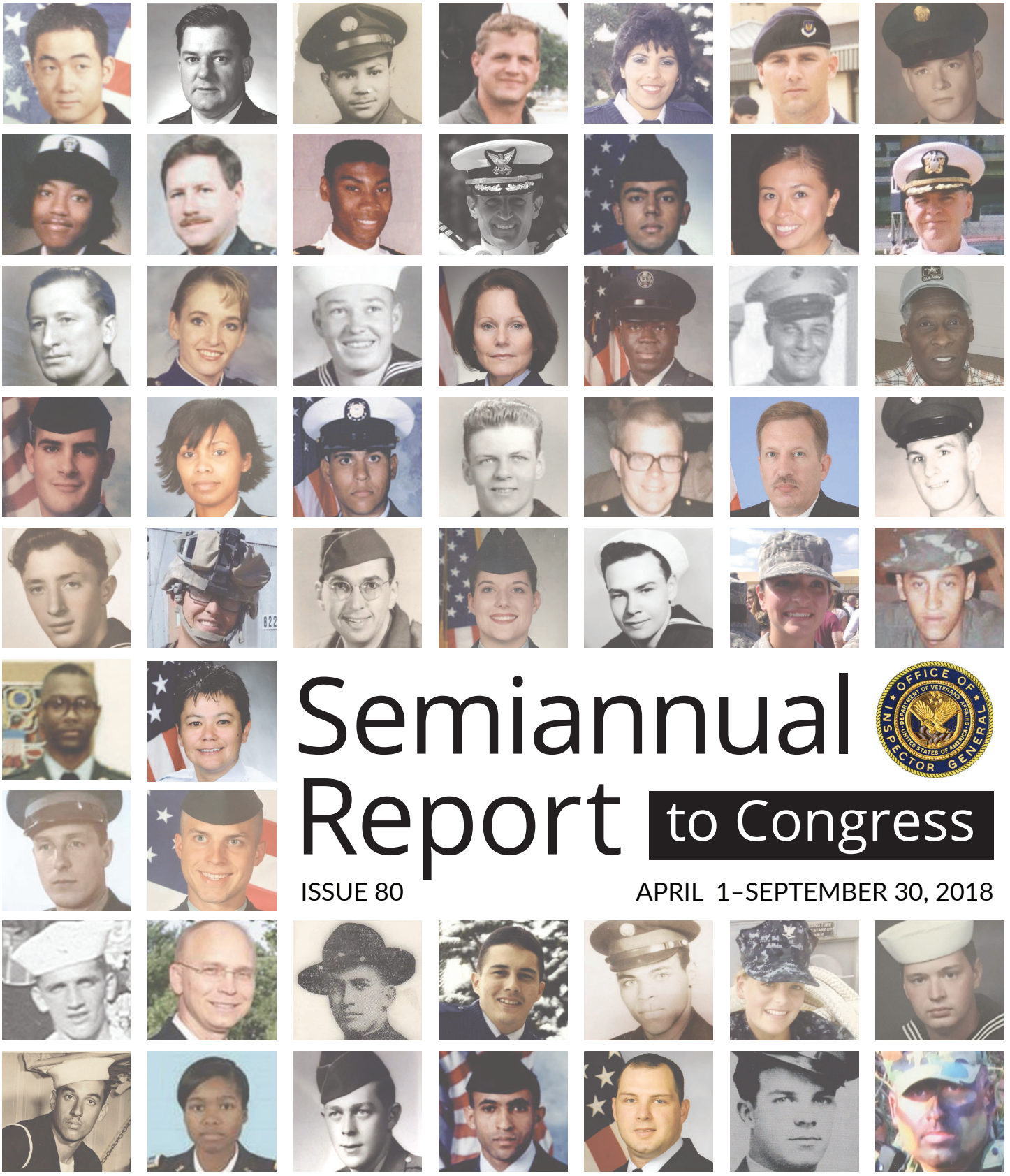
U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL



Semiannual Report to Congress

ISSUE 80

APRIL 1–SEPTEMBER 30, 2018

SERVING VETERANS AND THEIR FAMILIES FOR **40** YEARS

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

MISSION

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

VISION

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

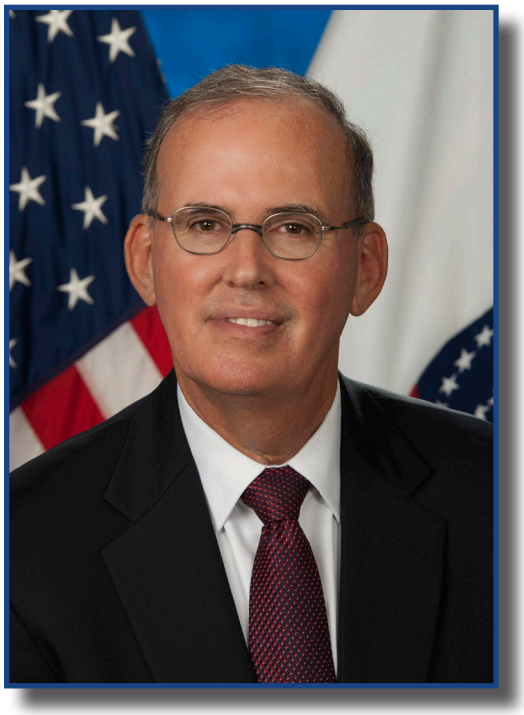
To achieve this vision, the Office of Inspector General (OIG) will

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

VALUES

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

Message from the Inspector General



I am pleased and honored to submit this Semiannual Report to Congress on the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for April 1 through September 30, 2018. This year we celebrate the 40th anniversary of the creation of the VA OIG, which was administratively established nine months before passage of the *Inspector General Act of 1978*, Public Law (P.L.) 95-452. The faces filling the covers of this report are those of veterans on the VA OIG staff—making up a third of all our personnel—and the family members of OIG employees that span the years our office has been serving veterans. The staff of the VA OIG are deeply committed to supporting our nation's veterans through oversight of VA and promoting high-quality services, programs, and benefits for military service men and women and their families. They are dedicated to ensuring that taxpayer dollars are being used efficiently and effectively, including detecting and addressing fraud, waste, and other wrongdoing.

Much of their oversight work is detailed in the more than 158 reports we issued for the second half of the 2018 fiscal year. These are complemented by a growing number of podcasts, monthly highlights, and other communications that enhance our transparency. We have worked diligently to make meaningful recommendations for VA that address the root causes for the problems we have identified. This reporting period has also resulted in a number of important new initiatives and significant accomplishments. These new initiatives include standing up an Office of Special Reviews to take on time-sensitive matters that do not fall squarely within one of our existing directorates and expanding Investigative Developmental Division teams that will focus on particularly high-risk areas for fraud.

In this six-month period, our office identified more than $1.15 billion in monetary impact for a return on investment of $17 for every dollar spent on oversight. The OIG Hotline received more than 18,772 contacts that have helped to identify wrongdoing, waste, abuse, and inefficiencies or deficiencies in VA programs and activities. OIG investigators opened 329 investigations and closed 251. Collectively, the OIG's work resulted in 1,060 administrative sanctions and corrective actions.

As we look ahead, we recognize that VA is charged with taking on new enterprises that are extremely complex and have the potential to affect millions of veterans' health and welfare, including implementation of the *VA Mission Act of 2018*, P.L. 115-182, reforms in community-based care, and the development of an integrated electronic health record system costing billions of dollars. With the support we have received from Congress, VA staff, veterans service organizations, and other stakeholders, the OIG is positioned to provide the oversight required for these and other high-risk ventures.

In recent months, our office has also released a new strategic plan that will guide how we conduct our activities in keeping with our mission, vision, and values. The plan focuses not only on the oversight of programmatic areas, such as VA health care and benefits, but also examines key factors that cut across VA administrations and program offices driving success or perpetuating deficiencies. These include VA's stewardship of taxpayer dollars, leadership and governance, and the future of VA and its capacity

for innovation. We look forward to working with Congress and our stakeholders in implementing this strategic plan to effect meaningful change.

MICHAEL J. MISSAL

Inspector General

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VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

The Department of Veterans Affairs (VA) has three administrations: the Veterans Health Administration (VHA) provides healthcare services; the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits; and the National Cemetery Administration (NCA) provides interment and memorial benefits.

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to their country.

VA is the second largest federal employer. For fiscal year (FY) 2018, VA operated under a $188.7 billion budget, with over 388,344 employees serving an estimated 20 million veterans. VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit the VA home page at www.va.gov.

VA Office of Inspector General

The Office of Inspector General's (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, reviews, and investigations. The VA OIG role as an independent agency was formalized and clarified by the *Inspector General Act of 1978* (Public Law (P.L.) 95-452, as amended). This act states that the Inspector General (IG) is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements. In addition, the *Veterans Benefits and Services Act of 1988*, 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.

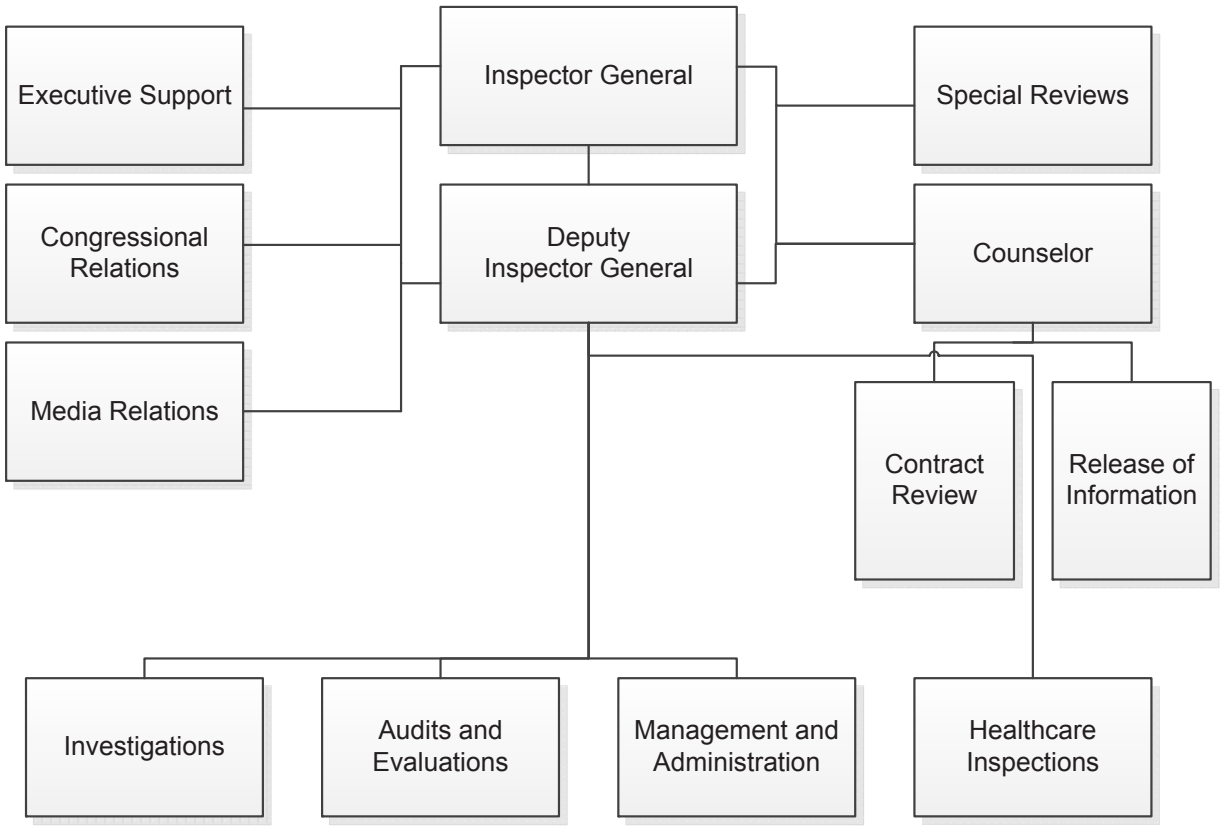
The OIG has nearly 900 staff positions organized into four primary directorates: the Offices of Investigations, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG Hotline). In addition, the OIG has integrated into its framework the Office of Contract Review (OCR), which is overseen by the Office of Counselor to the Inspector General, and a new Office of Special Reviews for significant projects not covered by other directorates. The OIG also has offices for congressional and media relations. The FY 2018 funding for OIG operations provided $164 million from ongoing appropriations. In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. For more information, visit www.va.gov/oig.

OIG Field Offices Map

Legend

- VA OIG Headquarters
- Hub Office with Three or More Directorates
- Office of Audits and Evaluations and Office of Healthcare Inspections
- Office of Management & Administration and Office of Healthcare Inspections
- Office of Audits and Evaluations and Data Processing Center
- Office of Investigations Only

OIG Organizational Chart



INSPECTOR GENERAL
Department of Veterans Affairs

Last Updated: October 18, 2018

Highlights of VA OIG Activities

Pursuant to the *Inspector General Act of 1978*, this Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the reporting period April 1–September 30, 2018. Highlighted below are some of the activities conducted during this period by the OIG's offices and their impact, followed by statistical tables that summarize key performance measures. The report then features examples of each office's high-impact publications and activities. This information is supplemented by appendixes that detail such information as titles of OIG publications released; the monetary impact of OIG products including savings, cost avoidance, and dollar recoveries; the status of VA's implementation of recommendations; and reporting requirements.

Office of Healthcare Inspections

The Office of Healthcare Inspections (OHI) has oversight responsibility for the Veterans Health Administration's healthcare system, which is the largest integrated healthcare system in the nation. OHI's activities have ranged from reporting on the falsification of blood pressure measurements by a VA physician and nurse to the issues surrounding the death of a veteran after complex heart surgery. During this SAR period, OHI has maintained a special focus on behavioral health concerns, which included care provided in domiciliary settings. For example, a September report addressed a veteran's suicide in a domiciliary, where lack of adherence to the physical security policy and the requirements for clinical treatment over weekends contributed to the likelihood of harm to veterans. As the result of other work, VA agreed on the need to adjust drug testing panels to check for substances that are commonly abused in the local population, such as fentanyl, even if the drugs are not on the standard test. OHI also worked with VA to strengthen policies that govern the relationships among medical professionals engaged in mental healthcare treatment teams. These actions clarify the relationships and reporting responsibilities of clinical staff with different training and licensing to help ensure patients' treatment plans are created and executed by appropriate team members.

As described in the reports section, OHI issued a highly visible review of the Washington, DC, VA Medical Center (following up on an interim report) that found deficiencies in hospital business processes such as supply chain management, that put patients at unnecessary risk for harm, and made it more difficult for healthcare providers to deliver quality care. OIG's work led to changes not only to that facility but to policies that affect VA facilities nationwide. OIG findings and recommendations for improvement were discussed at a subsequent House Committee on Veterans' Affairs hearing, specifically related to concerns about sterile processing and related activities. This emphasis on medical facilities' business operations is also reflected in the OIG's Comprehensive Healthcare Inspection Program (CHIP), which includes a focus on senior managers' ability to ensure the hospital's business processes support the delivery of quality medical care. OHI also released the results of the VA staffing shortages survey mentioned in the previous SAR. For the first time, the report reveals the self-reported gaps in both clinical and nonclinical occupations at individual medical centers, which allows users to examine the particular needs of an individual facility as opposed to only national data. Among other development work, OHI has also begun monitoring VA's plan to convert to a new electronic health record, which has many elements of risk.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) has continued its efforts to improve the timeliness and quality of audits, inspections, and reviews of VA programs and services. To accomplish this goal, the office devoted significant time and resources to strategic planning and staff development to align its annual audit operations plans with the OIG's new strategic plan. OAE is organized into three cohorts. Two of the cohorts provide oversight of benefits processing and healthcare delivery. The third cohort combines several functional areas: acquisitions, contracting, financial management, and information technology. In this SAR reporting period, each cohort worked on developing risk-based projects and strategies for accomplishing their mission. This work positions OAE staff to effectively focus on high-risk issues that will have a significant and positive impact on veterans and their families. The impact of OAE's work is evidenced by the cross-cutting procurement, financial, healthcare, and benefits issues identified throughout VA during this period. OAE developed findings and made recommendations in each of the major VA functional areas.

Among the many recommendations made by OAE staff, several were accepted that, when implemented, will help veterans avoid unnecessary exams for receiving their disability benefits, will better address the needs of veterans who experienced sexual trauma, and create a more equitable process for assessing traumatic brain injury and related benefits. OAE has also worked to ensure that staff conducting audits and inspections are highly trained and leverage expertise across the agency to ensure OIG recommendations are on point and practical. There has been an emphasis on specialization and on-the-job training. Staff with particular acumen are assigned without regard to geographical location or division, which allows subject matter expertise and institutional knowledge to be fully accessed for each project. Because of OAE's efforts to increase specialization and collaboration, staff are reporting greater engagement and productivity. The work of OAE received special recognition by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) for its work on veterans' wait times for appointments, consults, and access to care in the community as well as for its efforts on managing primary care providers' patient load. During this period, OAE identified an estimated $562 million in potential monetary benefits.

Office of Investigations

The Office of Investigations (OI) investigates crimes committed against VA programs and operations by employees and nonemployees, as well as allegations of serious violations of policies and procedures by high-ranking members of the Department. OI's criminal investigations continue to focus on such issues as benefits and procurement fraud (including Service-Disabled Veteran-Owned Small Business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems.

OI has expanded its Investigative Development Division, which is responsible for the identification and investigation of complex fraud cases related to construction, acquisition/procurement, community care, and grants and education. To enhance the OIG's oversight capabilities, OI created regional proactive working groups that were tasked with identifying specific high-risk program areas that are susceptible to high-impact fraud. The office is also expanding the forensic auditor program by adding new positions in Washington, DC; San Diego, CA; and Dallas, TX. Further, OI has moved forward with plans to open three new offices in Salt Lake City, UT; Trenton, NJ; and Miami, FL. In addition, OI is working with

other directorates within the OIG on fraud awareness and training on reporting wrongdoing that can potentially be used by all VA employees.

OI led the investigation of the VA Secretary and his delegation's travel to Europe and collaborated with other directorates to produce a final report. This work received one of CIGIE's most distinguished awards—the Gaston L. Gianni, Jr. Better Government Award. OI investigators were also recognized for their work on Service-Disabled Veteran-Owned Small Business Fraud. Other high-profile cases addressed VA medical professionals and other personnel accepting inducements to push products by a particular medical supply company—leading to arrests and potential recovery of millions of dollars—and cases in which veteran education or training programs were created to defraud VA without providing the services claimed to veterans.

Office of Management and Administration

The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency and to support the OIG's overall mission and goals. In the last six months, the office undertook work to enhance the OIG's ability to conduct impactful work by initiating a one-year predictive analytics pilot program. This pilot, which is in collaboration with the Department of Commerce, National Technical Information Service, and joint venture partners, will assist the OIG to leverage big data to inform oversight plans and determine the staffing and other resources needed to support a permanent predictive analytics program. OMA also enhanced the OIG's oversight capacity by spearheading efforts to recruit top talent and support the workforce. For example, in early December 2017, the office launched a company page for the OIG on LinkedIn, a large and well-known professional networking site with over 400 million users worldwide. The OIG already has nearly 2,000 followers and is actively using LinkedIn to advertise key vacancies. Further, OMA took steps to support the professional development of the OIG's workforce by expanding the mentorship program that pairs trained mentors with more junior staff and by addressing training and developmental needs identified through an organizational needs analysis. These types of efforts, in conjunction with OIG leaders' commitment to supporting the workforce, contributed to the OIG's placement within the top quartile for FY 2017 for Best Places to Work in the Federal Government for agency subcomponents by the Partnership for Public Service.

In addition, OMA enhanced customer services for external and internal stakeholders in multiple ways. With respect to external stakeholders, OMA improved communications with individuals who contact OIG's Hotline. In particular, in October 2017, OMA began sending customized responses to complainants who contact OIG's Hotline with concerns that are outside the agency's jurisdiction. Those responses provide helpful suggestions for other avenues of redress. In the first year of this initiative, OMA sent nearly 4,900 customized responses to complainants. Regarding internal services, the office strengthened its shared governance structure for several essential administrative functions, including budget formulation and execution. Through a series of recurring meetings and dashboards, OMA has helped to ensure that the budget request accurately reflects the resources the OIG needs to meet its oversight mission and that plans with budgetary implications are continually reviewed and effectively implemented.

Office of Counselor to the Inspector General

The Office of the Counselor continues to provide legal support to all components of the OIG. In this reporting period, that work included advising the IG in his efforts to secure access to the Department's Office of Accountability and Whistleblower Protection complaint database, assisting the Audits and Evaluations staff in completing a congressionally mandated review of leases at the Department's West Los Angeles campus, and teaming with Healthcare Inspections staff on an inspection of pathology oversight at a VA Medical Center (VAMC). Attorneys in the Counselor's Office also continued to represent the OIG in employment-related litigation and worked with OMA and other directorates to revise and update internal policies and directives. The Counselor's Office added a new attorney during this reporting period to provide expert advice on investigations and government contracting matters. Attorneys also continued to work closely with the OI on a number of *qui tam* matters and helped the OIG recognize significant recoveries as noted in this report, including over $3 million independently recovered by the Counselor's office. Finally, the Office of Information Release (OIR) continued to make substantial contributions to the OIG's work this reporting period. OIR represented the OIG in establishing data use agreements with several other OIGs to aid in ongoing criminal investigations. The Office also reviewed nearly 500 requests for agency records from the public and other government agencies, in addition to reviewing all OIG reports before publication for compliance with the *Privacy Act of 1974*, P.L. 93-579, and other disclosure laws.

