US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT to Congress

Issue 89 | October 1, 2022—March 31, 2023

A sampling of photos and letters submitted by VA OIG employees honoring family members' military service.

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.

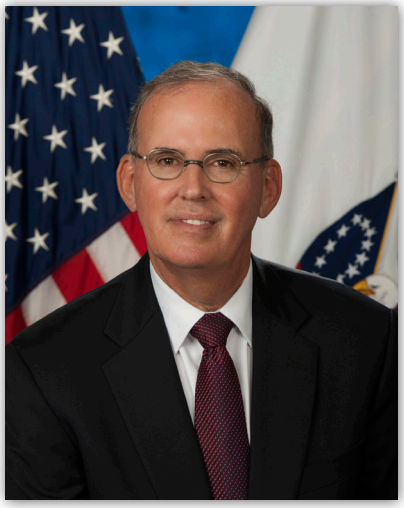
To achieve this vision, the Office of Inspector General (OIG) will

- 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



I am pleased and honored to submit our 89th *Semiannual Report to Congress*. This report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the very productive six-month reporting period (October 1, 2022, through March 31, 2023). We thank the many VA personnel and leaders who cooperated with our oversight work, even as they focus on the daily demands of serving veterans, their families, and caregivers. The OIG's work is meant to support and improve their efforts, identify deficiencies that affect their timely delivery of high-quality care and services, and to recommend effective corrective actions.

During this reporting period, I testified before the House Committee on Veterans' Affairs about the key components to building VA's accountability, which are critical to continuous improvement and fulfilling VA's promises to veterans:

1. Strong governance and clarity of roles and responsibilities
2. Adequate and qualified staffing to carry out those duties
3. Updated information technology systems and effectual business processes to support high-quality healthcare delivery, accurate and timely benefits, and efficient operations
4. Effective quality assurance and monitoring to detect and resolve issues
5. Stable leadership that fosters responsibility for actions and continuous improvement

OIG staff have identified significant deficiencies in these areas in many of the oversight reports and other activities highlighted in this *Semiannual Report to Congress*. Our oversight efforts spotlighted in this report help illustrate how weaknesses in any of these areas of accountability can negatively affect veterans and can waste or misuse taxpayer dollars.

I am grateful to have such a dedicated staff that serve veterans every day by working to make VA more effective and efficient. The covers of this report include just a few of the memorabilia staff submitted to honor family members who were veterans of wars long past. Their commitment is reflected in the impressive results of their efforts. In this six-month period, the OIG identified nearly $402 million in monetary impact with a return on investment of $4 for every dollar spent and issued 103 work products. Our hotline received and oversaw the disposition of 15,526 contacts that included incidences of alleged wrongdoing involving VA personnel or programs (such as fraud, waste, and abuse) and concerns with the department's care, services, benefits, and operations. Also during the reporting period, special

A Message from the Inspector General

agents opened 222 investigations and closed 217, with efforts leading to 122 arrests. The OIG's work resulted in 595 administrative sanctions and corrective actions as well.

OIG personnel are committed to conducting effective independent oversight of VA—a massive, complex, and constantly evolving organization—and continuing to employ new strategies to meet our mission. I thank members of Congress, veterans service organizations, and the veteran community for their unflagging support for our oversight work.

MICHAEL J. MISSAL

Contents

Organization Profile

The Department of Veterans Affairs

The VA OIG oversees VA's three administrations. The Veterans Health Administration (VHA) provides healthcare services, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits.

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

VA is the second-largest federal employer. For fiscal year (FY) 2023, VA is operating under a $313.6 billion budget with over 441,000 employees serving an estimated 18.6 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 **va.gov**.

The Office of Inspector General

MISSION

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

HISTORY AND STATUTORY AUTHORITY

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

1 Inspector General Act of 1978, 5 U.S.C. §§ 401–424, as amended by Pub. L. No. 117-263 § 5273 (2022). [The amendments in Pub. L. No. 117-263 have not yet been codified but are to be incorporated into current § 405(b) pursuant to Pub. L. No. 117-286, § 5(b), 136 Stat. 4196, 4360 (2022).]

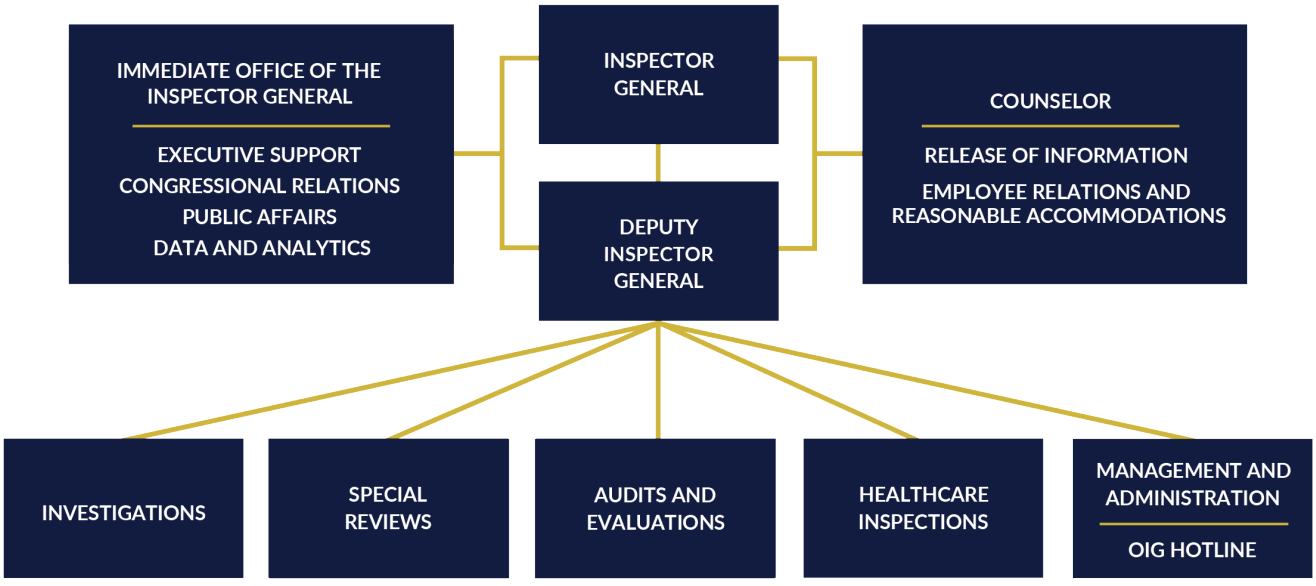
or other agreements with the Department. In addition, the Veterans Benefits and Services Act of 1988 charged the OIG with overseeing the quality of VA health care.[2] Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

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 2023 funding from ongoing appropriations provided $273 million for OIG operations—a $34 million increase from FY 2022.

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 the **VA OIG's website**.

