SEMIANNUAL REPORT to Congress

Issue 88 | April 1—September 30, 2022

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.

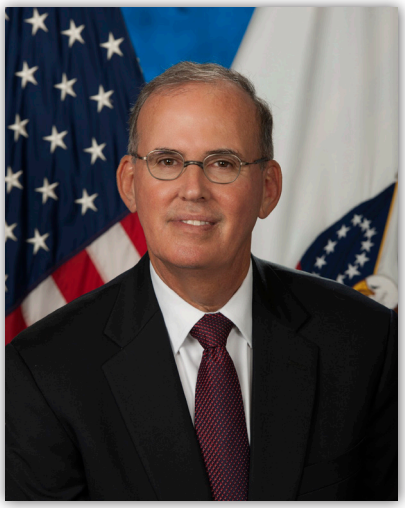
To achieve this vision, the Office of Inspector General (OIG) will

- 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*



This *Semiannual Report to Congress* details the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the second half of fiscal year (FY) 2022 (April 1–September 30, 2022). The productivity of our oversight and administrative staff remains high, and we continue to have a significant impact on VA's programs, operations, and services. During this period, we increased our efforts to get personnel back in the field and engaged with even more VA offices, staff, and other stakeholders.

VA is still adjusting to the changing landscape carved out by this pandemic. VA personnel are attacking backlogs and addressing other consequences of the pandemic, even as demands for their services, benefits, and programs continue to grow in many areas. The challenges are significant, as VA faces staffing shortages and other barriers to maintaining quality care, providing effective services, and delivering timely and accurate benefits to veterans and their families. They also must confront some significant new tests, such as implementing the PACT Act.[1] The act has been described as perhaps the largest healthcare and benefit expansion in VA history as it broadens eligibility for veterans subjected to burn pits and other toxic exposures during military service—potentially affecting as many as 3.5 million veterans and increasing benefits payments by hundreds of billions of dollars.

The OIG remains committed to helping VA identify risks and deficiencies in carrying out major initiatives, such as the expansion of benefits for toxic exposure and its electronic health record modernization (EHRM) program. In just this reporting period, OIG staff have published two reports on burn pits, one on toxic water exposure at Camp Lejeune, and five on the electronic health record (EHR) system. Those efforts should in no way overshadow, however, the vigilance that OIG staff demonstrated in their ongoing efforts to ensure veterans have prompt access to high-quality health care, benefits, and other services. In this past fiscal year, the OIG has taken a more proactive approach to helping VA identify threats to patient safety and high-quality care, process and program failures that affect the benefits veterans and their families receive, and other issues that affect veterans' quality of life and VA's mission.

This report also highlights the OIG's growing use of proactive cyclical inspections to conduct effective oversight of VA. In addition to the long-established Comprehensive Healthcare Inspection Program (CHIP), which examines key clinical and administrative processes in VA medical centers, we have established in recent years several other cyclical inspection programs. These include IT security inspections to oversee the security and sufficiency of IT at VA facilities; financial efficiency inspections that assess selected functions that can place taxpayer dollars at risk; vet center inspections to evaluate whether veterans are receiving high-quality and timely readjustment and mental health counseling services at community-based centers; national-level CHIPs that aggregate findings from inspections performed at multiple VHA medical facilities; and Care in the Community healthcare inspections that scrutinize processes associated with providing quality care in selected VA community-based outpatient clinics and through contracted non-VA care providers within each VA regional network. These cyclical inspections help identify concerns at multiple levels of VA and round out the OIG's portfolio of work

1 The full title of the act is the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022.

generated from complaints to the OIG hotline; data-driven projects; and those responsive to other allegations of fraud and other crimes, waste, and abuse of authority.

In this six-month period, the OIG identified more than $1.4 billion in monetary impact, bringing the fiscal year's total to nearly $4.6 billion in monetary impact with a return on investment of $24 for every dollar spent. We issued 309 products for the full year, with 166 products released during this reporting period alone. The OIG hotline received and triaged nearly 18,400 contacts in the past six months (more than 36,000 for the year) to help identify wrongdoing and address concerns with VA activities. Also during the past six months, special agents opened 178 investigations and closed 213, with efforts leading to 135 arrests. Collectively, the OIG's work also resulted in 599 administrative sanctions and corrective actions during the six-month reporting period.

The OIG is committed to conducting effective independent oversight of VA—a large, complex, and constantly evolving organization—and continues to employ new strategies to meet its mission. The OIG recognizes and appreciates VA leaders' stated dedication 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

Contents

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 FY 2022, VA is operating under a $272.5 billion budget with over 431,000 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.[2] 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.[3] 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.

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

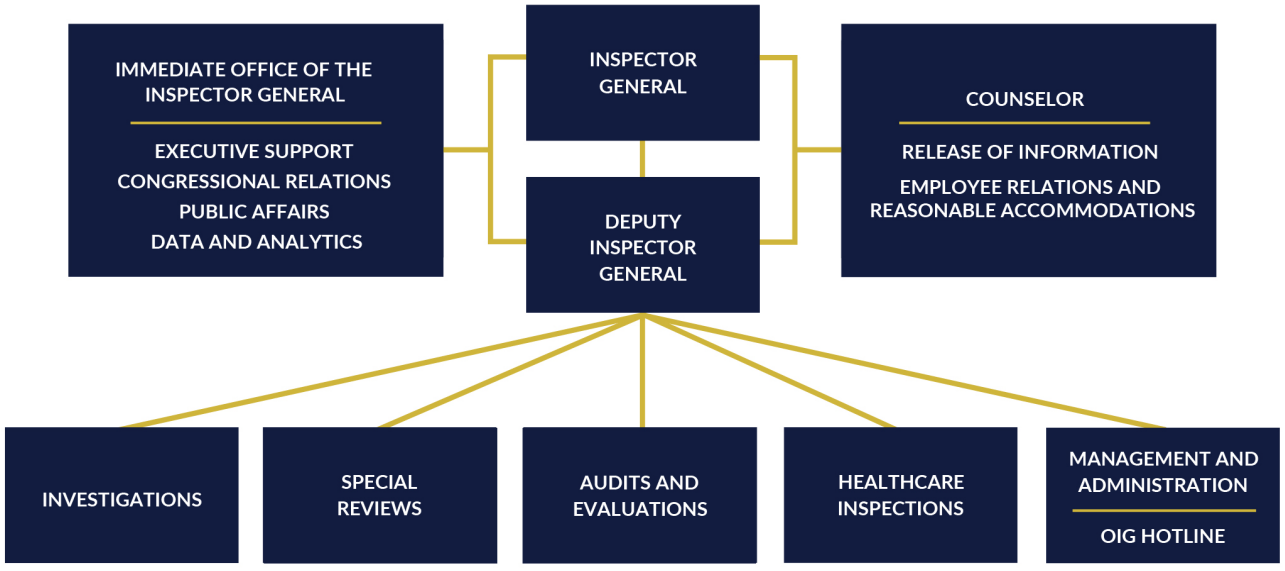
3 Pub. L. No. 100-322.

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, and 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.

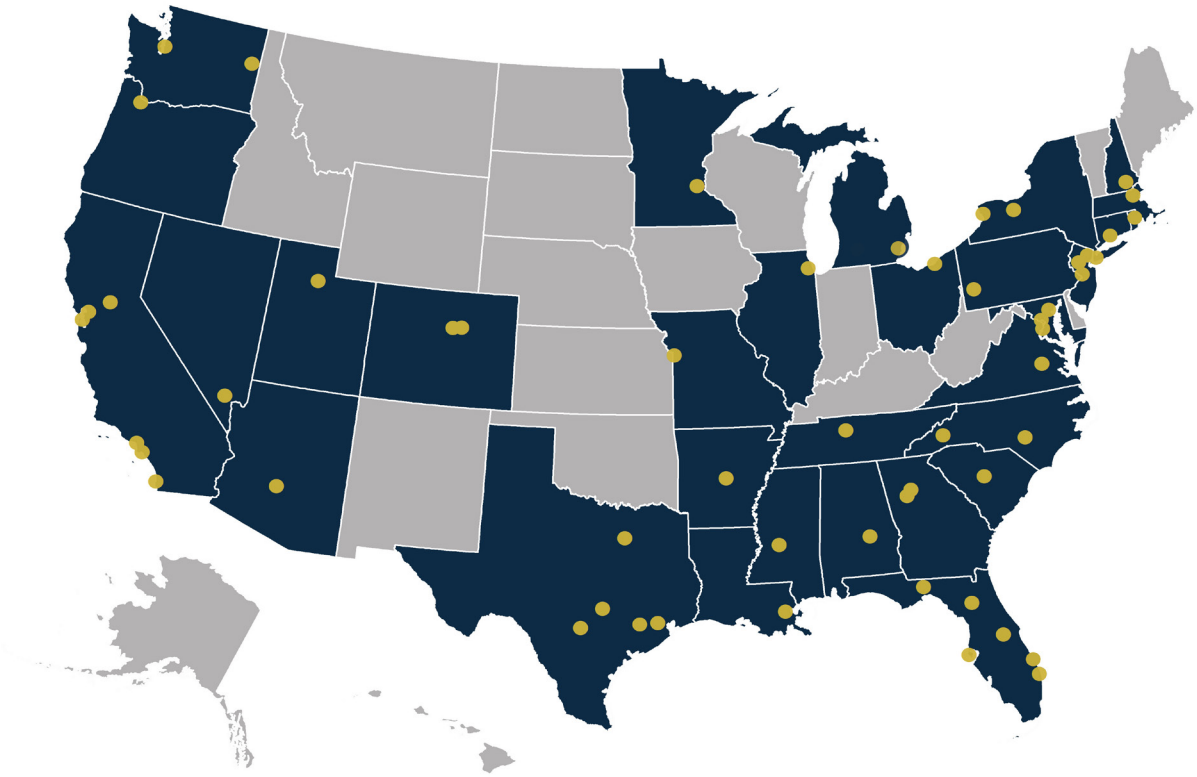
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff 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
Asheville, NC
Atlanta, GA
Aurora, CO
Austin, TX
Baltimore, MD
Bay Pines, FL
Bedford, MA
Buffalo, NY
Canandaigua, NY
Cleveland, OH
Columbia, SC
Dallas, TX
Decatur, GA
Denver, CO
Detroit, MI
Fayetteville, NC
Gainesville, FL
Hines, IL
Houston, TX
Jackson, MS
Kansas City, MO
Katy, TX
Las Vegas, NV
Long Beach, CA
Los Angeles, CA
Lyons, NJ
Manchester, NH
Martinez, CA
Minneapolis, MN
Miramar, FL
Montgomery, AL
Nashville, TN
New Orleans, LA
New York, NY
Newark, NJ
North Little Rock, AR
Oakland, CA
Orange, CT
Orlando, FL
Palm Beach Gardens, FL
Phoenix, AZ
Pittsburgh, PA
Portland, OR
Providence, RI
Richmond, VA
Sacramento, CA
Salt Lake City, UT
San Antonio, TX
San Diego, CA
Seattle, WA
Spokane, WA
Tallahassee, FL
Trenton, NJ
Washington, DC

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. The office also coordinates strategic planning and data services that include modeling (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, other beneficiaries, or 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 another 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, 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 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 selectively accept concerns after a review of the complaint, prioritizing those that pose 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 and Findings

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period April 1–September 30, 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 feature examples of each office's highly effective publications and priorities. This information is supplemented by appendixes that detail titles of OIG publications released, the monetary impact of OIG products, the status of VA's implementation of recommendations, and OIG reporting requirements.

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.

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 six congressional hearings on the EHRM program, the challenges VA faces in providing quality care to patients, and VA's progress toward implementing a robust cybersecurity program. The inspector general also submitted a statement for the record for a seventh hearing, regarding quality representation for veterans in the benefit claims process. In addition, OIG personnel participated in a roundtable held by the Senate Veterans' Affairs Committee to discuss VA's efforts to bolster its cybersecurity posture and better protect veterans' information. The inspector general and OIG personnel also conducted 80 briefings with congressional members and their staffs. Some of the OIG oversight work and recommendations for improvements discussed included

- the premature denial of compensation for veterans with conditions that could be associated with burn pit exposure,
- improvements needed for VHA's burn pit registry exam process,
- concerns about the consistency and transparency in the calculation of patient wait time data,
- deficiencies in oversight and response to allegations of sexual assault by a VA physician in West Virginia,
- failure to communicate and coordinate care for a community living center resident who later died,
- process improvements needed for claims of contaminated water exposure at Camp Lejeune,
- challenges VHA continues to face with billing private insurers for community care, and
- multiple failures in test results follow-up for a cancer patient at the Hampton VA Medical Center in Virginia.

President Joseph R. Biden signs the Strengthening Oversight for Veterans Act of 2021 (Pub. L. No. 117-136) into law on June 7, 2022, providing testimonial subpoena authority to the VA OIG through May 31, 2025.

The OIG also worked with Congress on the passage of the Strengthening Oversight for Veterans Act of 2021, which was signed into law in June 2022.[4] This legislation grants the OIG the authority to compel testimony from individuals previously out of reach such as former federal employees, contractors' personnel, and others with relevant information to enable the OIG to perform its statutory oversight of VA programs and operations.

OIG staff also fielded 43 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 104 ongoing projects, created 12 new internal data-monitoring tools, and made enhancements to several others. The new tools focused on evaluating community care referrals and usage, monitoring workloads, and improving the efficiency of internal administrative processes. Several data-monitoring

4 Pub. L. No. 117-136.

tool enhancements addressed concerns related to education benefits, healthcare quality and efficiency, pharmaceutical procurement, and prosthetic operations.

ODA also fulfilled a total of 295 data requests, including 88 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 use 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 to keep 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 report recommendations follow-up efforts included sending 425 status request memoranda to various offices within VA tasked with taking action. These efforts led to the closing of 479 recommendations during this reporting period.

The OIG continued to reach a diverse audience, including expanding its presence on LinkedIn and Twitter by nearly 10,200 followers (totaling more than 67,000). Staff published 225 updates on reports, hiring activities, and other news that resulted in about 331,000 impressions, and also posted more than 181 tweets to approximately 6,900 followers with more than 67,000 impressions. The OIG released 149 email bulletins through GovDelivery, reaching more than 115,000 subscribers—an increase of nearly 7,000 subscribers compared to the previous reporting period. Outreach efforts were further supplemented by two podcast series, *Veteran Oversight Now* and *Inside Oversight*, which are both available on all popular podcast platforms. *Veteran Oversight Now* features interviews with senior OIG leaders, discussions on high-profile reports, and highlights of OIG activities. *Inside Oversight* offers in-depth conversations with report authors who describe how the team conducted its work, what it found, and the impact on veterans and the public.

Several broadcast and print media outlets prominently featured the OIG's work, and these included the *New York Times*, *Washington Post, Los Angeles Times, Military.com, Newsday, U.S. News and World Report, Military Times*, and *Stars and Stripes*. The coverage highlighted reports on patient appointment wait-time data, military sexual trauma, VA's EHRM program failures that put patient safety at risk, and processing benefit claims related to burn pits and claims associated with Camp Lejeune toxic water exposure. In addition, episodes of *Forensic Files II*, " The Telltale Marks," and the A&E Network's *Interrogation Raw*, "Serial Killer at the VA Hospital," filmed and aired during this reporting period and featured OIG special agents discussing their work to solve the murders that took place at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

The Office of the Counselor to the Inspector General

During this reporting period, the counselor's office performed a wide range of activities, including working with the OIG's Office of Management and Administration to apply executive orders and Safer Federal Workforce Task Force guidance relating to COVID-19 protocols to facilitate the smooth transition of about 1,100 OIG employees back to the workplace, and evaluating the jurisdiction of VA's exercise of law enforcement authority.

The Employee Relations and Reasonable Accommodation Division processed 131 actions addressing employee discipline, grievances, and other issues; responded to 287 reasonable accommodation requests and 297 leave administration inquiries; and provided guidance to agency leaders implementing federal COVID-19 policies. Staff also developed a process for addressing COVID-19-associated religious accommodation requests, which it shared with other federal OIGs.

The Administrative Law Division represented the VA OIG in three cases before the Equal Employment Opportunity Commission and three cases before the Merit Systems Protection Board, five of which were resolved in the agency's favor, with the sixth pending a decision. Additionally, this division provided legal advice regarding all COVID-19-associated safety policies and protocols and all medical and religious accommodation requests associated with the COVID-19 vaccine mandate.

The Oversight and Contracting Division implemented a new subpoena review protocol and approved 183 subpoenas for records requested by special agents. Additionally, the division ensured that attorneys were assigned to all OIG audit, review, healthcare inspection, and administrative investigation projects, including those related to veteran burn pit exposure, patient harm caused by the EHRM unknown queue, and a joint audit with the Department of Defense (DoD) OIG regarding interoperability between DoD and VA electronic health record systems.[5] This division also developed procedures and protocols for the OIG to exercise its newly gained testimonial subpoena authority (allowing the OIG to compel nonfederal employees, including former VA employees and past and current contractors, to provide testimony), and assisted OIG inspectors with issuing the first such subpoenas.[6]

The Release of Information Office reviewed all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and responded to nearly 430 requests for OIG records. Staff 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

Office of Investigations (OI) staff investigate 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

5 More information on the EHRM unknown queue can be found on page 56.

6 Instances of the OIG exercising testimonial subpoena authority are detailed on page 77.

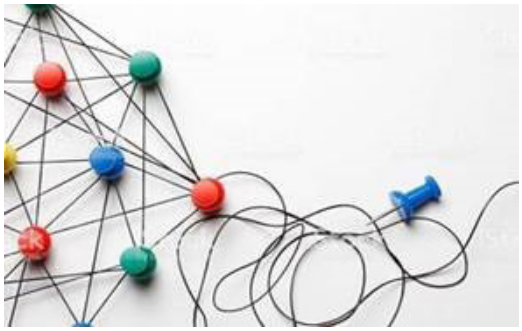
systems. During this six-month period, investigative efforts resulted in 135 arrests, 87 convictions, and over $424 million in monetary benefits for VA.

OI remained focused on high-impact investigations and coordinating with other OIG directorates, external law enforcement partners, and the Department of Justice to ensure that veterans, VA employees, and VA assets are protected and wrongdoers are held accountable. During this reporting period, OI created the Administrative and Civil Enforcement Division, which oversees law enforcement activities involving noncriminal cases, to include civil False Claims Act investigations, administrative remedies through the Program Fraud Civil Remedies Act, and suspensions and debarments for government contractors. Staff also provide investigative support to other OIG directorates. In addition, OI created an Investigative Support Unit that specializes in criminal intelligence and investigative analysis with a focus on social media, crime trends and patterns, and links among bad actors.

Also during this reporting period, OI developed an online toolkit that provides a list of key possible indicators specific to 10 different types of fraud and identifies common signs that VA personnel, contractors, and the veteran community should be aware of in order to report suspicious activity and alleged wrongdoing to the OIG hotline. OI also began disseminating periodic crime alerts, including one on fraud schemes in which VA was billed for unreceived home healthcare or other veteran services and another on a genetic testing scam. These and other efforts enhance the detection of high-dollar fraud and prevention of harm to veterans and support regional field offices in conducting impactful criminal investigations.

The Office of Special Reviews

The Office of Special Reviews (OSR) conducts administrative investigations and other reviews involving allegations of misconduct or gross mismanagement that implicate senior VA officials or significantly affect VA programs and offices. Its staff of investigative attorneys, administrative investigators, forensic auditors, and analysts provides the OIG with the flexibility to promptly examine issues not squarely within the scope of another directorate.



During this reporting period, OSR made multiple strategic investments and adjustments designed to enhance its operational efficiency. The office established a new eDiscovery group—supported by three full-time staff—to improve efforts to collect and analyze information from digital sources, such as emails, online chats, and cloud-based platforms. The office also significantly streamlined its process for handling OIG hotline case referrals and hired an experienced editor to bolster its quality assurance program.

Staff continued their cross-directorate collaboration efforts as well. In May, OSR published a joint audit with the DoD OIG examining the interoperability of both agencies' electronic health records. This joint project led by OSR relied heavily on subject matter expertise from the VA OIG's Offices of Healthcare Inspections and Audits and Evaluations. OSR also established an integrated cross-directorate

partnership by realigning its criminal investigators to OI, where they will serve as dedicated liaisons available to support OSR projects that deal with potentially criminal violations.

Finally, as detailed in the Results section, OSR published three additional reports addressing a range of significant topics including VA staff giving inaccurate information to OIG investigators and personnel being inadequately equipped when assigned to the protective details of the VA secretary and deputy secretary. Releases also included one VA management advisory memorandum in coordination with staff from the Office of Audits and Evaluations concerning VHA's efforts to improve accuracy in reporting veterans' wait times for medical appointments. OSR staff worked with subject matter experts in all OIG directorates to research potential future projects as well.

The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 44 publications summarizing results from its oversight work, including five VA management advisory memoranda that highlighted concerns requiring VA's prompt attention. Contracting review teams also conducted 47 preaward and postaward contract reviews to help VA obtain fair and reasonable pricing on products and services and compliance with contract terms. OAE identified potential cost savings of more than $125.9 million and recovered over $5.1 million in contract overcharges. Its published reports resulted in 206 recommendations with a potential monetary impact of more than $874 million for the reporting period.

OAE's work remained focused on weaknesses in VA's governance and oversight that affected many aspects of program performance. For example, one review focused on inefficiencies of VHA's process to bill private insurers for community care costs, with VHA failing to bill more than half of all billable claims in a three-and-a-half-year period. This left more than $217 million unrecovered. Another review revealed that oversight deficiencies resulted in less than half of patients issued video-capable devices for virtual care completing such an appointment. More than 3,000 patients improperly received multiple devices, and nearly 8,300 unused devices were not retrieved. The review team determined that VHA could have made better use of about $14.5 million in program funds with better device monitoring, retrieval controls, and oversight. OAE also continued its series of financial efficiency reviews and IT inspections, identifying potential strategies to improve the management of several key systems at selected VA facilities.

Lastly, several important recommendations put forth in previous OAE reports were implemented and closed during the reporting period that demonstrate progress on corrective actions. For example, regarding claims related to military sexual trauma, VBA developed a new process for correcting errors identified by the OIG and also established the military sexual trauma Operations Center to centralize and monitor claims processing. In addition, per the OIG's recommendation, VBA also implemented a new automated system for Post-9/11 GI Bill school enrollment that includes a field for school vacation breaks, a process that had been conducted manually, which caused many errors affecting beneficiary payments and entitlement. These and other oversight efforts by OAE continue to make a lasting impact on both VA and on the lives of veterans.

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 and continues to assess issues that affect key healthcare functions within VHA. During this reporting period, OHI maintained a focus on leadership and organizational risks, suicide risk reduction, quality of care, and patient safety. Several OHI reports during this period demonstrated how lapses in patient care standards and breakdowns in care coordination led to multiple adverse events, including delayed diagnoses and treatments, serious harm, and—as detailed in five reports—the deaths of patients.

While VHA is staffed with healthcare providers and support staff that honor and celebrate the mission to care for our nation's veterans, there continue to be real challenges in delivering that care to a population with distinct and complex medical and psychological conditions. Veterans are a tremendously diverse community with a culture, set of experiences, and sense of duty associated with military service that can differ dramatically from civilians. Veterans also experience mental health and substance abuse disorders, posttraumatic stress, and traumatic brain injuries at disproportionately high rates. This underscores both the magnitude of responsibility VHA assumes in supporting the unique needs of veterans, as well as the importance of meaningful, independent oversight of these programs.

Accordingly, OHI has continued to focus on VHA's suicide risk reduction efforts during this reporting period, with reports in development that examine Veterans Crisis Line processes, suicide risk assessments, VHA's Intensive Community Mental Health Recovery program (with an emphasis on contingency planning for emergencies), as well as firearms access assessments and safety planning for patients with suicidal behaviors. OHI also continues its cyclical inspection program of vet centers, which offer critical interventions for psychological and psychosocial readjustment problems related to various types of military service and deployment stressors, such as combat-related trauma and military sexual trauma. While no Vet Center Inspection Program reports were published within the last six months, several will be ready for release in FY 2023.

As part of OHI's continuous improvement of its oversight capabilities, it released the first report of a new Care in the Community Inspection Program during this reporting period. This program examines key clinical and administrative processes associated with providing quality VA and community care, specifically focusing on congestive heart failure management, home dialysis care, mammography services and results communications, and diagnostic evaluations following positive screenings for depression and alcohol misuse. OHI also continued its series of educational webcasts to further develop staff expertise.

The Office of Management and Administration

The Office of Management and Administration (OMA) advanced its support of the OIG's overall mission by providing multifaceted, reliable, and prompt administrative services promoting organizational effectiveness and efficiency. In this reporting period, OMA served as the focal point for OIG's COVID-19 pandemic response. This included supporting OIG's return-to-office efforts; administering the testing and notification program; and ensuring guidance was streamlined and readily available to promote the health, well-being, and safety of all employees. OMA bolstered the OIG's mission to grow a diverse workforce

and cultivate an inclusive and equitable work environment by being the first within the Council of the Inspectors General on Integrity and Efficiency community to create a diversity, equity, inclusion, and accessibility (DEIA) strategic plan mandated by Executive Order 14035. Related efforts included hosting numerous DEIA events, launching new equitable career development programs, and supporting staff engagement activities. Furthermore, OMA's ongoing recruitment and retention efforts in partnership with OIG directorates have contributed to the growth of the OIG to more than 1,100 employees.

OMA employed new software and modernized infrastructure to support the growing IT needs of OIG staff. Moreover, OMA facilitated updates to numerous internal policies to ensure guidance was accessible and that processes were clear, documented, and streamlined.

A significant OMA responsibility is also overseeing the OIG hotline, which manages and triages complaints to help identify wrongdoing and concerns with VA activities. Hotline staff received and triaged 18,396 contacts from VA employees and the general public during these six months.

At a Glance: Selected Metrics for the Fiscal Year

*Hotline and Investigations included

Table 1. Monetary Impact and Return on Investment

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Better Use of Funds	$959,914,442	$2,157,831,382	$3,117,745,824
Dollar Recoveries	$2,303,953	$2,761,733	$5,065,686
Fines, Penalties, Restitution, and Civil Judgments[7]	$278,129,773	$285,495,651	$563,625,424
Fugitive Felon Program	$70,200,000	$86,600,000	$156,800,000
Savings and Cost Avoidance	$74,674,811	$7,773,053	$82,447,864
Questioned Costs	$45,210,007	$593,657,978	$638,867,985
Total Dollar Impact	**$1,430,432,986**	**$3,134,119,797**	**$4,564,552,783**
Cost of OIG Operations[8]	$91,162,603	$98,285,591	$189,448,194
Return on Investment[9]	**$16:1**	**$32:1**	**$24:1**

Table 2. Publications

REPORT TYPE[10]		THIS PERIOD	LAST PERIOD	FISCAL YEAR
Administrative Investigations		3	2	5
Audits and Reviews		31	24	55
Care in the Community Inspections		1	0	1
Claim Reviews		0	0	0
Comprehensive Healthcare Inspection Program (CHIP)	Summary Reports	2	6*	8
	COVID-19-Related Summary Reports	1	1*	2
	VISN- and Facility-Level Reports	14	17	31
Financial Inspections		4	3	7
Healthcare Inspections		19	13	32
Information Technology Inspections		4	1	5
National Healthcare Reviews		4	1*	5
Postaward Reviews		18	17	35
Preaward Reviews		29	32	61

7 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 $54,373,844.

8 The six-month operating cost for OHI ($28,337,397), 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.

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

10 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.

Special Reviews	1	0	1
Vet Center Inspections	0	2	2
Subtotal	**131**	**119**	**250**
ALTERNATIVE WORK PRODUCTS	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Internal Investigations	1	0	1
Issue Statements	0	0	0
Management Advisory Memoranda	5	2	7
Subtotal	**6**	**2**	**8**
OTHER PUBLICATION TYPE	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Budget Request	0	1	1
Congressional Testimonies	7	7	14
Crime Alerts	2	0	2
Major Management Challenges	0	1	1
Monthly Highlights	6	6	12
Peer Reviews Completed of Other OIGs	0	0	0
Podcasts	14	7	21
Press Releases	0	0	0
Subtotal	**29**	**22**	**51**
Total	**166**	**143**	**309**

** In last period's SAR, seven CHIP summary reports, including one related to COVID-19, were categorized under national healthcare reviews. This table retroactively reclassifies those seven reports to reflect the OIG's updated categorization system.*

Table 3. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	3	6	9
Clinical Consultations to Other Federal Entities	0	0	0
Hotline Referrals Reviewed	2,233	2,528	4,761

Table 4. Selected Hotline Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	18,396	17,646	36,042
Cases Opened	552	752	1,304
Cases Closed	568	523	1,091
Administrative Sanctions and Corrective Actions	509	498	1,007
Substantiation of Allegations Percentage Rate	39%	43%	41%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	18	26	44

Individuals Provided Office of Special Counsel Contact Information	52	74	126
Individuals Provided Merit Systems Protection Board Contact Information	2	5	7
Individuals Provided Office of Resolution Management Contact Information	120	164	284

Table 5. Selected Office of Investigations Activities

TYPE[11]	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests[12]	135	104	239
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	39	37	76
Indictments	113	82	195
Indictments and Informations Resulting from Prior Referrals to Authorities	40	36	76
Criminal Complaints	32	22	54
Convictions	87	94	181
Pretrial Diversions and Deferred Prosecutions	12	8	20
Case Referrals to Department of Justice for Criminal Prosecution[13]	191	136	327
Case Referrals to State and Local Authorities for Criminal Prosecution[14]	33	15	48
Administrative Sanctions and Corrective Actions	90	59	149
Cases Opened	178	173	351
Cases Closed	213	224	437

11 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/monthlyhighlights.asp.

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

13 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.

14 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.

Results from the Office of Investigations

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 431,000 employees and contractors; and offenses affecting VA's assets, programs, and operations.

135
Arrests

87
Convictions

$424M
Monetary Benefits

Featured Investigations

The three investigations highlighted in this section illustrate OI's emphasis on cases that result in monetary recoveries for VA that can be reinvested in programs, services, and benefits; address fraud, waste, and abuse by VA employees in positions of trust; and help ensure benefits and services meant for veterans and other eligible beneficiaries are being received by the individuals for whom they were intended.

PRIVATE HELICOPTER FLIGHT INSTRUCTOR TRAINING COMPANY AND A COMMUNITY COLLEGE AGREE TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A multiagency investigation resolved allegations that a private helicopter flight instructor training company and a community college violated the False Claims Act by making false statements to VA in connection with their jointly operated training program. To qualify for Post-9/11 GI Bill funding, a school is required to certify to VA that no more than 85 percent of the students for any particular course are receiving VA benefits. This requirement, commonly referred to as the "85/15 rule," is intended to prevent abuse of GI Bill funding by ensuring that VA is paying fair market value tuition rates since at least 15 percent of the students would be paying the same rate with non-VA funds. The investigation alleges that the defendants falsely certified compliance with the 85/15 rule because the flight instructor program included certain expensive classes that were taken almost exclusively by veterans. To reach the required 15 percent threshold, the community college allegedly counted part-time students enrolled in only one online class per semester as full-time students, in violation of VA rules. The defendants agreed to pay $7.5 million to resolve these allegations. Of this amount, the helicopter company agreed to pay $7 million and the community college agreed to pay $500,000. The investigation was conducted by the VA OIG, US Attorney's Office for the District of Kansas, and the Fraud Section of the Department of Justice (DOJ) Civil Division's Commercial Litigation Branch.

FORMER EAST ORANGE VA MEDICAL CENTER EMPLOYEE SENTENCED FOR THEFT OF MEDICATION

An investigation by the VA OIG, FBI, and VA Police Service revealed that a former pharmacy technician at the VA medical center conspired with a man from New Jersey 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 her coconspirator, who in turn resold the medication for a

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profit. The defendant was sentenced in the District of New Jersey to 57 months of incarceration, three years of supervised release, and restitution of more than $8.2 million.

PHARMACY EXECUTIVE AND ASSISTANT SENTENCED TO PRISON FOR $88 MILLION COMPOUNDING PHARMACY SCHEME

A private sector pharmacy executive and his executive assistant conspired with others to fraudulently bill TRICARE (the healthcare program for active-duty service members) and VA's Civilian Health and Medical Program (CHAMPVA, which provides coverage to eligible spouses or widow(er)s and children of disabled or deceased veterans) for expensive, medically unnecessary compounded medications. In furtherance of the scheme, the coconspirators paid approximately $40 million in kickbacks to patients, patient recruiters, and doctors. The medications, which were ordered in excessively large quantities, were formulated to maximize profit without legitimate therapeutic value. The coconspirators also used phony charities to conceal that the pharmacy did not charge the patients for mandatory copayments. The fraudulent patient referrals caused a loss to TRICARE and CHAMPVA of approximately $88 million that should have been used to benefit service members and veterans' spouses and children eligible for VA healthcare with legitimate medication needs. The executive and executive assistant were sentenced in the Southern District of Florida to 90 months and 60 months in prison, respectively, and ordered to pay joint restitution of $75.1 million. The VA OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, Defense Criminal Investigative Service (DCIS), and FBI conducted the investigation.

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 91 cases; made 81 arrests; obtained over $178.8 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved nearly $3 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The following case summaries that follow illustrate the types of VHA investigations conducted during this period.