Office of Contract Review

The Office of Contract Review (OCR) conducts preaward and postaward reviews of significant VA proposals and contracts, and other projects concerning contracting matters as appropriate. The majority of OCR's reviews relate to contracts awarded by VA under the Federal Supply Schedule (FSS) program, construction contracts, and sole-source contracts with affiliated medical schools for physician services. These reviews assist VA in achieving the best prices during negotiations, resulting in cost savings to the government and ensuring contractors comply with all contract terms and conditions. The office also ensures pharmaceutical manufacturers' compliance with the pricing provisions contained in the *Veterans Health Care Act of 1992*, P.L. 102-585, and provides support to the Department of Justice in litigation and investigations involving VA contracts, such as *qui tam* lawsuits.

As previously reported earlier in FY 2018, OCR established a new Special Projects Team (SPT) to undertake systemic analyses of VA contracting matters and in-depth reviews of significant issues identified through the OIG's Hotline and other sources. The SPT began work on its first projects during this reporting period. Unlike preaward and postaward reviews that are provided only to VA due to the proprietary and confidential data involved, the work of the SPT will be published. During this reporting period, OCR made recommendations for lower pricing with potential cost savings of over $261.3 million and identified more than $7.5 million in contract overcharges.

Office of Special Reviews

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

Office of Congressional Relations

The OIG actively engages Congress on critical issues facing veterans. During this reporting period, the OIG testified before Congress at four hearings: (1) the House Committee on Veteran's Affairs' (HVAC) Subcommittee on Oversight and Investigations on the OIG report, *Review of Alleged Real Time Location System Project Mismanagement*; (2) the HVAC's consideration of the responsibilities and functions of the Veterans Integrated Service Network (VISN) and other governance issues, drawing from the OIG findings in *Critical Deficiencies at the Washington, DC VAMC*; (3) the HVAC Subcommittee on Health relating to VA's hiring authority and challenges regarding staff recruitment and retention, including OIG findings captured in its June 2018 report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*; and (4) the HVAC Subcommittee on Oversight and Investigations on reusable medical equipment sterilization issues. OIG staff also participated in the HVAC Subcommittee on Health Roundtable discussion on prosthetics.

The IG and OIG personnel had 64 briefings with Members and their staff during the reporting period. These included prerelease briefings regarding the OIG reports on Pain Management Services in VA health facilities, the Family Caregiver Program, and reports on VBA processing of claims for benefits. Briefings were also conducted on OIG CHIP reviews of individual VA medical centers. Congressional relations staff fielded more than 140 requests related to constituent casework for OIG review or referral as well.

Statistical Highlights

Table 1. Monetary Impact and Return on Investment

Type of Monetary Impact	Reporting Period (in Millions)	Fiscal Year (in Millions)
Better Use of Funds	$164.2	$1,030.0
Fines, Penalties, Restitution, and Civil Judgments	$100.4	$115.8
Fugitive Felon Program	$94.3	$238.5
Savings and Cost Avoidance	$342.7	$900.6
Questioned Costs	$397.4	$488.6
Dollar Recoveries	$53.7	$66.6
Total Dollar Impact	$1,152.7	$2,840.1
Cost of OIG Operations[1]	$67.2	135.4
Return on Investment[2]	**17:1**	**21:1**

[1] The six-month operating cost for OHI ($14.8 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

[2] The return on investment is calculated by dividing Total Dollar Impact by Cost of OIG Operations.

Table 2. Reports and Work Products

Types of Reports Issued	Reporting Period	Fiscal Year
Audits and Evaluations	20	50
National Healthcare Reviews	3	5
Hotline Healthcare Inspections	24	41
Comprehensive Healthcare Inspection Program Reviews	27	58
Administrative Investigations	3	7
Preaward Contract Reviews	63	107
Postaward Contract Reviews	14	35
Claim Reviews	4	6
Subtotal	**158**	**309**
Other Work Products Issued		
Administrative Investigation Advisories	0	3
Administrative Investigation Closures	0	0
Administrative Summaries of Investigation	0	1
Audit Work Products	0	0
Healthcare Closures	0	0
Subtotal	**0**	**4**
Total Reports and Work Products	**158**	**313**

Table 3. Investigative Activities

Type of Activities[1]	Reporting Period	Fiscal Year
Arrests[2]	211	361
Fugitive Felon Arrests	3	10
Fugitive Felon Arrests Made by Other Agencies with OIG Assistance	5	10
Indictments[3]	141	247
Indictments and Informations Resulting from Prior Referrals to Authorities	73	134
Criminal Complaints	84	129
Convictions	116	231
Pretrial Diversions and Deferred Prosecutions	12	23
Case Referrals to Department of Justice for Criminal Prosecution[4]	249	473
Cases Accepted	87	145
Cases Declined	65	157
Cases Pending	97	171
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	45	91
Cases Accepted	25	58
Cases Declined	10	15
Cases Pending	10	18
Administrative Investigations Opened	11	21
Administrative Investigations Closed	4	11
Administrative Sanctions and Corrective Actions	323	465
Cases Opened[6]	329	662
Cases Closed[7]	251	589

[1] All investigative data reported and analyzed were collected via OIG's case management system. Please note that the OIG does not publish or issue investigative reports related to criminal investigations.

[2] Total arrests do not include fugitive felon arrests by OIG or other agencies.

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

[4] The IG Act requires OIGs 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 OIGs 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] Cases opened include administrative investigations.

[7] Cases closed include administrative investigations. This total also includes cases opened in previous fiscal years.

Table 4. Hotline Activities

Type of Activities	Reporting Period	Fiscal Year
Contacts	18,772	35,092
Cases Opened (Internal and External)	1,093	2,461
Cases Closed (External Only)*	1,323	2,618
Administrative Sanctions and Corrective Actions*	737	1,448
Substantiation Percentage Rate*	40	40
Individuals Claiming Retaliation/Seeking Whistleblower Protection	62	114
Individuals Provided Office of Special Counsel Contact Information	90	149
Individuals Provided Merit Systems Protection Board Contact Information	41	70
Individuals Provided Office of Resolution Management Contact Information	137	280

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

Table 5. Other Office of Healthcare Inspections Activities

Type of Activities	Reporting Period	Fiscal Year
Clinical Consultations	9	15

Overview

During this reporting period, OHI published three national healthcare reviews and 24 inspection reports responsive to OIG Hotline complaints on topics that are related to Veterans Health Administration (VHA) operations and the access to and quality of care provided patients. They addressed a broad range of issues on such topics as veteran suicide, pain management, patient deaths, and medical facility cleanliness and operations. The office also published 27 CHIP reports, which resulted from unannounced OIG inspections of VA facilities' key clinical and administrative processes that are associated with promoting positive healthcare outcomes for veterans. Listings of all OHI report recommendations for corrective action made during the reporting period are detailed on the OIG's dashboard at www.va.gov/oig. The dashboard allows users to track the status of report recommendations published since October 2012.

Examples of High-Impact Reports

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

Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

Suicide is an all too frequent event within the veteran population. Although VA is committed to providing the best care possible for patients who struggle with mental health-related issues, there remain opportunities to improve the care VA provides to veterans. This report examines the care and management of a patient who committed suicide less than 48 hours after discharge. The report describes the significant events in this veteran's last days and highlights the need for VA staff to communicate with non-VA community mental healthcare providers and local government officials to ensure court-directed clinical care and restrictions are adhered to—whether the patient is in a VA medical facility or has recently moved from the VA facility to the community. A second patient was identified and reviewed as well. This report also addresses the relationship between clinical providers who have different levels of mental healthcare expertise and state licenses. The report includes OIG concerns that clinical pharmacists should provide care that is consistent with their state license authority and is properly coordinated within the VA mental healthcare team. OIG discussions with VA during and after the report's publication indicate that VA will take steps to clarify aspects of the mental healthcare team's operations, improve medical record documentation of intra-team consultation, and formalize aspects of the working relationships and roles among clinical pharmacists and other team members. The OIG made 11 recommendations related to institutional disclosures for both patients, an ethics review of the first patient's participation in a research study, an expanded evaluation of the first patient's death, court settlement agreements, revision of the mental health unit policy, prescribing practices, the use of collaborative agreements and assignment of prescribers for patients with complex mental health needs, and strengthening psychiatric clinical pharmacists' supervision processes.

Determination of Veterans Health Administration's Occupational Staffing Shortages FY 18

The report is the fifth annual report on VHA staffing shortages. For the first time, it reveals the self-reported gaps in both clinical and nonclinical occupations for 140 VA medical centers nationwide. Previous reports were obtained through VHA headquarters and conveyed data in the aggregate. In contrast, this report's data came directly from each medical facility director to the OIG for both clinical

and administrative positions. The results highlighted the gaps between the staffing levels that facility directors reported they require for particular occupations and their current staffing. This report allows users to examine the particular needs of an individual facility that were obscured by national data reporting. Although there was wide variability reported by medical centers, directors most commonly cited the need for medical officers and nurses. Within nonclinical occupations, the human resources management and general engineering staff were most often cited as shortages. The report also identified challenges to meeting staffing goals.

The report called for VHA to formalize a position categorization of individuals for use in models that will identify and prioritize staffing needs at the national level while supporting flexibility at the facility level. The report has prompted meaningful discussions at both the local and national levels about how to implement, support, and oversee staffing in VA medical facilities. In an important step, VHA has agreed to develop the recommended staffing models that will provide leaders with the data needed to inform recruiting and hiring decisions within medical centers that are responsive to local needs.

FY 2018 OIG Determination of Veterans Health Administration's Occupational Staffing Shortages

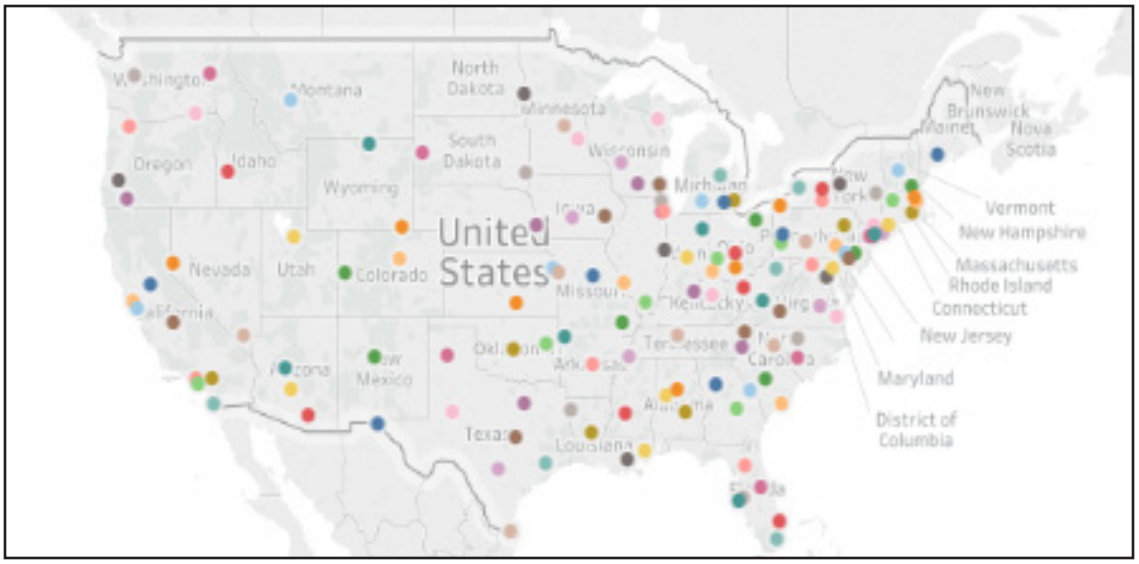


Figure 1. Tableau map displaying staffing shortages by facility. Interactive map can be accessed at: https://public.tableau.com/profile/va.oig#!/

Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York

VA domiciliary facilities provide a bridge between inpatient treatment for mental health issues and community-based day treatment clinics. There is a less restrictive environment for VA patients in a domiciliary as they move from VA inpatient care to the community in addressing their specific mental health needs. This report identified areas for improvement within the Bath residential treatment program as well as for VHA nationally. The report indicates that a veteran's treatment and movement through the domiciliary treatment plan was interrupted by opiate overdose. That case prompted a review of the Bath residential treatment program's fentanyl positive drug tests for FY 2017. The OIG found that the average turnaround time for results was 8.3 days and concluded that waiting this long for results compromised staff's ability to address substance use concerns in a timely and effective manner. OIG staff also found that the Bath VA's tracking of positive drug tests was inaccurate. Staff had recorded several test results incorrectly and did not include all confirmed positive test results. The team also identified

concerns with the use of color-coded stickers to identify patients at risk for opioid use or at high risk for suicide. The OIG made eight recommendations related to drug screening guidelines, regional drug abuse identification, timely laboratory turnaround times and result notifications, positive test tracking and monitoring, results interpretation training, color-coded sticker practices, and personal protective equipment and training for contraband searches.

Communities are often aware of the fluctuation in the rates of drugs being abused over time within their local area. This report underscores the need for VA facilities to remain aware of the prevalent drugs being abused in their community and then to apply the appropriate drug screens to treat and care for veterans who have substance use disorders.

National Reviews

Review of Pain Management Services in Veterans Health Administration Facilities

A number of members of Congress asked the OIG to assess pain management practices, including opioid prescribing and the treatment of substance abuse at VHA medical facilities. Of the more than 5.7 million VA patients (non-hospice/palliative care) with at least one clinical encounter in FY 2015, the OIG found that 16.7 percent were dispensed opioids. Of these, 93.9 percent had diagnoses of pain or mental health issues and 56.7 percent had both. Higher-risk groups included veterans on opioid doses greater than 200 morphine equivalents per day or both opioids and benzodiazepines. The OIG made 10 recommendations to the VHA Executive in Charge related to state prescription drug monitoring programs, the number of patients on chronic opioid therapy on a primary care provider's panel, pain management specialists, pain assessment tools, complementary and integrative health services, urine drug testing, concurrent use of benzodiazepines and opioids, and medication reconciliation.

Testosterone Replacement Therapy Initiation and VA Follow-Up Evaluation in Male Patients

The OIG conducted a study to assess whether VA providers established androgen deficiency (lower levels of male sex hormones, particularly testosterone, than is needed for good health) prior to initiating testosterone therapy. Staff also examined the extent to which VA providers performed follow-up evaluation after initiating the therapy, in accordance with applicable guidelines and criteria. The OIG found that VA providers generally did not follow applicable guidelines and criteria when initiating patients with testosterone replacement therapy or when following up with patients within three to six months after therapy initiation. In addition, VA providers generally did not perform both follicle-stimulating hormone and luteinizing hormone tests to distinguish between primary and secondary androgen deficiency before initiating testosterone replacement therapy. VA providers did not document a discussion of the risks and benefits of testosterone replacement therapy with approximately two out of three patients before therapy initiation. The OIG made seven recommendations to ensure that providers' practices are in alignment with VHA current guidance related to the initiation and maintenance of testosterone replacement therapy.

Hotline Inspections

Colorectal Cancer Screening, Timely Colonoscopies, and Physician Coverage in the Intensive Care Unit at the James H. Quillen VA Medical Center, Mountain Home, Tennessee

The OIG reviewed allegations of inadequate colorectal cancer screening resulting in patient deaths, untimely colonoscopies, and inadequate Intensive Care Unit (ICU) physician coverage. The OIG did not substantiate that veterans were dying due to fecal immunochemical tests (FIT) rather than screening with colonoscopies and could not substantiate that a specific delay impacted a particular patient's care. OIG staff did, however, identify deficiencies with the facility's FIT specimen labeling, tracking, and monitoring processes. Although the OIG substantiated a lack of attending physician coverage in the ICU between March and September 2016, temporary physicians provided coverage and inconsistent coverage was resolved in February 2017. The OIG made seven recommendations related to clinical patient reviews/disclosures, tracking patients' surveillance colonoscopies, tracking follow-up of positive FIT patients, ensuring availability of non-VA colonoscopy reports, providing a diagnostic colonoscopy after patients' positive FITs, notifying patients to resubmit FIT specimens, and tracking the distribution of patients' FIT kits.

Clinical and Administrative Concerns Related to the Podiatry Department at the Lexington VA Medical Center, Kentucky

The OIG evaluated allegations that a podiatrist did not perform adequate examinations or provide comprehensive care; misrepresented patients' clinical statuses; "disappeared" from the clinic and did not see patients in a timely manner; and called out on sick leave the day before clinic, inconveniencing patients and staff. The OIG did not or could not substantiate any of the allegations but made one recommendation to develop a clear action plan to resolve noted Podiatry Department work environment issues and monitor compliance to ensure patient safety.

Follow-Up to Clinical and Administrative Concerns at the Cincinnati VA Medical Center, Ohio

The OIG examined the adequacy of policies and practices in several areas, including the separation of clean and dirty materials in storage areas, reporting and follow-up of reusable medical equipment (RME) reprocessing errors, identification and management of Methicillin-resistant Staphylococcus aureus (MRSA) healthcare-associated infections, and recruitment and retention of nurses. The storage areas that the OIG inspected were generally clean, with clean and dirty materials stored separately. Although the facility did not have a written policy for reporting RME reprocessing errors, an appropriate process was in place. The facility's MRSA surveillance and prevention activities appeared to be improving, as the facility did not report any new infections during the second half of FY 2017. The facility was taking reasonable steps to ensure patient care and safety when ICU nurse staffing was not optimal and to improve nurse recruitment and retention through pay parity efforts. The OIG made no recommendations.

Alleged Mismanagement of Inpatient Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas

The OIG inspected the Colmery-O'Neil VA Medical Center in Topeka, Kansas, following allegations that physicians were practicing beyond their clinical privileges and expertise, failed to seek assistance from specialists, and that a nurse practitioner did not have physicians' help or supervision for the inpatient medical service. The OIG did not substantiate these allegations. The inspection did reveal that the VA Eastern Kansas Health Care System's bylaws were not updated to reflect VA's amended medical

regulations permitting full practice authority for advanced practice registered nurses. The OIG also found the facility did not meet VHA surgical complexity requirements for surgeons or the anesthesia service. In addition, staff could not provide lists of after-hours on-call social workers, mental health staff, specialists, or radiologists. The OIG made six recommendations related to providers' clinical privileges, bylaws updates, requirements for after-hours surgeon staffing and anesthesia service coverage, specialty care consults timeliness, on-call specialists' availability, and emergency department specialty service coverage.

Supervision and Care of a Residential Treatment Patient at a Veterans Integrated Service Network 10 Medical Facility

The OIG evaluated the overdose death of a patient in a residential treatment program at a VISN 10 medical facility. The purpose of the inspection was to review the supervision and care of the patient while enrolled in the program. The OIG identified issues relating to the supervision of the patient, to include inconsistent facility policy direction for patient check-ins, staff compliance with policies or procedures regarding the management of patient check-ins and missing patients, and random screening of patients for drug and alcohol abuse. The OIG also identified issues relating to the quality of care provided to the patient. The OIG made five recommendations to the facility director related to the development and implementation of uniform program policies and a comprehensive interdisciplinary plan, provision of daily services, the reassessment of patient privileges, and accurate electronic health record documentation.

Delays in Urological Care and Alleged Lack of Non-VA Care Funding at the Beckley VA Medical Center, West Virginia

The OIG conducted an inspection regarding allegations that delays in urological care and an increase in a kidney lesion's size adversely impacted a patient's urological health. The review further evaluated whether other patients experienced delays in urological care. The OIG substantiated that the patient experienced delays in urological care, including kidney surgery, and that a kidney lesion increased in size. However, the lesion size was not within the range that necessitated immediate intervention. The OIG did not find that delays caused an adverse clinical impact to the patient's urological health. The OIG also identified delays in scheduling urology consults for the VA Medical Center's Outpatient Urology Clinic but determined none of the reviewed patients experienced an adverse clinical impact to their urological health. The OIG made one recommendation related to reviewing consult management practices and ensuring consult timeliness.

Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania

The OIG did not substantiate that an anesthesiologist failed to follow VHA and facility policies for controlled medication waste because the anesthesiologist documented that the entire amount of each controlled medication removed from the facility's automated medication dispensing machine was used. The OIG also did not substantiate an allegation that the anesthesiologist failed to individualize patient medication dosing. The OIG did substantiate, however, allegations that the anesthesiologist used more anesthetic/sedation medication for outpatient procedures than Federal Drug Administation-approved manufacturer's instructions recommended and that facility leaders did not provide adequate oversight of the anesthesiologist according to VHA and facility privileging and monitoring policies. The OIG made four recommendations related to anesthesia needs and services, provider oversight, National Practitioner Data Bank and State Licensing Board reporting, and Patient Advocate Tracking Systems database requirements.

Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility

The OIG conducted an inspection in response to a complaint that a primary care provider at a VISN 20 facility continued to prescribe controlled substances to a patient at high risk for overdose. The OIG substantiated that the primary care provider was aware the patient was getting controlled substances from outside pharmacies and had a history of benzodiazepine abuse. The OIG also substantiated that the care provider prescribed controlled substances for the patient when he was no longer the patient's provider. The OIG could not substantiate that the provider had a reputation of prescribing narcotics "recklessly" or that the provider was warned about his prescribing practices. The OIG reviewed the facility's policies on controlled substance prescribing and identified limitations in oversight. The OIG made one recommendation to the VISN director to review the patient's care and provider's practice and seven recommendations to the facility director related to prescribing practices and peer review processes.

Patient Overdose Death in a Residential Rehabilitation Treatment Program at a Veterans Integrated Service Network 1 Medical Facility

The OIG reviewed the circumstances surrounding a residential rehabilitation treatment program's patient death from heroin overdose at a VISN 1 medical facility. The OIG determined that protocols were not in place for initiating patients' medication-assisted therapy. The OIG made recommendations related to the gap in protocols, compliance with no-show policies, and staff training on no-show procedures.

Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia

At the request of Senator Joe Manchin, the OIG conducted a healthcare inspection to review the postoperative care of a patient who had vascular surgery at the Martinsburg VA Medical Center. In general, the OIG team found the patient's immediate postoperative care was proper. However, the OIG had concerns with the Community Based Outpatient Clinic's (CBOC) care management when the patient presented with signs and symptoms of a known vascular procedure complication 10 days following surgery. The OIG found the CBOC lacked an adequate policy or standard operating procedure on the management of health emergencies and had inconsistent health record documentation for the patient. The OIG made three recommendations related to care coordination, health emergency management, and health record documentation.

Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

After environment of care (EOC) deficiencies were identified at a contracted clinic on May 23, 2018, the OIG conducted a healthcare inspection of six other contracted clinics of the Jackson, Mississippi, G.V. (Sonny) Montgomery VA Medical Center. The OIG inspectors found problems with general safety, medication safety and security, infection prevention and environmental cleanliness, and information technology. Although OIG inspectors did not find that the conditions placed patients or staff at risk, corrective actions were needed to ensure a clean and safe environment. The OIG team found inconsistencies between the requirements for VHA oversight described in the respective CBOC contracts, the expectations of the Contracting Officer's Representative, and facility managers' approach to conducting CBOC site visits. Facility managers did not consistently keep written records of deficiencies found on site visits or document the required dates for completing corrective action. The OIG made two recommendations related to comprehensive reviews of EOC issues and consistent oversight of CBOC operations.

Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York

The OIG reviewed allegations regarding a surgical oncologist's intraoperative radiofrequency ablation (IORFA) practices at the Albany VA Medical Center and related oversight. The IORFA procedure involves using a special type of needle that produces heat sufficient to destroy metastatic and small primary tumors. The OIG found deficiencies in peer reviews and in credentialing and privileging processes. The OIG also substantiated that the surgical oncologist completely or partially missed tumors when performing IORFA in three patients, and subsequently told patients they had residual tumors. Facility leaders did not provide required disclosures for the patients reviewed. The OIG did not substantiate the surgical oncologist performed surgery on patients who did not have cancer or that adverse events occurred during cancer surgeries. The report includes nine recommendations related to improving oversight and peer review, better monitoring patient care and IORFA outcomes, making institutional disclosures, ensuring external IORFA reviews, and evaluating appropriate actions for relevant staff.

Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware

The OIG evaluated allegations regarding the care of two patients in the Hemodialysis Unit at the Wilmington, Delaware, VA Medical Center. Although the OIG was unable to substantiate that care received in the dialysis unit contributed to the first patient's death, the OIG identified quality of care issues related to ordering and monitoring blood glucose levels and administration of non-scheduled medications. Seventeen hours after the dialysis treatment, the patient was found deceased in his/her car in the facility parking lot. The VA police actions were found to be inconsistent with requirements that may have facilitated detecting the patient in a visible, illegally parked vehicle. The OIG substantiated that staff initiated cardiopulmonary resuscitation on a second patient. The patient recovered, but the OIG identified concerns related to the emergency response. The VA concurred with OIG's 14 recommendations related to policy and processes, verbal medication orders, code blue documentation and reporting, and police policy.

Quality of Care Concerns Regarding a Patient Who Had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan

A healthcare inspection was conducted to assess the care of a patient who underwent cardiac surgery at the VA Ann Arbor Healthcare System. The OIG was unable to substantiate that the patient received inappropriate care during surgery that ultimately led to his/her death because there was a lack of evidence as to how or when a cardiopulmonary bypass catheter, inserted to divert blood flow from the heart, became misplaced. The OIG did not substantiate that the patient was abandoned by the anesthesiologist during surgery. The OIG determined the facility did not complete all required quality management processes and did not evaluate the success of the modifications that the surgeon and anesthesiologist made in their practices after the patient's surgery. The OIG made two recommendations related to the facility's compliance with quality management requirements and a review of modifications made by the anesthesiologist and surgeon in their cardiac surgery practices.

Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota

In response to a request from Representative Tim Walz, the OIG reviewed the care of a patient who died from a self-inflicted gunshot wound less than 24 hours after discharge from the inpatient mental

health unit of the Minneapolis VA Health Care System. The OIG determined the inpatient treatment team failed to collaborate with outpatient providers, facilitate outpatient medication management, and educate the patient about limiting firearms access. The Suicide Prevention Coordinator did not collaborate with the treatment team, determine the need for a Patient Record Flag prior to discharge, or provide required training. The Coordinator also did not complete Behavioral Health Autopsies within required time frames. Among additional deficits, the Health Care System did not comply with policy for conducting a root cause analysis. Although the OIG did not determine that identified deficits caused the patient's suicide, it made seven recommendations related to improving care coordination, documentation, training, and administrative processes.

Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio

The OIG conducted an inspection regarding the health care of a resident who died approximately 36 hours after admission to the Dayton VA Medical Center's Mental Health Residential Rehabilitation Treatment Program (MHRRTP). The OIG did not substantiate that staff failed to treat the resident or assign a counselor. However, one clinical opioid withdrawal symptom scale was not performed, counseling staff did not meet with the resident on admission, and the resident did not receive a therapeutic activity schedule. The OIG was unable to substantiate that the resident died by a suicidal act because there were no suicide indicators and the resident's intentions were unknown. The OIG also found that residents did not receive privileging levels program information at admission and that this program may not have been congruent with MHRRTP goals. The OIG made three recommendations related to clinical opioid withdrawal scales, timely therapeutic activity schedules, and the residents' privileging levels program.

Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky

The OIG assessed concerns that a primary care provider at the Berea, Kentucky, CBOC falsely documented patients' blood pressure readings. The provider documented repeat readings of 128/78 in 99.5 percent of the 1,370 primary care encounters reviewed. In a subset of high-risk patients, the provider's inadequate treatment of hypertension placed patients at risk for adverse clinical outcomes, including death. The OIG concluded that the provider's falsification of blood pressure readings was most likely due to the provider's attempt to reduce workload (as additional follow-up is required for higher readings). The OIG noted inadequate performance measure data validation processes, improper blood pressure rechecks documentation by a licensed practical nurse, and a likelihood that the provider and nurse knew about each other's deficient practices but did not take action. Facility leaders took prompt steps to evaluate the provider's actions and mitigate risk to patients. The OIG made seven recommendations related to administrative actions, patient follow-up, data integrity, policies and procedures, and training.

Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York

The OIG substantiated that a patient fell and required hip fracture repair surgery but did not substantiate the fall was caused by deficient fall precautions or that the patient's death was caused by abuse or neglect. Although the OIG substantiated the patient did not receive all required anticoagulation medication doses, the OIG did not substantiate the missing doses contributed to the patient's death. The OIG was unable to substantiate that the patient did not receive one-to-one observation because of conflicting evidence. The OIG did not substantiate that a nurse manager received complaints about staff that impacted patient care and failed to take corrective action or that facility leaders covered up

the patient's death. The OIG made three recommendations related to 24-hour observation flow sheets, updated quality management review, and institutional disclosure.

Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York

The OIG substantiated Patient A died after choking on food, but could not attribute the cause to nurse staffing. The OIG team also substantiated that staff called the wrong code, delaying Patient A's transport; that staff did not consistently document hourly rounds; and that a second patient's wrists were bound by a palm protector strap, although there was no evidence to suggest an intentional act of wrongdoing. The OIG was unable to substantiate whether patients were regularly left unsupervised while eating, or a lack of staff vigilance. The OIG did not substantiate that managers misrepresented the cause of Patient A's death, that one community living center (CLC) lacked security, or that CLC nursing managers were often unavailable. The OIG made nine recommendations related to emergency medical response processes and policies, CLC meal staffing and delivery processes, safety rounds, and reviews of Patient A's care.

Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York

The OIG substantiated that nursing leaders were aware of staffing shortages; administrative registered nurses provided CLC nursing care; facility leaders pressured CLC managers to accept admissions; and at times CLCs were closed to admissions, although residents were not transferred due to staffing deficiencies. The OIG was unable to substantiate that the use of float staff and overtime placed residents at a higher risk for adverse events. The OIG found the facility failed to use alternative staffing. There was also a delay in filling vacant positions and a lack of approval for increased staff. Also, overtime funding exceeded the cost of filling vacant positions. The OIG made three recommendations related to CLC nurse staffing and recruitment, alternative staffing, and overtime management.

Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia

OIG healthcare inspectors reviewed allegations that a non-VA imaging center reported mammogram results as normal for a patient with known breast cancer managed by the Atlanta VA Health Care System, which delayed the patient's care. The OIG substantiated that the 2016 mammogram results at issue were reported as "normal" but determined the interpretation was reasonable based on evidence available to the radiologist at the time of the interpretation and did not delay care. In the course of the inspection, the OIG identified multiple process concerns and made seven recommendations to ensure that patients who transitioned from a contract care provider in 2015 to other non-VA providers received care, facility mammography policy and practice are consistent, timely non-VA mammograms are scheduled and undergo consistent clinical review, availability of mammogram results improve, gender-specific care is provided by Women's Health primary care providers, and the facility provides executive oversight of its Women Veterans Program.

Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio

Senators Jon Tester and Sherrod Brown asked the OIG to review the care of a patient who fell to his death from a second-story window at the Chillicothe VA Medical Center. The OIG determined adequate security measures were not in place as required. The patient received care for medical and mental

health issues on a medical unit. A special observer was assigned to maintain sight of the patient at all times. However, the special observer was unable to maintain visual contact when the patient entered a bathroom, locked the door, and climbed out the window. The OIG also assessed the provision of grief counseling. Although the facility offered grief counseling, it did not disclose all significant facts about the death to the family. The OIG made recommendations to secure windows, monitor compliance with relevant policy and training requirements, and confer with Chief Counsel about family notification of the patient's death.

Comprehensive Healthcare Inspection Program Reports

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. The healthcare facility reviews are performed approximately every three years for each facility. There were 27 medical centers and healthcare systems reviewed in the six-month reporting period (see Appendix A for a full listing). The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus are depicted in the figure below.

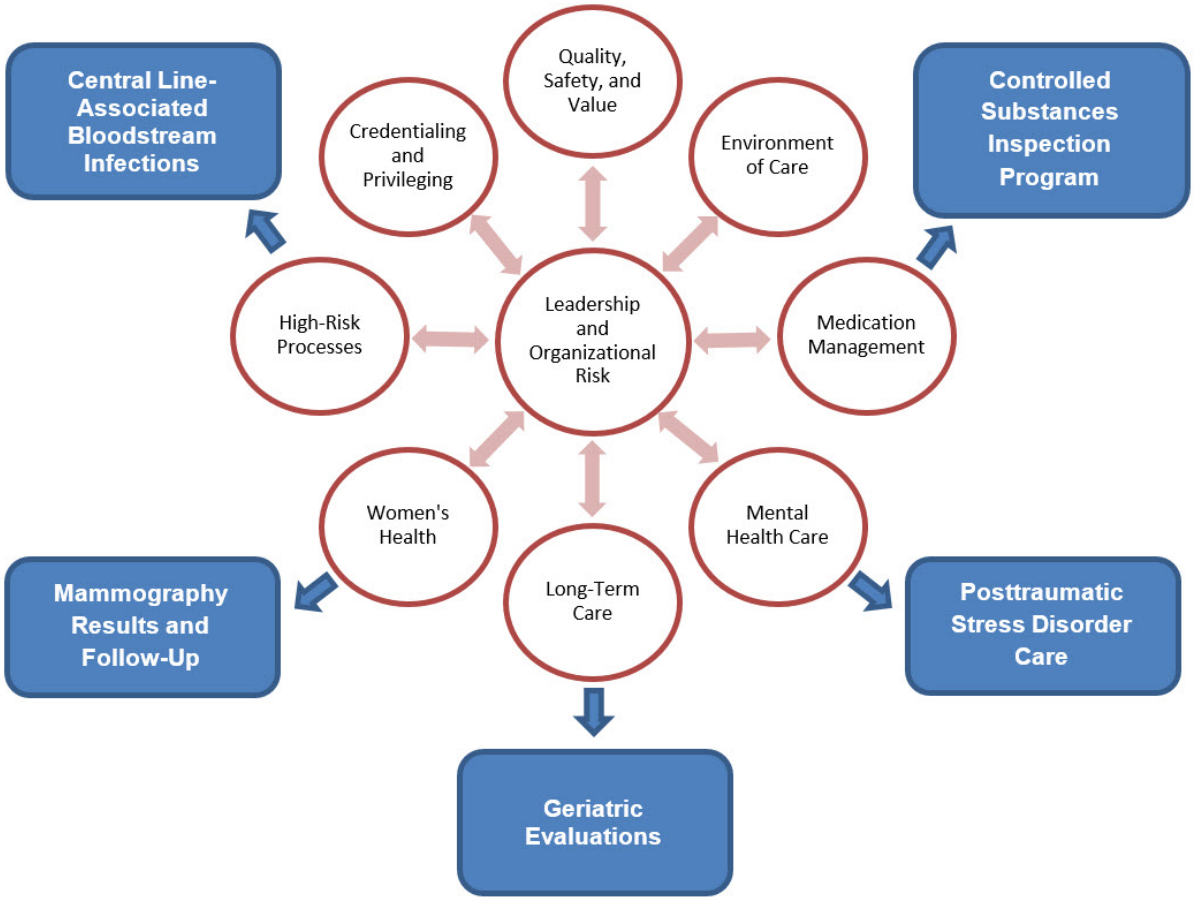


Figure 2. Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services

Overview

OAE published 20 reports during this SAR period. These include a focus on issues that have tremendous impact on veterans' health and benefits, management of VA resources and taxpayer dollars, and the effective operations of VA programs and services. As with other OIG published reports, the OAE recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on monetary impact and the implementation status of report recommendations published since October 2012. Figure 3 depicts OAE staff assignments for the SAR period by oversight areas to include health care, contracts and construction, information technology, benefits, financial management, and headquarters/support.

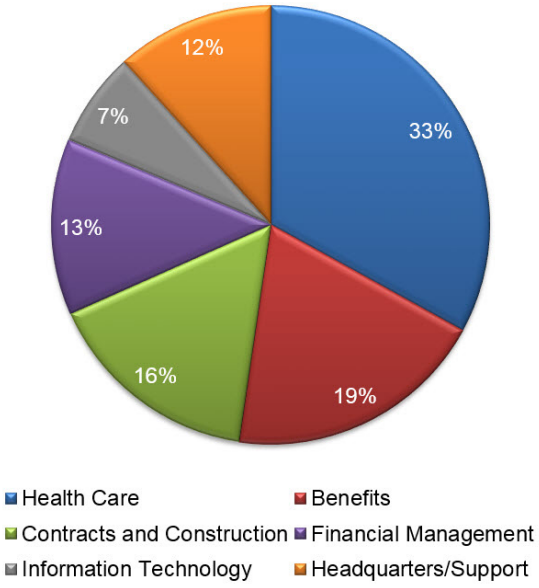


Figure 3. OAE Staff Assignments by Oversight Area

Examples of High-Impact Reports

The following three publications provide examples of the type of work OAE conducts that focuses on identifying problems and making recommendations that can have a significant impact on VA and the veterans it serves. These reports address the processing of claims related to military sexual trauma, the accuracy of VA bulk payments made to third party administrators under the Veterans Choice Program, and the management of the Family Caregiver Program.

Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma

The OIG reviewed VBA's denied claims related to veterans' military sexual trauma (MST) to determine whether staff correctly processed the claims. Due to multiple factors, service members often do not report MST when it occurs. If the MST leads to posttraumatic stress disorder, it is often difficult for victims to produce supporting evidence. VBA policy requires additional steps for processing these claims. The OIG estimated that about half of the MST-related claims denied during the audit period from April 2017 through September 2017 were incorrectly processed due to the lack of reviewers' specialization, no additional level of review, discontinued special focus reviews, and inadequate training. The OIG made six recommendations to the Under Secretary for Benefits including that VBA review all approximately 5,500 MST-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign MST-related claims to a specialized group of claims processors, and improve oversight and training on addressing MST-related claims. Since the release of this report, VA has reported updating its training for staff processing these claims and taking other corrective actions.


CNN politics 45 CONGRESS SUPREME COURT 2018 KEY RACES PRIMARY RESULTS

VA may have fumbled over 1,000 sexual trauma claims, report says

By Zachary Cohen, CNN
Updated 5:19 PM ET, Tue August 21, 2018

The seal of the Department of Veterans Affairs is seen in an auditorium on February 5, 2013 at the Department of Veterans Affairs in Washington. AFP PHOTO/Mandel NGAN (Photo credit should read MANDEL NGAN/AFP/Getty Images)

Washington (CNN) — The Department of Veterans Affairs incorrectly processed hundreds of claims related to military sexual trauma last year -- a breakdown in procedure that may have "resulted in the denial of benefits to veterans who could have been entitled to receive them," according to a report from the VA's Office of the Inspector General released Tuesday.

The Veterans Benefits Administration denied nearly half of the 12,000 claims that were filed in 2017 by veterans seeking support for post-traumatic stress disorder related to military sexual trauma, according to the department.

Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts

The OIG audited VHA's Office of Community Care (OCC) to determine the accuracy of bulk payments made to third party administrators (TPAs) under contracts that include care provided through the Veterans Choice Program. The Choice Program allows veterans to obtain care within their community and is administered under contracts with two TPAs, Health Net Federal Services and TriWest Healthcare Alliance Corporation. The TPAs perform a variety of administrative services, including paying claims from healthcare providers. In 2016, the OCC implemented a method to process healthcare claim payments to TPAs on an aggregated basis, referred to as bulk payments. This process did not have effective internal controls in place to detect improper claims. The OIG found $66.1 million in duplicate payments and $35.3 million in three other payment error types, for a total of $101.4 million in estimated overpayments to the TPAs. The OIG recommended that VHA continue to support processes to prevent duplicate payments, ensure that controls are in place to prevent duplicate payments to TPAs, and work with the Office of General Counsel to determine a process for reimbursement of overpayments by TPAs.

Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed

VHA's Program of Comprehensive Assistance for Family Caregivers pays a monthly stipend to caregivers of eligible veterans. The OIG audited this program from June 2017 through June 2018 to determine if VHA effectively provided program services. The OIG found that veterans and their caregivers did not receive consistent access to the program. Caregiver support coordinators also did not determine eligibility within the required 45 days for about 65 percent of the 1,822 veterans approved from January through September 2017. The OIG also found that VHA did not correctly apply eligibility criteria when enrolling veterans. Four percent of the 1,604 veterans discharged from the program from January through September 2017 were never eligible. As a result, VHA made about $4.8 million in improper payments. VHA failed to manage the Family Caregiver Program effectively because it did not establish governance that promoted accountability for program management. Also, VHA did not establish a staffing model to ensure medical facilities were well equipped to manage the program's workload. The OIG recommended designating additional program oversight, applying proper program criteria to confirm eligibility, ensuring application processing within required timelines, consistently monitoring and documenting veterans' health status, and establishing guidelines for when a veteran's need for care changes.

Veterans Health Administration Audit and Evaluation Reports

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

The Beneficiary Travel Program, Special Mode of Transportation Eligibility and Payment Controls

The OIG assessed whether the VHA Beneficiary Travel Program authorized Special Mode of Transportation (SMT) services only for eligible beneficiaries and processed SMT vendor payments in accordance with law and policy. The OIG found VA medical centers authorized SMT services for some ineligible beneficiaries, did not adequately validate some SMT vendor invoices prior to authorizing payment, and allowed some beneficiaries that used SMT services to improperly receive mileage

reimbursements for the same appointments. VHA also missed an opportunity to reduce program expenditures on ambulance services by paying more than rates authorized by law for SMT services. The OIG recommended the Under Secretary for Health implement additional and more effective controls to ensure compliance with VHA policy concerning SMT eligibility determinations and improper payments, as well as implement policy to use Centers for Medicare and Medicaid Services rates, when applicable, in order to reduce unnecessary SMT expenditures.

VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics

The OIG conducted a review concerning allegations that the VA Southern Nevada Health Care System's Prosthetics Laboratory was unnecessarily sending veterans to vendors to obtain prescribed compression garments and orthotic shoes, which resulted in the system paying higher prices for these items. The OIG substantiated this allegation and found that sending veterans to outside vendors was not justified because the system had sufficient personnel and inventory to provide the prescribed items. The OIG found that poor decision-making by laboratory employees, underutilized laboratory personnel, and unused inventory occurred because the former chief of prosthetics did not effectively monitor the laboratory's operations. The OIG recommended that the system continue to improve its oversight and use of laboratory resources. Because the system's previous chief of prosthetics is currently serving as the chief of prosthetics for the VA San Diego Health Care System, the OIG made similar recommendations for that system as well.

Alleged Split Purchases at the VA St. Louis Health Care System, Missouri

The OIG substantiated that purchase cardholders at the VA St. Louis Health Care System split purchases in violation of regulations and policy to install firestops (passive fire control components) at its facilities. In total, the OIG identified 235 purchases for firestops and other unrelated construction work valued at about $564,000 that were unauthorized commitments and improper payments. The OIG found that employees were following guidance from their accounting department that was in direct conflict with Federal Acquisition Regulation (FAR) requirements and annual purchase card training. Cardholders and approving officials did not have a clear understanding of what represented a "split purchase." The OIG made three recommendations, including submitting ratification requests for the improperly made purchases, providing additional training on how to avoid split purchases and comply with micro-purchase thresholds, and establishing a rigorous monitoring mechanism to identify and prevent improper purchase card transactions.

