269*	$378,147
Review of Termination Settlement Proposal Submitted under a VA Contract *Issued 9/30/2020 | Report Number 20-03586-278*	$531,624
Total	**$3,401,718**

Note: Numbers may not sum due to rounding.

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

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
VA Eastern Kansas Health Care System in Topeka	6/18/2020	19-06870-175
Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan	7/1/2020	20-00067-172
Tomah VA Medical Center in Wisconsin	7/7/2020	20-00082-189
Harry S. Truman Memorial Veteran's Hospital in Columbia, Missouri	7/9/2020	19-06864-183

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
John J. Pershing VA Medical Center in Poplar Bluff, Missouri	7/9/2020	19-09416-186
Marion VA Medical Center in Illinois	7/15/2020	20-00206-180
Kansas City VA Medical Center in Missouri	7/23/2020	19-06850-208
VA Illiana Health Care System in Danville, Illinois	7/29/2020	20-00062-205
William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin	8/4/2020	20-00068-206
VA St. Louis Health Care System in Missouri	8/12/2020	19-06873-210
Jesse Brown VA Medical Center in Chicago, Illinois	8/13/2020	20-00077-211
Robert J. Dole VA Medical Center in Wichita, Kansas	8/18/2020	19-06872-199
Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri	8/19/2020	19-06848-209
Edward Hines, Jr. VA Hospital in Hines, Illinois	8/25/2020	20-00069-222
Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin	8/26/2020	20-00075-225
Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois	8/27/2020	20-00064-238
Tuscaloosa VA Medical Center in Alabama	9/2/2020	20-00130-194
Central Alabama Veterans Health Care System in Montgomery	9/10/2020	20-00131-243
Birmingham VA Medical Center in Alabama	9/10/2020	20-00130-241
Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois	9/15/2020	20-00058-250

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington	4/27/2020	19-09447-136
Manipulation of Radiology Reports and Leadership Failures in the Medical Imaging Service at the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin	4/29/2020	18-06074-123
Radiology Concerns at the VA Illiana Health Care System in Danville, Illinois	5/5/2020	18-05350-135
Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center in Augusta, Georgia	5/12/2020	19-08296-118
Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center in North Carolina	5/19/2020	19-08256-124

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Death of a Patient, Deficiencies in Domiciliary Safety and Security, and Inadequate Contractual Agreement at the VA Northeast Ohio Healthcare System in Cleveland	5/28/2020	19-07091-159
Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center, in Baltimore, Maryland	6/11/2020	19-08857-171
Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center in Pennsylvania	6/11/2020	19-06391-119
Deficiencies in Virtual Pharmacy Services in the Care of a Patient	6/18/2020	19-07827-182
Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania	7/1/2020	19-09436-185
Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	7/2/2020	19-09377-192
Inadequate Care by a Clinical Pharmacy Specialist and a Primary Care Provider at the Tennessee Valley Healthcare System in Nashville	7/2/2020	19-07543-178
Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas	7/14/2020	19-09410-203
Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia	7/21/2020	18-01622-207
Alleged Deficiencies within the Cardiac Telemetry Monitoring Service at the Nashville VA Medical Center in Tennessee	7/23/2020	20-00513-216
Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center	7/28/2020	19-07507-214
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia	7/29/2020	19-07600-215
Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada	7/30/2020	19-09486-204
Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	8/4/2020	19-09776-223
Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center in Louisville, Kentucky	8/5/2020	19-08666-212

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds	8/20/2020	19-09669-236
Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon	8/27/2020	20-02240-248
Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee	9/3/2020	19-09493-249
Mismanagement of Emergency Department Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas	9/23/2020	20-01318-258
Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia	9/24/2020	20-01102-266
Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia	9/28/2020	19-07828-265
Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California	9/29/2020	20-00005-271
Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans	9/29/2020	19-07854-272
Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia	9/30/2020	19-08106-273

NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care	7/7/2020	19-00017-191
Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness	7/16/2020	20-03076-217
Improving VA and Select Community Care Health Information Exchanges	8/6/2020	20-01129-220
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages	9/23/2020	20-01249-259

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.4. PUBLICATIONS ISSUED BY THE OFFICE OF SPECIAL REVIEWS

ADMINISTRATIVE INVESTIGATIONS	ISSUE DATE	REPORT NUMBER
Alleged Misconduct by Employees of the Greater Los Angeles Healthcare System Addressed by VA	6/24/2020	18-02164-156
Improper Pay to Fee-Basis Providers Adequately Addressed by VA San Diego Healthcare System	6/24/2020	18-02929-157
Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel	6/24/2020	18-06501-158
Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration	7/8/2020	19-00230-190
Allegations of Nepotism at the Miami VA Healthcare System in Florida	7/28/2020	18-01781-200
Alleged Misuse of Official Time and Possible Ethics Violation by an Information Technology Employee	7/28/2020	17-04969-202
Alleged Conflict of Interest by a VA Medical Center Chief of Staff	8/20/2020	18-03275-240
Misuse of Funds, Improper Disposal of Equipment, and Destruction of Records	9/25/2020	17-00126-267

TABLE A.5. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$324,752,400
Better Use of Funds	$507,200,000
Savings and Cost Avoidance	$186,772,760
Dollar Recoveries	$18,578,004
Total	**$1,037,303,164**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	7	$324,752,400
Total inventory this reporting period	**7**	**$324,752,400**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	7	$324,752,400
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**7**	**$324,752,400**
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 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	3	$507,200,000
Total inventory this reporting period	**3**	**$507,200,000**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	3	$507,200,000
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**3**	**$507,200,000**
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 office of inspector general 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 recommendation. All data in the tables are current as of September 30, 2020. Real-time information on the status of VA OIG recommendations is available through the OIG's Recommendation Dashboard.