Schemes Related to COVID-19

MEDICAL TECHNOLOGY COMPANY PRESIDENT FOUND GUILTY FOR FRAUDULENT COVID-19 AND ALLERGY TESTING SCHEME

A multiagency investigation resulted in charges alleging that the president of a medical technology company conspired to improperly bill healthcare insurers for approximately $77 million in false and fraudulent claims for allergy and COVID-19 testing. The defendant and others allegedly schemed to manipulate the company's stock price by making false claims concerning the company's ability to provide accurate, fast, and cheap COVID-19 tests in compliance with federal and state regulations. It is further alleged the defendant and others made numerous misrepresentations to potential investors about the COVID-19 tests and used a VA solicitation to further the stock manipulation scheme. The defendant was found guilty at trial in the Northern District of California of conspiracy to commit healthcare fraud, conspiracy to commit wire fraud, healthcare fraud, conspiracy to pay kickbacks, payment of kickbacks, and securities fraud. This investigation was conducted by the VA OIG, US Postal Inspection Service, FBI, DCIS, and Department of Health and Human Services (HHS) OIG.

PHARMACEUTICAL EXECUTIVE PLEADED GUILTY TO CONSPIRING TO SELL EXCESSIVELY PRICED COVID-19 PERSONAL PROTECTIVE EQUIPMENT TO VA

According to an investigation the VA OIG undertook with the FDA Office of Criminal Investigations and the FBI, an executive for a pharmaceutical secondary wholesaler conspired with others to buy and then hoard designated "scarce" materials—including personal protective equipment—at the height of the COVID-19 pandemic. The executive admitted to using deceitful means to sell the equipment to VA, defrauding at least a dozen VA medical centers by selling the equipment at excessive prices. The company made $1.8 million in sales of the designated scarce materials at prices upwards of 300 percent over costs to hospital systems. The executive pleaded guilty in the Southern District of Mississippi to conspiracy to defraud the United States.

PHARMACEUTICAL COMPANY AGREED TO PAY $815,000 TO RESOLVE FRAUD ALLEGATIONS

A VA OIG investigation determined a pharmaceutical company sold potentially defective and sophisticated counterfeit 3M brand N95 respirators to at least five VHA facilities. The company entered into a civil agreement in the Southern District of Georgia under which it agreed to pay $815,000 to VA to resolve these allegations.

BUSINESS OWNER PLEADED GUILTY FOR ROLE IN FRAUD SCHEME INVOLVING COVID-19 AND CANCER GENETIC TESTING

A Georgia man who owned and operated a marketing company that generated leads for medical testing companies participated in a conspiracy to defraud federally funded and private healthcare benefits programs. From 2019 to 2020, he and his coconspirators provided testing companies with patient leads for medically unnecessary cancer genetic screening tests in exchange for kickbacks of approximately $1,000 to $1,500 for each test that resulted in a reimbursement from Medicare. The business owner fabricated a contract and invoices to make it appear as though he was being paid for legitimate services and to conceal the kickback scheme. In March 2020, he began receiving kickbacks on a per-test basis for COVID-19 tests, provided that those tests were bundled with a much more expensive respiratory pathogen panel test, which does not identify COVID-19. The defendant pleaded guilty in the District of New Jersey to conspiracy to violate the Anti-Kickback Statute and conspiracy to commit healthcare fraud. The loss to VA is approximately $330,000. To date, investigative efforts have led to 18 arrests and 14 convictions as part of these schemes. The VA OIG, DCIS, FBI, Internal Revenue Service Criminal Investigation (IRS CI), and HHS OIG conducted this investigation.

FORMER VA REGISTERED NURSE PLEADED GUILTY TO COVID-19 VACCINATION CARD FRAUD

A former registered nurse at the John D. Dingell VA Medical Center in Detroit, Michigan, stole authentic COVID-19 vaccination record cards from the facility, as well as the vaccine lot numbers necessary to make the cards appear legitimate. She then resold the cards and lot numbers for $150–$200 each to individuals within the metropolitan Detroit area. The defendant pleaded guilty in the Eastern District of Michigan to theft of government property. The VA OIG worked with the HHS OIG and VA Police Service to investigate this case.

Bribery and Kickbacks

SIX DEFENDANTS CHARGED IN CONNECTION WITH WORKERS' COMPENSATION BENEFITS FRAUD SCHEME INVOLVING COMPOUNDED MEDICATIONS

Six defendants were charged with conspiring to fraudulently bill compounded medications to the Department of Labor (DOL) Office of Workers' Compensation Programs. A pharmacy owner, doctor, and three other defendants were indicted in the Southern District of Texas on charges of conspiracy to pay healthcare kickbacks, healthcare fraud, and money laundering. A sixth defendant, who is the owner of a physical therapy clinic and pharmacy, was also charged via criminal information (a formal charging document). The total loss to the government is approximately $50 million, including about $6 million to VA. The VA OIG joined with the DOL OIG, DCIS, US Postal Service (USPS) OIG, and FBI to investigate this case.

FIFTEEN DOCTORS AGREED TO PAY OVER $2.8 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A multiagency investigation resulted in charges alleging that numerous doctors received thousands of dollars in illegal payments from management service organizations, which provide nonclinical administrative services to medical practices, in exchange for ordering laboratory tests. The laboratories allegedly funded the scheme by paying volume-based commissions to recruiters who used the management service organizations to pay the doctors for their laboratory referrals. The payments were disguised as investment returns but were based on, and offered in exchange for, the doctors' referrals. In connection with this investigation, 15 doctors entered into settlement agreements with the US Attorney's Office for the Eastern District of Texas to resolve False Claims Act allegations involving these illegal kickbacks that were in violation of the Anti-Kickback Statute and Stark Law. Pursuant to this civil settlement, the doctors will pay more than $2.8 million to the US government. Twenty-four additional defendants were also indicted in connection with this investigation, which was completed by the VA OIG, FBI, HHS OIG, and DCIS.

DEFENDANT CHARGED IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

The former owner of a home health company allegedly conspired to fraudulently bill federal and private healthcare insurance programs for compounded medication in exchange for more than $70,000 in kickbacks. The loss to VA is more than $2.8 million. The investigation conducted by the VA OIG, DCIS, HHS OIG, USPS OIG, DOL OIG, Texas Health and Human Services, and FBI led to the defendant being indicted in the Southern District of Texas for conspiracy to pay and receive kickbacks.

MISSOURI CHARITY AGREED TO PAY OVER $8 MILLION FOR EMBEZZLEMENT AND BRIBERY ALLEGATIONS

A multiagency investigation resulted in a nonprofit organization entering into a nonprosecution agreement in the Western District of Missouri under which it agreed to forfeit over $6.9 million to the US Treasury and to pay over $1 million in restitution to the state of Arkansas. This nonprofit organization contracted with VA to provide substance abuse counseling and housing services for veterans. As a condition of this nonprosecution agreement, representatives of the nonprofit organization admitted their former officers and employees conspired to embezzle funds and bribe several elected state officials. To increase the supply of funds to embezzle, the former officers and employees allegedly caused the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through political outreach that violated both law and public policy. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, including $1.7 million contributed by VA. To date, nine defendants have been indicted and arrested, seven convicted, and two sentenced. The investigation was conducted by the VA OIG, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, HHS OIG, FBI, DOL OIG, IRS CI, and the Medicaid Fraud Control Unit of the Missouri Attorney General's Office.

FORMER PURCHASING AGENT AT THE JESSE BROWN VA MEDICAL CENTER PLEADED GUILTY TO WIRE FRAUD

A VA OIG investigation revealed 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 about $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 pleaded guilty in the Northern District of Illinois to wire fraud.

PHYSICIAN PLEADED GUILTY IN CONNECTION WITH ORDERING UNNECESSARY TESTS AND TAKING BRIBES AND KICKBACKS

According to another multiagency investigation, a physician entered into an improper agreement with a diagnostic imaging company under which he was paid bribes and kickbacks to order unnecessary transcranial doppler tests. In exchange for billing government and private insurance companies as much as $3.25 million in unnecessary tests based on fraudulent diagnoses, the physician received about $148,000 in kickbacks. He pleaded guilty in the District of Massachusetts to conspiracy to commit healthcare fraud and conspiracy to violate the Anti-Kickback Statute. The potential loss to VA is at least $650,000. The investigation was conducted by the VA OIG, FBI, IRS CI, HHS OIG, US Postal Inspection Service, and DOL Employee Benefits Security Administration.

DEFENDANT SENTENCED IN CONNECTION WITH KICKBACK SCHEME

Two other laboratories also allegedly engaged in a kickback scheme involving marketers and physicians that resulted in approximately $300 million in losses to the government. The laboratories, through marketers, allegedly paid hundreds of thousands of dollars to doctors for "advisory services" that were never performed in return for laboratory test referrals. One defendant was sentenced in the Northern District of Texas to 18 months in prison, three years of supervised release, and restitution of close to $650,000 after previously pleading guilty. The VA OIG, FBI, HHS OIG, and DCIS carried out this investigation.

FORMER VA CONTRACTING OFFICER AND COCONSPIRATOR CHARGED FOR BRIBERY

A former South Texas Veterans Health Care System contracting officer and a coconspirator were indicted in the Western District of Texas on charges of conspiracy to commit bribery, bribery of a public official, and receipt of a bribe by a public official. A VA OIG and FBI investigation resulted in charges alleging that the coconspirator paid a bribe of $100,000 to the former VA contracting officer in exchange for the award of a set-aside contract to a company that he controlled.

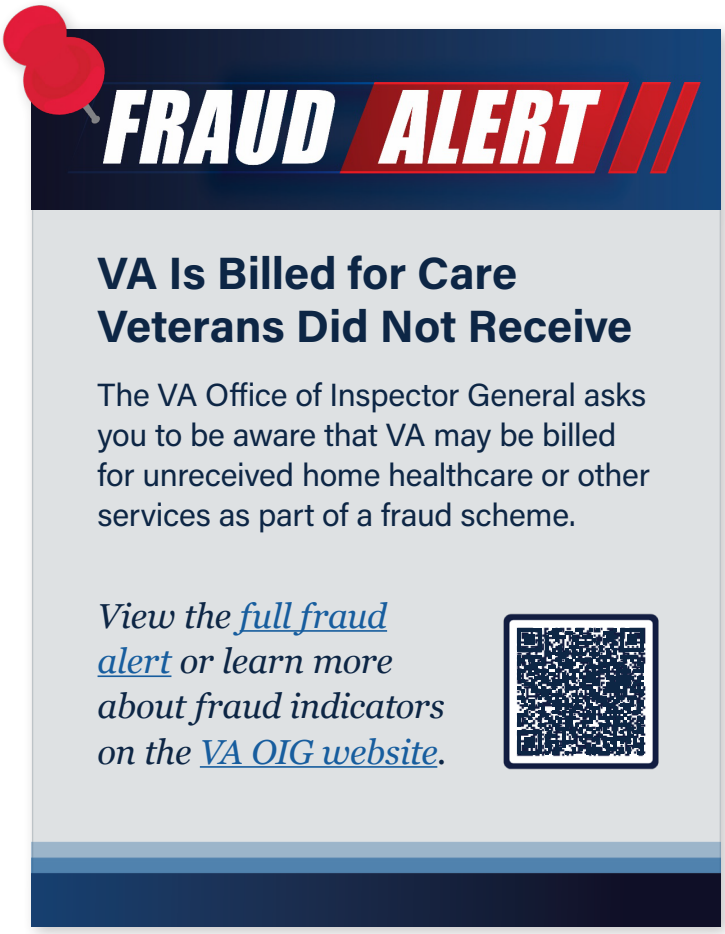
CHAMPVA and Other Healthcare Fraud

MEDICAL GROUP AGREED TO PAY $24.5 MILLION TO RESOLVE ALLEGATIONS OF BILLING THE GOVERNMENT FOR UNNECESSARY TESTS AND TELEMEDICINE VISITS, OF WHICH VA RECEIVED NEARLY $780,000

A medical group allegedly billed federal healthcare programs for unnecessary medical services and testing, including urinary drug tests, telemedicine visits, and genetic and psychological tests. The medical group also allegedly made unlawful remunerations to its physician employees in violation of the Stark Law and made a false statement in connection with a loan obtained through the Small Business Administration's (SBA) Paycheck Protection Program. The group entered into a civil agreement in the Middle District of Florida under which it will pay $24.5 million to resolve allegations that it violated the False Claims Act. Of this amount, VA will receive close to $780,000. The VA OIG, DOL OIG, HHS OIG, DCIS, and Office of Personnel Management OIG carried out the investigation.

PHARMACIST-IN-CHARGE AND PHARMACY TECHNOLOGY DIRECTOR SENTENCED IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

According to a multiagency investigation, several individuals participated in a scheme to fraudulently bill compounded medications to TRICARE and CHAMPVA. As a result of paid claims for compounding prescriptions, the loss to CHAMPVA is approximately $619,000. Two defendants pleaded guilty to conspiracy to commit healthcare fraud, including the technology director of a pharmacy, who was sentenced to 36 months of probation and $777,000 in restitution, and a pharmacist-in-charge, who was sentenced to 28 months in prison, one year of supervised release, and restitution of more than $3 million. These judicial actions occurred in the Eastern District of Louisiana. The investigation was conducted by the VA OIG, Department of Homeland Security, USPS OIG, and DCIS.



DEFENDANT SENTENCED FOR ROLE IN COMPOUNDING PHARMACY SCHEME

Multiple individuals engaged in a fraud scheme that involved charging inflated prices for medically unnecessary compounded medications to TRICARE, CHAMPVA, and private insurance companies. The defendants looked for compounded medication ingredients that could be billed at the highest rate and then provided doctors with blank prescription pads that listed those specific compounded medications. The compounded prescriptions were fraudulently dispensed by doctors located in different states than the patients, and for whom no doctor–patient relationship existed. The compounded prescriptions were often fraudulently dispensed to patients by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or billed for but never provided. The 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. One defendant was sentenced in the Southern District of Florida to 366 days in prison, three years of supervised release, and restitution of more than $937,000. Another defendant surrendered after being charged with conspiracy to receive kickbacks. This investigation was carried out by the VA OIG, FDA Office of Criminal Investigations, Army Criminal Investigation Division, DOL Employee Benefits Security Administration, and DCIS.

TWO DEFENDANTS SENTENCED FOR HEALTHCARE FRAUD

An investigation by the VA OIG, HHS OIG, FBI, and DCIS resulted in charges alleging that multiple defendants participated in a healthcare fraud scheme involving telemarketers, telemedicine doctors, and the sale of durable medical equipment (DME). The telemarketers allegedly solicited prospective patients to request orthotics and used telemedicine doctors to generate prescriptions. The telemedicine doctors did not have a relationship with the patients, and the telemarketers then sold the completed prescription orders to the DME companies. The companies would then cold call unsuspecting "patients" and coerce them into accepting the medically unnecessary DME. Many of the target companies identified in the scheme billed CHAMPVA. The loss to VA is approximately $330,000. One defendant was sentenced in the District of New Jersey to 120 months of incarceration, three years of probation, restitution of more than $33.7 million, and forfeiture of approximately $9.4 million. Another defendant was sentenced in the District of New Jersey to 22 months of incarceration, three years of supervised release, and restitution of more than $6.9 million.

Listen to the *Veteran Oversight Now* podcast episode as a VA OIG special agent in charge discusses the new Healthcare Fraud Division.

VETERAN PLEADED GUILTY FOR ALTERING MILITARY RECORDS TO OBTAIN VA BENEFITS

In 2011, a veteran registered for VA healthcare benefits by presenting altered military service records that falsely reflected that he served in Vietnam. He later used the same fraudulent documentation to obtain VA compensation benefits. The veteran also used altered documentation that claimed a different date of birth to obtain Social Security and Medicare benefits to which he was not entitled and to obtain a passport. The veteran pleaded guilty in the District of Alaska to healthcare benefits fraud, false statements relating to healthcare benefits, Social Security benefits fraud, false statements, and passport fraud. The total loss to the government is more than $530,000, of which $330,000 is the loss to VA. The VA OIG joined with the Social Security Administration (SSA) OIG, Department of State Diplomatic Security Service, and HHS OIG to conduct the investigation.

TWO INDIVIDUALS SENTENCED FOR ROLES IN COMPOUND PHARMACY CONSPIRACY

Another multiagency investigation resulted in charges alleging that numerous individuals participated in a conspiracy to fraudulently bill compounded medications to federal healthcare programs, including Medicare, DOL's Office of Workers' Compensation Programs, TRICARE, and CHAMPVA. The loss to VA is approximately $153,000. Two defendants were each sentenced in the Northern District of Oklahoma to 12 months of probation and ordered to pay combined restitution of close to $945,000 after pleading guilty to conspiracy to pay healthcare kickbacks. This investigation was conducted by the VA OIG, USPS OIG, FBI, HHS OIG, DOL OIG, and DCIS.

False Statements and Entries

TWO REGISTERED NURSES CHARGED WITH FALSE STATEMENTS

A former registered nurse and a former contract registered nurse for the Oklahoma City VA Medical Center were indicted in the Western District of Oklahoma for false statements. According to a VA OIG investigation, the nurses allegedly made false statements to investigators related to the suspicious death of a veteran inpatient, stating that they did not pause medication being administered to the victim prior to his death.

VA MEDICAL CENTER NURSE CHARGED WITH MAKING FALSE ENTRIES IN A MEDICAL CHART

A VA OIG investigation resulted in a criminal charge that alleges that a registered nurse at the Durham VA Medical Center in North Carolina made false entries in the medical chart of one of her patients. The nurse, who discovered the patient deceased, had not checked on him in over six hours and allegedly made these entries to cover that she had been derelict in her duties. She was indicted in the Middle District of North Carolina for making a false statement or entry.

Drug Diversion

FORMER KERRVILLE VA MEDICAL CENTER PHARMACY TECHNICIAN SENTENCED FOR DRUG DIVERSION SCHEME

A former pharmacy technician stole over 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville, which he subsequently sold to accomplices for further distribution. He was sentenced in the Western District of Texas to 12 months in prison and 36 months of supervised release. The investigation was performed by the VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and US Postal Inspection Service.

Caregiver Support Program Fraud

VETERAN AND WIFE SENTENCED FOR CONSPIRACY TO DEFRAUD THE GOVERNMENT

According to an investigation by the VA OIG, a veteran and his wife falsely reported to VA that the veteran was unable to walk or use his arms. Furthermore, when applying for a VA Caregiver Support Program grant, the wife allegedly stated that she cared for the veteran full time when in fact she often left the home while the veteran worked on the family ranch without assistance. The couple was previously indicted on charges of conspiracy to defraud the government, false statements, theft, and false claims.

They were found guilty in the Western District of Michigan on all counts. The veteran was sentenced to 60 months in prison, 36 months of supervised release, and a fine of $2,000. The veteran's wife was sentenced to 36 months of supervised release. The couple was also ordered to pay joint restitution of more than $264,600 to VA.

HIPAA Violation

VA EMPLOYEE PLEADED GUILTY AND COCONSPIRATOR SENTENCED FOR CRIMINAL HIPAA VIOLATIONS

A VA OIG investigation revealed that a former employee of the Des Moines VA Medical Center obtained and disclosed a veteran's behavioral health records without authorization to a coconspirator. Then the coconspirator disclosed the records to another party. The coconspirator was sentenced in the Southern District of Iowa to 27 months of imprisonment, three years of supervised release, and restitution of $2,000 after previously pleading guilty to conspiracy to wrongfully obtain and disclose individually identifiable health information and then wrongfully obtaining that information. The former VA employee previously pleaded guilty in connection with this investigation and is awaiting sentencing.

Workers' Compensation Fraud

FORMER MARION VA MEDICAL CENTER EMPLOYEE SENTENCED FOR WORKERS' COMPENSATION FRAUD SCHEME

A former VA medical center employee in Indiana submitted 670 false reimbursement claims for treatment, mileage, and other expenses pertaining to her workers' compensation disability claim. The former employee was receiving workers' compensation benefits in connection with a fall that she suffered while working at the medical center. Following an investigation by the VA OIG and DOL OIG, she was sentenced in the Northern District of Indiana to 27 months in prison, one year of supervised release, and restitution to VA of approximately $338,000.

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 one individual, recoveries of $513,023, and a projected five-year savings to VA estimated at $207,023.

OI also opened 68 investigations involving the fraudulent receipt of other VA monetary benefits, including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 45 arrests. OI obtained over $18.8 million in court-ordered fines, restitution, penalties, and civil

judgments; achieved more than $70 million in savings, efficiencies, and cost avoidance; and recovered over $2 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

Education Benefits Fraud

TWO DEFENDANTS PLEADED GUILTY FOR ROLES IN EDUCATION BENEFITS FRAUD SCHEME

Two former operators of a non-college degree technical school defrauded the VA Post-9/11 GI Bill education benefit program by falsifying attendance records, student grades, and professional certifications to conceal they were out of compliance with VA's "85/15" rule. As previously mentioned, this rule is intended to ensure that VA is paying fair market value tuition by requiring at least 15 percent of the enrolled students to pay the same rate with non-VA funds. Non-college degree schools require students to attend in-person classes, and online courses are not permitted. According to the VA OIG investigation, the defendants allowed students to complete course work online and at their own pace. In addition to the false records, they posed as students when contacted by the state approving agency to confirm graduation and job placement data so they could maintain school eligibility. The defendants pleaded guilty in the District of Columbia to conspiracy to commit wire fraud. The loss to VA is over $104.6 million. To date, this is the largest known incident of Post-9/11 GI Bill benefits fraud that has been prosecuted by DOJ.

FORMER BARBER SCHOOL OWNER SENTENCED FOR FRAUDULENTLY COLLECTING GI BILL FUNDS

From approximately October 2016 to March 2019, the former owner of a barber school offered a master course that was not accredited and approved by the state's Board of Barber Examiners. The defendant fraudulently represented that this course was approved, which resulted in his collection of GI Bill funds from veterans enrolled in the program. He was sentenced in the Southern District of Mississippi to one year and one day imprisonment, three years of supervised release, and restitution of more than $402,000 after previously pleading guilty to wire fraud.

Theft of Government Property and Identity Theft

VETERAN CLAIMING BLINDNESS FOR DISABILITY BENEFITS SENTENCED

A VA OIG proactive investigation uncovered that a veteran who maintained a valid Missouri driver's license was rated as 100 percent service-connected disabled for bilateral blindness since 2000. During the investigation, the veteran was observed driving routinely and mowing his lawn. He was sentenced in the Eastern District of Missouri to five years of supervised release and restitution of more than $671,000 after previously pleading guilty to theft of government property.

ANOTHER VETERAN CLAIMING BLINDESS SENTENCED FOR THEFT OF GOVERNMENT BENEFITS

VA OIG investigators also found that a veteran fraudulently led VA to believe he was blind. The veteran, who had been receiving service-connected disability benefits at a 100 percent rating 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. After previously being found guilty by a federal jury on charges of theft of government property and false statements, the veteran was sentenced in the Middle District of Florida to 27 months in prison, two years of supervised release, and more than $429,000 in restitution to VA.

A THIRD VETERAN SENTENCED FOR THEFT AFTER CLAIMING TO BE BLIND

An investigation revealed that a third veteran fraudulently received VA compensation benefits for blindness. The defendant was rated as having "light perception only" and a visual acuity of 5/200 for approximately 30 years following his discharge from the Army. This investigation by the VA OIG revealed that the defendant maintained a driver's license in multiple states while claiming blindness. During a 15-year period, the defendant and his wife purchased more than 30 automobiles that he routinely drove, including on long-distance trips, for errands, and to VA medical appointments. The defendant was sentenced in the Western District of North Carolina to 10 months of imprisonment (to include five months of home confinement), 36 months of supervised release, and restitution of more than $930,000 after previously pleading guilty to theft of government funds.

VETERAN INDICTED IN CONNECTION WITH DISABILITY FRAUD SCHEME

A proactive investigation by the VA OIG resulted in charges alleging that a veteran stole more than $800,000 from VA by falsely claiming he was unable to use both feet and his left arm. The veteran was reported to not only walk but was also able to drive unassisted and run a jukebox repair business from his home. He received nearly $9,000 per month from VA for his false claims of disabilities. The veteran was indicted in the District of South Carolina for theft of government funds.

SPOUSE OF VETERAN FOUND GUILTY IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

According to a VA OIG and SSA OIG investigation, a veteran fraudulently sought (and subsequently received) a 100 percent disability rating with special monthly compensation benefits for the alleged loss of the use of both feet based on false statements made during his military out-processing physical and subsequent VA examinations. Based on alleged false statements that were made by the now-deceased veteran and his spouse, the veteran also received Social Security disability payments and VA grants for specially adapted housing and automobile adaptive equipment. After receiving a home from a private charity in 2013, multiple witnesses, local media, and investigators observed the veteran walking, driving, performing yard work, and playing basketball. The total loss is more than $582,000 to VA, nearly $152,000 to SSA, and $339,000 to the private charity. The veteran's spouse was found guilty at trial in the Western District of Texas on charges of wire fraud, mail fraud, conspiracy to commit healthcare fraud, healthcare fraud, false statements related to a healthcare matter, theft of government funds, and aiding and abetting.

DEFENDANT ADMITTED TO FRAUDULENTLY OBTAINING VA BENEFITS IN DECEASED MOTHER'S NAME

From 1973 through 2021, the daughter of a deceased VA beneficiary signed her late mother's name on the back of her VA checks and forged her name on documents submitted to VA. The defendant also forged her mother's signature on a form that directed VA to deposit the benefits into a bank account that she controlled. When filing for bankruptcy, the defendant also falsely claimed that she had no income when at that time she was fraudulently receiving monthly VA benefits intended for her mother. The total loss to VA is approximately $462,000. The defendant pleaded guilty in the Southern District of Ohio to theft of government funds.

VETERAN INDICTED FOR COMPENSATION BENEFITS FRAUD

A VA OIG and FBI investigation resulted in charges alleging that a veteran fraudulently obtained disability compensation and individual unemployability benefits. The veteran allegedly made several

false statements to VA regarding purported service-connected disabilities that did not allow him to climb stairs or participate in any physical activity. However, the defendant allegedly participated in activities such as kickboxing, surfing, and running on a regular basis. Through a service-disabled veteran-owned small business that he owned, the defendant was awarded several contracts, which earned a substantial amount of money that he failed to report to VA on his individual unemployability application. He also allegedly failed to list the SDVOSB's income on personal bankruptcy filings. The potential loss to VA is approximately $389,000. The veteran was indicted in the Eastern District of Pennsylvania on charges of theft of government funds, wire fraud, false statements, and bankruptcy fraud.

MARINE VETERAN CHARGED FOR USING STOLEN IDENTITY AND ALLEGEDLY RECEIVING VA BENEFITS

A presumed Mexican national allegedly stole the identity of a deceased American teenager to enlist in the US Marine Corps in the 1970s. Despite having no legal basis for living or working in the United States, he served for approximately three years on active duty under the assumed identity and, in 2021, allegedly received VA education and medical benefits and applied for VA disability benefits. The defendant was arrested after being charged in the Southern District of California with identity theft and making false statements related to health care in his application for a passport and in his application for Social Security. The investigation was conducted by the VA OIG, SSA OIG, Diplomatic Security Service, and California Department of Motor Vehicles.

FORMER VA SOCIAL WORKER CLAIMING TO BE A PURPLE HEART AND BRONZE STAR RECIPIENT PLEADED GUILTY FOR STOLEN VALOR SCHEME THAT INCLUDED STEALING A VETERAN'S IDENTITY TO GAIN BENEFITS

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 defendant collected more than $250,000 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. The defendant also falsely claimed to have cancer due to her alleged military service after using her position to access the VA medical records of a veteran cancer patient. The former social worker pleaded guilty in the District of Rhode Island to wire fraud, aggravated identify theft, fraudulent representations about receipt of military medals or decorations, and forging military or naval discharge documents. This investigation was conducted by the VA OIG, FBI, DCIS, US Postal Inspection Service, Naval Criminal Investigative Service, VA Police Service, and IRS CI.

VETERAN SENTENCED FOR LYING ABOUT IMPAIRMENT

Following a hotline complaint, a VA OIG investigation brought to light that a veteran exaggerated his mental and physical impairments to fraudulently increase his VA compensation benefits. The veteran lied on a mental health test by reporting to VA that he had been in combat, qualifying him for posttraumatic stress disorder benefits. Investigators confirmed that the veteran was a competitive bodybuilder who faked physical ailments to VA examiners, including using a cane at the VA medical center and telling examiners he could not lift more than 10 to 20 pounds. The veteran was sentenced in the Southern District of Florida to one year of imprisonment, three years of supervised release, and restitution of about $246,000 after previously pleading guilty to theft of government funds.

DEFENDANT INDICTED ON CHARGES OF THEFT OF BENEFITS INTENDED FOR VETERAN

According to another VA OIG investigation, a nonveteran allegedly cashed Dependency and Indemnity Compensation benefits checks from 2010 to 2020 intended for a VA beneficiary who had passed away in 2009. The potential loss to VA is approximately $140,000. The defendant was arrested after being indicted in the Eastern District of New York on charges of theft of government funds and aggravated identity theft.

DEFENDANT CONVICTED OF THEFT OF GOVERNMENT FUNDS AND FALSE STATEMENTS OF DISABILITY

A VA OIG and SSA OIG investigation revealed that a veteran stole more than $420,000 from VA and SSA by falsely claiming he was unable to work due to a disability while simultaneously owning and operating an insurance company. The loss to VA is approximately $100,000. The veteran was convicted in the District of Massachusetts of theft of government funds and false statements.

VETERAN GUILTY AT TRIAL FOR FRAUDULENTLY CLAIMING UNEMPLOYABILITY AND DISABILITY BENEFITS

A veteran was found to have received VA individual unemployability benefits and SSA disability benefits while self-employed as a construction worker and business operator. He also obtained additional SSA benefits for his daughter based on his false claims. The veteran was found guilty by a federal jury in the Eastern District of Arkansas on charges of conspiracy to defraud the United States, theft of government funds, and bankruptcy fraud. The total loss to the government is approximately $396,000, of which the loss to VA was about $132,000. The VA OIG and SSA OIG conducted this investigation.

THREE DEFENDANTS GUILTY OF COMPENSATION BENEFITS FRAUD SCHEME

Another VA OIG and SSA OIG investigation resulted in charges alleging multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. One defendant allegedly received about $35,000 in SSA disability insurance benefits for her claimed disabilities. Two defendants previously pleaded guilty to conspiracy and theft of government property, while a third defendant was convicted at trial in the District of Maryland of the same charges. The loss to VA is approximately $820,000.

VETERAN FOUND GUILTY FOR MISREPRESENTING SYMPTOMS TO OBTAIN COMPENSATION BENEFITS

A hotline complaint to the VA OIG alleged that a veteran misrepresented symptoms of conversion disorder (a functional neurological system disorder) and choreiform gait disorder (irregular and involuntary movements exhibited when walking) to obtain a 100 percent service-connected disability rating, VA Aid and Attendance benefits, and VA Survivors' and Dependents' Educational Assistance. The total estimated loss to the government is about $567,000. Of this amount, the loss to VA is close to $423,000. The VA OIG and SSA OIG completed this investigation. The veteran was found guilty at trial by a federal jury in the District of Kansas of wire fraud and theft of government funds.

Fiduciary Fraud

FORMER VA-APPOINTED FIDUCIARY PLEADED GUILTY FOR STEALING BENEFITS FROM VETERANS

VA-appointed fiduciaries are required to oversee VA benefits to meet the needs of vulnerable veterans and other beneficiaries unable to manage them on their own due to injury, disease, advanced age, or youth. VA OIG investigators determined that a former VA-appointed fiduciary stole over $300,000 that was intended for use by 10 different veterans that he was appointed to represent. He pleaded guilty in the District of South Carolina to theft of government funds.

ANOTHER FORMER VA FIDUCIARY INDICTED FOR FRAUD AND EXPLOITATION

In collaboration with the South Carolina Attorney General's Office, the VA OIG conducted an investigation that resulted in charges alleging that a former VA-appointed fiduciary stole over $65,000 from a veteran she was appointed to represent. The former fiduciary was indicted in the County of Lexington (South Carolina) Court of General Sessions on charges of breach of trust with fraudulent intent and exploitation of a vulnerable adult.

A THIRD FORMER VA FIDUCIARY CHARGED WITH MISAPPROPRIATION

VA OIG investigators determined that a former VA-appointed fiduciary illegally spent over $115,000 in VA compensation benefits intended for her veteran uncle. The former fiduciary allegedly used the stolen funds as a down payment for a home and to pay for subsequent home improvement projects. She was charged in the Eastern District of Louisiana with misappropriation by a fiduciary.

Pension Benefits Fraud

US POSTAL EMPLOYEE SENTENCED FOR MAKING FALSE STATEMENTS ABOUT HIS INCOME

A USPS employee who previously served in the Army failed to disclose his employment to VA when he applied for monthly pension benefits in 2011. According to VA OIG investigators, despite earning more than $65,000 per year, the veteran signed and certified an application for VA pension benefits in which he falsely reported that he had no income. The veteran also reported that his home was his only asset and that he had a medical condition that prevented him from working. After approving this application, VA paid pension benefits to the veteran from 2011 to 2020. He was sentenced in the Southern District of Georgia to three years of probation and ordered to pay restitution of more than $244,000 after pleading guilty to false statements.