Use of Not Otherwise Classified Codes for Prosthetic Limb Components

The OIG substantiated allegations received in 2016 alleging VHA was overpaying for prosthetic items because it incorrectly used Not Otherwise Classified (NOC) codes on items for payment to vendors. Incorrectly using an NOC code can result in an overpayment because the payments are not based on preestablished reimbursement rates. The OIG found that VHA overpaid vendors about $7.7 million from October 2014 through July 2017. Prosthetists incorrectly used NOC codes because they were either unaware of the existing codes or because they allowed vendors to classify the items. The OIG made five recommendations, including determining which codes are appropriate to classify prosthetic items for reimbursement, establishing oversight for the approval of recommended classification codes, developing processes to monitor the use of NOC codes, and establishing pricing guidance that ensures VA pays a fair price for items classified using an NOC code.

VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016

The OIG conducted this audit to determine if VA is complying with the *West Los Angeles Leasing Act of 2016*, P.L. 114-226. The OIG assessed whether leases and other land use agreements complied with the Act, adhered with other federal laws, were veteran-focused, and managed effectively. The OIG reviewed 40 land use agreements and determined that 11 did not comply with the Act, other applicable laws, or the draft master plan, which was developed to assist VA in revitalizing the West LA campus to become veteran-focused. Fourteen non-VA entities were also operating with an expired or no documented agreement. The OIG found veteran input on land use was insufficient, policies governing "out leases" and revocable licenses lacked clarity, and capital asset inventory records were incomplete. The OIG recommended VA implement a plan that puts the West Los Angeles campus in compliance. VA should also obtain input from the veteran community advisory board on campus land use, update land use policies, and ensure the capital asset inventory reflects all agreements.

Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina

The OIG conducted this audit to determine whether community care providers associated with the Fayetteville, North Carolina, VA Medical Center stopped accepting Non-VA Care and Veterans Choice Program authorizations. In July 2017, the OIG received an allegation that two orthopedic providers stopped accepting VA patients because claim payments were not timely. The OIG substantiated that at least 15 community providers stopped accepting VA patients from January 2015 through July 2017, primarily because claims were not paid in a timely manner and there was difficulty resolving unpaid claims. Having fewer community providers available affected the ability to schedule patients for dermatology, neurosurgery, orthopedic, and urology services in the community. Also, VA paid about $156,000 in interest on delayed payments. If additional providers stop accepting VA patients, there is a risk of increased wait times and travel. The OIG made six recommendations to improve oversight of claims processing timeliness and monitoring of community provider participation.

Leasing Procedures Used to Acquire VA's Wilmington Health Care Center

The OIG reviewed the Wilmington Health Care Center in North Carolina in response to a request from Congressman Walter B. Jones, who asked the OIG to determine whether selecting the Wilmington airport site for the Center was in the best interest of taxpayers and if VA officials used appropriate procedures during the selection and award process. The OIG determined that the selection of the Wilmington airport site was not in the taxpayers' best interest. VA will pay $2.3 million more than fair market rent over the 20-year lease. This occurred because Construction and Facilities Management (CFM) leadership lacked oversight. CFM has since implemented policies and procedures negating the need for most recommendations. The OIG did recommend that the CFM establish a formal policy for transferring contract files. Because CFM was unable to provide information on all offers, the OIG could not determine whether CFM used appropriate selection and award procedures.

Veterans Benefits Administration Audit and Evaluation Reports

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

Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact

The OIG reviewed allegations that the Veterans Benefits Administration Office of Transition, Employment, and Economic Impact (OTEEI) authorized printing services that were out of scope, resulting in an unauthorized commitment. The OIG also reviewed allegations that OTEEI misused the General Operating Expense Appropriations to develop and maintain a dashboard and purchase IT equipment and software. The OIG made three recommendations to include taking action to remedy the unauthorized commitment, obtaining appropriate funding for all future IT costs, and making account adjustments to debit the IT account and credit the General Operating Expense account.

Unwarranted Medical Reexaminations for Disability Benefits

The OIG reviewed reexamination requests by VBA and estimated that, from March through August 2017, VBA spent $10.1 million on unwarranted reexaminations. The OIG estimated that VBA would waste an additional $100.6 million over the next five years unless it ensures that employees only request reexaminations when necessary. VBA policy requires a review of the veteran's claims folder before requesting a reexamination. VA Regional Office managers routinely bypassed the pre-exam review and routed these cases for scheduling the reexamination. The OIG made four recommendations including establishing internal controls to ensure that a reexamination is necessary, prioritizing the design and implementation of system automation to minimize unwarranted reexaminations, enhancing VBA's quality assurance reviews of requested reexaminations, and conducting a focused quality improvement review of cases with unwarranted reexaminations to understand and redress the causes of avoidable errors.

Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits

The OIG conducted a review to determine whether VBA staff assigned correct effective dates on claims for compensation benefits with an intent to file (ITF). An ITF allows claimants the opportunity to provide minimal information related to the benefit sought and up to one year to submit a complete claim. VA may use the date of receipt of an ITF as an earlier effective date for paying benefits. The OIG found that VBA staff did not always assign correct effective dates from March 24, 2015, to September 30, 2017, resulting in over $72.5 million in improper payments. Most errors occurred during the initial period of ITF implementation. This was largely due to a lack of standard operating procedures, inadequate procedural guidance for electronic ITF submissions, deficient and delayed training, and lack of functionality in the Veterans Benefits Management System (VBMS). The OIG recommended modernizing the ITF system and possibly integrating submissions into the VBMS. In addition, the OIG recommended a special review of ITFs submitted during the period of concern.

Accuracy of Effective Dates for Reduced Evaluations Needs Improvement

The OIG reviewed whether VBA accurately notified veterans of proposed reductions based on their disability evaluations and assigned correct effective dates for those reductions. The OIG estimated that 38 percent of cases reviewed were processed incorrectly by VBA staff, resulting in an average improper payment rate of $2,000 per veteran. If no changes were made to VBA practices, OIG estimated that over a five-year period, similar errors would result in improper payments to 22,300 veterans totaling over $27.5 million. The OIG recommended VBA implement a plan to ensure the timely processing of these cases, modify VBMS to apply correct effective dates, provide refresher training to processors, update guidance on when to send notifications when a reason for reduction changes, and conduct periodic reviews for veterans who had benefits reduced based on erroneous notification dates.

Timeliness of Final Competency Determinations

The OIG reviewed VA's Fiduciary Program to determine whether VBA finalized proposed incompetency determinations in a timely manner. The OIG found delays in final competency determinations completed from March 1 through August 31, 2017. Delays can result in incompetent beneficiaries receiving ongoing benefits payments without the protection of a VA-appointed fiduciary. The OIG estimated 13,600 unprotected beneficiaries received $62.4 million in ongoing benefits. Delays can also result in beneficiaries waiting longer for withheld retroactive benefits. The OIG estimated 12,400 beneficiaries had approximately $77.5 million in retroactive benefits payments withheld. The OIG made six recommendations related to entering cases into the Beneficiary Fiduciary Field System, reminding VBA staff to notify Fiduciary Hubs when waivers are received, ensuring Fiduciary Hubs have access to documents in the Legacy Content Manager, prioritizing cases, meeting VBA's timeliness standards, and distributing cases according to policy.

Review of Accuracy of Reported Pending Disability Claims Backlog Statistics

The OIG reviewed VBA's statistics related to pending disability claims to determine if it accurately reported its backlog of rating claims pending for more than 125 days. Although VBA reported it had reduced its claims backlog from a peak of 611,000 in March 2013 to 70,537 at the end of May 2018, the OIG found that VBA's reported backlog included only about 79 percent of all claims that were awaiting rating decisions for more than 125 days. The OIG found that what the backlog represented was not always clearly defined because VA reported four differently-worded definitions for the backlog. Also, VBA's prioritization of its backlog sometimes delayed processing other claims. Finally, inaccurate claims impaired VBA's ability to manage its workload. The OIG recommended that VBA reconsider which claims are reported in the disability claims backlog and provide a clear definition. Also, the OIG recommended VBA implement a plan to provide consistent oversight and training of claims assistants.

VA Policy for Administering Traumatic Brain Injury Examinations

The OIG conducted this review at the request of the HVAC Subcommittee on Disability Assistance and Memorial Affairs. The Subcommittee asked the OIG to respond to questions related to VA policies that specify the qualifications of medical professionals who conduct traumatic brain injury (TBI) medical examinations. In 2008, VA revised the criteria used to evaluate TBI. However, VA failed to implement procedures then to ensure veterans received adequate initial TBI medical examinations. Subsequent VBA and VHA policies regarding initial TBI medical examinations were not consistent. Between September 2007 and July 2015, VBA updated its policy relating to TBI medical examinations five times while VHA changed its policies four times. The OIG recommended that VBA coordinate with VHA to determine whether any qualified veterans were excluded from equitable relief and whether there are other veterans entitled to consideration for equitable relief.

Acquisition, Contracting, Financial Management, and Information Technology Audit and Evaluation Reports

The OIG performs audits of administrative support functions and financial management operations, focusing on the adequacy of VA systems in providing managers with information needed to efficiently and effectively oversee and safeguard VA assets and resources. OIG oversight work satisfies *Chief Financial Officers Act of 1990*, P.L. 101-576, audit requirements for federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

In addition, the OIG performs audits of IT and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and protecting veterans and VA employees, facilities, and information. OIG audit reports present VA with constructive recommendations to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Modernization Act of 2014*, P.L. 113-283, as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit.

VA's Federal Information Security Modernization Act Audit for Fiscal Year 2017

This audit identified continuing significant deficiencies related to access, configuration management, and change management controls, as well as service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. The report includes 29 recommendations for improving VA's information security program and an appendix addressing the status of prior recommendations and VA's plans for corrective action. VA successfully closed four recommendations in FY 2017. The Executive in Charge for the Office of Information and Technology generally concurred with the recommendations and submitted adequate corrective action plans. The OIG will continue to evaluate VA's progress during its audit of VA's information security program in FY 2018, although the OIG remains concerned that ongoing delays in implementing effective corrective actions might contribute to the continued reporting of an information technology material weakness in this year's audit of VA's Consolidated Financial Statements.

VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017

The OIG determined that VA met four of six *Improper Payments Elimination and Recovery Act* (IPERA), P.L. 111-204, requirements for FY 2017 by publishing the Agency Financial Report, performing risk assessments, reporting improper payment estimates, and providing information on corrective action plans. VA did not fully comply with two IPERA reporting requirements as specified by the Office of Management and Budget. Specifically, VA did not report a gross improper payment rate of less than 10 percent for seven of thirteen programs and activities that had an improper payment estimate in its FY 2017 Agency Financial Report. Also, VA did not meet annual reduction targets for seven programs and activities. The OIG recommended VHA and VBA implement steps to reduce improper payments for applicable programs and activities.

FY 2017 Risk Assessment of VA's Charge Card Programs

As annually required, the OIG conducted a risk assessment of the three types of charge cards used by VA—purchase cards, travel cards, and fleet cards. Based on its risk assessment of VA's FY 2017 charge card transactions, the OIG determined that VA's purchase card program remains at medium risk of illegal, improper, or erroneous purchases. The data mining of purchase card transactions identified potential misuse of purchase cards. OIG investigations, audits, and reviews continue to identify patterns of purchase card transactions that do not comply with the FAR or VA policies and procedures. The OIG determined that VA's travel and fleet card programs have a low risk of illegal, improper, or erroneous purchases because these transactions represented only 3.1 percent and 0.4 percent, respectively, of the approximately $4.4 billion VA spent on charge card transactions during FY 2017.

Overview

The Office of Investigations (OI) focuses on a wide range of cases that can have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 388,000 employees; offenses by VA employees and nonemployees affecting the Department's programs and operations; as well as allegations of serious violations of policies and procedures by high-ranking VA staff.

Examples of High-Impact Cases

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

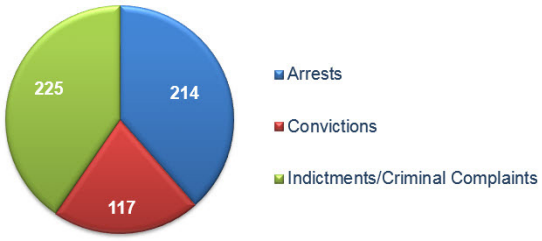


Figure 4. OI Prosecutive Statistics

VA Choice Contractor Paid $40.8 Million in Reimbursements for Overpayments

A contractor that acted as a third-party payer for the VA Choice Program (one of the community healthcare programs) reimbursed VA more than $40 million for overpayments that it received as a result of improperly submitting duplicate invoices. An OIG and VA investigation revealed that errors in the contractor's billing practices led to multiple overpayments. This contractor conceded that at least a portion of the overpayments were accurately identified by VA and reimbursed for that amount.

Three Former Greenville, South Carolina, VA Community Based Outpatient Clinic Employees Indicted for Bribery, Conflict of Interest, Healthcare Fraud, and Conspiracy

An OIG investigation resulted in charges alleging that the defendants conspired with officials from a medical product company to receive gratuities and payments while employed by VA, and also used large quantities of its skin graft product on VA patients for wound treatment. The OIG OHI staff helped investigators determine that the VA healthcare providers violated Department policy and misused the product in a number of ways for personal gain. VA employees used the product without a Consignment Agreement and stored it in their work spaces, which assisted the company in reporting inflated sales to investors. One defendant, a former VA physician, conducted a published research study using this product, which showed successful wound closure. However, subsequent to the study, this defendant continued to overuse the product on at least one of the research patients as if the patient's wound was not closed. One of the defendants resigned in lieu of termination and another defendant was fired. The third defendant retired when the investigation began. In addition, a physician and two nurses at the Greenville CBOC each received a one-day suspension. VA spent approximately $153 million on this product, with more than approximately $7 million from a South Carolina VA medical center and this CBOC.

Former Philadelphia, Pennsylvania, VA Regional Office Employee Pled Guilty to Wire Fraud and Identity Theft

A former Philadelphia VA Regional Office employee pled guilty to wire fraud and aggravated identity theft in a scheme to defraud VA of approximately $838,000. An OIG investigation revealed the defendant's duties included the review, approval, and authorization of veterans' benefits claims. The

defendant accessed the personally identifiable information of veterans and their spouses to manipulate preexisting claims and create fake claims. Prior to authorizing the fictitious or altered claims, the defendant changed the direct deposit claim information to divert the stolen funds to his co-conspirators' accounts. After receiving the direct deposits from VA, his co-conspirators provided the defendant with a kickback. The defendant manipulated records internally to avoid detection in this scheme. As a result of this investigation, nine individuals were arrested and convicted.

Veterans Health Administration Investigations

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this SAR period, OI opened 80 cases; made 95 arrests; obtained over $37.8 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved over $6.1 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The case summaries that follow provide a sample of the type of VHA investigations conducted during this period.

Veterans Health Administration Office of Community Care Employee Indicted for Conflict of Interest

A VHA Office of Community Care employee in Denver, Colorado, was arrested after being indicted for conflict of interest. An investigation by the OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service Criminal Investigation Division (IRS-CI) resulted in charges that allege the defendant referred seven spina bifida beneficiaries to a home health agency owned by his wife from September 2017 through June 2018. VA consequently paid his wife approximately $4.3 million during that timeframe, mostly due to retroactive claims. In total, this investigation identified almost $20 million paid to home healthcare agencies owned by the employee's relatives and associates for the care of 49 beneficiaries. Over 40 seizure warrants were simultaneously executed on accounts owned by the defendant, his relatives, and associated home healthcare agencies, resulting in a forfeiture of nearly $3.2 million. Eight vehicles were also seized under the warrants.

Former San Juan, Puerto Rico, VA Medical Center Employee Pled Guilty to Theft of Government Property

A former San Juan VA Medical Center Pharmacy Procurement Technician pled guilty to theft of government property. An investigation by OIG and VA Police Service revealed that the defendant used her position to order and subsequently steal large quantities of insulin with a commercial market value of over $6.7 million from the medical center. The loss to VA is approximately $762,000.

Home Healthcare Employee Indicted for Destruction, Alteration, or Falsification of Records in a Federal Investigation

A home healthcare company employee, who provided care to veterans as part of the community care program, was indicted for destruction, alteration, or falsification of records in a federal investigation. A VA OIG, FBI, and Department of Health and Human Services (HHS) OIG investigation resulted in charges that allege the defendant altered therapy notes for patients in order to obstruct the investigation of a home healthcare company that is under investigation for fraudulently billing VA and Medicare. The projected loss to the government is approximately $1 million, with VA's loss at approximately $600,000.

Business Owner Pled Guilty to Conspiracy to Commit Wire Fraud

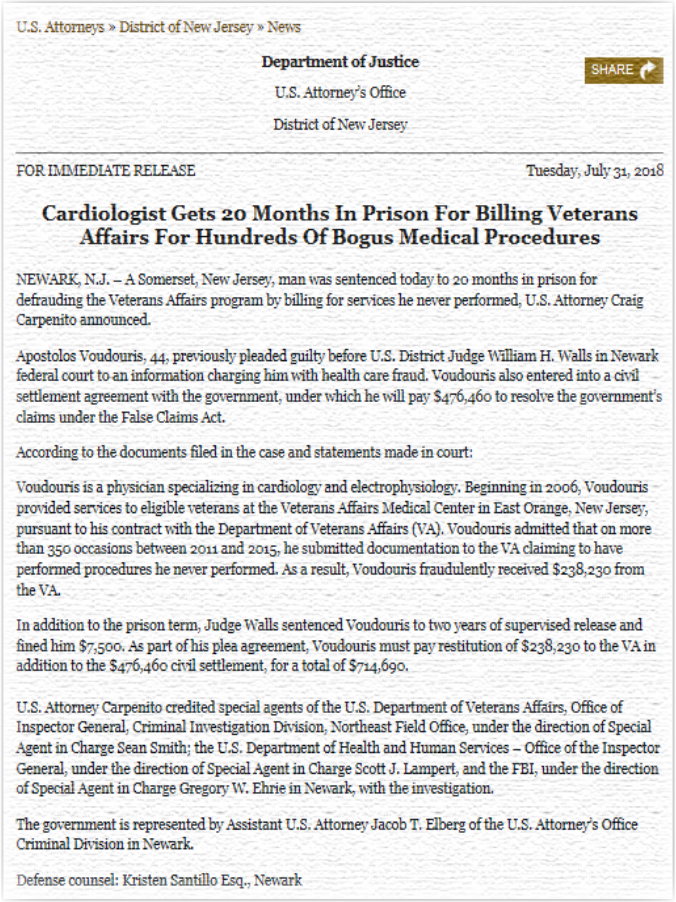
An individual pled guilty to conspiracy to commit wire fraud related to her co-ownership of a company providing services to the Houston, Texas, VA Medical Center Prosthetics Department. Her co-conspirator, a VA Prosthetics Representative, was previously charged with conspiracy, wire fraud, and theft of government property and is awaiting trial. An OIG investigation resulted in charges that allege from January 2011 through December 2014, the defendants conspired to bill VA for false and fraudulent claims for services and then split the proceeds. The overall loss to VA is approximately $499,000.

Individual Sentenced for Identity Theft Scheme

An individual was sentenced to 116 months' imprisonment, three years' supervised release, and was ordered to pay over $435,400 in restitution and $26,800 in forfeiture. An OIG, IRS-CI, and Tampa Police Department investigation revealed that the defendant illegally obtained numerous records maintained by the James A. Haley Veterans' Hospital in Tampa, Florida, containing personally identifiable information from at least 20 veterans, and proceeded to file fraudulent tax returns and open lines of credit in the victims' names.

Former East Orange, New Jersey, VA Medical Center Physician Sentenced for Fraud Scheme

A VA OIG, FBI, and HHS OIG investigation revealed that on more than 350 occasions between 2011 and 2015, the defendant submitted documentation to VA in which he claimed to have performed procedures that he had not actually conducted. The former VA physician, who was contracted to carry out medical procedures at the East Orange VA Medical Center on a fee basis, was sentenced to 20 months' imprisonment and 24 months' supervised release. The defendant was also ordered to pay restitution of approximately $238,000 to VA, an additional forfeiture of more than $238,000, and a fine of $7,500. As the result of a civil settlement, the defendant must pay an additional $476,460.



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FOR IMMEDIATE RELEASE — Tuesday, July 31, 2018

Cardiologist Gets 20 Months In Prison For Billing Veterans Affairs For Hundreds Of Bogus Medical Procedures

NEWARK, N.J. – A Somerset, New Jersey, man was sentenced today to 20 months in prison for defrauding the Veterans Affairs program by billing for services he never performed, U.S. Attorney Craig Carpenito announced.

Apostolos Voudouris, 44, previously pleaded guilty before U.S. District Judge William H. Walls in Newark federal court to an information charging him with health care fraud. Voudouris also entered into a civil settlement agreement with the government, under which he will pay $476,460 to resolve the government's claims under the False Claims Act.

According to the documents filed in the case and statements made in court:

Voudouris is a physician specializing in cardiology and electrophysiology. Beginning in 2006, Voudouris provided services to eligible veterans at the Veterans Affairs Medical Center in East Orange, New Jersey, pursuant to his contract with the Department of Veterans Affairs (VA). Voudouris admitted that on more than 350 occasions between 2011 and 2015, he submitted documentation to the VA claiming to have performed procedures he never performed. As a result, Voudouris fraudulently received $238,230 from the VA.

In addition to the prison term, Judge Walls sentenced Voudouris to two years of supervised release and fined him $7,500. As part of his plea agreement, Voudouris must pay restitution of $238,230 to the VA in addition to the $476,460 civil settlement, for a total of $714,690.