Visit the OIG's Recommendation Dashboard at www.va.gov/oig/recommendation-dashboard.asp 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, 2020, there are 189 total open reports, with 49 open more than a year and 140 open less than a year. However, table B.1 shows a total of 199 open reports, with 53 open more than a year and 146 open less than a year. This is because four reports are counted multiple times 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	37	118	155
Veterans Benefits Administration	8	11	19
Office of Acquisition, Logistics, and Construction	3	1	4
Office of General Counsel	0	3	3
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	3	4	7
Office of Information and Technology	2	5	7
Office of Management	0	2	2
Office of Accountability and Whistleblower Protection	0	1	1
Office of Electronic Health Record Modernization	0	1	1
Totals	**53**	**146**	**199**

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, 2020, there are 1,196 total open recommendations, with 136 open more than a year and 1,060 open less than a year. However, table B.2 shows a total of 1,203 open recommendations, with 142 open more than a year and 1,061 open less than a year. This is because seven 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	101	935	1,036
Veterans Benefits Administration	17	35	52
Office of Acquisition, Logistics, and Construction	6	5	11
Office of General Counsel	0	9	9
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	16	11	27
Office of Information and Technology	2	37	39
Office of Management	0	17	17
Office of Accountability and Whistleblower Protection	0	7	7
Office of Electronic Health Record Modernization	0	5	5
Totals	**142**	**1,061**	**1,203**

