SEMIANNUAL REPORT to Congress

Issue 87 | October 1, 2021—March 31, 2022

The OIG recognizes National Medal of Honor Day at the end of this reporting period and thanks all veterans for their service.

US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

MISSION

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

VISION

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

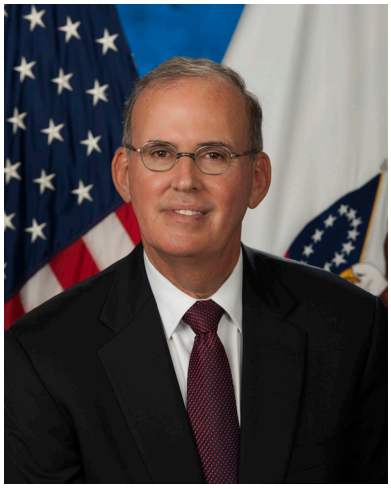
To achieve this vision, the Office of Inspector General (OIG) will

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

VALUES

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

A MESSAGE FROM THE INSPECTOR GENERAL



It is an honor and privilege 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 the period from October 1, 2021, through March 31, 2022. As we release this report, we have more staff returning to the office and conducting in-person site visits and other engagements. This reflects our "new normal" that will no doubt continue to evolve with changing conditions.

We want to recognize VA personnel's continued efforts these past six months in balancing exhausting personal and professional demands so they could provide needed care, services, and benefits to veterans, their families, and communities. Their efforts have also helped refine and expand methods of communications and engagement, as well as service delivery, both within VA and with the veteran community. The OIG has similarly expanded its approaches to oversight to navigate a largely virtual environment. As a product of the pandemic, both VA personnel and OIG staff have had to think more creatively about how to conduct our work on behalf of veterans. As a result, we now have a number of strategies and tools that can be deployed to ultimately better serve veterans and advance both innovation and productivity going forward.

In this past reporting period, the OIG has taken a more proactive approach to helping VA identify the obstacles to modernization and improvement in its programs, operations, and services. This has allowed us to obtain timely information about VA's efforts to overhaul major systems, including the system for patients' electronic health records, its supply inventory system that helps ensure items are available for medical care where and when they are needed, and financial management systems that can help prevent waste and fraud. Going forward, the OIG will be using all the data-monitoring tools developed during this pandemic to help VA clear obstacles to enterprise-wide improvements and innovation.

This report also chronicles the OIG's efforts during this reporting period to monitor the ongoing quality of VA health care and patients' ability to promptly access that care, the timeliness and accuracy of benefits, the security and sufficiency of information technology and other systems, and other VA programs. The OIG has made greater use of data analytics and virtual tools to provide deeper insights into and information about VA. The 397 OIG recommendations offered during this reporting period are meant to help VA better serve veterans and make the most effective use of taxpayer dollars.

In this six-month period, the OIG identified nearly $4.1 billion in monetary impact for a return of investment of $41 for every dollar spent on oversight. The OIG hotline received and triaged 17,646 contacts in this reporting period to help identify wrongdoing and address concerns with VA activities. Special agents opened 173 investigations and closed 224, with efforts leading to 104 arrests. Collectively, the OIG's work from October 2021 through March 2022 also resulted in 557 administrative sanctions and corrective actions.

A MESSAGE FROM THE INSPECTOR GENERAL

OIG leaders and staff greatly appreciate VA leaders' stated commitment to creating a culture of accountability and the many VA personnel who have engaged candidly and cooperatively with us. Finally, I thank members of Congress, veterans service organizations, and the veteran community for the steadfast support that is so vital to our work.

MICHAEL J. MISSAL

Inspector General

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THE DEPARTMENT OF VETERANS AFFAIRS

The VA OIG oversees VA's three administrations. The Veterans Health Administration (VHA) provides healthcare services, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (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) 2022, VA is operating under a $272.5 billion budget with over 425,000 employees serving an estimated 19.2 million veterans. VA maintains facilities in every state, the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the US Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit www.va.gov.

THE OFFICE OF INSPECTOR GENERAL

MISSION

The mission of the VA OIG is to serve veterans and the public by conducting meaningful independent oversight of VA.

HISTORY AND STATUTORY AUTHORITY

The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (the IG Act), as amended.[1] This Act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of—and to prevent and detect criminal activity, waste, abuse, and mismanagement in—VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The Inspector General has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the Department. In addition, the Veterans Benefits and Services Act of 1988 charged the OIG with overseeing the quality of VA health care.[2] 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.

1 Pub. L. No. 95-452, as amended.

2 Pub. L. No. 100-322.

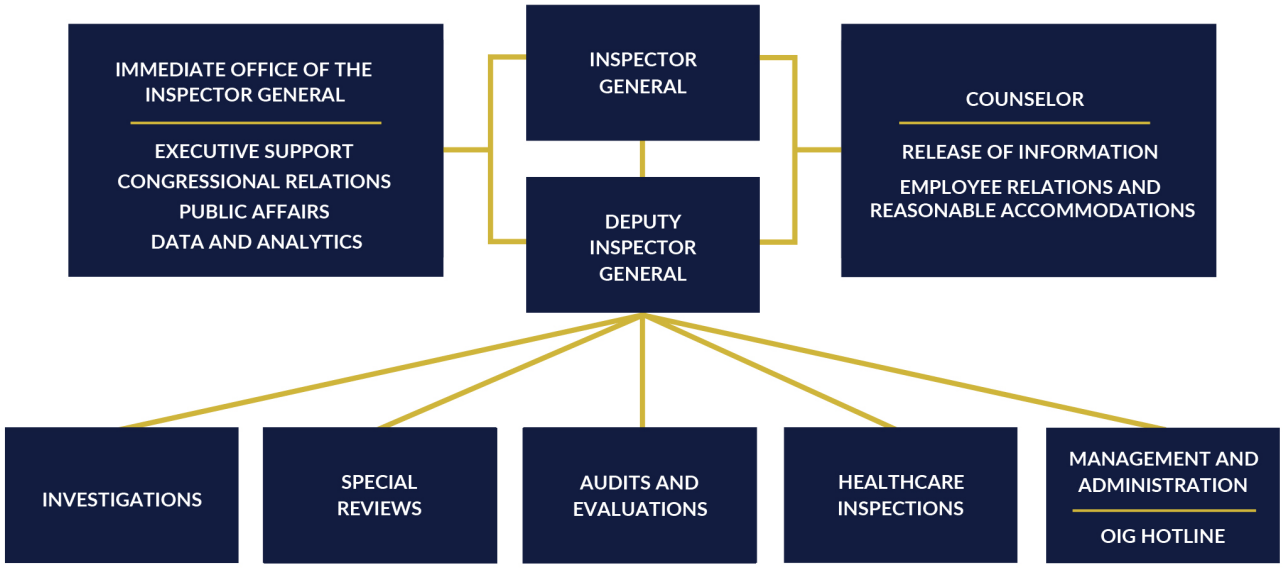
ORGANIZATION PROFILE

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has over 1,100 staff organized into five primary directorates: the Offices of Investigations, Special Reviews, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). The OIG also has offices for the Counselor to the Inspector General, Data and Analytics, Congressional Relations, Public Affairs, as well as staff dedicated to executive support. The FY 2022 funding from ongoing appropriations provided $239 million for OIG operations—an $11 million increase from FY 2021.

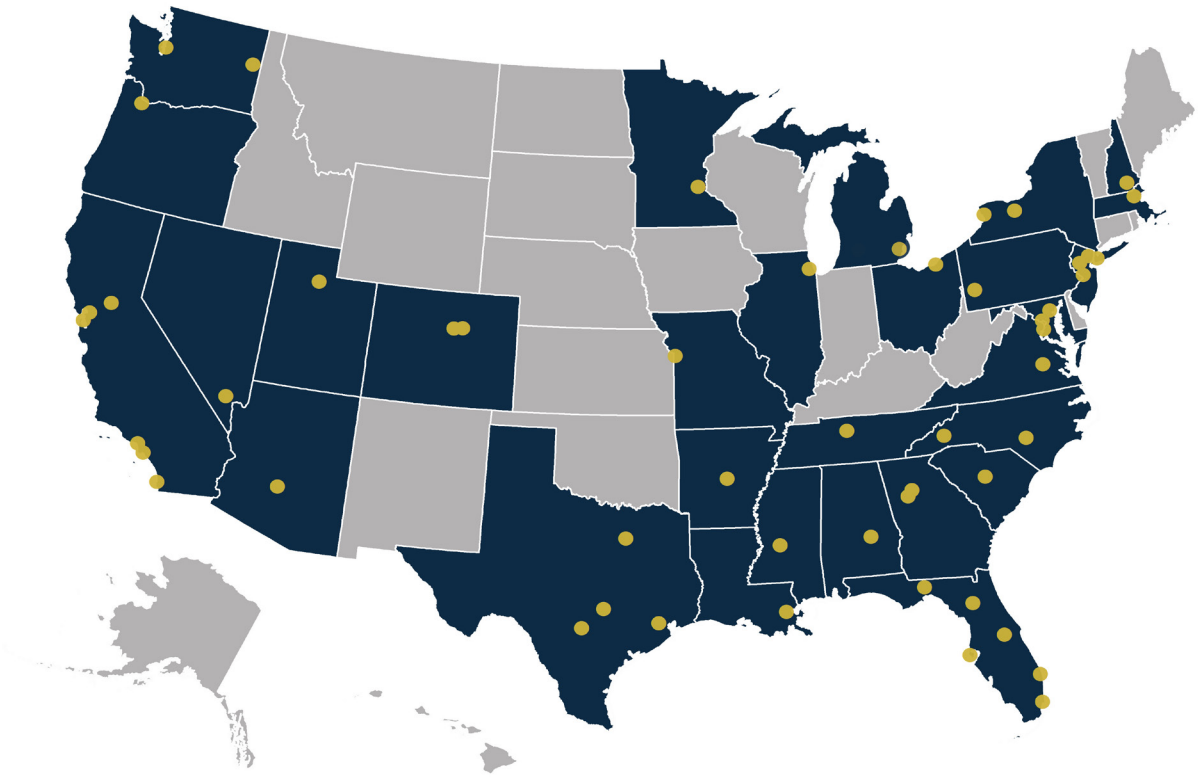
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. For more information, visit www.va.gov/oig.

OIG ORGANIZATIONAL CHART



ORGANIZATION PROFILE

OIG FIELD OFFICES MAP



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

ORGANIZATION PROFILE

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The Immediate Office of the Inspector General coordinates all executive correspondence, congressional testimony, stakeholder engagement, and media inquiries. Staff ensure that information is accurately and promptly released and that requests from VA, veterans, legislators, and reporters are appropriately addressed. It also coordinates strategic planning and data services that includes advanced analytics, information integration, and data visualization. The Inspector General and Deputy Inspector General provide leadership and set the direction for a nationwide staff of auditors, investigators, inspectors, attorneys, healthcare professionals, and support personnel who conduct independent oversight of the second-largest agency in the federal government. In addition, design, report production, and dissemination functions are within the immediate office. Report follow-up staff also make certain that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

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

THE OFFICE OF INVESTIGATIONS

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The office is staffed by special agents with full law enforcement authority, forensic auditors, and other professionals. Staff use data analytics, cybertools, covert operations, and other strategies to detect and address conduct that poses a threat to or has harmed veterans or other beneficiaries and VA personnel, operations, and property. Through criminal prosecutions and civil monetary recoveries, the OIG's investigations promote integrity, patient safety, efficiency, and accountability within VA.

THE OFFICE OF SPECIAL REVIEWS

Special Reviews staff conduct administrative investigations and increase the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. Staffed with professionals possessing a broad array of expertise, this office undertakes projects in response to referrals from VA employees, the OIG hotline, Congress, the Office of Special Counsel, veterans service organizations, and other sources. It also works collaboratively with the other OIG directorates to review topics of interest that span multiple offices or federal agencies.

ORGANIZATION PROFILE

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations provides independent oversight of VA's activities to improve the integrity of its programs and operations. Staff are involved in evaluating such diverse areas as medical supply and equipment inventory and financial systems, the administration of benefits, resource utilization, acquisitions, construction, and information security. This work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The office also reviews VA's contracts with outside organizations, providing preaward and postaward reviews of Federal Supply Schedule (FSS), construction, and healthcare provider contracts. Preaward reviews assist VA contracting officers with negotiating fair and reasonable prices, while postaward reviews assess compliance with contract terms and conditions and help recover overcharges.

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections personnel assess VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. Field staff participate in Comprehensive Healthcare Inspection Program (CHIP) reviews focusing on leadership, quality management, and adherence to requirements and standards for providing patient care. Facility results are aggregated annually into summary reports that identify national trends. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

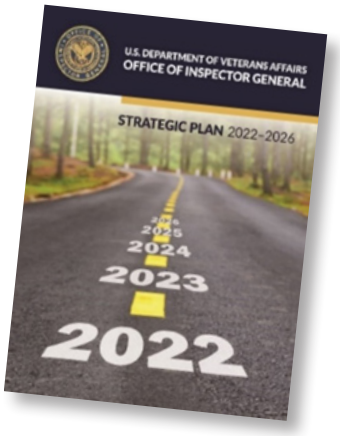
The Office of Management and Administration provides comprehensive support services to the OIG. Staff promote organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, information technology, and other critical services to the organization. The office also oversees the OIG hotline, which receives, screens, and refers all allegations and complaints for additional action. Staff determine which concerns to accept after a review of the complaint, prioritizing those having the most potential risk to veterans and VA programs and operations, or those for which the OIG may be the only avenue of redress.

HIGHLIGHTED ACTIVITIES

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period October 1, 2021–March 31, 2022. Highlighted below are some of the activities conducted during this period by the VA OIG's offices, followed by statistical tables that summarize key performance measures. Subsequent sections of the report then feature examples of each office's highly effective publications and activities. This information is supplemented by appendixes that list released OIG publications, the monetary impact of OIG products, the status of VA's implementation of recommendations, and OIG reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

This office is staffed by the Inspector General, the Deputy Inspector General, and executive support personnel, including employees who prepare reports for public distribution and follow up on recommendations. The immediate office of the Inspector General also includes personnel focused on special projects, congressional relations, data and analytics, and public affairs. For example, the Immediate Office staff led the development and publication of the OIG Strategic Plan 2022–2026, a guiding document that includes five strategic goals related to overseeing health care, benefits, fiscal responsibilities, leadership, and innovation. Outlining related objectives, strategies, and performance measures for each area, the strategic plan will help to ensure the OIG's work remains impactful, fair, and transparent, while making the best use of taxpayer dollars.



CONGRESSIONAL RELATIONS

The OIG actively engages with Congress to promptly inform members and staff on critical issues affecting VA programs and operations. During the reporting period, the Inspector General and other OIG leaders participated in seven congressional hearings on patient safety, military sexual trauma programs, the VA supply chain, vet center support, education fraud, and pending legislation regarding OIG subpoena authority and mandated training for VA personnel on engaging with and reporting to the OIG. In addition, OIG personnel participated in a roundtable held by the Oversight and Investigations Subcommittee of the House Committee on Veterans' Affairs on the governance structure of VA's police service. The Inspector General and OIG personnel also conducted 62 briefings

HIGHLIGHTED ACTIVITIES

with congressional members and their staff. Some of the OIG oversight work and recommendations for improvements that were discussed included

- reviews and inspections related to COVID-19 preparedness and response,
- the delayed cancer diagnosis of a veteran that resulted in his death,
- VA's adoption of the Defense Department's Defense Medical Logistics Standard Support (DMLSS) supply chain management system,
- Veterans Integrated Services Network (VISN) 21's management of its medical facilities' nonrecurring maintenance needs,
- management of the community care program, and
- the final disposition of the unclaimed remains of deceased veterans.

OIG staff also fielded 36 inquiries from congressional staff related to constituent matters for review or referral.

DATA AND ANALYTICS

The Office of Data and Analytics (ODA) continued to conduct advanced analyses, data visualization, and information synthesis to support proactive oversight of VA programs and operations. The office, in collaboration with personnel from across the OIG, created and refined user-friendly, self-service dashboards to empower all staff to advance their work using just-in-time information. During this reporting period, ODA continued work on 54 ongoing projects, created 12 new internal data-monitoring tools, and made enhancements to several others. The new tools focused on the evaluation of community care referrals and usage; the monitoring of procurement activity; and the accuracy of claim reimbursement. Several data-monitoring tool enhancements addressed concerns including purchases related to COVID-19, prosthetic devices, construction contracts, and nonexpendable medical equipment.

ODA also fulfilled a total of 332 data requests, including 292 that supported OIG oversight of VA's broad range of healthcare services and benefits programs involving disabilities, pensions, education, housing assistance, and burials. ODA teams have also continued to train OIG personnel to effectively leverage data tools and services, including an ongoing virtual training miniseries. The training series offers OIG staff continuing professional education credits through hour-long sessions. ODA also provides topic-specific training sessions and monthly senior leader briefings—all of which enhance the skills of OIG oversight staff and leverage available data resources.

PUBLIC AFFAIRS

The OIG is committed to maintaining transparency and to providing accurate and timely information to veterans and their families, the media, veterans service organizations, Congress, VA leaders and staff, and the public. To that end, public affairs staff disseminated report information, news releases, podcasts, and other communications products aimed at keeping its stakeholders informed of the OIG's oversight work. Staff also continued to work with US Attorneys' public affairs offices and other law enforcement partners to release statements and respond to requests for information on criminal investigations. The office's recommendation follow-up efforts included sending 445 status requests to various offices within the Department. These efforts led to the OIG closing about 500 recommendations during this reporting period.

HIGHLIGHTED ACTIVITIES

A VA OIG resident agent in charge participates in an interview for an A&E production on the investigation into the serial murders of veterans at the Clarksburg, West Virginia, VA medical center.

Staff continued to reach a diverse audience, including expanding the office's presence on LinkedIn and Twitter by nearly 6,600 followers (totaling more than 56,000). The public affairs team published 184 updates on reports, hiring activities, and other news that resulted in about 335,000 impressions, and also posted more than 150 tweets to approximately 6,400 followers with over 75,000 impressions. There were 141 email bulletins released through GovDelivery, reaching more than 108,000 subscribers—an increase of nearly 6,000 subscribers compared to the previous reporting period. Outreach efforts were further supplemented by the launch of Veteran Oversight Now, a podcast featuring interviews with key stakeholders, discussions on high-impact reports, and highlights of recent oversight work. The podcast is available on all popular podcast directories.

The OIG's work was featured prominently by broadcast and print media outlets that included *USA Today*, the *New York Times, Los Angeles Times, Washington Post, Miami Herald, Politico, Military Times,* and *Stars and Stripes*. Among the reports covered were those on VA's electronic health record (EHR) modernization program, military sexual trauma programs, patient safety issues, and vet center inspections. Special agents with the OIG were interviewed during this reporting period by both *Forensic Files* and the A&E Network for features on the VA OIG's work to solve the serial murders of veterans that took place at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

During this reporting period, the counselor's office performed a wide range of activities that included working with the Office of Management and Administration to interpret and apply executive orders; guidance issued by the Safer Federal Workforce Task Force; and Departmental policies to enhance the safety of VA patients, visitors, and federal employees and to limit the spread of COVID-19. The Employee Relations and Reasonable Accommodation Division (ER/RA) processed 204 actions for OIG managers and employees on matters involving employee discipline, performance and grievances, and other day-to-day workforce issues. Its staff also responded to 832 inquiries or requests for reasonable accommodation and 349 inquiries associated with leave administration. In addition, ER/RA created formal processes specific to the VA OIG for handling requests for medical and religious accommodations related to COVID-19 vaccination requirements or in-person safety protocols that expanded due process rights for employees. ER/RA shared its approach and processes for handling vaccine mandate-related reasonable accommodation requests with other federal OIGs as model templates. The division processed 54 such requests prior to the injunction against enforcement of the vaccine mandate on January 21, 2022, and continues to process requests related to safety protocols, such as testing and social distancing.

HIGHLIGHTED ACTIVITIES

During this reporting period, the counselor's office represented the VA OIG in four cases before the Equal Employment Opportunity Commission, all of which were decided in the OIG's favor. Additionally, while the OIG's involvement with VA labor unions has been limited in years past, the OIG was recently named in several grievances and a claimed unfair labor practice filed by VA union officials, all of which were also resolved in the OIG's favor. The counselor's office also engaged repeatedly with VA to ensure that VA staff know they have the right to communicate freely with the OIG, without the need to vet responses through their managers.

Staff continued to provide significant support to personnel from across the OIG as they evaluated various aspects of VA's EHR modernization program implementation. They also

- assisted healthcare inspectors with establishing criteria for a new series of reviews focused on counseling provided at vet centers and their coordination with local VA medical centers,
- worked with audit staff on an evaluation of VA's guide for the use of the Defense Logistics Agency's Electronic Catalog (ECAT) to order medical supplies and identified deficiencies,
- advised audit staff on a project that found VHA paid for acupuncture and chiropractic care in the community that was not authorized,
- dedicated several attorneys to provide legal counsel to healthcare inspection teams during their reviews of serious clinical and administrative failures, and
- approved more than 213 subpoena requests submitted by special agents.

Attorneys with the counselor's office also review every OIG oversight report to ensure the accuracy of legal arguments and related findings. The Release of Information Office personnel also continued to review all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and processed and responded to nearly 430 requests from the public and other government agencies for OIG records. The Release of Information Office also continued to support a US Attorney's Office's defense of the OIG in Privacy Act litigation filed in federal district court.

THE OFFICE OF INVESTIGATIONS

Staff investigate myriad types of potential criminal activity and civil violations of law, including fraud related to VA benefits, construction, education, procurement, and health care, as well as drug offenses, crimes of violence, threats against VA employees or facilities, and cyberthreats to VA information systems. During this reporting period, investigative efforts resulted in 104 arrests, 94 convictions, and over $382 million in monetary benefits for VA.

The Office of Investigations (OI) remained focused on high-impact investigations and coordinating with other OIG directorates, external law enforcement partners, and the Department of Justice (DOJ) to ensure that veterans, VA employees, and VA assets are protected and wrongdoers are held accountable. During this reporting period, OI worked with congressional affairs staff to inform legislative changes designed to close loopholes and make education fraud more difficult. OI also worked closely with OIG data analysts to develop and adopt new tools and statistical methods for reviewing VA programs. Its personnel continued to meet evolving criminal and civil investigation needs, which includes OI's

Cyber Investigations and Technical Operations Division deploying the OIG's first forensic enclave—a remotely accessible, independent, and secure network of servers and workstations to conduct digital forensics in support of criminal and administrative investigations. These and other efforts enhance the detection of high-dollar fraud and support regional field offices in their efforts to work impactful criminal investigations, some of which have recently garnered significant media attention.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews (OSR) focuses on significant incidents and administrative investigations, particularly involving senior VA officials. Its staff work on multiple review projects and administrative investigations pertaining to VA programs, operations, and employee misconduct. The office also collaborates with other directorates to address complex issues of concern. For example, OSR staff have been continuing to work with the OIG's healthcare staff on a joint audit project with the Department of Defense Inspector General to assess congressionally mandated interoperability requirements between the two Departments' EHR systems.

During this reporting period, OSR engaged outside experts to conduct a multiday training exercise for all staff intended to enhance investigative interview skills. Indicative of the importance of refining this core competency, OSR staff conducted 132 investigative interviews in their various projects during the six-month period.

OSR also closed out all open recommendations on two reports from prior reporting periods: *Alleged Irregularities Regarding Physician Incentive Compensation Were Not Substantiated* and *Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel*. The physician incentive compensation recommendation resulted in a medical provider returning an improperly paid bonus and the correction of the incentive payment calculation going forward. The implementation of the recommendations in the attorney misconduct matter resulted in employee accountability actions, the recovery of $25,000 in taxpayer funds, and the implementation of policy clarifications and enhanced supervision designed to prevent future ethical violations by VA attorneys.

Finally, as detailed later in the Results section, OSR published two reports in response to allegations of senior VA officials' misconduct and one VA management advisory memorandum on the need to clarify guidance on SES reassignments.

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations (OAE) issued 29 publications summarizing results from its oversight work, including one VA management advisory memorandum that highlighted concerns requiring VA's prompt attention. Contracting review teams also conducted 49 preaward and postaward contract reviews to help VA obtain fair and reasonable pricing on products and services. OAE identified potential cost savings of nearly $3.1 billion and recovered over $52.2 million in contract overcharges. Its published reports resulted in 128 recommendations with a potential monetary impact of about $545.8 million for

HIGHLIGHTED ACTIVITIES

the reporting period. The total potential monetary impact of all published and unpublished publications was $3.7 billion.

Weaknesses in VA's governance and oversight were identified as affecting many aspects of program performance. OAE reports identified numerous erroneous payments to veterans and organizations that could have been avoided. For example, one report concluded that a lack of oversight contributed to the incorrect processing of special monthly compensation (SMC) benefits, which led to about $165 million in improper payments. Another report found that a similar lack of oversight in VHA led to about $135.7 million in improper payments for acupuncture and chiropractic services over a two-year period. Improved program oversight would help ensure VA uses taxpayer dollars to their greatest effect in support of eligible veterans' and other beneficiaries' care and services.

OAE also identified potential strategies to improve the management of several key systems at selected VA facilities through financial efficiency reviews and information technology (IT) security inspections. Its staff also continued a series of oversight reports related to VA's multibillion-dollar EHR modernization effort. Finally, OAE reports continued to highlight the need for VA to address deficiencies with its aging supply chain management system, which is critical to ensuring that supplies and equipment are available when and where they are needed for patient care and safety. OAE found that VA's initial attempt to transform its supply chain management through the adoption of the Defense Department's DMLSS system was replete with operational gaps that resulted in VHA staff developing multiple work-arounds to maintain day-to-day operations.

THE OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) remains committed to ensuring that veterans have access to timely, high-quality health care. Staff has continued to assess issues that affect key healthcare functions within VHA. During this reporting period, OHI maintained a strong focus on leadership and organizational risks, COVID-19 pandemic readiness and response, suicide prevention and intervention processes, and deficiencies in care coordination. While VHA leaders and frontline staff continued to exhibit an enduring commitment to veterans in an extremely dynamic, high-risk environment, several OHI reports demonstrated how a lack of care coordination and breakdowns in patient safety practices can lead to delayed diagnoses, serious harm, and, as detailed in one report, a veteran's death.

Because organizational culture—which affects patient safety—is ultimately a function of proactive and engaged leadership, OHI's CHIP reports continued to highlight leadership stability and engagement. These include establishing consistent and reliable data and reporting mechanisms, carefully investigating and analyzing patient safety events, and evaluating corrective actions to reduce future risk and prevent further harm.

OHI's vet center inspections also focus on oversight and accountability, leadership stability, and quality improvement activities. They draw on employee, client, and leadership surveys to help gauge organizational performance.

Women's health care remains a VHA priority, as the population of female veterans is expected to increase. OHI released a CHIP Summary Report on the evaluation of women's health care within VHA facilities that uncovered multiple weaknesses regarding the provision of 24-hour gynecologic care coverage, the staffing of at least two women's health primary care providers for each community-based outpatient clinic, the appointment of full-time women veterans' program managers who are free of collateral duties, and the designation of maternity care coordinators.

OHI also continued its oversight of VA's implementation of the new EHR system—a multibillion-dollar modernization effort that can have a significant impact on patient safety and the quality of health care provided to veterans. OHI released a series of three reports on deficiencies in medication management, care coordination, and problem resolution identified following the new system's rollout at the initial operating site (detailed on page 47), which drew both congressional and national media attention.