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 15 cases and made six arrests. These investigations resulted in over $80.4 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $535,000 in savings, efficiencies, and cost avoidance, and recoveries of over $101,000.

Cases Related to Service-Disabled Veteran-Owned Small Businesses (SDVOSBs)

VETERAN CONSTRUCTION COMPANY OWNER AND COCONSPIRATOR SENTENCED FOR SDVOSB FRAUD SCHEME

Joining VA's SDVOSB program makes a business eligible to compete for set-aside contracts not otherwise available. A multiagency investigation disclosed that between 2009 and 2018, an SDVOSB in Missouri that was certified by the SBA's 8(a) business development program was awarded approximately $335 million in set-aside contracts, of which about $118 million was awarded by VA. Although a veteran claimed to control and operate the company, the investigation determined that the business was controlled by three nonveterans. When the company grew too large to compete for small business contracts, the veteran's coconspirators used the minority status of another coconspirator to set up a second company. This second company was awarded an additional $11 million in set-aside contracts. One of the coconspirators who controlled the two companies was sentenced in the Western District of Missouri to eight years in prison, four years of supervised release, forfeiture of over $4.6 million, and restitution of over $698,000. The veteran claiming to operate the first SDVOSB was sentenced in the Western District of Missouri to 12 months in prison and three years of supervised release. The investigation was conducted by the VA OIG, IRS CI, Naval Criminal Investigative Service, US Air Force Office of Special Investigations, SBA OIG, US Army Criminal Investigation Division, Department of Agriculture OIG, General Services Administration OIG, Defense Contract Audit Agency—Operations Investigative Support, US Secret Service, DOL OIG, DOL Employee Benefits Security Administration, and DCIS.

NONVETERAN FOUND GUILTY FOR ROLE IN SDVOSB FRAUD SCHEME

Two nonveterans fraudulently created an SDVOSB in Texas by installing a service-disabled veteran as the ostensible owner of the business, which remained under their control. Over 10 years, the SDVOSB was awarded more than $305 million in government contracts. Of this amount, approximately $77 million was awarded by VA, including a $24 million set-aside contract to build a parking garage at the VA Long-Term Spinal Cord Injury Clinic in Dallas, Texas. One of the nonveterans was found guilty at trial in the Western District of Texas of conspiracy to defraud the United States and wire fraud. The other nonveteran and the veteran previously pleaded guilty in connection with this investigation, which was conducted by the VA OIG, SBA OIG, General Services Administration OIG, DCIS, and Army Criminal Investigation Division.

TWO DEFENDANTS FOUND GUILTY IN CONNECTION WITH SDVOSB SCHEME

A VA OIG, SBA OIG, and Department of Interior OIG investigation, prompted by a hotline complaint, resulted in charges alleging that two nonveterans managed and controlled an SDVOSB to fraudulently obtain federal set-aside contracts. The small business allegedly made numerous false statements to SBA and provided fraudulent references to VA for past work performance to obtain federal contracts. The two nonveterans were found guilty at trial in the Eastern District of Tennessee of conspiracy to commit wire fraud, wire fraud, and major fraud against the United States. The total loss to the government is approximately $14.8 million. Of that amount, the total loss to VA is approximately $3.8 million.

Trade Agreement Act Violation

GLOBAL HEALTHCARE COMPANY AGREED TO PAY $6.3 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

The VA OIG, Army Criminal Investigation Division, and HHS OIG investigated allegations that a global health company violated the False Claims Act by selling items to the United States that were manufactured in nondesignated countries in violation of the Trade Agreements Act of 1979. From 2012 through 2019, the company allegedly sold medical supplies manufactured in nondesignated countries to VA that were valued at approximately $42.5 million. Noncompliant medical supplies were also allegedly provided to HHS and the Department of Defense (DoD) that were respectively valued at $11.5 million and $7.1 million. The company entered into a settlement in the District of New Jersey under which it agreed to pay $6.3 million to resolve these allegations.

Mortgage Lender Fraud

MORTGAGE LENDER AGREED TO PAY MORE THAN $1 MILLION TO RESOLVE FRAUD ALLEGATIONS

The VA OIG and HUD OIG investigated allegations that a mortgage lender improperly and fraudulently originated (funded) government-backed mortgage loans insured by the Federal Housing Administration (FHA). According to the investigation, the lender knowingly underwrote FHA mortgages and approved for insurance mortgages that did not meet FHA requirements or qualify for insurance, resulting in losses to the federal government when the borrowers defaulted on those mortgages. It was further alleged that the lender knowingly failed to perform required quality control reviews. VA paid more than $1.2 million in claims for loans originated by this lender. The mortgage lender entered into a civil settlement agreement in the Eastern District of Washington under which it agreed to pay more than $1 million to resolve these allegations.

Paycheck Protection Program Loan Fraud: Non-VA Case Conducted for Pandemic Response Accountability Committee

DEFENDANT INDICTED FOR PREPARING FRAUDULENT PAYCHECK PROTECTION PROGRAM LOANS

A VA OIG investigation resulted in charges alleging that a defendant operated a Paycheck Protection Program loan fraud scheme. The scheme involved the defendant recruiting applicants from whom she received payments ranging between $45 to $120 in exchange for submitting fraudulent Paycheck Protection Program sole proprietor loan applications on their behalf. The defendant was indicted in the Eastern District of Louisiana on charges of mail fraud and conspiracy to commit mail fraud. The total loss to the government is approximately $1.1 million. This investigation was the result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC).[15]

15 As one of the 21 different offices of inspector general that serve as members of the PRAC, the VA OIG provides assistance to the government's efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA's programs and operations.

Investigations Involving Firearms

VETERAN CHARGED FOR FIRING A WEAPON OUTSIDE VA MEDICAL FACILITY IN OHIO

A veteran discharged a 12-gauge shotgun outside the Ravenna VA Clinic in Ohio. The defendant was near the flagpole in front of the clinic entry, and after being approached by a security guard, he allegedly displayed the shotgun and discharged a shell into the ground. The VA clinic and a nearby school and private hospital were immediately locked down. After discussions with a SWAT team negotiator, the veteran ultimately surrendered and was later indicted in the Portage County Court of Common Pleas for inducing panic and possession of criminal tools, with firearms specifications. The VA OIG, Ravenna Police Department, and VA Police Service conducted the investigation.

VETERAN ARRESTED FOR ALLEGEDLY SHOOTING A FIREARM AT THE WEST HAVEN VA MEDICAL CENTER IN CONNECTICUT

In May 2021, a veteran allegedly discharged a .22 caliber long rifle from his vehicle, striking the eastern façade of the West Haven VA Medical Center approximately 15 times, which resulted in damage totaling more than $470,000. The veteran has also been criminally charged with 10 other shootings that occurred on that same day at multiple residences, a church, and the State Capitol building in Hartford, Connecticut. He was arrested after being charged in the Connecticut Superior Court with criminal mischief in the first degree. The VA OIG, West Haven Police Department, and VA Police Service investigated this case.

Sexual Abuse, Sexual Exploitation, and Child Pornography

THE FORMER CHIEF OF CARDIOLOGY AT THE VA PALO ALTO HEALTH CARE SYSTEM SENTENCED FOR FELONY ABUSIVE SEXUAL CONTACT

The former chief of cardiology at the VA Palo Alto Health Care System repeatedly subjected a subordinate doctor to unwanted sexual contact while on VA premises, according to an investigation by the VA OIG and VA Police Service. The former chief was sentenced in the Northern District of California to eight months of incarceration and one year of supervised release, and was ordered to pay $15,000 after previously pleading guilty to abusive sexual contact.

VA EMPLOYEE PLEADED GUILTY TO SEXUAL EXPLOITATION OF A CHILD AND POSSESSION OF CHILD PORNOGRAPHY

An accounting technician at the Orlando VA Medical Center used his VA-issued computer to solicit and receive sexual content from a 13-year-old victim. The accounting technician pleaded guilty in the Middle District of Florida to sexual exploitation of a child and possession of child pornography. The investigation was undertaken by the VA OIG, FBI, and the Orange County Sheriff's Office.

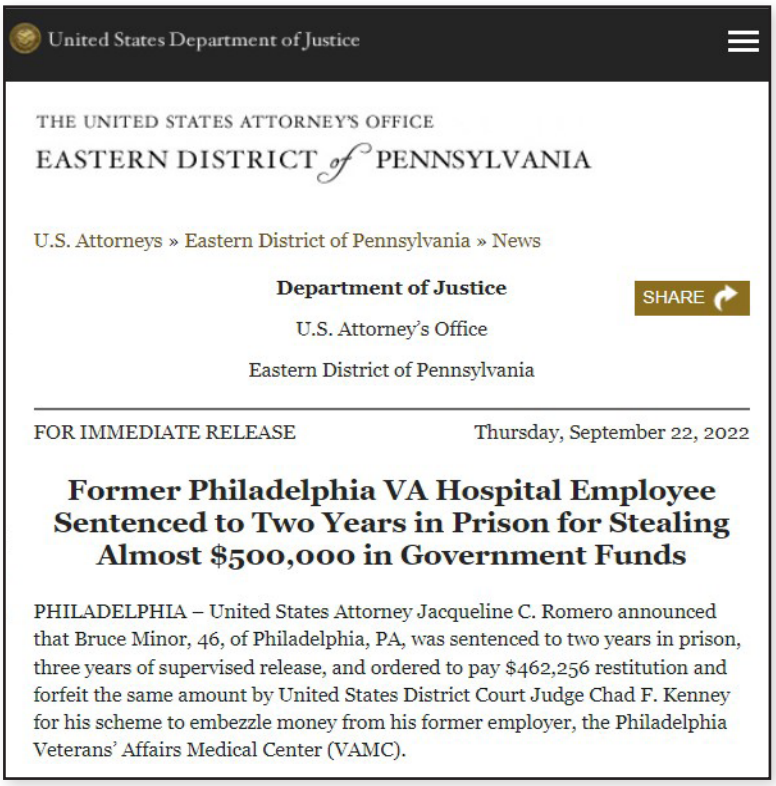
LICENSED PRACTICAL NURSE AT THE NORTHAMPTON VA MEDICAL CENTER IN MASSACHUSETTS INDICTED FOR DISTRIBUTION AND POSSESSION OF CHILD PORNOGRAPHY

A VA OIG, US Secret Service, and VA Police Service investigation resulted in charges alleging that a licensed practical nurse at a VA medical center in Leeds, Massachusetts, used the facility's public Wi-Fi to upload and download thousands of files to his personal computer that contained child pornography. The nurse was indicted in the District of Massachusetts on charges of distribution and possession of child pornography.

Theft of Government Property and Funds by Former VA Employees

FORMER PHILADELPHIA VA MEDICAL CENTER EMPLOYEE SENTENCED IN CONNECTION WITH FALSE TRAVEL REIMBURSEMENT CLAIMS SCHEME

A VA OIG and VA Police Service investigation revealed that a former employee at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania, used his access to VA's Concur travel reimbursement system to approve and certify false payments in the names of other VA employees. From December 2015 through September 2019, the former employee directed approximately $487,000 in bogus travel reimbursement payments to various bank accounts under his control. The former employee was sentenced in the Eastern District of Pennsylvania to two years in prison, three years of supervised release, and restitution of over $462,000 after previously pleading guilty to theft of government funds.



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THE UNITED STATES ATTORNEY'S OFFICE
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SHARE

FOR IMMEDIATE RELEASE — Thursday, September 22, 2022

Former Philadelphia VA Hospital Employee Sentenced to Two Years in Prison for Stealing Almost $500,000 in Government Funds

PHILADELPHIA – United States Attorney Jacqueline C. Romero announced that Bruce Minor, 46, of Philadelphia, PA, was sentenced to two years in prison, three years of supervised release, and ordered to pay $462,256 restitution and forfeit the same amount by United States District Court Judge Chad F. Kenney for his scheme to embezzle money from his former employer, the Philadelphia Veterans' Affairs Medical Center (VAMC).

FORMER PHOENIX VA HEALTHCARE SYSTEM EMPLOYEE SENTENCED FOR THEFT OF GOVERNMENT PROPERTY

A VA OIG investigation uncovered that a former Phoenix VA Healthcare System employee stole property, mostly consisting of home furnishings, that Walmart had donated to the healthcare system for veterans experiencing homelessness or poverty. The former employee used a truck belonging to VA's Voluntary Services to pick up donated items from a Walmart distribution center. On numerous occasions, he placed the items in his personal storage lockers instead of taking the donations to the healthcare system's facilities in Phoenix. He was sentenced in the District of Arizona to 60 months of supervised probation and $95,000 in restitution to VA after previously pleading guilty to theft of government property.

Threats and Assaults Involving VA Employees

During this reporting period, OI personnel initiated 26 criminal investigations resulting from assaults and threats involving VA facilities and employees. This work resulted in charges filed against 12 individuals. Investigations resulted in $75,713 in savings, efficiencies, cost avoidance, and dollar recoveries.

Threats and Assaults against VA and VA OIG Employees

VETERAN SENTENCED FOR ASSAULTING A FEDERAL EMPLOYEE

An investigation by the VA OIG and VA Police Service found a veteran made multiple threats to staff during visits to the emergency room of the Syracuse VA Medical Center in New York. During one

incident, the veteran was restrained by VA Police Service officers after lunging at and threatening to kill an employee. After pleading guilty to assaulting a federal employee, the veteran was sentenced in the Northern District of New York to time served (six weeks) and two years of probation. He was also mandated to participate in a VA inpatient psychiatric program.

VETERAN ARRESTED FOR ASSAULT WITH A DEADLY WEAPON

A veteran assaulted two VA police officers at the San Diego VA Medical Center after facility staff attempted to treat him. During the altercation with police, the defendant allegedly gained control of an officer's service-issued firearm and attempted to shoot another officer but missed. The round went through the patient room wall and into a neighboring patient's room that was occupied. The neighboring patient was unharmed. The defendant was charged in the Southern District of California with assault on a federal officer with a deadly or dangerous weapon. This investigation was also conducted by the VA OIG and VA Police Service.

VETERAN SENTENCED FOR ASSAULTING A FEDERAL OFFICER

A veteran assaulted a VA OIG agent who was assisting local police in performing an emergency medical detention based on the veteran being a threat to himself and others. At the time, the VA OIG was investigating alleged threats made by the veteran against multiple VA employees. The veteran had pleaded guilty and was sentenced in the District of Kansas to time served (over five months) and 12 months of probation, and was ordered to participate in mental health, behavioral health, and substance abuse treatment.

FORMER VA CONTRACT EMPLOYEE CHARGED WITH ASSAULTING A VA POLICE OFFICER WITH HIS VEHICLE

A former contract employee at the Edward Hines, Jr. VA Hospital in Chicago was arrested after being charged in the Northern District of Illinois with assaulting, resisting, or impeding certain officers or employees. A VA OIG and VA Police Service investigation resulted in charges alleging the defendant resisted a VA police officer's attempt to place him under arrest for possession of a controlled substance while conducting a traffic stop. When fleeing, the defendant's vehicle allegedly struck the VA police officer that resulted in several injuries.

VETERAN CHARGED WITH DESTRUCTION OF PROPERTY AT BATH VA MEDICAL CENTER

According to an investigation by the VA OIG and VA Police Service, a veteran allegedly drove his recreational vehicle through a locked entry gate at the Bath VA Medical Center in New York, which caused approximately $18,000 in damage. A loaded .22 caliber revolver and a substance suspected to be marijuana were recovered from the veteran's vehicle. He was arrested after being charged in the Western District of New York with destruction of government property, possession of a firearm on federal property, and possession of marijuana.

VETERAN SENTENCED FOR THREATENING A FEDERAL EMPLOYEE

A veteran was sentenced in the Northern District of Ohio to 18 months in prison after having been found guilty of threatening a federal employee. A VA OIG and VA Police Service investigation found that the veteran allegedly threatened to inflict serious physical harm on a VBA fiduciary supervisor on multiple occasions because VA was reviewing the defendant's ability to handle his own financial affairs.

INCARCERATED VETERAN INDICTED FOR THREATENING VA EMPLOYEES

A multiagency investigation resulted in charges alleging that an incarcerated veteran sent a communication to VA in which he threatened VA employees and the employees of a nonprofit organization. The veteran was allegedly angered after receiving a notification from VA that his monetary benefits would be reduced during his incarceration per VA policy. He was indicted in the District of Massachusetts for the interstate transmission of a threatening communication. The VA OIG, Federal Bureau of Prisons, and FBI carried out the investigation.

VETERAN PLEADED GUILTY TO MAKING THREATS TO CLINIC AND HELP LINE PERSONNEL

VA OIG investigators determined that a veteran repeatedly made vulgar and threatening comments to staff at the Lake Jackson VA Clinic in Texas, the Veterans Crisis Line, and the White House VA Hotline. The veteran pleaded guilty in the Southern District of Texas to making threats by interstate communications.

VETERAN INDICTED FOR MAKING THREATS AGAINST VA DOCTORS

A veteran allegedly called the White House VA Hotline and threatened to harm doctors at the Fargo VA Medical Center in North Dakota. The veteran was indicted in the District of North Dakota for communicating interstate threats following an investigation by the VA OIG, VA Police Service, and US Marshals.

VETERAN CHARGED FOR MAKING THREATS AGAINST VA BOSTON HEALTHCARE DIRECTOR AND THREATENING TO KILL VA OIG AGENTS

A VA OIG and VA Police Service investigation resulted in charges alleging a veteran threatened to harm the director of the VA Boston Healthcare System during a telephone call to the facility. While the veteran was under investigation for making these threats, he allegedly called the VA Police Service and threatened to kill the VA OIG agents who were attempting to interview him. He was arrested and charged in Brockton District Court (Massachusetts) with threatening to commit murder.

Assaults Committed by Former VA Employees

FORMER VA PATIENT ADVOCATE INDICTED FOR PHYSICALLY ASSAULTING A VETERAN

According to a VA OIG investigation, a former supervisory patient advocate at the Fort McPherson VA Clinic in Atlanta, Georgia, allegedly attacked a veteran who was seeking advocacy assistance, causing serious injuries. The former patient advocate was arrested after being indicted in Fulton County (Georgia) Superior Court on charges of elder abuse, aggravated battery, aggravated assault, and aggravated assault strangulation.

FORMER COATESVILLE VA MEDICAL CENTER EMPLOYEE SENTENCED FOR THREATENING FORMER COWORKERS

VA OIG investigators also found 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 former employee also targeted the family members of his former coworkers with similarly vulgar communications. He was sentenced in the Eastern District of Pennsylvania to 41 months of incarceration and three years of supervised release.

Fugitive Felon Program

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since the inception of the program in 2002, 104 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 131,334 investigative leads being referred to law enforcement agencies. More than 2,688 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. The OIG has also identified nearly $2.4 billion in estimated overpayments and cost avoidance of more than $3.2 billion since 2002. During this reporting period, OI made three arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of 39 additional fugitive felons, and identified $70.2 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.[16] 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 public.[17] When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed two criminal investigations with unsubstantiated allegations against senior government employees:

- The OIG received an allegation that a contract for a software package valued at approximately $343,000 was approved without proper authorization by staff at the Fayetteville VA Medical Center in North Carolina. The software package was a web-based solution designed to support budget calls, business planning, operational planning, and resource tracking for VA medical centers. Several VA employees indicated during interviews that the facility's senior leadership, including the facility's associate director of operations, wanted to procure this particular software package. This investigation determined that though funding was not approved, VA did not purchase this software package. The associate director of operations stated during an interview with investigators that he was simply trying to provide a better system to the facility and that he did not have a personal or professional relationship with the vendor or any of its employees. This

16 Pub. L. No. § 5(a)(19).

17 Pub. L. No. § 5(a)(22)(B).

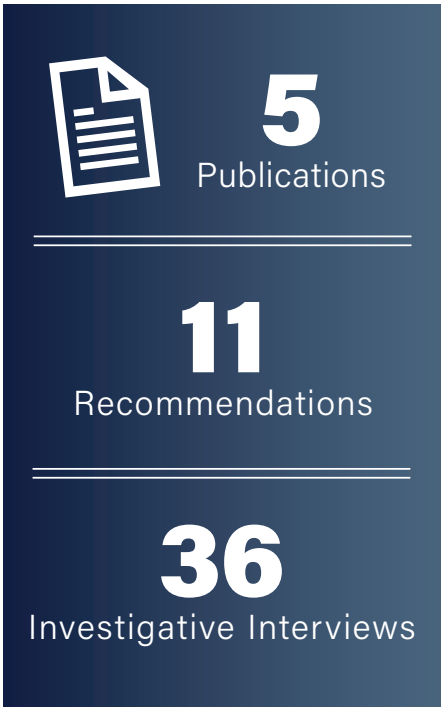
matter was not referred to the DOJ because no criminal conduct was identified. This investigation was closed on April 21, 2022.

- The OIG received a hotline allegation from a veteran who alleged that in December 2017, an unknown female physician at the VA medical center in Washington, DC, groped his chest and buttocks when he was naked in a changing room prior to an X-ray. This investigation was not able to substantiate based on available evidence that a female physician sexually assaulted the veteran. OIG agents conducted interviews of multiple female staff members who denied behaving in this manner with any VA patient (and uncovered no contrary evidence). The veteran subsequently contacted the assigned special agent to report that he had a high degree of certainty that a particular VA physician was the assailant after viewing her photo online. During an interview with investigators, this VA physician denied these allegations and stated that she had never been in the Radiology Department's changing room. This matter was not referred to the DOJ because no criminal conduct was identified. This investigation was closed on September 13, 2022.

Results from the Office of Special Reviews

Overview

OSR issued five publications in this reporting period: four reports and one VA management advisory memorandum. 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 http://www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.



Administrative Investigations

OSR conducts investigations concerning high-ranking VA officials and reports on matters of interest to Congress, the Department, and other stakeholders. The office's work regularly focuses on issues of integrity within VA offices, programs, and initiatives. 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.

SENIOR STAFF GAVE INACCURATE INFORMATION TO OIG REVIEWERS OF ELECTRONIC HEALTH RECORD TRAINING

This administrative investigation found that two leaders in the VA Office of Electronic Health Record Modernization's Change Management group did not intentionally seek to mislead OIG healthcare inspectors during a prior review of VA's training for medical facility staff on implementing a new record system. However, the leaders' carelessness resulted in delayed and inaccurate information being submitted to the OIG that impeded oversight efforts. Errors in removing all trainees' failing proficiency test scores and then not disclosing that the data were removed (and were possibly unreliable) had led to misreporting more favorable pass rates than those initially calculated internally—from 44 to 89 percent. VA concurred with two OIG recommendations to provide guidance to program staff on providing timely, accurate, and complete responses to OIG requests and encouraging direct staff-level communication to resolve questions. VA also agreed to consider whether administrative action should be taken concerning the conduct of the two leaders responsible.

ALLEGED UNAUTHORIZED ACCESS OF A VA SENIOR EXECUTIVE'S EMAIL NOT SUBSTANTIATED

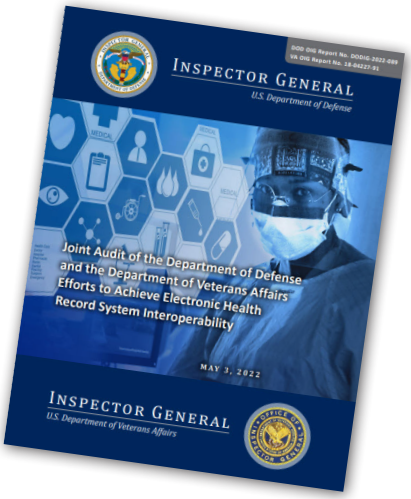
The OIG investigated an allegation that an attorney at the Board of Veterans' Appeals (BVA) may have accessed a BVA senior executive's government email account without permission, including email concerning a personnel matter involving the attorney. The complaint further alleged that the attorney should have known that access to the materials in the executive's email account was not authorized. The allegations were not substantiated, and the attorney has since left VA employment.

ALLEGED FAILURES TO ADEQUATELY EQUIP EXECUTIVE PROTECTION PERSONNEL ARE SUBSTANTIATED IN PART

This administrative investigation found that VA had not procured ballistic body armor (vests) for some personnel in VA's Executive Protection Division (EPD) despite a standard operating procedure requiring them to use their vests regularly in conducting their duties. VA did not have procedures to ensure EPD personnel promptly received suitable initial or replacement vests; to enforce their compliance with the requirement to wear a vest; or to track the fit, condition, or body armor warranty information. Based on available evidence, the OIG could not substantiate that senior leaders in the Office of Operations, Security, and Preparedness had denied previous vest procurement requests or knew that some personnel needed them. Conflicting testimony and lack of supporting documentation also meant the OIG could not substantiate allegations that EPD special agents' firearms were frequently malfunctioning and needed to be replaced. VA concurred with the OIG's five recommendations, including four focused on improvements in policies and procedures relating to the procurement, approval, tracking, and use of ballistic armor, and enforcement of the procedures. The final recommendation called for the assessment of firearms currently assigned to EPD special agents to determine whether any of them need to be replaced.

Reviews and Other Projects

JOINT AUDIT OF THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS EFFORTS TO ACHIEVE ELECTRONIC HEALTH RECORD SYSTEM INTEROPERABILITY



This joint audit led by the DoD OIG examined actions taken by DoD and VA to implement the Cerner Millennium EHR system throughout VA. The audit assessed internal controls and compliance with legal requirements, as well as actions by DoD, VA, and their joint Federal Electronic Health Record Modernization (FEHRM) Program Office to help ensure that healthcare providers serving veterans can access a patient's complete medical history—spanning from the start of military service through VA healthcare engagement. The audit found that some actions were taken to achieve interoperability between DoD, VA, and external healthcare providers, but challenges remain. DoD and VA did not consistently migrate information from legacy systems into the Cerner Millennium system to create a single, complete patient electronic health record (EHR); develop interfaces from all medical devices to the system; or ensure users were granted access to Cerner Millennium only for information needed for their duties. Contributing to these deficiencies was the fact that the FEHRM Program Office did not develop a clear plan to achieve full interoperability or actively manage the program's success. The audit report recommended that DoD and VA review FEHRM's actions and direct the program office to comply with its charter and applicable laws. The FEHRM should also coordinate with DoD and VA on implementing recommendations that include (1) determining the type of healthcare information that constitutes a complete EHR; (2) implementing a plan for accurately migrating legacy healthcare information; (3) creating medical device interfaces to directly transfer healthcare information to Cerner Millennium; and (4) executing a plan to modify system user roles to ensure their access is restricted to only information needed to perform their duties. This joint project led by OSR relied heavily on subject matter expertise from the VA OIG's Offices of Healthcare Inspections and Audits and Evaluations.

CONCERNS WITH CONSISTENCY AND TRANSPARENCY IN THE CALCULATION AND DISCLOSURE OF PATIENT WAIT TIME DATA[18]

In June 2021, a complainant alleged that the then acting principal deputy under secretary for health had been informed in the fall of 2019 that VHA's reporting on patient wait times for appointments may be misleading, but no responsive action was taken. OSR, working with OIG auditors, found no evidence of an intent or effort to mislead related to wait time reporting. This management advisory memo detailed, however, that VHA has employed varying methodologies for calculating wait times reported online since 2014 and for determining whether wait time criteria are met for community care program eligibility. The methodologies deviated in some cases from VHA's scheduling directive and its stated wait time measures announced in 2014. As a result, VHA has used inconsistent start dates that affect the overall calculations without clearly and accurately presenting that information publicly. This memo served to alert VA of the problems identified regarding wait time calculations and reporting.

Listen to the *Inside Oversight* podcast episode for this report.

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

18 This VA management advisory memorandum is a joint publication with the OIG's Office of Audits and Evaluations and is also listed in OAE's results section on page 42. The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses.

Overview

OAE produced 91 publications during this reporting period. These focus on issues that have a meaningful effect 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.

91
Publications

282
Recommendations

$1B
Monetary Benefits

Featured Publications

The following four publications provide examples of the type of work OAE staff conduct that focuses on identifying problems and making recommendations that can result in significant changes within VA and for the veterans it serves.

SUICIDE PREVENTION COORDINATORS NEED IMPROVED TRAINING, GUIDANCE, AND OVERSIGHT

As part of VHA's suicide prevention strategy, VA medical facilities' suicide prevention coordinators are required to reach out to veterans referred from the Veterans Crisis Line. Coordinators facilitate access to assessments, interventions, and effective care; encourage veterans to seek treatment, benefits, or services from VA or in the community; and follow up to connect veterans with appropriate supports after the call. The OIG conducted a review to evaluate whether coordinators properly managed crisis line referrals to ensure at-risk veterans were being reached. The review team found that coordinators mistakenly closed some veteran referrals due to inadequate training, guidance, and oversight. VHA also lacked comprehensive performance metrics to assess coordinators' management of crisis line referrals, which was particularly important given coordinators' lack of clear guidance from VHA's Office of Mental Health and Suicide Prevention. Until VHA provides appropriate training, issues adequate guidance, and improves performance metrics, coordinators could miss opportunities to reach and assist at-risk veterans. The OIG made five recommendations that include improving data integrity, training coordinators on using patient outcome codes, developing additional guidance, monitoring compliance with requirements to space calls over three days, and evaluating program data for additional opportunities to improve services for referred veterans. The under secretary for health concurred (or concurred in principle) with all recommendations and submitted action plans to address each of them.

Listen to the *Inside Oversight* podcast episode for this report.

TWO REPORTS ON BURN PIT EXPOSURE

About 3.5 million veterans since 1990 have served in areas that potentially exposed them to airborne hazards and open burn pit toxins, which have been associated with significant health problems. Following the recent passage of the PACT Act, which expands VA benefits and health care for veterans exposed to burn pits and other toxic substances, the demands on both VBA and VHA are expected to

escalate. The following reports highlight issues involving VBA's burn pit–related claims processing and VHA's airborne hazards and open burn pit registry exam program.

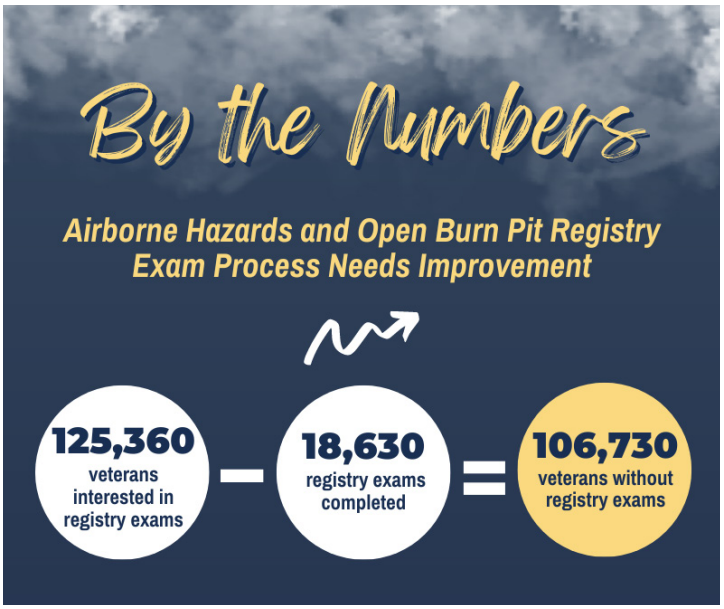
1. VETERANS PREMATURELY DENIED COMPENSATION FOR CONDITIONS THAT COULD BE ASSOCIATED WITH BURN PIT EXPOSURE

VBA staff processed more than 21,100 claims from June 2007 through September 2021 related to the burn pits used by the US military in Iraq, Afghanistan, and Djibouti. The OIG examined whether VBA staff followed regulations and procedures when processing those claims. Based on statistical samples, the OIG generally found burn pit–related claims that were granted were done so correctly, but that denials were premature. Seven recommendations were made to VBA to improve the processing of burn pit–related claims, including correcting four errors for improperly granted conditions, and reviewing and correcting prematurely denied claims. VBA should also update its adjudication procedures manual to provide separate and specific guidance for handling burn pit exposure claims and modify its medical examination request application to add burn pit fact sheet language. Finally, VBA should update training materials and ensure they are consistent with guidance.

Listen to the *Veteran Oversight Now* podcast episode for these reports.

2. AIRBORNE HAZARDS AND OPEN BURN PIT REGISTRY EXAM PROCESS NEEDS IMPROVEMENT

The OIG reviewed the management of VHA's airborne hazards and open burn pit registry exam program and found the 140-item questionnaire was not clear and oriented for veterans to easily use. Veterans did not always realize from the questionnaire and related information that they were responsible for scheduling their own exams. Improvements in the registry exam process would help ensure more eligible and interested veterans receive them, which became increasingly important since August 2021 when VA established a presumptive "service connection" for respiratory conditions due to exposure to particulate matter, such as asthma, sinusitis, and rhinitis. The OIG recommendations included revising the questionnaire to be more veteran-centric, identifying whether veterans with unscheduled exams are still interested in one, and implementing processes and metrics to ensure exams are completed. In addition, VHA should develop guidance to make certain that responsible parties review and discuss performance data and enhance registry information systems.