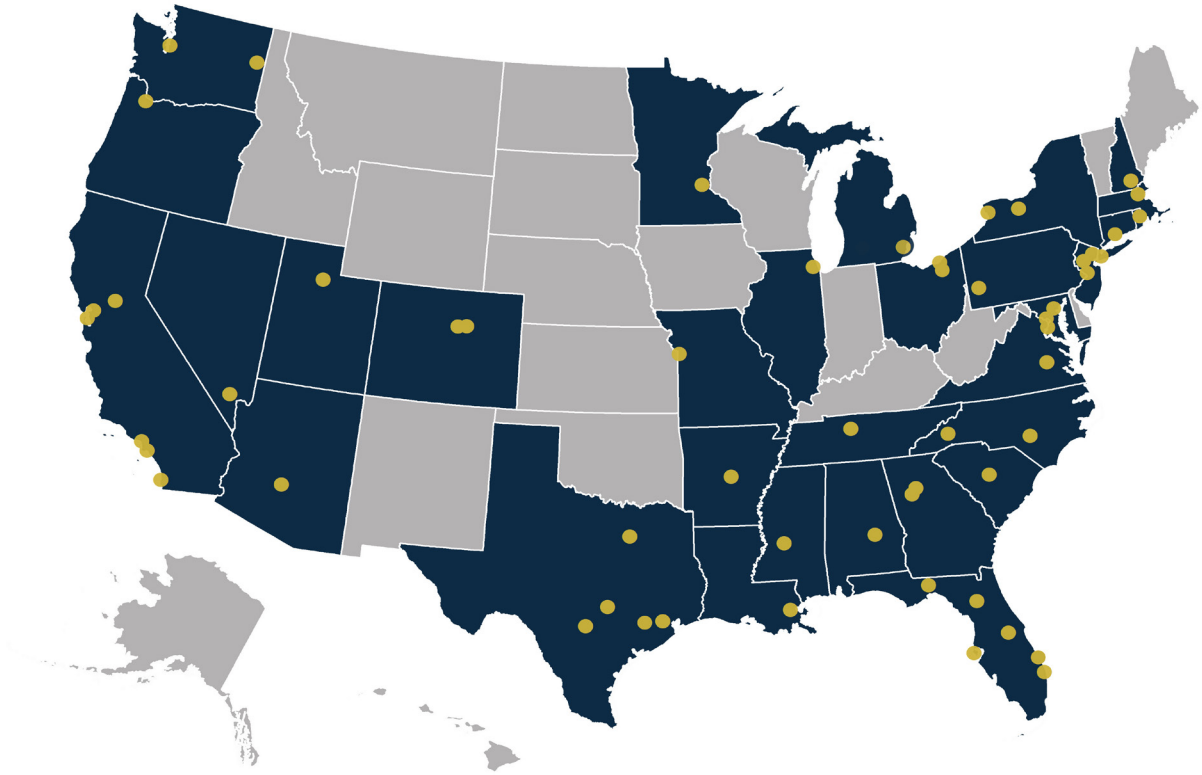
OIG ORGANIZATIONAL CHART



2 Veterans Benefits and Services Act of 1988, Pub. L. No. 100-322, 102 Stat. 487 (1988).

Organization Profile

OIG FIELD OFFICES MAP



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

Statistical Performance

At a Glance: Selected Metrics for the Reporting Period

103 WORK PRODUCTS

122 ARRESTS

103 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

1 CONGRESSIONAL TESTIMONY

595 ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS*

15,526 HOTLINE CONTACTS

$4:1 RETURN ON INVESTMENT

299 RECOMMENDATIONS TO VA

$401,853,993 MONETARY IMPACT

7 PODCASTS

* Figure includes combined results from the Hotline Division and the Office of Investigations.

Statistical Performance

Table 1. Work Products

REPORTS	THIS PERIOD
Administrative Investigations	1
Audits and Reviews	14
Care in the Community Inspections	2
Claim Reviews	0
Comprehensive Healthcare Inspection Program (National-Level)	4
Comprehensive Healthcare Inspection Program (VISN- and Facility-Level)	7
Financial Inspections	2
Healthcare Inspections	14
Information Security Inspections	2
Joint Reviews	1
National Healthcare Reviews	2
Postaward Contract Audits and Reviews*	14
Preaward Contract Audits and Reviews*	18
Special Reviews	0
Vet Center Inspections	2
Subtotal	**83**
OTHER WORK PRODUCTS	**THIS PERIOD**
Budget Request	1
Congressional Testimonies	1
Crime Alerts	1
Internal Investigation Summaries	1
Issue Statements	0
Major Management Challenges	1
Management Advisory Memoranda	1
Monthly Highlights	6
Peer Reviews Completed of Other OIGs	0
Podcasts	7
Press Releases	0
Whistleblower Reprisal Investigation Memoranda*	1
Subtotal	**20**
Total	**103**

* Denotes products prohibited from public release pursuant to federal law.

Table 2. Monetary Impact and Return on Investment

TYPE	THIS PERIOD
Better Use of Funds	$65,373,347
Dollar Recoveries	$4,926,630
Fines, Penalties, Restitution, and Civil Judgments[3]	$197,026,689
Fugitive Felon Program	$52,300,000
Savings and Cost Avoidance	$21,499,566
Questioned Costs	$60,727,761
Total Dollar Impact	**$401,853,993**
Cost of OIG Operations[4]	$109,474,143
Return on Investment[5]	**$4:1**

Table 3. Selected Hotline Division Activities

TYPE	THIS PERIOD
Contacts	15,526
Cases Opened	624
Cases Closed	528
Administrative Sanctions and Corrective Actions	477
Substantiation of Allegations Percentage Rate	42%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	27
Individuals Provided Office of Special Counsel Contact Information	39
Individuals Provided Merit Systems Protection Board Contact Information	0
Individuals Provided Office of Resolution Management Contact Information	100

Table 4. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	3
Clinical Consultations to Other Federal Entities	0
Hotline Referrals Reviewed	1,957

3 This category includes investigations conducted solely by the VA OIG and 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 $71,872,446.

4 The six-month operating cost for OHI ($27,025,857), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

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

Table 5. Selected Office of Investigations Activities

TYPE[6]	THIS PERIOD
Arrests[7]	122
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	18
Indictments	114
Indictments and Informations Resulting from Prior Referrals to Authorities	44
Criminal Complaints	15
Convictions	96
Pretrial Diversions and Deferred Prosecutions	7
Case Referrals to Department of Justice for Criminal Prosecution[8]	129
Case Referrals to State and Local Authorities for Criminal Prosecution[9]	33
Administrative Sanctions and Corrective Actions	118
Cases Opened	222
Cases Closed	217

Table 6. Selected Office of Special Reviews Activities

TYPE	THIS PERIOD
Hotline Referral Reviews	114
Investigative Interviews	58
Reviews of Complaints Alleging Whistleblower Reprisal by VA Contractors or Grantees	4
Substantiated Instances of Contractor/Grantee Whistleblower Reprisal	0

6 Pursuant to 5 U.S.C § 405(b)(12) (as amended by Pub. L. No. 117-263), all investigative data reported and analyzed were collected via the OIG's case management system. Although 5 U.S.C. § 405(b)(11) 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 1**. Summaries of selected criminal cases are summarized in the OIG's **Monthly Highlights** publication.

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

8 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) 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.

9 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) 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.

Highlighted Activities and Findings

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period October 1, 2022–March 31, 2023. Highlighted below are some of the priorities set, activities conducted, and oversight report findings issued during this six months by the VA OIG's offices. This information is supplemented by tables that identify OIG investigations and publications completed this reporting period, open (unimplemented) recommendations to VA with their monetary impact, and VA management's nonconcurrence with specific report recommendations. This *Semiannual Report to Congress* reflects changes made under the National Defense Authorization Act for Fiscal Year 2023 to simplify the reporting requirements in the IG Act, including that an OIG may provide hyperlinks directing readers to previously published information that satisfies reporting requirements in lieu of restating it in this report. All work products publicly released during this reporting period can be found by visiting the **VA OIG website**.

The Immediate Office of the Inspector General

This office is staffed by the inspector general, the deputy inspector general, and executive support personnel, including employees who prepare reports for public distribution and follow up on recommendations. The immediate office of the inspector general also includes senior leaders focused on special projects, congressional relations, data and analytics, and public affairs.