Finally, OHI remains committed to the continuous improvement of its oversight capabilities and, to this end, launched a new series of webcast conversations with national healthcare leaders. This new initiative provides an opportunity for OIG staff to discuss their ideas on how best to improve oversight efforts and the health care veterans receive.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

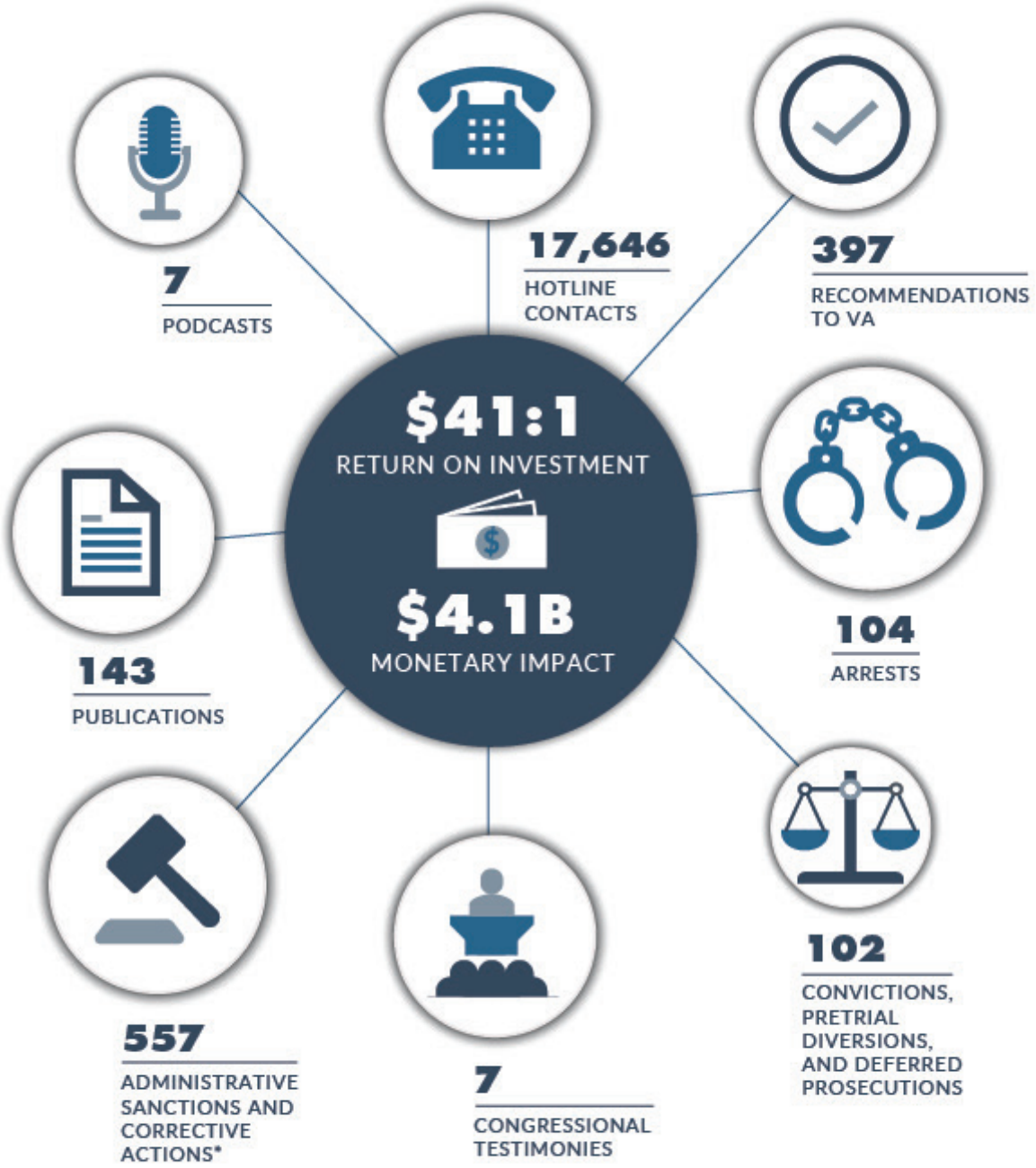
The Office of Management and Administration (OMA) continued to support the OIG's mission by providing wide-ranging, dependable, and prompt administrative services that improve effectiveness and efficiency. In this reporting period, OMA was responsible for deploying several major IT initiatives to modernize the OIG's infrastructure, strengthen security, and address evolving and complex IT needs. It facilitated hiring and onboarding nearly 200 employees, resulting in the largest workforce in OIG history. In addition, OMA personnel oversaw execution of the OIG's biggest budget to date in FY 2021. It strengthened the development of the OIG workforce by enhancing and expanding leadership training and mentorship opportunities as well.

The office's recently published FY 2022 priorities document identifies key focus areas that include fostering employee engagement and supporting a culture of diversity, equity, inclusion, and accessibility (DEIA). To this end, OMA created a new division that provides programs, services, and tools to enhance DEIA awareness throughout the OIG. The DEIA division also offers team building, coaching, mentoring, and resources to grow a diverse workforce and cultivate an inclusive and equitable work environment.

OMA is also responsible for overseeing the OIG hotline. During this reporting period, the hotline division received and screened 17,646 contacts from complainants—including VA employees, veterans, and the public—and directed potential cases to the appropriate OIG directorates or other entities for further review.

STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE REPORTING PERIOD



*These include results from hotline and investigations cases. The total for these activities include cases opened in previous fiscal years.

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD
Better Use of Funds	$3,101,867,154
Dollar Recoveries	$2,761,733
Fines, Penalties, Restitution, and Civil Judgments[3]	$285,495,651
Fugitive Felon Program	$86,600,000
Savings and Cost Avoidance	$ 7,773,053
Questioned Costs	$593,657,978
Total Dollar Impact	**$4,078,155,569**
Cost of OIG Operations[4]	$98,285,591
Return on Investment[5]	**$41:1**

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810 Vermont Avenue, NW, Washington, DC 20420

3 This category includes both investigations conducted solely by the VA OIG and joint investigations conducted in partnership with other law enforcement agencies. The amount reported reflects the total monetary recovery to all government entities, nongovernment entities, and private individuals as a result of these investigations. Of the total amount reported for this period, VA received $152,532,558.

4 The six-month operating cost for OHI ($21,214,409), 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.

5 The return on investment is calculated by dividing total dollar impact by cost of OIG operations.

STATISTICAL PERFORMANCE

TABLE 2: PUBLICATIONS

REPORT TYPE[6]	THIS PERIOD
Administrative Investigations	2
Audits and Reviews	24
Claim Reviews	0
Comprehensive Healthcare Inspections	17
Financial Inspections	3
Hotline Healthcare Inspections	13
Information Technology Inspections	1
National Healthcare Reviews	8
Postaward Contract Reviews	17
Preaward Contract Reviews	32
Special Reviews	0
Vet Center Inspections	2
Subtotal	**119**
ALTERNATIVE WORK PRODUCTS	**THIS PERIOD**
Issue Statements	0
Management Advisory Memoranda	2
Subtotal	**2**
OTHER PUBLICATION TYPES	**THIS PERIOD**
Budget Request	1
Congressional Testimonies	7
Major Management Challenges	1
Monthly Highlights	6
Peer Reviews Completed of Other OIGs	0
Podcasts	7
Press Releases	0
Subtotal	**22**
Total	**143**

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

STATISTICAL PERFORMANCE

TABLE 3: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	6
Clinical Consultations to Other Federal Entities	0
Hotline Referrals Reviewed	2,528

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD
Contacts	17,646
Cases Opened	752
Cases Closed	523
Administrative Sanctions and Corrective Actions[7]	498
Substantiation of Allegations Percentage Rate	43%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	26
Individuals Provided Office of Special Counsel Contact Information	74
Individuals Provided Merit Systems Protection Board Contact Information	5
Individuals Provided Office of Resolution Management Contact Information	164

7 The total for these activities include cases opened in previous fiscal years.

STATISTICAL PERFORMANCE

TABLE 5: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[8]	THIS PERIOD
Arrests[9]	104
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	37
Indictments[10]	82
Indictments and Informations Resulting from Prior Referrals to Authorities	36
Criminal Complaints	22
Convictions	94
Pretrial Diversions and Deferred Prosecutions	8
Case Referrals to Department of Justice for Criminal Prosecution[11]	136
Case Referrals to State and Local Authorities for Criminal Prosecution[12]	15
Administrative Sanctions and Corrective Actions	59
Cases Opened	173
Cases Closed[13]	224

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

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

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

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

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

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

RESULTS FROM THE OFFICE OF INVESTIGATIONS

104 Arrests | **94** Convictions | **$382M** Monetary Benefits

OVERVIEW

OI focuses on a wide range of criminal and civil cases, prioritizing those that have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect VA patient care and safety; the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 425,000 employees and contractors; and offenses affecting VA's assets, programs, and operations.

FEATURED INVESTIGATIONS

The investigations highlighted in this section illustrate OI's emphasis on cases that involve harm to VA patients; 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; help ensure benefits and services meant for veterans and other eligible beneficiaries are being received by the individuals for whom they were intended; and give some measure of relief to victims of crime and their loved ones.

The first of the three highlighted cases below spotlights the millions of dollars at risk when fraud schemes, such as this false surety bond case, go undetected. The second case involves the largest-ever False Claims Act recovery based on allegations of small business contracting fraud. The third case reflects OI's commitment to protecting the most vulnerable veterans from financial exploitation.

FOUR INDIVIDUALS SENTENCED FOR FALSE SURETY BOND CONSPIRACY THAT PUT A BILLION DOLLARS OF GOVERNMENT PROJECTS AT RISK OF DEFAULT

From March to December 2015, four individuals provided federal, state, and local government agencies and private construction companies with worthless surety bonds by using nonexistent assets (land, trusts, and gold) to back the bonds. The defendants collected nearly $6 million in fees for the fraudulent bonds from the government and private contractors. Over $1 billion of government and private construction projects were at risk of default due to this scheme, potentially leaving the government and private entities financially responsible for the total amount of the contracts. The contracts included construction projects at VA medical centers and national cemeteries, Department of Defense military bases, and vital public infrastructure, such as housing projects, bridges, and dams. Between November and December 2021, the defendants were sentenced collectively to 196 months of incarceration in the Southern District of Florida. Each defendant was also sentenced to 36 months of supervised release and ordered to jointly pay restitution of $2.6 million and the forfeiture of $1.2 million. The investigation was conducted by the VA OIG and Environmental Protection Agency OIG.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FOOD SERVICE EQUIPMENT COMPANY TO PAY RECORD $48.5 MILLION SETTLEMENT FOR SERVICE-DISABLED VETERAN-OWNED FRAUD ALLEGATIONS

A company based in Mansfield, Massachusetts, that provides kitchen and food service equipment to federal customers has agreed to pay $48.5 million to resolve allegations that its fraudulent actions led to federal agencies improperly awarding small business set-aside contracts to three small businesses with which the company worked. Between 2011 and 2021, the company identified federal set-aside contract opportunities for the three small businesses to bid on using their set-aside status; instructed them on how to prepare their bids and what prices to propose; ghostwrote emails for those companies to send to government officials to make it appear as though the small businesses were performing work; and affirmatively concealed its involvement in the contract. The case began in May 2019, when a whistleblower filed a *qui tam* complaint under seal in the US District Court for the Northern District of New York. Per the False Claims Act, such complaints require the United States to investigate the allegations and elect whether to intervene and take over the action. In this case, the United States elected to intervene in the action in December 2021 and subsequently reached the $48.5 million settlement, of which VA will receive over $10 million. The investigation was conducted by the VA OIG, US Attorney's Offices for the Northern District of New York and Eastern District of Washington, General Services Administration (GSA) OIG, Small Business Administration (SBA) OIG, Department of Homeland Security OIG, Army Criminal Investigation Division (CID), Air Force Office of Special Investigations (AFOSI), Naval Criminal Investigative Service (NCIS), and Defense Criminal Investigative Service (DCIS).

> **"The Department of Veterans Affairs Office of Inspector General is committed to identifying and stopping those individuals who misappropriate an opportunity meant solely for our nation's veterans with disabilities," said Inspector General Michael J. Missal.**

DOJ NEWS RELEASE: *Government Contractor Agrees to Pay Record $48.5 Million to Resolve Claims Related to Fraudulent Procurement of Small Business Contracts Intended for Service-Disabled Veterans*

DEFENDANT SENTENCED FOR IDENTITY THEFT AND OTHER CHARGES TARGETING THE ELDERLY

According to a multiagency investigation, multiple individuals in Jamaica allegedly engaged in a scheme that involved redirecting the monthly benefit payments of veterans and Social Security recipients to alternate bank accounts. The coconspirators removed the funds, kept a portion, and sent the remainder back to Jamaica. The stolen funds were then loaded onto prepaid credit cards and mailed to coconspirators in the Miami and Atlanta areas. These individuals also participated in telemarketing scams that targeted elderly US citizens, including veterans. One defendant was sentenced in the Southern District of Florida to 24 months of incarceration, four years of supervised release, and restitution of over $48,000. The VA OIG, Homeland Security Investigations (HSI), and US Postal Inspection Service (USPIS) conducted the investigation. To date, 18 coconspirators have been indicted in connection with this scheme, 15 of whom have been arrested and convicted, with 14 being sentenced to a combined 559 months of incarceration, 456 months of supervised release, 36 months of probation, and over $3.9 million in restitution. The loss to VA is more than $7 million.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this reporting period, OI opened 85 cases; made 65 arrests; obtained over $116.6 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved nearly $1.1 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The selected case summaries that follow illustrate the type of VHA-related investigations conducted during this period.

SCHEMES RELATED TO COVID-19

REGISTERED NURSE AT VA MEDICAL CENTER IN DETROIT INDICTED IN COVID-19 VACCINATION CARD FRAUD SCHEME

A registered nurse at the John D. Dingell VA Medical Center in Detroit, Michigan, allegedly stole from the facility authentic COVID-19 vaccination record cards and filled in the vaccine lot numbers necessary to make the cards appear legitimate. The nurse then resold the cards for $150 to $200 each to individuals within the Detroit area. She was indicted in the Eastern District of Michigan on charges of theft of government property and theft or embezzlement related to a healthcare program. The investigation was conducted by the VA OIG, Department of Health and Human Services (HHS) OIG, and VA Police Service.

FORMER ASSISTANT CHIEF OF SUPPLY CHAIN MANAGEMENT SENTENCED FOR THEFT OF N95 MASKS FROM BILOXI VA MEDICAL CENTER

From 2019 to 2020, the assistant chief of supply chain management for the Gulf Coast Veterans Healthcare System allegedly stole N95 masks, electronics, and medical devices from the Biloxi VA Medical Center in Mississippi, and then sold them to secondhand retailers. The defendant, who made more than $73,000, sold the 3M N95 masks for an average of $18.36 per mask (35 times their procured value of $0.53 per mask). He was sentenced in the Southern District of Mississippi to 12 months of incarceration, 36 months of probation, restitution of more than $23,000, and a fine of $40,000. The VA OIG, USPIS, and FBI conducted the investigation.

SEXUAL ABUSE AND INVASION OF PRIVACY

FORMER COMMUNITY-BASED OUTPATIENT CLINIC NURSE PRACTITIONER SENTENCED FOR SODOMY AND SEXUAL ABUSE

An investigation conducted by the VA OIG and VA Police Service revealed that a former VA nurse practitioner sexually assaulted two female veteran patients at the community-based outpatient clinic in Florissant, Missouri, in 2019. The former nurse practitioner was sentenced in the Circuit Court of St. Louis County, Missouri, to three years of incarceration and two years of probation after previously pleading guilty to felony sodomy and misdemeanor sexual abuse.

FORMER CHIEF OF CARDIOLOGY FOR THE VA PALO ALTO HEALTH CARE SYSTEM PLEADED GUILTY TO FELONY ABUSIVE SEXUAL CONTACT

Another investigation conducted jointly by the VA OIG and VA Police Service found that the former chief of cardiology for the VA Palo Alto Health Care System repeatedly subjected a subordinate doctor to unwanted sexual contact while on VA premises. The former chief continued to subject the subordinate doctor to this nonconsensual sexual conduct despite being told that she was not interested in a relationship with him. He pleaded guilty in the Northern District of California to abusive sexual contact.

FORMER PHYSICIAN AT THE CHULA VISTA VA CLINIC CHARGED WITH INVASION OF PRIVACY

A third VA OIG and VA Police Service investigation resulted in charges alleging that a former physician at the Chula Vista VA Clinic secretly planted a concealed video recorder in the facility to record numerous staff members as they used the restroom. The former physician was arraigned in San Diego County Superior Court after being charged with invasion of privacy.

THEFT OF MEDICATION AND MEDICAL SUPPLIES

NEW JERSEY MAN SENTENCED FOR THEFT OF HIV MEDICATION

According to an investigation by the VA OIG, FBI, and VA Police Service, a New Jersey man conspired with a pharmacy technician formerly employed at the East Orange VA Medical Center to steal prescription HIV medication from the facility for several years. The former pharmacy technician ordered large quantities of HIV prescription medication, which she stole and then sold to the defendant, who in turn resold the medication for a profit. The defendant was sentenced in the District of New Jersey to 42 months of incarceration, three years of supervised release, and ordered to pay restitution of $8.2 million to VA. The former pharmacy technician previously pleaded guilty to theft of government property.

FORMER VA PURCHASING AGENT SENTENCED FOR THEFT OF MEDICAL PRODUCTS

From 2013 to 2021, a former purchasing agent for the VA community-based outpatient clinic in Fort McPherson, Georgia, used his government purchase card to make hundreds of unauthorized purchases of continuous positive airway pressure (CPAP) supplies, which he stole and then resold for profit. The VA OIG investigated the matter, and the defendant was sentenced in the Northern District of Georgia to 27 months in prison, 36 months of supervised release, and restitution of $2 million.

BRIBERY AND KICKBACKS

FORMER MIAMI VA MEDICAL CENTER EMPLOYEE CHARGED IN CONNECTION WITH BRIBERY SCHEME

A former Miami VA Medical Center employee was arrested in the Eastern District of Pennsylvania for her alleged role in a bribery and kickback scheme involving multiple vendors and VA employees. The defendant was employed by VA as the assistant chief of logistics and was responsible for supervising the ordering of goods and services at the medical center. According to a VA OIG investigation, which was based on a hotline complaint, the defendant and other VA employees placed orders for supplies in exchange for cash bribes and kickbacks from corrupt vendors. The prices of supplies were often grossly inflated, and some orders were only partially filled or not fulfilled at all. After leaving VA, the defendant immediately began working for one of the vendors and allegedly paid kickbacks and bribes to VA

employees at multiple VA medical centers in exchange for the placement of orders. The vendors charged in this case were responsible for over $37.6 million in purchase card orders and contracts.

TWO INDIVIDUALS SENTENCED FOR BRIBERY SCHEME INVOLVING FORMER ANCHORAGE VA MEDICAL CENTER EMPLOYEE

According to a multiagency investigation, a former VA contracting officer's representative at the Anchorage VA Medical Center gave preferential treatment to two service-disabled veteran-owned small businesses (SDVOSBs) in return for nearly $30,000 in alleged bribery payments. The SDVOSBs obtained more than $5 million in set-aside snow removal and housekeeping contracts at the medical center. The companies' former bookkeeper was sentenced to 36 months of probation and restitution of more than $52,000. The owner of one of the companies was sentenced to 12 months and one day imprisonment, three years of supervised release, and restitution of $347,000. Both defendants were sentenced in the District of Alaska. The investigation was conducted by the VA OIG, FBI, SBA OIG, and GSA OIG.

FORMER PURCHASING AGENT AT THE JESSE BROWN VA MEDICAL CENTER AND MEDICAL SUPPLY COMPANY PRESIDENT INDICTED FOR WIRE FRAUD

A VA OIG investigation resulted in charges alleging that between 2017 and 2020, a former purchasing agent at the Jesse Brown VA Medical Center in Chicago, Illinois, conspired to purchase medical supplies from a vendor in exchange for kickbacks of at least $220,000. The vendor received approximately $2.8 million in VA purchase card orders from the former employee, of which approximately $1.38 million are alleged to have been fraudulent. The former employee and the president of the medical supply company were indicted in the Northern District of Illinois on charges of wire fraud.

ANOTHER FORMER PURCHASING AGENT AT THE JESSE BROWN VA MEDICAL CENTER AND MEDICAL SUPPLY COMPANY PRESIDENT INDICTED FOR ROLES IN BRIBERY SCHEME

According to a VA OIG investigation, a second former purchasing agent at the Jesse Brown VA Medical Center allegedly conspired to purchase medical supplies from a vendor in exchange for kickbacks. The vendor received approximately $330,000 in VA purchase card orders; the former employee received close to $40,000 in kickbacks. Both the former employee and the president of the medical supply company were indicted in the Northern District of Illinois on charges of bribery and conspiracy to commit bribery.

FORMER SURGICAL SERVICE SUPERVISOR AT THE VA MEDICAL CENTER IN CLEVELAND AND MEDICAL VENDOR SENTENCED FOR KICKBACK SCHEME

An investigation by the VA OIG and FBI revealed that a former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. To justify the purchase of surgical implant devices from the vendor, the supervisor falsified patient records to make it appear as if patients needed the implants, but in fact they did not correlate to any actual surgical or medical procedures. In a separate scheme, he fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to buy goods from a company that he controlled. The supervisor was sentenced in the Northern District of Ohio to 37 months in prison and ordered to pay more than $1.2 million in restitution to VA. The medical supplies vendor was sentenced to 18 months in prison and ordered to pay approximately $193,000 in restitution to VA.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

EIGHT PEOPLE PLEADED GUILTY FOR HEALTHCARE KICKBACKS

A multiagency investigation revealed that two laboratories engaged in a kickback scheme involving marketers and physicians. The laboratories provided kickbacks to marketers based on a percentage of their referrals for clinical testing. These referrals resulted in billings for expensive testing services that were not medically necessary. Claims submitted to all federal programs totaled approximately $300 million. Of this amount, VA paid claims of about $165,000. Eight defendants pleaded guilty in the Northern District of Texas to conspiracy to pay and receive healthcare kickbacks. The investigation was conducted by the VA OIG, HHS OIG, DCIS, and FBI.

FRAUD AGAINST THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA) AND OTHER HEALTHCARE FRAUD

BUSINESS OWNER SENTENCED FOR TWO CONSECUTIVE HEALTHCARE FRAUD CONSPIRACIES

The owner of a telemarketing company and multiple durable medical equipment (DME) supply companies was sentenced in the Middle District of Florida to 15 years in prison for his role in two consecutive conspiracies to commit healthcare fraud. From January 2018 to April 2019, the defendant and his coconspirators generated medically unnecessary physicians' orders via a telemarketing operation for DME. Through the telemarketing operation, the personal and medical information of Medicare beneficiaries was harvested to create the unnecessary DME orders. The orders were then forwarded to purported "telemedicine" vendors that, in exchange for a fee, paid illegal bribes to physicians to sign the orders, often without ever contacting the beneficiaries. The orders were then used as support for millions of dollars in false and fraudulent claims submitted to the Medicare program. To avoid Medicare scrutiny, the defendant spread the fraudulent claims across five DME storefronts operated under his ownership and control. The scheme led to about $25 million in fraudulent DME claims submitted to Medicare, resulting in approximately $12 million in payments. In April 2019, the storefronts were subject to search warrants and a civil action under which, among other ramifications, the defendant and his five storefronts were enjoined from engaging in any further healthcare business. Undeterred, he and other conspirators carried out a similar conspiracy using three new DME storefronts and different "telemedicine" vendors. This second conspiracy caused approximately $12 million in additional fraudulent DME claims to be submitted to Medicare, resulting in approximately $6.3 million in payments. In addition to his prison sentence, the defendant was sentenced to three years of supervised release and restitution of $18 million to Medicare and more than $20,000 to CHAMPVA. The court also issued a final order of forfeiture against the defendant for $10 million. This investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation (IRS CI), FBI, and HHS OIG.

OFFICE MANAGER SENTENCED FOR ROLE IN COMPOUNDING PHARMACY FRAUD CONSPIRACY

The office manager of a pharmacy was sentenced to 36 months of probation after pleading guilty in the Eastern District of Louisiana for her role in a multimillion-dollar healthcare fraud conspiracy. According to a multiagency investigation, the owner of the pharmacy colluded with physicians to provide compounding medication to CHAMPVA and TRICARE beneficiaries, even though the medication was not medically necessary or no doctor–patient relationship existed. The company billed CHAMPVA for

close to $619,000 and TRICARE for approximately $14 million. As the pharmacy's office manager, the defendant had knowledge of the fraud scheme and concealed it by knowingly submitting payment requests for the unnecessary compounded medications. She pleaded guilty to misprision (or knowing concealment). In addition to her probation sentence, she was ordered to pay $180,000 in restitution. The investigation was conducted by the VA OIG, DCIS, USPIS, and HSI.

TWO DEFENDANTS PLEADED GUILTY FOR HEALTHCARE FRAUD

From 2014 through 2016, multiple defendants allegedly conspired to commit healthcare fraud against the government by unnecessarily prescribing and billing for compound medication through a VA vendor and a coconspirator pharmacy in New Jersey. The pharmacy received over $8 million in reimbursements through federal healthcare programs. Of this amount, CHAMPVA paid approximately $493,000. Two defendants pleaded guilty in the District of New Jersey in connection with this investigation. The VA OIG, HHS OIG, DCIS, and FBI conducted the investigation.

TWENTY PEOPLE INDICTED ON CHARGES RELATED TO HEALTHCARE FRAUD CONSPIRACY

A multiagency investigation resulted in charges alleging that 20 defendants—including the two founders of a physical therapy practice and 18 of its employees—conspired to commit fraud through various means. From January 2007 to October 2021, the defendants allegedly used unlicensed technicians to provide physical therapy treatment and billed the treatment as if it were performed by a licensed physical therapist or physical therapy assistant, and regularly billed for treatment time in excess of the actual treatment time spent with patients. The defendants were indicted in the Western District of Pennsylvania on charges of conspiracy to commit wire fraud and healthcare fraud. The total amount of loss to the government is approximately $22 million. Of this amount, the total loss to VA is approximately $500,000. The VA OIG, HHS OIG, DCIS, Office of Personnel Management OIG, Pennsylvania Office of Attorney General, and FBI conducted this investigation.

THREE INDIVIDUALS PLEADED GUILTY FOR ROLES IN COMPOUNDING PHARMACY SCHEME

According to a multiagency investigation, three individuals submitted false claims for compounded prescriptions totaling close to $111 million to TRICARE, CHAMPVA, and private insurance companies. The compounded prescriptions were fraudulently dispensed by doctors located in different states than the patients, and for whom no doctor–patient relationship existed. According to the investigation, the compounded prescriptions were fraudulently dispensed by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or were billed for but never provided. The three defendants pleaded guilty in the Southern District of Florida to conspiracy to commit wire fraud. The overall estimated loss to the government and private insurance is approximately $29.3 million. Of this amount, the loss to VA is more than $450,000. The investigation was conducted by the VA OIG, Army CID, Department of Labor (DOL) Employee Benefits Security Administration, Food and Drug Administration Office of Criminal Investigations, and DCIS.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

THREE DEFENDANTS PLEADED GUILTY IN CONNECTION WITH HEALTHCARE FRAUD

Three defendants were charged with participating in a scheme involving several telemarketers, telemedicine doctors, and the sale of DME. Telemarketers allegedly solicited braces to prospective patients and then used telemedicine doctors to generate prescriptions, even though they had no relationship with the patients. The telemarketers, in turn, sold the completed orders to the DME companies. Many of the target companies identified in the scheme submitted claims for payment to CHAMPVA. The three defendants pleaded guilty in the District of New Jersey to conspiracy to commit healthcare fraud, with two also being indicted on various related charges. The loss to VA is approximately $330,000. To date, investigative efforts by the VA OIG, DCIS, FBI, and HHS OIG have led to 17 arrests and 13 convictions.

BUSINESS OWNER SENTENCED IN CONNECTION WITH HEALTHCARE FRAUD CONSPIRACY

According to a multiagency investigation, a business owner created hundreds of DME companies and placed them in the names of straw owners, leading to the submission of over $400 million in illegal DME claims to Medicare and CHAMPVA. The defendant's coconspirators allegedly purchased physician orders for DME from "marketers" who bribed doctors to sign the orders often without ever contacting the beneficiaries. The defendant also admitted to using company funds to purchase numerous personal items that she falsely claimed as business expenditures to the IRS. The defendant was sentenced in the Middle District of Florida to 51 months in prison; three years of supervised release; and $10.4 million in restitution to Medicare, $52,000 to CHAMPVA, and $48,000 to the IRS. The court also issued a final order of forfeiture against the defendant for $20.3 million. She previously pleaded guilty to conspiracy to commit healthcare fraud and filing a false tax return. The loss to VA is approximately $400,000. This investigation was conducted by the VA OIG, IRS CI, FBI, and HHS OIG.

PSYCHIATRIST AND OFFICE ASSISTANT AGREED TO PAY $3 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

From January 2013 through April 2021, a psychiatrist and his office assistant submitted false billings to the DOL's Office of Workers' Compensation Programs. The defendants allegedly billed for a level of service higher than what was actually provided, double billed for initial consultations, billed for no-show appointments, and falsified treatment records to reflect the fraudulent billing during that period. The defendants entered into a civil settlement with the US Attorney's Office for the Eastern District of Pennsylvania and agreed to pay $3 million to resolve these allegations. The investigation was conducted by the VA OIG, DOL OIG, and US Postal Service OIG.