IMPROVED PROCESSING NEEDED FOR VETERANS' CLAIMS OF CONTAMINATED WATER EXPOSURE AT CAMP LEJEUNE

The Agency for Toxic Substances and Disease Registry estimates that, from August 1953 through December 1987, one million individuals could have been exposed to contaminated drinking water at Camp Lejeune, a US military training facility. In March 2017, VA established a presumption of military service connection for eight illnesses related to veterans' exposure to that contaminated water. The OIG conducted this review to determine whether VBA staff followed regulations when processing and deciding claimed conditions potentially associated with contaminated water exposure at Camp Lejeune. Based on a statistical sample, the OIG estimated that of 57,500 Camp Lejeune–related claims for VA disability compensation benefits decided during the review period (March 14, 2017–March 31, 2021), VBA staff incorrectly processed 21,000. The two main errors were prematurely denying claims (17,200) by not sending required letters to veterans requesting evidence needed to document exposure and assigning incorrect effective dates for benefit entitlement (2,300 claims). Approximately 1,500 additional incorrectly processed claims involved technical or procedural errors. Premature denial of claims increased the risk that some veterans did not receive the benefits to which they were entitled, and veterans were underpaid at least $13.8 million in benefits over nearly four years because VA regional office staff did not assign the earliest effective date for benefits entitlement. The OIG found that errors were less likely to occur at the Louisville Regional Office, which processes most Camp Lejeune–related claims, as staff from other VA regional offices lacked experience processing these claims. The OIG recommended that VBA centralize all Camp Lejeune–related claims processing at the Louisville Regional Office or implement a plan to mitigate the error rate disparity with other regional offices. VBA should also conduct targeted quality reviews of Camp Lejeune–related claims from all regional offices processing these claims.

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.

THE ELECTRONIC HEALTH RECORD MODERNIZATION (EHRM) PROGRAM DID NOT FULLY MEET THE STANDARDS FOR A HIGH-QUALITY, RELIABLE SCHEDULE

VA has projected its EHRM program will be completed in FY 2028 and interoperable with the DoD system to provide a continuous health record for veterans. VA needs a high-quality, reliable integrated master schedule to successfully complete the program within that time and avoid potential cost overruns of about $1.95 billion for each year of delay. The OIG audited the EHRM program's master schedule for compliance with scheduling standards and identified reliability weaknesses that included missing tasks, no baseline schedule, and no risk analyses. VA also did not comply with the Federal Acquisition Regulation (FAR) when it paid its contractor for deliverables before accepting them (reviewing them for compliance with contract requirements). VA concurred with the OIG's six recommendations to ensure the development of a more reliable integrated master schedule and to comply with the FAR.

ATLANTA VA HEALTH CARE SYSTEM'S UNOPENED MAIL BACKLOG WITH PATIENT HEALTH INFORMATION AND COMMUNITY CARE PROVIDER CLAIMS

Backlogged mail at the Atlanta VA Health Care System in Decatur, Georgia

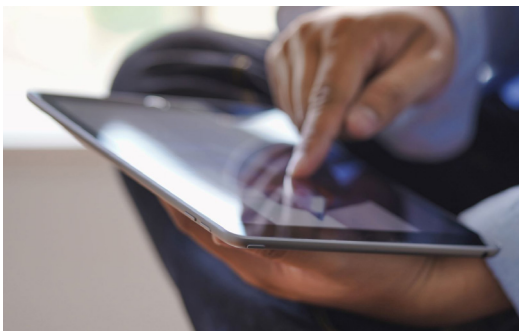
In September 2021, the media reported on large quantities of unopened mail stored in the warehouse basement of the Atlanta VA Medical Center. An OIG review found the Atlanta VA Health Care System (HCS) and VHA's Payment Operations and Management (POM) mismanaged incoming mail starting in November 2020, resulting in a 10-month backlog of more than 17,000 mailed items. The mail included veterans' medical records, claims for payment from veterans and community care providers, and checks totaling nearly $207,000. The mail backlog followed a verbal agreement that transferred POM's responsibility for mail to HCS personnel, despite affected staff's exclusion from the preceding discussions. HCS leaders lacked a clear understanding of the additional workload they assumed and did not ensure enough staff were adequately prepared for managing the influx of mail. POM officials were later reluctant to help, citing the verbal agreement. VA concurred with the OIG's five recommendations, including addressing all negative consequences and facilities' ongoing transfers of mail responsibility.

PURCHASES OF SMARTPHONES AND TABLETS FOR VETERANS' USE DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic accelerated efforts by VHA to expand telehealth. Accordingly, VHA created a new "digital divide" consult to issue iPhones to veterans experiencing homelessness who were enrolled in the Department of Housing and Urban Development VA Supportive Housing Program. VHA was already loaning iPads through the consult process to other veterans who lacked telehealth-capable devices. The OIG initiated this review to evaluate whether purchases of iPads and iPhones for veterans during the pandemic met mission needs. The OIG found that VHA incurred approximately $2.3 million in wasted data plan costs while the devices remained in storage. The OIG recommended that VHA establish a realistic goal and a process for monitoring days in storage and determine the viability of initiating data plan charges only when a device is issued to the veteran.

DIGITAL DIVIDE CONSULTS AND DEVICES FOR VA VIDEO CONNECT APPOINTMENTS

The OIG evaluated the efficiency and effectiveness of VHA's digital divide consult process that provides eligible patients with video-capable devices (iPads). The review found the program was successful in distributing devices to patients but identified gaps in oversight and guidance involving unused and multiple devices and the purchase of new ones while others awaited refurbishment. VHA could have made better use of about $14.5 million in program funds with better controls and oversight. The OIG made 10 recommendations to the under secretary for health, including alerting the requesting clinic that a patient can be scheduled, ensuring staff are trained on program changes, adding procedures to address duplicate devices, designating responsible officials to monitor appointment activity and device use, defining lead oversight responsibilities, establishing an automated report identifying unused devices,



enhancing tracking of device packages, and implementing detailed device refurbishment reporting to inform new device purchases.

VHA CONTINUES TO FACE CHALLENGES WITH BILLING PRIVATE INSURERS FOR COMMUNITY CARE

The OIG's audit was conducted to determine how effectively VHA billed private insurers for community care costs unrelated to military service. The OIG found the billing process was ineffective, estimating that more than half of billable claims over a three-year period were not submitted before filing deadlines expired. As a result, VHA did not collect an estimated $217.5 million that should have been recovered during the audit period. This total is estimated to grow to $805 million by the end of FY 2022 if VHA does not implement corrective action. Although officials were broadly aware of those problems, their responses were insufficient to correct them. The OIG recommended VHA develop procedures that prioritize processing to meet insurers' filing deadlines and strengthen its controls to ensure information needed to process bills for reimbursement is complete and accurate. VHA should also assess staff resources and workload to sufficiently align them to process the anticipated volume of claims to be billed.

Listen to the *Inside Oversight* podcast episode for this report.

CONCERNS WITH CONSISTENCY AND TRANSPARENCY IN THE CALCULATION AND DISCLOSURE OF PATIENT WAIT TIME DATA[19]

In June 2021, a complainant alleged that the then acting principal deputy under secretary for health had been informed in the fall of 2019 that VHA's reporting on patient wait times for appointments may be misleading, but no responsive action was taken. The OIG found no evidence of an intent or effort to mislead related to wait time reporting. This VA management advisory memo detailed, however, that VHA has employed varying methodologies for calculating wait times reported online since 2014 and for determining whether wait time criteria are met for community care program eligibility. The methodologies deviated in some cases from VHA's scheduling directive and its stated wait time measures announced in 2014. As a result, VHA has used inconsistent start dates that affect the overall calculations without clearly and accurately presenting that information publicly. This memo served to alert VA of the problems identified regarding wait time calculations and reporting.

VA MEDICAL FACILITIES TOOK STEPS TO SAFEGUARD REFRIGERATED PHARMACEUTICALS BUT COULD FURTHER REDUCE THE RISK OF LOSS

VA reportedly lost about $1.1 million in January 2019 because medical facilities failed to maintain appropriate storage temperatures for refrigerated pharmaceuticals, prompting VHA to issue requirements about responsibilities, processes, and procedures for safeguarding them. The OIG conducted an audit to determine if VA medical facilities met those requirements and found they generally stored the drugs safely. VA medical facilities reported about $1.7 million in losses for FY 2021 out of about $1.4 billion spent on refrigerated pharmaceuticals, which the OIG acknowledges is relatively minimal. Pharmacy Benefits Management Services officials agreed that medical facility officials should strengthen and reinforce safeguards to further reduce the risks of loss or of veterans receiving compromised medications or vaccines. The OIG recommended the under secretary for health reinforce requirements for storing refrigerated pharmaceuticals and establish a procedure to help ensure medical facilities comply with VHA Notice 2021-16, "Storage of Vaccines and Medications in Pharmaceutical Grade

19 This VA management advisory memorandum is a joint publication with OSR and is listed in OSR's results section on page 37.

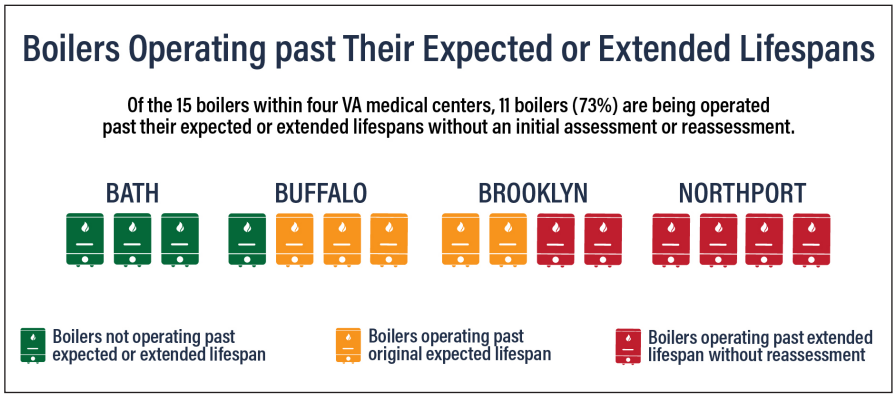
Purpose-Built Refrigerators and Freezers at VA Medical Facilities." Guidance should also be updated to clarify that medical facilities must report all refrigerated pharmaceutical losses.

HOME IMPROVEMENTS AND STRUCTURAL ALTERATIONS PROGRAM NEEDS GREATER OVERSIGHT

This audit assessed the VHA Home Improvements and Structural Alterations Program's effectiveness in providing medically necessary improvements and alterations to primary residences for eligible veterans. The audit team determined that from FY 2017 through FY 2021 the program overpaid roughly 2,600 veterans by an estimated $10.6 million of the total $206 million (about 5 percent). The program also paid about $935,000 for improvements not supported by diagnostic or medical justification as required. In some cases, eligibility information for the benefit was confusing or incorrect on associated VHA websites. VHA also did not create procedures to effectively monitor medical facilities' adherence to program timelines. The OIG made five recommendations to improve oversight of this program by strengthening guidance and documentation of eligibility, clarifying eligibility information, and creating procedures to monitor adherence to program timelines.

NEW YORK/NEW JERSEY VA HEALTH CARE NETWORK (VISN 2) SHOULD IMPROVE BOILER MAINTENANCE TO REDUCE SAFETY RISKS AND PREVENT CARE DISRUPTIONS

The OIG conducted this audit to determine whether VISN 2 effectively followed VA policy when inspecting and maintaining boiler plants. VISN 2 was selected because data from FY 2021 showed it had the most boiler plant components requiring maintenance and deficiencies associated with those being operated past their expected lifespans. The OIG found that VISN 2 did not fully comply with VHA Directive 1810 regarding the useful life assessments of boilers and the testing and inspection of boiler plant operations. Additionally, VHA leaders lacked information necessary for effective oversight. The report details six recommendations for facilities to manage the inspection and maintenance of boiler plants more effectively, including ensuring boilers in need of useful life assessments are evaluated for safe operation.



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. Reports issued during this review period follow.

ADDITIONAL ACTIONS CAN HELP PREVENT BENEFIT PAYMENTS BEING SENT TO DECEASED VETERANS

VBA provides monthly disability compensation or pension benefits to eligible veterans. To ensure that payments properly stop when there is a record of a veteran's death, VBA primarily relies on an automated process called the "death match." In conducting a limited evaluation, the OIG team reviewed three samples of data and determined that VBA was unaware its systems failed to complete one automated weekly death match, which resulted in payments continuing for 43 veterans after their deaths. VBA's electronic systems also contained incorrect social security numbers for 87 of 140 veterans in the OIG sample, which may also result in compensation or benefit payments continuing after those veterans' deaths. VBA also could have minimized improper payments to 121 deceased veterans by obtaining death notification data from VHA. The OIG made three recommendations to improve VBA's death match process and help prevent improper payments.

PROCESSING OF POST-9/11 GI BILL SCHOOL VACATION BREAKS AFFECTS BENEFICIARY PAYMENTS AND ENTITLEMENT

In this audit, the OIG found that VBA did not always accurately process vacation breaks for post-9/11 GI Bill students. An estimated 2,500 of 10,000 enrollments should have been adjusted but were not. Insufficient training and guidance meant school certifying officials frequently made mistakes. About 790 of the estimated errors involved officials either not reporting or underreporting vacation breaks. VBA claims examiners often mishandled enrollments even with the correct information. The OIG estimated that claims examiners incorrectly processed vacation breaks that were accurately reported for about 1,700 of the 2,500 enrollments with vacation break errors. Those estimated 2,500 enrollments resulted in about 14,400 days of undercharges to students' entitlement and about $624,000 in underpayments for monthly housing allowances and college funds. The five report recommendations included that VBA should update guidance and training for school certifying officials. In addition, VBA should submit amended enrollments for identified reporting errors for remedial action.

CONTRACT MEDICAL EXAM PROGRAM LIMITATIONS PUT VETERANS AT RISK FOR INACCURATE CLAIMS DECISIONS

OAE staff reviewed VBA's contract medical disability exam program and found that governance of and accountability for the program need to improve. Limitations with VBA's management and oversight of the program at the time of the review caused identified deficiencies to persist. VBA should enhance the program to help ensure vendors produce accurate exams to support correct decisions for veterans' claims. Some of the vendors' exams have not met contractual accuracy requirements. As a result, processors may have used inaccurate or insufficient medical evidence to decide veterans' claims. The OIG made four recommendations, including holding vendors contractually accountable for unsatisfactory performance and establishing procedures for vendors to correct errors. VBA's Medical Disability Examination Office should also improve its process to communicate errors and analyze all available data to identify systemic errors and trends.

SAFEGUARDING PII COLLECTED IN VBA EDUCATION COMPLIANCE SURVEYS

This review revealed that survey records for VA educational programs submitted remotely during the pandemic lacked sufficient protection for students' personally identifiable information. This VA management advisory memorandum conveyed information to help VBA determine the need for corrective actions. On March 16, 2020, VBA required in-person surveys to be conducted remotely and documents to be submitted electronically as COVID-19 precautions. About 4,570 surveys were conducted during a two-year period, with record requests for an estimated nearly 37,800 students.

OAE staff reviewed documents for 30 of those surveys and found 26 contained the personally identifiable information of 323 students, including full names, dates of birth, social security numbers, and addresses. Lack of standard procedures and oversight resulted in personally identifiable information not being consistently safeguarded as required. The OIG did not assess whether information had been inappropriately disclosed. VBA agreed to review and evaluate the OIG's findings and take needed corrective action.

THE FUGITIVE FELON BENEFITS ADJUSTMENT PROCESS NEEDS BETTER MONITORING

This OAE review found that VBA did not always adjust compensation and pension benefit payments for veterans who were fugitive felons. For example, VBA did not process fugitive felon cases in 2012 and 2013. Further, due to inadequate monitoring, it did not process about 46 percent of fugitive felon cases referred by the OIG in 2019 and 2020. As a result, some veterans may have received funds to which they were not entitled. In addition, due to a previously unnoted deficiency with VBA's automated letters, some veterans were not informed of their legal rights and potentially had their benefits improperly suspended. VBA concurred with the OIG's three recommendations to review unprocessed felony referrals, improve monitoring procedures, and ensure necessary information is provided to veterans, and also provided information on the actions taken to address these recommendations.

THE COMPENSATION SERVICE COULD BETTER USE SPECIAL-FOCUSED REVIEWS TO IMPROVE CLAIMS PROCESSING

Given the importance of accurately deciding veterans' claims for disability benefits, VBA includes in its quality assurance efforts special-focused reviews that target specific topics, such as military sexual trauma claims. The OIG assessed VBA's design and implementation of its special-focused review process and identified weaknesses in all five of the Government Accountability Office's (GAO) internal control components when determining whether VBA had met GAO standards. Among its findings, the OIG determined that the standard operating procedure for special-focused reviews did not provide sufficient guidance to fully support claims-processing improvement—including requiring that the causes of identified errors be included in final reports. The OIG made six recommendations to the under secretary for benefits, including that VBA update the special-focused review standard operating procedure to require an analysis of why errors occurred and establish controls to ensure reports communicate both benefit entitlement and procedural errors and that corrective actions are taken on all errors.

VBA COULD IMPROVE THE ACCURACY AND COMPLETENESS OF MEDICAL OPINION REQUESTS FOR VETERANS' DISABILITY BENEFITS CLAIMS

VBA has committed an estimated $6.8 billion in contracts to complete disability examinations and medical opinions over a five-year period starting in 2016. Because medical opinion requests can be vital to ensuring veterans receive the proper disability compensation benefits, the OIG examined whether staff correctly followed procedures when requesting medical opinions. The review revealed that VBA can help reduce inadequate medical opinions, incorrect or delayed claims decisions, and wasted resources by improving internal controls, personnel training, and monitoring of medical opinion requests. VBA concurred with OIG recommendations to (1) implement electronic system enhancements for identifying relevant evidence before a medical opinion request can be submitted, (2) enhance mandated training for all claims processors and then demonstrate that the training is achieving its intended impact, and (3) strengthen monitoring by refining quality review processes to help identify areas for improvement and show advancements in complying with required procedures.

VBA IMPROPERLY CREATED DEBTS WHEN REDUCING VETERANS' DISABILITY LEVELS

This review examined retroactive reductions in disability levels that affected veterans' compensation benefits. The review team found instances in which VBA employees erroneously created about $13.4 million in debts without always informing veterans. Some veterans were not given an opportunity to dispute the debts or request waivers and were likely unaware they did not receive all their benefits. Errors generally occurred because VBA's electronic system did not show employees each time a debt was created. VA concurred with the OIG's four recommendations, including correcting identified errors. VBA should also review all compensation awards completed since January 1, 2020, with debts related to reduced disability levels, and take appropriate action. Updating VBA's electronic system could make it easier for employees to see when their actions create a debt for veterans. Finally, VBA should conduct periodic reviews to determine whether recommendations were effectively implemented, or additional measures are needed.

VA DID NOT PROVIDE SOME VETERANS LEGALLY REQUIRED NOTICE AND DUE PROCESS BEFORE COLLECTING DEBTS FOR THE COMPENSATION PROGRAM

The OIG identified three scenarios in this related VA management advisory memorandum for which VA improperly collected debts from veterans without first providing them with legally required notice and due process. In all these scenarios, VBA changed veterans' benefits in ways that resulted in retroactive reductions in payment rates and debts for veterans to repay. VA improperly collected those debts by reducing retroactive payments or future monthly payments due to the veteran—without notifying veterans of the debt amount or of their right to dispute it or request a waiver. VA agreed the debts were collected improperly due to automated actions in the electronic debt management systems. In response, VBA commented that it plans to implement system upgrades to prevent veterans in similar circumstances from being subjected to improper debt collection and being denied notice and due process.

REQUIRED MEDICAL REEXAMINATIONS CANCELED

In a July 2018 report, the VA OIG found VBA disability claims processors did not consistently follow policy requiring that veterans' medical reexaminations be requested only when necessary. In response, VBA reduced the number of unwarranted reexaminations with the creation of "batch jobs" intended to automatically cancel reexaminations that meet certain parameters. However, the OIG found in this VA management advisory memorandum that VBA carried out two batch jobs that mistakenly included statutorily required reexaminations that should not have been canceled. As a result, affected veterans potentially received incorrect monthly compensation benefits. After the OIG raised concerns, VBA suspended a scheduled batch job and reestablished workload controls to determine if reexaminations were necessary. Since VBA took action, the OIG did not further review the batch jobs and provided this advisory memorandum for VBA leaders to further research and determine if additional actions are warranted. The OIG requested information on any further corrective actions taken.

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.[20]

RESULTS OF CONSULTING ENGAGEMENT RELATED TO SELECTED FINANCIAL REPORTING CONTROLS FOR THE INTEGRATED FINANCIAL AND ACQUISITION MANAGEMENT SYSTEM AT THE NATIONAL CEMETERY ADMINISTRATION

The OIG contracted with CliftonLarsonAllen LLP (CLA) for consulting services regarding selected financial reporting controls for the Integrated Financial and Acquisition Management System (iFAMS) at NCA. VA is implementing iFAMS using an incremental approach, with the first deployment having occurred at NCA in November 2020. The nature and scope of work were determined solely by agreement between the OIG and CLA and did not constitute an audit. In its consulting letter, CLA provided the OIG with observations and potential risks in such categories as obligations, reconciliations, opening balances, procurement, and intragovernmental transactions. The OIG shared this letter with VA management officials for their awareness.

REVIEW OF VA'S COMPLIANCE WITH THE PAYMENT INTEGRITY INFORMATION ACT FOR FISCAL YEAR 2021

The Payment Integrity Information Act of 2019 requires federal agencies to review all programs and activities they administer that may be susceptible to significant improper payments based on Office of Management and Budget guidance. The OIG reviewed whether VA complied with the law in FY 2021 and found that VA reported improper and unknown payment estimates totaling $5.12 billion for seven programs and activities. Though VA had an overall decrease in total improper payments and unknown payments, the overall monetary loss more than doubled from $892 million in FY 2020 to $1.97 billion. Though VA satisfied nine of the law's 10 requirements, it failed to report an improper and unknown payment rate of less than 10 percent for four programs and activities that had estimates in materials accompanying their financial statements. The OIG recommended the under secretary for health reduce improper and unknown payments to below 10 percent for those noncompliant programs.

FINANCIAL EFFICIENCY REVIEW OF THE VA EL PASO HEALTHCARE SYSTEM IN TEXAS AND NEW MEXICO

This financial efficiency review—the first of four published during this reporting period—assessed the oversight and stewardship of funds by the VA El Paso Healthcare System and identified potential cost efficiencies in carrying out medical center functions. The financial activities and administrative processes examined to determine whether the healthcare system had appropriate oversight processes and controls were for open obligations, purchase card use, Medical/Surgical Prime Vendor–Next Generation program use, and pharmacy operations. The review team identified several opportunities for the healthcare system to improve oversight and ensure the appropriate use of funds. The OIG made 12 recommendations to the VA El Paso Healthcare System director to use as a road map to improve financial operations. The recommendations address issues that, if left unattended, may interfere with effective financial efficiency practices and the strong stewardship of VA resources.

FINANCIAL EFFICIENCY REVIEW OF THE VA BOSTON HEALTHCARE SYSTEM IN MASSACHUSETTS

The second financial efficiency review focused on the VA Boston Healthcare System, specifically looking at open obligation oversight, purchase card usage, inventory and supply management, and pharmacy

20 Pub. L. 101-576.

operations. The team found 35 percent of open obligations sampled were not reviewed to see if they were still valid and necessary; 28 percent of tested purchase card transactions were intentionally split to stay below the cardholder's single purchase limit rather than purchased through contracts; amounts of stock on hand were insufficient in more than 70 percent of tested cases due to inaccurate inventory system entries; and the pharmacy drug turnover rate was low because pharmacy technicians were unable to properly forecast needed drug inventories. The OIG made eight recommendations to improve the stewardship of VA resources and address issues that could adversely affect patient care.

FINANCIAL EFFICIENCY REVIEW OF THE VA BLACK HILLS HEALTH CARE SYSTEM IN SOUTH DAKOTA

The third review examined how the VA Black Hills Health Care System in South Dakota was also overseeing and spending funds and potential cost efficiencies in carrying out its functions. The same financial activities and administrative processes were evaluated as the prior report. The review team identified opportunities for improvement in all areas. The OIG made seven recommendations to redress issues that could interfere with effective financial practices and VA resource stewardship.

FINANCIAL EFFICIENCY REVIEW OF THE VA CINCINNATI HEALTHCARE SYSTEM

In the final financial efficiency review of this reporting period, the OIG assessed the VA Cincinnati Healthcare System's oversight and stewardship of funds. The team examined whether appropriate controls and oversight were in place. Among the findings were that reviews were not completed for some obligations; the healthcare system did not comply with policy and did not meet the utilization goal; and the pharmacy's efficiency could be improved. The report has eight recommendations to the system director to ensure staff (1) review open obligations and pharmacy invoice reconciliations; (2) develop a plan to address adequate stock for system needs; (3) submit prime vendor waiver requests; (4) obtain approval before purchasing items from nonprime vendors; (5) use tools that related prime vendor performance concerns and challenges; (6) develop processes for efficiency and use data to make business decisions; (7) develop and implement a plan to increase inventory turnover; and (8) develop a plan to complete facility-based inventory audits.

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 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 (FISMA) of 2014, as well as IT security evaluations conducted as part of the consolidated financial statements audit.[21] VA did not concur with recommendations from three of the following nine reports. More information on these nonconcurrences can be found in table A.8 on page 95.

21 Pub. L. No. 113-283.

MISSION ACCOUNTABILITY SUPPORT TRACKER LACKED SUFFICIENT SECURITY CONTROLS

Following a May 2021 hotline complaint, the OIG evaluated the merits of an allegation that VBA disregarded privacy procedures so it could more quickly use a workload tracking system without receiving the appropriate security authorization. The Mission Accountability Support Tracker (MAST) helps quantify the work VBA staff do in response to employee requests for support services. Staff enter personally identifiable information into the system, which could be compromised in an unauthorized, unsecure application. The OIG found that VBA and the Office of Information and Technology (OIT) did not correctly assess the privacy impact, misclassified MAST, and lacked authority to operate MAST before using it. The report's four recommendations included ensuring future IT projects follow an approved management process and providing sufficient guidance to staff to make certain that MAST is used as intended, while keeping the personally identifiable information of VA employees and contractors safe and secure.

VA NEEDS TO IMPROVE GOVERNANCE OF IDENTITY, CREDENTIAL, AND ACCESS MANAGEMENT PROCESSES

Acting on another hotline complaint, the OIG reviewed whether VA was effectively governing its identity, credential, and access management (ICAM) processes and found that VA was not complying with Office of Management and Budget requirements. This was primarily because leaders of the different offices performing VA's ICAM functions had not agreed on how it should be governed. Without proper governance, VA risks both restricting information from users who need it to perform their job functions and leaving information vulnerable to improper use. The OIG recommended the VA deputy secretary designate roles and responsibilities for all program offices involved in the ICAM process and ensure appropriate oversight and coordination. The OIG also recommended that the assistant secretary for information and technology and the assistant secretary for human resources and administration/operations, security, and preparedness update and publish the VA directives and handbooks associated with identity and access management, common employee identification standards, and VA's personnel security and suitability program.

FEDERAL INFORMATION SECURITY MODERNIZATION ACT AUDIT FOR FISCAL YEAR 2021

The OIG again contracted with CLA to evaluate VA's information security program for FY 2021 for compliance with FISMA. CLA evaluated 50 major applications and general support systems hosted at 24 VA sites and on the VA Enterprise Cloud. CLA concluded that VA continues to face challenges meeting requirements and made 26 recommendations, some for repeat deficiencies. CLA recommended that VA address security-related issues that contributed to the IT material weakness reported in the FY 2021 audit of VA's consolidated financial statements; improve deployment of security patches, system upgrades, and system configurations; and enhance performance monitoring. CLA will follow up on the outstanding recommendations in the FY 2022 audit of VA's information security program.

VETERANS DATA INTEGRATION AND FEDERATION ENTERPRISE PLATFORM LACKS SUFFICIENT SECURITY CONTROLS

VA is required by law to ensure veterans' sensitive personal information is safely shared across a highly fragmented healthcare system. The OIG audited whether OIT developed and implemented the Veterans Data Integration and Federation Enterprise Platform's (VDIF) security controls to ensure confidentiality, data integrity, and the safeguarding of sensitive health information according to federal standards. The OIG found OIT let VDIF become operational without effectively executing all required risk management framework steps. OIT inappropriately categorized some security objectives (resulting in 22 important

controls not being applied) and did not adequately determine whether the implemented controls were correctly applied. Because of insufficient oversight, VDIF became operational with inadequate security controls, heightening the risk to personal health information within more than 10 million veteran records. VA did not concur with OIG recommendations to reestablish VDIF to ensure appropriate high-level controls but agreed to more effectively oversee establishing and monitoring security controls to ensure proper processes are followed.

VA IS MOVING TOWARD FULL COMPLIANCE WITH GEOSPATIAL DATA COVERED AGENCY RESPONSIBILITIES

Following up on a January 2021 report titled *VA Needs to Comply Fully with the Geospatial Data Act of 2018*, the OIG conducted this audit to determine whether VA—one of the "covered agencies" identified in the Geospatial Data Act—complied with the law's 12 applicable requirements. Geospatial data are tied to a location on the earth and are identified by geographic location and characteristics of natural or constructed features and boundaries. VA uses geospatial data to support budget, strategic planning, and policy decisions to provide health care, benefits, and burial services to veterans. The OIG found VA met nine of the 12 requirements. VA has taken steps toward compliance, but all necessary actions have not been completed for requirement 1 (prepare and implement a strategy for advancing geospatial data activities appropriate to the agency's mission) and requirement 3 (promote geospatial data integration). Although VA was previously compliant with requirement 9, it has not met additional recommended criteria to protect personal privacy and maintain confidentiality. The OIG recognizes the complexity of integrating multiple geographic information systems across the agency. In light of the significant progress VA has made to comply with the act's requirements, the OIG made no recommendations for improvement but encourages VA to complete its planned actions to ensure compliance.

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE CONSOLIDATED MAIL OUTPATIENT PHARMACY IN DALLAS, TEXAS

During this reporting period, the OIG conducted four IT inspections, which assess whether VA facilities are meeting federal security requirements. They are typically conducted at selected facilities that have not been assessed in the annual FISMA audit or at facilities that previously performed poorly. In the first IT inspection, the OIG selected the Dallas Consolidated Mail Outpatient Pharmacy (CMOP) because it had not been previously visited as part of the OIG's annual FISMA audit. The inspections focus on configuration management, contingency planning, security management, and access controls. Deficiencies were found by the inspection team in configuration management and access controls, but none in contingency planning or security management controls. The report includes 10 recommendations to the Dallas CMOP director intended to fix the control deficiencies. The assistant secretary for information and technology provided comments for the Dallas CMOP. The assistant secretary concurred with nine recommendations but did not concur with one recommendation to implement an effective vulnerability and flaw remediation program. The nonconcurrence was attributed to OIT claims of being able to demonstrate vulnerability identification, remediation, mitigation, and management rates of 96 percent for all critical and high vulnerabilities at the Dallas CMOP. However, the OIG found there was insufficient evidence to support that assertion and stands by its recommendation.

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

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE CONSOLIDATED MAIL OUTPATIENT PHARMACY IN TUCSON, ARIZONA

The OIG conducted its second IT inspection at the Tucson CMOP and found that the pharmacy had inaccurate component inventories, ineffective vulnerability management, and inadequate flaw remediation. The pharmacy also had not implemented the configuration management plan, lacked a disaster recovery plan, had not changed the default username and password for the security camera system, and did not consistently generate or forward audit records. Without these controls, critical systems may be at risk of unauthorized access or destruction. Six recommendations were directed to the Tucson CMOP director to implement (1) effective inventory management tools, (2) an effective vulnerability and flaw remediation program, and (3) a disaster recovery plan. The director was also called on to (4) ensure CMOP staff understand their roles and responsibilities, (5) task the facility manager with changing the security camera system passwords, and (6) ask OIT to configure audit logging. The assistant secretary for information and technology again did not concur with the recommendation to implement a more effective vulnerability and flaw remediation program.

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE ALEXANDRIA VA MEDICAL CENTER IN LOUISIANA

In its third IT inspection of the reporting period, which took place at the Alexandria VA Medical Center, the OIG found deficiencies with configuration management, security management, and access controls. The configuration management deficiencies included inaccurate inventories, uninstalled patches, and out-of-date operating systems—all of which deprive users of reliable access to information and risk the alteration or destruction of critical systems and unauthorized access. The security management deficiency could affect the integrity and protection of the center's video surveillance system. Weak physical access controls compromised the security and maintenance of the information system, and an outdated operating system prevented accurate tracking of access to the data center. The assistant secretary for information and technology and chief information officer concurred with the OIG's eight recommendations, which included implementing a more effective process to maintain consistent inventory information, additional configuration control processes, database authentication processes that comply with VA security requirements, and a physical access control security system that meets VA security standards. Recommendations also addressed improving the vulnerability and flaw remediation program; ensuring proper installation of network equipment and conducting routine maintenance on uninterruptible power supplies; and performing security control assessments for the video surveillance system.