U.S. Attorney Carpenito credited special agents of the U.S. Department of Veterans Affairs, Office of Inspector General, Criminal Investigation Division, Northeast Field Office, under the direction of Special Agent in Charge Sean Smith; the U.S. Department of Health and Human Services – Office of the Inspector General, under the direction of Special Agent in Charge Scott J. Lampert, and the FBI, under the direction of Special Agent in Charge Gregory W. Ehrie in Newark, with the investigation.

The government is represented by Assistant U.S. Attorney Jacob T. Elberg of the U.S. Attorney's Office Criminal Division in Newark.

Defense counsel: Kristen Santillo Esq., Newark

Former Reno, Nevada, VA Medical Center Physician's Assistant and Nonveteran Sentenced for Conspiracy to Violate the Uniform Controlled Substance Act

A former Reno VA Medical Center Physician's Assistant (PA) and a nonveteran pled guilty to conspiracy to violate the *Uniform Controlled Substance Act*, P.L. 91-513. Both individuals were sentenced to suspended jail sentences of 34 months and 60 months' probation. An OIG, Reno Police Department, and Nevada Department of Public Safety investigation revealed that the former PA used his position at the facility to write more than 100

prescriptions for narcotics for personal use. The nonveteran then assisted with the submission and retrieval of the prescriptions from various commercial pharmacies in northern Nevada.

Veterans Benefits Administration Investigations

VBA implements a number of programs for eligible veterans and family members, including education, insurance, and monetary benefits, as well as VA guaranteed home loans. Investigations routinely concentrate on benefits provided to ineligible individuals. With respect to home loans, the OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. The OIG also investigates allegations of fraud committed by VA-appointed fiduciaries.

OIG's IT and Data Analysis Division, in coordination with OI, conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. 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 25 individuals, recoveries of $2.4 million, and a projected five-year savings to VA estimated at $5.8 million.

OI opened 178 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 96 arrests. OI obtained over $29.3 million in court-ordered fines, restitution, penalties, and civil judgements; achieved more than $59.3 million in savings, efficiencies, and cost avoidance; and recovered more than $4.9 million. The case summaries that follow provide a sample of the type of VBA investigations conducted during this reporting period.

Veteran Indicted for Bank Fraud, Wire Fraud, and Money Laundering

A veteran, who is a licensed attorney, was indicted and arrested on charges of bank fraud, wire fraud, and money laundering. A VA OIG, Small Business Administration (SBA) OIG, and FBI investigation resulted in charges alleging the defendant executed a scheme that involved the use of false information about his business and personal income to obtain a personal loan for $2.9 million from a federally insured bank. The defendant obtained the loan through VA's Home Loan Guaranty Program. Because the defendant failed to make the required monthly mortgage payments, the home is now in foreclosure. The defendant also provided false information about his law office's and personal income to secure a $250,000 business loan through SBA's loan guaranty program.

Owner of a Dog-Handling School Indicted for Charges Related to Education Benefits Fraud

An OIG, IRS-CI, and FBI investigation resulted in charges that allege the owner of a San Antonio-based dog-handling school fraudulently obtained VA approval to receive licensure to operate in the state by submitting multiple material false statements regarding its certifications and its on-staff instructors. Similarly, the owner submitted falsified certification materials to the State of Texas. The owner of the school was indicted for wire fraud, aggravated identity theft, and money laundering. The loss to VA is approximately $1.2 million in education benefits.

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

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

Veteran Convicted of Theft of Government Funds

A veteran was convicted of theft of government funds following a one-week trial. An OIG investigation revealed that over a 14-year time span, the defendant fraudulently received more than $538,000 in service-connected disability benefits for an eye disorder (granular corneal dystrophy). This investigation revealed that the defendant held a valid driver's license, frequently drove, operated heavy machinery (tractors), and performed routine tasks such as yard work while in receipt of VA benefits for bilateral blindness.

Veteran Sentenced for Wire Fraud

A veteran who previously pled guilty to wire fraud was sentenced to 36 months' imprisonment, 24 months' probation, and 200 hours of community service and was ordered to pay restitution of $362,933 to VA. An OIG investigation revealed that the defendant received a special monthly pension for the loss of use of both of his legs. During this investigation, the defendant was audibly and visually recorded in a wheelchair telling a VA examiner that he had not been able to walk in 10 years. The investigation revealed the defendant, a street gang member, showed no signs of disability and had numerous arrests in Chicago during the time frame in which he claimed to be unable to walk. Video surveillance evidence was obtained showing the defendant walking with no apparent difficulty.

Veteran Sentenced for Healthcare Fraud

A veteran was sentenced to six months' imprisonment, followed by six months of electronic monitoring during home detention, and three years' probation. The defendant also was ordered to pay restitution of over $244,000 to VA after previously pleading guilty to healthcare fraud. An OIG and FBI investigation revealed that the defendant used an altered DD-214 to report that he had 23 years of military service, including serving in combat during the Gulf War and Operation Iraqi Freedom. The investigation revealed that the defendant never left the United States during his two brief enlistments in the U.S. Army Reserves. The defendant falsely claimed to various VA healthcare professionals that while serving in Iraq, he was exposed to gunfire, witnessed other soldiers die, and was injured by an improvised explosive device. The defendant was subsequently awarded an 80-percent service-connected disability rating for multiple conditions, including posttraumatic stress disorder, but was paid at 100 percent due to Individual Unemployability. The defendant's former spouse was also paid over $40,000 in VA Caregiver Support Program payments.

Nonveteran Pled Guilty to Theft of Government Funds

A nonveteran pled guilty to theft of government funds following an OIG investigation that revealed he forged the certificate of release or discharge from active duty he submitted to VA, falsely claiming to have served in the U.S. Marine Corps during the Korean War and to have received the Purple Heart for being shot during a battle. The defendant received approximately $219,700 in VA pension and healthcare benefits over a 12-year period, to include attending a residential VA Blind Rehabilitation program with limited admissions.

Commercial Airline Pilots Indicted for False Statements

Four airline pilots were indicted in separate cases for making false statements to the Federal Aviation Administration (FAA). A VA OIG and Department of Transportation (DOT) OIG proactive investigation resulted in charges that allege each of the defendants submitted forms to the FAA that deny the existence of medical conditions for which each were receiving VA service-connected disability benefits. The cumulative potential loss to VA is $337,837.

Other Investigations

OI investigates a diverse array of criminal offenses in addition to those listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. 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 53 cases and made 20 arrests. These investigations resulted in over $30.1 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $15 million in savings, efficiencies, and cost avoidance.

Two Construction Companies and Six Individuals Charged in Conspiracy Scheme

A VA OIG, FBI, General Services Administration (GSA) OIG, SBA OIG, Defense Criminal Investigative Service (DCIS), DOT OIG, and U.S. Army Criminal Investigation Division (CID) investigation resulted in charges that allege construction companies used straw owners, who qualified as service-disabled veterans (or as socially and economically disadvantaged individuals) but did not actually control the companies, in order to gain contracts. A grand jury indicted two nonveterans and two construction companies allegedly involved in the conspiracy to commit wire fraud, mail fraud, misprision of felony, and money laundering. The scheme involved more than $190 million in VA contracts. In addition to this indictment, two veterans and two nonveterans were each charged with information (a formal criminal charge that begins court proceedings) for conspiracy and/or false statements.

Three Individuals Sentenced for Wire Fraud

The former owner of a private business, a past executive employee of that business, and a prior dean of a New Jersey university were sentenced after each pled guilty to conspiracy to commit wire fraud. A VA OIG, FBI, and Department of Education OIG investigation revealed that the defendants engaged in a conspiracy to defraud VA by fraudulently obtaining tuition assistance and other education-related benefits under the Post-9/11 GI Bill. The owner of the business was sentenced to five years' imprisonment and three years' supervised release. The remaining two defendants were both sentenced to three years' probation. All three were ordered to jointly pay restitution of approximately $24.2 million, which represents the amount VA paid to the school. Both the former business owner and dean had forfeiture judgments levied against them for approximately $700,000 each.

Healthcare Executive Sentenced for Role in Workers' Compensation Scheme

A healthcare executive was sentenced after being found guilty at trial of conspiracy, healthcare fraud, wire fraud, and money laundering relating to his and his co-defendants' ownership and operation of multiple Office of Workers' Compensation Program clinics throughout the United States. The defendant was sentenced to nineteen years and five months' incarceration, three years' probation, and was ordered to pay restitution of approximately $14.5 million. A VA OIG, U.S. Postal Service (USPS) OIG,

Department of Labor (DOL) OIG, Department of Homeland Security OIG, and IRS-CI investigation resulted in these defendants being charged with conspiring since January 2011 to bill multiple federal agencies for false and fraudulent claims and for services not rendered. The investigation also revealed that shortly after the execution of a federal search warrant on the business, two of the defendants laundered $700,000 in an attempt to conceal the money's location from law enforcement.

Former Government Contractor Sentenced for Role in Procurement Fraud Scheme

A former government contractor who illegally managed and controlled a Kansas City Service-Disabled Veteran-Owned Small Business (SDVOSB) construction company was sentenced to 18 months' imprisonment without parole and three years' supervised release for his role in a "Rent-A-Vet" scheme to fraudulently obtain $13.7 million in VA contracts for work in nine states. An OIG investigation, with assistance from the GSA OIG, revealed that the defendant used a veteran's service-disabled veteran status to create a "pass-through" company to obtain 20 set-aside SDVOSB and Veteran-Owned Small Business contracts. The work was then subcontracted to the defendant's non-SDVOSB company, which he owned. Sentencing is pending for the veteran. Both defendants also consented to a federal civil forfeiture of approximately $2.1 million.

Parking Services Company Owner Sentenced for Wire Fraud and Conspiracy to Commit Wire Fraud and Major Fraud against the United States

The owner of a parking services company was sentenced to 70 months' imprisonment, three years' supervised release, and ordered to pay restitution of over $12.5 million to the VA. An investigation by the VA OIG, FBI, and IRS-CI revealed that the defendant bribed a VA contracting officer with over $286,000 in cash in order to defraud VA of over $13 million between 2003 and 2017. The defendant had entered into a sharing agreement with VA that required the defendant to pay 60 percent of the collected gross parking revenue to VA. The defendant instead paid bribes to the contracting officer in order to continue the conspiracy even after the contracting officer retired from VA in 2014. The defendant also underreported income and overreported improvements to VA, which allowed him to keep over $13 million that was owed to VA.

Business Owner Pled Guilty to False Statements Related to VA's Service-Disabled Veteran-Owned Small Business Program

An OIG investigation resulted in charges that allege a veteran and another defendant conspired to defraud the government by forming a joint venture and falsely representing that the venture and another company qualified as SDVOSBs. The defendants fraudulently obtained approximately $11 million in VA-funded SDVOSB set-aside construction contracts or task orders. Four separate federal search warrants executed at various business locations yielded vital documents and information supporting the indictment of these defendants. As part of the guilty plea, the veteran and the government agreed to a 24-month deferment of judgment, 24 months' supervised release, and a payment of approximately $24,400, which is the amount the veteran claimed on his tax returns as payments he received from the government contracts. The veteran also agreed not to contest any administrative action, including suspension or debarment from procurement and non-procurement programs administered by any agency within the Executive Branch of the federal government

Thirty-Eight Individuals Charged in Education Benefits Conspiracy Scheme

Five principals of a trucking school were charged with conspiracy, grand theft, identity theft, forgery, false and fraudulent claims, preparing false evidence, and engaging in criminal profiteering activity for

their roles in enrolling at least 108 veterans who never attended or received training at the school. In addition, 33 veterans were charged with conspiracy, grand theft, and false and fraudulent claims. A VA OIG, FBI, and Department of Justice OIG investigation resulted in charges that allege the school officials and veterans conspired to defraud VA of over $4.3 million between 2011 and 2015. The school received inflated, unearned tuition and fees ranging from $5,000 to $13,000 per course, while the veterans received a housing allowance and a books-and-supplies stipend totaling over $2,000 per month.

Owner of a Massage and Digital Media School Pled Guilty to Bribery

The owner of a massage and digital media school approved for VA benefits under the Vocational Rehabilitation and Employment (VR&E) program pled guilty to bribery. An OIG and FBI investigation revealed that a VR&E counselor approached the defendant to propose that she open a school that would be approved by VA under the VR&E program. The VR&E counselor then steered veterans to the defendant's school and two other educational institutions approved to receive benefits under the program. The defendant obtained VR&E benefits by providing false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. The investigation revealed that enrolled veterans rarely, if ever, received instruction from school employees. In addition, the defendant made kickback payments to the VR&E counselor. The loss to VA is over $3 million.

Three Subjects Charged for Participating in a Compound Pharmacy Fraud Scheme

Three owners/controllers of multiple pharmacies were indicted for conspiring and engaging in a scheme to defraud the U.S. government and private healthcare insurance companies of more than $200 million across multiple states. A VA OIG, FBI, IRS-CI, DCIS, Mississippi Bureau of Narcotics, DOL OIG, HHS OIG, and U.S. Postal Inspection Service investigation resulted in charges that allege the defendants fraudulently formulated, marketed, prescribed, and billed for compound medications produced and dispensed by pharmacies in southern Mississippi. As a result of the fraudulent activity, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) paid these pharmacies approximately $2.4 million.

Thirteen Subjects Charged for Participating in a Workers' Compensation Scheme

Thirteen individuals were charged with variations of conspiracy and fraud offenses, as well as violations of the Anti-Kickback Statute, relating to their involvement in a scheme to defraud DOL's Office of Workers' Compensation Program. The defendants included doctors, pharmacists, marketers, pharmacy owners, and health clinic owners. A VA OIG, DOL OIG, USPS OIG, and DCIS investigation resulted in charges that allege since September 2014, the defendants conspired to unlawfully bill multiple federal agencies for services that were not medically necessary and for services that were induced by kickbacks and bribes. The loss to VA is currently $2.3 million, and the overall loss to the government is approximately $40 million.

Nonveteran Business Owner Sentenced for Wire Fraud and Money Laundering Scheme Related to VA's Service-Disabled Veteran-Owned Small Business Program

A nonveteran business owner who previously pled guilty to wire fraud and money laundering was sentenced to 24 months' imprisonment, 36 months' supervised release, and ordered to forfeit $640,000. A VA OIG investigation involving FBI, IRS-CI, DCIS, GSA OIG, SBA OIG, U.S. Army CID, and the Naval Criminal Investigative Service revealed that the defendant recruited his service-disabled veteran father-in-law to falsely claim majority ownership in his construction company in order to fraudulently

obtain SDVOSB status. As a result, this Utah-based company unlawfully obtained 11 SDVOSB set-aside contracts worth over $16.5 million, to include $1.9 million in VA contracts that the business was not entitled to receive.

Former Nonprofit Organization Executive Pled Guilty to Fraud Scheme

A former nonprofit organization executive pled guilty to misprision of a felony. A VA OIG, IRS-CI, FBI, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, HHS OIG, DOL OIG, and Medicaid Fraud Control Unit of the Missouri Attorney General's Office investigation revealed the defendant unjustly enriched himself and others through the nonprofit, which was contracted by VA to provide substance abuse counseling and housing for veterans. The defendant admitted that he knew executives conspired to embezzle, steal, and misapply millions of dollars in charity funds but did not inform the board of directors or law enforcement authorities. The defendant aided the conspirators in the preparation and submission of federal grant applications, which falsely certified the charity's compliance with restrictions on lobbying. The defendant acknowledged that he embezzled, stole, and misapplied funds totaling $4.3 million. From 2010 to 2016, the nonprofit's revenues were approximately $837 million, to include over $1.7 million contributed by VA.

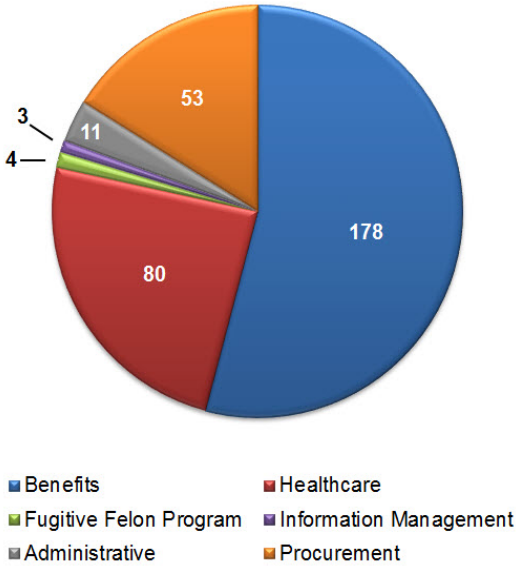

Figure 5. OI Investigations Opened during Reporting Period

Three Individuals Indicted for Scheme to Defraud Incompetent Veterans

A VA Community Residential Care (CRC) home sponsor and her adult son, along with a former CRC home sponsor, were each indicted and arrested for engaging in organized criminal activity. An OIG, Texas Department of Public Safety's Criminal Investigations Division, and Texas Office of the Attorney General investigation resulted in charges that allege the defendants convinced incompetent veterans that were placed in their CRC homes to create new wills that make the defendants the beneficiaries of the veterans' estates. These charges further allege that the defendants defrauded the veterans' estates of approximately $1.7 million.

Individual Sentenced for Healthcare Fraud Scheme

An individual who previously pled guilty to conspiracy to commit healthcare fraud was sentenced to 36 months' imprisonment, three years' supervised release, and was ordered to repay over $4.7 million in restitution to the government. Of this amount, approximately $655,000 will be paid to VA. A VA OIG, DCIS, Office of Personnel Management OIG, FBI, and HHS OIG investigation revealed that the defendant and three codefendants created a fraud scheme by which TRICARE and CHAMPVA were billed approximately $5 million for unnecessary lab testing. Sentencing of the other three defendants is pending.

Business Owner Sentenced for Role in Procurement Fraud Scheme

An OIG investigation revealed that the defendant recruited a service-disabled veteran to falsely claim majority ownership in his small business to fraudulently obtain SDVOSB status. As a result, the

defendant's Houston-based company unlawfully obtained 12 VA set-aside contracts valued at over $1.6 million. The company owner was sentenced to 12 months and one day of incarceration, two years' supervised release, and was ordered to pay approximately $450,000 in restitution to VA.

Assaults and Threats 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 15 individuals. Investigations resulted in $113,665 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Arrested for Making Threats against VA Employees, a U.S. Congresswoman, and Congressional Staff

A veteran was arrested in Oregon after allegedly threatening to kill at least five specific VA employees at the Palo Alto and San Francisco VA Medical Centers, as well as threatening to "end" a U.S. Congresswoman and kill members of her staff. The defendant also repeatedly "threatened to shoot all [African Americans] at the VA with a 1911 handgun." During March 2018, the defendant called various VA facilities in Northern California more than 600 times. The OIG was notified by the VA Police Service. The San Mateo Police Department subsequently requested OIG's assistance in locating the defendant. The OIG worked with the FBI to track the individual to a hotel along the border of Oregon and Washington. Once the defendant's location was confirmed, the Gresham Police Department arrested the defendant without incident.

Nonveteran Charged with Assault on a Federal Officer at the American Lake, Washington, VA Medical Center

A grand jury indicted a nonveteran on charges of assault on a federal officer and being a felon in possession of a firearm. An OIG, FBI, and VA Police Service investigation resulted in charges that allege the defendant, who is a convicted felon, was involved in a hit-and-run collision with VA Police Service officers at the American Lake VA Medical Center in Tacoma, Washington. One of the officers was injured in the collision. The suspect possessed a handgun at the time of the incident.

Veteran Arrested for Making Threats at the Wilmington, Delaware, VA Medical Center

A veteran was arrested on charges of threatening to assault a VA employee. An OIG investigation resulted in charges that allege the defendant gained access to the executive area of the Wilmington VA Medical Center while in possession of an axe and two knives. Upon subsequent medical evaluation at the medical facility, the defendant became violent and threatened VA personnel.

Fugitive Felons Arrested with OIG Assistance

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 78 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 147,518 investigative leads being referred to law enforcement agencies. Over 2,615 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has nearly $1.5 billion in estimated overpayments with cost avoidance of more than $1.9 billion. During this reporting period, OI identified $94.3 million in estimated overpayments.

Administrative Investigations

The OIG's Administrative Investigations Division independently reviews allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress and the Department. During this reporting period, the OIG opened 11 administrative investigations and closed four. The work resulted in the issuance of three reports, which are listed in Appendix A. Recommendations for corrective action resulting from these reports can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on the status and monetary impact of report recommendations published since October 2012.

The Division also conveys advisory memoranda to the Department when warranted by information gathered in the course of an investigation, but where findings do not give rise to formal report recommendations. During this reporting period, the Division did not issue any advisory memorandums.

Alleged Misuse of VA Position and Resources

The OIG investigated allegations that a senior manager at a VA medical facility abused that position and VA resources. The senior manager allegedly instructed a subordinate to provide the senior manager's family member with additional daily Home-Based Primary Care home nursing visits as well as additional fee-basis homemaker services. More specifically, the complainant alleged that the senior manager requested these services be provided to a family member while the senior manager was on vacation. The senior manager also allegedly misused the position when instructing subordinates to waive any additional copayments for services rendered to the family member. Finally, the complainant alleged that the senior manager's spouse acted as the senior manager's surrogate by requesting expedited scheduling with VA Choice Program physicians while self-identifying as the spouse of the senior manager. The OIG did not substantiate any of these allegations, so no recommendations were issued.

Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana

The VA OIG Administrative Investigations Division sustained an allegation that a Supervisory Industrial Engineer misused VA time and resources to start a privately owned business and solicited subordinate staff to join this business. The OIG found that the engineer, who worked within VHA's Office of Strategic Integration's Veterans Engineering Resource Center (VERC), used a VA email account to communicate with subordinate staff, criticize VERC restructuring, and propose they use their collective experience to create a company to offer services to outside organizations. The OIG found VA time and resources were misused to conduct non-VA business during and after official duty hours. At one point, 43 VA employees, most of whom have since left VA, were on the company roster. The OIG also found that the engineer misused his VA email on several occasions to manage multiple personally owned rental properties.

Alleged Misuse of Government-Owned Vehicles within the Long Island and Calverton National Cemeteries in New York

The OIG investigated an allegation that the Executive Director of the Florida National Cemetery improperly stored his personal vehicle in a garage on Long Island National Cemetery property after he transferred to Florida and asked subordinates to drive him in government vehicles to and from his residence on the Long Island National Cemetery property to the airport. The Executive Director of the Calverton National Cemetery also allegedly asked subordinates to drive him in government vehicles to and from his residence and the airport. Additionally, two employees allegedly misused VA resources by taking two government vehicles from New York to training in Virginia and one extended his travel to

sightsee with his spouse. The OIG did not substantiate any of these allegations, so no recommendations were issued.

Closed Senior Government Employee Criminal Investigations Not Disclosed to the Public

When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, there were no instances of previously undisclosed investigations of senior government officials that were closed or referred out after allegations were unsubstantiated.

Office of Management and Administration Activities

Overview

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations, including the Hotline for reporting fraud, waste, abuse, and other misconduct. The Coordination and Internal Controls Division coordinates training for nearly 900 employees to ensure personnel have the skills and expertise to effectively conduct their work. It oversees the internal controls program and proper records management. The Human Resources and Operations Division works to recruit and retain qualified and committed staff, conducts critical follow-up of OIG report recommendations to VA, prepares and disseminates published reports, and develops policies and procedures, among its many support functions. Data Analysis staff manage access to information requests, help identify fraud-related activities, and support OIG comprehensive initiatives. The Administrative and Financial Operations Division oversees such areas as employee travel, logistical coordination, purchase card coordination, and space and property management. Finally, the Budget Division provides a broad range of budgetary formulation and execution services to include making certain the OIG properly targets and executes its spending plans to the greatest effect. Together, these divisions ensure the efficiency and effectiveness of activities OIG-wide to best serve veterans and their families.

Oversight Activities

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

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

- Received and screened 18,772 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 1,005 cases to and required a written response from applicable VA offices after determining that allegations pertained to higher-risk topics; however, insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 564 non-case referrals to appropriate VA offices after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 1,160 cases for which nearly 40 percent of allegations were substantiated, over 737 administrative sanctions and corrective actions were taken, and nearly $1.2 million in monetary benefits were achieved
- Responded to more than 498 requests for record reviews from VA staff offices

Examples of Hotline Cases

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

Veteran Out-of-Pocket Expenses for Veterans Choice Program Care

The OIG Hotline referred a case to the VA Office of Community Care (OCC) after it was reported that a veteran paid out-of-pocket for care authorized by the Choice Program. VA OCC determined that an authorization for care was in place but that the provider had no contractual agreement with Health Net for providing Choice Program care. As a result, the provider required the veteran to sign a self-pay contract. The Department determined that the provider's stance was well documented, and that Health Net should not have authorized care. VA, the provider, and Health Net worked to find a solution, and the veteran was reimbursed the full $25,000 previously paid to the provider.

Provider Payment Issue

After receiving allegations that a chiropractor had yet to receive payment for treating veterans, the OIG Hotline referred a case to the VA OCC. Despite numerous attempts, the provider had been unable to achieve resolution during the previous 13 months. The VA contacted Health Net on behalf of the provider and Health Net found that the original payment, sent to the provider months prior, had never cleared the system. As a result, Health Net cancelled the initial check, reissued payment, and confirmed receipt with the provider.

Dependency and Indemnity Compensation Benefits Fraud

The OIG Hotline sent a case to the Pension Management Center (PMC) based on allegations that a widower was collecting Dependency and Indemnity Compensation benefits despite being remarried. After providing the veteran spouse appropriate due process, PMC terminated the benefit effective January 1, 2012, the alleged date of remarriage, and initiated an overpayment of approximately $94,100.

Disability Benefits Fraud

OIG's Hotline referred a case to VBA regarding a veteran, incarcerated since 1999, who was allegedly receiving full benefits instead of 10 percent of the entitlement as required by law. It was further alleged that doctors in both Florida and California were complicit in the wrongdoing. The VA determined that the veteran's pension benefits were rightfully terminated in 2004 for the period covering 2002 to 2010, but he was erroneously granted compensation benefits, at the reduced rate, from 2010 to present. As such, the Department initiated an overpayment of $46,200.

Missing Retroactive Disability Payment

OIG's Hotline referred a case to the Winston-Salem VA Regional Office regarding a $4,100 disability check that was deposited to the wrong account. Upon review, the VA Regional Office confirmed that the payment had been erroneously sent to another veteran's account and promptly reissued payment to the correct veteran.

Office of Contract Review Activities

Overview

The Office of Contract Review provides VA's Office of Acquisition, Logistics, and Construction (OALC) with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for OALC contracting activities. The OIG completed 81 reviews in this reporting period and the tables that follow provide an overview of the Office of Contract Review's performance.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Sixty-three preaward reviews identified nearly $258.7 million in potential cost savings during this reporting period.

In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included 16 healthcare provider proposals, accounting for approximately $25.8 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2017–March 31, 2018	44	$532,881,003
April 1–September 30, 2018	63	$258,663,861
Fiscal Year	**107**	**$791,544,864**

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 $7.5 million, including approximately $5.1 million related to the *Veterans Health Care Act*, compliance with pricing requirements, recalculation of federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 14 postaward reviews performed, nine involved voluntary disclosures. In seven of the nine voluntary disclosure reviews, the OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2017–March 31, 2018	21	$9,057,782
April 1–September 30, 2018	14	$7,534,921
Fiscal Year	**35**	**$16,592,703**

Claim Reviews

The OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, the OIG reviewed four

claims and determined that approximately $2.6 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2017–March 31, 2018	2	$2,201,806
April 1–September 30, 2018	4	$2,649,254
Fiscal Year	**6**	**$4,851,060**

Inspector General Act Reporting Requirements Not Elsewhere Reported

Peer and Qualitative Assessment Reviews

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

The Act also requires OIGs to report the results of any peer review they conducted of another OIG's audit operations during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period. VA OIG completed a generally accepted government auditing standards external peer review of the Social Security Administration (SSA) OIG during this reporting period. The VA OIG issued a final report on August 8, 2018, and determined that SSA OIG was in compliance with the quality standards established by the Council of the Inspectors General on Integrity and Efficiency.

False Claims Act Settlements

For this reporting period, the Counselor to the IG's Office, independent of OI, recovered over $3 million from a settlement agreement filed under the *qui tam* provisions of the *False Claims Act*, P.L. 97-258.

Government Contractor Audit Findings

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each IG appointed under the *Inspector General Act of 1978*, as amended, to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the SAR. During this reporting period, the OIG did not issue any reports meeting these requirements.

OIG Reviews of Proposed Legislation and Regulations

The OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, the OIG reviewed 79 proposals and made four comments.

Refusals to Provide Information or Assistance

The *Inspector General Act of 1978*, as amended, authorizes the OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to OIG in the Act. The OIG is required to provide a summary of instances when such information or assistance is refused.

During this reporting period, Department leadership resisted OIG requests to obtain access to the complaint database maintained by the Office of Accountability and Whistleblower Protection (OAWP). OIG staff first requested access to the records through OAWP staff beginning in November 2017. Such requests continued to be made through May 2018. No access was provided. In June 2018, the IG sent

a request directly to the Acting Secretary to obtain access to this information. The Acting Secretary refused to provide the requested access. During June and July 2018, numerous communications on this topic occurred between the IG and his staff and the Acting Secretary and VA General Counsel. OIG staff briefed the staff of the congressional committees of jurisdiction on the matter. In mid-July, following the Acting Secretary's testimony before the House Committee on Veterans' Affairs, in which members of the Committee raised the access issue, the General Counsel informed the OIG that access to the database would be provided. The OIG obtained the requested access on or about July 12, 2018.

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

The *Inspector General Act of 1978*, as amended, also requires the OIG to report instances in which VA imposes budget constraints designed to limit OIG capabilities. Additionally, the Act requires the OIG to report incidents in which VA has resisted OIG oversight or delayed OIG access to information. In connection with the dispute over access to the OAWP complaint database described above, the Acting Secretary sought to interfere with the independence of the OIG. In correspondence with the IG, the Acting Secretary asserted without citing specific cases that the OIG had failed to adhere to CIGIE standards of professional care and alleged that the IG "appear[s] to misunderstand the independent nature of [his] role" and that "in your specific case as the VA Inspector General, I am your immediate supervisor. You are directed to act accordingly." Whatever the intent of this statement, it did not impair the OIG's independent oversight of VA.

Instances of Whistleblower Retaliation

The *Inspector General Act of 1978*, as amended, requires the OIG to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires the OIG to detail the consequences imposed by the Department to hold the official accountable. However, the OIG's current practice is to forward allegations of whistleblower reprisal to the Office of Special Counsel. As a result, the OIG has no information responsive to this requirement to report.

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

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

Employee Recognition of Military Personnel

OIG Employees Currently Serving or Returning from Active Military Duty

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

- Matthew Clark, Auditor in Dallas, Texas, returned from duty in September 2018.

- Wessley Dumas, Criminal Investigator in Little Rock, Arkansas, returned from duty in May 2018.
- Dana Epperson, Special Agent in Seattle, Washington, returned from duty in October 2018.
- George Kurtzer, Information Technology Specialist in Hines, Illinois, was activated by the Department of the Air Force in May 2018.
- John Moore, Program Specialist in Washington, D.C., returned from duty in October 2018.
- Trevor Rogers, Management and Program Analyst in Decatur, Georgia, was activated by the Department of the Army in March 2018.
- Randall Snow, Supervisory Health System Specialist in Arlington, Virginia, was activated by the Department of the Air Force in April 2018.
- Thea Sullivan, Health Systems Specialist in Decatur, Georgia, was activated by the Army National Guard in April 2018.

2018 Council of the Inspectors General for Integrity and Efficiency Award Recipients

VA OIG staff were recognized by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) for these outstanding accomplishments:

- A cross-directorate team that worked on the *VA Secretary and Delegation Travel to Europe* report was awarded the Gaston L. Gianni, Jr. Better Government Award in recognition of its highly scrutinized ethics investigation of the then VA Secretary's travel. The investigation resulted in leadership changes, employee retraining, and recovery of taxpayer dollars.
- A multiagency team was recognized with an Award for Excellence in Investigations for its efforts in identifying more than $100 million in Service-Disabled, Veteran-Owned Small Business fraud.
- The team that produced the *Audit of Veteran Wait Time Data, Choice, Access, and Consult Management in VISN 15* was selected for an Award for Excellence in Audit.
- The individuals engaged in the *Audit of Management of Primary Care Panels* also won an Award for Excellence in Audit.

The Gaston L. Gianni, Jr. Better Government Award recognizes the efforts, accomplishments, or actions of an individual or group that demonstrate courage, determination, and integrity and that enhance the public's confidence in and exemplify the highest ideals of government service.

Awards for Excellence are given in recognition of individual or group achievements that are substantive; meaningful to an individual agency or across the OIG community; and illustrate a high level of skill, dedication, and impact in the named category.

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

Presidential Rank Award Recipient

The VA OIG proudly recognizes that Dr. John D. "David" Daigh, Jr., has been awarded the FY 2018 Presidential Distinguished Rank Award. The Presidential Rank Award is one of the most prestigious awards conferred to the career Senior Executive Service (SES) by the President of the United States. The higher of two award categories presented annually, the Distinguished Rank Award recognizes extraordinary achievements by career executives in federal service. In addition to effecting meaningful change, nominees must demonstrate the highest level of leadership acumen. Only one percent of the career SES may receive this rank.

Dr. Daigh has been the Assistant Inspector General for the VA OIG's Office of Healthcare Inspections since 2004. Dr. Daigh directs more than 174 physicians, nurses, psychologists, statisticians, and inspectors. During his VA OIG tenure, he has championed vital oversight of the Veterans Health Administration (VHA), the nation's largest integrated healthcare system. As a board-certified neurologist, certified public accountant, engineer, and retired Army Colonel, Dr. Daigh has brought extraordinary expertise to OIG's healthcare oversight of VHA. Dr. Daigh has published more than 1,600 reports, delivered testimony at more than a dozen congressional hearings, and conducted hundreds of briefings on issues that affect how veterans can access and receive quality care, including evaluations of the following:

- Mental health care, including crisis intervention services, prompting VA to establish the Veterans Crisis Line
- Medical programs for patients with substance use disorders, including helping VA to institute national guidelines on narcotics for pain management
- The needs of women veterans who have suffered combat stress or been subject to military sexual trauma, now receiving greater consideration by VA
- Processes for identifying veterans who required timely medical care that could best be provided by non-VA providers because of access limitations within the VA system of care
- How VA hospital "business practices" that are often deprioritized, such as inventory management and patient scheduling systems, deeply impact patient care
- Adequacy of emergency care for veterans presenting with stroke symptoms, prompting VA to make nationwide changes to its stroke protocols
- The examinations for traumatic brain injury by qualified professionals to make fair and consistent decisions about veterans' benefits

Dr. Daigh's work has resulted in improvements to VHA healthcare that has, and will continue to benefit, the more than 9 million enrolled patients who access that system.

Appendix A: Reports Issued during the Reporting Period

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

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

Report Information	Better Use of Funds	Questioned Costs
VA's Federal Information Security Modernization Act Audit for Fiscal Year 2017 *Issued 4/11/2018 | Report Number 17-01257-136*		
Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact *Issued 5/2/2018 | Report Number 16-04555-138*		$11,700,000
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	$150,600,000	$23,229,000
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017 *Issued 5/15/2018 | Report Number 17-05460-169*		
FY 2017 Risk Assessment of VA's Charge Card Programs *Issued 6/26/2018 | Report Number 17-03801-204*		
VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics *Issued 6/27/2018 | Report Number 16-02247-165*		$242,000
Alleged Split Purchases at the VA St. Louis Health Care System *Issued 7/17/2018 | Report Number 16-02863-199*		$564,000
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*		$100,600,000
Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed *Issued 8/16/2018 | Report Number 17-04003-222*		$41,572,912
Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits *Issued 8/21/2018 | Report Number 17-04919-210*		$72,500,000
Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma *Issued 8/21/2018 | Report Number 17-05248-241*		
Use of Not Otherwise Classified Codes for Prosthetic Limb Components *Issued 8/27/2018 | Report Number 16-01913-223*	$13,600,000	$7,700,000

Report Information	Better Use of Funds	Questioned Costs
Accuracy of Effective Dates for Reduced Evaluations Needs Improvement *Issued 8/29/2018 | Report Number 17-05244-226*		$37,900,000
Bulk Payments Made under Patient-Centered Community Care/ Veterans Choice Program Contracts *Issued 9/6/2018 | Report Number 17-02713-231*		$101,400,000
Review of Accuracy of Reported Pending Disability Claims Backlog Statistics *Issued 9/10/2018 | Report Number 16-02103-265*		
VA Policy for Administering Traumatic Brain Injury Examinations *Issued 9/10/2018 | Report Number 16-04558-249*		
Leasing Procedures Used to Acquire VA's Wilmington Health Care Center *Issued 9/12/2018 | Report Number 16-04658-250*		
Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina *Issued 9/20/2018 | Report Number 17-05228-279*		
Timeliness of Final Competency Determinations *Issued 9/28/2018 | Report Number 17-05535-292*		
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*		
Total Monetary Impact	**$164,200,000**	**$397,407,912**

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

Comprehensive Healthcare Inspection Program Reviews
VA Puget Sound Health Care System, Seattle, Washington *Issued 5/8/2018 | Report Number 18-00334-164*
William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina *Issued 5/17/2018 | Report Number 18-00412-173*
VA Sierra Nevada Health Care System, Reno, Nevada *Issued 5/17/2018 | Report Number 18-00605-174*
Cincinnati VA Medical Center, Ohio *Issued 5/23/2018 | Report Number 17-05398-172*
Phoenix VA Health Care System, Arizona *Issued 6/5/2018 | Report Number 18-00611-180*
Memphis VA Medical Center, Tennessee *Issued 6/19/2018 | Report Number 18-00609-185*

VA Hudson Valley Health Care System, Montrose, New York
Issued 6/26/2018 | Report Number 17-05399-194

VA San Diego Healthcare System, California
Issued 7/11/2018 | Report Number 18-00616-212

VA Palo Alto Health Care System, California
Issued 7/31/2018 | Report Number 18-00617-227

Tomah VA Medical Center, Wisconsin
Issued 8/9/2018 | Report Number 17-05400-246

Chillicothe VA Medical Center, Ohio
Issued 8/9/2018 | Report Number 18-01012-228

Beckley VA Medical Center, West Virginia
Issued 8/13/2018 | Report Number 17-05401-240

Dayton VA Medical Center, Ohio
Issued 8/14/2018 | Report Number 18-00619-242

VA Ann Arbor Healthcare System, Michigan
Issued 8/14/2018 | Report Number 18-00621-245

Erie VA Medical Center, Pennsylvania
Issued 8/20/2018 | Report Number 18-00618-261

Ralph H. Johnson VA Medical Center, Charleston, South Carolina
Issued 8/22/2018 | Report Number 18-00600-259

John J. Pershing VA Medical Center, Poplar Bluff, Missouri
Issued 8/22/2018 | Report Number 18-01011-253

VA St. Louis Health Care System, Missouri
Issued 8/23/2018 | Report Number 18-00612-260

Bay Pines VA Healthcare System, Florida
Issued 8/28/2018 | Report Number 17-01857-264

Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
Issued 8/30/2018 | Report Number 18-01013-263

Gulf Coast Veterans Health Care System, Biloxi, Mississippi
Issued 9/11/2018 | Report Number 18-00608-247

Battle Creek VA Medical Center, Michigan
Issued 9/12/2018 | Report Number 18-01139-267

Roseburg VA Health Care System, Oregon
Issued 9/17/2018 | Report Number 18-00620-277

Northport VA Medical Center, New York
Issued 9/18/2018 | Report Number 18-01018-281

Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
Issued 9/18/2018 | Report Number 18-00613-275

Oklahoma City VA Health Care System, Oklahoma
Issued 9/27/2018 | Report Number 18-01141-309

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

Issued 9/27/2018 | Report Number 18-01143-302

National Healthcare Reviews

Testosterone Replacement Therapy Initiation and Follow-Up Evaluation in VA Male Patients

Issued 4/11/2018 | Report Number 15-03215-154

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018

Issued 6/14/2018 | Report Number 18-01693-196

Review of Pain Management Services in Veterans Health Administration Facilities

Issued 9/17/2018 | Report Number 16-00538-282

Hotline Healthcare Inspections

Clinical and Administrative Concerns Related to the Podiatry Department, Lexington VA Medical Center, Kentucky

Issued 5/9/2018 | Report Number 17-05440-167

Follow-up to Clinical and Administrative Concerns at the Cincinnati VA Medical Center, Ohio

Issued 5/23/2018 | Report Number 17-05398-177

Colorectal Cancer Screening, Timely Colonoscopies, and Physician Coverage in the Intensive Care Unit at the James H. Quillen VA Medical Center, Mountain Home, Tennessee

Issued 5/31/2018 | Report Number 16-02940-183

Alleged Mismanagement of Inpatient Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas

Issued 6/18/2018 | Report Number 17-02484-189

Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility

Issued 7/2/2018 | Report Number 17-04354-187

Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania

Issued 7/5/2018 | Report Number 16-00284-214

Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility

Issued 7/5/2018 | Report Number 16-05323-200

Delays in Urological Care and Alleged Lack of Non-VA Care Funding at the Beckley VA Medical Center, West Virginia

Issued 7/10/2018 | Report Number 17-05432-217

Supervision and Care of a Residential Treatment Program Patient at a Veterans Integrated Service Network 10 Medical Facility

Issued 7/12/2018 | Report Number 16-03137-208

Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin

Issued 8/1/2018 | Report Number 17-02643-239

Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics

Issued 8/14/2018 | Report Number 18-04633-254

Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia

Issued 8/16/2018 | Report Number 17-05381-258

Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York *Issued 8/29/2018 | Report Number 17-01770-188*
Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York *Issued 9/12/2018 | Report Number 17-01823-287*
Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio *Issued 9/12/2018 | Report Number 17-04569-262*
Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia *Issued 9/13/2018 | Report Number 17-02679-283*
Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-285*
Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-290*
Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-293*
Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio *Issued 9/20/2018 | Report Number 17-03382-294*
Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky *Issued 9/20/2018 | Report Number 18-01963-284*
Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota *Issued 9/25/2018 | Report Number 18-02875-305*
Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware *Issued 9/27/2018 | Report Number 17-03676-307*
Quality of Care Concerns Regarding a Patient Who had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan *Issued 9/27/2018 | Report Number 17-04875-308*

Table 3. List of Reports Issued by the Office of Investigations

Administrative Investigations
Alleged Misuse of VA Position and Resources *Issued 6/13/2018 | Report Number 17-03802-197*
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*
Alleged Misuse of Government-Owned Vehicles within the Long Island and Calverton National Cemeteries in New York *Issued 9/26/2018 | Report Number 18-00884-251*