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

Table B.3 identifies the 140 reports and 1,060 recommendations that, as of September 30, 2020, have been open less than one year. The total monetary benefit attached to these recommendations is $1,423,005,455.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 *Issued 10/10/2019 | Report Number 19-07040-243*	VHA	1–16	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives *Issued 10/17/2019 | Report Number 19-06125-218*	OIT	3	—
Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas *Issued 10/23/2019 | Report Number 19-00035-247*	VHA	1, 2, 4, 5, 8–11	—
Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017 *Issued 10/24/2019 | Report Number 18-04968-249*	OAWP OGC OHRA/OSP	OAWP: 3, 4, 8, 11, 13, 18, 19 OGC: 6 OHRA/OSP: 10	—
FY 2019 Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2019 | Report Number 19-07247-251*	OM	1–16	—
Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia *Issued 11/12/2019 | Report Number 18-04682-256*	VHA	6, 7, 14, 16, 17, 19, 20, 21	—
Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital, Tampa, Florida *Issued 11/14/2019 | Report Number 19-00011-255*	VHA	5–6	—
Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters *Issued 11/14/2019 | Report Number 19-05960-244*	VBA	3	—
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut *Issued 11/20/2019 | Report Number 18-04675-23*	VHA	1–4, 6–8	—
Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut *Issued 11/20/2019 | Report Number 19-00075-14*	VHA	1, 5, 11	—
VHA Did Not Effectively Manage Appeals of Non VA Care Claims *Issued 11/21/2019 | Report Number 18-06294-213*	VHA	1, 6, 8	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 11/21/2019 | Report Number 19-00013-15*	VHA	2, 5, 6, 9, 20, 21	—
Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire *Issued 11/25/2019 | Report Number 19-00040-10*	VHA	1–3, 6, 10–14	—
Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania *Issued 11/26/2019 | Report Number 18-04667-13*	VHA	1–6	—
Comprehensive Healthcare Inspection of the El Paso VA Health Care System, Texas *Issued 11/26/2019 | Report Number 19-00033-11*	VHA	1–3, 6	—
Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland *Issued 11/26/2019 | Report Number 19-05916-24*	VHA	2–4	—
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Boston VA Research Institute *Issued 12/2/2019 | Report Number 18-00711-211*	VHA	2, 3, 5, 7	$45,903,000
Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California *Issued 12/2/2019 | Report Number 18-04671-25*	VHA	1, 3, 8, 12–15, 17–20, 22–24	—
Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System, South Dakota *Issued 12/3/2019 | Report Number 19-00019-26*	VHA	5–8	—
Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, Arizona *Issued 12/5/2019 | Report Number 19-00014-33*	VHA	14–18	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System, Honolulu, Hawaii *Issued 12/5/2019 | Report Number 19-00023-29*	VHA	1, 4, 10	—
Delays and Deficiencies in Management of Selected Radiology and Nuclear Medicine Outpatient Exams *Issued 12/10/2019 | Report Number 18-02300-236*	VHA	1, 3, 6	—
Comprehensive Healthcare Inspection of the VA Butler Health Care Center, Pennsylvania *Issued 12/10/2019 | Report Number 19-00049-43*	VHA	1–5	—
Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in VISN 15 *Issued 12/11/2019 | Report Number 19-06562-30*	VHA	3	—
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center, Missouri *Issued 12/12/2019 | Report Number 18-06504-27*	VHA	6, 9–13	—
Insufficient Oversight of VA's Undelivered Orders *Issued 12/16/2019 | Report Number 17-04859-196*	VHA OM	VHA: 1–6 OM: 3	$132,600,000
Inadequate Oversight of the Medical/ Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers *Issued 12/17/2019 | Report Number 17-03718-240*	VHA	1–8, 11	$84,000,000
Comprehensive Healthcare Inspection of the Coatesville VA Medical Center, Pennsylvania *Issued 12/18/2019 | Report Number 19-00048-48*	VHA	2, 4, 11, 12, 16	—
Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio *Issued 12/18/2019 | Report Number 19-00051-40*	VHA	1, 2, 4–13	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Louis Stokes Cleveland VA Medical Center, Ohio *Issued 12/19/2019 | Report Number 19-00015-47*	VHA	4, 6, 8	—
Comprehensive Healthcare Inspection of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Issued 12/19/2019 | Report Number 19-00052-54*	VHA	2	—
Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System, Minnesota *Issued 12/19/2019 | Report Number 19-00055-38*	VHA	1, 3	—
Comprehensive Healthcare Inspection of the VA Western New York Healthcare System, Buffalo, New York *Issued 1/7/2020 | Report Number 18-04666-55*	VHA	1, 13, 14, 17	—
Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 1/8/2020 | Report Number 19-00053-57*	VHA	1–17	—
Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center Spokane, Washington *Issued 1/8/2020 | Report Number 19-09017-64*	VHA	1, 2	—
Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland *Issued 1/9/2020 | Report Number 19-00016-61*	VHA	1–17, 22, 23	—
Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York *Issued 1/9/2020 | Report Number 19-00037-58*	VHA	1, 4	—
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts *Issued 1/13/2020 | Report Number 19-00038-63*	VHA	1–8, 11, 13, 14, 16–27, 29, 30	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts *Issued 1/13/2020 | Report Number 19-00043-66*	VHA	1, 3–6, 8–9, 11–12, 14–18, 20–21	—
Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana *Issued 1/14/2020 | Report Number 19-00012-51*	VHA	2, 3, 5–7, 11–13	—
Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes *Issued 1/14/2020 | Report Number 19-00021-41*	VHA	2, 3	$261,300,000
Comprehensive Healthcare Inspection of the West Texas VA Health Care System, Big Spring, Texas *Issued 1/15/2020 | Report Number 19-00034-62*	VHA	3, 7, 9, 10	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas *Issued 1/15/2020 | Report Number 19-06863-69*	VHA	4, 5	—
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Cincinnati Education and Research for Veterans Foundation *Issued 1/16/2020 | Report Number 18-00711-42*	VHA	3, 4	$938,000
Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities *Issued 1/16/2020 | Report Number 18-05121-36*	VHA	1, 5	—
Comprehensive Healthcare Inspection of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana *Issued 1/16/2020 | Report Number 19-00046-60*	VHA	1, 14, 15	—
A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York *Issued 1/21/2020 | Report Number 19-07070-75*	VHA	1, 2	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System *Issued 1/23/2020 | Report Number 19-06378-73*	VHA	5, 7–9, 15–18	—
Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska *Issued 1/28/2020 | Report Number 19-00054-72*	VHA	2, 3, 4, 6	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts *Issued 1/29/2020 | Report Number 19-06866-68*	VHA	1–8	—
Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims *Issued 1/30/2020 | Report Number 19-06757-70*	VBA	1	$311,000
Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction, Colorado *Issued 2/4/2020 | Report Number 19-06435-84*	VHA	1, 2	—
Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments *Issued 2/11/2020 | Report Number 18-05738-56*	VBA	1, 2, 4	$56,900,000
Review of Veterans Health Administration Community Living Centers and Corresponding Star Ratings *Issued 2/12/2020 | Report Number 18-05113-81*	VHA	1–3	—
Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio *Issued 2/20/2020 | Report Number 18-01275-89*	VHA	4, 7–8, 11–13	—
Alleged Issues in the Cardiology Department at the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana *Issued 2/27/2020 | Report Number 19-07090-90*	VHA	1–4	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficient Staffing and Competencies in Sterile Processing Services at the VA Black Hills Healthcare System, Fort Meade Campus, South Dakota *Issued 3/23/2020 | Report Number 19-07096-108*	VHA	2	—
Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri *Issued 3/24/2020 | Report Number 19-07682-103*	VHA	1, 4–5	—
Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center, Pennsylvania *Issued 3/25/2020 | Report Number 19-08374-112*	VHA	1	—
Federal Information Security Modernization Act Audit for Fiscal Year 2019 *Issued 3/31/2020 | Report Number 19-06935-96*	OIT	1–25	—
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System *Issued 4/27/2020 | Report Number 19-08980-95*	OEHRM	3–7	—
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 4/27/2020 | Report Number 19-09447-136*	VHA	1–8	—
Manipulation of Radiology Reports and Leadership Failures in the Medical Imaging Service at Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 4/29/2020 | Report Number 18-06074-123*	VHA	1, 2, 4	—
Radiology Concerns at the VA Illiana Health Care System Danville, Illinois *Issued 5/5/2020 | Report Number 18-05350-135*	VHA	1–6	—
Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 5/12/2020 | Report Number 19-08296-118*	VHA	1–6	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2019 *Issued 5/14/2020 | Report Number 19-09563-142*	VHA	1	—
Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina *Issued 5/19/2020 | Report Number 19-08256-124*	VHA	1–12	—
Death of a Patient, Deficiencies in Domiciliary Safety and Security, and Inadequate Contractual Agreement at the VA Northeast Ohio Healthcare System in Cleveland *Issued 5/28/2020 | Report Number 19-07091-159*	VHA	1–3	—
VA Improved the Transparency of Mandatory Staffing and Vacancy Data *Issued 6/3/2020 | Report Number 20-00541-149*	OHRA/ OSP	1, 2	—
Improvements Needed to Reduce Aging Infrastructure Risks at Northport VA Medical Center in New York *Issued 6/4/2020 | Report Number 19-07482-91*	VHA	1–3	—
VA's Implementation of the FITARA Chief Information Officer Authority Enhancements *Issued 6/9/2020 | Report Number 18-04800-122*	OIT	1, 2, 4–10	—
Disability Compensation Benefit Adjustments for Hospitalization Need Improvement *Issued 6/10/2020 | Report Number 19-06249-94*	VBA	1, 5, 6	$40,000,000
Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center, Pennsylvania *Issued 6/11/2020 | Report Number 19-06391-119*	VHA	1–5, 7, 8	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center in Baltimore, Maryland *Issued 6/11/2020 | Report Number 19-08857-171*	VHA	1–5	—
Financial Controls and Payments Related to VA-Affiliated NPCs: Middle Tennessee Research Institute *Issued 6/16/2020 | Report Number 18-00711-106*	VHA	1–3	$1,900,000
Financial Controls Related to VA-Affiliated Nonprofit Corporations: Deficient for Northern California Institute for Research and Education *Issued 6/16/2020 | Report Number 18-00711-141*	VHA	1, 2	$25,940,000
VA Police Information Management System Needs Improvement *Issued 6/17/2020 | Report Number 19-05798-107*	OHRA/OSP OIT	OHRA/OSP: 1–6 OIT: 7	—
Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka *Issued 6/18/2020 | Report Number 19-06870-175*	VHA	1–39	—
Deficiencies in Virtual Pharmacy Services in the Care of a Patient *Issued 6/18/2020 | Report Number 19-07827-182*	VHA	1–4	—
Overtime Use in the Office of Community Care to Process Non-VA Care Claims Not Effectively Monitored *Issued 6/23/2020 | Report Number 18-06292-117*	VHA	1–4	—
Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel *Issued 6/25/2020 | Report Number 18-06501-158*	OGC	1–7	—
VA Should Examine Options to Expand Retail Pharmacy Drug Discounts *Issued 6/30/2020 | Report Number 19-07281-105*	VHA	1, 2	$345,100,000