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE HARLINGEN VA HEALTH CARE CENTER IN TEXAS

The final IT inspection found deficiencies at the Harlingen VA Health Care Center's component inventory, vulnerability management, and system life-cycle management. The center had an inaccurate component inventory; unsupported versions of applications, missing patches, and vulnerable plug-ins; and weaknesses in the network that had gone unidentified. Additionally, the center used unsupported applications and had deficiencies in contingency planning and access controls. If these deficiencies are not addressed, users will not have assurance that the system and network will perform as intended, and the center's response to incidents could be impeded. The OIG made four recommendations to the assistant secretary for information and technology and chief information to implement more effective programs and processes related to (1) maintaining consistent inventory information for all network segments, (2) managing vulnerability, (3) improving the system life cycle, and (4) retaining database logs

for a period consistent with VA's record retention policy. One recommendation was also made to the center's director to validate that appropriate physical and environmental security measures are executed.

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 helps ensure 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.

CONTRACT CLOSEOUT COMPLIANCE NEEDS IMPROVEMENT AT REGIONAL PROCUREMENT OFFICES CENTRAL AND WEST

In FY 2020, the OIG published a report on contract closeout compliance at the regional procurement office (RPO) East. Because of problems identified there, the OIG examined whether RPO Central and RPO West contracting officers adequately performed and documented contract closeout requirements. When contracting officers do not follow the necessary steps to close out contracts, they increase future financial and legal risk to the government. The OIG reviewed a random sample of contracts and found that contracting officers at the two RPOs did not adequately perform required closeout duties. Reasons included unclear policies and systems, ineffective oversight of the process, and heavy workload. Recommendations to the executive directors for RPO Central and RPO West were to establish consistent quality assurance reviews, balance contracting officer workload, update guidance on simplified acquisition procedures, consider additional strategies to ensure contract closeout compliance, and verify that the contract files for the 81 sampled contracts have complete closeout documentation.

INADEQUATE ACCEPTANCE OF SUPPLIES AND SERVICES AT REGIONAL PROCUREMENT OFFICE WEST RESULTED IN $12.8 MILLION IN QUESTIONED COSTS

The OIG also reviewed whether RPO West contracting officials administered contracts and accepted supplies and services in accordance with federal and VA regulations and found they did not always maintain documentation to demonstrate proper acceptance of supplies and services. Several factors contributed to noncompliance, including officials not understanding their responsibilities, heavy workload, ineffective oversight, and the prioritization of awarding contracts. This noncompliance resulted in $12.8 million in questioned costs. Until VHA improves oversight of contracting officials and ensures their compliance with federal regulations, it lacks assurance that veterans are receiving critical supplies and services. The OIG made eight recommendations to RPO West's executive director to strengthen contract administration. These measures included establishing controls to ensure electronic files are created for all contracts requiring a representative, completing delegation memoranda when required, and making certain that representatives upload required acceptance documentation. The executive director should also assess existing contracts for compliance and correct as needed.

BUY AMERICAN ACT COMPLIANCE DEFICIENCIES AT REGIONAL PROCUREMENT OFFICE CENTRAL

This audit of RPO Central evaluated its compliance with the Buy American Act of 1933 and associated guidance. The audit team reviewed contracts and related files created from October 2017 through March 2021 and chose 40 contracts for foreign-made items and another 40 for domestic items. The team also examined internal compliance reviews. The OIG determined that insufficient oversight and training

resulted in about $280.6 million spent on foreign-made items and $351 million on domestic items using contracts not compliant with the Buy America Act. RPO Central reviewers failed to identify deficiencies in almost 75 percent of the reviewed foreign-made contracts. Contracting officers indicated training did not address all of the act's complexities. In addition, RPO Central's executive director did not fully implement recommendations from a 2017 internal VA review. The OIG recommended the VA Office of Acquisition and Logistics' executive director evaluate policies and procedures to make certain they require heads of contracting offices to assess compliance weaknesses identified by internal reviews, implement corrective actions, and require refresher training for contracting officers responsible for the deficiencies identified by internal reviews. The OIG also recommended the VHA procurement executive director evaluate contract file review procedures to strengthen oversight of compliance with the act.

VA'S COMPLIANCE WITH THE VA TRANSPARENCY AND TRUST ACT OF 2021 SEMIANNUAL REPORT: SEPTEMBER 2022

The VA Transparency and Trust Act of 2021 outlines oversight of emergency relief fund spending. VA must provide Congress a detailed plan outlining its intent and justification for obligations. The OIG must, in turn, submit reports comparing how VA is obligating and expending covered funds to VA's plans. Two prior OIG report recommendations remained open when this report was published in mid-September 2022: (1) consult with VA officials to determine whether Coronavirus Aid, Relief, and Economic Security (CARES) Act funds used for a cemetery project violated the purpose statute, and remedy if violated and (2) determine obligations to sustain essential information technology, update the obligation schedule, provide Congress an updated spend plan, and include this information in biweekly updates. In this second report, the OIG found VA generally complied with the act, but VA's spend plan and biweekly reports could be improved. VA expected spend plan changes in September 2022 and that when a modern financial system management is implemented, errors will be reduced.

Reviews of VA Contracts and Vendor Proposals

OAE provides VA's Office of Acquisition, Logistics, and Construction (OALC) with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, staff provide advisory services for OALC contracting activities and conduct healthcare preaward reviews for VHA. During this reporting period, the OIG issued 47 of these unpublished reports, which are released only to the contracting officer because of the proprietary and privacy information they contain. In the interest of transparency, the OIG published the two following reports summarizing the issues identified in some of the FY 2021 unpublished reviews.

A SUMMARY OF PREAWARD REVIEWS OF VA FEDERAL SUPPLY SCHEDULE PHARMACEUTICAL PROPOSALS ISSUED IN FISCAL YEAR 2021

The VA OIG reviews pharmaceutical proposals submitted to the VA National Acquisition Center for Federal Supply Schedule contracts valued annually at $5 million or more. This report summarizes the 15 preaward reviews of the pharmaceutical proposals that the OIG conducted in FY 2021. The 15 proposals had a cumulative 10-year estimated contract value of about $8.3 billion and included a total of 846 offered drug items. The review team concluded, in part, that commercial disclosures were accurate, complete, and current for four of the 15 proposals reviewed. This means only those four disclosures were reliable for determining negotiation objectives and for fair and reasonable pricing. The remaining 11 proposals could not be reliably used for negotiations until the noted deficiencies were corrected. The OIG made recommendations for lower prices than offered for 10 of the 15 proposals by also examining comparable "tracking customers," resulting in total recommended cost savings of approximately $328.8 million over

the life of the contracts. Of that total, about $42.6 million in cost savings resulted from the Acquisition Center awarding contracts or modifications based on the OIG price recommendations. This report details the actions the OIG took in these reviews but does not propose any additional VA corrective actions.

SUMMARY OF FISCAL YEAR 2021 PREAWARD REVIEWS OF HEALTHCARE RESOURCE PROPOSALS FROM AFFILIATES

The OIG completed 32 preaward reviews of sole-source healthcare proposals in FY 2021 and identified about $102.5 million in potential cost savings, with at least $44 million in sustained cost savings as of March 2022. This report summarizes the OIG's prior findings and recommendations for costs underlying proposed hourly rates, offered per-procedure prices, and potential conflicts of interest. For 27 of the 29 proposals that included hourly rates, the prices offered to the government were higher than the supported amounts for costs such as provider salaries, administrative expenses, fringe benefits amounts, and malpractice insurance premiums. The OIG also determined the four proposals with per-procedure pricing all offered prices higher than properly calculated Medicare rates. In addition, 22 proposals had potential conflicts of interest that warranted an opinion from VA's Office of General Counsel on whether these individuals would have a financial interest in the proposal.

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. The 29 preaward reviews identified approximately $123.6 million in potential cost savings during this reporting period. In addition to and Architect/ Engineer Services proposals, preaward reviews during this reporting period included 13 healthcare provider proposals, accounting for approximately $82 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.[22] Postaward reviews resulted in VA recovering contract overcharges totaling more than $5.1 million and nearly $2.3 million in better use of funds, including approximately $1.2 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 18 postaward reviews performed, six involved voluntary vendor disclosures. In five of the six 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.

22 Pub. L. No. 102-585.

Claim Reviews

The OIG assists contracting officers when contractors have filed claims against VA. The objective of these reviews is to determine the validity of 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 (responsible 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.[23] During this reporting period, the VA OIG did not issue any reports meeting these requirements.

23 Pub. L. No. 110-181.

Overview

During this reporting period, OHI published 19 healthcare inspection reports and four 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 medication management, pharmacy deficiencies, care coordination, community living centers (CLCs), and leadership. The office published 17 Comprehensive Healthcare Inspection Program (CHIP) reports—including two VISN-level and 12 facility-level reports, two summary reports drawn from all inspected facilities, and one COVID-19 pandemic readiness and response report. The CHIP reports are drawn 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. In addition, OHI published its first Care in the Community report that examined key clinical and administrative processes associated with providing quality VA and community care. 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.

41
Publications

2,233
Hotline Referral Reviews

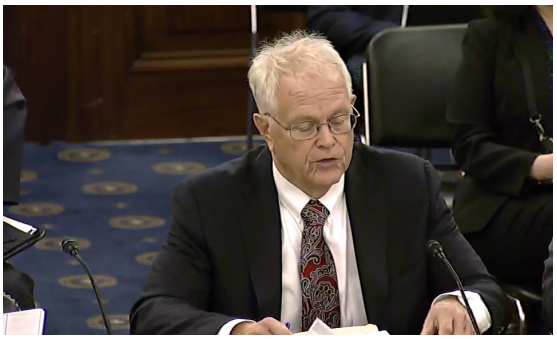
3
In-depth Clinical Consultations

Featured Publications

Highlighted below are three OHI 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 that is delivered with compassion and respect..

THE NEW ELECTRONIC HEALTH RECORD'S UNKNOWN QUEUE CAUSED MULTIPLE EVENTS OF PATIENT HARM

This national review assessed a safety concern with the new EHR system that resulted in patient harm. The OIG found that the new EHR system sent thousands of orders for medical care to an undetectable location, or unknown queue, instead of to the requested location for service delivery. In December 2021, VHA assessed the risk of the unknown queue as "major severity," "frequently occurring," and "very difficult to detect," and recognized immediate mitigation was needed. Oracle Cerner (the contractor developing the system) failed to inform VA end-users of the existence of this queue and put the burden on VHA to mitigate the problem. Beginning in June 2021, VHA staff spent substantial time completing clinical reviews to assess patient risk and harm related to the unknown queue and found the unknown queue caused



Deputy Inspector General David Case testifying at the hearing on "Examining the Status of VA's Electronic Health Record Modernization Program" on July 20, 2022.

149 patient harm events. In late 2021, VHA staff provided the deputy secretary and the executive director for VA's EHRM effort with information on the unknown queue safety issue and identified patient harm. Each facility that goes live with the new EHR will require an ongoing commitment from facility staff to monitor and address the unknown queue. While Oracle Cerner and VHA took actions to minimize orders being routed to the unknown queue, the OIG found more than 200 orders in the queue in May 2022 and remains concerned with the effectiveness of Oracle Cerner's plan to mitigate the safety risk that it poses.

FAILURE TO PROVIDE EMERGENCY CARE TO A PATIENT AND LEADERS' INADEQUATE RESPONSE TO THAT FAILURE AT THE MALCOM RANDALL VA MEDICAL CENTER IN GAINESVILLE, FLORIDA

The OIG conducted an inspection to review the care of an unresponsive patient by emergency department staff and the subsequent action of leaders at the Malcom Randall VA Medical Center, following the patient's death at a university hospital. The inspection team found the VA medical center's emergency department nurses failed to provide emergency care to an unresponsive patient who arrived by ambulance. Despite emergency medical services (EMS) personnel having relayed the criticality of the patient's condition while en route to the facility and the limited patient identifying information available, emergency department nurses and an administrative officer of the day wasted critical time determining whether or not the patient was a veteran (which the patient was) rather than on patient care. As a result, EMS personnel reloaded the patient into the ambulance for transport to the university hospital. The VA emergency department nurses disregarded EMS personnel's patient status report, failed to recognize the patient's emergency medical condition, and inaccurately assessed the patient's condition. The OIG also identified deficiencies in nursing competencies and confirmed that the competency folders for two nurses did not contain the 2019 Ongoing Competency Assessments as required. Although the emergency department nurse educator provided newly created, backdated competency assessment documentation for these two nurses, the inspection team did not consider these "replicated" documents to be acceptable forms of verification that the competency assessments were actually completed by the two nurses. The facility had prior instances of VHA Emergency Medical Treatment and Labor Act related policy violations in 2019, resulting in emergency department staff being required to complete related training. The actions implemented by medical center leaders to address concerns were not effective in preventing the occurrence of additional patient incidents, and delays in the provision of emergency care to patients continued. The OIG made one recommendation to the VISN director regarding consideration of administrative action and reporting to state licensing boards. The OIG made four recommendations to the medical center director on prioritizing emergency patient care and nursing competencies.

CARE IN THE COMMUNITY HEALTHCARE INSPECTION OF VA MIDWEST HEALTH CARE NETWORK (VISN 23)

The OIG's new Care in the Community healthcare inspection program examines clinical and administrative processes associated with providing quality outpatient healthcare to veterans. This report provides a focused evaluation of VISN 23 and its oversight of the quality of care delivered in community-based outpatient clinics and through its community care referrals to non-VA providers. Although it is difficult to measure the value of well-delivered and coordinated care between VA and non-VA providers, the findings in this report may help VISN leaders identify vulnerable areas of community care that, if properly addressed, should improve healthcare quality for veterans. The OIG reviewed care coordination for congestive heart failure management, primary care, and mental health (diagnostic evaluations following positive screenings

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for depression or alcohol misuse). The team also examined the quality of home dialysis care and mammography care, including the communication of results. The report included three recommendations for improvement: (1) completing initial and annual home visits for patients accepted into the VISN 23 home dialysis program, (2) monitoring the quality of home dialysis contracted clinical services, and (3) receiving timely procedure results from community providers.

National Healthcare Reviews

During this reporting period, the OIG published four national healthcare reviews. In addition to the EHR unknown queue publication discussed above, these reports focus on VA healthcare personnel's emotional well-being support during the pandemic, the Intimate Partner Violence Assistance Program, and occupational staffing shortages. Healthcare inspection staff continued to work on several other national reviews that address such topics as veteran suicide prevention efforts through firearms access and safe storage discussions (and documentation of those discussions) and VHA's Intensive Community Mental Health Recovery program.

THE VETERANS HEALTH ADMINISTRATION NEEDS TO DO MORE TO PROMOTE EMOTIONAL WELL-BEING SUPPORTS AMID THE COVID-19 PANDEMIC

The OIG reviewed how VHA addressed the emotional well-being of employees during the COVID-19 pandemic, and performed an overview of programs developed and deployed in response to the pandemic. The review team interviewed VA and VHA leaders and then deployed a survey focused on VHA guidance regarding employees' emotional well-being during the pandemic, available resources, monitoring those resources, and employees' use of them. The National Center for Organization Development (NCOD) created a COVID-19 consultation process for VHA leaders in a supervisory role. The consult with NCOD provided counseling to VHA leaders about leadership skills in a virtual environment, communication, and employee support needs. The Organizational Health Council team also developed a COVID-19 employee support toolkit and other resources. Several program offices independently generated and disseminated pandemic-related employee well-being resources. The OIG's survey identified that awareness of employee emotional well-being supports generally diminished the less senior the position. Also, leaders and employees made little use of resources and employees perceived leaders' support to be inadequate. The OIG recommended that the under secretary for health review the processes by which COVID-19 emotional well-being resources were developed and disseminated and take action as needed to increase staff awareness of these resources.

INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM IMPLEMENTATION STATUS AND BARRIERS TO COMPLIANCE

The OIG reviewed the Intimate Partner Violence Assistance Program (IPVAP) implementation status and perceived barriers to compliance. More than half of VHA facilities were not using the required IPVAP protocol. IPVAP coordinator work may be a collateral duty, with 82 percent of IPVAP coordinators reporting more than half of their time was dedicated to fulfilling the role. Most coordinators also reported providing training at fewer than half the new employee orientation sessions and to fewer than half the intimate partner violence screeners. Fourteen percent of IPVAP coordinators reported not implementing routine intimate partner violence screening. VHA did not establish standardized program evaluation methods or measures, and VISN champions identified the need for clearer role expectations, mandatory screening, and a designated VISN IPVAP coordinator. About half of VISN lead coordinators reported dissatisfaction with VISN champion support. The OIG made seven recommendations to the under secretary for health on developing protocols at medical centers, evaluating the sufficiency of guidance

and operational status regarding IPVAP coordinators' dedicated time and population needs, determining guidance for dedicated administrative staff support, establishing standardized intimate partner violence staff training as well as evaluating training efficacy, developing intimate partner violence screening requirements, expediting program evaluation processes, and evaluating guidance related to the roles and oversight functions of the VISN IPVAP champions and lead coordinators.

OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES, FISCAL YEAR 2022

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and nonclinical occupations experiencing staffing shortages within VHA. This is the ninth iteration of the staffing report, and the fifth evaluating facility-level data. The information evaluated for this report was compared to the previous four years. The OIG found that every VHA facility identified at least one severe occupational staffing shortage. Every year since 2014, the medical officer and nurse occupations were identified as severe occupational shortages. Practical nurse was the most frequently reported clinical severe occupational staffing shortage, and custodial worker was the most frequently identified nonclinical severe staffing shortage. In FY 2022, facilities reported 22 percent more severe occupational staffing shortages than in FY 2021. Additionally, FY 2022 was the first time that facilities identified more than 90 occupations as severe shortages.

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Healthcare Inspections

These inspections (often previously referred to as including "hotlines") assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. During this reporting period, the OIG published 19 healthcare inspections, involving serious harm to one or more patients (including the featured report above on failure to provide appropriate emergency care to a patient in a Gainesville, Florida, VA medical facility), 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.

FACILITY LEADERS' RESPONSE TO INAPPROPRIATE MENTAL HEALTH PROVIDER–PATIENT RELATIONSHIPS AT THE VA ILLIANA HEALTH CARE SYSTEM IN DANVILLE, ILLINOIS

This inspection evaluated leaders' responses to the knowledge of inappropriate provider–patient relationships. Facility leaders took initial actions to address three inappropriate relationships between mental healthcare providers (providers A, B, and C) and their respective patients. However, effective facility leader actions to investigate and address the inappropriate relationships of providers A and B occurred only after an Office of Accountability and Whistleblower Protection complaint. Facility leaders ineffectively addressed provider C's inappropriate relationship before the involved patient died by overdose. Facility leaders failed to report provider A to the appropriate professional certification board, did not report providers B and C to their state licensing boards in a timely manner, and did not address the circumstances that contributed to the overdose death. The OIG made one recommendation to the VISN 12 director related to evaluating processes that facility supervisors should take to identify and address inappropriate relationships. The OIG also made two recommendations to the facility director regarding timely reporting of providers to state licensing or certification boards, and reviewing the

deceased patient's care to determine whether provider C's actions or inactions were contributing factors and, if so, whether institutional disclosure is warranted.

DEFICIENCIES IN LIFE-SUSTAINING TREATMENT PROCESSES AT THE MICHAEL E. DEBAKEY VA MEDICAL CENTER IN HOUSTON, TEXAS

The inspection team substantiated an allegation that a CLC nurse at the medical center in Houston delayed life-sustaining treatment for a patient who was experiencing cardiac arrest and died, and that a second patient had resuscitation initiated by inpatient staff despite an active do not resuscitate (DNR) order. The team identified additional concerns related to the use of DNR armbands and the suspension of DNR orders in the operating room. The OIG made one recommendation to the under secretary for health to review DNR processes and five recommendations to the facility director related to staff (1) verifying in patients' electronic record any life-sustaining treatment orders and code statuses, (2) evaluating corrective actions from management reviews, (3) locating life-sustaining treatment orders within the health record, (4) modifying patients' life-sustaining treatment orders, and (5) reviewing patients' code statuses when they returned to facility units after surgical procedures.

INADEQUATE DISCHARGE COORDINATION FOR A VULNERABLE PATIENT AT THE PORTLAND VA MEDICAL CENTER IN OREGON

The OIG assessed allegations that staff inappropriately discharged a patient with a severe cognitive impairment, "turned away" the patient, and failed to provide the patient's records to Adult Protective Services (APS), a county government office that investigates abuse of adults ages 60 and older. A patient came to the emergency department with gangrene and had a history of alcohol use, cognitive impairment, and experiencing homelessness. Approximately one hour after discharge, the patient returned to the emergency department a second time. A social worker provided the patient with a bus ticket "to return to the shelter." The OIG did not substantiate the patient was inappropriately discharged and was unable to determine whether staff discussed the patient's discharge plan with family. The OIG did substantiate that staff did not establish a safe transportation plan after the patient returned after being discharged. Finally, the OIG did not substantiate that staff failed to provide the patient's records to APS. The VISN and facility directors concurred with the OIG's three recommendations, which were related to requiring staff to document family contacts, conducting a review of the emergency department social worker's care coordination of this patient, and Privacy Office staff communicating the missing elements needed to complete a release of information request when returning it to the requestor.

DEFICIENCIES IN FACILITY LEADERS' OVERSIGHT AND RESPONSE TO ALLEGATIONS OF A PROVIDER'S SEXUAL ASSAULTS AND PERFORMANCE OF ACUPUNCTURE AT THE BECKLEY VA MEDICAL CENTER IN WEST VIRGINIA

The inspection team examined the oversight that VA conducted of a healthcare provider who engaged in sexual misconduct targeting patients and who practiced acupuncture without credentials or privileges. The team also reviewed leaders' awareness and responses to these allegations. Identified deficiencies included the inadequate supervision of the provider and that former facility leaders did not act on their initial awareness of the provider's sexual misconduct toward patients, refusal to use chaperones, and performance of acupuncture without credentials and privileges. VISN leaders initiated an administrative investigation to determine if the complaints related to the sexual misconduct were addressed; however, not all complaints were reviewed. Whether the provider performed acupuncture on patients was also not reviewed. After the OIG expressed concerns to VISN leaders that no review had been conducted, the VISN subsequently commenced a review of the provider's patients to identify those who received

acupuncture and initiated clinical and quality management corrective actions. The OIG made five recommendations related to incomplete administrative investigation board actions, oversight, quality management actions, training, and reporting providers to state licensing boards.

NONCOMPLIANT AND DEFICIENT PROCESSES AND OVERSIGHT OF STATE LICENSING BOARD AND NATIONAL PRACTITIONER DATA BANK REPORTING POLICIES BY VA MEDICAL FACILITIES

This report focuses on VA medical facilities' compliance and processes regarding VHA policies for reporting healthcare professionals to state licensing boards and the National Practitioner Data Bank (NPDB). The OIG found widespread noncompliance with state and national board reporting processes applied by facilities to healthcare professionals whose conduct or competence led to separation from employment. Failures were related to staff misunderstanding policies, poor facility practices, and a lack of VHA programmatic oversight. Additionally, conflicting language between VHA policies and federal regulation contributed to NPDB reporting noncompliance. The OIG made four recommendations to the under secretary for health regarding ensuring state licensing board and NPDB reporting compliance and programmatic oversight, as well as aligning NPDB policy with federal regulation.

FAILURE TO COMMUNICATE AND COORDINATE CARE FOR A COMMUNITY LIVING CENTER RESIDENT AT THE VA GREATER LOS ANGELES HEALTH CARE SYSTEM IN CALIFORNIA

The OIG assessed allegations that CLC nursing staff failed to assess a resident, document assessments or interventions, and implement the healthcare provider's order. The inspection team substantiated that a nurse delayed an assessment and failed to document other assessments, interventions, and a telephone order to transfer the resident to the emergency department. The resident did not have the needed equipment when admitted to the CLC, and facility staff failed to conduct a comprehensive review of the events surrounding the resident's death. The VISN and facility directors concurred with the OIG's 10 recommendations, which included completing and documenting an institutional disclosure; reviewing policy and admission processes; and conducting training for CLC staff regarding documentation, assessments, procedures for managing verbal and telephone orders, hand-off communication policies, the joint patient safety report submission process, and administrative reviews.

QUALITY OF CARE CONCERNS AND LEADERS' RESPONSES AT THE AMARILLO VA HEALTH CARE SYSTEM IN TEXAS

This report details the OIG's examination of allegations related to hypertension treatment and post-stroke care, nursing staff communications, and telephone communications processes. While the OIG could not determine from the documentation whether delays in treatment for hypertension and headaches caused the patient's stroke, the OIG found the care provider and clinic nurse failed to ensure the patient received urgent medical attention after presenting to the clinic with stroke-like symptoms in early 2021. The OIG did not substantiate allegations regarding problems with cardiology and neurology consults, a licensed vocational nurse, or telephone communications processes. There was insufficient evidence to determine whether nurses' communications were dismissive and condescending. However, multiple leaders were identified as having failed to assess and follow through on the provider's ongoing quality of care deficits, which resulted in patients experiencing adverse outcomes. The OIG recommended the VISN director assess the system leaders' actions related to professional practice evaluations. The system leader received five recommendations, including ensuring emergency department staff follow established protocols; evaluating the registered nurse's failure to take proper action; reiterating expectations of respectful communications with

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patients; completing a retrospective review of critical view alerts; and making certain that staff follow communication protocols and EHR documentation requirements.

FAILURE TO FOLLOW A CONSULT PROCESS RESULTING IN UNDOCUMENTED PATIENT CARE AT THE CHILLICOTHE VA MEDICAL CENTER IN OHIO

To evaluate allegations related to quality and management of patient care and the availability of resources, the OIG conducted a healthcare inspection at the Chillicothe VA Medical Center. The team found that a patient was referred by an urgent care provider to the Complementary and Alternative Medicine (CAM) Clinic for pain management of a T12 vertebrae compression fracture. However, the urgent care provider delayed entering the consult for eight days, resulting in a chiropractor and clinical massage therapist's inability to review the consult details before treating the patient and documenting that care. The patient returned eight days later with an acute burst fracture and rib fractures. Due to the lack of documentation and provider recall, the OIG was unable to conclusively determine the relationship of the care provided and the bone fractures. The inspection team reviewed nine additional allegations, which were unsupported. The OIG made two recommendations to the facility director related to educating providers, chiropractors, and clinical massage therapists on the use of consults and timely documentation, and conducting an internal review of the CAM program processes related to patient care, reviewing consults, scheduling appointments, checking in patients, and documentation.

DEFICIENCIES IN A BEHAVIORAL HEALTH PROVIDER'S DOCUMENTATION AND ASSESSMENTS, AND OVERSIGHT OF NURSE PRACTITIONERS AT THE VA PITTSBURGH HEALTHCARE SYSTEM IN PENNSYLVANIA

This inspection focused on a behavioral health certified registered nurse practitioner's (BHNP) assessment and documentation practices and leaders' completion of the BHNPs' ongoing professional practice evaluations (OPPEs) at the VA Pittsburgh Healthcare System. The inspection revealed multiple deficiencies in the BHNP's assessment and documentation practices and found adverse clinical outcomes for one of eight patients. The BHNP did not document a comprehensive suicide risk assessment for that patient, as required by The Joint Commission. A nurse manager evaluated the BHNP as "satisfactory" against the OPPE elements regarding their "copy and paste use" and "safety plan completion for high risk for suicide patients" but had not actually evaluated these elements. Recommendations for improvement centered on the BHNP's assessment and documentation practices, better alignment of policy with leaders' expectations related to patients prescribed antipsychotic medications, behavioral health managers' verification of the BHNPs' OPPE reviews, and managers' oversight of those OPPEs.

DEFICIENCIES IN THE CARE OF A PATIENT WHO DIED AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

This report reviews the adequacy of a patient's outpatient care prior to surgery and during preoperative and postoperative care. After surgery, the patient was admitted, suffered alcohol withdrawal and declining health, and died under hospice care. In the months prior to the patient's surgery, primary care staff failed to provide sufficient care coordination and treatment. During the patient's hospital stay, medical-surgical nurses did not consistently assess the patient's alcohol withdrawal symptoms or administer medications according to the facility alcohol withdrawal treatment protocol or according to physician orders. In addition, medical-surgical unit nursing leaders did not have adequate quality controls or training in place to ensure the provision of safe and effective alcohol withdrawal nursing care. Moreover, the alcohol withdrawal protocol could improperly be discontinued before a patient began experiencing withdrawal symptoms. The OIG recommended the VISN director review the provider's

care of the patient. Nine recommendations to the facility director related to same-day care access, communication of test results and treatment plans, assigned surrogates, preoperative care including quality reviews, medical-surgical unit nurses' patient care, Trendelenburg position usage and staff education, nursing competencies for alcohol withdrawal assessments and treatment, medical-surgical unit nurses' quality control oversight, and the facility's alcohol withdrawal treatment protocol.

DEFICITS WITH METRICS FOLLOWING IMPLEMENTATION OF THE NEW ELECTRONIC HEALTH RECORD AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON

The OIG evaluated the availability and utilization of key performance and patient safety metrics more than a year after the Mann-Grandstaff VA Medical Center became the first VHA medical center to implement the new EHR system. With VA's transition to the new EHR, metrics were created by adding the new EHR data to the existing VA data repository and by using the new EHR's functionality. Identified gaps in available metrics were due to the new EHR transition and impaired the facility's ability to measure and act on issues of organizational performance, quality of care and patient safety, and access to healthcare services. Further deployment of the new EHR without addressing these issues may impede the ability of the facility and future sites to provide timely, effective, safe, and veteran-centered care. The deputy secretary concurred with the OIG's recommendations to evaluate gaps in new EHR metrics and the factors affecting their availability, and then taking action as warranted.

MULTIPLE FAILURES IN TEST RESULTS FOLLOW-UP FOR A PATIENT DIAGNOSED WITH PROSTATE CANCER AT THE HAMPTON VA MEDICAL CENTER IN VIRGINIA

This inspection assessed concerns related to a facility providers' failures to communicate, act on, and document abnormal test results that led to a delay in a patient's diagnosis of prostate cancer. The patient, a male in his 60s, was diagnosed with metastatic prostate cancer in April 2021. Previously, in July 2019, a vascular surgeon failed to communicate and act on an abnormal computerized tomography scan. In fall 2020, a primary care provider failed to communicate test results to the patient and to act on an abnormal prostate-specific antigen test result. The primary care provider also failed to correctly enter bone scan orders, and a radiologic technologist incorrectly attempted to correct this error. Consequently, the appropriate care provider was not notified of the results showing diffuse metastatic bone disease. Finally, facility leaders did not initiate quality reviews as required by VHA policy. The OIG made seven recommendations to the facility director related to test results, clarity in urology consults, nuclear medicine orders, patient safety reporting, and initiation of quality management reviews.

FAILURE OF LEADERS TO ADDRESS SAFETY, STAFFING, AND ENVIRONMENT OF CARE CONCERNS AT THE TUSCALOOSA VA MEDICAL CENTER IN ALABAMA

This report details OIG findings that facility leaders in Tuscaloosa failed to address CLC safety and security issues, and fill several key positions. The team did not, however, substantiate allegations that facility leaders failed to use available space to provide care for patients or did not ensure the environment of care and grounds provided a safe setting. The OIG recommended the VISN director ensure VISN site visit recommendations have been completed. Nine recommendations were also made to the facility director to assess CLC security; develop a plan for the coverage, recruitment, and retention of difficult-to-fill positions; and improve facility environmental care rounds.

PHARMACISTS' PRACTICES DELAYED BUPRENORPHINE REFILLS FOR PATIENTS WITH OPIOID USE DISORDER AT THE NEW MEXICO VA HEALTH CARE SYSTEM IN ALBUQUERQUE

The OIG conducted an inspection in response to allegations regarding the policy and practices related to buprenorphine treatment for patients with an opioid use disorder at the New Mexico VA Health Care

System. The team substantiated that pharmacists improperly declined early refills of this treatment based on a policy that was not applicable. The OIG determined that despite providers' rationale for early refills, facility pharmacists' routine practice was to decline early refills of buprenorphine to guard against misuse or diversion of opioids. The OIG determined that pharmacy practice made no delineation between prohibition of early refills of partial opioid agonists, including buprenorphine, for opioid use disorder and full opioid agonists for pain, despite the different indications for each medications' use and associate risks. The Opioid Safety Committee pharmacist was found to have appropriately placed standing orders for urine drug screening, which the scope of practice allowed and part of the facility's implementation of VHA guidance associated with COVID-19 mitigation strategies. The OIG did not substantiate that the Opioid Safety Committee chairperson interfered with prescribing providers' practices, that the buprenorphine standing operating procedure (SOP) was inconsistent with VHA guidance, that practices varied from VHA guidance on increasing buprenorphine access, or that leaders failed to respond to a provider's patient safety concerns. Five recommendations were made to the facility director to align early buprenorphine refill practices with policy, communicate about early medication refills, educate staff about the Opioid Safety Committee, revise the buprenorphine SOP to ensure it is consistent with evidence-based treatment, and review provider staffing.