CONGRESSIONAL RELATIONS

With the leadership and guidance of staff from the Office of Congressional Relations, the OIG actively engages with Congress to promptly inform members and staff on critical issues affecting VA programs and operations. As stated in his message for this report, the inspector general participated in a hearing before the House Committee on Veterans' Affairs during this reporting period that focused on enhancing accountability at VA. In addition to discussing the five key elements of accountability, which he detailed in his **written statement to Congress**, Inspector General Missal provided information regarding leadership challenges VA faces across the enterprise; VA's follow-up on OIG recommendations from the report *Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune*; and the OIG's oversight plans for VA's implementation of the PACT Act. A recording of the hearing is available on the **committee website**.

Inspector General Michael J. Missal (right) speaks with US Comptroller General Gene Dodaro before testifying at the House Committee on Veterans' Affairs hearing on "Building an Accountable VA: Applying Lessons Learned to Drive Future Success."

Also during this reporting period, the inspector general, congressional relations staff, and other OIG personnel conducted 41 briefings with members and their staffs. Some of the OIG oversight work discussed included

- complex appeals decisions being made by VBA staff who were not properly trained or designated;
- multiple security vulnerabilities identified at VA medical facilities;
- deficiencies in the patient safety program at the Tuscaloosa VA Medical Center in Alabama;
- improvements for visit frequency and contingency planning for emergencies in intensive community mental health recovery programs;
- a completed criminal case regarding fraud in the service-disabled veteran-owned small business (SDVOSB) program;
- obstacles to veterans with visual impairments' participating fully in VBA's disability compensation program; and
- deficiencies in lethal means safety training, firearms access assessment, and safety planning for patients with suicidal behaviors involving a firearm.

Following the briefings, staff work to keep congressional offices informed of VA's progress in implementing OIG recommendations. OIG staff also respond to requests for technical assistance from congressional offices and committees during legislation drafting and after introduction of a bill to help clarify anticipated oversight efforts. During this reporting period, the OIG congressional affairs staff fielded 54 inquiries from House and Senate offices related to constituent matters for review or referral.

OIG congressional relations staff also serve as the OIG's liaison with the Government Accountability Office, as well as other oversight entities such as the Pandemic Response Accountability Committee. Active engagement with these entities is crucial to avoiding duplication of oversight efforts and to leveraging one another's work. Staff also ensure that other OIG directorates are aware of these agencies' efforts and facilitate information-sharing sessions to shape more impactful oversight efforts.

DATA AND ANALYTICS

The OIG continues to use data-driven approaches to guide oversight efforts and identify the areas of greatest risk to veterans and their families, VA programs, and the misuse of taxpayer dollars. The Office of Data and Analytics (ODA) has developed new tools and direction to all OIG directorates using advanced analyses, data visualization, and comprehensive data services to support proactive oversight of VA programs and operations. The office, in collaboration with directorate teams 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 108 ongoing projects, created 13 new internal data-monitoring tools, and made enhancements to several others. The new tools focused on a broad range of subjects, including VA's budgeting and expenditure, access to VHA health care, community care referrals and usage, and contracts and procurements. Several data-monitoring tool enhancements related to VA's information technology (IT) requirements, healthcare quality, and pharmaceutical practices.

Staff has used these tools to monitor unusual changes in clinical practices and the cost and use of VA services that resulted in follow-up directorate projects and investigations. For example, ODA noticed a

medical facility was paying significantly higher than the VA average for filling eyeglasses prescriptions from 2018 to 2020. Following an OIG inquiry, the facility was able to take prompt actions, yielding a potential cost avoidance of $7 million over two years.

This office also fulfilled a total of 242 data requests and 435 data system access requests that supported OIG oversight of VA's broad range of healthcare services and benefits programs involving disabilities, pensions, education, housing assistance, and veterans' burials. To help OIG staff feel confident in using data and the data products, ODA has continued to offer formal trainings and partnered with directorate teams to develop facility-level information to guide proactive healthcare inspections. The ongoing training series enriches OIG staff expertise through continuing professional education. ODA personnel also provide 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, VA leaders and staff, the media, veterans service organizations, Congress, 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 public statements and respond to requests for information on criminal investigations. Personnel within this office also have responsibility for following up on the implementation of OIG report recommendations. In this six-month reporting period, those efforts included sending 404 requests for status updates to various offices within VA tasked with taking action. These efforts led to the closing of 399 recommendations during this reporting period.

The OIG continued to reach a diverse audience, including expanding its presence on **LinkedIn** and **Twitter** by nearly 12,000 followers (totaling more than 79,000). Staff published 174 updates on reports, hiring activities, and other news and posted more than 127 tweets. The office released 108 email bulletins through GovDelivery, reaching more than 127,850 subscribers—an increase of nearly 13,000 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. The public affairs office also launched the *My VA OIG Story* video series during this reporting period, which features the unique background stories of individual OIG employees. The videos are used as a recruitment tool designed to support the OIG's efforts to attract individuals with a broad range of perspectives and lived experiences.

Several broadcast and print media outlets prominently featured the OIG's work, and these included the *New York Times Magazine*, Fox News, CNN, *New York Post*, *Daily Mail, Washington Examiner, Los Angeles Times*, Military.com, *U.S. News and World Report, Atlanta Journal-Constitution,* Politico, *Military Times,* and

Highlighted Activities and Findings

Stars and Stripes. The coverage highlighted OIG findings regarding the lack of training by VA staff who develop suicide safety plans, significant police officer staffing shortages at VHA facilities, VA's Electronic Health Record Modernization program failures that put patient safety at risk, concerns with VA's personnel suitability process, as well as investigations involving the sale of fraudulent nursing degrees and a former VA social worker engaging in a stolen valor scheme.

The Office of the Counselor to the Inspector General

During this reporting period, the counselor's office provided legal advice to OIG leaders, managers, and other staff on a wide range of matters. This included the application of federal laws, regulations, executive orders, and VA policy to each audit, inspection, and review completed during the six-month period. Attorneys also provided guidance on federal employment and contracting laws, assisted various US Attorneys' offices with litigation in federal district court, and represented the OIG before administrative tribunals, including the Merit Systems Protection Board and the Equal Employment Opportunity Commission.

The Strengthening Oversight for Veterans Act of 2021, signed into law in June 2022, granted the OIG authority to compel testimony from individuals previously out of reach, such as former federal employees, VA contractors' personnel, and others with relevant information to enable the OIG to perform its statutory oversight of VA programs and activities. In September 2022, Inspector General Missal issued a subpoena in accordance with statutory requirements to obtain testimony from a former VA physician concerning care the physician provided to two VA patients, as well as related privileging and credentialing processes. The former VA physician failed to comply with the subpoena and refused to testify. Lawyers from the Oversight Division of the counselor's office then worked with the US Attorney's Office for the District of Montana to file a subpoena enforcement action in US district court and to counter numerous legal arguments raised by the former VA physician. As of March 31, 2023, the matter is pending a decision from the court.

The Administrative Law Division of the counselor's office represented the 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. The Employee Relations and Reasonable Accommodation Division processed 156 actions addressing employee discipline, grievances, and other issues; responded to 93 reasonable accommodation requests and 241 leave administration inquiries; and completed an employee climate survey to assess the working environment within an OIG division and to make recommendations for improvements.

The Release of Information Office reviewed all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and responded to more than 500 record requests and appeals. Staff also continued to support US Attorney's offices in five FOIA or Privacy Act cases, including the successful conclusion of a Privacy Act case that was dismissed with prejudice at no cost to the OIG, and which preserved the OIG's ability to report on serious misconduct committed by VA senior officials.

Highlighted Activities and Findings

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 systems. During this six-month reporting period, investigative efforts resulted in 122 arrests, 96 convictions, and nearly $275 million in monetary benefits for VA.