LOUISIANA DOCTOR PLEADED GUILTY IN CONNECTION WITH WORKERS' COMPENSATION FRAUD CONSPIRACY

A multiagency investigation found that a Louisiana doctor was paid more than $650,000 in kickbacks from a medical supply company for his purchase of topical medications, which he dispensed to his clinic's patients engaged with the Office of Workers' Compensation Programs. The doctor pleaded guilty in the Western District of Arkansas to conspiracy to commit healthcare fraud, wire fraud, and illegal remunerations (taking kickbacks). The VA OIG, DOL OIG, DCIS, and US Postal Service OIG conducted this investigation.

CAREGIVER SUPPORT PROGRAM FRAUD

FORMER VA EMPLOYEE SENTENCED FOR THEFT OF GOVERNMENT FUNDS RELATED TO FALSE NEED FOR CAREGIVER

According to an investigation by the VA OIG, from October 2015 through April 2020, a veteran made numerous false statements to VA indicating that he was unemployed and in need of a full-time caregiver. During this same time frame, the defendant worked full-time as a veteran service representative at the VA regional office in San Diego, California. He was sentenced in the Southern District of California to eight months in prison, three years of supervised release, and restitution of approximately $183,000 after previously pleading guilty to theft of government funds. The caregiver entered into a deferred prosecution agreement under which she will not be sentenced for 24 months.

TRAVEL FRAUD

VETERAN SENTENCED IN CONNECTION WITH HEALTHCARE APPOINTMENT TRAVEL FRAUD SCHEME

An investigation by the VA OIG found that from November 2016 to August 2019 a veteran submitted nearly 500 travel reimbursement claims to VA, which resulted in his receipt of over $95,000. For most of these claims, the veteran reported that he traveled about 450 miles round trip an average of three to four times per week for chiropractic and physical therapy appointments. In reality, the defendant stayed at a residence less than 15 miles from his chiropractic and physical therapy appointments. He was sentenced in the District of Kansas to 24 months of probation and ordered to pay $50,000 in restitution to VA after previously pleading guilty to making false statements.

IDENTITY THEFT

FORMER SOCIAL WORKER AT THE PROVIDENCE VA MEDICAL CENTER CHARGED FOR IDENTITY THEFT SCHEME

A multiagency investigation resulted in charges alleging that a former social worker at the Providence VA Medical Center in Rhode Island fraudulently claimed to be a wounded US Marine Corps veteran who was the recipient of a Purple Heart and a Bronze Star. The former social worker allegedly schemed to collect hundreds of thousands of dollars in benefits from veteran-focused charities using the personally identifiable information of an actual Marine to falsely claim she served in the Marine Corps from 2009 to 2016, achieved the rank of corporal, was wounded in action, and was honorably discharged. She also falsely claimed to have cancer due to her military service after using her position to access the VA medical records of a veteran cancer patient. This investigation was conducted by the VA OIG, NCIS, USPIS, VA Police Service, IRS CI, FBI, and DCIS.

DRUG DIVERSION BY VA EMPLOYEES AND DRUG TRAFFICKING

FORMER CHIEF OF PHARMACY AT THE ERIE VA MEDICAL CENTER PLEADED GUILTY TO DIVERTING PAINKILLERS

From 2017 to 2020, the former chief of pharmacy at the Erie VA Medical Center diverted at least 300 hydrocodone and oxycodone tablets for his personal use by removing the tablets from prescription

bottles that were waiting to be mailed to veterans. Following an investigation by the VA OIG, the defendant pleaded guilty in the Western District of Pennsylvania to acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge.

FORMER CERTIFIED NURSE ANESTHETIST AT VA ANN ARBOR HEALTHCARE SYSTEM SENTENCED IN CONNECTION WITH DRUG DIVERSION SCHEME

An investigation by the VA OIG and Drug Enforcement Administration revealed that between July 2018 and February 2019, a former VA Ann Arbor Healthcare System certified nurse anesthetist diverted more than 2,200 vials of Schedule II and Schedule IV controlled substances for her own personal use. She was sentenced to three years of probation in the Eastern District of Michigan after previously pleading guilty to obtaining controlled substances by misrepresentation, fraud, forgery, deception, or subterfuge.

NONVETERAN DRUG TRAFFICKER SENTENCED IN CONNECTION WITH DISTRIBUTION SCHEME

A nonveteran was sentenced for being part of a drug-trafficking organization that distributed cocaine, heroin, and controlled pharmaceuticals throughout Connecticut, including to veterans at the VA medical center in West Haven. He was sentenced in the District of Connecticut to 70 months of incarceration and 48 months of supervised release. The VA OIG, DEA, West Haven Police Department, and FBI conducted the investigation.

KIDNAPPING AND EXTORTION

NEW YORK MAN PLEADED GUILTY TO KIDNAPPING AND EXTORTION

According to an investigation by the VA OIG and FBI, a man from Bronx, New York, kidnapped an elderly woman with dementia from a parking lot at the West Los Angeles VA Medical Center and obtained more than $17,000 from the victim's checking account without her consent. The defendant pleaded guilty in the Central District of California to kidnapping and extortion.

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

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

The OIG's data analysis staff, in coordination with OI personnel, conducts an ongoing "Death Match" project to proactively identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. Within this reporting period, field personnel (including investigative assistants and special agents) teamed with headquarters staff to process and

work death match cases resulting in the arrest of two individuals, recoveries of $206,877, and a projected five-year savings to VA estimated at $919,863.

OI opened 64 investigations involving the fraudulent receipt of VA monetary benefits, including those for deceased payees identified through the death match project, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 29 arrests. OI obtained over $80.3 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $6 million in savings, efficiencies, and cost avoidance; and recovered close to $650,000. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

EDUCATION BENEFITS FRAUD

DIRECTOR OF TRUCKING SCHOOL SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

The director and certifying official of a trucking school was sentenced in connection with a scheme that involved the fraudulent enrollment of veterans at the school from 2011 to 2015. According to the investigation, which was conducted by the VA OIG, FBI, and DOJ OIG, the school's owner, employees, and veteran students either conspired or had knowledge of the scheme. The director was sentenced in the Central District of California to 15 months in prison, three years of supervised release, and restitution of over $4 million. The total loss to VA is approximately $4.1 million.

DIVING SCHOOL OWNER SENTENCED FOR EDUCATION BENEFITS FRAUD

From January 2012 through July 2018, a woman from Haddon Heights, New Jersey, owned a private, for-profit commercial diving school that offered educational programs in commercial diving. As a for-profit institution, the diving school was required to be accredited through an approved accreditation body to be eligible to receive tuition funds from the Department of Education's Higher Education Act programs. VA also relies on the accreditation in evaluating the eligibility of veteran students to receive student aid funding. When renewing the diving school's accreditation in 2012, the owner of the school submitted fraudulent information to the accrediting authority regarding employment rates of the school's graduates and wholly fabricated meeting minutes for advisory board meetings purportedly held by the school, which are required for accreditation. The fraudulent reaccreditation enabled the school to maintain eligibility for federal education benefits from VA and the Department of Education. The owner was sentenced in the District of New Jersey to 27 months in prison, three years of supervised release, restitution of $1.1 million, and a fine of $50,000 after previously pleading guilty to wire fraud. The investigation was conducted by the VA OIG, Department of Education OIG, and FBI.

THEFT AND EMBEZZLEMENT

INDIVIDUAL SENTENCED FOR EMBEZZLEMENT

A multiagency investigation resulted in charges alleging that an individual, with the assistance of four coconspirators, embezzled funds from deceased or elderly bank account holders at a major financial institution. The defendant allegedly laundered the stolen funds through relatives, associates, or shell companies owned by relatives and associates, misappropriating more than $6.9 million in funds from the bank account holders. Many of the affected account holders were VA and Social Security Administration (SSA) beneficiaries. The defendant was sentenced in the Eastern District of New York to

48 months in prison, 48 months of supervised release, and restitution of almost $1.4 million. Three of his coconspirators previously pleaded guilty in connection with this investigation, which was conducted by the VA OIG, Manhattan District Attorney's Office, New York City Police Department, HSI, IRS CI, USPIS, and SSA OIG.

VETERAN PLEADED GUILTY FOR ROLE IN COMPENSATION BENEFITS FRAUD SCHEME

According to an investigation by the VA OIG and SSA OIG, a veteran allegedly conspired with her father and her then husband, both of whom are also veterans, to submit fraudulent documents and misrepresent the severity of their respective disabilities to obtain VA compensation benefits. The defendant fraudulently received about $35,000 in Social Security Disability Insurance benefits for her claimed disabilities. The total loss to VA is approximately $820,000. The defendant pleaded guilty in the District of Maryland to charges of conspiracy to commit theft of government property and theft of government property.

WOMAN SENTENCED FOR THEFT OF GOVERNMENT FUNDS MEANT FOR VETERAN BOYFRIEND

Another investigation by the VA OIG and SSA OIG determined that from October 2002 until December 2019, a nonveteran stole VA and SSA benefit checks (in this case, withdrawing funds) intended for her veteran boyfriend who died in 2002. The defendant also accessed two different bank accounts held in the deceased veteran's name into which the VA and SSA benefits were electronically deposited. The total loss to the government is approximately $674,000. Of this amount, the loss to VA is more than $548,000. The defendant was sentenced in the Eastern District of Pennsylvania to six months of home confinement, three years of probation, and restitution of about $674,000 after previously pleading guilty to theft of government funds.

VETERAN CLAIMING BLINDNESS FOUND GUILTY OF THEFT OF GOVERNMENT FUNDS AND FALSE STATEMENTS

A VA OIG investigation resulted in charges alleging that a veteran fraudulently led VA to believe he was blind. The veteran, who had been receiving 100 percent service-connected disability benefits since June 2011, falsely stated to VA that he was unable to drive and had someone drive for him. Despite these claims, he possessed a valid driver's license with a motorcycle endorsement and drove on a routine basis. He was found guilty by a federal jury in the Middle District of Florida on charges of theft of government property and false statements. The loss to VA is approximately $430,000.

ANOTHER VETERAN CLAIMING BLINDNESS PLEADED GUILTY TO THEFT OF GOVERNMENT PROPERTY

A VA OIG proactive investigation revealed that a second veteran rated as 100 percent service-connected disabled for bilateral blindness since 2000 maintained a valid Missouri driver's license. During the investigation, the defendant was observed driving routinely and mowing his lawn. The defendant pleaded guilty in the Eastern District of Missouri to theft of government property. The loss to VA is more than $671,000.

A THIRD VETERAN INDICTED FOR THEFT AFTER CLAIMING TO BE BLIND

According to a multiagency investigation, a third veteran purported to be blind in order to receive government disability benefits. Despite claiming to be blind, the veteran maintained a valid Nebraska driver's license, drove nearly daily, and obtained a Nebraska concealed carry weapons permit. He was

arrested after being indicted in the District of Nebraska for theft of government funds. The total loss to the government is approximately $604,000. Of this amount, the loss to VA is approximately $211,000. The VA OIG, SSA OIG, and HHS OIG conducted the investigation.

DECEASED VETERAN'S SON SENTENCED FOR THEFT OF GOVERNMENT FUNDS

A VA OIG investigation revealed that from September 2006 until June 2018, the son of a deceased VA beneficiary repeatedly conducted withdrawals of VA survivors pension benefits from the beneficiary's bank account. The defendant was sentenced in the District of New Jersey to 14 months of home confinement, three years of probation to be served concurrent with the home confinement, and restitution of over $201,000 to VA after previously pleading guilty to theft of government funds.

ROOMING HOUSE OPERATOR INDICTED IN CONNECTION WITH THEFT SCHEME

From March 2009 to February 2020, a rooming house operator allegedly used VA and SSA benefit funds for her own personal use that were intended for the care of beneficiaries who are elderly, have mental illness or physical disabilities, and are veterans. The defendant was arrested after being indicted in the District of Columbia on charges of theft of government property, mail fraud, wire fraud, aggravated identity theft, first-degree theft, representative payee fraud, making a false statement, and tampering with documents. The scheme resulted in the theft of more than $400,000 in government benefits from tenants of her rooming house, including at least $170,000 in VA funds. The investigation was conducted by VA OIG, SSA OIG, and the Special Inspector General for the Troubled Asset Relief Program.

EX-WIFE OF DECEASED VA BENEFICIARY SENTENCED FOR THEFT OF GOVERNMENT FUNDS

A VA OIG investigation revealed that the ex-wife of a deceased VA beneficiary was awarded VA Dependency and Indemnity Compensation benefits based on multiple false documents that she submitted to VA. Despite being divorced at the time of the beneficiary's death, she provided an amended death certificate that falsely indicated that she was the deceased VA beneficiary's widow. She was sentenced in the Western District of Missouri to one year and a day of incarceration, three years of supervised release, and restitution of more than $100,000 to VA.

SISTER OF DECEASED VETERAN SENTENCED FOR THEFT OF PUBLIC FUNDS

From December 2006 to September 2017, the sister of a deceased VA beneficiary repeatedly conducted withdrawals of VA Dependency and Indemnity Compensation benefits from her sister's bank account. She was sentenced in the District of Massachusetts to one month of imprisonment, three years of supervised release, and restitution of over $102,000 to VA after previously pleading guilty to theft of public funds.

LOAN FRAUD

ATTORNEY FOUND GUILTY OF LOAN FRAUD TOTALING MORE THAN $8 MILLION

According to a multiagency investigation, a licensed attorney fraudulently applied for over $8 million in loans from five financial institutions, laundered money, and made material misrepresentations during bankruptcy proceedings between 2015 and 2018. To obtain loans from the financial institutions, the attorney allegedly provided banks with misleading documents that suggested that he was operating a lucrative law firm. The law firm's purported income was allegedly based on bogus, unpaid invoices the firm submitted to entities that the attorney controlled, including bankrupt entities. The fraudulent loans

included a VA-guaranteed loan for $2.9 million. The attorney was found guilty of bank fraud, wire fraud, money laundering, and making misrepresentations during bankruptcy proceedings after a two-week bench trial in the District of New Hampshire. The VA OIG, FBI, and SBA OIG conducted the investigation.

FIDUCIARY FRAUD

FORMER VA FIDUCIARY SENTENCED FOR MISAPPROPRIATION OF BROTHER'S BENEFITS

A VA OIG investigation found that a former VA-appointed fiduciary embezzled VA funds intended for his veteran brother, including over $130,000 in unauthorized money transfers, over $25,000 in ATM cash withdrawals, and numerous purchases for his own personal use. The purchases included a diamond ring, a pickup truck, and two motorcycles. The former fiduciary was sentenced in the Western District of Pennsylvania to one day of incarceration, three years of supervised release, restitution of $75,000, and a fine of $4,000 after previously pleading guilty to misappropriation by a fiduciary.

VA FIDUCIARY INDICTED FOR MISAPPROPRIATION OF FUNDS FROM A DISABLED VETERAN'S ACCOUNT

From March 2017 to March 2018, another former VA-appointed fiduciary allegedly made 44 unauthorized withdrawals from a disabled veteran's bank account totaling over $34,000. The former fiduciary used these funds for his own personal benefit, including paying for his own phone bills, medical bills, and mortgage payments. He was indicted in the Western District of Pennsylvania on a charge of misappropriation by a fiduciary. The VA OIG conducted this investigation.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including information management crimes, such as theft of IT equipment and data, network intrusions, and child pornography. OI also investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices alone, OI opened 16 cases and made five arrests. These investigations resulted in over $88.5 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $2.2 million in savings, efficiencies, and cost avoidance.

CASES RELATED TO SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESSES

NONVETERAN CONSTRUCTION COMPANY OWNERS SENTENCED FOR SDVOSB FRAUD SCHEME

Between 2009 and 2018, a nonveteran owner of a construction company and his coconspirators allegedly controlled and operated an SDVOSB that was awarded approximately $335 million in set-aside contracts, of which about $118 million was awarded by VA. When the company grew too large to compete for small business contracts, the owner and his coconspirators used the minority status of another

coconspirator to set up a second company that was certified by the SBA's 8(a) Business Development Program. The second business was awarded an additional $11 million in set-aside contracts. The nonveteran owner was sentenced in the Western District of Missouri to 28 months of incarceration, three years of supervised release, and a personal money judgment of more than $5 million after pleading guilty to defrauding the government. The owner of the second business was sentenced to 12 months of home confinement and five years of probation. The investigation was conducted by the VA OIG, DCIS, GSA OIG, SBA OIG, Army CID, Department of Agriculture OIG, IRS CI, US Secret Service, AFOSI, NCIS, Defense Contract Audit Agency—Operations Investigative Support, DOL OIG, and DOL EBSA.

CONSTRUCTION COMPANY AGREED TO PAY $4.75 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A multiagency investigation resolved allegations that a construction company violated the False Claims Act by creating an SDVOSB as a "pass-through" to obtain set-aside contracts for which it was otherwise ineligible. The company entered into a consent judgment with the US Attorney's Office for the Western District of New York under which the company agreed to pay approximately $4.75 million to resolve the allegations. The total value of the VA contracts awarded to the SDVOSB was approximately $20 million. The VA OIG, SBA OIG, DCIS, and Army CID conducted the investigation.

SECOND DEFENDANT SENTENCED IN CONNECTION WITH SDVOSB CONSTRUCTION FRAUD SCHEME

A multiagency investigation found that two individuals fraudulently obtained several SDVOSB set-aside construction contracts valued at more than $16 million. Of this amount, the total value of the VA set-aside contracts is approximately $4.3 million. One defendant was previously sentenced to 24 months of probation and a fine of $52,500 after pleading guilty. The second defendant was sentenced in the District of Utah to 12 months of probation and a fine of over $105,000 after also previously pleading guilty to major program fraud. This investigation was conducted by the VA OIG, GSA OIG, AFOSI, Army CID, Department of Transportation OIG, Department of Agriculture OIG, SBA OIG, and FBI.

VETERAN PLEADED GUILTY TO WIRE FRAUD AFTER FALSELY CLAIMING TO OWN AND CONTROL BUSINESS

According to an investigation by the VA OIG, DOL OIG, and GSA OIG, a veteran owner of an SDVOSB participated in a "pass-through" scheme in which she falsely claimed to control the business, when in fact it was controlled by other individuals who also held ownership interest. The veteran submitted false information to several government agencies to qualify the business as an SDVOSB. From March 2010 to February 2018, her company was awarded approximately $4.8 million in set-aside contracts, of which approximately $4.2 million was awarded by VA. The veteran pleaded guilty in the District of Kansas to wire fraud.

CONTRACTOR FRAUD

FORMER FEDERAL CONTRACTOR FOUND GUILTY OF WIRE FRAUD AND AGGRAVATED IDENTITY THEFT

A multiagency investigation found that a former federal contractor obtained federal contracts while he was debarred and posed as a federal contracting officer to negotiate fraudulent contracts with victim companies. The scheme resulted in approximately $2.4 million in government funds, of which about

$800,000 was awarded by VA. The defendant pleaded guilty in the Eastern District of Washington to wire fraud and aggravated identity theft. This investigation was conducted by the VA OIG, DCIS, Army CID, GSA OIG, DOJ OIG, Department of State OIG, AFOSI, and NCIS.

FALSE STATEMENTS

VETERAN ARRESTED FOR FALSE STATEMENTS

In September 2017, a veteran from Fayetteville, New York, allegedly made false statements to the Federal Aviation Administration (FAA) on a Form 8500-8, which is an application pilots submit to the FAA to renew their medical certifications. The indictment alleges that the veteran stated on the form that he had no history of criminal convictions and had never received medical disability benefits, despite having an extensive criminal record dating back several decades and having received VA service-connected disability benefits for many years. He was arrested in the Northern District of New York after previously being indicted for making false statements to the FAA on his pilot's medical certificates. This case is being investigated by the VA OIG and Department of Transportation OIG.

THREATS AND ASSAULTS INVOLVING VA EMPLOYEES

During this reporting period, OI personnel initiated 18 criminal investigations resulting from assaults and threats involving VA facilities and employees. This work resulted in charges filed against six individuals. Investigations resulted in $217,174 in savings, efficiencies, cost avoidance, and dollar recoveries.

THREATS AND ASSAULTS AGAINST VA EMPLOYEES

VETERAN SENTENCED FOR LEAVING HARASSING VOICEMAILS FOR VA MEDICAL CENTER STAFF

An investigation by the VA OIG and VA Police Service revealed that a veteran, who was previously convicted for making threats against the VA medical centers in Albany and Canandaigua, also left threatening and harassing voicemail messages for multiple employees at the Albany Stratton VA Medical Center in New York. The veteran was sentenced in the Northern District of New York to 24 months of imprisonment and one year of supervised release after previously pleading guilty to aggravated harassment.

FORMER SHUTTLE DRIVER AT THE OMAHA VA MEDICAL CENTER SENTENCED FOR THREATENING VA EMPLOYEES

A VA OIG investigation found that a former shuttle driver at the VA medical center in Omaha, Nebraska, described to multiple VA medical officials a detailed plan to gather her weapons—including an Uzi, AR-15 rifle, sawed-off shotgun, and Glock 9 mm handgun—and then drive to the facility to shoot and kill two coworkers and her supervisor. The defendant, who was detained for 14 months prior to sentencing, previously pleaded guilty to influencing, impeding, or retaliating against a federal official by threats. She was sentenced in the District of Nebraska to 12 months of imprisonment (time served) and three years of supervised release with conditions related to mental health treatment, substance abuse, and restricted weapons possession.

VETERAN SENTENCED FOR MAKING THREATS

A VA OIG investigation determined that a veteran sent a threatening text message to his VA social worker's government-issued cell phone after he was discharged from housing provided through the US Department of Housing and Urban Development–VA Supportive Housing Program due to misconduct. The defendant threatened to kill the social worker's family members because he blamed the social worker for his removal from the program. The defendant was sentenced in the Northern District of Ohio to 12 months of imprisonment and three years of supervised release after previously pleading guilty to influencing, impeding, or retaliating against a federal employee by threatening a family member.

VETERAN FOUND GUILTY OF THREATENING A VETERANS BENEFITS ADMINISTRATION SUPERVISOR

An investigation by the VA OIG and VA Police Service resulted in charges alleging that on multiple occasions a veteran threatened to inflict serious physical harm on a VBA fiduciary supervisor because VA was reviewing the defendant's ability to handle his own financial affairs. The veteran was found guilty by a federal jury in the Northern District of Ohio of threatening a federal employee and acquitted of assault of an officer.

VETERAN PLEADED GUILTY TO ASSAULT WITH A DEADLY WEAPON

An investigation by the VA OIG and Las Vegas Metropolitan Police Department revealed that on multiple occasions, a veteran threatened to kill himself and VA employees during calls to the VA Hotline, White House VA Hotline, and VA Crisis Line. On one occasion, the veteran said he possessed weapons and the knowledge to build chemical weapons, and he also established a timeline to start killing people. He pleaded guilty in the District Court for Clark County, Nevada, to assault with a deadly weapon.

VETERAN CHARGED WITH MAKING THREATS AGAINST HEALTHCARE PROVIDER

According to an investigation by the VA OIG and VA Police Service, a veteran left a threatening voicemail message at the VA outpatient clinic in Mansfield, Ohio, after his prescription for a controlled substance medication was discontinued by his medical provider. The veteran allegedly threatened to kill the medical provider and her entire family. He was arrested after being charged in the Northern District of Ohio with making threats against a federal employee.

THREATS AND ASSAULTS BY FORMER VA EMPLOYEES

FORMER MEDICAL SUPPORT ASSISTANT AT THE MEMPHIS VA MEDICAL CENTER SENTENCED FOR ASSAULTING FEDERAL OFFICERS

A former medical support assistant at the VA medical center in Memphis, Tennessee, assaulted two VA police officers as they carried out their official duties. The defendant was initially observed assaulting a third individual in the facility's parking lot. As a VA police officer attempted to detain the defendant, she resisted arrest and struck him several times. After being escorted to the VA Police Service's holding area, she punched another VA police officer in the face, leaving visible marks and scratches. The VA OIG and VA Police Service investigated the matter, and the defendant was sentenced in the Western District of Tennessee to 10 months in prison and one year of supervised release.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FORMER VA MEDICAL CENTER EMPLOYEE PLEADED GUILTY TO THREATENING FORMER COWORKERS

A VA OIG investigation revealed that a former employee of the Coatesville VA Medical Center in Pennsylvania sent sexually explicit, harassing, and threatening interstate communications and packages to former coworkers. The defendant also targeted the family members of his former coworkers with similarly vulgar communications. The defendant pleaded guilty in the Eastern District of Pennsylvania to threatening and cyberstalking his former coworkers.

FUGITIVE FELON PROGRAM

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since 2002, 100.1 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 121,105 investigative leads being referred to law enforcement agencies. More than 2,685 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified nearly $2.3 billion in estimated overpayments and cost avoidance of more than $3.1 billion. During this reporting period, OI made five arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of 37 additional fugitive felons, and identified $86.6 million in estimated overpayments.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES

SUBSTANTIATED ALLEGATIONS OF MISCONDUCT AGAINST SENIOR GOVERNMENT OFFICIALS

Per the IG Act, inspectors general must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) in which allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including (1) whether the matter was referred to the DOJ, (2) the date of such referral, and (3) if applicable, the date of declination by the DOJ.[14] During this reporting period, OI closed no criminal investigations with substantiated allegations against senior government employees.

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

The IG Act requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the

14 Pub. L. No. § 5(a)(19).

public.[15] When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed one criminal investigation with unsubstantiated allegations against a senior government employee, as described below.

ALLEGED PURCHASING IRREGULARITIES BY A VISN 9 CHIEF LOGISTICS OFFICER

The OIG received an allegation that a VISN 9 chief logistics officer ordered the purchase of medical gowns at an exorbitant cost from a vendor. The investigation determined that the VISN 9 chief logistics officer violated Federal Acquisition Regulations but there was not evidence of criminal activity. Because VA used the ordered medical gowns, there was no financial loss to the agency. After being served with a proposal of termination, the VISN 9 chief logistics officer retired. On April 24, 2021, this case was referred for prosecution to, and declined by, the US Attorney's Office for the Middle District of Tennessee. The investigation was closed on January 3, 2022.

Check out the latest

MONTHLY HIGHLIGHTS

Each month, the VA OIG publishes highlights of our investigative work, oversight reports, and congressional testimony. The highlights are meant to provide a brief overview of the most significant OIG work conducted in that period. To read more summaries from the Office of Investigations or the other VA OIG directorates, see the highlights website.

15 Pub. L. No. § 5(a)(22)(B).

RESULTS FROM THE OFFICE OF SPECIAL REVIEWS

3	1	132
Publications	Recommendation	Investigative Interviews Conducted

OVERVIEW

OSR issued three publications in this reporting period: two reports and one VA management advisory memorandum. Staff conducted extensive work and triaged matters for further review that will be the subject of future reports as well. The publications listed below reflect OSR's commitment to holding VA employees accountable for wrongdoing and promoting the highest standards of professional and ethical conduct. As with other OIG published reports, OSR recommendations for corrective action are detailed at www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

ADMINISTRATIVE INVESTIGATIONS

OSR evaluates allegations regarding the integrity or operations of VA offices, programs, or initiatives that often involve allegations of individual misconduct. Staff conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders. OSR publishes all administrative cases of senior government employees (substantiated and not substantiated) in compliance with the IG Act and Title 38 requirements. Therefore, there are no additional disclosures to be made in this report to Congress of cases that were closed without a public release.

ALLEGED MISCONDUCT BY CONSTRUCTION AND FACILITIES DEPUTY EXECUTIVE DIRECTOR NOT SUBSTANTIATED

This administrative investigation assessed allegations that the deputy executive director of VA's Office of Construction and Facilities Management (OCFM), during his tenure as acting executive director, failed to respond appropriately to a 2018 audit by OCFM's Quality Assurance Service. While his failure to respond was not substantiated, the OIG found that he did not broadly communicate how he responded, except to his executive leadership team after an 11-month delay, which led some OCFM staff to believe he ignored the report and failed to adequately follow up on the risk of fraud. The OIG determined that OCFM lacks a governing policy related to tracking this type of audit. The OIG also investigated whether in 2019 the deputy executive director falsely attested to the effectiveness of OCFM's internal controls. Based on interviews and contemporaneous evidence, the OIG did not find that he made false statements, despite his comments at a February 2020 meeting that he had concerns about the quality of OCFM's controls and its assessment process. VA concurred with the OIG's findings and its recommendation to determine whether the Quality Assurance Service should conduct special reviews, and if so, establish policy or procedures to govern this work, including standardized processes for communicating and tracking the implementation of recommendations.