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania *Issued 7/1/2020 | Report Number 19-09436-185*	VHA	1, 2, 4–6	—
Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan *Issued 7/1/2020 | Report Number 20-00067-172*	VHA	1–7, 10, 11	—
Inadequate Care by a Clinical Pharmacy Specialist and a Primary Care Provider at the Tennessee Valley Healthcare System in Nashville *Issued 7/2/2020 | Report Number 19-07543-178*	VHA	1, 2	—
Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina *Issued 7/2/2020| Report Number 19-09377-192*	VHA	2–5	—
Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care *Issued 7/7/2020 | Report Number 19-00017-191*	VHA	1–4	—
Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin *Issued 7/7/2020 | Report Number 20-00082-189*	VHA	1–4	—
Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration *Issued 7/8/2020 | Report Number 19-00230-190*	OALC OHRA/OSP OGC	OALC: 1, 2, 4, 6, 7 OHRA/OSP: 3, 8 OGC: 5	$4,999,500
Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veteran's Hospital in Columbia, Missouri *Issued 7/9/2020 | Report Number 19-06864-183*	VHA	1–14	—
Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri *Issued 7/9/2020 | Report Number 19-09416-186*	VHA	1–17	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research *Issued 7/14/2020 | Report Number 19-06451-165*	VHA	1–5	—
Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas *Issued 7/14/2020 | Report Number 19-09410-203*	VHA	1–6	—
Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois *Issued 7/15/2020 | Report Number 20-00206-180*	VHA	1–29	—
Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia *Issued 7/21/2020 | Report Number 18-01622-207*	VHA	1–6	—
Deficiencies in the Quality Review Team Program *Issued 7/22/2020 | Report Number 19-07054-174*	VBA	1–5	—
The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies *Issued 7/22/2020 | Report Number 19-07059-169*	VBA	1–6	—
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri *Issued 7/23/2020 | Report Number 19-06850-208*	VHA	2–6, 8–15, 20	—
Alleged Deficiencies within the Cardiac Telemetry Monitoring Service at the Nashville VA Medical Center in Tennessee *Issued 7/23/2020 | Report Number 20-00513-216*	VHA	1	—
Alleged Misuse of Official Time and Possible Ethics Violation by an Information Technology Employee *Issued 7/28/2020 | Report Number 17-04969-202*	OIT	1	—
Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center *Issued 7/28/2020 | Report Number 19-07507-214*	VHA	1–11	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia *Issued 7/29/2020 | Report Number 19-07600-215*	VHA	1–10	—
Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois *Issued 7/29/2020 | Report Number 20-00062-205*	VHA	1–13	—
Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada *Issued 7/30/2020 | Report Number 19-09486-204*	VHA	1	—
Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia *Issued 8/4/2020 | Report Number 19-09776-223*	VHA	1–3	—
Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin *Issued 8/4/2020 | Report Number 20-00068-206*	VHA	1–11, 14–16	—
Accuracy of Disability Benefit Evaluations for Veterans' Service-Connected Heart Diseases *Issued 8/5/2020 | Report Number 19-08095-198*	VBA	2, 3	$61,800,000
Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center, Louisville, Kentucky *Issued 8/5/2020 | Report Number 19-08666-212*	VHA	1–15	—
Improving VA Patients and Select Community Care Health Information Exchanges *Issued 8/6/2020 | Report Number 20-01129-220*	VHA	1–4	—
Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri *Issued 8/12/2020 | Report Number 19-06873-210*	VHA	1–20	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois *Issued 8/13/2020 | Report Number 20-00077-211*	VHA	1–22	—
Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas *Issued 8/18/2020 | Report Number 19-06872-199*	VHA	1–24, 26	—
Site Visit Program Can Do More to Improve Nationwide Claims Processing *Issued 8/18/2020 | Report Number 19-07062-230*	VBA	1–3	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri *Issued 8/19/2020 | Report Number 19-06848-209*	VHA	1, 2, 4, 6, 8–10	—
Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds *Issued 8/20/2020 | Report Number 19-09669-236*	VHA	1–7	—
Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois *Issued 8/25/2020 | Report Number 20-00069-222*	VHA	1–18, 20, 22–23	—
Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin *Issued 8/26/2020 | Report Number 20-00075-225*	VHA	1–15, 17–24, 27–28	—
Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois *Issued 8/27/2020 | Report Number 20-00064-238*	VHA	1–27	—
Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon *Issued 8/27/2020 | Report Number 20-02240-248*	VHA	1–5	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Appointment Management During the COVID-19 Pandemic *Issued 9/1/2020 | Report Number 20-02794-218*	VHA	1–3	—
Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources *Issued 9/2/2020 | Report Number 18-03800-232*	VHA	1, 3	—
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama *Issued 9/2/2020 | Report Number 20-00130-194*	VHA	1–14	—
Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee *Issued 9/3/2020 | Report Number 19-09493-249*	VHA	1–12, 14–16	—
The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions *Issued 9/10/2020 | Report Number 19-00227-226*	VBA	1–4	$122,000,000
Comprehensive Healthcare Inspection of the Birmingham VA Medical Center in Alabama *Issued 9/10/2020 | Report Number 20-00130-241*	VHA	1–18	—
Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery *Issued 9/10/2020 | Report Number 20-00131-243*	VHA	1–30	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois *Issued 9/15/2020 | Report Number 20-00058-250*	VHA	1–4	—
Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care *Issued 9/17/2020 | Report Number 18-06039-229*	VHA	1–3, 5–6	$30,000,000