IMPROVEMENTS IN STERILE PROCESSING SERVICE AND LEADERSHIP OVERSIGHT AT THE EDWARD HINES, JR. VA HOSPITAL IN HINES, ILLINOIS

Following allegations of deficient practices within the Sterile Processing Service (SPS) and associated leadership failures, the OIG did not substantiate allegations of inappropriate reprocessing of reusable medical equipment. The team also did not find SPS standard operating procedures were chaotic and incomplete. Facility action plans from April 2021 had been implemented to address prior SPS deficiencies, and the facility had sustained process improvement actions. The OIG also did not substantiate that SPS leaders failed to provide adequate oversight, quality control, education, and training to SPS staff and did not find SPS leaders or education and training personnel lacked appropriate knowledge to provide staff training. Facility leaders worked with VISN subject matter experts to ensure continuity of SPS leadership when vacancies existed. Both the VISN and facility leaders maintained adequate oversight—identifying and taking actions in response to concerns and providing support for quality improvement efforts within SPS.

REVIEW OF VETERANS HEALTH ADMINISTRATION'S RESPONSE TO A MEDICATION RECALL

This review focuses on VHA's process in responding to a medication recall. The recall included two medications incorrectly packaged together in the same bottle by the distributor. The VHA medication recall process generally met requirements. However, the OIG identified potential vulnerabilities related to monitoring and reporting adverse drug events and variations in the software used to record medication lot numbers. The VHA National Center for Patient Safety monitored communications and responded according to VHA policy requirements. In addition, VHA Pharmacy Benefits Management personnel distributed medication recall safety information to ensure patient notification. The OIG could not, though, determine if VHA monitored all adverse drug events from recalled medications.

COMMUNITY CARE COORDINATION DELAYS FOR A PATIENT WITH ORAL CANCER AT THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS IN FAYETTEVILLE, ARKANSAS

A healthcare inspection was conducted at the Veterans Health Care System of the Ozarks related to community care coordination delays for a patient with oral cancer. The OIG determined that the facility's Office of Community Care (OCC) staff failed to act or delayed taking action on five community care consults resulting in the patient waiting 205 days for surgery. Facility OCC staff failed to coordinate the

patient's radiation therapy and delayed coordinating chemotherapy within the requested timeline. They canceled a community appointment, noting a lack of VHA OCC guidance on community care referrals. The patient was placed on palliative care and died. The OIG made one recommendation to the under secretary for health related to standardizing community care coordination for follow-up requests from community providers and two recommendations to the facility director related to completing consults and coordinating community care.

SURGICAL ADVERSE CLINICAL OUTCOMES AND LEADERS' RESPONSES AT THE COLUMBIA VA HEALTH CARE SYSTEM IN SOUTH CAROLINA

The OIG assessed allegations of adverse clinical outcomes related to three patients' surgical or invasive procedures at the Columbia VA Health Care System. Although all had adverse outcomes, quality-of-care concerns were identified with two patients. The third patient's post-surgical complication had no such concern. In one case, an intensivist (critical care specialist) and surgeon incorrectly placed a chest catheter and tube while attempting to drain a patient's pleural infusion and the care deficiencies led to events contributing to the patient's death. The OIG also found weaknesses in peer review and quality management processes. A vascular surgeon in another case conducted a wrong-site surgery, amputating a patient's third toe instead of the fourth. The surgeon failed to acknowledge and discuss the deviation with the patient and surgical team, and leaders did not address the surgeon's undermining of patient safety protocols. The OIG recommended the VISN director to remain consistent with other summaries facilitate a comprehensive review of the first patient's episode of care. Six recommendations were made to the facility director on admitting and transferring medically complex patients, peer review for quality management practices, timeliness of institutional disclosures and root cause analysis, the vascular surgeon's disregard of patient safety protocols, and informed consent and time-out practices.

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. All CHIP reports are based on inspections that are routinely and proactively performed approximately every three years for each VA medical facility to help examine key conditions and activities on a consistent basis. The OIG then analyzes findings across the individual CHIP reports completed during the fiscal year and, from these analyses, produces CHIP summary reports that provide national-level evaluations that focus on specific areas of care. During this reporting period, the OIG published two such reports, which examine the areas of medication management and care coordination across 45 VHA medical facilities during FY 2021. Additionally, the OIG continued its series of COVID-19-related CHIP summary reports during this reporting period, which aggregate findings from facility-level CHIP inspections, also conducted in FY 2021, that specifically relate to COVID-19 readiness and response. The three CHIP summary reports published during this six-month period are described below.

CHIP Summary Reports

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM SUMMARY REPORT: EVALUATION OF MEDICATION MANAGEMENT IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2021

This report highlights the results of a focused examination of VHA facilities' medication management related to remdesivir (an antiviral medication that has been used to treat some COVID-19 patients). The OIG found that VHA met many elements of expected performance, including the availability

of staff to receive remdesivir shipments. However, VHA did not consistently provide patient and caregiver education for remdesivir or report adverse events to FDA in accordance with emergency use authorization requirements. Given FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the emergency use authorization requirements. However, because VHA facility staff continue to administer other medications under emergency use authorizations, the OIG issued one recommendation related to informing patients and caregivers when the medication is not FDA-approved; the option to refuse the medication; and the known risks, benefits, and alternatives prior to administration.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM SUMMARY REPORT: EVALUATION OF CARE COORDINATION IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2021

The results of a focused evaluation of VHA facilities' care coordination programs centered on interfacility patient transfers. The report describes findings from healthcare inspections performed at VHA medical facilities during FY 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The OIG found general compliance with some of the selected care coordination requirements. However, four recommendations are included to address identified gaps or weaknesses related to facility policies for interfacility transfers, monitoring and evaluation of these transfers, transmission of patients' active medication lists and advance directives to receiving facilities, and communication between nurses at sending and receiving facilities. The OIG recommended that the under secretary for health, in conjunction with VISN directors and facility leaders, ensure (1) written policies are implemented at each facility for the safe, appropriate, orderly, and timely transfer of patients; (2) chiefs of staff and associate directors of patient care services monitor and evaluate all transfers as part of VHA's quality management program; (3) transferring providers send patients' active medication lists and copies of advance directives to receiving facilities during interfacility transfers; and (4) nurse-to-nurse communication occurs during the interfacility transfer process.

COVID-19-Related CHIP Summary Report

COMPREHENSIVE HEALTHCARE INSPECTION OF FACILITIES' COVID-19 PANDEMIC READINESS AND RESPONSE IN VETERANS INTEGRATED SERVICE NETWORKS 2, 5, AND 6

This national-level CHIP report focused on evaluating facilities' COVID-19 pandemic readiness and response within VISNs 2, 5, and 6. Specifically, it examines emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; community living center (nursing home) patient care and operations; facility staff feedback; and VA and the VISNs' vaccination efforts. The OIG has aggregated the findings from its routine inspections and grouped them by VISN. This report, the fourth in a series, provides a snapshot of the pandemic's demands on these facilities' operations during the inspection period, including a review of VA's vaccination statistics. Interviews and survey results provide additional context on lessons learned and perceptions of readiness and response.

VISN- and Facility-Level CHIP Reports

During this reporting period, the OIG issued 12 facility-level CHIP reports, the findings of which were incorporated into two additional VISN-level CHIP reports, all listed in appendix A, table A.2. For CHIP inspections, the OIG selects and evaluates specific areas of focus on a rotating basis each year. In FY 2021—the year in which each of these 12 facility inspections took place—the areas of focus were (1) leadership and organizational risks, (2) COVID-19 pandemic readiness and response, (3) quality, safety, and value, (4) registered nurse credentialing, (5) medication management (remdesivir use), (6) mental health (emergency department and urgent care center suicide risk screening and evaluation),

(7) care coordination (interfacility transfers), and (8) high-risk processes (management of disruptive and violent behavior). The FY 2022 areas of focus are depicted in the illustration below.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS, FY 2022

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—Customer Support, Enterprise Systems, Information Security, and Web Applications—provide nationwide support to personnel, systems development, and integration and perform continuous monitoring to secure OIG systems and data.
- The Diversity, Equity, Inclusion, and Accessibility (DEIA) Division provides programs, services, and tools designed to enhance DEIA awareness throughout the OIG and cultivate an inclusive and equitable work environment.
- 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 60 OIG offices across the country.
- The Training and Development Division coordinates centralized instruction and staff professional development activities.

OMA's DEIA Division released its Strategic Plan for FYs 2022–2026 to OIG staff in April 2022. The plan provides a road map and formalizes the actions the OIG will take to enhance its culture, making it more diverse, equitable, inclusive, and accessible to help every employee experience a sense of belonging.

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. Hotline staff receive, screen, and respond

to complaints regarding VA programs and services. The hotline director also serves as the whistleblower protection coordinator and 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 18,396 contacts from complainants during this reporting period to determine which are immediately directed to OIG offices, the Hotline Division

- referred 552 cases to and required a written response from applicable VA offices as appropriate, after determining that allegations pertained to higher-risk topics but where insufficient resources were available for OIG staff to complete a prompt independent review at that time;
- made 767 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 568 cases for which nearly 39 percent of allegations were substantiated, 509 administrative sanctions and corrective actions were taken, and $1,204,085 in monetary benefits were achieved;
- responded to more than 550 requests for record reviews from VA staff offices; and
- issued 5,443 semicustom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope.[24]

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.

COMMUNICATION LAPSES BETWEEN STAFF OF DAYTON VA MEDICAL CENTER AND A PATIENT'S CAREGIVER LED TO INADEQUATE SOCIAL SERVICES AND POOR CARE MANAGEMENT

A complainant contacted the OIG to allege that a caregiver was providing inadequate care to a veteran patient of the Dayton VA Medical Center in Ohio. The OIG referred this matter to the facility for investigation, which determined that the patient was last seen by a primary care provider in 2019. As a result of the case, the facility's Social Work Service contacted the patient and caregiver to reestablish care. In addition, the local police department conducted a wellness check, which revealed the veteran did not have a bed and was sleeping on a couch. There was also an odor present from an unknown source; however, the police officer confirmed there was food in the house and the veteran had eaten. A report was made with Adult Protection Services due to concerns of neglect. The Social Work Service began working to secure a hospital bed for the veteran and was engaged to work with the caregiver to ensure proper care going forward.

24 The number of hotline contacts exceeds the number of cases because some contacts are resolved over the phone, are made multiple times, involve an issue that is unrelated to VA programs or operations, could be more appropriately addressed in another legal or administrative forum, or were made anonymously via the web and have insufficient information to permit follow-up or referral.

FAILURE TO COMPLY WITH POLICY RELATED TO THE PREVENTION OF AMPUTATION IN VETERANS EVERYWHERE (PAVE) PROGRAM AT THE BECKLEY VA MEDICAL CENTER IN WEST VIRGINIA

The OIG received a confidential complaint alleging that there is no active PAVE program oversight at the Beckley VA Medical Center in West Virginia. The matter was referred to the facility for investigation, which determined that the increased workload in the podiatry clinic made it difficult for the full-time podiatry provider and nurse to comply with VHA policy, including establishing monitoring guidelines for foot checks and foot screenings, and determining the level of risk for limb loss per established performance measure standards. As a result of this case, the facility approved a position for a podiatry mid-level/PAVE coordinator who not only performs these functions but provides additional clinic availability in the podiatry clinic and collaborates with the prosthetics department when deemed clinically necessary to order appropriate prosthetic or orthotic appliances.

POOR FACILITIES MANAGEMENT RESULTS IN DELAYED EMERGENCY RESPONSE TO A PATIENT THREATENING TO COMMIT SUICIDE AT THE WICHITA VA MEDICAL CENTER IN KANSAS

The response to a VA OIG hotline complaint resulted in changes being made to the Wichita VA Medical Center's network-based duress and emergency notification system. The medical center conducted a review and found that a behavioral healthcare provider's duress alarm failed to alert VA police when the provider hit the button nine times after a patient threatened suicide by gun in the provider's office. Although the provider's duress alarm failed, the provider telephoned VA police and they responded. When they arrived, the patient had already left the premises. A welfare check was conducted, and the patient was found unharmed. The medical center has since begun transitioning to a more reliable emergency notification system that allows users to activate the duress alarm even when not logged into their computers.

DELAYED SCHEDULING FOR RETURN-TO-CLINIC APPOINTMENTS RESULTED IN A BACKLOG AT THE PRINCETON, WEST VIRGINIA, COMMUNITY-BASED OUTPATIENT CLINIC

A complainant alleged patients of the VA clinic in Princeton, West Virginia, experienced delays in care due to a backlog of orders for return-to-clinic appointments. Princeton VA clinic's parent facility, the Beckley VA Medical Center, conducted an independent review of the allegations and identified all patients seen at the Princeton VA clinic from January 1, 2020, to December 31, 2021. The review found some patients experienced a wait time greater than 60 days from the patient indicated date (the date the patient communicates to VA they would like to be seen). In response to the findings, the Princeton VA clinic implemented several corrective actions to address issues that led to the backlog for scheduling follow-up appointments. These included directing resources from the medical center to help the clinic reduce their backlog, facility leadership developing a daily checklist for medical support assistants to certify requirements were met, establishing a new local standard operating procedure for how medical support assistants process orders and other documents, and eliminating unnecessary processes of providers.

INADEQUATE PATIENT SUPERVISION RESULTS IN A PATIENT'S ELOPEMENT FROM RALPH H. JOHNSON VA MEDICAL CENTER'S MENTAL HEALTH UNIT IN CHARLESTON, SOUTH CAROLINA

The response to a hotline complaint resulted in multiple preventative strategies being implemented at the Ralph H. Johnson VA Medical Center. The medical center substantiated an OIG-conveyed complaint that alleged a patient eloped (left without authorization) from an inpatient mental health unit by entering a utility closet with a self-closing and self-locking door, dropping down a laundry chute, and exiting the building. The elopement was not detected for approximately two hours. Staff worked with community

responders and a probate court to return the patient to the inpatient unit where the course of treatment was completed without further incident. The medical center has since implemented multiple preventative strategies to reduce the risk for future incidents of elopement. These strategies include installation of a lock on the laundry chute; modification to the medical center's safety observations standard operating procedure to specify a patient's identity must be verified and three breaths must be observed during each 15-minute check; installation of a visual alarm on the door to the utility room; requiring patients assigned to the unit to wear scrubs with a unique color; purchasing and installing a patient elopement monitoring system on the unit; and requiring all staff assigned to the unit to complete the annual mental health environment of care training.

VETERAN FRAUDULENTLY RECEIVED INDIVIDUAL UNEMPLOYABILITY BENEFITS WHILE MAINTAINING GAINFUL EMPLOYMENT

A confidential complainant reported that a veteran was collecting disability benefits related to unemployability despite being gainfully employed. A review of the VA benefits database revealed that the veteran had been in receipt of benefits since 2009. OIG hotline staff referred the matter to the St. Louis Regional Office for further investigation. The regional office determined that the veteran had been working since 2010 and had submitted false information on more than one occasion related to both his employment status and the status of his dependents. As a result of these findings, the veteran's claim was adjusted to retroactively discontinue individual unemployability benefits from 2010 to 2015; the veteran's dependents were removed from eligibility for benefits for the same period; and an overpayment of almost $178,000 was created. This matter was disclosed to OIG investigators but was declined for prosecution because the five-year statute of limitations precluded pursuing criminal charges against the subject for conduct that occurred before August 2016.

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

DEPUTY INSPECTOR GENERAL TESTIFIES ON THE ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM BEFORE THE HOUSE VETERANS AFFAIRS' SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

Deputy Inspector General David Case testified before the House Committee on Veterans Affairs' Subcommittee on Technology Modernization on April 26, 2022. His testimony focused on VA's progress deploying the new patient EHR. He highlighted the OIG's recent reports on issues regarding the user and veteran experience at the Mann-Grandstaff VA Medical Center (the initial operating site) in Spokane, Washington. He also spotlighted the overall program's lack of a reliable implementation schedule that makes VA vulnerable to annual cost overruns of nearly $2 billion. Deputy Inspector General Case answered questions about the medication management challenges that VA staff have faced; significant training deficiencies, which led system users feeling unprepared at deployment; the OIG definition of patient harm for oversight purposes; and the need for VA to develop an integrated master schedule that identifies all work to be done, accounts for infrastructure upgrades and improved training, and includes a risk assessment.

INSPECTOR GENERAL TESTIFIES BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS ON THE QUALITY OF VA'S HEALTH CARE

Inspector General Michael J. Missal testified before the Senate Committee on Veterans' Affairs on May 11, 2022. His testimony focused on the challenges VA faces in providing quality care to patients, particularly during the COVID-19 pandemic and the implementation of the new EHR system. Emphasizing the importance of patient safety, he stated that inconsistent or ineffective leadership cultivates a complacent and disengaged medical facility culture, making the VHA goal of "zero patient harm" improbable without a cultural transformation. Mr. Missal's testimony also focused on the unprecedented challenges VHA faces regarding the hiring of skilled healthcare workers in the aftermath of the pandemic, emphasizing the need for staffing models to support hiring decisions

Inspector General Michael J. Missal speaks with West Virginia Senator Joe Manchin III prior to the start of a Senate Committee on Veterans' Affairs hearing on the quality of VA health care.

as well as decisions related to enhancing community care networks to meet the demands of the veteran population. Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for Healthcare Inspections, also attended the hearing. Both Mr. Missal and Dr. Kroviak responded to questions about OIG reports and findings related to facility leadership.

TESTIMONY BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION AND SENATE COMMITTEE ON VETERANS' AFFAIRS ROUNDTABLE ON INFORMATION TECHNOLOGY AND CYBERSECURITY

Mike Bowman, Director of Information Technology and Security in the OIG Office of Audits and Evaluations, testified before the House Veterans' Affairs Subcommittee on Technology Modernization on June 7, 2022. The hearing focused on VA's progress toward implementing a robust cybersecurity program and the difficulties VA faces in adapting its antiquated legacy systems to continuously evolving operational and security requirements. Mr. Bowman discussed the OIG's annual FISMA audits, the most recent of which identified repeat findings and deficiencies related to configuration management, identity management and access, and contingency planning controls. He also discussed the OIG's IT security inspection program, which examines sites not evaluated under the annual FISMA audits, and how this and other ongoing oversight efforts can help spur progress, especially if OIG recommendations are proactively reviewed and implemented by IT leaders across the enterprise. The following day, Mr. Bowman appeared at a Senate Committee on Veterans' Affairs roundtable in which participants discussed VA's efforts to bolster its cybersecurity posture and better protect veterans' information. The roundtable also included VA's Office of Information and Technology representatives and private sector healthcare company executives who shared their best practices.

DEPUTY INSPECTOR GENERAL CASE TESTIFIES BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS REGARDING VA'S ELECTRONIC HEALTH RECORDS MODERNIZATION PROGRAM

Deputy Inspector General David Case testified before the Senate Committee on Veterans' Affairs on July 20, 2022. The hearing focused on VA's challenges with deploying the new EHR, a recently released life cycle cost estimate for the program, and the OIG's recent reports discussing an "unknown queue" of unfulfilled medical orders and other risks to patient safety at the medical facility and clinic initial operating sites. Mr. Case answered questions about the system's unknown queue of thousands of medical orders that the system did not deliver to their intended locations and other concerns the OIG has about VA's implementation and transparency.

DEPUTY INSPECTOR GENERAL TESTIFIES BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION ABOUT THE ELECTRONIC HEALTH RECORDS MODERNIZATION PROGRAM

On July 27, 2022, Deputy Inspector General David Case, accompanied by Principal Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak, testified before the House Veterans' Affairs Subcommittee on Technology Modernization. The hearing focused on VA's deployment timeline for the new EHR, the program's costs, and the OIG's recent reports detailing problems that included the unknown queue and other risks to patient safety, as well as the barriers new system users face to providing prompt access to high-quality care. They answered questions about patient harm resulting from the unknown queue and voiced concerns about identified problems and their mitigation. Of note, they discussed the lack of transparency when the then Change Management leaders from VA's Office of Electronic Health Record Modernization (a predecessor program office for the new EHR) submitted

inaccurate information to the OIG during a review of the user training for the new EHR and its evaluation of trainees' proficiency.

DEPUTY INSPECTOR GENERAL TESTIFIES ON VA'S ELECTRONIC HEALTH RECORD MODERNIZATION BEFORE THE SENATE APPROPRIATIONS' SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES

Deputy Inspector General David Case testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on September 21, 2022. This hearing discussed VA's deployment of a new EHR, as well as the status of recommendations from related OIG reports—including the 15 recommendations that have remained open for more than a year. Mr. Case emphasized that VA staff continue to implement work-arounds in an effort to mitigate known issues, which can lead to delays, increased errors, and deficiencies in care. Mr. Case answered several questions about the true cost of the program and timeline for implementation, emphasizing the ongoing need for an integrated master schedule.

TABLE 6. OIG CONGRESSIONAL TESTIMONY APRIL 1–SEPTEMBER 30, 2022

WITNESS	COMMITTEE	TOPIC	DATE
Deputy Inspector General David Case	Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives	Next Steps: Evaluating Plans for the Continuation of the Department of Veterans Affairs Electronic Health Record Modernization Program	4/26/2022
Inspector General Michael J. Missal	Subcommittee on Disability Assistance and Memorial Affairs, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives	At What Cost? — Ensuring Quality Representation in the Veteran Benefit Claims Process*	4/27/2022
Inspector General Michael J. Missal	Committee on Veterans' Affairs, US Senate	Examining Quality of Care in VA and the Private Sector	5/11/2022
Director of the Information Technology and Security Audits Division Michael Bowman	Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives	Cybersecurity and Risk Management at VA: Addressing Ongoing Challenges and Moving Forward	6/7/2022
Deputy Inspector General David Case	Committee on Veterans' Affairs, US Senate	The Department of Veterans Affairs' Electronic Health Record Modernization Program	7/20/2022

* Inspector General Missal submitted a statement for the record at the request of the Subcommittee.

WITNESS	COMMITTEE	TOPIC	DATE
Deputy Inspector General David Case	Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives	Protecting Our Veterans: Patient Safety and the Electronic Health Record Modernization Program	7/27/2022
Deputy Inspector General David Case	Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, US Senate Committee on Appropriations	VA's Electronic Health Record Modernization: An Update on Rollout, Cost, and Schedule	9/21/2022

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.[25] During this reporting period, the OIG reviewed three legislative or regulatory proposals 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 of its operations conducted 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.[26] 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.[27]

During the reporting period, the Department of Justice (DOJ) OIG completed a peer review of the VA OIG's audit operations. The most recent peer reviews completed of the VA OIG's audit, inspection and evaluation, and investigative operations are listed in table 7. None of the peer reviews completed of the VA OIG have outstanding recommendations. The VA OIG did not complete any peer reviews of other OIGs this reporting period. The most recent audit, inspection and evaluation, and investigative peer reviews completed by the VA OIG are listed in table 8.

TABLE 7. MOST RECENT PEER REVIEWS CONDUCTED OF THE OIG

TYPE	DATE COMPLETED	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
Audits	4/26/2022	DOJ 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

** During the COVID-19 pandemic, the Council of the Inspectors General on Integrity and Efficiency paused the peer review program. The program has since resumed, and the VA OIG Office of Investigations is scheduled to undergo a peer review in 2024.*

25 Pub. L. No. 95-452 § 4(a)(2).

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

27 Pub. L. No. 95-452 § 5(a)(16).

TABLE 8. MOST RECENT PEER REVIEWS COMPLETED BY THE 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.[28] The VA OIG reports no such instances occurring during this reporting period.

Instances of the OIG Exercising Testimonial Subpoena Authority

The VA OIG is authorized by the Strengthening Oversight for Veterans Act of 2021 to require by subpoena the attendance and testimony of witnesses as necessary in the performance of its functions.[29] During this reporting period, the VA OIG reports the following information with respect to the use of its testimonial subpoena authority:

- Inspector General Missal issued two testimonial subpoenas and staff interviewed one individual pursuant to the subpoena authority. The interview of the second witness is pending.
- The US Attorney General did not object to any proposed subpoenas.
- The inspector general has not encountered any challenges or concerns exercising the authority.
- There are no other matters to report.

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.[30] 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

28 Pub. L. No. 95-452 § 5(a)(5).

29 Pub. L. No. 117-136 § 2(a).

30 Pub. L. No. 95-452 § 5(a)(20).

investigate allegations of whistleblower reprisal made by employees of VA contractors or grantees. No such investigations were completed during this reporting period.

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.[31]

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.[32] The Office of the Counselor to the Inspector General published one report during this period meeting this criteria, as detailed below.

INTERNAL INVESTIGATION REGARDING UNAUTHORIZED POSSESSION OF OIG-ISSUED FIREARM

VA OIG attorney-advisors conducted this internal investigation, which was overseen by the deputy inspector general, following allegations of misconduct by OIG employees, including a former senior executive in the Office of Investigations. The senior executive was found to have possessed an OIG-issued firearm and special agent credentials without authorization after he assumed a deputy position within that office and was no longer a special agent. Other personnel were found to have been aware of these issues but did not take appropriate action. An administrative process was completed as to the personnel still employed with the OIG, along with other associated corrective actions. This matter was not referred to the DOJ. To promote transparency and accountability, the OIG publishes summaries of internal investigations concerning allegations of misconduct by its senior personnel. Summary information released is consistent with applicable privacy laws and regulations.

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.[33] The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

31 Pub. L. No. 95-452 § 5(21).

32 Pub. L. No. § 5(a)(19).

33 Pub. L. No. 95-452 § 5(a)(22)(A).

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:

- Jennifer Siegel, a management and program analyst in Bay Pines, Florida, was activated by the US Army in February 2021 and returned in March 2022.
- Christopher Sizemore, an auditor in Bay Pines, Florida, was activated by the US Air Force in June 2022.
- Dillon Fishman, a criminal investigator in Washington, DC, was activated by the US Marine Corps in July 2022.
- Tasha Felton Williams, a nurse consultant in Decatur, Georgia, was activated by the US Air Force in July 2022.
- George Kurtzer, an IT specialist in Hines, Illinois, was activated by the US Air Force in August 2022.

US Attorney General's Award for Distinguished Service

The annual US attorney general's awards recognize DOJ employees and partners for extraordinary contributions to the enforcement of the nation's laws. For FY 2022, close to 300 DOJ employees received awards, while 54 non-DOJ individuals were also honored, including two VA OIG employees: Special Agent in Charge Colin Davis and Resident Agent in Charge Keith Vereb received an award for their work in the investigation and prosecution of former VA nursing assistant Reta Mays, who pleaded guilty to seven counts of second degree murder and one count of assault with the intent to commit murder at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

2022 Council of the Inspectors General on Integrity and Efficiency (CIGIE) Awards

Each year, CIGIE presents awards for remarkable accomplishments in the inspector general community. These awards offer an opportunity to recognize some of the very best work conducted by OIGs as determined by a panel of peers. VA OIG staff were recognized by CIGIE for these outstanding achievements:

- The Glenn/Roth Award for Exemplary Service was awarded to the OAE and OHI review teams responsible for the reports, *Improvements Still Needed in Processing Military Sexual Trauma Claims* and *Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations*,

Teams from OAE and OHI received awards at the 25th Annual CIGIE Awards Ceremony for their outstanding oversight work.

which detailed failures in providing disability compensation benefits and healthcare coordinators' services to veterans who have experienced military sexual trauma.

- An Award for Excellence in Evaluations was earned by the OHI inspection team responsible for the report, *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*, which led to improvements in training, documentation, assessments, and safety planning.
- An Award for Excellence in Evaluations was presented to the OAE inspection team responsible for the report, *Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains*, which led to multiple recommended corrective actions and process improvements, including developing a comprehensive estimate of all deceased veterans whose remains are unclaimed awaiting burials and implementing system indicators to help identify unclaimed remains.
- A third Award for Excellence in Evaluations was awarded to the OHI team responsible for the report, *Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, which identified leaders' failures to prevent and detect an impaired pathologist's criminal conduct, resulting in death and harm to veterans from more than 500 major errors.
- An Award for Excellence in Audit was given to OAE's VHA Drug Return Program Team for their exceptional efforts in the planning, execution, and reporting of a highly complex audit, *Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA*, which identified millions in cost savings and program improvements.
- A second Award for Excellence in Audit acknowledged OAE's team for their work on *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays*, which found that the system was not functioning as expected in its first deployment and ultimately resulted in VA pausing further adoption of the system and exploring other options.
- An Award for Excellence in Multiple Disciplines recognized the cross-directorate team responsible for the report, *VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care*, which identified deficiencies with VHA's emergency department data and the monitoring of high-risk patients' access to emergency care.

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.[33] Tables A.1 through A.4 provide a listing of VA OIG publications issued this period with results sorted according to the authoring directorate. If applicable, the total dollar value of questioned costs and recommendations that funds be put to better use are identified. Table A.5 summarizes all monetary benefits for OIG reports issued this reporting period.

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.[34] This information is provided in tables A.6 and A.7.

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.[35] 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 generally receive substantive feedback from the Department within 30 days of transmitting the draft report although this period may be adjusted to respond to changing circumstances..

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.[36] This information is presented in table A.8.

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. Government employees or contractors who publicly disclose such protected information are subject to criminal penalties.[37] Further, the reports are exempt, in whole or in part, from mandatory public disclosure under the Freedom of Information Act (FOIA).[38]

33 Pub. L. No. 95-452 § 5(a)(6).

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

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

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

37 18 U.S.C. § 1905.

38 FOIA, 5 U.S.C. § 552(b)(3–5). Portions of the reports that pertain to contractor proposals are also protected from disclosure by 41 U.S.C. § 4702 (prohibiting disclosure of contractor proposals under FOIA).