FORMER EDUCATION SERVICE EXECUTIVE VIOLATED ETHICS RULES AND HER DUTY TO COOPERATE FULLY WITH THE OIG

At the request of Congress, the OIG conducted an administrative investigation to assess allegations that the former executive director of VBA's Education Service committed ethical violations arising from her spouse's consulting work for Veterans Education Success (VES). VES is a nonprofit advocacy group that regularly had business before the Education Service. As a result of the investigation, the OIG made four findings. First, the former executive director participated in Education Service matters involving VES without considering whether it raised an apparent conflict of interest and acted contrary to ethics guidance she received from her supervisors. Second, she sought résumé feedback from the president of VES to aid in her search for career advancement without considering whether this raised apparent conflict of interest concerns in subsequent VES matters. VES also endorsed her for presidential appointment positions. Third, although she provided insufficient detail about her spouse's business in 2019 and 2020 public financial disclosures, VA ethics attorneys had found them compliant. She remedied the subsequently identified deficiency in her 2021 disclosure. Finally, the OIG found that she refused to cooperate fully in the investigation by refusing to complete her follow-up interview. Her husband and VES president also refused to participate in OIG interviews, and the OIG lacks testimonial subpoena authority over individuals who are not VA employees. The former executive director resigned from VA in January 2022 and, as a result, the OIG made no recommendations. VA concurred with the OIG's findings.

REVIEW OF SES REASSIGNMENTS IN THE VETERANS BENEFITS ADMINISTRATION

Concerns about the proper use and justification of relocation payments for VA SES (Senior Executive Service) employees have been long-standing. In response to a congressional request, the review team examined the reassignments of two executive directors in VBA to determine whether VA's policies and procedures were followed for determining the directors' eligibility for relocation allowances. The OIG found nothing improper with the allowances paid to the two executive directors. There were, however, inconsistencies in VA's guidance found during the course of the review regarding the approval of relocation allowances. The OIG issued a management advisory memorandum to provide information to VA leaders about its findings. No additional OIG steps are being taken at this time, including any further reporting on the examination of the two executive directors' circumstances, as no wrongdoing or violation of law or policy was identified. VA's Office of Human Resources and Administration will inform the OIG of what action, if any, it takes to address identified concerns, including any revisions to the guidance and processes for approving relocation allowances and related documentation.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

78 Publications | **187** Recommendations | **$3.7B** Monetary Benefits

OVERVIEW

OAE produced a total of 78 publications during this reporting period. These focus on issues that have a meaningful impact on veterans' health care and benefits, the effective operations of VA programs and services, and the management of VA resources and taxpayer dollars. The list of all OAE report recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig/recommendation-dashboard.asp. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

FEATURED PUBLICATIONS

The following three publications provide examples of the type of work OAE staff conducts that focuses on identifying problems and making recommendations that can have a significant effect on VA and the veterans it serves.

NEW PATIENT SCHEDULING SYSTEM NEEDS IMPROVEMENT AS VA EXPANDS ITS IMPLEMENTATION

The OIG assessed whether VHA and the Office of Electronic Health Record Modernization (OEHRM) effectively implemented the patient scheduling component of VA's new electronic health record system at two sites in 2020: the Chalmers P. Wylie VA Ambulatory Care Center in Columbus, Ohio, and the Mann–Grandstaff VA Medical Center in Spokane, Washington. The new scheduling system is part of VA's multibillion-dollar EHR contract with Cerner and has the potential to transform VHA scheduling. However, the OIG found that VHA and OEHRM knew of but did not fully resolve significant limitations before and after implementing the system at the Columbus and Spokane facilities, leading to reduced effectiveness and increased risk of patient care delays. With limited guidance and inadequate training on how to respond to unresolved issues, schedulers developed work-arounds. VHA employees also worked with Cerner to try to correct issues using a ticketing process; however, the ticketing process was ineffectively managed and OEHRM did not assess Cerner's compliance with contract terms for handling tickets. VA planned to implement the system at all 11 VISN 20 facilities by December 2021, which includes facilities in Alaska, Washington, Oregon, Idaho, and one county each in California and Montana. However, OEHRM paused future deployment in March 2021 to conduct a strategic review of the full EHR program. The OIG issued eight recommendations: (1) improve training for scheduling, (2) better engage schedulers in testing and improvements, (3) issue guidance on measuring patient wait times, (4) track help tickets consistent with contract terms; (5) develop a strategy to promptly resolve identified issues, (6) develop oversight of schedulers' accuracy, (7) evaluate patient care timeliness, and (8) provide guidance to consistently address system limitations. This is one of a series of oversight reports the OIG has been working on during this reporting period related to the EHR modernization effort.

IMPROVEMENTS NEEDED TO ENSURE FINAL DISPOSITION OF UNCLAIMED VETERANS' REMAINS

The OIG examined whether VA has an effective governance structure for ensuring the unclaimed remains of deceased veterans are interred with dignity in a final resting place, such as burial in a national cemetery. The review was initiated in response to reports that deceased veterans' unclaimed remains were being kept in a funeral home's storage for decades, which may have been indicative of a nationwide problem. While VA is required by law to ensure that deceased veterans without next of kin receive these burials, the responsibility for providing related benefits and services is dispersed among approximately 27 offices across all three VA administrations. The lack of a single program office or executive responsible for VA-wide oversight hampers VA's ability to identify and respond to program risks, such as overlapping benefit programs, poor use of data and interagency partnerships, or insufficient outreach to likely custodians of unclaimed veterans' remains. The OIG found that VA could not identify potential fraud or duplicate payments for burial benefits and services because payments cannot be reconciled across administrations that can reimburse for similar services (for example, two administrations could reimburse the costs of transportation for interment at a national cemetery). The OIG also found that VA missed opportunities to collaborate with entities that tracked unclaimed remains to help identify deceased veterans or engage funeral homes and others to locate them. The review team identified more than 400 probable veterans with records in a DOJ database of unclaimed deceased persons and also noted 1,700 cases in which VA confirmed that veterans in an external database were eligible for burials but could not demonstrate they had been interred. As a result, VA does not have an accurate count of deceased veterans whose remains are unclaimed, and remains that are left unidentified could be placed in mass graves or stored for years unnoticed. VA concurred with the OIG's 11 recommendations to address the issues identified.

DMLSS SUPPLY CHAIN MANAGEMENT SYSTEM DEPLOYED WITH OPERATIONAL GAPS THAT RISK NATIONAL DELAYS

In March 2019, VA directed the deployment of the Defense Department's DMLSS system to modernize and standardize VHA's supply chain management and replace up to 12 legacy systems. The deployment is expected to cost $2.2 billion over 15 years. The OIG reviewed VA's oversight and coordination of the system's implementation at the pilot site, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, to identify challenges that could affect future deployments. The OIG found that the system did not meet more than 40 percent of the high-priority essential business requirements identified by pilot site staff. Consequently, staff had to develop work-arounds to maintain day-to-day operations. Although VA's acquisition framework policies outline a process to ensure the DMLSS system meets high-priority requirements, the VA Logistics Redesign (VALOR) program manager did not follow the framework as required. The VALOR program office, which was tasked with overseeing the effort, has had a slow and unsteady start. It was created in early 2019 to manage deployment of the DMLSS system but did not receive funding until January 2020 and has been led by six different program managers since its inception. Additionally, VALOR did not effectively coordinate with key stakeholders early enough to minimize operational issues. These operational gaps should be addressed to prevent increasing costs, workloads, and delays at future sites. VA concurred with the OIG's recommendations and reported progress on aligning the DMLSS deployment process with VA's acquisition framework policy; better identifying unmet high-

Visit the OIG's **Recommendations Dashboard** to track VA's progress in implementing OIG recommendations.

priority business requirements and postdeployment challenges; and obtaining adequate staffing and stable VALOR leadership.

PUBLICATIONS ON HEALTHCARE ACCESS AND ADMINISTRATION

OIG audits and evaluations include a focus on the effectiveness of VA programs delivering health care to veterans. Reports on these programs identify opportunities for VA leaders and staff to improve the processes, procedures, and policies needed to better manage these operations. The recommendations are meant to support patients' timely access to high-quality healthcare services while making responsible use of taxpayer dollars.

SYSTEMS AND TOOLS IMPLEMENTED TO TRACK COVID-19 VACCINE DATA

The OIG examined whether VHA implemented systems to report on COVID-19 vaccine supply to VA medical facilities and doses administered to VA employees and veterans enrolled in VA's healthcare system. The team determined that facility-level vaccine supply data, which are manually entered, were not verified and vaccination data in key systems contained inaccuracies due to inadequate validation and user error. The team also found that some VHA staff initially lacked system access to enter employee vaccination data and the VHA COVID-19 vaccine dashboard contained unvalidated data. Accurate data are needed to schedule COVID-19 vaccinations, report the percentages of vaccinated veterans and employees to the Centers for Disease Control and Prevention, and help prevent COVID-19 vaccine theft. The OIG made three recommendations: verify medical facility vaccine supply data; monitor and minimize data entry errors; and ensure the dashboard data are reliable, accurate, and complete.

AUDIT OF COMMUNITY CARE CONSULTS DURING COVID-19

During COVID-19, VHA's Office of Community Care took steps to ensure veterans continued to have expanded access to health care in the community, as required by the VA MISSION Act of 2018. The VA OIG conducted this audit to determine whether VHA effectively managed community care consults for routine appointments during the pandemic. The OIG found that routine community care consults were unscheduled for an average of 42 days, not meeting VHA's timeliness goal of 30 days. Although staff faced scheduling challenges beyond their control, the OIG also found community care providers and staff did not consistently comply with requirements to manage routine consults. The OIG recommended developing guidelines to improve efforts to document contact with patients to schedule an appointment, monitoring whether clinicians are indicating and offering appropriate alternative forms of care, and reassessing the frequency of and approach to community care consults training.

INADEQUATE OVERSIGHT OF VHA'S HOME OXYGEN PROGRAM

VHA uses contractors to provide oxygen services to veterans who need respiratory care in their homes. The OIG examined whether VHA's oversight of the home oxygen program ensured patients received reevaluations of their need for home oxygen, home visits were conducted as required, contractor performance was monitored, and invoicing and payments were checked for accuracy. The OIG found that prescribing providers did not always timely reevaluate home oxygen patients and medical facility staff did not consistently conduct home visits for the required number of patients. In addition, monitoring by contracting officers and their representatives was inadequate due to a lack of oversight

and differing interpretations of guidance. Payments, however, were generally processed accurately. The team also found that VHA paid for services using expired contracts for two facilities. The OIG made six recommendations to the under secretary for health to address the issues identified.

IMPROVED GOVERNANCE WOULD HELP PATIENT ADVOCATES BETTER MANAGE VETERANS' HEALTHCARE COMPLAINTS

The Patient Advocacy Program helps VHA to improve customer service, support veterans' access to quality care, and resolve healthcare issues. Patient advocates document concerns, communicate resolutions, and provide follow-up and feedback. The OIG conducted this audit to determine whether VHA patient advocates resolved about 162,000 serious complaints in its patient advocate tracking systems on time and as required in FY 2020. The audit also assessed whether program leaders used program data to identify and address pervasive healthcare issues. The audit found the program lacked adequate governance and monitoring at the local, regional, and national program levels. Moreover, patient advocates and supervisors did not always enter complaints into the tracking system. Although patient advocates generally closed serious complaints on time, they did not always adhere to documentation requirements. VA concurred with the three OIG recommendations to revise program policy, strengthen controls for record reviews, and improve program management.

MISSION ACT MARKET ASSESSMENTS CONTAIN INACCURATE SPECIALTY CARE WORKLOAD DATA

The OIG audited the accuracy of data measuring VA's specialty healthcare capacity. As required by the MISSION Act, VHA will use assessment data to identify gaps in furnishing care and implement recommendations for modernizing or realigning VA facilities. The audit examined the accuracy of three data components: workload, wait times, and provider clinical time allocations. The OIG concluded that only the workload data inaccuracies were significant enough to affect potential management decisions. VHA's reported FY 2019 workload for 12 specialties across all VA care providers was found to be overstated by 10.7 percent, or about 563 full-time equivalent physician positions. This overstatement could result in a waste of taxpayer dollars and diminish access to care for some veterans. The OIG recommended that the acting under secretary for health perform additional analyses to ensure materially accurate data are used for implementing recommendations regarding facility modernization.

INDEPENDENT REVIEW OF VA'S SPECIAL DISABILITIES CAPACITY REPORT FOR FISCAL YEAR 2020

VA must report annually to Congress on its capacity in five areas: (1) spinal cord injuries and disorders, (2) traumatic brain injury, (3) blindness, (4) prosthetics, and (5) mental health issues. The requirement was established to ensure that VA's capacity to serve disabled veterans does not fall below 1996 levels. The OIG is required to report to Congress on the accuracy of VA's report. This OIG report identified minor errors, omissions, and inconsistencies in the FY 2020 capacity report that have persisted from the OIG's FY 2019 review. However, VA issued its FY 2020 report before the OIG released its FY 2019 review and therefore could not correct some of the identified issues. As the OIG previously reported, VA cannot compare current mental health capacity data with 1996 capacity because of changes in diagnosis and treatment, service provision, and data collection. The OIG believes that by modernizing the reporting metrics, Congress would be better positioned to assess VA's capacity to provide care for today's veterans with disabilities.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

PUBLICATIONS ON BENEFITS DELIVERY AND ADMINISTRATION

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

SUCCESSIVE VA ERRORS CREATED A $210,000 DEBT FOR A VETERAN

In April 2021, the OIG discovered VBA had incorrectly created a debt of about $210,000 for a veteran. Staff created the debt during an attempt to correct a disability-rating error. Subsequently, the overpayment should have been considered an administrative error, which veterans are not responsible for paying. The veteran reasonably believed that he was entitled to 100 percent disability evaluation, and the veteran or his representative contacted VBA at least 21 times over a two-year period regarding his evaluation. His many attempts to clarify the record are indicative of the stress veterans feel when there is uncertainty about their compensation or potential debt. When VBA discovered the overpayment, staff assured the veteran he would not be responsible for repayment; however, employees created the debt anyway. The OIG review team contacted VBA's Compensation Service with a detailed accounting of the case. The next day, Compensation Service attributed the debt to administrative error and approved waiving the debt, which was ultimately eliminated from VA's electronic system. The OIG did not request any further action on this case, but VBA should consider steps to avoid this type of error in the future as it can cause significant financial and emotional stress for beneficiaries.

IMPROPER PROCESSING OF AUTOMATED PENSION REDUCTIONS BASED ON SOCIAL SECURITY COST OF LIVING ADJUSTMENTS

Social Security payments may increase annually based on changes to the cost of living. When this happens, VA reduces pensions for veterans and other beneficiaries because they are receiving more income from another source. The OIG received two allegations in 2020 that the automated letters sent to beneficiaries failed to provide proper notification before pensions were reduced or discontinued. The review team found that pensions were not reduced in accordance with VA policies to (1) include specific information in the notification letters (such as the current and proposed pension amounts) and (2) consider evidence that the pension should not be reduced. The team determined that the monetary impact on each beneficiary was limited. However, inadequate processing of pension reductions could result in improper benefit payments, unnecessary debts, and undue stress for beneficiaries. The OIG made three recommendations to the under secretary for benefits to address the issues identified.

FOLLOW-UP REVIEW OF THE ACCURACY OF SPECIAL MONTHLY COMPENSATION HOUSEBOUND BENEFITS

VBA provides monthly benefits to veterans with disabilities caused by diseases or injuries incurred or aggravated during active military service. SMC pays additional benefits, such as housebound entitlement, for certain disabilities or a combination of disabilities. In September 2016, the OIG found that VBA incorrectly processed about 27 percent of high-risk housebound SMC cases. The OIG conducted this review to determine whether VBA implemented the OIG's 2016 recommendations and found VBA continues to have the same estimated error rate, resulting in about $165 million in improper payments. Without improving oversight, accountability, and monitoring, VBA risks wasting taxpayer dollars and

potentially subjecting veterans to repay overpayments. The OIG made six recommendations: VBA should review active high-risk housebound cases and conduct ongoing reviews, update and monitor SMC housebound training, ensure system enhancements are created and cannot be bypassed, and correct all processing errors identified in this review.

PUBLIC DISABILITY BENEFITS QUESTIONNAIRES REINSTATED BUT CONTROLS COULD BE STRENGTHENED

The OIG reviewed VBA's compliance with legal requirements to reinstate disability benefits questionnaire forms from non-VA medical providers used to submit medical information for processing disability claims. The OIG also examined whether claims processors followed procedures for using the published questionnaires. VBA complied with the requirements of the law. However, disability benefits questionnaires that were incomplete, inaccurate, or of questionable authenticity from non-VA medical providers were not always processed correctly when determining benefits entitlement—causing underpayments of about $13,900 and overpayments of $74,800 over the nine months studied. Improper processing occurred because VBA lacked sufficient controls to ensure that questionnaires from non-VA medical providers were properly relied on when determining entitlement to benefits. VBA concurred with the OIG's recommendations to correct all identified processing errors, revise and update VBA's adjudication procedures manual, and ensure claims processors understand the need to document the evaluation of evidence when using publicly available disability benefits questionnaires.

PUBLICATIONS ON MANAGEMENT OF FINANCIAL OPERATIONS AND SYSTEMS

Audits and reviews of VA's administrative support functions and financial management operations focus on the adequacy of infrastructure to provide program managers and leaders with the information needed to be good stewards of the funds entrusted to them by efficiently and effectively overseeing and safeguarding VA assets and resources. OIG oversight work satisfies the Chief Financial Officers Act of 1990 audit requirements for federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.[16]

VISN 21'S MANAGEMENT OF MEDICAL FACILITIES' NONRECURRING MAINTENANCE

The OIG examined whether VISN 21 effectively managed its nonrecurring maintenance (NRM) needs by executing medical facilities' long-range action plans. Within VISN 21, deferred maintenance cost estimates had significantly increased in the prior decade from $599.3 million in FY 2012 to $1.4 billion by March 2021. VISN 21 medical facilities executed only 18 percent of their approved NRM projects for FYs 2015–2018, increasing the risk for health service interruptions, environmental problems, accidents, and driving up operating costs. Several factors contributed to these issues: execution of nonurgent, out-of-cycle projects; insufficient engineering staffing; misalignment of long-range action plans with the NRM program's budget; and a lack of program performance metrics. The OIG made seven recommendations to help VA more effectively manage its NRM needs. The recommendations included establishing and enforcing urgent-need criteria, implementing and annually reviewing an engineering staffing model that

16 Pub. L. No. 101-576.

aligns with NRM needs, ensuring feasible long-range action plans, and establishing NRM performance metrics.

VHA RISKS OVERPAYING COMMUNITY CARE PROVIDERS FOR EVALUATION AND MANAGEMENT SERVICES

This review examined the risk of VHA improperly paying non-VA healthcare providers for evaluation and management services not supported by medical documentation. The review team found that some providers billed VA at a significantly higher rate than their peers for high-level evaluation and management services. In addition, some providers billed separately for evaluation and management services during periods when the global surgery package was in effect. This package is supposed to cover all surgery-related services for a set period. The OIG determined VHA risked overpaying for evaluation and management services by about $19.9 million in FY 2020. The OIG made two recommendations to the undersecretary for health related to (1) reviewing medical documentation for evaluation and management services billed by non-VA providers and then developing processes to act on the review results, and (2) ensuring non-VA providers receive continuing education materials on proper medical documentation for these services.

VHA IMPROPERLY PAID AND REAUTHORIZED NON-VA ACUPUNCTURE AND CHIROPRACTIC SERVICES

The OIG evaluated whether VHA paid for non-VA acupuncture and chiropractic care that was not authorized or supported by medical documentation, and whether VHA followed guidance for reauthorizing care. The team found that VHA paid for care that was not authorized, including for more visits than allowed and for treatment codes that deviated from established standards for care. In addition, VHA paid for acupuncture and chiropractic services that were not appropriately supported by medical documentation. The audit team estimated that improper payments for acupuncture and chiropractic care amounted to about $136.7 million during FYs 2018 and 2019. The OIG made six recommendations to the under secretary for health related to adding automated payment system controls, auditing the payment process, retrospectively auditing non-VA medical documentation, making continuing education materials related to medical documentation available to non-VA providers, following the Office of Community Care's field guidebook, and documenting clinical justification for non-VA care.

FINANCIAL EFFICIENCY REVIEW OF THE EASTERN OKLAHOMA VA HEALTH CARE SYSTEM

The OIG assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Eastern Oklahoma VA Health Care System. The team focused on four areas: (1) the system's review of open obligations for goods and services to determine whether they were still valid and necessary; (2) use of purchase cards, such as requirements for documenting transactions; (3) the number of administrative staff compared to similar facilities and the accurate recording of labor costs; and (4) efficiency in pharmacy operations, such as inventory management and the healthcare system's efforts to reduce costs. The OIG made nine recommendations for improving cost efficiency. The number of recommendations should not be used, however, to gauge the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations in the areas reviewed.

FINANCIAL EFFICIENCY REVIEW OF THE MARION VA MEDICAL CENTER IN ILLINOIS

Another financial inspection was conducted at the Marion VA Medical Center in Illinois. It also assessed the oversight and stewardship of funds and identified opportunities for cost efficiency. The review focused on four areas, three of which were the same as for the Oklahoma system above on open obligations for goods and services, the use of purchase cards, and the efficiency of pharmacy operations. Instead of focusing on administrative labor costs, this review focused on the use of the MSPV-NG program, a collection of contracts that streamlines purchasing for certain medical supplies. Topics differ across healthcare systems and facilities for OIG financial reviews in order to tailor them to high-risk or site-specific needs. The OIG made eight recommendations for improving cost efficiency; however, as with all financial efficiency reviews, the number of recommendations should not be used to gauge the healthcare system's overall financial health.

FINANCIAL EFFICIENCY REVIEW OF THE DURHAM VA HEALTH CARE SYSTEM IN NORTH CAROLINA

The OIG conducted its third financial inspection of the reporting period at the Durham VA Health Care System, which had 200 obligations totaling $74 million that were inactive for 181 days or more. In a subsample of 20 obligations, VA staff had not reviewed 17. Without reviews, funds cannot be reobligated to support veterans. Healthcare system staff used purchase cards instead of contracts for 21 of 40 sampled transactions, which lacked required supporting documentation, resulting in $308,000 in questioned costs. The healthcare system did not conduct required quarterly audits and had 105 more administrative FTE staff than expected. Pharmacy efficiency could be improved at the healthcare system by narrowing the gap between observed and expected drug costs, decreasing turnover rates, and conducting noncontrolled drug line audits. The OIG made nine recommendations to the healthcare system director and one recommendation to the director of contracting for the VA Mid-Atlantic Health Care Network.

AUDIT OF VA'S FINANCIAL STATEMENTS FOR FISCAL YEARS 2021 AND 2020

The OIG contracted with CliftonLarsonAllen LLP (CLA) to audit VA's financial statements, which is an annual requirement. CLA provided an unmodified opinion on VA's financial statements for FY 2020 and FY 2021. It identified three material weaknesses: controls over significant accounting estimates, financial systems and reporting, and IT security controls. CLA made recommendations for addressing each of these weaknesses. CLA also identified two significant deficiencies: (1) obligations, undelivered orders, and accrued expenses and (2) entity-level controls. CLA is responsible for this audit report and the conclusions expressed in it.

INDEPENDENT REVIEW OF VA'S FISCAL YEAR 2021 DETAILED ACCOUNTING AND BUDGET FORMULATION COMPLIANCE REPORTS TO THE OFFICE OF NATIONAL DRUG CONTROL POLICY

The OIG reviewed VHA assertions required by the Office of National Drug Control Policy in its FY 2021 detailed accounting report and budget formulation compliance report. The OIG's review was conducted in accordance with generally accepted government auditing standards, which incorporate the attestation standards established by the American Institute of Certified Public Accountants. The OIG believes this review provides a reasonable basis for its conclusion. In the detailed accounting report, VHA reported three material weaknesses, two significant deficiencies, and five matters concerning noncompliance with laws and regulations. These are identified in the OIG report, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, which is summarized above. Based on the OIG's review, except for any effects of

the matters described in the preceding sentence, the OIG is not aware of any material modifications that should be made to VHA management's assertions for them to be fairly stated.

VA'S COMPLIANCE WITH THE VA TRANSPARENCY & TRUST ACT OF 2021

A new federal law requires VA to report to Congress how it plans to spend emergency COVID-19 relief funding, and charges the OIG with overseeing the use of that funding. The OIG's inaugural report found VA's plans generally outlined how it intended to spend the funds. However, NCA's plan included $3.6 million for a shrine project that may have violated the law because the work did not appear to be directly related to COVID-19. The OIG also identified planned use of funds that did not include a projected cost related to maintaining information technology projects. The OIG recommended the assistant secretary for management/chief financial officer consult appropriate officials to determine whether emergency funds used for the shrine project violates the law and take corrective action if necessary. He should also determine obligations for sustaining essential information technology investments, provide an updated spending plan to Congress, and include that information in future updates.

VA'S USE OF THE DEFENSE LOGISTICS AGENCY'S ELECTRONIC CATALOG FOR MEDICAL ITEMS

In January 2018, VA began using the Defense Logistics Agency's electronic catalog (ECAT) to order medical supplies and equipment unavailable through existing contracts. The OIG conducted this review to determine whether ECAT procurements complied with regulations, policies, and the agreement's terms. The OIG found that the ECAT Ordering Guide does not require VA officials to consider FSS contracts before ordering through ECAT. The guide incorrectly describes how to apply the Rule of Two, which requires contracting officers to award contracts to veteran-owned small businesses if they reasonably expect that at least two such businesses will submit offers and that the awards can be made at fair and reasonable prices that offer the best value to the government. An incorrect application of the rule could potentially exclude veteran-owned businesses from contracting opportunities. Officials did not follow documentation requirements, and VHA's Procurement and Logistics Office did not annually review the ECAT agreement, as required. The OIG recommended that VHA update the guide to clarify the Rule of Two and that staff must consider FSS contracts before ECAT, identify recurring acquisitions that might be cheaper using other contracts, require justifications for ECAT orders if available FSS contracts are not used, ensure compliance with requirements, and conduct and document annual reviews.

FIRST-PARTY BILLING ADDRESS MANAGEMENT NEEDS IMPROVEMENT TO ENSURE VETERAN DEBT NOTIFICATION BEFORE COLLECTION ACTIONS

The OIG reviewed a complaint that employees at the Central Plains Consolidated Patient Account Center mismanaged veterans' billing addresses at the Minneapolis VA Health Care System. The complainant claimed bills were mailed to outdated addresses, returned, and then referred to debt collection without veterans' knowledge. The OIG found VA mailed bills using outdated addresses from one file while newer information was available from another file in the same record system. Some accounts were previously referred to debt collection, but the OIG could not establish whether this was because veterans did not receive the bills. VHA lacked defined processes for managing returned bills and correcting addresses. Veterans may face unanticipated financial demands if bills are sent to outdated addresses and accounts are referred to collection without notice. The OIG recommended VHA review and correct address data for first-party bills and improve policies detailing responsibilities and procedures for remediating returned bills and updating addresses.

PUBLICATIONS ON MANAGEMENT OF INFORMATION TECHNOLOGY AND SECURITY

OAE personnel audit and review VA's IT systems and security operations. This work helps determine whether there are adequate policies in place and fully implemented that focus on protecting veterans and VA employees, facilities, and information. These audit reports present VA with recommendations to improve IT management and security. The OIG is also statutorily required to review VA's compliance with the Federal Information Security Modernization Act of 2014, as well as IT security evaluations conducted as part of the consolidated financial statements audit.[17]

AUDIT OF VA'S COMPLIANCE UNDER THE DATA ACT OF 2014

The OIG again contracted with CLA to audit VA's compliance under the Digital Accountability and Transparency Act of 2014 (DATA Act). CLA conducted this performance audit with data sampled from the fourth quarter of FY 2020, in accordance with generally accepted government auditing standards. CLA primarily conducted its audit work during FY 2021, and the results of the audit are presented in this report. Overall, CLA made 12 recommendations. The OIG did not express an opinion on VA's compliance under the DATA Act.