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

Report Information	Savings and Cost Avoidance
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 4/3/2018 | Report Number 18-01620-151*	$729,299
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 4/3/2018 | Report Number 18-01697-152*	$3,098,360
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/5/2018 | Report Number 17-04149-155*	$43,079,180
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/5/2018 | Report Number 18-02368-153*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/11/2018 | Report Number 18-03044-160*	
Review of Proposal Submitted Under a Solicitation *Issued 4/11/2018 | Report Number 17-05827-156*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/12/2018 | Report Number 18-02625-158*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/16/2018 | Report Number 18-01044-159*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 4/17/2018 | Report Number 18-00703-157*	$45,967,554
Review of Request for Modification – Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 4/17/2018 | Report Number 18-01694-161*	
Review of Proposal Submitted Under a Solicitation *Issued 4/18/2018 | Report Number 17-05935-162*	
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 4/18/2018 | Report Number 18-00755-163*	$4,367,250
Review of Proposal Submitted Under a Solicitation *Issued 4/27/2018 | Report Number 18-01958-166*	$1,640,398
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/4/2018 | Report Number 18-01042-168*	$24,963
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/4/2018 | Report Number 18-02169-170*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/7/2018 | Report Number 18-03244-171*	$15,669,801
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/8/2018 | Report Number 18-02182-175*	$30,166,900
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/15/2018 | Report Number 18-02151-176*	$2,654,631
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/15/2018 | Report Number 18-03415-178*	

Report Information	Savings and Cost Avoidance
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 5/23/2018 | Report Number 18-00380-181*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 5/24/2018 | Report Number 17-04280-184*	$11,097,606
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 6/5/2018 | Report Number 18-00336-193*	
Review of Proposal Submitted Under a Solicitation *Issued 6/5/2018 | Report Number 18-03004-190*	$1,594,770
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 6/7/2018 | Report Number 18-03125-198*	$7,510,120
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 6/20/2018 | Report Number 18-01284-202*	$4,297,090
Review of Proposal Submitted Under a Solicitation *Issued 6/21/2018 | Report Number 18-04173-203*	$1,224,074
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 6/25/2018 | Report Number 18-03130-215*	$6,855,846
Review of Request for Modification – Product Additions Submitted Under a Contract *Issued 6/25/2018 | Report Number 18-03355-207*	$565,725
Review of Proposal Submitted Under a Solicitation *Issued 6/25/2018 | Report Number 18-04346-211*	$881,894
Review of Proposal Submitted Under a Solicitation *Issued 6/25/2018 | Report Number 18-04347-205*	$2,013,641
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 6/26/2018 | Report Number 18-01750-216*	$6,277,350
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 6/28/2018 | Report Number 18-02337-209*	
Review of Contract Extension Proposal and Request for Modification – Product Additions, Submitted Under a Federal Supply Schedule Contract *Issued 6/28/2018 | Report Number 18-03167-218*	$2,799,030
Review of Contract Extension Proposal and Request for Modification – Product Additions, Submitted Under a Federal Supply Schedule Contract *Issued 6/28/2018 | Report Number 18-03165-219*	$6,086,950
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 7/3/2018 | Report Number 18-03590-220*	
Review of Proposal Submitted Under a Solicitation *Issued 7/5/2018 | Report Number 18-04825-224*	$1,530,731
Review of Proposal Submitted Under a Solicitation *Issued 7/11/2018 | Report Number 18-04450-225*	$31,703
Review of Proposal Submitted Under a Solicitation *Issued 7/12/2018 | Report Number 18-04672-230*	$1,565,053

Report Information	Savings and Cost Avoidance
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 7/17/2018 | Report Number 18-03388-233*	$1,149,037
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 7/17/2018 | Report Number 18-04563-235*	
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 7/19/2018 | Report Number 18-02686-237*	$16,435,580
Review of Request for Modification – Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 7/23/2018 | Report Number 18-04565-238*	
Review of Proposal Submitted Under a Solicitation *Issued 7/23/2018 | Report Number 18-05048-236*	$5,650,831
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 7/30/2018 | Report Number 18-02682-244*	$749,980
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 7/31/2018 | Report Number 18-02917-252*	$667,900
Review of Proposal Submitted Under a Solicitation *Issued 8/2/2018 | Report Number 18-02575-243*	$2,561,774
Review of Proposal Submitted Under Solicitation *Issued 8/2/2018 | Report Number 18-02576-248*	$1,068,196
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 8/6/2018 | Report Number 18-03902-256*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 8/9/2018 | Report Number 18-03579-257*	$2,509,291
Review of Proposal Submitted Under a Solicitation *Issued 8/17/2018 | Report Number 18-05200-272*	$799,985
Review of Proposal Submitted Under a Solicitation *Issued 8/17/2018 | Report Number 18-05247-270*	$57,545
Review of Contract Extension Proposal Under a Federal Supply Schedule Contract *Issued 8/21/2018 | Report Number 18-03477-278*	$3,182,794
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 8/22/2018 | Report Number 18-03898-280*	$115,360
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 8/30/2018 | Report Number 18-04945-286*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 9/5/2018 | Report Number 18-02378-229*	
Review of Proposal Submitted Under a Solicitation *Issued 9/6/2018 | Report Number 18-05402-288*	$1,697,149
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 9/12/2018 | Report Number 18-03984-298*	$219,200
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 9/12/2018 | Report Number 17-04279-295*	

Report Information	Savings and Cost Avoidance
Review of Proposal Submitted Under a Solicitation *Issued 9/12/2018 | Report Number 18-01413-299*	
Review of Proposal Submitted Under a Solicitation *Issued 9/14/2018 | Report Number 18-05540-297*	$3,462,860
Review of Request for Modification – Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 9/14/2018 | Report Number 18-03172-303*	
Review of Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 9/19/2018 | Report Number 18-05327-304*	
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 9/26/2018 | Report Number 18-04566-310*	$16,606,460
Total Monetary Impact	**$258,663,861**

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

Report Information	Dollar Recoveries
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 5/29/2018 | Report Number 18-00169-186*	$83,638
Review of Compliance with Public Law 102-585, Section 603, Under a Federal Supply Schedule Contract *Issued 6/4/2018 | Report Number 18-00902-191*	$1,160,734
Review of Compliance with Public Law 102-585, Section 603, Under a Federal Supply Schedule Contract *Issued 6/6/2018 | Report Number 18-02584-195*	$1,529
Review of Compliance with Public Law 102-585, Section 603, Under a Federal Supply Schedule Contract *Issued 6/14/2018 | Report Number 18-02580-192*	
Review of Disclosure of Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 7/11/2018 | Report Number 18-00930-206*	$8,367
Review of Voluntary Disclosure of Price Reduction Errors Under a Federal Supply Schedule Contract *Issued 7/13/2018 | Report Number 18-01216-232*	$221,464
Review of Overcharge Analysis Under a Federal Supply Schedule Contract *Issued 8/15/2018 | Report Number 18-03501-269*	$29,403
Review of Voluntary Disclosure of Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 8/17/2018 | Report Number 17-01027-268*	$46,247
Review of Compliance with Public Law 102-585, Section 603, Under an Interim Agreement and Federal Supply Schedule Contract *Issued 8/17/2018 | Report Number 17-01028-274*	$310,576

Report Information	Dollar Recoveries
Review of Voluntary Disclosure of Price Reductions and Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 8/17/2018 | Report Number 18-01206-273*	$3,070,266
Review of Voluntary Disclosure of Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 8/17/2018 | Report Number 18-03880-255*	$51,086
Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 8/17/2018 | Report Number 18-03243-276*	$31,912
Review of Request for Price Increases Under a Federal Supply Schedule Contract *Issued 9/11/2018 | Report Number 15-02017-296*	$2,018,549
Review of Voluntary Disclosure of Price Reductions and Public Law Pricing Errors Under a Federal Supply Schedule Contract *Issued 9/20/2018 | Report Number 17-01447-306*	$501,150
Total Monetary Impact	**$7,534,921**

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

Report Information	Savings and Cost Avoidance
Review of Overhead Rate Proposal Submitted Under a Solicitation *Issued 6/26/2018 | Report Number 18-03383-213*	
Limited Review of Certified Claim Under a Lease Contract *Issued 7/9/2018 | Report Number 18-03155-221*	
Review of Certified Claim Submitted Under a VA Contract *Issued 9/5/2018 | Report Number 18-02739-289*	$2,028,880
Review of Certified Claim Submitted Under a VA Contract *Issued 9/26/2018 | Report Number 18-03414-311*	$620,374
Total Monetary Impact	**$2,649,254**

Table 7. Total Potential Monetary Benefits of Reports Issued

Report Type	Better Use of Funds	Questioned Costs	Savings and Cost Avoidance	Dollar Recoveries
Audits and Reviews	$164,200,000	$397,407,912		
Preaward Reviews			$258,663,861	
Postaward Reviews				$7,534,921
Claim Reviews			$2,649,254	
Subtotals	**$164,200,000**	**$397,407,912**	**$261,313,115**	**$7,534,921**
Total				**$830,455,948**

Table 8. Resolution Status of Reports with Questioned Costs

Resolution Status	Number	Dollar Value
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	10	$397,407,912
Total inventory this period	**10**	**$397,407,912**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	10	$397,407,912
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**10**	**$397,407,912**
Total carried over to next period	**0**	**$0**

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

Resolution Status	Number	Dollar Value
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	2	$164,200,000
Total inventory this period	**2**	**$164,200,000**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$164,200,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**2**	**$164,200,000**
Total carried over to next period	**0**	**$0**

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

Appendix B: Unimplemented Reports and Recommendations

The follow-up reporting and tracking of OIG report 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 an OIG's report within 12 months of its issuance/publication. If the agency fails to complete final action within the 12-month period, the OIG is required to identify the matter in each *Semiannual Report to Congress* until final action on the management decision is completed.

Tables 1 and 2, respectively, identify the number of open OIG reports and recommendations with results sorted by action office. Table 3 provides a list of the reports and recommendations that have been open less than one year. Table 4, in contrast, identifies the reports and recommendations that remain open for more than one year. All figures in the tables are current as of September 30, 2018. OIG recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig. Information is available there on monetary impact and the implementation status of report recommendations published since October 2012.

Table 1. Number of Unimplemented OIG Reports by VA Office

Table 1 identifies the number of OIG reports with at least one unimplemented recommendation with results sorted by action office. As of September 30, 2018, there are 163 total open reports. However, Table 1 shows a total of 170 open reports. This is because seven reports are counted twice in Table 1, as they have open recommendations at more than one office. Two of the seven reports have been open more than 1 year, while the remaining five reports have been open less than 1 year.

VA Action Office	Open More Than 1 Year	Open Less Than 1 Year	Total Open
Veterans Health Administration	29	109	138
Veterans Benefits Administration	4	12	16
Office of Acquisition, Logistics, and Construction	0	2	2
Office of Management (OM)	1	1	2
Office of Information and Technology (OIT)	3	3	6
Office of Human Resources and Administration (OHRA)	1	0	1
Office of Operations, Security, and Preparedness (OSP)	1	1	2
Office of General Counsel (OGC)	1	1	2
Office of the Secretary (OSVA)	0	1	1
Totals	**40**	**130**	**170**

Table 2. Number of Unimplemented OIG Recommendations by VA Office

Table 2 identifies the number of open OIG recommendations with results sorted by action office. As of September 30, 2018, there are 686 total open recommendations. However, Table 2 shows a total of 694 open recommendations. This is because eight recommendations are counted twice in Table 2, as they have actions pending at more than one office. Two of the eight recommendations have been open more than 1 year, while the remaining six recommendations have been open less than 1 year.

VA Action Office	Open More Than 1 Year	Open Less Than 1 Year	Total Open
Veterans Health Administration	62	517	579
Veterans Benefits Administration	5	34	39
Office of Acquisition, Logistics, and Construction	0	4	4
Office of Management (OM)	1	21	22
Office of Information and Technology (OIT)	3	29	32
Office of Human Resources and Administration (OHRA)	2	0	2
Office of Operations, Security, and Preparedness (OSP)	1	8	9
Office of General Counsel (OGC)	1	1	2
Office of the Secretary (OSVA)	0	5	5
Totals	**75**	**619**	**694**

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

Table 3 identifies the 125 reports and 613 recommendations that, as of September 30, 2018, have been open less than one year. The total monetary benefit attached to these reports is $1,443,510,957.

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Review of Potential Misuse of Purchase Cards at Veterans Integrated Service Network 15 *Issued 10/26/2017 | Report Number 15-05519-377*	VHA	3	
Audit of the National Pension Call Center *Issued 11/1/2017 | Report Number 16-03922-392*	VBA	2, 6	
Healthcare Inspection – Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma *Issued 11/2/2017 | Report Number 16-02676-13*	VHA	7, 18, 19, 21, 23, 24	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor Healthcare System, Ann Arbor, Michigan *Issued 11/7/2017 | Report Number 17-01208-07*	VHA	6	
Audit of VA's Compliance With the DATA Act *Issued 11/8/2017 | Report Number 17-02811-21*	OM	1-21	
Healthcare Inspection – Unexpected Death of a Patient: Alleged Methadone Overdose, Grand Junction VA Health Care System, Grand Junction, Colorado *Issued 11/30/2017 | Report Number 16-04208-30*	VHA	3	
Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia *Issued 12/5/2017 | Report Number 17-00397-364*	VBA	2	
Audit of Management of Primary Care Panels *Issued 12/6/2017 | Report Number 15-03364-380*	VHA	1, 3	$843,000,000
Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center, Bath, New York *Issued 12/7/2017 | Report Number 17-01752-32*	VHA	2, 10	
Comprehensive Healthcare Inspection Program Review of the VA Eastern Kansas Health Care System, Topeka, Kansas *Issued 12/7/2017 | Report Number 17-01850-38*	VHA	2, 4, 5	
Review of Alleged Mismanagement of the Real Time Location System Project *Issued 12/19/2017 | Report Number 15-05447-383*	VHA OIT	VHA: 1, 2 OIT: 1, 2	
Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	1-7	$39,000,000
Healthcare Inspection – Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility *Issued 1/4/2018 | Report Number 16-03576-53*	VHA	2, 6, 11	
Healthcare Inspection – Alleged Women's Health Care Issues, Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 1/4/2018 | Report Number 16-03705-60*	VHA	5	
Comprehensive Healthcare Inspection Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 1/4/2018 | Report Number 17-01741-58*	VHA	4, 9	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the South Texas Veterans Health Care System, San Antonio, Texas *Issued 1/8/2018 | Report Number 17-01852-59*	VHA	3	
Comprehensive Healthcare Inspection Program Review of the Minneapolis VA Health Care System, Minneapolis, Minnesota *Issued 1/11/2018 | Report Number 17-01755-61*	VHA	6-8, 10, 11, 16	
Comprehensive Healthcare Inspection Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Issued 1/11/2018 | Report Number 17-01740-62*	VHA	2	
Healthcare Inspection – Delays in Processing Release of Information Requests, Bay Pines VA Healthcare System, Bay Pines, Florida *Issued 1/17/2018 | Report Number 16-02864-71*	VHA	3, 4, 6	
Comprehensive Healthcare Inspection Program Review of the Grand Junction Veterans Health Care System, Grand Junction, Colorado *Issued 1/18/2018 | Report Number 17-01744-69*	VHA	8	
Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities *Issued 1/30/2018 | Report Number 17-04460-84*	VHA	1-4	
Comprehensive Healthcare Inspection Program Review of the Huntington VA Medical Center, Huntington, West Virginia *Issued 1/31/2018 | Report Number 17-01760-85*	VHA	3, 5, 6	
Comprehensive Healthcare Inspection Program Review of the Alexandria VA Health Care System, Pineville, Louisiana *Issued 2/1/2018 | Report Number 17-01853-89*	VHA	1, 3, 4, 8	
Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System, Big Spring, Texas *Issued 2/5/2018 | Report Number 17-01742-90*	VHA	4, 9	
Comprehensive Healthcare Inspection Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama *Issued 2/6/2018 | Report Number 17-01851-72*	VHA	1, 3	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York *Issued 2/7/2018 | Report Number 17-01762-88*	VHA	4, 6, 7, 11-14	
Review of Excessive Procurement Costs at the Rural Outreach Clinic, Laughlin, Nevada *Issued 2/8/2018 | Report Number 16-02695-51*	VHA	2	$202,045
Comprehensive Healthcare Inspection Program Review of the VA Black Hills Health Care System, Fort Meade, South Dakota *Issued 2/8/2018 | Report Number 17-01745-96*	VHA	1, 3	
Comprehensive Healthcare Inspection Program Review of the Miami VA Healthcare System, Miami, Florida *Issued 2/13/2018 | Report Number 17-01756-86*	VHA	5, 10	
Comprehensive Healthcare Inspection Program Review of the VA Northern California Health Care System, Mather, California *Issued 2/15/2018 | Report Number 17-01750-97*	VHA	2, 4, 7, 9	
Healthcare Inspection – Alleged Failure in Patient Notification of Test Results, VA Connecticut Healthcare System, West Haven, Connecticut *Issued 2/27/2018 | Report Number 17-02678-107*	VHA	1	
Comprehensive Healthcare Inspection Program Review of the Hampton VA Medical Center, Hampton, Virginia *Issued 2/28/2018 | Report Number 17-01758-104*	VHA	1, 5	
Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 3/1/2018 | Report Number 17-01746-116*	VHA	1, 2, 4, 5, 8	
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*	VHA	1-16, 18-23, 25-40	
Healthcare Inspection – Mismanagement of a Resuscitation and Other Concerns, Buffalo VA Medical Center, Buffalo, New York *Issued 3/12/2018 | Report Number 17-01485-128*	OGC VHA	OGC: 1 VHA: 2, 4-9	
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*	VHA	3, 5, 7, 9, 10	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Audit of the Timeliness of VISN 7 Power Wheelchair and Scooter Repairs *Issued 3/14/2018 | Report Number 16-04655-70*	VHA	1-4	
Comprehensive Healthcare Inspection Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin *Issued 3/14/2018 | Report Number 17-01854-115*	VHA	6-8, 10	
Comprehensive Healthcare Inspection Program Review of the Providence VA Medical Center, Providence, Rhode Island *Issued 3/21/2018 | Report Number 17-01761-129*	VHA	1, 6, 10, 11	
Review of Selected Construction Projects at Oklahoma City VA Health Care System *Issued 3/22/2018 | Report Number 17-00253-102*	VHA	1, 2, 4	
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	OSP VHA	OSP: 1-5, 9-11 VHA: 5-8, 11	
Comprehensive Healthcare Inspection Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska *Issued 3/26/2018 | Report Number 17-05402-137*	VHA	1, 5-7	
Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma *Issued 3/27/2018 | Report Number 15-04678-114*	VHA	2	
Comprehensive Healthcare Inspection Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee *Issued 3/27/2018 | Report Number 17-01764-143*	VHA	1-6, 12-15	
Review of Alleged Unsecured Patient Database at the VA Long Beach Healthcare System *Issued 3/28/2018 | Report Number 15-04745-48*	OIT	3	
Review of Timeliness of the Appeals Process *Issued 3/28/2018 | Report Number 16-01750-79*	VBA	4	
Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System *Issued 3/28/2018 | Report Number 17-00253-93*	VHA	7, 10-13	$507,000
Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 3/28/2018 | Report Number 17-01856-135*	VHA	3, 5-7, 9, 10	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the VA Illiana Health Care System, Danville, Illinois *Issued 3/28/2018 | Report Number 17-05424-142*	VHA	1-3, 6, 7	
Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System *Issued 3/29/2018 | Report Number 16-02742-77*	VHA	2, 4-6	
Administrative Investigation of Conflict of Interest, Nepotism, and False Statements within the VA Office of General Counsel *Issued 3/29/2018 | Report Number 17-03324-123*	OSVA	1-5	
Comprehensive Healthcare Inspection Program Review of the VA North Texas Health Care System, Dallas, Texas *Issued 3/29/2018 | Report Number 17-05404-149*	VHA	1-4, 6	
Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York *Issued 3/29/2018 | Report Number 17-05407-141*	VHA	1-10	
Comprehensive Healthcare Inspection Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia *Issued 3/29/2018 | Report Number 17-05409-140*	VHA	1-3, 5	
Healthcare Inspection – Testosterone Replacement Therapy Initiation and Follow-Up Evaluation in VA Male Patients *Issued 4/11/2018 | Report Number 15-03215-154*	VHA	1-7	
VA's Federal Information Security Modernization Act Audit for Fiscal Year 2017 *Issued 4/11/2018 | Report Number 17-01257-136*	OIT	1-26	
Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact *Issued 5/2/2018 | Report Number 16-04555-138*	VBA	1, 3	$11,700,000
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	1-6	$173,829,000
Comprehensive Healthcare Inspection Program Review of the VA Puget Sound Health Care System, Seattle, Washington *Issued 5/8/2018 | Report Number 18-00334-164*	VHA	1, 5	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Healthcare Inspection – Clinical and Administrative Concerns Related to the Podiatry Department, Lexington VA Medical Center, Kentucky *Issued 5/9/2018 | Report Number 17-05440-167*	VHA	1	
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017 *Issued 5/15/2018 | Report Number 17-05460-169*	VHA VBA	VHA: 1, 2, 4 VBA: 3, 5, 6	
Comprehensive Healthcare Inspection Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina *Issued 5/17/2018 | Report Number 18-00412-173*	VHA	1-3	
Comprehensive Healthcare Inspection Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada *Issued 5/17/2018 | Report Number 18-00605-174*	VHA	2, 3, 5-7	
Comprehensive Healthcare Inspection Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio *Issued 5/23/2018 | Report Number 17-05398-172*	VHA	2-5, 7	
Colorectal Cancer Screening, Timely Colonoscopies, and Physician Coverage in the Intensive Care Unit at the James H. Quillen VA Medical Center, Mountain Home, Tennessee *Issued 5/31/2018 | Report Number 16-02940-183*	VHA	1-7	
Comprehensive Healthcare Inspection Program Review of the Phoenix VA Health Care System, Phoenix, Arizona *Issued 6/5/2018 | Report Number 17-00611-180*	VHA	1-13	
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY18 *Issued 6/14/2018 | Report Number 18-01693-196*	VHA	1, 2	
Alleged Mismanagement of Inpatient Care at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System Topeka, Kansas *Issued 6/18/2018 | Report Number 17-02484-189*	VHA	1, 3-6	
Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Memphis, Tennessee *Issued 6/19/2018 | Report Number 18-00609-185*	VHA	1-13	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the VA Hudson Valley Health Care System, Montrose, New York *Issued 6/26/2018 | Report Number 17-05399-194*	VHA	1-3, 5, 6	
Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility *Issued 7/2/2018 | Report Number 17-04354-187*	VHA	1-3	
Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VA Medical Center, Altoona, Pennsylvania *Issued 7/5/2018 | Report Number 16-00284-214*	VHA	2, 3	
Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility *Issued 7/5/2018 | Report Number 16-05323-200*	VHA	1-3, 5, 6	
Comprehensive Healthcare Inspection Program Review of the VA San Diego Healthcare System, San Diego, California *Issued 7/11/2018 | Report Number 18-00616-212*	VHA	1, 3-5	
Supervision and Care of a Residential Treatment Program Patient at a Veterans Integrated Service Network 10 Medical Facility *Issued 7/12/2018 | Report Number 16-03137-208*	VHA	1-5	
Review of Alleged Split Purchases at the VA St. Louis Health Care System *Issued 7/17/2018 | Report Number 16-02863-199*	VHA	3	
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	1-4	$100,600,000
Comprehensive Healthcare Inspection Program Review of the VA Palo Alto Health Care System, Palo Alto, California *Issued 7/31/2018 | Report Number 18-00617-227*	VHA	2-4, 6-8	
Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin *Issued 8/1/2018 | Report Number 17-02643-239*	VHA	1-5, 7-11	
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*	VHA	1-5	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the Tomah VA Medical Center, Wisconsin *Issued 8/9/2018 | Report Number 17-05400-246*	VHA	2	
Comprehensive Healthcare Inspection Program Review of the Chillicothe VA Medical Center, Ohio *Issued 8/9/2018 | Report Number 18-01012-228*	VHA	1, 2	
Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia *Issued 8/13/2018 | Report Number 17-05401-240*	VHA	1-4, 6-8	
Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio *Issued 8/14/2018 | Report Number 18-00619-242*	VHA	1-6, 8-10	
Comprehensive Healthcare Inspection Program Review of the VA Ann Arbor Healthcare System, Michigan *Issued 8/14/2018 | Report Number 18-00621-245*	VHA	1-3	
Review of Environment of Care Conditions at Mississippi VA-Contracted Clinics *Issued 8/14/2018 | Report Number 18-04633-254*	VHA	1, 2	
Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed *Issued 8/16/2018 | Report Number 17-04003-222*	VHA	1-6	$41,572,912
Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia *Issued 8/16/2018 | Report Number 17-05381-258*	VHA	1-3	
Comprehensive Healthcare Inspection Program Review of the Erie VA Medical Center, Pennsylvania *Issued 8/20/2018 | Report Number 18-00618-261*	VHA	1-3	
Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits *Issued 8/21/2018 | Report Number 17-04919-210*	VBA	1, 2	$72,500,000
Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma Issued *8/21/2018 | Report Number 17-05248-241*	VBA	1-6	
Comprehensive Healthcare Inspection Program Review of the Ralph H. Johnson VA Medical Center, Charleston, South Carolina *Issued 8/22/2018 | Report Number 18-00600-259*	VHA	3, 4	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri *Issued 8/22/2018 | Report Number 18-01011-253*	VHA	1, 2	
Comprehensive Healthcare Inspection Program Review of the VA St. Louis Health Care System, Missouri *Issued 8/23/2018 | Report Number 18-00612-260*	VHA	1-3, 5-7	
Use of Not Otherwise Classified Codes for Prosthetic Limb Components *Issued 8/27/2018 | Report Number 16-01913-223*	VHA	1-5	$21,300,000
Comprehensive Healthcare Inspection Program Review of the Bay Pines VA Healthcare System, Florida *Issued 8/28/2018 | Report Number 17-01857-264*	VHA	3	
Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York *Issued 8/29/2018 | Report Number 17-01770-188*	VHA	1, 3-6	
Accuracy of Effective Dates for Reduced Evaluations Needs Improvement *Issued 8/29/2018 | Report Number 17-05244-226*	VBA	2, 4-6	$37,900,000
Comprehensive Healthcare Inspection Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas *Issued 8/30/2018 | Report Number 18-01013-263*	VHA	1-9	
Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts *Issued 9/6/2018 | Report Number 17-02713-231*	VHA	1, 2	$101,400,000
Review of Accuracy of Reported Pending Disability Claims Backlog Statistics *Issued 9/10/2018 | Report Number 16-02103-265*	VBA	1, 2	
VA Policy for Administering Traumatic Brain Injury Examinations *Issued 9/10/2018 | Report Number 16-04558-249*	VBA	2	
Comprehensive Healthcare Inspection Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 9/11/2018 | Report Number 18-00608-247*	VHA	1-13	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Leasing Procedures Used to Acquire VA's Wilmington Health Care Center *Issued 9/12/2018 | Report Number 16-04658-250*	OALC	1	
Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York *Issued 9/12/2018 | Report Number 17-01823-287*	VHA	1-3, 5, 6, 8	
Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio *Issued 9/12/2018 | Report Number 17-04569-262*	VHA	1-4	
Comprehensive Healthcare Inspection Program Review of the Battle Creek VA Medical Center, Michigan *Issued 9/12/2018 | Report Number 18-01139-267*	VHA	1-3	
Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia *Issued 9/13/2018 | Report Number 17-02679-283*	VHA	1-7	
Review of Pain Management Services in Veterans Health Administration Facilities *Issued 9/17/2018 | Report Number 16-00538-282*	VHA	1-10	
Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon *Issued 9/17/2018 | Report Number 18-00620-277*	VHA	1-4, 7	
Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-285*	VHA	1-3	
Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-290*	VHA	1-9	
Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-293*	VHA	1-3	
Comprehensive Healthcare Inspection Program Review of the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas *Issued 9/18/2018 | Report Number 18-00613-275*	VHA	1-6	