Appendix A: Reports Issued during the Reporting Period

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data *Issued 4/7/2022 | Report Number 21-02761-125*	—	—
Federal Information Security Modernization Act Audit for Fiscal Year 2021 *Issued 4/13/2022 | Report Number 21-01309-74*	—	—
Additional Actions Can Help Prevent Benefits Payments from Being Sent to Deceased Veterans *Issued 4/21/2022 | Report Number 21-00836-124*	—	$677,385
The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule *Issued 4/25/2022 | Report Number 21-02889-134*	—	—
Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims *Issued 4/27/2022 | Report Number 21-03916-103*	—	—
Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement *Issued 5/3/2022 | Report Number 21-02437-120*	—	$624,000
Purchases of Smartphones and Tablets for Veterans' Use during the COVID-19 Pandemic *Issued 5/4/2022 | Report Number 21-02125-132*	$2,336,381	—
VHA Continues to Face Challenges with Billing Private Insurers for Community Care *Issued 5/24/2022 | Report Number 21-00846-104*	$805,200,000	—
Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls *Issued 6/1/2022 | Report Number 21-01123-97*	—	—
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona *Issued 6/1/2022 | Report Number 21-02453-99*	—	—

Appendix A: Reports Issued during the Reporting Period

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas *Issued 6/1/2022 | Report Number 21-03305-139*	—	—
Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight *Issued 6/6/2022 | Report Number 20-02186-78*	—	—
Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions *Issued 6/8/2022 | Report Number 21-01237-127*	—	—
Financial Efficiency Review of the VA El Paso Healthcare System in Texas and New Mexico *Issued 6/14/2022 | Report Number 21-02197-165*	—	$185,533
Results of Consulting Engagement Related to Selected Financial Reporting Controls for the Integrated Financial and Acquisition Management System at the National Cemetery Administration *Issued 6/15/2022 | Report Number 21-02924-166*	—	—
Mission Accountability Support Tracker Lacked Sufficient Security Controls *Issued 6/22/2022 | Report Number 21-03080-142*	—	—
A Summary of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2021 *Issued 6/23/2022 | Report Number 22-00180-169*	—	—
Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2021 *Issued 6/28/2022 | Report Number 22-00576-178*	—	—
VA Medical Facilities Took Steps to Safeguard Refrigerated Pharmaceuticals but Could Further Reduce the Risk of Loss *Issued 6/30/2022 | Report Number 21-01898-152*	$5,100,000	—
Safeguarding PII Collected in VBA Education Compliance Surveys *Issued 7/6/2022 | Report Number 22-01637-176*	—	—

Appendix A: Reports Issued during the Reporting Period

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Financial Efficiency Review of the VA Boston Healthcare System in Massachusetts *Issued 7/7/2022 | Report Number 21-03853-174*	$4,439	$375,000
Contract Closeout Compliance Needs Improvement at Regional Procurement Offices Central and West *Issued 7/13/2022 | Report Number 21-02599-156*	$4,400,000	—
Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Resulted in $12.8 Million in Questioned Costs *Issued 7/20/2022 | Report Number 21-01081-155*	—	$12,800,000
Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure *Issued 7/21/2022 | Report Number 21-02704-135*	—	$78,300
Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement *Issued 7/21/2022 | Report Number 21-02732-153*	—	—
Financial Efficiency Review of the VA Black Hills Health Care System in South Dakota *Issued 7/27/2022 | Report Number 22-00066-184*	$174,468	—
VBA Improperly Created Debts When Reducing Veterans' Disability Levels *Issued 7/28/2022 | Report Number 21-01351-151*	—	—
The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring *Issued 8/3/2022 | Report Number 21-02401-190*	—	—
VA Needs to Improve Governance of Identity, Credential, and Access Management Processes *Issued 8/3/2022 | Report Number 22-00210-191*	—	—
Digital Divide Consults and Devices for VA Video Connect Appointments *Issued 8/4/2022 | Report Number 21-02668-182*	$14,478,000	—

Appendix A: Reports Issued during the Reporting Period

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing *Issued 8/9/2022 | Report Number 21-01361-192*	—	—
Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune *Issued 8/25/2022 | Report Number 21-03061-209*	—	$13,800,000
Financial Efficiency Review of the VA Cincinnati Healthcare System *Issued 9/1/2022 | Report Number 22-00208-221*	$2,000	$940
VA Did Not Provide Some Veterans Legally Required Notice and Due Process before Collecting Debts for the Compensation Program *Issued 9/7/2022 | Report Number 22-01279-206*	—	—
VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims *Issued 9/7/2022 | Report Number 22-00404-207*	—	—
New York/New Jersey VA Health Care Network (VISN 2) Should Improve Boiler Maintenance to Reduce Safety Risks and Prevent Care Disruptions *Issued 9/19/2022 | Report Number 21-00887-211*	—	—
Required Medical Reexaminations Canceled *Issued 9/20/2022 | Report Number 21-01503-231*	—	—
Summary of Fiscal Year 2021 Preaward Reviews of Healthcare Resource Proposals from Affiliates *Issued 9/20/2022 | Report Number 22-00564-216*	—	—
VA Is Moving toward Full Compliance with Geospatial Data Covered Agency Responsibilities *Issued 9/21/2022 | Report Number 22-00563-224*	—	—
Home Improvements and Structural Alterations Program Needs Greater Oversight *Issued 9/22/2022 | Report Number 21-03906-226*	$2,299,741	$11,498,703

Appendix A: Reports Issued during the Reporting Period

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana *Issued 9/22/2022 | Report Number 22-00971-217*	—	—
VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2022 *Issued 9/22/2022 | Report Number 22-00879-236*	—	—
Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas *Issued 9/27/2022 | Report Number 22-00973-215*	—	—
Buy American Act Compliance Deficiencies at Regional Procurement Office Central *Issued 9/28/2022 | Report Number 21-02641-229*	—	—
Total	**$833,995,029**	**$40,039,861**

PREAWARD REVIEWS	BETTER USE OF FUNDS
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 4/5/2022 | Report Number 22-01073-121*	$30,625,897
Review of a Federal Supply Schedule Proposal under a Solicitation *Issued 4/12/2022 | Report Number 22-00497-131*	$6,114,800
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 4/13/2022 | Report Number 22-01387-122*	$1,788,799
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 4/26/2022 | Report Number 22-00523-137*	—
Review of Request for Modification—Product Addition—Submitted under a Federal Supply Schedule Contract *Issued 4/26/2022 | Report Number 22-00770-141*	$2,029,680
Review of Product Addition Proposals Submitted under a Federal Supply Schedule Contract *Issued 4/29/2022 | Report Number 21-03262-138*	$2,599,466

Appendix A: Reports Issued during the Reporting Period

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 5/18/2022 | Report Number 22-01920-160*	$2,103,760
Independent Audit Report of the Proposal Submitted under a Solicitation *Issued 5/24/2022 | Report Number 22-02075-164*	$2,791,251
Preaward Review of the Proposal Submitted under a Solicitation *Issued 5/31/2022 | Report Number 22-00865-146*	$21,472,334
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 6/14/2022 | Report Number 22-02352-172*	$967,254
Review of a Request for Modification—Product Addition—Submitted under a Federal Supply Schedule Contract *Issued 6/15/2022 | Report Number 21-03474-183*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 6/29/2022 | Report Number 22-01337-193*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 7/1/2022 | Report Number 22-01502-171*	$1,029,149
Independent Audit Report of a Modification—Product Addition Proposal—Submitted under a Federal Supply Schedule Contract *Issued 7/7/2022 | Report Number 22-01582-197*	$283,984
Independent Audit Report of Request for Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/12/2022 | Report Number 22-01577-199*	$22,513,221
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 7/14/2022 | Report Number 22-01402-195*	$72,180
Independent Audit Report of Request for Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 7/19/2022 | Report Number 22-01752-203*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 7/25/2022 | Report Number 22-01297-205*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 7/28/2022 | Report Number 22-02077-210*	—

Appendix A: Reports Issued during the Reporting Period

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Independent Audit Report of the Proposal Submitted under Solicitation *Issued 8/10/2022 | Report Number 22-02280-212*	$1,500,219
Review of Contract Extension and Product Addition Proposals Submitted under a Federal Supply Schedule Contract *Issued 8/22/2022 | Report Number 22-02716-223*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 8/30/2022 | Report Number 22-03130-222*	$1,385,118
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/2/2022 | Report Number 22-03440-225*	$1,781,720
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/6/2022 | Report Number 22-01206-238*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/21/2022 | Report Number 22-02529-240*	$898,289
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/21/2022 | Report Number 22-01904-241*	—
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/23/2022 | Report Number 22-01596-235*	$7,999,905
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/23/2022 | Report Number 22-03306-247*	$1,862,018
Independent Audit Report of a Proposal Submitted under a Solicitation *Issued 9/29/2022 | Report Number 22-03058-242*	$13,825,421
Total	**$123,644,467**

Note: Numbers may not sum due to rounding.

POSTAWARD REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Review of a Voluntary Disclosure of Price Reductions under a Federal Supply Schedule Contract *Issued 4/12/2022 | Report Number 22-00333-133*	—	$31,771
Independent Auditor's Report under Contract *Issued 4/18/2022 | Report Number 22-02079-143*	—	—

POSTAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Review of Termination Settlement Proposal Submitted under a Prime Contract *Issued 4/28/2022 | Report Number 21-03165-149*	$104,263	—
Post Award Review of Unreported Sales under a Federal Supply Schedule Contract *Issued 4/28/2022 | Report Number 21-01857-150*	—	$6,294
Review of a Breach of Contract Claim Submitted under a VA Lease *Issued 6/15/2022 | Report Number 22-00257-177*	$731,922	—
Independent Audit Report of a Post Award Review under a Federal Supply Schedule Contract *Issued 6/15/2022 | Report Number 22-01788-179*	—	$90,471
Review of a Termination Settlement Proposal Submitted under a VA Contract *Issued 6/17/2022 | Report Number 22-00255-181*	$199,164	—
Review of a Voluntary Disclosure of Price Reductions under a Federal Supply Schedule Contract *Issued 7/7/2022 | Report Number 21-03821-196*	—	$1,679
Review of Termination Settlement Proposal Submitted under a VA Contract *Issued 7/29/2022 | Report Number 21-03168-213*	$1,239,597	—
Review of Noncompliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts *Issued 8/2/2022 | Report Number 22-00181-201*	—	$199,437
Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract *Issued 8/25/2022 | Report Number 22-02150-227*	—	$45,219
Review of Noncompliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts *Issued 9/12/2022 | Report Number 22-00061-228*	—	$979,553
Postaward Review of a Voluntary Disclosure under a Federal Supply Schedule Contract *Issued 9/15/2022 | Report Number 22-00192-245*	—	$15,339

POSTAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Postaward Review of a Voluntary Disclosure under a Federal Supply Schedule Contract *Issued 9/19/2022 | Report Number 22-00190-246*	—	$681,055
Independent Audit Report of a Post Award Review under a Federal Supply Schedule Contract *Issued 9/21/2022 | Report Number 22-02730-249*	—	$39,307
Report of a Settlement Agreement *Issued 9/22/2022 | Report Number 21-02400-244*	—	$2,917,320
Independent Audit Report of a Post Award Review under a Federal Supply Schedule Contract *Issued 9/23/2022 | Report Number 22-02322-251*	—	$7,895
Independent Audit Report of a Post Award Review under a Federal Supply Schedule Contract *Issued 9/29/2022 | Report Number 22-01489-252*	—	$154,808
Total	**$2,274,946**	**$5,170,146**

Note: Numbers may not sum due to rounding.

Table A.2. Publications Issued by the Office of Healthcare Inspections

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
CHIP SUMMARY REPORTS		
Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2021	9/11/2022	22-00814-230
Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021	9/15/2022	22-00815-232
COVID-19-RELATED CHIP SUMMARY REPORT		
Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6	4/7/2022	21-03917-123
VISN- AND FACILITY-LEVEL CHIP REPORTS		
VA Western New York Healthcare System in Buffalo	4/6/2022	21-00290-116
Syracuse VA Medical Center in New York	4/19/2022	21-00294-128
VA Finger Lakes Healthcare System in Bath, New York	5/4/2022	21-00291-136

Appendix A: Reports Issued during the Reporting Period

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Northport VA Medical Center in New York	5/5/2022	21-00300-130
VA New Jersey Health Care System in East Orange	5/5/2022	21-00296-145
Samuel S. Stratton VA Medical Center in Albany, New York	5/25/2022	21-00295-161
VA NY Harbor Healthcare System in New York	5/26/2022	21-00299-162
Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network in Bronx, New York	5/31/2022	21-00240-158
Beckley VA Medical Center in West Virginia	6/2/2022	21-00286-163
Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia	6/2/2022	21-00293-170
VA Maryland Health Care System in Baltimore	6/14/2022	21-00283-173
Washington DC VA Medical Center	6/16/2022	21-00288-175
Martinsburg VA Medical Center in West Virginia	7/13/2022	21-00287-194
Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland	7/14/2022	21-00239-180

HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities	4/7/2022	20-00827-126
Quality of Care Concerns and Leaders' Responses at the Amarillo VA Health Care System in Texas	4/14/2022	21-02491-129
Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois	5/3/2022	19-08364-140
Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania	5/3/2022	21-01712-144
Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon	5/4/2022	21-02209-147
Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio	5/12/2022	21-03525-148
Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia	5/12/2022	21-01048-154

Appendix A: Reports Issued during the Reporting Period

HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida	5/31/2022	20-04443-167
Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington	6/1/2022	21-03020-168
Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia	6/28/2022	21-03349-186
Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama	6/29/2022	21-03201-185
Pharmacists' Practices Delayed Buprenorphine Refills for Patients with Opioid Use Disorder at the New Mexico VA Health Care System in Albuquerque	6/30/2022	21-03195-189
Improvements in Sterile Processing Service and Leadership Oversight at the Edward Hines, Jr. VA Hospital in Hines, Illinois	7/7/2022	22-00158-188
Review of Veterans Health Administration's Response to a Medication Recall	7/19/2022	21-02194-198
Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia	7/26/2022	21-03339-208
Deficiencies in Life-Sustaining Treatment Processes at the Michael E. DeBakey VA Medical Center in Houston, Texas	8/4/2022	21-02903-214
Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California	8/17/2022	21-03595-219
Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	9/12/2022	21-02326-233
Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	9/27/2022	21-03203-239

NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6	4/7/2022	21-03917-123
The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic	5/10/2022	21-00533-157
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022	7/7/2022	22-00722-187
The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm	7/14/2022	22-01137-204
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2021	9/11/2022	22-00814-230
Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021	9/15/2022	22-00815-232
Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance	9/28/2022	21-00797-248
CARE IN THE COMMUNITY HEALTHCARE INSPECTION	**ISSUE DATE**	**REPORT NUMBER**
Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23)	5/19/2022	21-01820-159

Table A.3. Publications Issued by the Office of Special Reviews

SPECIAL REVIEW	ISSUE DATE	REPORT NUMBER
Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability	5/5/2022	18-04227-91
ADMINISTRATIVE INVESTIGATIONS	**ISSUE DATE**	**REPORT NUMBER**
Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training	7/14/2022	21-02201-200
Alleged Unauthorized Access of a VA Senior Executive's Email Not Substantiated	8/2/2022	20-01460-202
Alleged Failures to Adequately Equip Executive Protection Personnel Are Substantiated in Part	9/27/2022	21-02145-243

MANAGEMENT ADVISORY MEMORANDUM	ISSUE DATE	REPORT NUMBER
Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data	4/7/2022	21-02761-125

Table A.4. Publications Issued by the Office of the Counselor

INTERNAL INVESTIGATION	ISSUE DATE	REPORT NUMBER
Summary of Internal Investigation Regarding Unauthorized Possession of OIG-Issued Firearm	8/4/2022	22-03477-220

Table A.5. Total Monetary Benefits Identified in Publications

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$45,210,007
Better Use of Funds	$959,914,442
Total	**$1,005,124,449**

Table A.6. Resolution Status of Publications with Questioned Costs

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	22	$45,210,007
Total inventory this reporting period	**22**	**$45,210,007**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	22	$45,210,007
Reports with disallowed costs (not agreed to by management)	0	$0
Total management decisions this period	**22**	**$45,210,007**
Total carried over to next reporting period	**0**	**$0**

Table A.7. Resolution Status of Publications with Recommended Funds to Be Put to Better Use by Management

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with recommended funds to be put to better use issued during the reporting period	33	$959,914,442
Total inventory this reporting period	**33**	**$959,914,442**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	33	$959,914,442
Reports with disallowed costs (not agreed to by management)	0	$0
Total management decisions this period	**33**	**$959,914,442**
Total carried over to next reporting period	**0**	**$0**

Table A.8. Nonconcurrences or Significantly Revised Decisions Made by VA Management Officials

REPORT	ACTION OFFICES	RECOMMENDATIONS	MONETARY IMPACT
Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls *Issued 6/1/2022 | Report Number 21-01123-97*	OIT	1-2	—
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona *Issued 6/1/2022 | Report Number 21-02453-99*	VHA	2	—
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas *Issued 6/1/2022 | Report Number 21-03305-139*	OIT	2	—

- In the report *Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls*, OIT concurred with recommendation 3 but nonconcurred with recommendations 1 and 2, which were related to categorizing VDIF at a high-risk level and reestablishing VDIF in eMASS at the high-risk level. Appendix D of the report includes the full text of OIT's comments. The OIG stands by these recommendations and considers both recommendations open.

Appendix A: Reports Issued during the Reporting Period

- In the report *Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona*, OIT concurred with recommendations 1, 3, 4, 5, and 6 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 maintains its recommendation and considers recommendation 2 open.
- In the report *Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas*, the VA deputy secretary concurred with recommendations 1 and 3 through 10 but nonconcurred with recommendation 2, which was again related to vulnerability and flaw remediation. Appendix D of the report includes the full text of VHA's comments. The OIG also stands by its recommendation and considers recommendation 2 open.

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 recommendations. All data in the tables are current as of September 30, 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 September 30, 2022, there were 210 total open reports with 84 open more than a year and 126 open less than a year. However, table B.1 shows a total of 228 open reports, with 90 open more than a year and 136 open less than a year. This is because 13 reports are counted multiple times in the table (including two reports counted more than twice), 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	68	96	164
Veterans Benefits Administration	8	13	21
National Cemetery Administration	1	1	2
Office of Acquisition, Logistics, and Construction	4	2	6
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	2	2	4
Office of Information and Technology	2	10	12
Office of Management	1	3	4
Office of Electronic Health Record Modernization	3	7	10
Office of Enterprise Integration	0	1	1
Office of Asset Enterprise Management	1	0	1
Office of the Secretary	0	1	1
Total	**90**	**136**	**226**

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 September 30, 2022, there are 750 total open recommendations with 212 open more than a year and 538 open less than a year. However, table B.2 shows a total of 762 open recommendations, with 214 open more than a year and 548 open less than a year. This is because 12 recommendations are counted multiple times in the table, as they have actions pending for more than one VA office.

Appendix B: Unimplemented Reports and Recommendations

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	169	409	578
Veterans Benefits Administration	15	40	55
National Cemetery Administration	4	1	5
Office of Acquisition, Logistics, and Construction	6	3	9
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	5	6	11
Office of Information and Technology	2	48	50
Office of Management	1	13	14
Office of Electronic Health Record Modernization	10	21	31
Office of Enterprise Integration	0	5	5
Office of Asset Enterprise Management	2	0	2
Office of the Secretary	0	2	2
Total	**214**	**548**	**762**

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

Table B.3 identifies the 126 reports and 538 recommendations that, as of September 30, 2022, have been open less than one year. The total monetary benefit attached to these recommendations is $1,419,752,468.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance *Issued 10/21/2021 | Report Number 19-06004-225*	VHA	3-4, 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	5, 7, 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	3	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Orlando VA Healthcare System in Florida *Issued 11/3/2021 | Report Number 21-00275-11*	VHA	4	—
Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2021 | Report Number 20-04237-09*	OM	1, 3-4, 6-12	—
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	1-2, 4	—
Deficiencies in Select Community Care Consult (Stat) Processes During the COVID-19 Pandemic *Issued 11/10/2021 | Report Number 20-03437-26*	VHA	1-5	—
DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays *Issued 11/10/2021 | Report Number 20-01324-215*	VHA	1-3	—
New Patient Scheduling System Needs Improvement as VA Expands Its Implementation *Issued 11/10/2021 | Report Number 21-00434-233*	EHRM IO VHA	EHRM IO: 8 EHRM IO, VHA: 1-7	—
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	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
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	1-2, 6	—
VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements *Issued 12/2/2021 | Report Number 20-00426-02*	OIT	1	—
Vet Center Inspection of Continental District 4 Zone 1 and Selected Vet Centers *Issued 12/2/2021 | Report Number 20-04050-37*	VHA	1, 3-4, 8-10, 17	—
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	—
VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services *Issued 12/8/2021 | Report Number 20-01099-249*	VHA	1, 3, 5-6	$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	$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	2-4, 6	—
Comprehensive Healthcare Inspection of the Hampton VA Medical Center in Virginia *Issued 12/14/2021 | Report Number 21-00278-23*	VHA	4, 6	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains *Issued 12/15/2021 | Report Number 19-09592-262*	NCA OEI OM VHA	NCA: 11 OEI: 1-5 OM: 6 VHA: 9	—
Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits *Issued 12/15/2021 | Report Number 20-04219-07*	VBA	1-3, 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, 3	—
Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma VA Health Care System in Muskogee *Issued 12/15/2021 | Report Number 21-01801-45*	VHA	1-4	—
Inadequate Oversight of VHA's Home Oxygen Program *Issued 12/16/2021 | Report Number 19-07812-29*	VHA	3-6	—
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	1-3	—
MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data *Issued 12/20/2021 | Report Number 20-03351-08*	VHA	1	—
Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers *Issued 12/20/2021 | Report Number 21-01804-56*	VHA	3-6, 8-11, 15-16	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
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	—
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	5	—
Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina *Issued 2/3/2022 | Report Number 21-00276-67*	VHA	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	3, 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	2-3, 5-6	—
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	1-4, 7-8	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
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	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	1-2, 4, 6-9	—
Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened *Issued 3/9/2022 | Report Number 21-02750-63*	VBA	5	$88,700
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*	EHRM IO VHA	EHRM IO, 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*	EHRM IO	1-3	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
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*	EHRM IO	1	—
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, 3-4	—
Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints *Issued 3/24/2022 | Report Number 21-00510-105*	VHA	1-3	—
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	—
Financial Efficiency Review of the Durham VA Health Care System in North Carolina *Issued 3/29/2022 | Report Number 21-02458-94*	VHA	1, 3-6, 9-10	$308,000
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	1-2, 4-5	—
Inspection of Information Technology Security at the VA Financial Services Center *Issued 3/31/2022 | Report Number 21-01221-24*	OIT	3	—
Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo *Issued 4/6/2022 | Report Number 21-00290-116*	VHA	1-2, 6-7	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities *Issued 4/7/2022 | Report Number 20-00827-126*	VHA	1-4	—
Federal Information Security Modernization Act Audit for Fiscal Year 2021 *Issued 4/13/2022 | Report Number 21-01309-74*	OIT	1-26	—
Quality of Care Concerns and Leaders' Responses at the Amarillo VA Health Care System in Texas *Issued 4/14/2022 | Report Number 21-02491-129*	VHA	1-6	—
Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York *Issued 4/19/2022 | Report Number 21-00294-128*	VHA	1-2, 6-7	—
Additional Actions Can Help Prevent Benefits Payments from Being Sent to Deceased Veterans *Issued 4/21/2022 | Report Number 21-00836-124*	VBA	1-3	$677,385
The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule *Issued 4/25/2022 | Report Number 21-02889-134*	EHRM IO	1-6	—
Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims *Issued 4/27/2022 | Report Number 21-03916-103*	VHA	1-5	—
Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement *Issued 5/3/2022 | Report Number 21-02437-120*	VBA	5	$624,000

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania *Issued 5/3/2022 | Report Number 21-01712-144*	VHA	4-5	—
Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York *Issued 5/4/2022 | Report Number 21-00291-136*	VHA	5	—
Purchases of Smartphones and Tablets for Veterans' Use during the COVID-19 Pandemic *Issued 5/4/2022 | Report Number 21-02125-132*	VHA	1-2	$2,336,381
Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon *Issued 5/4/2022 | Report Number 21-02209-147*	VHA	2	—
Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability *Issued 5/5/2022 | Report Number 18-04227-91*	EHRM IO	1	—
Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York *Issued 5/5/2022 | Report Number 21-00300-130*	VHA	3-5	—
Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange *Issued 5/5/2022 | Report Number 21-00296-145*	VHA	1, 3, 6-7	—
The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic *Issued 5/10/2022 | Report Number 21-00533-157*	VHA	1	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia *Issued 5/12/2022 | Report Number 21-01048-154*	VHA	1, 3, 5-6, 9-10	—
Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23) *Issued 5/19/2022 | Report Number 21-01820-159*	VHA	1-3	—
VHA Continues to Face Challenges with Billing Private Insurers for Community Care *Issued 5/24/2022 | Report Number 21-00846-104*	VHA	1-3	$805,200,000
Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York *Issued 5/25/2022 | Report Number 21-00295-161*	VHA	1-10	—
Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York *Issued 5/26/2022 | Report Number 21-00299-162*	VHA	1-8	—
Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida *Issued 5/31/2022 | Report Number 20-04443-167*	VHA	1-5	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network in Bronx, New York *Issued 5/31/2022 | Report Number 21-00240-158*	VHA	1-4	—
Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls *Issued 6/1/2022 | Report Number 21-01123-97*	OIT	1-3	—
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona *Issued 6/1/2022 | Report Number 21-02453-99*	OIT	4	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas *Issued 6/1/2022 | Report Number 21-03305-139*	OIT	1-2, 5, 8, 10	—
Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 6/1/2022 | Report Number 21-03020-168*	VHA	1-2	—
Comprehensive Healthcare Inspection of the Beckley VA Medical Center in West Virginia *Issued 6/2/2022 | Report Number 21-00286-163*	VHA	4	—
Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia *Issued 6/2/2022 | Report Number 21-00293-170*	VHA	2-6	—
Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight *Issued 6/6/2022 | Report Number 20-02186-78*	VHA	1-5	—
Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions *Issued 6/8/2022 | Report Number 21-01237-127*	VBA	1-3	—
Financial Efficiency Review of the VA El Paso Healthcare System in Texas and New Mexico *Issued 6/14/2022 | Report Number 21-02197-165*	VHA	1-12	$185,533
Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore *Issued 6/14/2022 | Report Number 21-00283-173*	VHA	1-8	—
Comprehensive Healthcare Inspection of the Washington DC VA Medical Center *Issued 6/16/2022 | Report Number 21-00288-175*	VHA	1-9	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Mission Accountability Support Tracker Lacked Sufficient Security Controls *Issued 6/22/2022 | Report Number 21-03080-142*	OIT VBA	OIT: 1 OIT, VBA: 2-3 VBA: 4	—
Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia *Issued 6/28/2022 | Report Number 21-03349-186*	VHA	1-7	—
Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2021 *Issued 6/28/2022 | Report Number 22-00576-178*	VHA	1	—
Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama *Issued 6/29/2022 | Report Number 21-03201-185*	VHA	1-10	—
VA Medical Facilities Took Steps to Safeguard Refrigerated Pharmaceuticals but Could Further Reduce the Risk of Loss *Issued 6/30/2022 | Report Number 21-01898-152*	VHA	1-2	$5,100,000
Pharmacists' Practices Delayed Buprenorphine Refills for Patients with Opioid Use Disorder at the New Mexico VA Health Care System in Albuquerque *Issued 6/30/2022 | Report Number 21-03195-189*	VHA	1-5	—
Financial Efficiency Review of the VA Boston Healthcare System in Massachusetts *Issued 7/7/2022 | Report Number 21-03853-174*	VHA	1-8	$379,439
Contract Closeout Compliance Needs Improvement at Regional Procurement Offices Central and West *Issued 7/13/2022 | Report Number 21-02599-156*	VHA	1-5	$4,400,000

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia *Issued 7/13/2022 | Report Number 21-00287-194*	VHA	1-9	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland *Issued 7/14/2022 | Report Number 21-00239-180*	VHA	1	—
Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training *Issued 7/14/2022 | Report Number 21-02201-200*	EHRM IO	3	—
The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm *Issued 7/14/2022 | Report Number 22-01137-204*	VHA	2	—
Review of Veterans Health Administration's Response to a Medication Recall *Issued 7/19/2022 | Report Number 21-02194-198*	VHA	1-2	—
Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Resulted in $12.8 Million in Questioned Costs *Issued 7/20/2022 | Report Number 21-01081-155*	VHA	1-8	$12,800,000
Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure *Issued 7/21/2022 | Report Number 21-02704-135*	VBA	1-7	$78,300
Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement *Issued 7/21/2022 | Report Number 21-02732-153*	VHA	1-7	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia *Issued 7/26/2022 | Report Number 21-03339-208*	VHA	1-3, 5	—
Financial Efficiency Review of the VA Black Hills Health Care System in South Dakota *Issued 7/27/2022 | Report Number 22-00066-184*	VHA	1-7	$174,468
VBA Improperly Created Debts When Reducing Veterans' Disability Levels *Issued 7/28/2022 | Report Number 21-01351-151*	VBA	1-4	—
The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring *Issued 8/3/2022 | Report Number 21-02401-190*	VBA	1, 3	—
VA Needs to Improve Governance of Identity, Credential, and Access Management Processes *Issued 8/3/2022 | Report Number 22-00210-191*	OHRA/OSP OIT OSVA	OHRA/OSP: 4 OIT: 3 OSVA: 1-2	—
Digital Divide Consults and Devices for VA Video Connect Appointments *Issued 8/4/2022 | Report Number 21-02668-182*	VHA	1-10	$14,478,000
Deficiencies in Life-Sustaining Treatment Processes at the Michael E. DeBakey VA Medical Center in Houston, Texas *Issued 8/4/2022 | Report Number 21-02903-214*	VHA	1, 6	—
The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing *Issued 8/9/2022 | Report Number 21-01361-192*	VBA	1-6	—
Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California *Issued 8/17/2022 | Report Number 21-03595-219*	VHA	1, 4-5, 7-10	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune *Issued 8/25/2022 | Report Number 21-03061-209*	VBA	1-2	$13,800,000
Financial Efficiency Review of the VA Cincinnati Healthcare System *Issued 9/1/2022 | Report Number 22-00208-221*	VHA	1-8	$2,940
Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2021 *Issued 9/1/2022 | Report Number 22-00814-230*	VHA	1	—
VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims *Issued 9/7/2022 | Report Number 22-00404-207*	VBA	1-3	—
Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas *Issued 9/12/2022 | Report Number 21-02326-233*	VHA	1-3	—
Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021 *Issued 9/15/2022 | Report Number 22-00815-232*	VHA	1-4	—
New York/New Jersey VA Health Care Network (VISN 2) Should Improve Boiler Maintenance to Reduce Safety Risks and Prevent Care Disruptions *Issued 9/19/2022 | Report Number 21-00887-211*	VHA	1-6	—
Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana *Issued 9/22/2022 | Report Number 22-00971-217*	OIT	3-5, 8	—

Appendix B: Unimplemented Reports and Recommendations

REPORT (CONTINUED)	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Home Improvements and Structural Alterations Program Needs Greater Oversight *Issued 9/22/2022 | Report Number 21-03906-226*	VHA	1-5	$13,798,444
Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina *Issued 9/27/2022 | Report Number 21-03203-239*	VHA	1-7	—
Alleged Failures to Adequately Equip Executive Protection Personnel Are Substantiated in Part *Issued 9/27/2022 | Report Number 21-02145-243*	OHRA/ OSP	1-5	—
Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas *Issued 9/27/2022 | Report Number 22-00973-215*	OIT VHA	OIT: 1-3 VHA: 5	—
Buy American Act Compliance Deficiencies at Regional Procurement Office Central *Issued 9/28/2022 | Report Number 21-02641-229*	OALC VHA	OALC: 1-2 VHA: 3	—
Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance *Issued 9/28/2022 | Report Number 21-00797-248*	VHA	1-7	—
Total			**$1,419,752,468**

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

Table B.4 identifies the 84 reports and 212 recommendations that, as of September 30, 2022, remain open for more than one year. The total monetary benefit attached to these reports is $610,447,205.

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
Recommendation 5: The OIG recommended the under secretary for health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).		
VA's 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.		
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	OHRA/ OSP, VHA	—
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 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.		

Appendix B: Unimplemented Reports and Recommendations

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

Appendix B: Unimplemented Reports and Recommendations

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

Appendix B: Unimplemented Reports and Recommendations

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.		
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System *Issued 4/27/2020 | Report Number 19-08980-95*	EHRM IO	—
Recommendation 5: Evaluate physical infrastructure for consistency with OEHRM requirements and monitor completion of those evaluations. Recommendation 7: Ensure physical security assessments are completed and addressed at future electronic health record deployment sites.		
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. 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.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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 Officer's authority and roles in the planning, programming, budgeting, and execution of all information technology resources.		
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.		
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. 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 Veterans Benefits Administration procedures.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri *Issued 8/12/2020 | Report Number 19-06873-210*	VHA	—
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 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 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.		
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 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.		
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.		

Appendix B: Unimplemented Reports and Recommendations

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

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 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 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.		
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.		
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 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.		
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.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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 | 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.		
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*	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 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.

Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics *Issued 3/31/2021 | Report Number 20-01386-107*	VHA	—

Recommendation 2: The under secretary for health strengthens requirements for colonoscopy quality assurance monitoring that includes analysis of quality indicators to identify trends and monitors for compliance.

Recommendation 3: The under secretary for health, in conjunction with the National Gastroenterology Program director, evaluates implementation of standardized endoscopy software across Veterans Health Administration facilities where colonoscopies are performed and takes action as indicated.