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency *Issued 9/17/2020 | Report Number 20-02825-242*	VBA	1–3	—
Mismanagement of Emergency Department Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas *Issued 9/23/2020 | Report Number 20-01318-258*	VHA	1–10	—
Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia *Issued 9/24/2020 | Report Number 20-01102-266*	VHA	1–5	—
Financial Controls Related to VA-Affiliated Nonprofit Corporations: Idaho Veterans Research and Education Foundation *Issued 9/24/2020 | Report Number 18-00711-251*	VHA	1–5	$112,400
The Veterans Health Administration's Governance of Robotic Surgical System Investments Needs Improvement *Issued 9/25/2020 | Report Number 19-07103-252*	VHA	1–5	—
Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia *Issued 9/28/2020 | Report Number 19-07828-265*	VHA	1–6	—
Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide *Issued 9/29/2020 | Report Number 19-07062-255*	VBA	1–4	—
Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans *Issued 9/29/2020 | Report Number 19-07854-272*	VHA	1–8	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California *Issued 9/29/2020 | Report Number 20-00005-271*	VHA	1–10	—
VA's Noncompliance with Preaward Review Requirements for Sole-Source Proposals for Healthcare Services *Issued 9/30/2020 | Report Number 18-04150-261*	VHA	1–3	$4,101,555
Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System *Issued 9/30/2020 | Report Number 19-00226-245*	VHA	1–8	205,100,000
Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia *Issued 9/30/2020 | Report Number 19-08106-273*	VHA	1–18	—
Total			**$1,423,005,455**

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

Table B.4 identifies the 49 reports and 136 recommendations that, as of September 30, 2020, remain open for more than one year. The total monetary benefit attached to these reports is $1,173,900,000.

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.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
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 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.		
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.		
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	—
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.		

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.

Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	VHA OHRA/ 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.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
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.		
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).		
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.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
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.		
Accuracy of Effective Dates for Reduced Evaluations *Issued 8/29/2018 | Report Number 17-05244-226*	VBA	—
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.		
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.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The Under Secretary for Health ensures that VA facilities without pain specialists have formalized designated resources of pain care provided by providers.		
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.		
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	VHA OHRA/ OSP	—
Recommendation 1: Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.		
Recommendation 2: Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.		
Recommendation 3: Make certain medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives.		
Recommendation 4: Assess the staffing levels for the Office of Security and Law Enforcement police inspection program, and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.		
Recommendation 5: Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 | Report Number 17-03499-20*	OHRA/ OSP	—
Recommendation 2: The Acting Assistant Secretary for Human Resources and Administration makes certain that an adequate threat assessment is developed and kept current for each principal secured by the Executive Protection Division.		
Recommendation 7: The Acting Assistant Secretary for Human Resources and Administration establishes written procedures for documenting the review and approval of employee overtime within the Executive Protection Division and ensures compliance.		
Recommendation 8: The Acting Assistant Secretary for Human Resources and Administration assesses and takes remedial action, if necessary, to make certain that Executive Protection Division staff use parking and transit benefits in accordance with VA policy.		
Recommendation 9: The Acting Assistant Secretary for Human Resources and Administration confers with the Offices of General Counsel and Accountability and Whistleblower Protection to determine whether any agents inappropriately accepted transit benefits while using VA parking spaces, and if so, determine the appropriate administrative action to take, if any.		
Recommendation 10: The Acting Assistant Secretary for Human Resources and Administration works with the Offices of General Counsel and Accountability and Whistleblower Protection to institute procedures for an ombudsman or similar function that will enable the Executive Protection Division agents to address management disputes without needing to involve the VA Secretary.		
Recommendation 12: The Acting Assistant Secretary for Human Resources and Administration consults with the Offices of General Counsel and Accountability and Whistleblower Protection to provide adequate mechanisms and training for all staff within the Office of Operations, Security, and Preparedness, including the Executive Protection Division, that ensure allegations of perceived misconduct by the VA Secretary can be appropriately addressed without the threat of retaliation.		
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center *Issued 1/28/2019 | Report Number 17-01757-50*	VHA	—
Recommendation 1: The Facility Director ensures that recommended actions from peer reviews and root cause analyses are implemented and monitored for improvement.		
Recommendation 3: The Chief of Staff ensures an interdisciplinary Facility group reviews utilization management data and monitors the group's compliance.		
Recommendation 5: The Chief of Staff ensures that Focused and Ongoing Professional Practice Evaluations are completed, and that the Professional Standards Board reviews these evaluations in considering whether to continue provider privileges, and monitors compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 6: The Associate Director ensures that safety and infection prevention processes are in place at construction sites and monitors compliance.		
Recommendation 8: The Associate Director ensures that a safe and clean environment is maintained throughout the Facility and monitors compliance.		
Recommendation 12: The Facility Director ensures that all deficiencies identified on the Annual Physical Security Survey are addressed or corrected and monitors compliance.		
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package *Issued 5/1/2019 | Report Number 17-05246-98*	VHA	—
Recommendation 3: The Executive in Charge, Office of the Under Secretary for Health, strengthens procedures for VA medical centers to sufficiently conduct and document physical inventory results and retain documentation as required by VHA policy.		
Recommendation 4: The Executive in Charge, Office of the Under Secretary for Health, strengthens controls at VA medical centers to ensure supplies are consistently secured.		
Recommendation 5: The Executive in Charge, Office of the Under Secretary for Health, ensures VA medical centers affix barcode labels for all expendable supplies at the locations where the inventory items are stored.		
Recommendation 6: The Executive in Charge, Office of the Under Secretary for Health, strengthens procedures for the Veteran Integrated Service Network Quality Control Review process, ensuring a thorough review is conducted and action plans are developed and executed to address identified deficiencies at the VAMCs. In addition, update the Quality Control Review document regarding VA medical center security, access requirements, and improper distribution of supplies.		
Deferrals in the Veterans Benefits Management System *Issued 5/15/2019 | Report Number 18-00215-83*	VBA	—
Recommendation 3: The Under Secretary for Benefits update guidance to clarify why certain reason selections should be made for deferrals, provide training on this guidance, and monitor the effectiveness of the training.		
Recommendation 4: The Under Secretary for Benefits establish plans to modify the Veterans Benefits Management System to allow sufficient space for inputting deferral instructions and require claims processors to input references when creating deferrals.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018 *Issued 6/3/2019 | Report Number 18-05864-127*	VHA	—
Recommendation 1: The Under Secretary for Health implement steps to achieve stated reduction targets for the following programs and activities: Communications, Utilities, and Other Rent; Medical Care Contracts and Agreements; and State Home Per Diem.		
Inadequate Oversight of Contracted Disability Exam Cancellations *Issued 6/10/2019 | Report Number 18-04266-115*	VBA	—
Recommendation 1: The Under Secretary for Benefits improve the exam management systems to ensure visibility of the information needed to conduct adequate oversight of contracted disability exam cancellations.		
VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract *Issued 6/13/2019 | Report Number 17-04178-46*	OALC	$ 37,500,000
Recommendation 1: The Technology Acquisition Center associate executive director provide written requirements, in designation memoranda or other written medium, that identify the method and level of detail required for program office contracting officers' representatives to adequately document their review of contractor deliverables and determination of acceptability. Recommendation 2: The Technology Acquisition Center associate executive director develop procedures for Technology Acquisition Center contracting officers to ensure review and acceptability of contractor deliverables is adequately documented in contract files to help prevent improper payments. Recommendation 7: The Technology Acquisition Center associate executive director enhance written procedures by providing Technology Acquisition Center contracting officers with standards that define higher-risk financial stability risk scores and subsequent actions that should be taken when these scores are identified.		
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, Illinois *Issued 6/18/2019 | Report Number 18-04673-138*	VHA	—
Recommendation 10: The chief of staff confirms that providers notify patients of abnormal cervical pathology results within the required timeframe and monitors providers' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility *Issued 6/26/2019 | Report Number 19-00022-153*	VHA	—
Recommendation 1: The Under Secretary for Health ensures that the planning and implementation of the new electronic medical record includes, (a) a fail-safe system that allows communication and tracking of test results to multiple clinical staff members who coordinate patient notification, appropriate follow-up testing and clinical management, and (b) the ability to monitor actions taken by the responsible provider(s).		
Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities *Issued 6/27/2019 | Report Number 18-00037-154*	VHA	—
Recommendation 6: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews and provides input into the patient referral process to mental health clinical pharmacists with consideration for ensuring that accurate diagnoses can be reliably identified by and conveyed to the mental health clinical pharmacists. Recommendation 7: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews the patient referral process to mental health clinical pharmacists and provides input with consideration for clinical settings or scenarios in which a review of the clinical complexity of the referral by a licensed independent practitioner with prescribing authority would be appropriate, prior to treatment. Recommendation 9: The Under Secretary for Health initiates a risk assessment of outpatient mental health clinical pharmacists' practice and establish mitigation plans; and includes the Veterans Health Administration Office of Mental Health and Suicide Prevention Director in the design, implementation, and analysis processes.		