VA APPLICATIONS LACKED FEDERAL AUTHORIZATIONS, AND INTERFACES DID NOT MEET SECURITY REQUIREMENTS

The Federal Risk and Authorization Management Program (FedRAMP) standardizes security and risk assessment for cloud technologies for federal agencies, including VA. In April 2019, the OIG received allegations that VA's Office of Information and Technology's (OIT) Project Special Forces was not following FedRAMP policies for software-as-a-service applications. The OIG found that OIT authorized some applications without FedRAMP authorization and that Project Special Forces did not follow security requirements in developing interfaces. This noncompliance occurred for two reasons: (1) OIT had not fully implemented a formal process for granting the authority to operate until April 2019, and (2) OIT staff misunderstood the FedRAMP authorization requirements for applications containing data classified as less sensitive. Failure to comply with FedRAMP standards increases the risk that VA and veterans' data could be compromised. The OIG made two recommendations to address the applications without federal authorization and two recommendations to ensure that Project Special Forces improves security controls and documentation. VA concurred with all recommendations.

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE VA FINANCIAL SERVICES CENTER

VA's Financial Services Center provides products and services to VA and other government agencies. The OIG inspected whether the Financial Services Center was meeting federal guidance related to configuration management, contingency planning, security management, and access controls. Within configuration management, the inspection team identified deficiencies with component inventory, vulnerability management, and flaw remediation. While the team did not identify deficiencies with contingency-planning controls, its review of security management controls identified a deficiency with system and information integrity procedures. Finally, the team identified access control deficiencies

17 Pub. L. No. 113-283.

in system audit and video surveillance controls. Without these controls, VA may be placing critical systems at unnecessary risk of unauthorized access, alteration, or destruction. The OIG recommended maintaining an accurate inventory, implementing a more effective patch and vulnerability management program, developing local system and information integrity procedures, generating and forwarding audit reports for analysis, and continuing to upgrade the video surveillance system.

PUBLICATIONS ON ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT

The OIG audits and reviews VA's acquisition processes and oversight operations. These reports provide insight into the challenges of a large, decentralized purchasing system, in which a variety of offices play significant roles. Compliance with the FAR (as well as Title 48 C.F.R.) and VA's internal acquisition regulations ensures VA staff and veterans receive the best supplies and services in a timely manner. The recommendations in these reports present VA with constructive means to improve the acquisition and procurement processes. During this reporting period, the OIG published one such report, highlighted at the start of this section, related to operational gaps in VA's initial deployment of the DMLSS supply chain management system.

PUBLICATION ON NATIONAL CEMETERY MAINTENANCE

REVIEW OF ALLEGATIONS OF IMPROPER MAINTENANCE AT VA'S HOUSTON NATIONAL CEMETERY IN TEXAS

Following a whistleblower disclosure referred from the US Office of Special Counsel, the OIG assessed allegations that the Houston National Cemetery's equipment, grave sites, and other features were not maintained as required. Although the OIG found that the cemetery was generally well maintained, some of the allegations were substantiated. Four pieces of motorized equipment were not maintained in accordance with NCA standards because cemetery staff stopped conducting routine preventive maintenance checks during the pandemic. Some grave sites were improperly maintained, and one water feature had an inoperable pump. None of the substantiated allegations at the Houston National Cemetery were pervasive issues. The OIG recommended that the cemetery director (1) revise the equipment policy to ensure that routine activities are resumed after emergencies and (2) provide an action plan to repair the grave sites. VA concurred with and has already taken action on both recommendations, with the first being closed as implemented at publication.

REVIEWS OF VA CONTRACTS AND VENDOR PROPOSALS

The OIG also 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 and conducts healthcare preaward reviews for VHA. The OIG issued 49 of these types of unpublished reports during this reporting period. These reports are released only to the contracting officer because of the proprietary and privacy information they contain. However, in the interest of transparency, the OIG published one report summarizing the issues identified in some of these unpublished reviews:

SUMMARY OF PREAWARD REVIEWS OF VA FEDERAL SUPPLY SCHEDULE NONPHARMACEUTICAL PROPOSALS, FISCAL YEARS 2018–2020

The OIG reviewed 103 nonpharmaceutical Federal Supply Schedule (FSS) contract proposals valued annually at $10 million or more for high-tech medical equipment, $3 million or more for all other FSS contracts, $100,000 or more based on manufacturer sales under dealers or resellers, or as requested by the National Acquisition Center. These preaward reviews help contracting officers negotiate fair and reasonable prices for the government and taxpayers. This report summarizes reviews conducted in FYs 2018–2020, which were not published because they contain proprietary commercial information protected from release under the Trade Secrets Act. The OIG determined commercial disclosures were accurate, complete, and current for 24 of the 103 proposals reviewed. The remaining 79 could not reliably be used for negotiations until corrected. The OIG recommended lower prices than offered for 76 proposals, resulting in the National Acquisition Center awarding contracts or modifications with cost savings of about $242.4 million.

PREAWARD REVIEWS

As mentioned above, preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Thirty-two preaward reviews identified approximately $3.1 billion in potential cost savings during this reporting period. In addition to FSS and Architect/Engineer Services proposals, preaward reviews during this reporting period included 11 healthcare provider proposals, accounting for approximately $89.7 million of the identified potential savings.

POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the Veterans Health Care Act of 1992 for pharmaceutical products.[18] Postaward reviews resulted in VA recovering contract overcharges totaling over $52.2 million, including approximately $39.4 million related to compliance with the Veterans Health Care Act's pricing requirements, recalculation of federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 17 postaward reviews performed, eight involved voluntary disclosures. In five of the eight voluntary disclosure reviews, the OIG identified additional funds due. VA recouped 100 percent of the recommended recoveries for postaward contract reviews. Because these reports contain proprietary and privacy information, they are released only to the contracting officer.

18 Pub. L. No. 102-585.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

CLAIM REVIEWS

The OIG assists contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, the OIG did not conduct any claim reviews.

GOVERNMENT AUDIT CONTRACT FINDINGS

The IG Act, as amended by the National Defense Authorization Act for FY 2008, requires each inspector general to submit an appendix on final, completed contract audit reports issued to the contracting activity (agency component) that contain significant audit findings—unsupported, questioned, or disallowed costs in excess of $10 million, or other significant findings—as part of the semiannual report.[19] The following reports, in order by monetary impact, are exempt from publication but highlight the VA OIG's work in this area.

REPORT NUMBER	NATURE OF REVIEW	ISSUE DATE	MONETARY IMPACT
21-01480-03	Review of a Federal Supply Schedule Proposal Submitted under a Solicitation	10/26/2021	$1,910,683,875
22-00616-87	Review of a Proposal Submitted under a Solicitation	3/10/2022	$67,832,048
21-02610-52	Review of a Federal Supply Schedule Proposal Submitted under a Solicitation	12/15/2021	$58,750,774
20-04359-59	Review of a Voluntary Disclosure Submitted under Multiple Federal Supply Schedule Contracts	2/2/2022	$37,060,123
21-02877-47	Review of a Federal Supply Schedule Proposal Submitted under a Solicitation	12/10/2021	$33,677,829
21-03820-53	Review of a Request for Product Addition under a Federal Supply Schedule Contract	12/14/2021	$20,938,200

19 Pub. L. No. 110-181.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

40 Publications | **2,528** Hotline Referrals Reviewed | **6** In-Depth Clinical Consultations

OVERVIEW

During this reporting period, OHI published 13 hotline healthcare inspection reports and eight national healthcare reviews responsive to OIG hotline complaints and topics that are related to VHA operations and the access to and quality of care provided to patients. They addressed a broad range of topics, such as mental health care, pharmacy deficiencies, care coordination, community living centers, and leadership. The office also published 17 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, and an analysis of those findings. Additionally, the office published two Vet Center Inspection Program (VCIP) reports, which are examinations of community-based clinics that provide a range of services to veterans and active-duty service members. OHI recommendations for corrective action are detailed at www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

FEATURED PUBLICATIONS

Highlighted below are a trilogy of reports and two additional publications that focus on issues and recommendations that can have a significant impact on VA programs and processes and veterans' timely access to quality care delivered with compassion and respect.

THREE REPORTS ON VA ELECTRONIC HEALTH RECORD IMPLEMENTATION DEFICIENCIES AT THE INITIAL OPERATING SITE

Listen to the OIG's companion podcast for these reports.

Given the enormity of VA's 10-year, multibillion-dollar electronic health record modernization effort and its potential impact on patient safety and the quality of health care provided to veterans, the OIG released three reports in its ongoing oversight of VA's implementation of this new system. These reports focus on the system's rollout at the initial operating site. Since the October 2020 go-live event at the Mann-Grandstaff VA Medical Center in Spokane, Washington, the OIG has received wide-ranging complaints to its hotline as well as concerns from members of Congress. The following reports focus on a number of those complaints and the failings specifically found with medication management, care coordination, and the "ticketing" process for staff to request help and report problems:

1. **MEDICATION MANAGEMENT DEFICIENCIES AFTER THE NEW ELECTRONIC HEALTH RECORD GO-LIVE AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON**

   Deficiencies in medication data migration and management resulted in patients having inaccurate, or incomplete medications in their records or made filling prescriptions accurately more difficult—all of which

can affect patient care and safety. Areas of concern included (1) data migration, (2) medication formulary availability, (3) medication order processing, (4) provider notification and alerts, (5) controlled substance tracking, (6) prescription drug monitoring program documentation, (7) medication reconciliation, and (8) medication list accuracy.

2. **CARE COORDINATION DEFICIENCIES AFTER THE NEW ELECTRONIC HEALTH RECORD GO-LIVE AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON**

   The EHR rollout caused problems in coordinating veterans' care that ranged from the flags for patients at high risk for suicide not transferring, to both veterans and their care providers having trouble accessing video appointments and patient portal messaging. Although the OIG did not identify associated patient deaths, future deployment of the new EHR without resolving identified deficiencies could increase risks to patient safety.

3. **TICKET PROCESS CONCERNS AND UNDERLYING FACTORS AFTER THE NEW ELECTRONIC HEALTH RECORD GO-LIVE AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON**

   The failures to process and respond to VHA staff ticketing requests for help, or to report concerns, resulted in issues with reporting, tracking, and resolving problems. These deficiencies made it difficult for clinicians and administrative staff to serve patients and impeded EHR fixes that can affect future sites. The inspection team also identified five causal factors contributing to the deficiencies identified in the two companion reports above: usability, training, interoperability, needed fixes, and problem resolution.

DEFICIENCIES IN SELECT COMMUNITY CARE CONSULT (STAT) PROCESSES DURING THE COVID-19 PANDEMIC

The OIG conducted a national review of stat community care consults (urgent consults that must be completed within 24 hours) generated at the outset of the COVID-19 pandemic to evaluate consult processes. The evaluation included electronic health record reviews of more than 2,200 stat community care consults in an active, scheduled, or completed status from March 20 to June 30, 2020. The OIG review found that care was not provided within 24 hours for 16.9 percent of the consults, but that care was provided as requested for 91.6 percent, irrespective of being within or outside of 24 hours. The OIG also conducted an electronic survey regarding facility stat community care consult processes and identified that approximately 10 percent of facilities reported not processing stat consults in community care. Of these, almost three-fourths referenced difficulties meeting consult requirements, such as preauthorization of care, obtaining community provider medical documentation, and completing consults within 24 hours. The OIG made six recommendations to the under secretary for health related to community care resources, facility practices, and VHA requirements that specifically focused on stat community care consults. The OIG did not identify any negative patient care outcomes.

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT: EVALUATION OF WOMEN'S HEALTH CARE IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

This CHIP summary report provides an evaluation of VHA facilities' selected women's health program requirements, focusing on provision of care requirements, program oversight and monitoring of performance improvement data, and assignments of required staff. The report describes findings related to women's health from OIG inspections initiated at 36 VHA medical facilities from November

4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff, reviews of clinical and administrative processes, and evaluations of meeting minutes and other relevant documents. While the OIG found general compliance with many of the selected requirements, the report identifies weaknesses with the provision of 24/7 gynecologic care coverage, assignment of at least two women's health primary care providers for each community-based outpatient clinic, women veterans health committees' inclusion of core members and reporting to clinical executive leaders, assignment of full-time women veterans program managers who are free of collateral duties, and designation of maternity care coordinators.

HEALTHCARE INSPECTIONS

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

DELAYED CANCER DIAGNOSIS OF A VETERAN WHO DIED AT THE RAYMOND G. MURPHY VA MEDICAL CENTER IN ALBUQUERQUE, NEW MEXICO

This inspection assessed concerns regarding delays in clinical care and deficiencies in care coordination that led to a delay in the diagnosis of lung cancer in a patient who died at the Raymond G. Murphy VA Medical Center. The OIG also evaluated facility leaders' responses to quality and timeliness of care and the medical center's teleradiology processes. Teleradiology is the transmission of diagnostic images to a location beyond the immediate area, where the images were shared with other radiologists and physicians. The inspection found that a resident ordered an abdomen and pelvis CT scan, but did not follow up on the result. The radiologist had noted a possible spiculated lung nodule (generally typified as a stripe shadow extending from the nodule indicative of malignancy) and recommended a follow-up chest CT scan in 90 days. Because both the resident and the supervising provider failed to address the result, the follow-up scan took 175 days for completion. The results indicated resolution of the previously noted lung nodule but also revealed worsening of opacities in the lung, representing a possible infection or cancer. While a follow-up positron emission tomography (PET)/CT scan showed a lesion in the right lung, a biopsy was not completed. The patient was examined and diagnosed with cancer at a non-VA hospital.

The OIG concluded that poor oversight of resident physicians and deficiencies in care coordination between primary care, pulmonary, and emergency departments' staff contributed to delays in diagnosis. In addition, contract teleradiologists did not use available prior images for comparison and the medical center failed to use quality management and patient safety processes to evaluate the patient's care. The OIG made six recommendations to the facility director related to oversight of residents; care coordination between primary, emergency, and specialty care; review of the patient's care; leaders' review of facility responses provided to the OIG; consistency in the review of relevant radiological images by facility radiologists and contract teleradiologists; and patient safety reporting.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

INADEQUATE CARE COORDINATION FOR A MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM RESIDENT IN VISN 20 (IN OREGON)

The inspection team assessed an allegation of inadequate care coordination at the Southern Oregon Rehabilitation Center and Clinics in White City (facility) and Roseburg VA Health Care System (Roseburg) in Oregon. The OIG did not substantiate that a resident was inappropriately admitted to the facility's Mental Health Residential Rehabilitation Treatment Program but found the resident's discharge was not coordinated. The resident, whose transport to Roseburg did not comply with policy, was determined by its staff to not meet Roseburg admission criteria and was discharged to the community. An OIG record review of five residents found that four met admission criteria. The team was unable to determine if the fifth resident met criteria. The OIG also determined that three residents fell in the shower area, with one suffering an injury. Five recommendations were made to the facility director related to discharges, the discharge template, transport of residents, medical evaluations, and a review of shower area falls.

DESCRIPTIVE ANALYSIS OF SELECT PERFORMANCE INDICATORS AT TWO HEALTHCARE FACILITIES IN THE SAME VETERANS INTEGRATED SERVICE NETWORK

Select aspects of operations and performance at two VHA facilities in the same VISN were reviewed, with one historically rating as lower performing and the other as higher performing. The OIG found that both facilities approached and addressed many patient safety and quality-of-care issues similarly. However, after an in-depth review of data, policies, governance structures, and leadership interviews, the OIG found several factors directly shaped each facility's ability to focus, prioritize, and accomplish progressively higher performance. Two broad factors were (1) leadership and (2) the integration of an effective quality, safety, and value program with high-reliability organization principles. The OIG also determined that facility culture and human resource–related considerations affected operations and performance. Although the OIG did not make formal recommendations, the report identified opportunities for improvement and provided eight suggestions for VISNs to consider for providing meaningful and timely assistance to both struggling and better-performing facilities.

DISCHARGE PLANNING DEFICITS FOR A VETERAN AT THE MALCOM RANDALL VA MEDICAL CENTER IN GAINESVILLE, FLORIDA

This report focuses on concerns related to discharge planning and care coordination for a patient who died 17 days after discharge from a 33-day hospital stay. Among its findings, the facility's interdisciplinary team failed to develop a discharge plan that adequately ensured patient safety and continuity of care. In addition, the facility did not have a discharge-planning policy that outlined interdisciplinary team membership, communication expectations, or roles in discharge planning. The attending physician, an occupational therapist, and a social worker did not perform necessary functions or collaborate effectively to ensure patient safety at discharge. The report includes five recommendations to the facility director related to roles and responsibilities of interdisciplinary team members, communication of changes in patient care among providers, and a review of the care rendered to the patient by providers involved in discharge planning.

DEFICIENCIES IN DISCLOSURES AND QUALITY PROCESSES FOR PERFORATIONS RESULTING FROM UROLOGICAL SURGERIES AT WEST PALM BEACH VA MEDICAL CENTER IN FLORIDA

The OIG substantiated an allegation that a urologist perforated two patients' organs during procedures. However, facility leaders took reasonable actions based on the results of management reviews. The inspection also identified deficiencies in disclosures, quality reviews, timeliness of management reviews,

and the process for delineating urologists' privileges. The urologist did not complete clinical disclosures to the patients or their designees as required, and institutional disclosures were not considered. Adverse events were not reported to the patient safety manager. The surgical work group did not oversee surgical service morbidity and mortality conferences. In addition, a planned peer review was not completed, and management reviews were delayed. The OIG also found that the form used to delineate privileges for urologists was not subjected to a required annual review for appropriateness of available privileges. The report includes seven recommendations.

DEFICIENCIES IN THE CARE OF A PATIENT WITH GASTROINTESTINAL SYMPTOMS AT THE EASTERN OKLAHOMA HEALTH CARE SYSTEM IN MUSKOGEE

This inspection was responsive to an allegation from a patient who sought help with gastrointestinal symptoms at the facility three times in 2020 and was reportedly sent away each time. The patient was diagnosed with colorectal cancer in early 2021 at a non-VA hospital. The OIG did not substantiate that the patient was sent away three times. There was no documented evidence that a fecal immunochemical test was mailed to or discussed with the patient. An emergency department physician failed to perform a digital rectal examination when the patient's presentation included having blood in the stool. Facility staff did not adequately review and respond to the patient's complaints. In addition, leaders did not fully respond to complaints about the emergency department physician. The OIG made four recommendations to the facility director related to fecal immunochemical tests, emergency department providers' physical examinations, patient complaints, and emergency department physician-related complaints.

DEFICIENCIES IN A PATIENT'S LUNG CANCER SCREENING, RENAL NODULE FOLLOW-UP, AND PROSTATE CANCER SURVEILLANCE AT THE VA SOUTHERN NEVADA HEALTHCARE SYSTEM IN LAS VEGAS

During this inspection, the OIG substantiated an allegation that the medical facility failed to diagnose and treat a patient's cancer. Primary care providers did not ensure completion of annual lung cancer screening and failed to follow up after a renal nodule had increased in size. One primary care provider delayed ordering an oncology consult, copied and pasted documentation, and did not document an assessment of the patient's lung nodules. Beyond 2013, pulmonary staff failed to follow up with the patient or schedule pulmonary appointments. Despite not contacting the family to discuss a reported complaint and request for care for the patient, facility staff documented resolution of a family member's complaint. The OIG made five recommendations to the facility director related to lung cancer screening and follow-up care, abnormal radiology finding follow-up, patient surveillance after prostatectomy, documentation, and complaint responses.

INSPECTION OF STERILE PROCESSING SERVICES AT THE CARL T. HAYDEN VA MEDICAL CENTER IN PHOENIX, ARIZONA

The OIG conducted an inspection to assess allegations concerning Sterile Processing Services (SPS) at the Carl T. Hayden VA Medical Center in Phoenix, Arizona. The OIG found that SPS staff failed to don personal protective equipment (PPE) in SPS decontamination areas. The OIG observed SPS and other facility staff enter decontamination areas without required PPE. The OIG also found that, while some Resi-Test kits (residual protein detection kits used as cleaning indicators) had the same lot numbers, that was not an indication of falsified tests, and concluded that SPS staff completed Resi-Tests in accordance with policy. The OIG made one recommendation related to wearing PPE.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

LACK OF CARE COORDINATION AND HEPATOCELLULAR CARCINOMA SURVEILLANCE OF A PATIENT AT THE VA EASTERN COLORADO HEALTH CARE SYSTEM IN AURORA

The inspection team assessed allegations that lack of care coordination and surveillance led to a delay in a patient being diagnosed with hepatocellular carcinoma (HCC), which is a common type of primary liver cancer. The OIG substantiated the lack of care coordination due to providers' failure to communicate important information during patient hand-offs. In addition, facility providers failed to properly document the patient's problem list. The patient did not receive the necessary HCC surveillance or varices (blood vessel) monitoring, leading to a delay in the diagnosis of HCC. The OIG reviewed additional cases and determined that facility providers did not consistently comply with recommended HCC surveillance guidelines or consistently update patient problem lists for patients with a similar diagnosis. Ultimately, this could result in missed opportunities for identifying needed HCC surveillance. The OIG made six recommendations.

CARE IN THE COMMUNITY CONSULT MANAGEMENT DURING THE COVID-19 PANDEMIC AT THE MARTINSBURG VA MEDICAL CENTER IN WEST VIRGINIA

The OIG received allegations of a failure to schedule a Care in the Community (CITC) COVID Priority 1 consult (referral) within VHA time requirements, and inadequate staffing caused scheduling delays. The OIG substantiated that the consult was not scheduled within 30 days of the clinically indicated date (when a healthcare provider deems an appointment is clinically appropriate). The facility had a backlog of unscheduled CITC consults but did not have plans to address the backlog, maximize use of available reports, or conduct clinical reviews of unscheduled consults. The facility also lacked a process to review potential adverse events due to delayed consults and work-arounds were created by other departments to avoid patient care delays. Inadequate CITC staffing did cause delays in consult scheduling. Reported contributing factors included frequent staff turnover, outdated local processes, lack of training, and staffing challenges during the pandemic. The OIG made eight recommendations.

NATIONAL HEALTHCARE REVIEWS

National healthcare reviews focus on VHA programs, activities, or functions from a systemwide perspective. Such reviews may be used to provide factual and analytical information, monitor compliance with established criteria and standards, measure performance, assess the efficiency and effectiveness of programs and operations, or identify and share best practices among VHA facilities. National reviews may be mandated or requested by Congress or initiated by the OIG. During this reporting period, the OIG published eight national healthcare reviews, including a review on the deficiencies in select community care consult (stat) processes during the COVID-19 pandemic (detailed above on page 48), as well as the third in a series of COVID-related reports drawn from comprehensive healthcare inspections. Staff also analyzed findings on other topic areas across all inspected facilities in a prior fiscal year to produce subject-specific CHIP summary reports that provide a useful overview of key issues across VA facilities. There were six CHIP summary reports published in this reporting period. Healthcare inspection staff continued to work on several other national reviews that address such topics as staffing, lung screening, and the deployment of the new EHR system.

COMPREHENSIVE HEALTHCARE INSPECTION OF FACILITIES' COVID-19 PANDEMIC READINESS AND RESPONSE IN VETERANS INTEGRATED SERVICE NETWORKS 1 AND 8

The CHIP team reported on VISN 1 and VISN 8 facilities' COVID-19 pandemic readiness and response, focusing on emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; community living center patient care and operations; facility staff feedback; and vaccination efforts. The OIG has aggregated findings on COVID-19 preparedness and responsiveness from routine inspections to ensure prompt dissemination of information given the quickly changing landscape and the continual shifting of infection rates and demands. This report, the third in a series, describes findings on COVID-19 practices from healthcare inspections performed at facilities within VISNs 1 and 8 during the second quarter of FY 2021. It includes data compiled as of July 2021 that illustrate the tremendous COVID-19-related demands on VA healthcare services, as these inspections took place during VA's third pandemic peak, which was longer and involved more patients than previous peaks. The report also describes leader and staff experiences, assessments, shared sentiments, and best practices to help improve operations and clinical care during public health crises.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM SUMMARY REPORTS

The following five reports are part of the series of CHIP Summary Reports published during this reporting period that aggregate findings from inspections performed at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. (Information on individual CHIP reports for the most recent review cycle can be found on page 54.)

EVALUATION OF LEADERSHIP AND ORGANIZATIONAL RISKS IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

This CHIP summary report provides a descriptive evaluation of VHA facilities' leadership and organizational risks. The evaluation focused on executive leadership position stability and engagement, accreditation surveys and oversight inspections, factors related to possible lapses in care, and VHA performance data. Incorporating interviews with facility leaders and staff, reviews of administrative processes, and evaluations of meeting minutes and other relevant documents, the OIG found that leaders were generally knowledgeable about their facilities and various performance metrics and could speak to actions taken to improve their respective facility's performance. The OIG observed that lower-complexity facilities had fewer reported sentinel events (a patient safety event resulting in death, permanent harm, or severe temporary harm) than higher-complexity facilities.

EVALUATION OF MENTAL HEALTH IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

This report evaluates selected mental health program requirements for VHA facilities, focusing on suicide prevention coordinator processes, provision of suicide prevention care, and suicide prevention training. After conducting interviews with facility leaders and staff and reviews of clinical and administrative processes, the OIG found general compliance with many of the selected requirements; however, the OIG identified weaknesses in various key mental health-related processes, including the completion of follow-up visits within the required time frame, appropriate follow-up with veterans who have a "high risk for suicide" patient record flag and who fail to attend mental health appointments, and the completion of monthly outreach activities. The OIG issued four recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

EVALUATION OF CARE COORDINATION IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

The CHIP team reported on selected requirements and guidelines for care coordination for VHA facilities, targeting compliance with program requirements related to life-sustaining treatment decisions for hospice patients. During the time frame of this retrospective review, VHA policy required certain elements of "goals of care" conversations to be documented in patients' EHRs. However, in March 2020, VHA revised its policy to require fewer elements. The OIG observed general compliance with the selected requirements after these rules were updated during the review period. However, under the original VHA requirements in place when patients received their care, the OIG estimated that providers did not consistently identify a surrogate should the patient lose decision-making capacity; address previous advance directives, state-authorized portable orders, and/or life-sustaining treatment plans; or address the patient's or surrogate's understanding of the patient's condition. The OIG did not issue recommendations but developed this summary report for leaders to consider when improving operations and clinical care at VHA facilities.

EVALUATION OF MEDICATION MANAGEMENT IN VHA FACILITIES, FISCAL YEAR 2020

This report evaluates VHA facilities' selected requirements and guidelines for medication management. The healthcare inspection team focused on compliance with program requirements and processes related to long-term opioid use for pain. After conducting interviews with facility leaders and staff and reviews of clinical and administrative processes, the OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with aberrant behavior risk assessments, concurrent benzodiazepine therapy, urine drug testing, informed consent, patient follow-up, and quality measure oversight.