OI continues to prioritize high-impact investigations. Its personnel coordinate 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. In addition, OI provides expert advice to Congress on VA-related anticrime measures. For example, in January, the president signed the Veterans Auto and Education Improvement Act of 2022, which included the text of an education fraud bill drafted with the assistance of OI investigators. The goals of this law include reducing the amount of education fraud and making fraud easier to detect. The law mandates, for example, that VA requires educational institutions to use a uniform application when seeking VA approval to participate in the education assistance benefit program for veterans. It also requires state approving agencies to contact the Secretary of Education to determine whether the institution seeking VA approval has ever been withdrawn or suspended from receiving benefits under Title 4 of the Higher Education Act.

To further combat education fraud, OI issued a crime alert that focused on VA-approved schools that bill veterans whose enrollment is funded by VA at a higher tuition rate than civilian students for the same courses. The alert identified multiple indicators of schools that engage in this type of education fraud, including offering discounts, tuition waivers, or scholarships exclusively to civilian students, as well as billing at least 20 percent more than non-VA-approved schools with similar course offerings. These and other OI efforts enhance the detection of high-dollar fraud in a number of risk areas to help prevent harm to veterans, their families, and caregivers. Also of note, an investigations team collaborated with the OIG's audit staff to help assess the adequacy of physical security and incident preparedness at VA medical centers nationwide.

Listen as a VA OIG senior investigator highlights the noble mission of protecting veterans on the *Veteran Oversight Now* **podcast** (Season 1, Episode 10).

During this reporting period, OI's dedicated staff conducted numerous successful investigations resulting in arrests, indictments, and sentencing. The selected investigations summarized below illustrate OI's emphasis on cases that lead to monetary recoveries for VA that can be reinvested in its 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.

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 case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period. Additional cases are listed in **table 7.**

DEFENDANT SENTENCED FOR ROLE IN MULTIPLE EDUCATION BENEFITS FRAUD SCHEMES

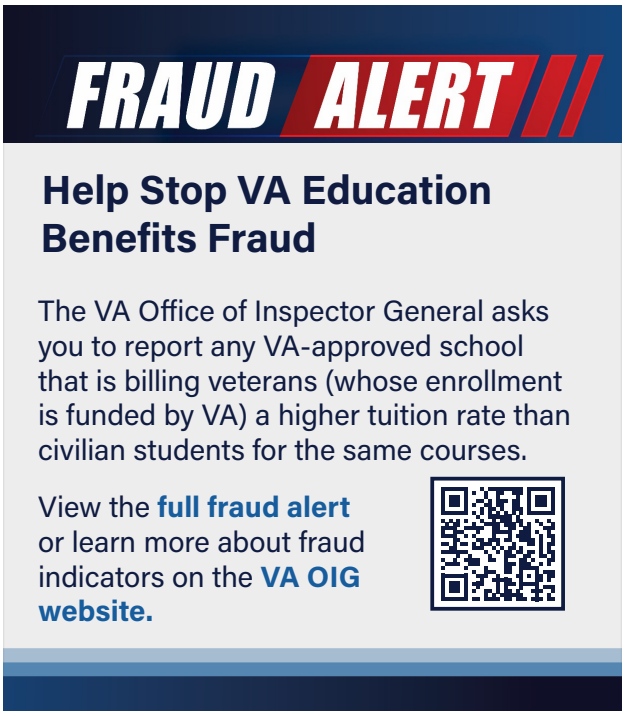
A VA OIG proactive investigation involved an individual who served as a school-certifying official and course director for a for-profit diving school and subsequently became a consultant and an instructor for another diving school. The investigation revealed that the defendant made false representations to VA by misstating the schools' compliance with VA regulations, dates of students' attendance, and hours of instruction. The defendant also falsely represented to VA that the schools were in compliance with a rule that is designed to ensure that no more than 85 percent of the students in any course are receiving VA benefits. This requirement 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 defendant was sentenced in the Southern District of Georgia to 54 months in prison, three years of probation, and restitution of more than $6 million.

TWO FORMER HOME HEALTH BUSINESS OWNERS CHARGED WITH WIRE FRAUD

Two former owners of a business that claimed they provided home health services to VA beneficiaries allegedly conspired to submit hundreds of fraudulent applications to VA for pension with aid and attendance benefits on behalf of veterans or their surviving spouses. Aid and attendance is a higher monthly pension amount paid to a qualified veteran or surviving spouse for assistance with activities of daily living. The defendants also were alleged to have falsely claimed that they provided home assistance to the veterans or surviving spouses before submitting the applications. As a result of these claims, the defendants allegedly received over $2.1 million in VA funds intended for more than 70 veterans or their surviving spouses. Following the VA OIG investigation, the former business owners were charged in the Eastern District of Louisiana with wire fraud.

DEFENDANT SENTENCED IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

An investigation by the VA OIG and Social Security Administration (SSA) OIG revealed that multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. One defendant was



sentenced in the District of Maryland to five years' probation after being found guilty at trial of conspiracy and theft of government property. The defendant's daughter and ex-son-in-law were previously sentenced in connection with this investigation after pleading guilty to the same charges. The daughter was sentenced to 30 months' imprisonment and 36 months' probation; the ex-son-in-law was sentenced to 18 months' home detention and five years' probation. All three defendants were ordered to jointly pay restitution of approximately $1 million. The loss to VA is approximately $964,000. The daughter also fraudulently received about $36,000 in SSA disability insurance benefits for her claimed disabilities.

ROOMING HOUSE OPERATOR SENTENCED IN CONNECTION WITH THEFT SCHEME

From March 2009 to February 2020, a rooming house operator used VA and SSA benefit funds for personal expenses that were intended for the care of elderly veterans with mental illnesses or physical disabilities. The house operator was sentenced in the District of Columbia to 32 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $523,600 after previously pleading guilty to mail fraud and false statements. The scheme resulted in the theft of more than $400,000 in government benefits from tenants of her rooming house, including at least $170,000 in VA funds. The VA OIG, SSA OIG, and the Special Inspector General for the Troubled Asset Relief Program conducted the investigation.

FORMER VA FIDUCIARY SENTENCED FOR MISAPPROPRIATION OF HUSBAND'S BENEFITS

A VA OIG investigation revealed that a former VA-appointed fiduciary misappropriated funds intended for her husband by spending the money on methamphetamines for herself and others, living expenses for five other people, vehicles for numerous individuals, and other items not for her husband's benefit. The fiduciary was sentenced in the Eastern District of Arkansas to 20 months in prison, three years of supervised release, and restitution of $143,000 after previously pleading guilty to misappropriation by a fiduciary.

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. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period. Additional cases are listed in **table 7.**

CARDIAC MONITORING COMPANIES AGREED TO PAY MORE THAN $44.8 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A multiagency investigation resolved allegations that a cardiac monitoring company and its subsidiary submitted claims to federal healthcare programs for heart-monitoring tests that were remotely performed in part outside the United States, which violates federal law, and in many cases by technicians who were not qualified to perform such tests. The defendants entered into a civil settlement in the Eastern District of Pennsylvania under which the companies agreed to pay more than $44.8 million to resolve these alleged False Claims Act violations. Of this amount, VA will receive $681,000. The VA OIG, Office of Personnel Management OIG, Department of Health and Human Services OIG, and Defense Criminal Investigative Service (DCIS) investigated.

TWO FORMER DALLAS VA MEDICAL CENTER EMPLOYEES PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

Two VA medical center employees in Dallas, Texas, participated in a scheme to embezzle $2.9 million from VA. The defendants used government-issued General Services Administration (GSA) purchase cards to make phony purchases through two fictitious shell companies. To conceal the scheme, they created fake invoices and used existing items in the facility's inventory to conceal that the fictitious companies never delivered any materials. Both defendants pleaded guilty in the Northern District of Texas to theft of government funds. The VA OIG, GSA OIG, and FBI conducted the investigation.