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings *Issued 5/18/2021 | Report Number 20-00049-122*	VBA	—
Recommendation 1: Develop and implement a written plan to strengthen oversight of the quality assurance program for disability compensation benefits and monitor the plan to ensure identified deficiencies are adequately addressed.		
Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio *Issued 5/19/2021 | Report Number 20-01276-131*	VHA	—
Recommendation 5: The chief of staff evaluates and determines additional reasons for noncompliance and ensures that service chiefs document the results of focused professional practice evaluations in practitioner profiles. Recommendation 6: The chief of staff evaluates and determines additional reasons for noncompliance and ensures that service chiefs collect service-specific ongoing professional practice evaluation data. Recommendation 9: The medical center director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from the medical center. Recommendation 14: The associate director for Patient Care Services evaluates and determines any additional reasons for noncompliance and makes certain that CensiTrac is fully operational.		
Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program *Issued 5/25/2021 | Report Number 20-03178-116*	EHRM IO, OM	—
Recommendation 1: The executive director for the Office of Electronic Health Record Modernization should ensure an independent cost estimate is performed for program life cycle cost estimates including related physical infrastructure costs funded by the Veterans Health Administration. Recommendation 2: The VA assistant secretary for management and chief financial officer should ensure the Office of Programming, Analysis and Evaluation, or another office performing its duties, conducts independent cost estimates as required by VA financial policy, and performs an independent estimate of Electronic Health Record Modernization program life cycle cost estimates including physical infrastructure.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 5: Ensure costs for physical infrastructure upgrades funded by the Veterans Health Administration or other sources needed to support the Electronic Health Record Modernization program are disclosed in program life cycle cost estimates presented to Congress.		
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	—
Recommendation 1: The under secretary for health ensures that the Veterans Health Administration competency process for locum tenens, newly hired specialty care providers, and newly hired service chiefs is evaluated to confirm that the results of the assessment accurately reflects the clinical competency of providers who are privileged, and takes action, as indicated.		
Recommendation 8: The under secretary for health confers with the Office of General Counsel and the Office of Human Resources and Administration/Operations, Security, & Preparedness to determine whether administrative action is warranted for Veterans Health Administration leaders who did not adequately perform their duties with respect to the issues within this report, and takes action, as appropriate.		
Recommendation 9: The under secretary for health explores the development of a mandatory alcohol testing policy for individuals including healthcare workers who perform functions that would put patients at risk should the employee work while impaired.		
Recommendation 10: The under secretary for health evaluates Veterans Health Administration's guidance related to impaired healthcare workers and ensures that it addresses the circumstances under which alcohol and or drug testing may be performed; the extent of a retrospective review of care if one is indicated; and the availability of advisors who are knowledgeable on the management of an impaired provider, and takes action, as indicated.		
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	—
Recommendation 1: The OIG recommended that the under secretary for health initiate efforts to revise or amend VHA Directive 1047 to clarify when changes to emergency cache activation procedures are appropriate, and develop the communication and documentation requirements for these situations to ensure all relevant parties including medical facility directors and pharmacy chiefs are aware of and comply with any changes to routine activation protocols as well as the responsibilities they maintain.		
Recommendation 2: The OIG recommended that the under secretary for health establish minimum time frames, for example by assessing Emergency Pharmacy Service's data on the typical length of time it takes to replenish emergency cache inventory items, by which the Emergency Pharmacy Service initiates resupply orders to make sure caches are fully stocked with unexpired inventory.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: The OIG recommended that the under secretary for health make sure that the Emergency Pharmacy Service and the Watch Office are maintaining accurate and complete records of emergency cache activations.		
Review of VHA's Financial Oversight of COVID-19 Supplemental Funds *Issued 6/10/2021 | Report Number 20-02967-121*	VHA	—
Recommendation 1: The OIG recommends that the deputy under secretary for health coordinate with VA's Office of Management to implement internal control procedures to ensure the completeness and accuracy of the data in VA's reports to the Office of Management and Budget and to Congress.		
Recommendation 2: The OIG recommends that the deputy under secretary for health coordinate with VA's Office of Management to execute data validation procedures to make certain that reports to the Office of Management and Budget and to Congress can be traced back efficiently to the source transactions.		
Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency *Issued 6/10/2021 | Report Number 20-00541-133*	OHRA/ OSP, VHA	—
Recommendation 1: The OIG recommended the acting assistant secretary for human resources and administration/operations, security, and preparedness develop and implement an enterprise wide plan to independently examine and validate the HR Smart position inventory.		
Recommendation 2: The OIG recommended the acting assistant secretary for human resources and administration/operations, security, and preparedness establish standard guidance to ensure positions are consistently approved, created, and maintained.		
Recommendation 3: The OIG recommended the acting assistant secretary for human resources and administration/operations, security, and preparedness implement enterprise wide oversight mechanisms to monitor position management on a regular basis and ensure the HR Smart position inventory is properly maintained.		
Recommendation 4: The OIG recommended the acting under secretary for health develop and implement a standardized national policy and procedures for the documentation and communication of staffing level approvals at VA medical facilities.		
Recommendation 5: The OIG recommended the acting under secretary for health publish detailed and prescriptive guidance establishing authoritative position management documents.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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	—
Recommendation 1: The under secretary for health direct the Medical Supplies Program Office to provide Veterans Integrated Service Network and VA medical facility chief logistics officers guidance on how to use and monitor the emergency and continuous supply strategies offered in prime vendors' contingency plans to help mitigate acute emergency and continuous supply shortages during the current pandemic and future emergencies. Recommendation 2: The Office of Acquisition, Logistics, and Construction direct the Strategic Acquisition Center's Medical/Surgical Prime Vendor Program contracting officer to provide guidance to Veterans Integrated Service Network and VA medical facilities' program contracting officer's representatives on the emergency and continuous supply provisions in the contracts, and ensure contracting officers' representatives inform network and facility managers of the strategies offered by the prime vendors.		
Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs *Issued 6/15/2021 | Report Number 20-01487-142*	VHA	$129,709,810
Recommendation 1: The OIG recommended the under secretary for health revise the Veterans Health Administration handbook to include detailed roles, responsibilities, and procedures for determining entitlement to and monitoring of the clothing allowance benefit. Recommendation 2: The OIG recommended the under secretary for health develop and initiate a plan to reevaluate veterans' entitlement to recurring clothing allowance benefits in collaboration with the Veterans Benefit Administration.		
Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System *Issued 6/16/2021 | Report Number 19-07719-113*	VHA	$5,420,000
Recommendation 1: The OIG recommended the Maryland Health Care System director implement internal controls for healthcare system staff to submit and document approvals for all equipment requests in the Enterprise Equipment Request Portal before ordering and paying for equipment. Recommendation 6: The OIG recommended the Maryland Health Care System director establish processes and controls for cardholders to comply with the record retention requirements in the Federal Acquisition Regulation and VA's Financial Policy, Volume XVI, Charge Card Program.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 7: The OIG recommended the Maryland Health Care System director ensure all staff are provided clear guidance on overtime approval and payment policies and procedures that meet VA requirements. Recommendation 8: The OIG recommended the Maryland Health Care System director implement policies and procedures for supervisors to effectively monitor overtime worked and maintain documentation required to support related payments.		
Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records *Issued 6/17/2021 | Report Number 19-08658-153*	VHA	—
Recommendation 1: Ensure facilities create and implement standard operating procedures that clearly define all Health Information Management and community care staff responsibilities and the procedures for accurately scanning, importing, and indexing non-VA medical records. Recommendation 2: Require facility directors ensure that Health Information Management leaders provide or formally delegate training, quality checks, and quality assurance monitoring for community care staff responsible for medical record management.		
VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care *Issued 6/23/2021 | Report Number 20-01141-145*	VHA	—
Recommendation 4: The OIG recommended the under secretary for health establish routine oversight responsibilities for Veterans Integrated Service Network and facility leaders of emergency departments' efforts to improve the reliability of their emergency department data.		
Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic *Issued 6/24/2021 | Report Number 19-09808-171*	VHA	—
Recommendation 1: The under secretary for health ensures the Office of Connected Care Telehealth Services and the Office of Mental Health and Suicide Prevention collaborate to develop a consistent process for facility implementation of telehealth emergency plans tailored for telehealth care and the patient-clinic locations that are inclusive of procedures addressing mental health and medical emergencies and technological disruptions during telemental health care. Recommendation 2: The under secretary for health verifies the Office of Connected Care Telehealth Services reviews and implements oversight of telehealth emergency plan processes to include expectations for updating and monitoring.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: The under secretary for health confirms the Office of Connected Care Telehealth Services develops consistent processes for healthcare systems to define and communicate individual telehealth staff responsibilities during telehealth emergencies, specific to the patient-clinic locations.		
Recommendation 4: The under secretary for health ensures the Office of Connected Care Telehealth Services has a consistent process for healthcare systems to develop, maintain and communicate accurate, patient-clinic location specific telehealth emergency contact information to all telehealth staff, to include remote providers.		
Veterans 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	—
Recommendation 3: The OIG recommended the under secretary for memorial affairs evaluate all current national headstone and niche cover contracts for appropriate penalties and clauses for timeliness and quality issues and enforce and amend those contracts as necessary.		
Recommendation 5: The OIG recommended the under secretary for memorial affairs require all state and tribal cemeteries to submit certified condition and operations performance assessments annually.		
Recommendation 10: The OIG recommended the under secretary for memorial affairs use accountability measures in the Code of Federal Regulations when appropriate if grantees do not take adequate steps to correct significant long standing deficiencies.		
Recommendation 11: The OIG recommended the under secretary for memorial affairs work with the State of Hawaii Office of Veterans' Services to conduct an extensive assessment of all eight Hawaii state veterans cemeteries, including organizational oversight and operations, staffing needs (including training), gravesite marker accuracy, and grounds conditions.		
Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk *Issued 6/29/2021 | Report Number 20-00345-77*	VHA	—
Recommendation 1: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to ensure contracting officers obtain and maintain evidence of contractor-provided lists of all personal identity verification cards issued to contractor employees.		

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REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to ensure contracting officers maintain evidence documenting personal identity verification cards were returned to the issuing or designated office when the cards were no longer required and prior to closing the contract.		
Recommendation 3: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to evaluate the role of contracting officer's representatives in the personal identity verification card process for contractor employees and assess whether updates to their letter of delegation and standard operating procedures are necessary.		
Recommendation 4: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to establish policies and procedures outlining specific supervisory responsibilities for contracting officer oversight in accordance with the Government Accountability Office Standards for Internal Controls in the Federal Government.		
Recommendation 5: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to assess the contract completion statement template to determine whether to include the contractor-related personal identity verification card requirements.		
Recommendation 6: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to establish procedures within the Procurement Audit Office for periodic reviews of contract files to determine compliance with the personal identity verification card requirements established in the Federal Acquisition Regulation and the Veterans Health Administration procurement manual. Further, require the results of these reviews to be reported to senior management to help determine whether corrective actions are required.		
Recommendation 7: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to determine whether existing or planned systems can have the functionality to allow management to effectively and routinely monitor contractor employee personal identity verification cards or whether a new system should be established.		
Recommendation 8: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to assess whether contracting officers should be required to include the contractor-provided list as an explicit requirement in all Veterans Health Administration contracts that require issuance of personal identity verification cards to contractor employees.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 9: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to establish procedures to ensure contracting officers include Federal Acquisition Regulation clause 52.204-9, Personal Identity Verification of Contractor Personnel, in contracts when required.		
Recommendation 10: The OIG recommended the acting under secretary for health collaborate, as necessary, with other offices within VA that have responsibilities regarding personal identity verification cards to consider directing contracting officers to delay final payment to contractors on future contracts until all personal identity verification cards have been returned.		
VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules *Issued 7/1/2021 | Report Number 20-01646-139*	VHA	$16,600,000
Recommendation 1: Ensure payroll personnel complete overdue reconciliations of part-time physicians on adjustable work schedule agreements and take any necessary actions to address overpayments and underpayments.		
Recommendation 2: Establish oversight procedures to make certain that part-time physicians submit and validate their subsidiary time sheets and that supervisors promptly certify the time sheets.		
Recommendation 3: Train newly assigned payroll personnel on agreement reconciliation procedures and develop follow-up procedures to prevent missed reconciliations because of staff turnover.		
Recommendation 4: Implement procedures to confirm service chiefs conduct quarterly reviews of all adjustable work hour agreements that include identifying physicians with significant variances from the agreements or indicators that the cap on part-time hours is likely to be exceeded and taking corrective actions.		
Recommendation 5: Document oversight procedures for monitoring and validating compliance with the requirements of the part-time physician on adjustable work schedules program.		
Recommendation 6: Direct the program office, in coordination with the VA Office of General Counsel, to determine whether medical centers committed Antideficiency Act violations by not correcting underpayments and preventing physicians from working above the annual limit of 1,820 hours.		
Recommendation 7: Establish oversight procedures for monitoring and validating their medical centers' compliance with the requirements of the part-time physician on adjustable work schedules program.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program *Issued 7/7/2021 | Report Number 20-03185-151*	EHRM IO	—
Recommendation 1: Ensure an independent cost estimate is performed for program life-cycle cost estimates related to information technology infrastructure costs. Recommendation 2: Reassess the cost estimate for Electronic Health Record Modernization program–related information technology infrastructure and refine as needed to comply with VA's cost-estimating standards. Recommendation 3: Develop procedures for cost-estimating staff that align with VA cost-estimating guidance. Recommendation 4: Ensure costs for all information technology infrastructure upgrades funded by the Office of Information and Technology and the Veterans Health Administration or other sources needed to support the Electronic Health Record Modernization program are disclosed in program life-cycle cost estimates presented to Congress. Recommendation 5: Formalize agreements with the Office of Information and Technology and the Veterans Health Administration identifying the expected contributions from each entity toward information technology infrastructure upgrades in support of the Electronic Health Record Modernization program. Recommendation 6: Establish procedures that identify when life-cycle cost estimates should be updated and ensure those updated estimates are disclosed in the program's congressionally mandated reports.		
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	—
Recommendation 1: The under secretary for health explores the establishment of a group of Veterans Health Administration staff comprised of core user roles with expertise in Veterans Health Administration operations and Cerner electronic health record use with data architect level knowledge to lead the effort of generating optimized Veterans Health Administration clinical and administrative workflows.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Adaptive Sports Grants Management Needs Improvement *Issued 7/13/2021 | Report Number 20-01807-173*	VHA	$247,000
Recommendation 1: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director develop standard operating procedures for all processes related to managing the adaptive sports grants program.		
Recommendation 3: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director establish and execute a plan to evaluate risks posed by grant applicants before awarding grants, in accordance with VA financial policy.		
Recommendation 4: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director establish procedures to ensure the timely reimbursement of grant recipient expenses.		
Recommendation 5: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director establish grant closeout procedures that include communicating timelines with the grant recipients, documentation requirements for proper grant closeout, availability of grant funds, and a process to approve modification and extension requests.		
Recommendation 6: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director act to ensure all adaptive sports grants are closed out on time.		
Recommendation 7: The OIG recommended the under secretary for health ensure the Office of National Veterans Sports Programs and Special Events director determine, in coordination with VA's Office of Finance and Office of General Counsel, whether a Purpose Statute violation occurred, whether account adjustments need to be made, whether Antideficiency Act violations occurred, and report any Purpose Statute and Antideficiency Act violations.		
Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon *Issued 7/13/2021 | Report Number 20-01257-180*	VHA	—
Recommendation 11: The system director evaluates and determines any additional reasons for noncompliance and makes certain that employees complete annual suicide prevention refresher training.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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	—
Recommendation 3: The Eastern Oklahoma VA Health Care System director requires the chief of staff, the service chief, and the supervisory audiologist to complete clinical disclosures, as appropriate, for patients identified as being affected by the audiologist's poor care.		
Comprehensive Healthcare Inspection of the VA Puget Sound Health Care System in Seattle, Washington *Issued 7/28/2021 | Report Number 20-01261-194*	VHA	—
Recommendation 12: The system director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven business days of licensed healthcare professionals' departure from the healthcare system.		
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	—
Recommendation 3: The OIG recommended the under secretary for health reduce improper payments to below 10 percent for Beneficiary Travel; Communications, Utilities, and Other Rent; Medical Care Contracts and Agreements; Purchased Long Term Services and Supports; and VA Community Care Programs and activities.		
Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program *Issued 8/4/2021 | Report Number 20-02828-174*	VHA	$6,570,395
Recommendation 1: The OIG recommended the under secretary for health establish a process to ensure program personnel document veterans' quarterly monitoring in their electronic health records, such as by using a standardized template. Recommendation 2: The OIG recommended the under secretary for health establish a process to ensure the provider agency list in the Electronic Claims Adjudication Management System is updated as new provider agencies are added to the program. Recommendation 5: The OIG recommended the under secretary for health establish guidance to include processes that medical facilities must follow to determine if veterans are receiving the same personal care services through the Veteran Directed Care program and the Program of Comprehensive Assistance for Family Caregivers, and how to address these situations, as appropriate.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 7: The OIG recommended the under secretary for health establish procedures to identify program staffing needs and define program personnel's roles and responsibilities at the national, network, and local levels. Recommendation 8: The OIG recommended the under secretary for health update procedures for tracking and reporting demand for and use of program services and use these data to inform yearly cost estimates for the program.		
Improvements Still Needed in Processing Military Sexual Trauma Claims *Issued 8/5/2021 | Report Number 20-00041-163*	VBA	—
Recommendation 2: Develop, implement, and monitor a written plan to address continuing military sexual trauma claims processing deficiencies identified by the review team, including reassessing previously decided claims when appropriate, and report the results to the OIG. Recommendation 3: Strengthen controls to effectively implement and promote compliance with 2018 OIG report recommendations related to military sexual trauma claims. Recommendation 4: Develop, implement, and monitor a written plan that requires the Compensation Service and the Office of Field Operations to strengthen communication, oversight, and accountability of military sexual trauma claims processing.		
Review of Veterans Health Administration Staffing Models *Issued 8/19/2021 | Report Number 20-01508-214*	VHA	—
Recommendation 1: The under secretary for health coordinates with VA to review the roles, responsibilities, and number of staff required for the VA and Veterans Health Administration offices involved in the development, validation, and implementation of staffing models, and ensure that staffing model–related efforts are prioritized and supported. Recommendation 2: The under secretary for health coordinates with VA to evaluate the status of, and provide a timeline for, the development, validation, and implementation of Veterans Health Administration staffing models for all occupations. Recommendation 3: The under secretary for health coordinates with VA to evaluate the status of, and provide a timeline for, the implementation of HR Smart–related requirements referenced in VA and Veterans Health Administration policy, with a specific focus on the authorizations, vacancies, budgeted positions, and unbudgeted requirements at the facility, Veterans Integrated Service Network, and national levels.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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	—
Recommendation 2: The Fayetteville VA Medical Center director verifies that interdisciplinary assessments of homemaker and/or home health aide referrals are completed to determine patient eligibility for services. Recommendation 7: The Fayetteville VA Medical Center director makes certain that patient aligned care team providers and outpatient psychiatrists are educated about initiating specialty care consults for patients.		
Comprehensive Healthcare Inspection of the VA Eastern Colorado Health Care System in Aurora *Issued 8/25/2021 | Report Number 21-00246-228*	VHA	—
Recommendation 7: The system director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.		
Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin *Issued 8/26/2021 | Report Number 20-01917-242*	VHA	—
Recommendation 6: The Tomah VA Medical Center director ensures inpatient medical unit providers and nursing staff compliance with patient restraint management, as required by to the Tomah VA Medical Center Policy, PCS-03, Restraint and Seclusion Use.		
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	—
Recommendation 1: The under secretary for health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities fully implement action items recommended by the committees responsible for quality, safety, and value oversight functions. Recommendation 3: The under secretary for health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that root cause analyses include a review of the underlying systems to determine where system redesigns might reduce risk.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The under secretary for health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities fully implement approved root cause analysis action items and outcome measures show sustained improvement.		
Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island *Issued 9/1/2021 | Report Number 21-00265-231*	VHA	—
Recommendation 3: The associate director for patient care evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between sending and receiving facilities.		
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System in Muskogee *Issued 9/2/2021 | Report Number 21-00251-212*	VHA	—
Recommendation 6: The chief of staff evaluates and determines any additional reasons for noncompliance and ensures that all required members attend Disruptive Behavior Committee meetings.		
Recommendation 7: The chief of staff evaluates and determines any additional reasons for noncompliance and makes certain the Disruptive Behavior Committee documents patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System.		
Recommendation 8: The system director evaluates and determines any additional reasons for noncompliance and makes certain that Employee Threat Assessment Team members complete the required training.		
Recommendation 9: The system director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
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, VHA	—
Recommendation 1: The under secretary for health makes certain that policies and procedures are developed to require VA police, and other VHA staff as appropriate, to conduct searches for all persons who are reported missing on medical center campuses.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: The assistant under secretary for health for operations, in consultation with the VA chief security officer, requires VA police chiefs at medical centers to obtain approval from the facility associate director or the medical center director prior to excluding a building or area of the medical center's campus from regular patrols, and, if the building or area is subject to an enhanced-use lease, confirms with the Office of Enterprise Asset Management and the Office of General Counsel that the exclusion is not in conflict with the terms of the lease.		
Recommendation 4: For all medical centers that have property subject to enhanced-use leases, the assistant under secretary for health for operations, in consultation with the VA chief security officer, requires the medical center director or the director's designee to meet with the assigned oversight monitor at the Office of Asset Enterprise Management, the designated local site monitor, and a representative of the Office of General Counsel at least annually or sooner if there is a change of lease terms or facility leadership to discuss the terms of the enhanced-use leases and the lessee's and VA's responsibilities with respect to the leased properties.		
Recommendation 6: The executive director of the Office of Asset Enterprise Management, in conjunction with the Office of General Counsel, reviews all active enhanced-use leases to determine whether any involve portions of buildings also occupied by VA, and, if so, whether they are clear regarding the maintenance and security obligations.		
Recommendation 7: The executive director of the Office of Asset Enterprise Management modifies its existing Annual Oversight Compliance Certificate policies to include a review of VA's performance with respect to any services VA is required to provide under the terms of enhanced-use leases.		
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts *Issued 9/9/2021 | Report Number 21-00260-232*	VHA	—
Recommendation 2: The chief of staff and associate director Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that the referring physician completes all required elements of the VA Inter-Facility Transfer Form or facility-defined equivalent prior to patient transfer.		
Recommendation 3: The chief of staff and associate director Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure that staff send all pertinent medical records to the receiving facility during inter-facility transfers.		
Recommendation 4: The associate director Nursing and Patient Care Services determines the reasons for noncompliance and makes certain that nurse-to-nurse communication occurs between the sending and receiving facility.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 6: The hospital director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
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	$1,900,000
Recommendation 3: The OIG recommended the Southeast Louisiana Veterans Health Care System director ensure Federal Acquisition Regulation violations that resulted when purchase cards were used to acquire the approximately $1.9 million of supplies are reported to the Financial Services Center, and appropriate remedies, discipline, or penalties are taken in accordance with VA Financial Policy, Volume XVI. Recommendation 4: The OIG recommended the Southeast Louisiana Veterans Health Care System director request the Veterans Health Administration's head of contract activity ratify the approximately $1.9 million of identified split purchases.		
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds *Issued 9/14/2021 | Report Number 21-00263-246*	VHA	—
Recommendation 4: The system director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
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	—
Recommendation 1: The Tuscaloosa VA Medical Center director reviews informed treatment consent processes for the Inpatient Mental Health Unit and Community Living Center, confirms staff understanding of required processes, and monitors compliance.		
Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont *Issued 9/15/2021 | Report Number 21-00258-230*	VHA	—
Recommendation 2: The medical center director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire *Issued 9/15/2021 | Report Number 21-00262-247*	VHA	—
Recommendation 3: The chief of staff evaluates and determines any additional reasons for noncompliance and ensures that transferring providers identify the receiving provider on the VA Inter-Facility Transfer Form or facility-defined equivalent note. Recommendation 5: The associate director of Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures nurse-to-nurse communication occurs between the sending and receiving facility.		
Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors *Issued 9/23/2021 | Report Number 20-01802-234*	VHA	$20,000,000
Recommendation 1: Coordinate with appropriate officials, including the VA Office of General Counsel, and determine if 38 U.S.C. 1703(i) and other reimbursement practices cited in this report apply to the reimbursement rates medical facilities should pay for prosthetic and orthotic items provided by vendors. If they do apply, develop and issue guidance requiring medical facilities to adhere to them; if they do not apply, develop and issue guidance on steps medical facilities need to take to ensure they purchase prosthetic and orthotic items at reasonable prices. Recommendation 2: Develop and implement effective procedures to monitor prosthetic spending to make sure medical facilities reimburse vendors at reasonable prices for all prosthetic and orthotic items in accordance with updated pricing policies and processes. Recommendation 3: Coordinate with appropriate officials such as the Prosthetic and Sensory Aids Service executive director and the executive director, Rehabilitation and Prosthetics Service, to establish a formal oversight structure that defines the roles and responsibilities of those charged with providing oversight of the prosthetics program, rescind handbooks that reflect an outdated oversight structure, and communicate updated oversight expectations to the Veterans Integrated Service Networks to promote consistent program oversight. Recommendation 4: Resolve National Prosthetics Patient Database limitations and establish requirements to routinely monitor medical facilities' input of data to improve accuracy.		
Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta *Issued 9/23/2021 | Report Number 21-00257-252*	VHA	—
Recommendation 6: The chief of staff and associate director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that providers document patients' informed consent prior to inter-facility transfers.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 7: The chief of staff and associate director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and ensure that appropriately privileged providers complete or co-sign the VA Inter-Facility Transfer Form or equivalent note prior to patient transfers.		
Recommendation 8: The chief of staff and associate director for Patient and Nursing Services evaluate and determine any additional reasons for noncompliance and make certain that nurse-to-nurse communication between the sending and receiving facility occurs during the inter-facility transfer process.		
Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts *Issued 9/24/2021 | Report Number 21-00261-266*	VHA	—
Recommendation 5: The chief of staff and nurse executive evaluate and determine any additional reasons for noncompliance and ensure staff monitor and evaluate patient transfers.		
Recommendation 6: The chief of staff and nurse executive evaluate and determine any additional reasons for noncompliance and ensure appropriately privileged providers complete the VA Inter-Facility Transfer Form or a facility-defined equivalent note, that includes all required elements, in the electronic health record prior to patient transfers.		
Recommendation 7: The chief of staff and nurse executive evaluate and determine any additional reasons for noncompliance and make certain that staff send patients' active medication lists to the receiving facility during inter-facility transfers.		
Recommendation 8: The chief of staff and nurse executive evaluate and determine any additional reasons for noncompliance and ensure that nurse-to-nurse communication occurs as part of the inter-facility transfer process.		
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	—
Recommendation 2: The system director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.		
Recommendation 3: The chief of staff and associate director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure the referring provider identifies the receiving physician in the electronic health record.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The chief of staff and associate director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that referring providers send patients' active medication lists to receiving facilities.		
Recommendation 5: The system director evaluates and determines any additional reasons for noncompliance and ensures that staff complete the assigned prevention and management of disruptive behavior training or required training for transitory, part-time, and intermittent clinical staff.		
Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened *Issued 9/27/2021 | Report Number 20-01910-244*	OALC	—
Recommendation 1: The OIG recommended the executive director of the Office of Acquisition and Logistics assess the warrant justification template and determine whether additional information and guidance should be required.		
Recommendation 2: The OIG recommended the executive director of the Office of Acquisition and Logistics determine whether any additional formalized procedures to monitor contracting officer workload should be implemented and required throughout VA.		
Recommendation 3: The OIG recommended the executive director of the Office of Acquisition and Logistics identify updates to warrant program policies that can increase the consistency of standards and practices across VA to promote fairness and stringency of warrant requirements.		
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	—
Recommendation 4: The Fayetteville VA Coastal Health Care System director monitors that follow-up appointments for dietitians are scheduled as ordered.		
Recommendation 5: The Fayetteville VA Coastal Health Care System director ensures that non-VA dental appointments are scheduled within recommended time frames by the Community Care program scheduling staff and monitors compliance.		
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	—
Recommendation 1: Implement a plan that brings the five new noncompliant land use agreements into compliance with the West Los Angeles Leasing Act of 2016, the draft master plan, and other federal laws, allowing reasonable time to correct deficiencies noted in this report.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven *Issued 9/29/2021 | Report Number 21-00266-281*	VHA	—
Recommendation 1: The system director evaluates and determines any additional reasons for noncompliance and ensures the chief of staff regularly attends Surgical Performance Improvement Committee meetings. Recommendation 4: The chief of staff and associate director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program. Recommendation 5: The system director and associate director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that referring physicians identify the receiving physicians on the Inter-Facility Transfer Form or facility-defined equivalent note. Recommendation 6: The chief of staff and associate director for Nursing and Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure nurse-to-nurse communication occurs during the inter-facility transfer process. Recommendation 8: The system director evaluates and determines any additional reasons for noncompliance and makes certain that staff complete the required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
Comprehensive Healthcare Inspection of the West Palm Beach VA Medical Center in Florida *Issued 9/29/2021 | Report Number 21-00272-283*	VHA	—
Recommendation 2: The medical center director evaluates and determines any additional reasons for noncompliance and ensures that employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers *Issued 9/30/2021 | Report Number 20-02014-270*	VHA	—
Recommendation 6: The district director determines reasons for noncompliance with critical incident quality reviews (currently known as morbidity and mortality reviews) for serious suicide attempts, ensures completion, and monitors compliance. Recommendation 9: The district director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers.		

Appendix B: Unimplemented Reports and Recommendations

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers *Issued 9/30/2021 | Report Number 20-04051-287*	VHA	—
Recommendation 7: The district director ensures lethality risk assessments are completed and monitors compliance across all zone vet centers. Recommendation 12: The district director ensures clinical staff complete crisis reports as required and monitors compliance across all zone vet centers.		
Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida *Issued 9/30/2021 | Report Number 21-00268-273*	VHA	—
Recommendation 3: The chief of staff evaluates and determines any additional reasons for noncompliance and makes certain that referring physicians record all required elements in the electronic health record prior to patient transfers. Recommendation 5: The system director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.		
Total		**$610,447,205**

Appendix C: Reporting Requirements

Table C.1. Reporting Requirements

REQUIREMENT	SAR SECTION(S)
5a U.S.C.	
§ 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: Statutory 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

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: Statutory 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
(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

REQUIREMENT	SAR SECTION(S)
(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
(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

Appendix C: Statutory Reporting Requirements

REQUIREMENT	SAR SECTION(S)
(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
38 U.S.C. § 312(d)	
(1)(A) In addition to the authority otherwise provided by the Inspector General Act of 1978 (5 U.S.C. App.) and in accordance with the requirements of this subsection, the Inspector General, in carrying out the provisions of this section, may require by subpoena the attendance and testimony of witnesses as necessary in the performance of the functions assigned to the Inspector General by the Inspector General Act of 1978 (5 U.S.C. App.) and this section, which in the case of contumacy or refusal to obey, such subpoena shall be enforceable by order of any appropriate district court of the United States.	--
(3)(A) The Inspector General shall notify the Attorney General of the intent to issue a subpoena under paragraph (1). (B) Not later than 10 days after the date on which the Attorney General is notified pursuant to subparagraph (A), the Attorney General may object in writing to the issuance of the subpoena if the subpoena will interfere with an ongoing investigation and, if the Attorney General makes such an objection, the Inspector General may not issue the subpoena.	--

REQUIREMENT	SAR SECTION(S)
(6)(A) Along with each semiannual report submitted by the Inspector General pursuant to section 5(b) of the Inspector General Act of 1978 (5 U.S.C. App. 5(b)), the Inspector General shall include a report on the exercise of the authority provided by paragraph (1). (B) Each report submitted under subparagraph (A) shall include, for the most recently completed six-month period, the following: (i) The number of testimonial subpoenas issued and the number of individuals interviewed pursuant to such subpoenas. (ii) The number of proposed testimonial subpoenas with respect to which the Attorney General objected under paragraph (3)(B). (iii) A discussion of any challenges or concerns that the Inspector General has encountered exercising the authority provided by paragraph (1). (iv) Such other matters as the Inspector General considers appropriate.	Other 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;

Appendix C: Statutory Reporting Requirements

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

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

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

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

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

(F) any other savings which are specifically identified;

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

Final action means—

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

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

Senior government employee means—

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

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

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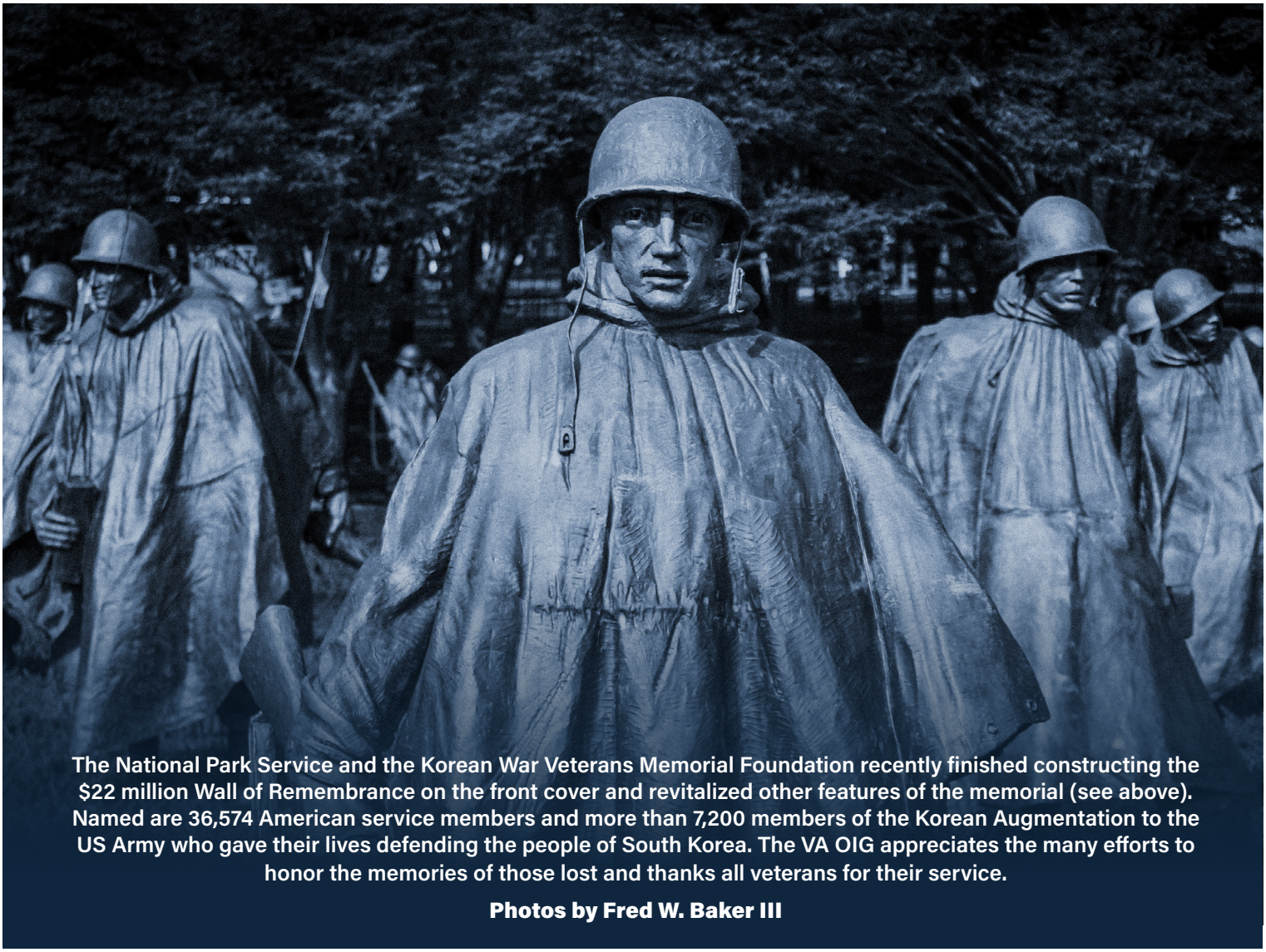

The National Park Service and the Korean War Veterans Memorial Foundation recently finished constructing the $22 million Wall of Remembrance on the front cover and revitalized other features of the memorial (see above). Named are 36,574 American service members and more than 7,200 members of the Korean Augmentation to the US Army who gave their lives defending the people of South Korea. The VA OIG appreciates the many efforts to honor the memories of those lost and thanks all veterans for their service.

Photos by Fred W. Baker III

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