EVALUATION OF MEDICAL STAFF PRIVILEGING IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

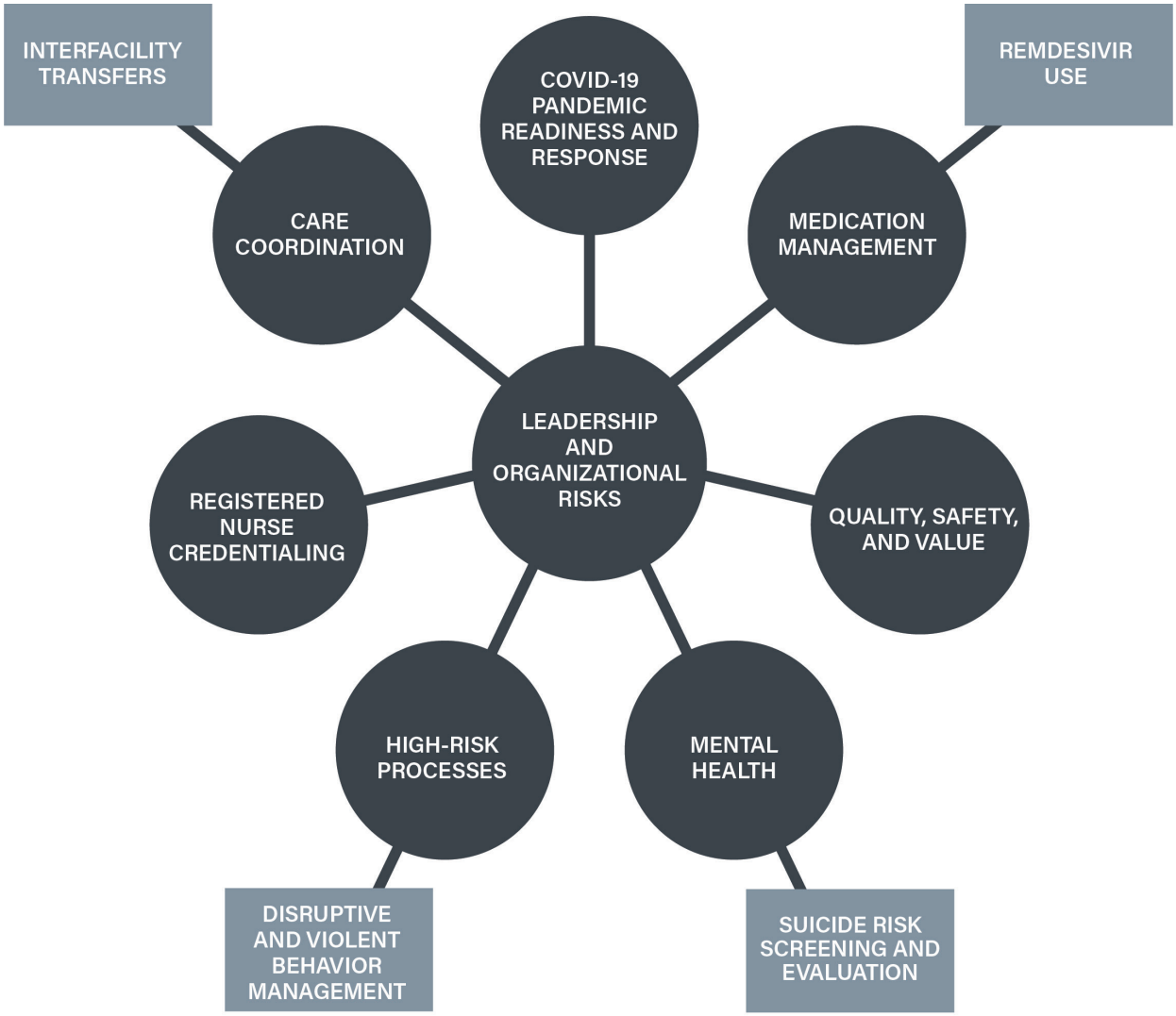
This CHIP summary report provides a focused evaluation of VHA facilities' selected medical staff privileging program requirements. Incorporating interviews with facility leaders and staff, reviews of clinical and administrative processes, and evaluations of meeting minutes and other relevant documents, the OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with focused professional practice evaluation criteria, reprivileging decision processes, ongoing professional practice evaluations, processes for recommending continuing privileges, timely completion of and required signatures for provider exit review forms, and state licensing board reporting. The OIG issued six recommendations, including three repeat recommendations related to minimum specialty criteria for focused professional evaluations, inclusion of service-specific criteria in ongoing professional practice evaluations, and use of professional practice evaluation results in executive committee recommendations to continue licensed independent practitioners' privileges.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM REPORTS

The Comprehensive Healthcare Inspection Program is one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. In contrast to the healthcare inspections listed above, these CHIP inspections are routinely and proactively performed approximately

every three years for each VA medical facility to help consistently examine key conditions and activities. The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus are depicted in the illustration below. During the reporting period, the OIG issued 17 CHIP reports, which are listed in appendix A, table A.2. There were reports on 14 medical centers and healthcare systems and three VISNs published in the six-month reporting period.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS, FISCAL YEAR 2022



RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

VET CENTER INSPECTION PROGRAM REPORTS

VCIP reports provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. The following are the OIG's current inspection areas of focus:

1. Leadership and organizational risks
2. Quality reviews
3. Suicide prevention
4. Consultation, supervision, and training
5. Environment of care

During the reporting period, the OIG issued two VCIP reports, which are listed in appendix A, table A.2. These reports included a review of vet center and district operations across two zones and eight vet centers. Since the VCIP's first inspection in October 2020, a sample of vet centers and zones within all five districts have been inspected. Overall, vet centers had positive feedback scores from clients and leaders demonstrated a solid understanding of quality improvement opportunities. However, noncompliance was identified with the majority of requirements reviewed for suicide prevention and consultation, supervision, and training.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

OMA provides the structure and services needed to support OIG operations. Together, the divisions listed below help ensure the efficiency and effectiveness of activities OIG-wide to best serve veterans and their families.

- The Human Resources Division works to recruit and retain qualified and committed staff.
- The Budget Division provides a broad range of formulation and execution services to make certain that OIG expends funds appropriately and to the greatest effect.
- The four IT Divisions—IT Customer Support, Enterprise Systems, Information Security, and Web Applications—provide nationwide support to personnel, systems development, and integration and perform continuous monitoring to fully secure OIG systems and data.
- The Hotline Division receives, screens, and refers complaints and allegations of misconduct involving VA. It also analyzes and synthesizes information to inform decisions on selecting cases for examination with priority given to issues having the greatest potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress.
- The Operations Division oversees the internal controls and records management programs, directs the senior executive services program, and writes and publishes organizational policies.
- The Procurement and Financial Operations Division has fully warranted contracting officers and is responsible for the OIG's acquisition-related functions, as well as a range of financial services, including paying invoices and administering the employee travel and purchase card programs.
- The Space and Facility Management Division develops space plans and manages the more than 50 OIG offices across the country.
- The Training and Development Division coordinates centralized instruction and staff professional development activities.

OVERSIGHT ACTIVITIES

OMA staff deliver comprehensive services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support. In addition to providing essential support services to advance the OIG's overall mission and goals, OMA has noteworthy oversight responsibilities related to the operation of the Hotline Division. The hotline receives, screens, and acts in response to complaints regarding VA programs and services. The hotline director also serves as the whistleblower protection coordinator who is responsible for educating agency employees about prohibitions on retaliation for disclosing serious wrongdoing or gross mismanagement and the rights and

remedies against retaliation associated with those disclosures. In addition to receiving and screening more than 17,640 contacts from complainants during this reporting period, the Hotline Division

- referred 553 cases to and required a written response from applicable VA offices as appropriate, after determining that allegations pertained to higher-risk topics but where the OIG had insufficient resources to complete a prompt independent review at that time;
- made 791 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 523 cases for which nearly 43 percent of allegations were substantiated, resulting in 498 administrative sanctions and corrective actions taken as well as $480,071 in monetary benefits achieved;
- responded to more than 1,064 requests for record reviews from VA staff offices; and
- issued 4,776 semicustom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope, and also finalized a contract to significantly increase the volume of semicustom responses in the future.[20]

FEATURED HOTLINE CASES

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

DELAY IN CARE AT JERRY L. PETTIS MEMORIAL VETERANS' HOSPITAL IN LOMA LINDA, CALIFORNIA

The hotline received allegations that a below-the-knee amputee submitted a multiple-item service order for his leg but found after waiting several weeks, the VA medical center only processed half the order. Additionally, the veteran was unable to get resolution through the prosthetics department, the patient advocate office, or the White House VA Hotline. The OIG referred the case to VISN 22, and their review of the issues found that there was a monthlong delay between the veteran's request and the order for parts. They also determined that the veteran's queries had not been answered in a timely manner. As a result of the findings, the VISN mandated four corrective actions to both immediately rectify the situation and prevent similar occurrences in the future.

PATIENT SAFETY ISSUE AT THE HARRY S. TRUMAN MEMORIAL VETERANS' HOSPITAL IN COLUMBIA, MISSOURI

A complainant reported to hotline staff that a patient suffered a respiratory emergency in the intensive care unit, the assigned respiratory therapist declined to optimize ventilation and oxygenation of the patient, and false information was placed into the patient's chart to cover up the incident. The OIG

20 The number of hotline contacts exceeds the number of cases because some contacts are resolved over the phone, may have been made multiple times, or may have been made anonymously via the web and have insufficient information for follow-up or referral.

referred the allegations to the VA medical center director for a response. According to the review, an incident took place and inaccurate information regarding the circumstances was entered into the patient record; however, this was unintentional and caused by the registered nurse not being fully aware of all the actions taking place. The allegation involving the respiratory therapist could not be verified. However, the case resulted in eight corrective actions by the medical center, including the development of new standard operating procedures for ventilator management.

DELAYED APPOINTMENT SCHEDULING AT THE CARL T. HAYDEN VA MEDICAL CENTER IN PHOENIX, ARIZONA

OIG hotline staff sent a case referral to VISN 22 to review allegations of staff mismanagement, distribution, and hiring and retention practices that resulted in over 5,700 veterans waiting for care. The VISN substantiated the Care in the Community service was inadequate and that patients were waiting months to be scheduled. To address the issues, 12 corrective actions were established related to staff scheduling, standardized training, elimination of full-time telework, establishment of a staff communication plan, and performance standards.

ISSUES WITH THE TRAVELING VETERAN PROGRAM AT THE FAYETTEVILLE VA MEDICAL CENTER IN NORTH CAROLINA

A confidential complainant alleged that 76 traveling veterans experienced delays in establishing care. Six of the veterans had been waiting for at least a year, and one veteran had been assigned a "temporary" provider that lasted more than a year. The case was referred to VISN 6, which substantiated the allegations. The corrective actions included an immediate internal review of 46 known cases for risk assessment or scheduling, contacting all veterans, and a clinical review of consults. Additionally, scheduling actions for the Traveling Veteran Coordinator program were consolidated under one clinical service for enhanced management and accountability.

IMPROPER DISABILITY PAYMENT

An anonymous complainant reported a veteran for continuing to collect disability benefits that included payments for dependents, despite having been divorced since 2019 and having no parental rights for her biological children. A case referral was sent to the responsible VA regional office, which reviewed the allegations and contacted the veteran, providing ample time for the veteran to respond to a query about the status of her dependents. The veteran failed to reply. As a result, the VA regional office removed her dependents from her award effective November 2016, which was the last time they were verified, and established an overpayment of close to $10,000 to the veteran, resulting in a five-year cost savings to the government of $15,000.

CONGRESSIONAL TESTIMONY

CONGRESSIONAL RELATIONS

During this reporting period, OIG leaders testified at seven congressional hearings on the OIG's oversight of VA's programs and operations. Table 6 on page 63 provides links to the OIG's full statements for each hearing. All previous statements made by the OIG before Congress are available at www.va.gov/oig/publications/statements.asp.

DEPUTY AIG FOR HEALTHCARE INSPECTIONS TESTIFIES ON PATIENT SAFETY BEFORE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

Dr. Julie Kroviak, the deputy assistant inspector general for the Office of Healthcare Inspections, testified on October 27, 2021, before the House Veterans Affairs' Subcommittee on Health. Her testimony focused on patient safety and the quality of care at VHA medical facilities—highlighting several OIG healthcare inspections and criminal investigations. She emphasized the need for creating an environment that encourages staff reporting of concerns, immediate review and corrective action on patient safety issues, consistent accountability, information sharing on lessons learned, and the engagement of strong experienced leaders who constantly communicate key values to achieve transformation. In response to questions, Dr. Kroviak discussed the need to standardize governance structures at the level of the Veteran Integrated Services Network (the regional network that oversees VA's healthcare facilities). She also highlighted the need for collaboration between VA medical facilities and vet centers, which are community-based counseling centers that assist with the transition from and traumas related to prior military service, which drew on findings from recent OIG comprehensive inspection reports of these centers. Dr. Kroviak noted that although the vast majority of VHA staff are dedicated to providing high-quality care, patient safety must be a continuous activity that fuels every interaction with patients.

INSPECTOR GENERAL TESTIFIES ON MILITARY SEXUAL TRAUMA BEFORE US HOUSE VETERANS' AFFAIRS SUBCOMMITTEES

Inspector General Michael J. Missal testified before the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health on November 17, 2021, about the OIG's work regarding benefits and health care for individuals who have experienced military sexual trauma (MST). His testimony focused on the findings from two OIG reports published in August 2021 that address VBA and VHA actions related to MST benefits and healthcare services. In the first report, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, the OIG noted that VBA had not effectively implemented the recommendations from an OIG August 2018 report on MST claims. Based on a sample of claims processed after VBA acted on the prior OIG recommendations, the review team estimated about 57 percent of denied claims were still incorrectly processed. That rate reflects a decided lack of improvement from the 49 percent error rate noted in the August 2018 report. VBA did not adequately manage the MST-related claims process or provide sufficient oversight. In the second report, *Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations*, the OIG found that MST coordinators at VA medical facilities were often unable to fulfill their roles and responsibilities due to insufficient protected administrative time, competing role demands, limited support staff, and inadequate funding and outreach materials. Inspector General Missal stressed that VA must improve its processes and practices that provide compensation and healthcare services to those who have experienced MST to ensure that those seeking care are not retraumatized and that their needs are met.

CONGRESSIONAL TESTIMONY

COUNSELOR TO THE INSPECTOR GENERAL TESTIFIES ON PENDING LEGISLATION BEFORE THE SENATE VETERANS' AFFAIRS COMMITTEE

Chris Wilber, counselor to the Inspector General, testified before the Senate Veterans' Affairs Committee on November 17, 2021, at a hearing to consider pending legislation. He testified in support of both the *Strengthening Oversight for Veterans Act of 2021* (S.2687), and the *Department of Veterans Affairs Office of Inspector General Training Act of 2021* (S.2431). The first bill would give the VA OIG testimonial subpoena authority. It currently lacks the authority to compel testimony from former federal employees, former contractors, or contractors' former employees, as well as others not employed or involved in VA contracts at the time of an OIG audit, review, inspection, or administrative investigation. For example, a VA employee can retire or quit after learning of an OIG investigation, effectively taking away the individual's duty to answer OIG investigators' questions. Mr. Wilber discussed the safeguards associated with ensuring this authority is properly used. He also detailed examples of when the OIG has been unable to interview witnesses whose testimony was important to conducting thorough oversight of VA personnel, programs, and operations. The second bill would mandate that VA employees receive one-time training on when and how to both report suspected wrongdoing to the OIG and engage with its staff. The bill would also enable the OIG to send all-employee emails to VA staff, such as for crime or fraud alerts. Mr. Wilber noted that passage of this legislation would empower VA employees to help the OIG identify and address wrongdoing. Enhanced cooperation and reporting outlined in the training can also lead to improvements to VA's operations, cost-saving efforts, patient safety and quality care, and timely benefits and services to eligible veterans. Although VA Secretary McDonough directed one-time training for VA employees as of September 22, 2021, for which the OIG is grateful, the bill would institutionalize the training and help ensure the OIG's training is not dependent on the ongoing approval of future VA leaders and their willingness to allow the OIG to communicate directly with VA employees.

DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS TESTIFIES ON VA'S MEDICAL SUPPLY CHAIN BEFORE US HOUSE VETERANS' AFFAIRS SUBCOMMITTEES

Leigh Ann Searight, deputy assistant inspector general for Audits and Evaluations, testified about VA's efforts to modernize its supply chain before two subcommittees of the House Veterans' Affairs Committee: the Subcommittee on Oversight and Investigation and the Subcommittee on Technology Modernization. She focused on the recent OIG report, *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays*, and referenced past OIG work related to supply chain deficiencies that can affect getting supplies for patient care when and where they are needed. She responded to questions regarding the ability of the DMLSS system to handle VA's requirements across the enterprise and its capability to provide real-time information on supply levels. She noted that VA did not follow its own acquisition framework requirements to ensure the DMLSS system meets the high-priority needs of medical facilities and that the VALOR program office, which was tasked with managing the deployment of the DMLSS system, lacked a supportive structure and coordination with stakeholders. She concluded that VA still faces considerable challenges to modernize its supply chain systems.

DEPUTY AIG FOR HEALTHCARE INSPECTIONS TESTIFIES ON THE VET CENTER INSPECTION PROGRAM BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

On February 3, 2021, Dr. Kroviak again testified before the House Veterans Affairs' Subcommittee on Health. Her testimony focused on the findings and recommendations from the OIG's five published vet center inspection reports. She emphasized the need for improved collaboration between vet centers and

CONGRESSIONAL TESTIMONY

VHA facilities for high-risk veterans with complex mental health conditions. The reports identified a need for continued VA leadership engagement at all levels and greater attention to training, internal controls, and oversight. In response to questions, Dr. Kroviak discussed requirements for better documentation of vet center processes and an improved record-keeping system. This will ensure vet center leaders and oversight bodies can verify that required training, client assessments, and internal reviews are being completed in a timely manner. Dr. Kroviak also stressed that vet centers should prioritize addressing any deficiencies in their suicide prevention activities.

DEPUTY INSPECTOR GENERAL TESTIFIES ON PENDING LEGISLATION BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON ECONOMIC OPPORTUNITY

On March 16, 2022, Deputy Inspector General David Case testified before the House Veterans' Affairs Subcommittee on Economic Opportunity. He focused on the OIG's support for the provisions in draft legislation titled *Quality Education for Veterans Act of 2022*, emphasizing how the bill's provisions would help prevent fraud in VA's education and job training programs. In response to questions, Mr. Case elaborated on the potential impact of the bill and stressed how it would strengthen the OIG's efforts to detect fraud. He also referenced multiple audits examining the accuracy of payments made to veterans participating in the Post-9/11 GI Bill and Veteran Readiness and Employment programs, as well more than 200 criminal investigations since 2017 involving educational institutions accused of misconduct.

COUNSELOR TO THE INSPECTOR GENERAL TESTIFIES ON PENDING LEGISLATION BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Chris Wilber, counselor to the Inspector General, testified before the House Veterans' Affairs Subcommittee on Oversight and Investigations on March 30, 2022 regarding pending legislation. As in his November 17, 2021, testimony to the Senate Committee on Veterans' Affairs, Mr. Wilber again expressed the OIG's support of H.R. 6052, *Department of Veterans Affairs Office of Inspector General Training Act of 2021*, which would mandate VA employees receive one-time training on how to cooperate with and report suspected wrongdoing to the OIG. Illinois Rep. Lauren Underwood sponsored the bill. As stated above, it would also enable the Inspector General to send at least two messages a year through VA's email system to all personnel on OIG matters. Mr. Wilber explained that the training needs to be codified so that the independent OIG does not need to rely on future VA secretaries to continue the training requirement for new hires. He also took questions regarding the VA OIG's need for testimonial subpoena authority.

CONGRESSIONAL TESTIMONY

TABLE 6. OIG CONGRESSIONAL TESTIMONY
OCTOBER 1, 2021–MARCH 31, 2022

WITNESS	COMMITTEE	TOPIC	DATE
Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak	Subcommittee on Health, Committee on Veterans' Affairs, US House of Representatives	Lessons Learned? Building a Culture of Patient Safety within the Veterans Health Administration	10/27/2021
Inspector General Michael Missal	Subcommittee on Disability Assistance and Memorial Affairs, Subcommittee on Health, Committee on Veterans' Affairs, US House of Representatives	Supporting Survivors: Assessing VA's Military Sexual Trauma Programs	11/17/2021
Counselor to the Inspector General Chris Wilber	Committee on Veterans' Affairs, US Senate	Hearing to Consider Pending Legislation	11/17/2021
Deputy Assistant Inspector General for Audits and Evaluations Leigh Ann Searight	Subcommittee on Oversight and Investigations, Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives	Examining the U.S. Department of Veterans Affairs Supply Chain	11/18/2021
Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak	Subcommittee on Health, Committee on Veterans' Affairs, US House of Representatives	Close to Home: Supporting Vet Centers in Meeting the Needs of Veterans and Military Personnel	2/3/2022
Deputy Inspector General David Case	Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, US House of Representatives	Hearing on Pending Legislation	3/16/2022
Counselor to the Inspector General Chris Wilber	Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives	Hearing on Pending Legislation	3/30/2022

OTHER REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors general are required by the IG Act to review existing and proposed legislation and regulations and make recommendations in the *Semiannual Report to Congress* 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.[21] During this reporting period, the OIG reviewed one legislative proposal and made one comment. The OIG also reviewed 20 internal VA directives and handbooks that guide the work of VA employees and provided two comments.

PEER AND QUALITATIVE ASSESSMENT REVIEWS

The IG Act, as amended by the Dodd–Frank Wall Street Reform and Consumer Protection Act, requires inspectors general to report the results of any peer review conducted of its operations by another office of inspector general during the reporting period or identify the date of the last peer review conducted by another office of inspector general, in addition to any outstanding recommendations that have not been fully implemented.[22] The VA OIG's offices of Investigations, Special Reviews, Audits and Evaluations, and Healthcare Inspections are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards.

The IG Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general's audit operations during the reporting period, as well as any outstanding recommendations that have not been fully implemented from any peer review completed during or prior to the reporting period.[23] No peer reviews were conducted by the VA OIG or of the VA OIG by other offices of inspector general during this reporting period, and no recommendations from peer reviews completed prior to the reporting period are outstanding.

TABLE 7. MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

TYPE	DATE COMPLETED	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
Audits	10/10/2018	Department of Energy OIG	Pass	None
Inspections and Evaluations	6/25/2020	HHS OIG (Lead), HUD OIG, DOI OIG, SBA OIG	Pass	None
Investigations	12/10/2018	NASA OIG	Pass	None

21 Pub. L. No. 95-452 § 4(a)(2).

22 Pub. L. No. 95-452 § 5(a)(14) and (15); Pub. L. No. 111-203.

23 Pub. L. No. 95-452 § 5(a)(16).

OTHER REPORTING REQUIREMENTS

TABLE 8. MOST RECENT PEER REVIEWS CONDUCTED BY THE VA OIG

TYPE	DATE COMPLETED	OIG REVIEWED	RATING	OUTSTANDING RECOMMENDATIONS
Audits	8/8/2018	SSA OIG	Pass	None
Inspections and Evaluations	9/14/2021	DoD OIG	Pass	None
Investigations	12/13/2018	Department of Education OIG	Pass	None

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

The IG Act authorizes federal inspectors general to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. OIGs are required by the IG Act to provide a summary of instances when such information or assistance is refused.[24] The VA OIG reports no such instances occurring during this reporting period.

INSTANCES OF WHISTLEBLOWER RETALIATION

Inspectors general are required by the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers.[25] In addition, the Act requires inspectors general to detail the consequences imposed by the Department to hold those officials accountable. However, the OIG's current practice is to refer VA employees alleging whistleblower reprisal to either the VA Office of Accountability and Whistleblower Protection or the US Office of Special Counsel, as each of those offices has specific statutory authority to address reprisal claims that the OIG does not. The OIG does investigate allegations of whistleblower reprisal made by employees of VA contractors or grantees. One such investigation was completed during this SAR period in which a claim of whistleblower retaliation by a VA grantee was substantiated.

The OIG investigated an allegation of unlawful whistleblower reprisal by a VA grantee (under 41 U.S.C. § 4712). The OIG found that the complainant (an employee of the grantee) made a "protected" disclosure to a federal inspector general alleging her employer had engaged in fraud, waste, and abuse. This whistleblower disclosure contributed to the complainant being fired. The grantee was unable to show that it would have terminated the complainant absent the disclosure. The OIG substantiated that the complainant suffered reprisal and provided a confidential report of its investigation to the VA Secretary, the grantee, and the complainant as required by law. Because the OIG is prohibited by law from otherwise disclosing "any information from or about any person alleging the reprisal" except as

24 Pub. L. No. 95-452 § 5(a)(5).

25 Pub. L. No. 95-452 § 5(a)(20).

necessary to conduct its investigation, its report will not be published. The VA Secretary makes the final determination regarding reprisal and orders remedial action, if any.

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

The IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information.[26] During this reporting period, there were no such incidents.

CLOSED OFFICE OF INSPECTOR GENERAL WORK NOT DISCLOSED TO THE PUBLIC

The VA OIG is required by the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, and audit conducted by the OIG that is closed and was not disclosed to the public.[27] The OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the OIG has no information responsive to this reporting requirement.

26 Pub. L. No. 95-452 § 5(21).

27 Pub. L. No. 95-452 § 5(a)(22)(A).

AWARDS AND RECOGNITION

EMPLOYEE RECOGNITION OF MILITARY PERSONNEL

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

- Branton Blount, a criminal investigator in Las Vegas, Nevada, was activated by the Navy in February 2022.
- Matthew Clark, an auditor in Dallas, Texas, was activated by the Army in February 2022.
- Keith Cook, a criminal investigator in San Antonio, Texas, was activated by the National Guard in January 2022.
- Jose Flores-Marrero, an auditor in Washington, DC, was activated by the Air Force in January 2022.
- Danielle Head, a procurement analyst in Arlington, Virginia, was activated by the Army in January 2021 and returned from active duty in December 2021.
- Ricardo Wallace-Jimenez, a criminal investigator in Spokane, Washington, was activated by the Army in January 2022.

PRESIDENTIAL RANK AWARD RECIPIENTS

In December 2021, Assistant Inspector General for Audits and Evaluations Larry Reinkemeyer and Principal Deputy Counselor to the Inspector General Roy Fredrikson both received presidential rank awards in the category of Meritorious Executive. Among the most prestigious awards given to career senior executives, presidential rank awards recognize executives who have made significant and lasting contributions to their agencies and the federal government. In addition to delivering meaningful results, nominees must demonstrate the highest level of leadership competencies.

Mr. Reinkemeyer directs the OIG's national audit and evaluation program, engaging a network of geographically dispersed field and headquarters staff. His work involves formulating audit policies, programs, plans, and special initiatives within the dictates of relevant legislation, policy, regulations, and budget. Since his appointment in June 2016, Mr. Reinkemeyer has guided the publication of more than 220 reports with more than 900 recommendations to senior department leaders, identifying approximately $9.9 billion in potential monetary benefits. The reports span all aspects of VA operations, including reviews of denied PTSD claims related to military sexual trauma, post-9/11 GI Bill benefit payments, and VBA's home loan guaranty funding fee refund process, the latter resulting in refunds of over $400 million to veterans.

AWARDS AND RECOGNITION

Since joining the OIG in February 2015, Mr. Fredrikson helped transform the OIG's Office of the Counselor from a team of five attorneys to a more appropriately resourced and diverse team of 35, including attorneys, paralegals, and employee relations and government information specialists. The 18 attorney-advisors who report to him provide counsel to auditors, investigators, inspectors, and support personnel to ensure the work produced by the OIG is legally sound. His staff also administers the OIG's Freedom of Information Act and Privacy Act programs and represents the OIG in litigation before the Merit Systems Protection Board and Equal Employment Opportunity Commission. Mr. Fredrikson also oversees the operations of the OIG's employee relations and reasonable accommodation teams.

VA Inspector General Michael J. Missal presents Larry Reinkemeyer (left), the assistant inspector general for audits and evaluations, and Roy Fredrikson (right), the principal deputy counselor to the inspector general, with FY 2021 Presidential Rank Awards for Meritorious Executive.

OUTSTANDING LAW ENFORCEMENT OFFICER OF THE YEAR AWARD RECIPIENT

The US Attorney's Office for the Middle District of Florida presented Special Agent Daniel Henson with an award for Outstanding Law Enforcement Officer of the Year for his investigation of a former VA transportation assistant at VA's outpatient clinic in The Villages, Florida. The investigation revealed that the former transportation assistant, who had the authority to award transportation assignments to vendors, conspired with his daughter and ex-wife to create and control two companies to which he steered VA transportation contracts. As a result, VA paid over $305,000 to these companies. The transportation assistant also solicited and received over $76,000 in kickbacks from two other transportation vendors. He was sentenced to 18 months in prison and forfeiture of over $382,000. The US Attorney's Office commended Special Agent Henson for his "dogged perseverance and exceptional investigative efforts."

AWARDS AND RECOGNITION

INVESTIGATIVE ACHIEVEMENT AWARD RECIPIENTS

The Acting US Attorney for the District of Massachusetts presented Senior Special Agent Jason Kravetz and Special Agent Brendan Callanan with an Investigative Achievement Award for their investigation of a vendor providing services for several VA medical centers. The vendor created false invoices and reports for medical gas inspections that never took place. After pleading guilty to wire fraud, the vendor was subsequently sentenced to two years' probation and ordered to pay restitution of close to $9,000 to VA.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

The IG Act requires federal inspectors general to provide information on the reports they publish and any associated monetary impact.[28] Tables A.1 through A.3 provide a listing of VA OIG publications issued this period with results sorted according to the authoring directorate. If applicable, the total dollar value of questioned costs and recommendations that funds be put to better use are identified. Table A.4 summarizes all monetary benefits for OIG reports issued this reporting period.

Per the IG Act, offices of inspector general must provide statistical tables showing the total number of reports issued during the reporting period with questioned costs or recommendations that funds be put to better use (1) for which no management decision had been made by the commencement of the reporting period, (2) which were issued during the reporting period, (3) for which a management decision was made during the reporting period, and (4) for which no management decision was made by the end of the current reporting period.[29] This information is provided in tables A.5 and A.6.