MEDICAL EQUIPMENT MANUFACTURER AGREED TO PAY $2.5 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A VA OIG investigation resolved allegations that from 2014 to 2019, a medical equipment manufacturer failed to follow the price reductions clause in a VA contract that required the defendant to provide VA with the lower prices offered to another customer. As a result, VA allegedly paid more than it should have for patient monitoring equipment. The settlement also resolves allegations that the manufacturer failed to follow a related clause in a Defense Logistics Agency contract. The manufacturer entered into a civil settlement in the District of Columbia under which it agreed to pay $2.5 million to resolve these alleged False Claims Act violations.

VA REGISTERED NURSE CHARGED WITH COMMITTING A LEWD AND LASCIVIOUS ACT ON A DEPENDENT PERSON

Another VA OIG investigation resulted in charges alleging that a VA Palo Alto Healthcare System registered nurse engaged in inappropriate sexual contact at the facility with a mentally incapacitated veteran who was receiving inpatient treatment. The nurse was arrested after being charged in Santa Clara County Superior Court with committing a lewd or lascivious act on a dependent person.

DEFENDANT SENTENCED FOR DRUG DIVERSION SCHEME

A pharmacy technician employed at the VA medical center in Kerrville, Texas, stole more than 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville and sold the substances to accomplices for further distribution. One of the accomplices was sentenced in the Western District of Texas to 35 months in prison and 36 months of supervised release. The investigation was conducted by the VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and US Postal Inspection Service.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. OI also investigates information management crimes, such as theft of IT equipment and data, network intrusions, and child pornography, as well as threats and assaults involving VA employees and facilities. The case summaries that follow provide a sampling of these investigations conducted during the reporting period. Additional cases are listed in **table 7.**

Highlighted Activities and Findings

BUSINESS OWNER SENTENCED FOR MULTIMILLION-DOLLAR COVID-19 SCAM

In March 2021, a business owner made fraudulent misrepresentations in an attempt to secure orders from VA for face masks and other personal protective equipment that would have totaled more than $806 million. This individual promised that he could obtain millions of genuine 3M masks from domestic factories but knew that fulfilling the orders would not be possible. He attempted to acquire an upfront payment from VA of over $3 million and received approximately $7.4 million from state governments and private entities by making similar false representations regarding his ability to get the protective equipment. The business owner was sentenced in the Western District of New York to 244 months in prison and restitution of $107 million after previously pleading guilty to wire fraud in connection with this COVID-19 scam and an unrelated Ponzi scheme. He also agreed to forfeit approximately $3.2 million that was seized by the VA OIG and Homeland Security Investigations.

NONVETERAN SENTENCED FOR ROLE IN SDVOSB FRAUD SCHEME

Five federal agencies conducted an investigation that revealed two nonveterans fraudulently created an SDVOSB in Texas by installing a service-disabled veteran as the ostensible owner of the business, which actually remained under their control. Over 10 years, the SDVOSB was awarded more than $254 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 sentenced in the Western District of Texas to 27 months in prison, 36 months of supervised release, and a fine of $1.75 million after previously being found guilty at trial of conspiracy to defraud the United States and wire fraud. The other nonveteran and the veteran named as the owner previously pleaded guilty in connection with this investigation, which was conducted by the VA OIG, Small Business Administration OIG, GSA OIG, DCIS, and Army Criminal Investigation Division.

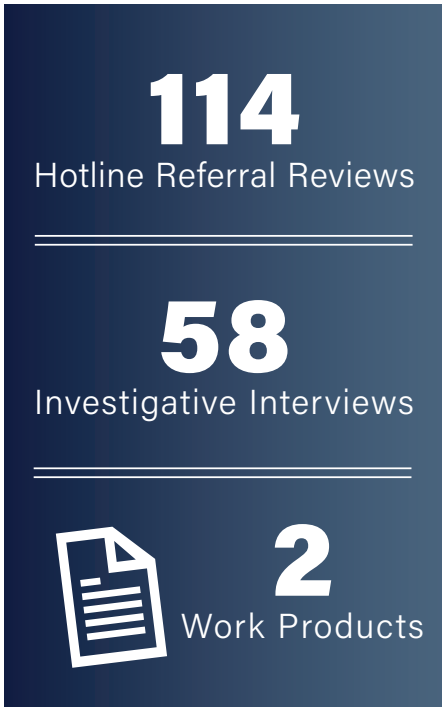
FORMER VA ACCOUNTING TECHNICIAN SENTENCED FOR PRODUCING AND POSSESSING CHILD SEXUAL ABUSE MATERIAL

A former accounting technician at the Orlando VA Medical Center in Florida used his VA-issued computer to solicit and receive sexual content from a 13-year-old victim. The defendant was sentenced in the Middle District of Florida to 35 years in prison and 15 years of supervised release, and was ordered to register as a sex offender after previously pleading guilty to sexual exploitation of a child and possession of child pornography. The investigation was conducted by the VA OIG, FBI, and the Orange County Sheriff's Office.

VETERAN SENTENCED FOR ASSAULT ON A FEDERAL OFFICER

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 veteran 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 veteran was sentenced in the Southern District of California to 18 months' imprisonment and three years' supervised release after previously pleading guilty to assault on a federal officer. The VA OIG and VA Police Service conducted this investigation.

The Office of Special Reviews



The Office of Special Reviews (OSR) provides the OIG with the flexibility to promptly examine issues not squarely within the scope of another directorate. Its multidisciplinary staff of attorneys, investigators, and analysts evaluates allegations of misconduct or gross mismanagement that implicate senior VA officials or that significantly affect VA programs and offices. The office's work also includes oversight projects that focus on issues of VA program effectiveness, waste, and ethics.

During this reporting period, OSR continued efforts to enhance its operational efficiency. The office surveyed a number of other offices of inspectors general to identify best practices for the intake and handling of statutorily mandated investigations of whistleblower reprisal against employees of VA contractors or grantees. The office is analyzing the peer OIG processes for potential incorporation in its own procedures and continued to refine aspects of its quality assurance program. OSR issued one public report and conveyed one nonpublic report to VA during this reporting period.

FEATURED REPORTS

STRONGER CONTROLS HELP ENSURE PEOPLE BARRED FROM PAID FEDERAL HEALTHCARE JOBS DO NOT WORK FOR VHA

Under federal law, VHA cannot employ individuals who have been formally excluded from having a paid position in a federal healthcare program. Exclusions can result from an individual committing healthcare fraud, patient abuse, controlled substance violations, acts resulting in license revocation, and other misconduct as specified by federal law. The List of Excluded Individuals and Entities (LEIE) is maintained by the Department of Health and Human Services OIG. LEIE screening is meant to prevent individuals who have been found unsuited for working in a federally funded healthcare program from having access to medical facilities that are responsible for protecting patients, assets, and information systems.

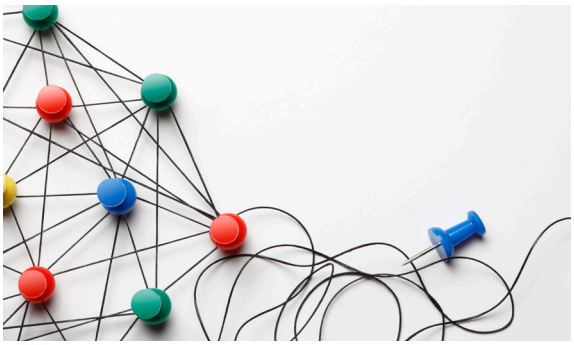
The VA OIG matched VHA personnel pay data against LEIE data for the first pay period of January 2022 and found VHA was employing four former nursing professionals excluded from having VHA positions. They had housekeeping, clerical, or support positions; they were not engaged in patients' health care. Three of them were on the list because of nursing license revocation or suspension, while the fourth was convicted of healthcare fraud.