Management of Major Medical Leases Needs Improvement *Issued 7/2/2019 | Report Number 17-05859-131*	OALC	$ 152,300,000
Recommendation 6: The Deputy Under Secretary for Health for Operations and Management and the Executive Director, Office of Construction Facilities Management, ensure VA uses appropriate security measure requirements when acquiring VA major medical leases by performing Interagency Security Committee risk evaluations prior to solicitation.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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	—
Recommendation 1: The Veterans Integrated Service Network Director solicits an ethics consult regarding the patient's final episode of care and treatment course including the failure to inform the patient or family of impending arrest and lack of family inclusion in decision-making. Recommendation 3: The Facility Director evaluates the inpatient mental health unit assessment practices of patients' decision-making capacity and voluntary admission status, and takes actions as appropriate.		
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 7/11/2019 | Report Number 19-00497-161*	VHA	—
Recommendation 17: The Charlie Norwood VA Medical Center Director ensures that critical care unit staffing decisions include contingencies for staff absences. Recommendation 20: The Charlie Norwood VA Medical Center Director ensures that the emergency department security system is upgraded to meet current security requirements and to provide a safe environment for patients and staff. Recommendation 21: The Charlie Norwood VA Medical Center Director continues efforts to recruit and hire for critical laboratory staff vacancies, and ensures that until optimal staffing is attained, alternate methods are consistently available that meet patient care needs. Recommendation 24: The Charlie Norwood VA Medical Center Director ensures the Contracting Officer's Representative responsible for the technical administration of the transportation contract conducts surveillance of the contractor's performance and provides oversight of the contractual agreements. Recommendation 25: The Charlie Norwood VA Medical Center Director ensures contingency plans are in place to rapidly mobilize staff when emergency department patients' care demands exceed the current staffing resources.		
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	—
Recommendation 3: The Northern Indiana Health Care Director ensures monitoring of the quality of pain assessments and the effectiveness of pain management interventions and monitors compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 5: The Northern Indiana Health Care Director establishes a formal transfer process for tertiary, interdisciplinary pain rehabilitation program referrals as required by Veterans Health Administration's stepped care model for pain management.		
Recommendation 8: The Northern Indiana Health Care Director ensures that the system policy is followed for providers to routinely review an opioid risk assessment for patients on long-term opioid therapy and monitors compliance.		
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	—
Recommendation 3: The New Mexico VA Health Care System Director reviews open and completed consult data as well as new patient data and develops action plans to address identified issues.		
Recommendation 4: The New Mexico VA Health Care System Director evaluates the underutilization of non-VA and telemental health services for the outpatient mental health department and develops an action plan to address identified issues.		
Recommendation 5: The New Mexico VA Health Care System Director ensures that patients with outpatient mental health consults and return-to-clinic orders, including telemental health, are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult/return-to-clinic timeframe and that the scheduling process is monitored for compliance.		
Recommendation 9: The New Mexico VA Health Care System Director ensures outpatient mental health staff follow Veterans Health Administration requirements for no-show patients and monitors compliance with this process.		
Recommendation 10: The New Mexico VA Health Care System Director confirms that the Administrative Investigative Board recommendations and action plans are completed as required by VHA and managers monitor compliance.		
Recommendation 12: The New Mexico VA Health Care System Director evaluates the practice of marking outpatient mental health consults as complete without an appointment and without documenting a mental health risk evaluation and takes action as necessary.		
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming *Issued 7/24/2019 | Report Number 18-04680-162*	VHA	—
Recommendation 12: The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related services and initiatives with leadership and monitors the coordinator's compliance.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 15: The chief of staff confirms that clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians' compliance.		
Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland *Issued 7/29/2019 | Report Number 18-05731-176*	VHA	—
Recommendation 3: The VA Maryland Health Care System director ensures staff complete root cause analyses or aggregated reviews for adverse events as required by Veterans Health Administration policy and monitors to ensure completion.		
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	—
Recommendation 1: The Veterans Crisis Line director ensures analysis of rescue efforts ending because the caller's location cannot be found, identifies and analyzes metrics that may have contributed to the inability to locate these rescues, and takes remedial action.		
Non VA Emergency Care Claims Inappropriately Denied and Rejected *Issued 8/6/2019 | Report Number 18-00469-150*	VHA	533,000,000
Recommendation 1: The Under Secretary for Health reevaluates all claims denied after April 8, 2016, for the reason of "other health insurance" for appropriate corrective action. Recommendation 10: The Under Secretary for Health develops and implements clearly defined controls to ensure Claims Adjudication and Reimbursement processing facilities routinely communicate backlogs of incoming mail to Office of Community Care leaders with associated action plans to accurately record the date the documents were received.		
Health Information Management Medical Documentation Backlog *Issued 8/21/2019 | Report Number 18-01214-157*	VHA	—
Recommendation 1: Establish a policy that formally defines "medical document backlog"—specifically, the age of unscanned and unindexed medical documentation.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: Implement formal controls to monitor medical document backlogs—specifically, the description of unscanned and unindexed documents, size of the backlog, and age of health records—as well as subsequent actions to reduce the backlogs.		
Recommendation 4: Implement policy to require chiefs of Health Information Management to notify facility directors when a medical document backlog exists and to take appropriate action.		
Recommendation 5: Assess the scanning process, including staffing and productivity levels, within each facility to ensure authorized staffing levels can support future workload.		
Recommendation 6: Ensure facility directors act on staffing level assessments and obtain the necessary resources within scanning departments.		
Recommendation 7: Implement standardized quality assurance monitoring procedures to improve accurate updating of patients' electronic health records and completion of corrective actions when errors are identified.		
Recommendation 8: Ensure original documents are retained until the scanning supervisor or designee verifies that scanning staff have met quality assurance monitoring standards established in Recommendation 7.		
Recommendation 9: Develop procedures to ensure facility directors provide adequate document scanning/indexing training, consistent with Veterans Health Administration Handbook 1907.07, prior to allowing employees to scan/index documents without direct supervision and as needed for corrective actions.		
Comprehensive Healthcare Inspection of the Central California VA Health Care System Fresno, California *Issued 8/22/2019 | Report Number 19-00006-191*	VHA	—
Recommendation 1: The facility director makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.		
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	—
Recommendation 1: The West Palm Beach VA Medical Center Director ensures that mental health multidisciplinary treatment plans are completed in accordance with Veterans Health Administration and The Joint Commission guidelines.		
Recommendation 7: The Under Secretary for Health takes action to ensure that the Mental Health Environment of Care Checklist Work Group reviews and ranks hazards as submitted through the Patient Safety Assessment Tool, and ensures abatement (or waiver of abatement), as indicated.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
National Review of Hospice and Palliative Care at the Veterans Health Administration *Issued 9/5/2019 | Report Number 17-05251-194*	VHA	—
Recommendation 1: The Under Secretary for Health ensures the development and implementation of a consistent and standardized approach for hospice and palliative care documentation, consult management, and coding.		