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

Finally, federal inspectors general are also required by the IG Act to provide a description and explanation of the reasons for any significant revised management decision made during the reporting period, as well as information concerning any significant management decisions with which the Inspector General is in disagreement.[31] The VA OIG reports that there were no significant revised management decisions made during the reporting period. While VA OIG reports that there were no significant revised management decisions made during the reporting period, there were significant management decisions in two reports with which the Inspector General is in disagreement:

- In the report *Inspection of Information Technology Security at the VA Financial Services Center*, the Office of Information and Technology (OIT) concurred with recommendations 1, 3, 4, and 5 but nonconcurred with recommendation 2, which was related to the OIG's findings regarding vulnerability management and flaw remediation. Appendix D of the report includes the full text of VHA's comments. The OIG stands by its recommendation and considers recommendation 2 open.
- In the report *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, the VA deputy secretary concurred with recommendation 1 but nonconcurred with recommendation 2 on the basis that it creates a continuous reporting requirement to the OIG with no end date or defined parameters to otherwise permit closure of the recommendation. Appendix C of the report

28 Pub. L. No. 95-452 § 5(a)(6).

29 Pub. L. No. 95-452 § 5(a)(8) and (9).

30 Pub. L. No. 95-452 § 5(a)(10)(A) and (B).

31 Pub. L. No. 95-452 § 5(a)(11) and (12).

includes the full text of VHA's comments. The OIG stands by its recommendation and considers recommendation 2 open.

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

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

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

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance *Issued 10/21/2021 | Report Number 19-06004-225*	—	—
Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments *Issued 10/28/2021 | Report Number 20-03898-236*	—	—
Successive VA Errors Created a $210,000 Debt for a Veteran with a "Service-Connected Mental Illness" *Issued 11/4/2021 | Report Number 21-02447-05*	—	—
Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2021 | Report Number 20-04237-09*	—	—
New Patient Scheduling System Needs Improvement as VA Expands Its Implementation *Issued 11/10/2021 | Report Number 21-00434-233*	—	—
DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays *Issued 11/10/2021 | Report Number 20-01324-215*	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Audit of VA's Financial Statements for Fiscal Years 2021 and 2020 *Issued 11/15/2021 | Report Number 21-01052-33*	—	—
VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements *Issued 12/2/2021 | Report Number 20-00426-02*	—	—
Systems and Tools Implemented to Track COVID-19 Vaccine Data *Issued 12/7/2021 | Report Number 21-00913-267*	—	—
VHA Risks Overpaying Community Care Providers for Evaluation and Management Services *Issued 12/8/2021 | Report Number 21-01807-251*	—	$59,600,000
VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services *Issued 12/8/2021 | Report Number 20-01099-249*	—	$341,700,000
Financial Efficiency Review of the Eastern Oklahoma VA Health Care System *Issued 12/15/2021 | Report Number 21-00942-16*	—	$95,000
Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits *Issued 12/15/2021 | Report Number 20-04219-07*	—	$136,000,000
Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains *Issued 12/15/2021 | Report Number 19-09592-262*	—	—
Inadequate Oversight of VHA's Home Oxygen Program *Issued 12/16/2021 | Report Number 19-07812-29*	—	—
Financial Efficiency Review of the Marion VA Medical Center in Illinois *Issued 12/16/2021 | Report Number 21-00960-17*	—	—
MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data *Issued 12/20/2021 | Report Number 20-03351-08*	—	—
VA's Use of the Defense Logistics Agency's Electronic Catalog for Medical Items *Issued 1/13/2022 | Report Number 20-00552-30*	$4,420,878	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Audit of Community Care Consults during COVID-19 *Issued 1/19/2022 | Report Number 21-00497-46*	—	—
Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2020 *Issued 2/9/2022 | Report Number 21-03260-60*	—	—
First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions *Issued 2/17/2022 | Report Number 20-03086-70*	—	—
Summary of Preaward Reviews of VA Federal Supply Schedule Nonpharmaceutical Proposals, Fiscal Years 2018–2020 *Issued 3/3/2022 | Report Number 20-03814-64*	—	—
Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened *Issued 3/9/2022 | Report Number 21-02750-63*	—	$88,700
Review of Allegations of Improper Maintenance at VA's Houston National Cemetery in Texas *Issued 3/10/2022 | Report Number 21-03325-86*	—	—
VA's Compliance with the VA Transparency & Trust Act of 2021 *Issued 3/22/2022 | Report Number 22-00879-118*	—	$3,600,000
Independent Review of VA's Fiscal Year 2021 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy *Issued 3/22/2022 | Report Number 21-03164-115*	—	—
Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints *Issued 3/24/2022 | Report Number 21-00510-105*	—	—
Financial Efficiency Review of the Durham VA Health Care System in North Carolina *Issued 3/29/2022 | Report Number 21-02458-94*	—	$308,000
Inspection of Information Technology Security at the VA Financial Services Center *Issued 3/31/2022 | Report Number 21-01221-24*	—	—
Total	**$4,420,878**	**$541,391,700**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS	BETTER USE OF FUNDS
Review of a Proposal Submitted under a Solicitation *Issued 10/14/2021 | Report Number 21-02918-01*	$1,159,793
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/22/2021 | Report Number 21-02735-12*	$6,749,140
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/22/2021 | Report Number 21-02629-14*	$3,548,020
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/26/2021 | Report Number 21-01408-03*	$1,910,683,875
Review of a Proposal Submitted under a Solicitation *Issued 10/28/2021 | Report Number 22-00056-19*	$319,357
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 11/1/2021 | Report Number 21-03132-18*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/10/2021 | Report Number 21-02964-15*	—
Review of a Proposal Submitted under a Solicitation *Issued 11/17/2021 | Report Number 22-00269-28*	$3,613,088
Review of a Proposal Submitted under a Solicitation *Issued 11/18/2021 | Report Number 21-03706-31*	$4,301,878
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 11/24/2021 | Report Number 21-03059-40*	—-
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/2/2021 | Report Number 21-03254-34*	—
Review of a Proposal Submitted under a Solicitation *Issued 12/3/2021 | Report Number 22-00050-36*	$62,016
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 12/7/2021 | Report Number 21-03240-50*	$2,421,280

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/10/2021 | Report Number 21-02877-47*	$33,677,829
Review of a Request for Product Addition under a Federal Supply Schedule Contract *Issued 12/14/2021 | Report Number 21-03820-53*	$20,938,200
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/15/2021 | Report Number 21-02610-52*	$58,750,774
Review of a Proposal Submitted under a Solicitation *Issued 12/16/2021 | Report Number 22-00034-51*	$7,357,215
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 12/21/2021 | Report Number 21-03897-57*	—
Review of a Proposal Submitted under a Solicitation *Issued 12/23/2021 | Report Number 22-00552-55*	$886,303
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/23/2021 | Report Number 21-03377-58*	$951,842,335
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/13/2022 | Report Number 21-03222-62*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/1/2022 | Report Number 22-00267-75*	$6,267,140
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/2/2022 | Report Number 21-02688-71*	$5,540,615
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/7/2022 | Report Number 21-01566-79*	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/18/2022 | Report Number 21-02391-80*	$61,475
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 3/1/2022 | Report Number 22-00032-92*	$5,941,200

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of Product Addition Proposal under a Federal Supply Schedule Contract *Issued 3/1/2022 | Report Number 22-00366-95*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 3/4/2022 | Report Number 22-00992-85*	$550,784
Review of a Proposal Submitted under a Solicitation *Issued 3/10/2022 | Report Number 22-00616-87*	$67,832,048
Review of Federal Supply Schedule Proposal Submitted under Solicitation Number *Issued 3/10/2022 | Report Number 21-03672-113*	$847,449
Independent Audit Report of a Proposal Submitted under a Solicitation Number *Issued 3/15/2022 | Report Number 22-01112-88*	$145,645
Independent Audit Report of a Proposal Submitted under a Solicitation Number *Issued 3/30/2022 | Report Number 22-01231-107*	$3,456,481
Total	**$3,096,953,940**

POSTAWARD REVIEWS	QUESTIONED COSTS
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 11/10/2021 | Report Number 21-03331-06*	$37,351
Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 11/18/2021 | Report Number 21-01381-27*	$230,317
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 11/24/2021 | Report Number 17-04050-42*	$412,817
Review of a Voluntary Disclosure Submitted under Multiple Federal Supply Schedule Contracts *Issued 2/2/2022 | Report Number 20-04359-59*	$37,060,123
Report of a Settlement Agreement *Issued 2/7/2022 | Report Number 22-00431-81*	$369,350

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)	QUESTIONED COSTS
Report of a Settlement Agreement *Issued 2/7/2022 | Report Number 22-00432-82*	$5,145,928
Report of a Settlement Agreement *Issued 2/7/2022 | Report Number 22-00435-83*	$3,372,519
Review of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 2/15/2022 | Report Number 20-02793-65*	$1,930,696
Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 2/23/2022 | Report Number 20-01330-66*	$91,623
Review of a Voluntary Disclosure under a Federal Supply Schedule Contract due to Price Reductions Clause Violations *Issued 3/1/2022 | Report Number 20-03530-93*	$1,979,229
Review of Price Reductions Clause Violations under a Federal Supply Schedule Contract *Issued 3/1/2022 | Report Number 21-02557-96*	$1,527,886
Postaward Review of a Federal Supply Schedule Contract *Issued 3/1/2022 | Report Number 22-00319-98*	$9,373
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 3/15/2022 | Report Number 21-03340-102*	$98,564
Review of the Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 3/21/2022 | Report Number 22-00279-106*	$502
Total	**$52,266,278**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS	BETTER USE OF FUNDS
Review of a Request for an Equitable Adjustment Proposal under a VA Contract *Issued 10/22/2021 | Report Number 21-02127-10*	$268,253
Review of Termination Settlement Proposal Submitted under a Prime Contract *Issued 3/2/2022 | Report Number 21-03267-101*	$78,843
Review of Termination Settlement Proposal Submitted under a Prime Contract, Subcontract Agreement *Issued 3/18/2022 | Report Number 21-03291-117*	$145,240
Total	**$492,336**

TABLE A.2. PUBLICATIONS ISSUED BY THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Bay Pines VA Healthcare System in Florida	10/13/2021	21-00267-290
James A. Haley Veterans' Hospital in Tampa, Florida	10/13/2021	21-00274-289
VA Caribbean Healthcare System in San Juan, Puerto Rico	10/26/2021	21-00270-04
Orlando VA Healthcare System in Florida	11/3/2021	21-00275-11
Veterans Integrated Service Network 1: VA New England Healthcare System in Bedford, Massachusetts	11/18/2021	21-00235-13
Fayetteville VA Coastal Health Care System in North Carolina	12/9/2021	21-00277-41
Hampton VA Medical Center in Virginia	12/14/2021	21-00278-23
Charles George VA Medical Center in Asheville, North Carolina	1/11/2022	21-00279-54
Veterans Integrated Service Network 8: VA Sunshine Healthcare Network in St. Petersburg, Florida	1/12/2022	21-00236-44
Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	1/31/2022	21-00292-73
Durham VA Health Care System in North Carolina	2/3/2022	21-00276-67
VA Hudson Valley Health Care System in Montrose, New York	2/8/2022	21-00298-72
James J. Peters VA Medical Center in Bronx, New York	3/3/2022	21-00289-90
Hunter Holmes McGuire VA Medical Center in Richmond, Virginia	3/8/2022	21-00280-89
Salem VA Medical Center in Virginia	3/16/2022	21-00281-100
W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	3/23/2022	21-00282-111
Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network in Durham, North Carolina	3/29/2022	21-00237-114

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon	11/9/2021	21-01682-25
Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network	11/16/2021	20-02899-22
Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico	11/23/2021	20-03700-35
Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida	11/30/2021	21-01695-38
Deficiencies in Disclosures and Quality Processes for Perforations Resulting from Urological Surgeries at West Palm Beach VA Medical Center in Florida	12/9/2021	21-01049-39
Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma Health Care System in Muskogee	12/15/2021	21-01801-45
Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas	12/16/2021	21-01038-49
Inspection of Sterile Processing Services at the Carl T. Hayden VA Medical Center in Phoenix, Arizona	1/26/2022	21-02489-69
Lack of Care Coordination and Hepatocellular Carcinoma Surveillance of a Patient at the VA Eastern Colorado Health Care System in Aurora	2/9/2022	21-02492-77
Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia	2/16/2022	21-01724-84
Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	3/17/2022	21-00781-108
Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	3/17/2022	21-00781-109
Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	3/17/2022	21-00656-110
NATIONAL HEALTHCARE REVIEWS	**ISSUE DATE**	**REPORT NUMBER**
Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic	11/10/2021	20-03437-26
Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8	11/18/2021	21-02969-20

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

NATIONAL HEALTHCARE REVIEWS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health Care in Veterans Health Administration Facilities, Fiscal Year 2020	12/7/2021	21-01508-32
Comprehensive Healthcare Inspection Summary Report: Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2020	12/14/2021	21-01524-43
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020	1/20/2022	21-01507-61
Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2020	2/10/2022	21-01505-68
Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020	2/17/2022	21-01506-76
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020	3/28/2022	21-01503-112
VET CENTER INSPECTIONS	**ISSUE DATE**	**REPORT NUMBER**
Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers	12/2/2021	20-04050-37
Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	12/20/2021	21-01804-56

TABLE A.3. PUBLICATIONS ISSUED BY THE OFFICE OF SPECIAL REVIEWS

ADMINISTRATIVE INVESTIGATIONS	ISSUE DATE	REPORT NUMBER
Alleged Misconduct by Construction and Facilities Deputy Executive Director Not Substantiated	11/9/2021	20-02908-21
Review of SES Reassignments in the Veterans Benefits Administration	12/15/2021	21-01526-48
Former Education Service Executive Violated Ethics Rules and Her Duty to Cooperate Fully with the OIG	3/24/2022	21-02076-119

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.4. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$593,657,978
Better Use of Funds	$3,101,867,154
Total	**$3,695,525,132**

TABLE A.5. RESOLUTION STATUS OF PUBLICATIONS WITH QUESTIONED COSTS

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	21	$593,657,978
Total inventory this reporting period	**21**	**$593,657,978**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	21	$593,657,978
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**21**	**$593,657,978**
Total carried over to next reporting period	**0**	**$0**

TABLE A.6. RESOLUTION STATUS OF PUBLICATIONS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	28	$3,101,867,154
Total inventory this reporting period	**28**	**$3,101,867,154**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	NUMBER	DOLLAR VALUE
Reports with disallowed costs (agreed to by management)	28	$3,101,867,154
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**28**	**$3,101,867,154**
Total carried over to next reporting period	**0**	**$0**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

Follow-up reporting and tracking of federal inspector general recommendations are required by the Federal Acquisition Streamlining Act of 1994, as amended by the National Defense Authorization Act of 1996. The acts require agencies to complete final action on each management decision required with regard to a recommendation in any federal office of inspector general report within 12 months of the report's issuance/publication. If the agency fails to complete final action within the 12-month period, federal inspectors general are required by the IG Act to identify the matter in each semiannual report to congress until final action on the management decision is completed. The tables that follow identify all unimplemented VA OIG reports and recommendation. All data in the tables are current as of March 31, 2022. Real-time information on the status of VA OIG recommendations is available through the OIG's Recommendation Dashboard.

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

Table B.1 identifies the number of VA OIG reports with at least one unimplemented recommendation, with results sorted by action office. As of March 31, 2022, there were 193 total open reports with 51 open more than a year and 142 open less than a year. However, table B.1 shows a total of 208 open reports, with 54 open more than a year and 154 open less than a year. This is because 15 reports are counted multiple times in the table, as they have open recommendations for more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	39	126	165
Veterans Benefits Administration	7	6	13
National Cemetery Administration	0	3	3
Office of Acquisition, Logistics, and Construction	2	5	7
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	2	2	4
Office of Information and Technology	3	3	6
Office of Management	0	4	4
Office of Electronic Health Record Modernization	1	3	4
Office of Enterprise Integration	0	1	1
Office of Asset Enterprise Management	0	1	1
Total	**54**	**154**	**208**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

Table B.2 identifies the number of open VA OIG recommendations with result sorted by action office. As of March 31, 2022, there are 817 total open recommendations with 114 open more than a year and 703 open less than a year. However, table B.2 shows a total of 828 open recommendations, with 117 open more than a year and 711 open less than a year. This is because 11 recommendations are counted multiple times in the table as they have actions pending for more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	88	601	689
Veterans Benefits Administration	15	21	36
National Cemetery Administration	0	9	9
Office of Acquisition, Logistics, and Construction	3	9	12
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	5	4	9
Office of Information and Technology	3	34	37
Office of Management	0	10	10
Office of Electronic Health Record Modernization	3	16	19
Office of Enterprise Integration	0	5	5
Office of Asset Enterprise Management	0	2	2
Total	**117**	**711**	**828**

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

Table B.3 identifies the 142 reports and 703 recommendations that, as of March 31, 2022, have been open less than one year. The total monetary benefit attached to these recommendations is $780,992,074.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics *Issued 3/31/2021 | Report Number 20-001386-107*	VHA	1-3	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Ann Arbor VA Medical Center in Michigan *Issued 4/22/2021 | Report Number 20-01266-117*	VHA	3, 5	—
Federal Information Security Modernization Act Audit for Fiscal Year 2020 *Issued 4/29/2021 | Report Number 20-01927-104*	OIT	1-26	—
Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan *Issued 5/5/2021 | Report Number 20-01272-129*	VHA	3	—
Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio *Issued 5/6/2021 | Report Number 20-01523-102*	VHA	8	—
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia *Issued 5/11/2021 | Report Number 20-03593-140*	VHA	5-8, 11	—
The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings *Issued 5/18/2021 | Report Number 20-00049-122*	VBA	1	—
Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio *Issued 5/19/2021 | Report Number 20-01276-131*	VHA	4-10, 14, 16	—
Drug Interactions Related to a Patient Death, Marion VA Medical Center in Illinois *Issued 5/20/2021 | Report Number 20-03380-136*	VHA	1-2	—
Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program *Issued 5/25/2021 | Report Number 20-03178-116*	OEHRM, OM, VHA	1-3, 5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Chillicothe VA Medical Center in Ohio *Issued 5/27/2021 | Report Number 20-01268-143*	VHA	5-6, 8	—
Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan *Issued 6/1/2021 | Report Number 20-01267-148*	VHA	4-6, 9-11	—
Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas *Issued 6/2/2021 | Report Number 18-02496-157*	VHA	1-10	—
Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic *Issued 6/9/2021 | Report Number 20-03326-124*	VHA	1-3	—
Review of VHA's Financial Oversight of COVID-19 Supplemental Funds *Issued 6/10/2021 | Report Number 20-02967-121*	VHA	1-2	—
Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency *Issued 6/10/2021 | Report Number 20-00541-133*	OHRA/ OSP, VHA	1-5	—
Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available Before the COVID-19 Pandemic *Issued 6/14/2021 | Report Number 20-03075-138*	OALC, VHA	1-2	—
Comprehensive Healthcare Inspection of the VA Northern Indiana Health Care System in Marion *Issued 6/15/2021 | Report Number 20-01270-154*	VHA	2, 8-12, 18	—
Entitled Veteran's Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs *Issued 6/15/2021 | Report Number 20-01487-142*	VHA	1-2	$129,709,810
Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System *Issued 6/16/2021 | Report Number 19-07719-113*	VHA	1-2, 6-8	$5,420,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records *Issued 6/17/2021 | Report Number 19-08658-153*	VHA	1-2	—
Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens *Issued 6/22/2021 | Report Number 20-02968-170*	VHA	3, 5	—
VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care *Issued 6/23/2021 | Report Number 20-01141-145*	VHA	3-4	—
Deficiencies in Emergency Preparedness for Veteran's Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic *Issued 6/24/2021 | Report Number 19-09808-171*	VHA	1-4	—
Veteran's Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards *Issued 6/24/2021 | Report Number 20-00176-125*	NCA	3-6, 10-11	—
Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veteran's Sensitive Information and Facility Security at Risk *Issued 6/29/2021 | Report Number 20-00345-77*	VHA	1-10	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati *Issued 7/1/2021 | Report Number 20-01265-172*	VHA	7	—
VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules *Issued 7/1/2021 | Report Number 20-01646-139*	VHA	1-7	$16,600,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program *Issued 7/7/2021 | Report Number 20-03185-151*	OEHRM	1-6	—
Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque *Issued 7/8/2021 | Report Number 20-00716-177*	VHA	1, 3	—
Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 7/8/2021 | Report Number 20-01930-183*	VHA	1-5, 7-8, 10	—
Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations *Issued 7/8/2021 | Report Number 20-03704-165*	VHA	1-2	$17,900,000
Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho *Issued 7/12/2021 | Report Number 20-01256-179*	VHA	5	—
Adaptive Sports Grants Management Needs Improvement *Issued 7/13/2021 | Report Number 20-01807-173*	VHA	1, 3-7	$247,000
Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon *Issued 7/13/2021 | Report Number 20-01257-180*	VHA	8-9, 11, 13	—
Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee *Issued 7/21/2021 | Report Number 20-04341-182*	VHA	3, 6	—
Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services *Issued 7/22/2021 | Report Number 19-08267-147*	VHA	2-3	$35,300,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the VA Puget Sound Health Care System in Seattle, Washington *Issued 7/28/2021 | Report Number 20-01261-194*	VHA	5-6, 8-21	—
Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon *Issued 8/2/2021 | Report Number 20-01259-196*	VHA	5-6	—
Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020 *Issued 8/2/2021 | Report Number 21-00519-192*	VHA	3	—
Deficiencies in the Management of a Patient's Reported Intimate Partner Violence, Ralph H. Johnson VA Medical Center, Charleston, South Carolina *Issued 8/3/2021 | Report Number 20-03763-207*	VHA	4	—
Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program *Issued 8/4/2021 | Report Number 20-02828-174*	VHA	1-2, 5-8	$6,570,395
Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 8/4/2021 | Report Number 20-01262-191*	VHA	1, 4-10, 13	—
Improvements Still Needed in Processing Military Sexual Trauma Claims *Issued 8/5/2021 | Report Number 20-00041-163*	VBA	1-4	—
Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations *Issued 8/5/2021 | Report Number 20-01979-199*	VHA	1	—
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center in Wyoming *Issued 8/9/2021 | Report Number 21-00255-200*	VHA	3	—
Financial Efficiency Review of the Miami VA Healthcare System *Issued 8/11/2021 | Report Number 20-01796-195*	VHA	3, 7	$287,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA *Issued 8/12/2021 | Report Number 20-00418-166*	VHA	5	—
Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas *Issued 8/18/2021 | Report Number 20-03635-217*	VHA	1, 3-7	—
Review of Veterans Health Administration Staffing Models *Issued 8/19/2021 | Report Number 20-01508-214*	VHA	1-3	—
Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California *Issued 8/24/2021 | Report Number 20-03359-220*	VHA	2	—
Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina *Issued 8/24/2021 | Report Number 21-00371-222*	VHA	1-2, 4-7	—
Comprehensive Healthcare Inspection of the VA Eastern Colorado Health Care System in Aurora *Issued 8/25/2021 | Report Number 21-00246-228*	VHA	7	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 8/26/2021 | Report Number 21-01502-240*	VHA	1-4	—
Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin *Issued 8/26/2021 | Report Number 20-01917-242*	VHA	3, 6	—
Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah *Issued 8/31/2021 | Report Number 21-00254-213*	VHA	1-6	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island *Issued 9/1/2021 | Report Number 21-00265-231*	VHA	1-3	—
Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma *Issued 9/2/2021 | Report Number 21-00253-239*	VHA	5	—
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System in Muskogee *Issued 9/2/2021 | Report Number 21-00251-212*	VHA	1, 3-9	—
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts *Issued 9/9/2021 | Report Number 21-00260-232*	VHA	2-6	—
Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus *Issued 9/9/2021 | Report Number 20-03465-243*	OAEM, OHRA/OSP, VHA	1-4, 6-7	—
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds *Issued 9/14/2021 | Report Number 21-00263-246*	VHA	1-4	—
Excess Purchase of Surgical Supplies and Improper Purchase Card Transactions at the New Orleans VA Medical Center in Louisiana *Issued 9/14/2021 | Report Number 20-00395-224*	VHA	1, 3-4, 6	$3,145,291
Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama *Issued 9/15/2021 | Report Number 20-02907-254*	VHA	1-5, 7	—
Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire *Issued 9/15/2021 | Report Number 21-00262-247*	VHA	3-7	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont *Issued 9/15/2021 | Report Number 21-00258-230*	VHA	2	—
Facility Leaders' Response to Level 2 and Level 3 Pathology Reading Errors at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas *Issued 9/21/2021 | Report Number 21-01677-259*	VHA	2-3	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 9/22/2021 | Report Number 21-01509-264*	VHA	1-7	—
Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta *Issued 9/23/2021 | Report Number 21-00257-252*	VHA	1-2, 5-8, 10-11	—
Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California *Issued 9/23/2021 | Report Number 21-00271-258*	VHA	5-6	—
Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors *Issued 9/23/2021 | Report Number 20-01802-234*	VHA	1-4	$20,000,000
Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts *Issued 9/24/2021 | Report Number 21-00261-266*	VHA	1-2, 4-8	—
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida *Issued 9/24/2021 | Report Number 21-00269-268*	VHA	2-5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina *Issued 9/27/2021 | Report Number 21-01304-275*	VHA	1, 4-5	—
Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened *Issued 9/27/2021 | Report Number 20-01910-244*	OALC	1-3	—
Failure to Mitigate Risk of and Manage a COVID-19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois *Issued 9/28/2021 | Report Number 21-00553-285*	VHA	4-5, 7, 9, 12-13	—
VA's Management of Land Use under the West Los Angeles Leasing Act of 2016 Five-Year Report *Issued 9/29/2021 | Report Number 20-03407-253*	OALC, VHA	1-2	—
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven *Issued 9/29/2021 | Report Number 21-00266-281*	VHA	1-2, 4-8	—
Comprehensive Healthcare Inspection of the West Palm Beach VA Medical Center in Florida *Issued 9/29/2021 | Report Number 21-00272-283*	VHA	2	—
Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida *Issued 9/30/2021 | Report Number 21-00268-273*	VHA	1-5	—
Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers *Issued 9/30/2021 | Report Number 21-01805-286*	VHA	1-2, 4, 6-12, 14, 17-19, 22	—
Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers *Issued 9/30/2021 | Report Number 20-02014-270*	VHA	2-10, 15, 17, 19, 20	—
Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers *Issued 9/30/2021 | Report Number 20-04051-287*	VHA	1, 3-9, 11-12, 16	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System in Florida *Issued 10/13/2021 | Report Number 21-00267-290*	VHA	3-5	—
Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance *Issued 10/21/2021 | Report Number 19-06004-225*	VHA	1-5, 7	—
Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico *Issued 10/26/2021 | Report Number 21-00270-04*	VHA	1-10	—
Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments *Issued 10/28/2021 | Report Number 20-03898-236*	VBA	1-3	—
Comprehensive Healthcare Inspection of the Orlando VA Healthcare System in Florida *Issued 11/3/2021 | Report Number 21-00275-11*	VHA	1-4	—
Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2021 | Report Number 20-04237-09*	OM	1-12	—
Alleged Misconduct by Construction and Facilities Deputy Executive Director Not Substantiated *Issued 11/9/2021 | Report Number 20-02908-21*	OALC	1	—
Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon *Issued 11/9/2021 | Report Number 21-01682-25*	VHA	1-5	—
Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic *Issued 11/10/2021 | Report Number 20-03437-26*	VHA	1-6	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
New Patient Scheduling System Needs Improvement as VA Expands Its Implementation *Issued 11/10/2021 | Report Number 21-00434-233*	OEHRM, VHA	1-8	—
DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays *Issued 11/10/2021 | Report Number 20-01324-215*	OALC	1-3	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1, VA New England Healthcare System in Bedford, Massachusetts *Issued 11/18/2021 | Report Number 21-00235-13*	VHA	1-5	—
Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico *Issued 11/23/2021 | Report Number 20-03700-35*	VHA	1-6	—
Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida *Issued 11/30/2021 | Report Number 21-01695-38*	VHA	1-5	—
VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements *Issued 12/2/2021 | Report Number 20-00426-02*	OIT	1-4	—
Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers *Issued 12/2/2021 | Report Number 20-04050-37*	VHA	1-20	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health Care in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 12/7/2021 | Report Number 21-01508-32*	VHA	1-4	—
Systems and Tools Implemented to Track COVID-19 Vaccine Data *Issued 12/7/2021 | Report Number 21-00913-267*	VHA	1-3	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services *Issued 12/8/2021 | Report Number 20-01099-249*	VHA	1-6	$341,700,000
VHA Risks Overpaying Community Care Providers for Evaluation and Management Services *Issued 12/8/2021 | Report Number 21-01807-251*	VHA	1-2	$59,600,000
Comprehensive Healthcare Inspection of the Fayetteville VA Coastal Health Care System in North Carolina *Issued 12/9/2021 | Report Number 21-00277-41*	VHA	1-7	—
Deficiencies in Disclosures and Quality Processes for Perforations Resulting from Urological Surgeries at West Palm Beach VA Medical Center in Florida *Issued 12/9/2021 | Report Number 21-01049-39*	VHA	1-7	—
Comprehensive Healthcare Inspection of the Hampton VA Medical Center in Virginia *Issued 12/14/2021 | Report Number 21-00278-23*	VHA	1-6	—
Improvements Needed to Ensure Final Disposition of Unclaimed Veteran's Remains *Issued 12/15/2021 | Report Number 19-09592-262*	NCA, OEI, OM, VBA, VHA	1-11	—
Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits *Issued 12/15/2021 | Report Number 20-04219-07*	VBA	1-6	$136,000,000
Financial Efficiency Review of the Eastern Oklahoma VA Health Care System *Issued 12/15/2021 | Report Number 21-00942-16*	VHA	1-9	$95,000
Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma Health Care System in Muskogee *Issued 12/15/2021 | Report Number 21-01801-45*	VHA	1-4	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas *Issued 12/16/2021 | Report Number 21-01038-49*	VHA	1-5	—
Inadequate Oversight of VHA's Home Oxygen Program *Issued 12/16/2021 | Report Number 19-07812-29*	VHA	3-6	—
Financial Efficiency Review of the Marion VA Medical Center in Illinois *Issued 12/16/2021 | Report Number 21-00960-17*	VHA	1-8	—
Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers *Issued 12/20/2021 | Report Number 21-01804-56*	VHA	1-17	—
MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data *Issued 12/20/2021 | Report Number 20-03351-08*	VHA	1	—
Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina *Issued 1/11/2022 | Report Number 21-00279-54*	VHA	1-5	—
VA's Use of the Defense Logistics Agency's Electronic Catalog for Medical Items *Issued 1/13/2022 | Report Number 20-00552-30*	VHA	1-6	$4,420,878
Audit of Community Care Consults during COVID-19 *Issued 1/19/2022 | Report Number 21-00497-46*	VHA	1-3	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 1/20/2022 | Report Number 21-01507-61*	VHA	1-7	—
Inspection of Sterile Processing Services at the Carl T. Hayden VA Medical Center in Phoenix, Arizona *Issued 1/26/2022 | Report Number 21-02489-69*	VHA	1	—