When notified, VA took prompt action to terminate the employees and the OIG confirmed they are no longer with VHA. VHA leaders also outlined actions to address the process failures the OIG identified. In addition, leaders concurred with the report's three recommendations for completing those policy and process improvements, taking additional actions to prevent violations from recurring, and conducting

a one-time audit to confirm compliance with the federal law outside the review period. The OIG will continue to monitor VA's progress until sufficient documentation has been received to close the recommendations as implemented.

NONPUBLIC REPORT OF INVESTIGATION OF WHISTLEBLOWER RETALIATION CLAIM UNDER 41 U.S.C. § 4712

OSR also investigates allegations of whistleblower reprisal made by employees of VA contractors or grantees pursuant to 41 U.S.C. § 4712. Federal law prohibits inspectors general from disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not publicly released. To promote transparency of its activities to the greatest extent permitted by law, the OIG does release statistical information about these cases. During the reporting period, OSR completed one of these investigations and determined that the allegations of reprisal were not substantiated. As required by statute, the OIG referred the completed investigation to the VA Secretary, who is responsible for making the final agency determination to grant or deny relief.



The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 19 publications summarizing results from its oversight work, including one VA management advisory memorandum that highlighted concerns revealed across four prior oversight reports about VBA decision-making on claims-processing issues that adversely affected some beneficiaries.[10] In addition Office of Healthcare Inspections (OHI) and OHI staff helped author the report *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic* published by the Pandemic Response Accountability Committee in December 2022. Overall, its published oversight reports resulted in 77 recommendations with a potential monetary impact for VA of more than $27 million for the reporting period. Specialized OAE teams also conducted 32 preaward and postaward contract audits and reviews to help VA obtain fair and reasonable pricing on products and services as well as compliance with contract terms. OAE identified potential cost savings of nearly $65.3 million and recovered almost $33.8 million in overcharges from preaward and postaward audits and reviews.

OAE's work remained focused on weaknesses in VA's governance and oversight that affected many aspects of program performance and operations. Several of these were highlighted in both congressional testimony and the media. For example, persistent police staffing shortages and growing concerns about risks to VA staff, patient, and visitor safety at healthcare facilities led to an OIG review of observed security and incident preparedness conditions. As mentioned in the highlights from the Office of Investigations, OAE teams worked with OIG investigators to visit 70 VA medical facilities in September 2022 to provide a snapshot assessment of whether each had established minimum security plans and taken required preparedness actions consistent with VA policy. The review identified multiple security vulnerabilities and deficiencies, most notably security staffing shortages that contributed to the lack of a visible and active police presence. This oversight report also launched OAE's efforts to provide video introductions to high-profile publications and was complemented by a podcast to provide additional context to the report's findings.

Watch a VA OIG Deputy Assistant IG discuss this recent report on security vulnerabilities and deficiencies.

Although some OAE reports lead to near-immediate corrective action, others contribute to longer-term decisions that can affect key systems. For example, in this reporting period VA announced in December 2022 that it will not deploy a multibillion-dollar supply chain management system VA had been working toward for several years to replace up to 12 legacy systems. That decision was made following a prior

10 VA OIG, *VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs*, Report No. 22-01290-237, December 8, 2022.

Highlighted Activities and Findings

OIG review of VA's oversight and coordination of the proposed system's implementation at a pilot site. The OIG found that the system did not meet more than 40 percent of the high-priority business requirements identified by VA medical facility staff at the pilot site. OAE also continues to oversee other key systems such as those involving patients' electronic health records and VA's financial management.

OAE has a significant portfolio of congressionally mandated work that in this reporting period included reports on VA's compliance with financial reporting and management requirements. Of note, OAE has completed its third report of VA's compliance with the VA Transparency & Trust Act of 2021 (Transparency Act). To comply, VA must provide a detailed plan to Congress outlining its intent and justification for obligating and expending COVID-19 emergency relief funding, including Families First Coronavirus Response Act funds. While this third report found that VA generally complied with the Transparency Act, VA did not provide sufficient supporting documentation to assess line-level details needed to make a full assessment. In addition, there are two unimplemented recommendations from a March 2022 OIG report related to Transparency Act funds that could interfere with VA's long-term compliance with the act if not addressed.

The following 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. In addition, this directorate has been advancing its proactive inspections related to financial efficiency and information security at healthcare facilities—with four of these inspections in all published during this review period.

FEATURED REPORTS

VETERANS ARE STILL BEING REQUIRED TO ATTEND UNWARRANTED MEDICAL REEXAMINATIONS FOR DISABILITY BENEFITS

VBA requires reexaminations for veterans when there is a need to verify the continued existence or the current severity of a disability. VBA's policy is to request reexaminations only when mandated by law or as necessary before reducing an evaluation (i.e., reducing a veteran's disability rating due to improvements in the disability). While required reexaminations are important to ensure taxpayer dollars are spent appropriately, unwarranted reexaminations are a waste of appropriated funds, could cause undue hardships for veterans, and reduce the efficiency and timeliness of claims processing. The OIG found VBA did not require staff to cite objective evidence for why reexaminations were needed per policy. Further, it did not define criteria for claims processors responsible for reviewing reexamination controls, establishing training requirements, or monitoring completion of relevant training. VBA concurred with the OIG's three recommendations to update guidance, training, and information systems to reduce unwarranted medical reexaminations for veterans.

PERSONNEL SUITABILITY PROCESS CONCERNS AT THE BECKLEY VA MEDICAL CENTER IN WEST VIRGINIA

VHA's personnel suitability program is intended to ensure that employees hired to care for patients or handle veterans' sensitive information undergo background investigations and are suited to hold their positions. After a former nursing assistant pleaded guilty in 2020 to second-degree murder of seven patients at a VA medical center in Clarksburg, West Virginia, an OIG inspection found the Clarksburg facility did not adjudicate her background investigation within the required 90 days. This prompted an

OIG audit of the suitability program, during which deficiencies were identified at the Beckley VA Medical Center in West Virginia. Some employees did not have a background investigation initiated or were not fingerprinted, while other investigations were delayed, incorrectly discontinued, or not completed within timelines. This was due to understaffing at the facility and inadequate regional and national oversight. VHA concurred with the OIG's three recommendations to ensure suitability personnel meet background investigation requirements at Beckley.

IMPROVEMENTS NEEDED TO REDUCE DUPLICATE PAYMENTS BY VHA AND MEDICARE AND ENSURE VHA HAS AUTHORIZED COMMUNITY MEDICAL SERVICES

This review was conducted to determine whether providers were receiving duplicate payments for the same healthcare services from VHA and Medicare, as well as assessing whether VHA paid these claims without authorization. The OIG determined that VHA and Medicare had made duplicate payments for services authorized by VHA. Without an interagency system, duplicate payment risks are increased. The report includes three recommendations to the under secretary for health, including working with the Centers for Medicare and Medicaid Services to establish a data-sharing agreement with VA. The OIG also recommended identifying overpayments made for care provided to dual-eligible veterans that were not authorized by VHA and ensure documentation of care is completed or that VA seeks reimbursement for any unauthorized care. The final recommendation called on VHA to make sure all nonemergency community care is preauthorized and that documentation for all authorizations is complete and properly stored before services are provided.