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/5/2019 | Report Number 18-05663-189*	VBA	$64,800,000
Recommendation 1: Implement a plan to conduct a focused analysis of claims processor compliance with the requirements set forth by recent court decisions regarding examiner opinions and formulate a plan to review and take corrective action on affected claims if deemed necessary based on the results of that review.		
Recommendation 2: Develop a plan to update the rating schedule to establish more objective criteria for each level of evaluation for peripheral nerves.		
Recommendation 3: Review all sections of the procedures manual related to peripheral nerve disability evaluations and develop a plan to make updates and clarifications where applicable.		
Recommendation 4: Review the disability benefits questionnaire forms for conditions of the spine and determine whether updates are needed to help ensure more accurate and consistent claims decisions.		
Recommendation 5: Update the Evaluation Builder tool to help users provide more accurate, comprehensive, and consistent information for claims decisions involving the spine and peripheral nerves.		
State Prescription Drug Monitoring Programs Need Increased Use and Oversight *Issued 9/23/2019 | Report Number 18-02830-164*	OIT VHA	—
Recommendation 1: Develop national processes to oversee medical facility compliance with VHA Directive 1306, Querying State Prescription Drug Monitoring Programs, and coordinate the possible automated information technology solutions and inter-office and -disciplinary communications necessary to improve prescription drug monitoring program monitoring and usage in Veterans Health Administration.		
Recommendation 2: Update the Pain Management and Opioid Safety training course to specifically address VHA Directive 1306, Querying State Prescription Drug Monitoring Programs, query requirements and recommendations.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: Ensure VA clinicians who prescribe opioids take the Pain Management and Opioid Safety training once, with annual refresher training.		
Recommendation 6: Develop automated information technology solutions to facilitate clinicians' access to prescription drug monitoring program query information and reinforce the need to complete minimum annual VA-required prescription drug monitoring program queries.		
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	—
Recommendation 2: The New Mexico VA Health Care System Director verifies that the Ophthalmology and Optometry Departments' consult management and scheduling practices are consistent with Veterans Health Administration patient indicated date timeframe requirements, incorporates patient preference, and includes receiving provider review of consults, and monitors compliance.		
Recommendation 5: The New Mexico VA Health Care System Director conducts a timeliness review of the authorization process for non-VA Care routine eye appointments, including diabetic eye examinations, and implement action plans if the process fails to adhere to Veterans Health Administration directives.		
Recommendation 7: The New Mexico VA Health Care System Director establishes a routine review of Gastroenterology Department consult performance measures and a method to monitor identified deficiencies consistent with Veterans Health Administration requirements.		
Recommendation 10: The New Mexico VA Health Care System Director ensures that Gastroenterology Department-ordered test results are communicated timely in accordance with Veterans Health Administration and facility policy and the timeliness is monitored through the ongoing peer review process as required by facility policy.		
Recommendation 11: The New Mexico VA Health Care System Director ensures that the Gastroenterology Department Service Chief develop a process for delegating responsibility and accountability for test results and follow-up when multiple providers are involved, and monitors compliance.		
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 9/24/2019 | Report Number 18-06510-222*	VHA	—
Recommendation 1: The chief of staff makes certain that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors compliance.		
Recommendation 7: The facility director confirms that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 10: The facility director confirms that the Women Veterans Health Committee includes required core members and monitors the committee's compliance.		
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	—
Recommendation 1: The Veteran Integrated Service Network 10 Medical Facility Director ensures the Credentialing and Privileging process for primary source verification of foreign education is performed and documented in accordance with Veterans Health Administration requirements. Recommendation 2: The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Credentialing and Privileging process for verifying and accepting professional references meets sufficiency standards in accordance with Veterans Health Administration guidance. Recommendation 3: The Veteran Integrated Service Network 10 Medical Facility Director ensures that the Focused Professional Practice Evaluation process used to determine technical competence and skills meets Veterans Health Administration requirements.		
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	—
Recommendation 6: The VA Caribbean Healthcare System Director ensures that the findings identified by Veterans Integrated Service Network reviewers as noted in this report are addressed and resolved.		
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming *Issued 9/26/2019 | Report Number 18-04681-228*	VHA	—
Recommendation 6: The facility director works with the VISN director and contracting officer to make certain that the Rock Springs VA Clinic property owners correct deficiencies and monitors compliance. Recommendation 7: The associate director ensures the VA police document response time to panic alarm testing at the locked inpatient mental health unit and monitors compliance. Recommendation 8: The associate director ensures flooring that provides cushioning is installed in the mental health seclusion rooms. Recommendation 15: The chief of staff ensures clinicians provide and document patient/caregiver education for newly prescribed medications and monitors the clinicians' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 16: The facility director ensures the Women Veterans Health Committee includes required core members and monitors the committee's compliance.		
Recommendation 18: The facility director ensures that the urgent care center is staffed with a licensed physician and a minimum of two registered nurses at all times of operation and monitors compliance.		
Recommendation 21: The facility director ensures appropriate signage directs patients to the urgent care center and monitors compliance.		
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia *Issued 9/27/2019 | Report Number 18-04679-239*	VHA	—
Recommendation 17: The chief of staff makes certain that clinicians provide and document patient and/or caregiver education and assess understanding of education provided specific to newly prescribed medications and monitors compliance.		
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida *Issued 9/27/2019 | Report Number 19-00010-237*	VHA	—
Recommendation 4: The chief of staff ensures that clinical managers clearly define focused professional practice evaluation criteria in advance with providers and monitors clinical managers' compliance.		
Recommendation 5: The chief of staff confirms that clinical managers include service/section-specific criteria in ongoing professional practice evaluations and monitors compliance.		
Recommendation 6: The chief of staff makes certain that service chiefs' determination to recommend continuation of privileges be based in part on results of ongoing professional practice activities and monitors service chiefs' compliance.		
Recommendation 21: The facility director makes certain that the Women Veterans Health Committee includes required core members and monitors committee's compliance.		
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Alabama *Issued 9/27/2019 | Report Number 19-00057-238*	VHA	—
Recommendation 13: The chief of staff confirms that the Women Veterans Health Committee includes required core members and monitors committee's compliance.		
Total		**$1,173,900,000**

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—	--

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(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 Results from the Office of Special Reviews
(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 Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations Results from the Office of Special Reviews
(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 IG, unreasonably refused or not provided;	Other Reporting Requirements

REQUIREMENT	SAR SECTION(S)
(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 Special Reviews
(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

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(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
(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

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(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
(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

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including the name of the senior government official (as defined by the department or agency) if already made public by the Office, and 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 Results from the Office of Special Reviews
(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.

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