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia *Issued 1/31/2022 | Report Number 21-00292-73*	VHA	3-5	—
Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina *Issued 2/3/2022 | Report Number 21-00276-67*	VHA	1-8	—
Comprehensive Healthcare Inspection of the VA Hudson Valley Health Care System in Montrose, New York *Issued 2/8/2022 | Report Number 21-00298-72*	VHA	1-7	—
Lack of Care Coordination and Hepatocellular Carcinoma Surveillance of a Patient at the VA Eastern Colorado Health Care System in Aurora *Issued 2/9/2022 | Report Number 21-02492-77*	VHA	1-6	—
Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia *Issued 2/16/2022 | Report Number 21-01724-84*	VHA	1-8	—
First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions *Issued 2/17/2022 | Report Number 20-03086-70*	VHA	1-3	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 2/17/2022 | Report Number 21-01506-76*	VHA	1-4	—
Comprehensive Healthcare Inspection of the James J. Peters VA Medical Center in Bronx, New York *Issued 3/3/2022 | Report Number 21-00289-90*	VHA	4-5	—
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia *Issued 3/8/2022 | Report Number 21-00280-89*	VHA	1-9	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened *Issued 3/9/2022 | Report Number 21-02750-63*	VBA	1-5	$88,700
Review of Allegations of Improper Maintenance at VA's Houston National Cemetery in Texas *Issued 3/10/2022 | Report Number 21-03325-86*	NCA	2	—
Comprehensive Healthcare Inspection of the Salem VA Medical Center in Virginia *Issued 3/16/2022 | Report Number 21-00281-100*	VHA	1-2	—
Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 3/17/2022 | Report Number 21-00781-109*	VHA	1	—
Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 3/17/2022 | Report Number 21-00781-108*	VHA	1-3	—
Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 3/17/2022 | Report Number 21-00656-110*	VHA	1-2	—
VA's Compliance with the VA Transparency & Trust Act of 2021 *Issued 3/22/2022 | Report Number 22-00879-118*	OM	1-2	$3,600,000
Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina *Issued 3/23/2022 | Report Number 21-00282-111*	VHA	1-4	—
Improved Governance Would Help Patient Advocates Better Manage Veteran's Healthcare Complaints *Issued 3/24/2022 | Report Number 21-00510-105*	VHA	1-3	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020 *Issued 3/28/2022 | Report Number 21-01503-112*	VHA	1-6	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network in Durham, North Carolina *Issued 3/29/2022 | Report Number 21-00237-114*	VHA	1-5	—
Financial Efficiency Review of the Durham VA Health Care System in North Carolina *Issued 3/29/2022 | Report Number 21-02458-94*	VHA	1-10	$308,000
Inspection of Information Technology Security at the VA Financial Services Center *Issued 3/31/2022 | Report Number 21-01221-24*	OIT	1-4	—
Total			**$780,992,074**

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

Table B.4 identifies the 51 reports and 114 recommendations that, as of March 31, 2022, remain open for more than one year. The total monetary benefit attached to these reports is $614,650,600.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 7/11/2014 | Report Number 13-01452-214*	VBA	$205,000,000
Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.		
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	$34,500,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 5: The OIG recommended the Under Secretary for Health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).		
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	$100,600,000
Recommendation 1: The Under Secretary for Benefits establishes internal controls sufficient to ensure that a reexamination is necessary prior to employees ordering it, and modifies VBA procedures as appropriate to reflect these improved business processes. Recommendation 4: The Under Secretary for Benefits conducts a special focused quality improvement review of cases with unwarranted reexaminations to develop data sufficient to understand and redress the causes of any avoidable errors.		
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/08/2018 | Report Number 17-04156-234*	VHA	—
Recommendation 3: The Principal Deputy Under Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Employee 3.		
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*	OALC, VHA	—
Recommendation 1: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System implement a plan that puts the West LA campus in compliance with the West Los Angeles Leasing Act of 2016, the Draft Master Plan, and other federal laws, including reasonable time periods to correct deficiencies noted in this report. Recommendation 2: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure all non-VA entities operating on the West LA campus with expired or undocumented land use agreements establish new agreements compliant with the West Los Angeles Leasing Act.		
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	OHRA/ OSP, VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 1: Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.		
Recommendation 2: Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.		
Recommendation 4: Assess the staffing levels for the Office of Security and Law Enforcement police inspection program, and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.		
Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities *Issued 6/27/2019 | Report Number 18-00037-154*	VHA	—
Recommendation 6: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews and provides input into the patient referral process to mental health clinical pharmacists with consideration for ensuring that accurate diagnoses can be reliably identified by and conveyed to the mental health clinical pharmacists.		
Recommendation 7: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews the patient referral process to mental health clinical pharmacists and provides input with consideration for clinical settings or scenarios in which a review of the clinical complexity of the referral by a licensed independent practitioner with prescribing authority would be appropriate, prior to treatment.		
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming *Issued 7/24/2019 | Report Number 18-04680-162*	VHA	—
Recommendation 15: The chief of staff confirms that clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians' compliance.		
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/05/2019 | Report Number 18-05663-189*	VBA	$64,800,000
Recommendation 2: Develop a plan to update the rating schedule to establish more objective criteria for each level of evaluation for peripheral nerves.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida *Issued 9/27/2019 | Report Number 19-00010-237*	VHA	—
Recommendation 4: The chief of staff ensures that clinical managers clearly define focused professional practice evaluation criteria in advance with providers and monitors clinical managers compliance.		
Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 *Issued 10/10/2019 | Report Number 19-07040-243*	VHA	—
Recommendation 3: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that an interdisciplinary group or committee, that includes all required representatives, consistently reviews utilization management data and monitor committees compliance.		
Recommendation 4: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that clinical managers provide feedback about root cause analysis actions to the individuals or departments who reported the incidents and monitor clinical managers' compliance.		
Recommendation 9: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that managers maintain a clean and safe environment throughout the facilities and monitor managers' compliance.		
Recommendation 10: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that VA Police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas and monitor VA Police compliance.		
Recommendation 13: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that facility managers correct identified deficiencies from annual physical security surveys and monitor facility managers' compliance.		
Mishandling of Veteran's Sensitive Personal Information on VA Shared Network Drives *Issued 10/17/2019 | Report Number 19-06125-218*	OIT	—
Recommendation 3: The assistant secretary for information and technology implements improved oversight procedures, including specific facility-level procedures, to ensure that sensitive personal information is not being stored on shared network drives.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California *Issued 12/2/2019 | Report Number 18-04671-25*	VHA	—
Recommendation 15: The facility director ensures that controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections and monitors inspectors compliance. Recommendation 18: The facility director ensures that controlled substances inspectors verify that drugs held for destruction are secured and documented during monthly pharmacy inspections and monitors inspectors' compliance.		
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers *Issued 12/17/2019 | Report Number 17-03718-240*	VHA	$84,000,000
Recommendation 1: The executive in charge, office of under secretary for health, and the principal executive director, office of acquisition, logistics, and construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to develop a formal process to validate correct order fulfillment reporting by the prime vendors, ensure the correct algorithms are used, and help prevent missed opportunities to identify and mitigate issues. Recommendation 4: The executive in charge, office of under secretary for health, and the principal executive director, office of acquisition, logistics, and construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to strengthen processes and procedures so that staff use the Medical/Surgical Prime Vendor Next Generation formulary to change unit of issuance and product pricing information in the item master files. Recommendation 7: The executive in charge, office of under secretary for health, and the principal executive director, Office of Acquisition, Logistics, and Construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to monitor the Integrated Product Team's development and implementation of a process to validate performance metric reporting such as on unadjusted fill rates. Recommendation 8: The executive in charge, office of under secretary for health, requires the Procurement and Logistics Office to strengthen controls, monitor the Healthcare Commodities Program Office monthly, and ensure adherence to the established Medical/Surgical Prime Vendor Next Generation program control plan.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts *Issued 1/13/2020 | Report Number 19-00043-66*	VHA	—
Recommendation 17: The facility director confirms that the Women Veterans Health Committee is comprised of required core members and monitors the committee's compliance.		
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts *Issued 1/13/2020 | Report Number 19-00038-63*	VHA	—
Recommendation 17: The chief of staff certifies that clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and evaluate understanding when education is provided, and monitors clinicians' compliance.		
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System *Issued 1/23/2020 | Report Number 19-06378-73*	VHA	—
Recommendation 8: The VA North Texas Health Care System Director ensures implementation of an effective tracking mechanism to ensure VA providers receive results for women veterans referred to care in the community and monitors for compliance with Veterans Health Administration policy. Recommendation 9: The VA North Texas Health Care System Director verifies review of the electronic health records of women veterans referred to Care in the Community whose medical records have not been obtained and takes action if indicated.		
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 4/27/2020 | Report Number 19-09447-136*	VHA	—
Recommendation 1: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, evaluates the impact of the new electronic health record implementation on productivity and provides operational guidance and required resources to facilities prior to go-live.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, identifies the impact of the mitigation strategies on user and patient experience at go-live and takes action, as needed. Recommendation 4: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, reevaluates the electronic health record modernization deployment timeline to minimize the number of required mitigation strategies at go-live.		
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System *Issued 4/27/2020 | Report Number 19-08980-95*	OEHRM	—
Recommendation 5: Evaluate physical infrastructure for consistency with OEHRM requirements and monitor completion of those evaluations. Recommendation 6: Fill infrastructure-readiness team vacancies until optimal staffing levels are attained. Recommendation 7: Ensure physical security assessments are completed and addressed at future electronic health record deployment sites.		
Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina *Issued 5/19/2020 | Report Number 19-08256-124*	VHA	—
Recommendation 3: The Fayetteville VA Medical Center Director ensures that facility Community Care staff process Community Care consults according to the Veterans Health Administration policy.		
VA's Implementation of the FITARA Chief Information Officer Authority Enhancements *Issued 6/9/2020 | Report Number 18-04800-122*	OIT	—
Recommendation 5: The OIG recommends the Chief of Staff for Veterans Affairs ensures the Chief Information Officer, in conjunction with VA administration and staff offices revise VA Directive 6008 to clarify the Chief Information Officers authority and roles in the planning, programming, budgeting, and execution of all information technology resources.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
VA Police Information Management System Needs Improvement *Issued 6/17/2020 | Report Number 19-05798-107*	OHRA/ OSP	—
Recommendation 1: The OIG recommends that the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness in consultation with the Under Secretary for Health evaluate the appropriateness of having the Law Enforcement Training Center serve as the manager of the records management systems for VA police. Recommendation 4: The OIG recommended the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness, in consultation with the Under Secretary for Health, update security and law enforcement program procedures to ensure they meet information management needs and requirements.		
Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka *Issued 6/18/2020 | Report Number 19-06870-175*	VHA	—
Recommendation 14: The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the healthcare system and include the signature of the first- or second-line supervisor in the properly designated area. Recommendation 30: The System Director evaluates and determines any additional reasons for noncompliance and ensures that each CBOC has at least two designated womens health primary care providers or arrangements for leave coverage when CBOCs have only one designated provider.		
The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research *Issued 7/14/2020 | Report Number 19-06451-165*	VHA	—
Recommendation 4: The Under Secretary for Health review local accounting records and cost allocations to determine the total amount of FY 2018 and 2019 funds spent on canine research before the VA Secretary approved the studies and report this information to the House and Senate appropriations committees.		
Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia *Issued 7/21/2020 | Report Number 18-01622-207*	VHA	—
Recommendation 1: The Atlanta VA Health Care System Director reviews the process for non-VA community care consult performance measurements, evaluates compliance with Veterans Health Administration policy, and implements an action plan as needed.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: The Atlanta VA Health Care System Director ensures managers review the backlog of open non-VA community care consults and implements an action plan as needed.		
Deficiencies in the Quality Review Team Program *Issued 7/22/2020 | Report Number 19-07054-174*	VBA	—
Recommendation 4: The OIG recommends that the under secretary for benefits revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures.		
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri *Issued 7/23/2020 | Report Number 19-06850-208*	VHA	—
Recommendation 5: The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.		
Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri *Issued 8/12/2020 | Report Number 19-06873-210*	VHA	—
Recommendation 5: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that service chiefs reprivileging recommendations are based on ongoing professional practice evaluation activities. Recommendation 7: The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the healthcare system.		
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois *Issued 8/13/2020 | Report Number 20-00077-211*	VHA	—
Recommendation 4: The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that first- or second-line supervisors complete provider exit review forms within seven calendar days of providers departure from the medical center. Recommendation 22: The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures that Sterile Processing Services staff receive properly completed competency assessments for reprocessing reusable medical equipment.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas *Issued 8/18/2020 | Report Number 19-06872-199*	VHA	—
Recommendation 15: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on patients prior to initiating long-term opioid therapy. Recommendation 16: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that healthcare providers consistently obtain and document informed consent for patients who are initiating long-term opioid therapy. Recommendation 17: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures healthcare providers follow up with patients within three months after initiating long-term opioid therapy.		
Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources *Issued 9/2/2020 | Report Number 18-03800-232*	VHA	—
Recommendation 1: The OIG recommended the executive in charge, Office of the Under Secretary for Health, establish financial controls, such as key performance indicators, that align with medical center operations and can be used to assess the efficient use of operating funds.		
Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery *Issued 9/10/2020 | Report Number 20-00131-243*	VHA	—
Recommendation 22: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers complete and document goals of care conversations prior to hospice referrals.		
The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions *Issued 9/10/2020 | Report Number 19-00227-226*	VBA	$122,000,000
Recommendation 1: The under secretary for benefits ensures the adjudication procedures manual is updated for consistency with all applicable laws, regulations, and policies related to permanent and total determinations in consultation with the office of general counsel. Recommendation 2: The under secretary for benefits ensures decision-making staff support their permanent and total status decisions in the Reasons for Decision section of the rating decision by describing the evidence used to support their conclusions.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The under secretary for benefits ensures appropriate training is provided to decision-making staff based on the changes made to permanent and total procedures related to Recommendations 1, 2 and 3, and monitors the effectiveness of that training.		
Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency *Issued 9/17/2020 | Report Number 20-02825-242*	VBA	—
Recommendation 2: Conduct a review to ensure claims received and completed from March 1, 2020, had the correct date of entitlement applied.		
Financial Controls Related to VA-Affiliated Nonprofit Corporations Idaho Veterans Research and Education Foundation *Issued 9/24/2020 | Report Number 18-00711-251*	VHA	$50,600
Recommendation 4: The Boise VAMC director establishes procedures that require the Research and Development Budget Office staff to review VA-affiliated nonprofit corporation invoices to confirm services were performed or goods were received in accordance with Intergovernmental Personnel Act agreements before approving invoices for payment.		
The Veterans Health Administration's Governance of Robotic Surgical System Investments Needs Improvement *Issued 9/25/2020 | Report Number 19-07103-252*	VHA	—
Recommendation 1: The OIG recommended the under secretary for health update the high cost, high tech medical equipment application to provide clearer instructions on preparing requests and providing supporting documentation for robotic surgical systems. The application and instructions should be disseminated to medical facilities, Veterans Integrated Service Networks, and responsible central office organizations. Recommendation 2: The OIG recommended the under secretary for health establish controls to ensure information in high-cost, high-tech medical equipment applications is reviewed and validated before recommending final approval to the assistant deputy under secretary for health for administrative operations. Recommendation 3: The OIG recommended the under secretary for health evaluate the need and justification of the 10 robotic surgical systems at VA medical facilities that were acquired without approval by the assistant deputy under secretary for health for administrative operations.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the Atlanta VA Health Care System in Decatur, Georgia *Issued 11/18/2020 | Report Number 20-00129-09*	VHA	—
Recommendation 4: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that clinical managers consistently implement improvement actions recommended from peer review activities. Recommendation 7: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in practitioners' profiles. Recommendation 8: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs complete and document focused professional practice evaluation results in licensed independent practitioners' profiles. Recommendation 10: The Chief of Staff determines the reasons for noncompliance and makes certain that service chiefs' determinations to continue privileges are based in part on results of ongoing professional practice evaluation activities.		
Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans *Issued 11/23/2020 | Report Number 19-07316-262*	VHA	—
Recommendation 1: The under secretary for health assess whether current program policies and practices meet the needs of medical facilities' local homemaker and home health aide programs and update them as necessary. Recommendation 3: The under secretary for health updates homemaker and home health aide program guidance to include procedures that medical facilities must follow to determine the suitability of veterans for program services when they cannot meet veterans program needs within the required period of time because of facility or community resource constraints. Recommendation 4: The under secretary for health implements procedures for medical facility directors to use data on veteran demand, including unmet demand, for homemaker and home health aide program services to manage their local program resources. Recommendation 5: The under secretary for health updates homemaker and home health aide program guidance to include processes that medical facilities must complete when veterans with care needs have been refused services from home health agencies because of demonstrated behavioral issues.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019 *Issued 11/24/2020 | Report Number 20-01994-18*	VHA	—

Recommendation 4: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures focused professional practice evaluation criteria are defined in advance.

Recommendation 8: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that ongoing professional practice evaluations use assessments by providers with similar training and privileges.

Recommendation 19: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that controlled substances inspectors complete emergency drug cache inspections that include checks for lock tampering and verification of lock numbers.

Recommendation 20: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinical managers implement processes for reviewing automated drug dispensing cabinet override reports.

Recommendation 23: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures mental health and primary care providers complete mandatory military sexual trauma training within the required time frame.

Recommendation 24: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinicians provide and document education on newly prescribed medications and assess patient/caregiver understanding of the information provided.

Recommendation 25: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinicians review and reconcile patients' medications and maintain and communicate accurate medication information in electronic health records.

Recommendation 27: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that clinical managers implement quality assurance processes that include tracking of cervical cancer screening notification and follow-up care.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Management and Oversight of the Electronic Wait List for Healthcare Services *Issued 12/1/2020 | Report Number 19-09161-02*	VHA	—
Recommendation 1: The Under Secretary for Health has oversight controls developed and implemented to monitor all facilities' patient care requests that are identified as unable to schedule to ensure patients across the Veterans Health Administration are scheduled in a timely manner.		
Recommendation 2: The Under Secretary for Health ensures standard operating procedures are being implemented so that facility employees routinely review and act on patient care requests identified as unable to schedule in the consult toolbox.		
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida *Issued 1/13/2021 | Report Number 18-01321-56*	VHA	—
Recommendation 3: The Under Secretary for Health clarifies Veterans Health Administration policy regarding providers' responsibilities to document complications in operative reports.		
VA Needs to Comply Fully with the Geospatial Data Act of 2018 *Issued 1/26/2021 | Report Number 20-02339-35*	OIT	—
Recommendation 2: The assistant secretary for Information and Technology, in conjunction with the director of Enterprise Records Service, establishes a process to ensure geospatial data and activities are included on VA record schedules that have been approved by the National Archives and Records Administration in accordance with requirement 4 of the law.		
Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi *Issued 2/10/2021 | Report Number 20-01036-70*	VHA	—
Recommendation 1: The Under Secretary for Health initiates review of policies related to the role and training requirements of providers, including gynecologists, who conduct sensitive exams, to determine the need for the inclusion of trauma-informed care principles into training, policy, and practice.		
Recommendation 2: The Under Secretary for Health ensures a review of policies related to the role and training requirements of chaperones for sensitive examinations and takes action as appropriate.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits *Issued 2/23/2021 | Report Number 20-00295-61*	VHA	—
Recommendation 4: The OIG recommended that the under secretary for health direct the Veterans Health Administration's Office of Community Care to develop a process to ensure those beneficiaries who are not using the services for which they are eligible, or need assistance with locating those services, receive them.		
Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic *Issued 2/24/2021 | Report Number 20-02959-62*	VHA	—
Recommendation 2: Communicate effective verification measures for facilities and Veterans Integrated Service Networks to improve the reliability and consistency of reported personal protective equipment on-hand quantity and usage information.		
Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement *Issued 2/25/2021 | Report Number 19-07053-51*	VHA	—
Recommendation 6: Monitor facility compliance with the use of an approved inventory management system for completeness and accuracy. Recommendation 7: Direct the Procurement and Logistics Office to ensure logistics staff perform inventory reviews of biologic implants, as required. Recommendation 9: Establish a structure for oversight responsibility that can provide guidance for tracking implanted biologics. Recommendation 10: Create policies and procedures for facilities to follow as they implement effective controls for tracking biologic implants. Recommendation 11: Establish standardized systems and requirements for facility staff to appropriately record necessary biologic implant attributes for accurate and accessible tracking of recipients to advance patient safety.		
Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center *Issued 2/25/2021 20-01508-214 | Report Number 20-00563-68*	VHA	—
Recommendation 2: The Washington DC VA Medical Center Director evaluates the processes for notification of mammography exam results by ordering providers and takes actions as necessary.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
The Office of Community Cares Oversight of Non-VA Healthcare Claims Processed by Its Contractor *Issued 3/2/2021 | Report Number 19-06902-23*	VHA	—
Recommendation 2: The OIG recommended the under secretary for health ensures there is a contract requirement that the contractors' employees must follow Office of Community Care guidance for processing non-VA care claims. Recommendation 3: The OIG recommended the under secretary for health ensures the contractors' standard operating procedures for claims processing are accurate and a mechanism is put in place to keep the contractors' procedures updated to reflect current Office of Community Care claims processing procedures.		
VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors *Issued 3/3/2021 | Report Number 20-00421-63*	VBA	—
Recommendation 1: The under secretary for benefits creates written guidelines for tracking, identifying, notifying, registering, and exempting individuals required to take skills certification tests. Recommendation 2: The under secretary for benefits establishes a tracking mechanism to ensure all eligible individuals required to take tests are identified and notified of testing dates at least 30 days prior to test administration. Recommendation 3: The under secretary for benefits provides an update to the plan submitted to Congress explaining why all employees and supervisors who have claims-processing functions listed in the original plan are not subject to skills certification testing. Recommendation 4: The under secretary for benefits implements a plan to ensure staff who failed their most recent skills certification test and remain in the same position are provided training from individual training plans to remediate the deficiencies in their skills and competencies. Recommendation 5: The under secretary for benefits establishes an oversight plan to ensure training set out in approved training plans is provided to individuals who fail skills certification tests. Recommendation 6: The under secretary for benefits notifies Congress of plans to take personnel actions against individuals who fail consecutive skills certification tests after remediation for the same positions in compliance with the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing *Issued 3/4/2021 | Report Number 19-06147-50*	OALC, VHA	$3,700,000

Recommendation 1: Direct the Medical Supplies Program Office to implement procedures requiring chief logistics officers at Veterans Integrated Service Networks to monitor facility processes for verification and certification of distribution fee invoices to ensure invoice accuracy prior to payment by the Financial Services Center.

Recommendation 2: Require Veterans Integrated Service Network directors to ensure their chief logistics officers develop distribution fee monitoring and review procedures for facility logistics audits and compliance reviews to ensure invoices are adequately reviewed, verified, and certified.

Recommendation 3: Require Veterans Integrated Service Network directors to ensure facility chief logistics officers and contracting officers' representatives review and update the election forms according to contract requirements and provide copies to the Medical/Surgical Prime Vendors for acknowledgment.

Recommendation 4: Require Veterans Integrated Service Network directors to ensure facility contracting officers' representatives verify that distribution fee rates match with those on the election forms and pricing schedule by comparing transaction data from the vendors to VHA-maintained transaction data, and reconcile payments as appropriate.

Recommendation 7: Require the Strategic Acquisition Center to appropriately modify the Medical/ Surgical Prime Vendor contract to define annual facility purchase as well as adding a provision for paying the annual facility purchase amount based on the estimated total spend until year-end reconciliation.

Recommendation 8: Require the Strategic Acquisition Center to also appropriately modify the Medical/ Surgical Prime Vendor contract to require the prime vendors rather than the facility to reconcile to annual facility purchases at the end of the year.

Recommendation 9: Require the Medical Supplies Program Office to establish policy that clearly defines the source VA medical facilities should use to estimate their annual facility purchase amounts and determine the year-end amounts.

Recommendation 10: Require VA medical facilities to review their on-site representative fees paid during fiscal year 2018 and future years to ensure they were paid based on the actual annual facility purchase amounts, consistent with the Medical/Surgical Prime Vendor-Next Generation contract, and reconcile payment discrepancies as appropriate.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery *Issued 3/11/2021 | Report Number 20-00427-92*	VHA	—
Recommendation 4: The Central Alabama Veterans Health Care System Director ensures that initial and ongoing provider training and support for the clinical management of view alerts is provided, and monitors compliance. Recommendation 5: The Central Alabama Veterans Health Care System Director issues guidance and ensures providers are trained on a clearly defined process for the designation of surrogates and the associated responsibilities, and monitors compliance. Recommendation 6: The Central Alabama Veterans Health Care System Director evaluates the two cases discussed in this report to determine if an institutional disclosure or formal quality management review is needed and takes action accordingly. Recommendation 9: The Central Alabama Veterans Health Care System Director ensures the development and implementation of a policy to address the communication of all test results to ordering providers, or designee, and to patients as required by Veterans Health Administration policy, and monitors compliance.		
Total		**$614,650,600**

APPENDIX C: REPORTING REQUIREMENTS

TABLE C.1. REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(16) a list of any peer reviews conducted by the Inspector General of another Office of the Inspector General during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review conducted before the reporting period) that remain outstanding or have not been fully implemented;	Other Reporting Requirements
(17) statistical tables showing— (A) the total number of investigative reports issued during the reporting period; (B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period; (C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and (D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;	Statistical Performance
(18) a description of the metrics used for developing the data for the statistical tables under paragraph (17);	Statistical Performance
(19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including the name of the senior government official (as defined by the department or agency) if already made public by the Office, and a detailed description of— (A) the facts and circumstances of the investigation; and (B) the status and disposition of the matter, including— (i) if the matter was referred to the Department of Justice, the date of the referral; and (ii) if the Department of Justice declined the referral, the date of the declination;	Results from the Office of Investigations Results from the Office of Special Reviews

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

DEFINITIONS

As defined in the IG Act:

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

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

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

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

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

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

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

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

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

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

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

(F) any other savings which are specifically identified;

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

Final action means—

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

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

APPENDIX C: REPORTING REQUIREMENTS

Senior government employee means—

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

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

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