Report Information	Action Office(s)	Open Recommendations by Number	Monetary Impact of Open Recommendations
Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 18-01018-281*	VHA	1, 2, 4-11	
Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio *Issued 9/20/2018 | Report Number 17-03382-294*	VHA	1-3	
Alleged Nonacceptance of VA Authorizations by Community Care Providers *Issued 9/20/2018 | Report Number 17-05228-279*	VHA	1-6	
Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky *Issued 9/20/2018 | Report Number 18-01963-284*	VHA	4-6	
Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota *Issued 9/25/2018 | Report Number 18-02875-305*	VHA	1-7	
Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware *Issued 9/27/2018 | Report Number 17-03676-307*	VHA	1-14	
Quality of Care Concerns Regarding a Patient Who had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan *Issued 9/27/2018 | Report Number 17-04875-308*	VHA	1, 2	
Comprehensive Healthcare Inspection Program Review of the Oklahoma City VA Health Care System, Oklahoma *Issued 9/27/2018 | Report Number 18-01141-309*	VHA	1, 2	
Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois *Issued 9/27/2018 | Report Number 18-01143-302*	VHA	1-5	
Timeliness of Final Competency Determinations *Issued 9/28/2018 | Report Number 17-05535-292*	VBA	1-6	
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	VHA: 1-3, 5 OALC: 1, 2, 4	
Totals			**$1,443,510,957**

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

Table 4 identifies the 38 reports and 73 recommendations that, as of September 30, 2018, remain open for more than one year. The total monetary benefit attached to these reports is $317,700,000.

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Audit of VA Regional Offices' Appeals Management Processes *Issued 5/30/2012 | Report Number 10-03166-75*	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals.		
Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.		
Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC *Issued 9/28/2012 | Report Number 12-00375-290*	OM OGC	None
Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel immediately determine what services VOA is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.		
Review of Alleged Delays in VA Contractor Background Investigations *Issued 9/30/2012 | Report Number 12-00165-277*	OSP OIT	None
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.		
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.		
Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama *Issued 7/29/2015 | Report Number 14-04530-452*	VHA	None
Recommendation 2: We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Audit of the Seismic Safety of VA's Facilities *Issued 11/12/2015 | Report Number 14-04756-32*	VHA	None
Recommendation 9: We recommended the Under Secretary for Health develop policies and procedures requiring Veterans Health Administration medical facilities to develop and test Continuity of Operations Plans, to include documenting the testing performed, in accordance with Federal Continuity Directive 1 requirements.		
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona *Issued 3/9/2016 | Report Number 15-05160-161*	VHA	None
Recommendation 16: We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive posttramatic stress disorder screens. Recommendation 17: We recommended that further diagnostic evaluations are offered to patients with positive posttramatic stress disorder screens.		
Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Web Site *Issued 4/7/2016 | Report Number 15-02781-153*	OIT	None
Recommendation 4: We recommended the Assistant Secretary for Information and Technology strengthen policy to ensure Electronic and Information Technology products are compliant with Section 508 prior to their deployment, which includes providing an expectation of when to establish compliance, how to document compliance, and what specifically constitutes compliance with Section 508.		
Review of Claims-Related Documents Pending Destruction at VA Regional Offices *Issued 4/14/2016 | Report Number 15-04652-146*	VBA	None
Recommendation 1: We recommended the Acting Under Secretary for Benefits revise Veterans Benefits Administration's Policy on Management of Veterans' and Other Governmental Paper Records to ensure documents printed from Veterans Benefits Management System are clearly identified.		
Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System *Issued 4/26/2016 | Report Number 11-00826-261*	VHA	None
Recommendation 4: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review of VA New Jersey Health Care System purchase card transactions for building renovations and take corrective action for all identified inappropriate transactions.		
Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 5/11/2016 | Report Number 16-00101-300*	VHA	None
Recommendation 3: We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance. Recommendation 17: We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance. Recommendation 18: We recommended that the Medical Records Committee provide oversight and coordination of the review of the quality of entries in electronic health records.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 5/11/2016 | Report Number 16-00010-302*	VHA	None
Recommendation 7: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.		
Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 9/30/2016 | Report Number 15-00084-370*	VHA	None
Recommendation 1: We recommended that the Facility Director ensure that recommendations, if any, from other reviews of the surgical program be implemented.		
Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses *Issued 12/6/2016 | Report Number 16-00790-417*	OIT	$7,200,000
Recommendation 1: We recommended the Assistant Secretary for Information and Technology implement a policy to ensure cost-effective utilization of information technology equipment, installed software, and services and ensure coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions.		
Audit of Recruitment, Relocation, and Retention Incentives *Issued 1/5/2017 | Report Number 14-04578-371*	OHRA	$77,500,000
Recommendation 1: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to ensure recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement.		
Recommendation 3: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor compliance with its employee certification requirement before relocation incentives are authorized for payment.		
Review of the Implementation of the Veterans Choice Program *Issued 1/30/2017 | Report Number 15-04673-333*	VHA	None
Recommendation 2: We recommended the Under Secretary for Health develop accurate forecasts of demand for care purchased in the community.		
Audit of Automated Burial Payments *Issued 2/8/2017 | Report Number 15-01436-456*	VBA	$28,000,000
Recommendation 2: We recommended the Principal Deputy Under Secretary for Benefits, performing the Duties of Under Secretary for Benefits, strengthen controls to ensure intended recipients meet entitlement requirements before authorizing automated burial payments.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Clinical Assessment Program Review of the Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio *Issued 3/13/2017 | Report Number 16-00553-135*	VHA	None
Recommendation 7: We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, and identification of transferring and receiving provider or designee and that facility managers monitor compliance.		
Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California *Issued 3/31/2017 | Report Number 15-04976-191*	VHA	None
Recommendation 1: We recommended that the System Director ensure that nursing staff comply with pressure ulcer documentation requirements and physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.		
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	None
Recommendation 5: We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.		
Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities, Fiscal Year 2016 *Issued 3/31/2017 | Report Number 16-03743-193*	VHA	None
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy.		
Evaluation of Computed Tomography Radiation Monitoring in Veterans Health Administration Facilities *Issued 4/11/2017 | Report Number 16-03920-197*	VHA	None
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure a medical physicist inspects computed tomography scanners after completion of repairs or modifications that affect the dose or image quality prior to returning the scanners to clinical service.		
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	None
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.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Clinical Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont *Issued 6/20/2017 | Report Number 16-00556-244*	VHA	None
Recommendation 8: We recommended that facility managers ensure anticoagulation clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.		
Recommendation 23: We recommended that facility managers ensure appropriate individuals conduct debriefings after incidents of disruptive or violent behavior and monitor compliance.		
Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 7/10/2017 | Report Number 16-02676-297*	VHA	None
Recommendation 13: We recommended that the System Director continue efforts to enhance call center timeliness and monitor outcomes for continued improvement.		
Recommendation 17: We recommended that the System Director ensure that a Mental Health-related Strategic Analytics for Improvement and Learning workgroup identify priorities, and develop and implement improvement actions accordingly.		
Clinical Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan *Issued 7/17/2017 | Report Number 16-00549-302*	VHA	None
Recommendation 1: We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.		
Recommendation 5: We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.		
Recommendation 6: We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.		
Recommendation 7: We recommended that clinical teams, including the providers performing the procedures, conduct and document timeouts prior to moderate sedation procedures and that facility managers monitor compliance.		
Recommendation 9: We recommended that facility managers ensure all required disciplines attend Community Nursing Home Oversight Committee meetings.		
Recommendation 13: We recommended that facility managers ensure employees consistently use the disruptive behavior reporting and tracking system and monitor compliance.		
Clinical Assessment Program Review of the Lexington VA Medical Center, Lexington, Kentucky *Issued 7/19/2017 | Report Number 16-00580-303*	VHA	None
Recommendation 22: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure the training is documented in employee training records, and monitor compliance.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care *Issued 8/1/2017 | Report Number 16-00576-310*	VHA	None
Recommendation 9: We recommended that providers consistently complete VA form 10-2649A or use a properly templated inter-facility transfer note template for patients transferred out of the facility and that facility managers monitor compliance.		
Recommendation 10: We recommended that for patients transferred out of the facility, providers consistently include date of transfer, documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in VA Form 10-2649A, Inter-Facility Transfer Form, and that facility managers monitor compliance.		
Recommendation 13: We recommended that facility managers ensure that for emergent transfers, provider transfer notes include a statement of patient stability for transfer and that facility managers monitor compliance.		
Recommendation 23: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure training is documented in employee training records, and monitor compliance.		
Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care *Issued 8/1/2017 | Report Number 17-01846-316*	VHA	None
Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with Opioid Safety Initiative guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.		
Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana *Issued 8/7/2017 | Report Number 16-00566-314*	VHA	None
Recommendation 2: We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.		
Recommendation 5: We recommended that the Patient Safety Manager consistently provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.		
Recommendation 15: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		
Audit of VHA's Consolidated Patient Account Center Controls To Prevent Improper Billings for Service-Connected Conditions *Issued 8/9/2017 | Report Number 16-00589-264*	VHA	None
Recommendation 6: We recommended the Under Secretary for Health require Consolidated Patient Account Center management to track and monitor incorrect medical provider service-connection determinations and coordinate training to ensure identified issues are appropriately addressed.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	None
Recommendation 1: We recommended the Acting Under Secretary for Health develop standardized national policy and procedures for the health care enrollment program at VA medical facilities.		
Recommendation 2: We recommended the Acting Under Secretary for Health implement national oversight of the health care enrollment program to continually review operations and performance of Veterans Health Administration medical facilities.		
Recommendation 3: We recommended the Acting Under Secretary for Health provide mandatory and standardized training on eligibility and enrollment to ensure health care applications are processed accurately and timely.		
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.		
Healthcare Inspection – Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York *Issued 8/17/2017 | Report Number 16-02998-345*	VHA	None
Recommendation 4: We recommended that the VA New York Harbor Healthcare System Director ensure that pressure ulcer-related documentation adheres to Veterans Health Administration policy.		
Healthcare Inspection – Patient Flow, Quality of Care, and Administrative Concerns in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland *Issued 8/23/2017 | Report Number 15-03418-350*	VHA	None
Recommendation 1: We recommended that the Veterans Integrated Service Network Director ensure that VA Maryland Health Care System managers strengthen patient flow processes.		
Recommendation 2: We recommended that the Veterans Integrated Service Network Director ensure that VA Maryland Health Care System managers evaluate staff's Emergency Department Integrated Software data entry and implement action plans to ensure data accuracy and timeliness.		
Recommendation 6: We recommended that the System Director strengthen processes to improve timeliness of bed cleaning.		
Recommendation 8: We recommended that the System Director review and address processes that contribute to delays of inpatient discharge.		
Recommendation 9: We recommended that the System Director strengthen nursing service communication processes to ensure consistent inpatient care coverage and nurses' availability for Emergency Department handoff.		
Recommendation 11: We recommended that the System Director improve and monitor compliance with response time requirements for after-hour computerized tomography scan services.		
Clinical Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware *Issued 9/20/2017 | Report Number 16-00548-361*	VHA	None
Recommendation 3: We recommended that employees document when they access information technology network rooms by using the visitor logs and that facility managers monitor compliance.		

Report Information	Action Office(s)	Monetary Impact of Open Recommendations
Recommendation 11: We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.		
Healthcare Inspection – Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona *Issued 9/26/2017 | Report Number 16-02241-375*	VHA	None
Recommendation 1: We recommended that the System Director ensure that primary care appointment scheduling processes are assessed and action is taken to ensure timely access for new and established patients.		
OIG Determination of VHA Occupational Staffing Shortages, FY 2017 *Issued 9/27/2017 | Report Number 17-00936-385*	VHA	None
Recommendation 1: We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations.		
Recommendation 3: We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model.		
Recommendation 4: We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.		
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 9/29/2017 | Report Number 16-00546-388*	VHA	None
Recommendation 3: We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data and that facility managers monitor compliance.		
Recommendation 8: We recommended that facility managers ensure horizontal surfaces, ventilation grills, and floors in patient care areas are clean and monitor compliance.		
Recommendation 16: We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in transfer documentation and that facility managers monitor compliance.		
Recommendation 17: We recommended that facility managers ensure that for emergent transfers, provider transfer notes include patient stability for transfer and monitor compliance.		
Recommendation 18: We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.		
Recommendation 19: We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.		
Recommendation 25: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		
Total		**$317,700,000**

Appendix C: Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by the *Inspector General Act of 1978* (P.L. 95-452), as amended.

Reporting Requirements	Section(s)
§ 4 (a) (2) to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA.	• Other Significant OIG Activities
§ 5 (a) (1) a description of significant problems, abuses, and deficiencies relating to the administration of VA programs and operations disclosed during the reporting period.	• Office of Healthcare Inspections Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities • Office of Contract Review Activities • Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period.	• Office of Healthcare Inspections Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed.	• Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted.	• Office of Investigations Activities
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided.	• Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use.	• Appendix A
§ 5 (a) (7) a summary of each particularly significant report.	• Office of Healthcare Inspections Reports • Office of Audits and Evaluations Reports • Office of Investigations Activities
§ 5 (a) (8) and (9) Statistical tables showing the total number of reports and the total dollar value of both questioned costs and recommendations that funds be put to better use by management.	• Statistical Highlights • Appendix A
§ 5 (a) (10) a summary of each audit report issued before the commencement of the reporting period for which no management decision has been made by the end of the reporting period, for which no establishment comment was returned within 60 days of providing the report to the establishment, and for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations.	• Other Significant OIG Activities • Appendix B

Reporting Requirements	Section(s)
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period.	• Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement.	• Appendix A
§ 5 (a) (13) information described under section 804(b) of the *Federal Financial Management Improvement Act of 1996.*	• Office of Audits and Evaluations Reports
§ 5 (a) (14) an appendix containing the results of any peer review conducted by another OIG during the reporting period or a statement identifying the date of the last peer review conducted by another OIG.	• Other Significant OIG Activities
§ 5 (a) (15) a list of any outstanding recommendations from any peer review conducted by another OIG that have not been fully implemented.	• Other Significant OIG Activities
§ 5 (a) (16) a list of any peer reviews conducted by the [VA] OIG of another OIG during the reporting period and a list of any recommendations made from any previous peer review that remain outstanding or have not been fully implemented.	• Other Significant OIG Activities
§ 5 (a) (17) statistical tables showing the total number of investigative reports issued, the total number of persons referred to the Department of Justice for criminal prosecution, the total number of persons referred to state and local prosecuting authorities for criminal prosecution, the total number of indictments and criminal informations that resulted from any prior referral to prosecuting authorities, and a description of the metrics used for developing the data for the statistical tables.	• Statistical Highlights
§ 5 (a) (18) a description of the metrics used for developing the data for the statistical tables under paragraph (17).	• Statistical Highlights
§ 5 (a) (19) a report on each investigation conducted by the Office involving a senior government employee where allegations of misconduct were substantiated, including a detailed description of the facts and circumstances of the investigation as well as the status and disposition of the matter.	• Office of Investigations Activities
§ 5 (a) (20) a detailed description of any instance of whistleblower retaliation.	• Other Significant OIG Activities
§ 5 (a) (21) a detailed description of any attempt by the establishment to interfere with the independence of the OIG.	• Other Significant OIG Activities
§ 5 (a) (22) detailed descriptions of the particular circumstances of each inspection, evaluation, and audit or investigation involving a senior government employee that is closed and was not disclosed to the public.	• Office of Investigations Activities

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