ADDITIONAL ACTIONS NEEDED TO FULLY IMPLEMENT AND ASSESS THE IMPACT OF THE PATIENT REFERRAL COORDINATION INITIATIVE

The OAE review team evaluated VA's implementation of the Referral Coordination Initiative (RCI), a program designed to improve veterans' access to quality care at VA facilities and community care settings for veterans eligible under the MISSION Act of 2018. In 2019, VHA began implementing the RCI at 139 VA medical facilities and set a completion deadline of June 30, 2021. Based on interviews with leaders and four facility site visits, the OIG made seven recommendations with which the under secretary of health concurred. Among the findings were that, as of June 2022, no facility had fully implemented the RCI for all specialties. Facilities struggled with implementation due to insufficient staffing and resources, unreliable data on community care wait times, lack of required training, and confusion about which of two implementation models to apply. The program office responsible for overseeing the RCI also lacked the ability to monitor progress due to insufficient data.

VBA'S COMPENSATION SERVICE DID NOT FULLY ACCOMMODATE VETERANS WITH VISUAL IMPAIRMENTS

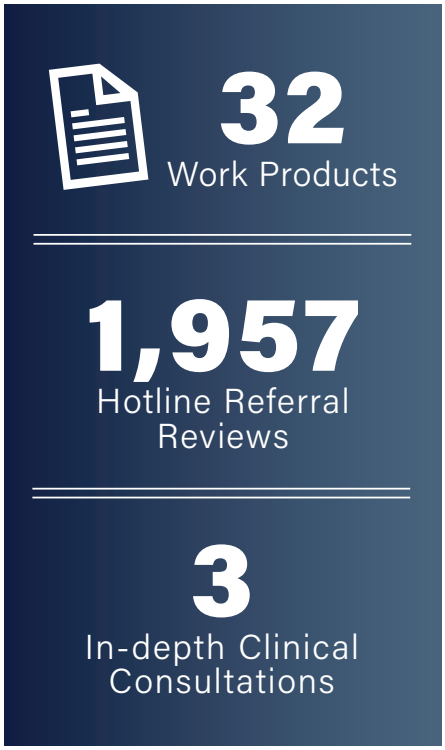
This report revealed that VBA's Compensation Service did not fully comply with section 504 of the Rehabilitation Act. Although VBA's Adjudication Procedures Manual instructs claims processors to contact visually impaired veterans by telephone to discuss the contents of decision notices, 87 of 100 claims reviewed showed no documentation of processors making such calls. Consequently, some veterans may not have been made aware of adverse claims decisions or their rights to challenge such decisions. The OIG made five recommendations to (1) update the process for developing, approving,

and issuing guidance for accommodating visually impaired veterans to include steps for consulting with other offices; (2) update the adjudication procedures to comply with federal regulations and VA policies; (3) develop and implement a quality assurance mechanism to ensure compliance with accessibility requirements; (4) assign accessibility coordinators, publicize their names, and conduct a self-evaluation of policies; and (5) coordinate a process to ensure visually impaired veterans are informed of accommodations.

IMPROVEMENTS NEEDED IN INTEGRATED FINANCIAL AND ACQUISITION MANAGEMENT SYSTEM DEPLOYMENT TO HELP ENSURE PROGRAM OBJECTIVES CAN BE MET

To modernize its financial and acquisition management systems, VA established the Financial Management Business Transformation program to replace legacy systems with the Integrated Financial and Acquisition Management System, which will be implemented in 18 waves, starting with the National Cemetery Administration. The new system went live within that administration on November 9, 2020. The VA OIG conducted this audit as part of its oversight of this extensive modernization program because of risks associated with the legacy financial systems and VA's previous failed attempts to replace them. The OIG identified four system functionality issues and three procedural weaknesses from the first Integrated Financial and Acquisition Management System deployment and made five recommendations. Improving risk management, system testing, and communication could help the Financial Management Business Transformation Service prevent issues from affecting a significantly greater number of staff at VA's larger administrations. It would also allow the Financial Management Business Transformation Service to achieve program goals of promoting operational efficiency, strengthening compliance, increasing compliance, strengthening automated controls, mitigating audit deficiencies, and improving data reliability and reporting.

The Office of Healthcare Inspections



OHI remains committed to ensuring that veterans have access to timely, high-quality health care and its staff continues to assess issues that affect key functions within VHA. During this reporting period, OHI focused on leadership and organizational risks, quality of care, mental health, suicide risk reduction, and care coordination. Several OHI reports demonstrated how deficiencies in leaders' oversight and engagement may have contributed to instances of poor and delayed care, and in some cases, adverse outcomes for patients. These deficiencies were related to critical functions such as comprehensive clinical assessments, patient safety incident reporting, prescribing practices, suicide risk assessments, and emergency department discharge planning.

OHI is also continually identifying areas that require improvements in VHA oversight, internal controls, governance structures, the clarity of roles and responsibilities, and staff training. Oversight reports in development examine a range of failures, including communication breakdowns, lack of facility emergency preparedness, inadequate responses to reports of sexual harassment, and alleged misconduct and inappropriate relations between leaders and their staff. VHA's laudable goal of consistently providing high-quality care for every patient is only possible with engaged and accountable leaders at all levels. Whenever possible, OHI staff identify the root causes of healthcare deficiencies at VHA facilities and provide recommendations to promote a leadership culture that fosters responsibility for corrective actions and continuous improvement.

During this six-month reporting period, OHI also began updating its proactive cyclical inspection programs to improve the depth of inquiry and relevance of the resulting oversight reports. These enhancements include those made to the Comprehensive Healthcare Inspection Program (CHIP), which is being enriched to offer community and population data, including education level, income level, disease burden, and myriad other factors that influence how care is delivered by specific facilities. OHI is also piloting a new Mental Health Inspection Program, which will conduct cyclical reviews of the quality of care delivered by VHA's continuum of mental health service providers. The goals of this program include identifying areas of both vulnerability and strong practices to improve patient outcomes and assessing fidelity to recovery-oriented care that supports the whole veteran.

Listen to a *Veteran Oversight Now* **podcast** in which a senior leader shares how VA OIG is changing some healthcare inspections (Season 2, Episode 3).

OHI published 31 oversight reports during the six-month period, including two national healthcare reviews and 14 reports responsive to OIG hotline complaints. These reports addressed a wide variety of topics, such as weaknesses in credentialing and privileging healthcare providers, noncompliance with community care referrals, and failure to adhere to opioid safety protocols. Of the remaining 16 reports, two each were the result of work under the OIG's cyclical Care in the Community (CITC) healthcare

inspection program and Vet Center Inspection Program (VCIP) respectively, as well as seven facility-level CHIP reports, and four CHIP summary reports that drew from all FY 2021 inspected facilities. In addition to the 31 oversight reports published during the six-month reporting period, OHI and OAE staff helped author the report *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic* published by the Pandemic Response Accountability Committee in December 2022. All OHI reports are listed in **table 8** and on the VA OIG **website**.

The selection of OHI publications highlighted below reflect the extensive array of findings and recommendations that can have a significant impact on VA programs and processes and ultimately veterans' timely access to quality care that is delivered with compassion and respect.

NATIONAL HEALTHCARE REVIEWS

The two national healthcare reviews published during this reporting period explore lethal means safety training and contingency planning for emergencies in intensive community mental health recovery programs. OHI staff also continued work on several other national reviews, including an examination of care transition from DoD to VHA for service members with opioid use disorders.

DEFICIENCIES IN LETHAL MEANS SAFETY TRAINING, FIREARMS ACCESS ASSESSMENT, AND SAFETY PLANNING FOR PATIENTS WITH SUICIDAL BEHAVIORS BY FIREARMS

The OIG conducted a review of VHA's lethal means safety (LMS) training, firearms access and safe storage discussions with patients, and clinicians' perspectives on lethal means interventions. The review team examined the electronic health records of 480 patients with firearm-related suicide behavior events. Among patients with nonfatal events, VHA staff failed to document required safe storage discussions in approximately 30 percent of comprehensive suicide risk evaluations and in 21 percent of safety plans. Six of VHA's 18 VISNs fell below an average of 90 percent compliance with required LMS training. Clinicians who reported completing the LMS training reported documenting firearms access and safe storage information in suicide risk assessments and safety plans at a higher rate than those who did not complete the training. VHA concurred with the OIG's seven recommendations related to training compliance and oversight; comprehensive suicide risk evaluation and safety plan completion; and evaluation of staff barriers to conducting and documenting the suicide risk identification strategy and firearms access and safe storage discussions.

Listen to a VA OIG psychiatrist discuss this report on the *Veteran Oversight Now* **podcast** (Season 2, Episode 1).

IMPROVEMENTS RECOMMENDED IN VISIT FREQUENCY AND CONTINGENCY PLANNING FOR EMERGENCIES IN INTENSIVE COMMUNITY MENTAL HEALTH RECOVERY PROGRAMS

This review assessed elements of the VHA Intensive Community Mental Health Recovery (ICMHR) programs, which provide high-intensity, community-based care to veterans with serious mental illness. The OHI team examined the frequency with which ICMHR veterans received care, as well as VHA healthcare systems' contingency planning for veterans' medication access during emergencies, including long-acting injectable antipsychotic medications. The OIG found

Listen to a VA OIG health system specialist discuss this report on the *Inside Oversight* **podcast** (Episode 11).

ICMHR programs did not meet VHA's requirement of conducting two to three weekly visits, on average, for high-intensity services. The majority of VHA healthcare systems also did not have ICMHR-specific contingency plans for veteran medication access. The report's three ICMHR-focused recommendations therefore relate to visit frequency and the intensity of care provided, the ongoing role of virtual care in the delivery of services, and specific contingency planning for veterans' medication access during emergencies.

HEALTHCARE INSPECTIONS

These for-cause reviews (including those previously referred to as "hotline" inspections) assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. Of the 14 healthcare inspections published during the first half of FY 2023, two summaries are highlighted below—one on suicide risk assessments and another on opioid safety.

DEFICIENCIES IN SUICIDE RISK ASSESSMENTS, CONTINUITY OF CARE, AND LEADERSHIP AT THE SOUTH BEND VET CENTER IN INDIANA

This inspection assessed allegations and concerns related to client care and the leadership at the South Bend Vet Center in Indiana. The OIG substantiated that facility staff inaccurately assessed three clients' suicide risk levels, including one client who died by suicide. The vet center director also guided staff to rate suicide risk levels as low to avoid having to complete additional steps, including the coordination of higher-level care for the veteran (which a higher rating would require); failed to provide adequate oversight and instruction to a counseling intern, including on actions needed to mitigate suicide risk; and did not facilitate a time-sensitive transition of care and ensure measures were in place that were consistent with a client's high-risk behaviors, hospitalization, and posthospitalization needs. The OIG also determined (1) a district leader that removed the vet center director from clinical care failed to report clinical deficiencies to the state licensing board; (2) vet centers lacked a clear process for state licensing board reporting; and (3) district leaders failed to ensure remediation of repeat deficiencies identified during the facility's quality reviews. VA concurred with the OIG's eight recommendations: three to the chief readjustment counseling officer related to adverse events, intern oversight, and state licensing boards, as well as five recommendations to the Midwest District 3 director related to assessing and mitigating suicide risk, continuity of care, adverse events, and state licensing board reporting.

OPIOID SAFETY AT THE VA NORTHERN CALIFORNIA HEALTH CARE SYSTEM IN MATHER

OHI staff conducted an examination of opioid therapy management practices by patient aligned care team providers and supervisors at the VA Northern California Health Care System (the facility), as well as local and VISN oversight processes for opioid therapy. The OIG found facility providers and supervisors, along with facility and VISN opioid safety leaders, followed and implemented VHA requirements and recommendations related to safe opioid therapy prescribing. However, the facility did not meet all VHA requirements. Specifically, the facility did not have a required state prescription drug monitoring program policy and its pain management policy contained outdated guidance about using opioid pain care agreements. The facility director concurred with the OIG's two recommendations related to creating and updating the policies.

Highlighted Activities and Findings

PROACTIVE, CYCLICAL INSPECTION PROGRAMS

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM

CHIP reviews are an important 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 consistently examine key conditions and activities. CHIP inspections evaluate specific areas of focus on a rotating basis each year. For the seven facility-level CHIP reports published during this reporting period, the areas of focus were (1) leadership and organizational risks; (2) quality, safety, and value; (3) medical staff privileging; (4) environment of care; and (5) mental health (emergency department and urgent care center suicide prevention initiatives). OHI also released four CHIP summary reports during this period, which analyzed individual CHIP inspection findings to provide national-level assessments. These four CHIP summary reports aggregate the findings of 45 facility-level CHIP inspections completed during FY 2021.

CARE IN THE COMMUNITY HEALTHCARE INSPECTION PROGRAM

The CITC healthcare inspection program examines key clinical and administrative processes that are associated with providing quality VA and community (non-VA) 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. The two CITC reports published during this reporting period focused on the VA Southeast Network (VISN 7) and the VA Heartland Network (VISN 15).

VET CENTER INSPECTION PROGRAM

VCIP reports provide a focused evaluation of the quality of care delivered at vet centers. These centers are community-based clinics that 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. Their services are meant to support a successful transition from military to civilian life and are open to eligible veterans, active-duty service members, National Guard members, reservists, and their families. Currently, the VCIP reports' areas of focus are (1) leadership and organizational risks; (2) quality reviews; (3) suicide prevention; (4) consultation, supervision, and training; and (5) environment of care. OHI issued two VCIP reports that included a review of vet center and district operations across two zones and eight vet centers.

The Office of Management and Administration

15,526
Hotline Contacts

477
Administrative Sanctions and Corrective Actions

42%
Allegation Substantiation Rate

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations. OMA has been overseeing the execution of the OIG's largest budget to date for FY 2023 at about $273 million. Furthermore, OMA's ongoing recruitment and retention efforts, conducted in partnership with OIG directorates, have contributed to the growth of the OIG to more than 1,100 employees. A robust diversity, equity, inclusion, and accessibility effort permeates office-wide activities. To continue bolstering the OIG's commitment to a diverse workforce and cultivating an inclusive and equitable work environment, OMA updated the hiring processes in accordance with the President's executive order on "Modernizing and Reforming the Assessment and Hiring of Federal Job Candidates."[11] It also expanded enterprise-wide mentorship opportunities. Staff training programs, which are also managed by OMA, have been recognized by the federal oversight community for their excellence, with staff from other agencies attending the OIG's orientation sessions for new personnel or supervisors. To ensure the workspaces meet operational needs, OMA opened two offices, relocated three offices, and initiated the redesign of another five offices during this reporting period.

OMA provided reliable and prompt administrative services to promote organizational effectiveness and efficiency. In the first half of FY 2023, this office was responsible for deploying several IT initiatives to modernize the OIG's infrastructure and address staff's evolving and complex needs. A new IT project management team was established to oversee these efforts to streamline oversight operations and help better secure OIG information. OMA also took steps to transform finance and acquisition operations, including coordinating and preparing for a transition to VA's Integrated Financial and Acquisition Management System and reforming internal procurement processes.

In addition to providing these and other essential support services, OMA oversees Hotline Division operations. Hotline staff receive, screen, and respond to complaints regarding VA programs and services. The hotline director also serves as the whistleblower protection coordinator. She is responsible for educating agency employees about disclosing serious wrongdoing or gross mismanagement and the rights and remedies against retaliation associated with those disclosures. In addition to receiving and screening 15,526 contacts from complainants during this six-month reporting period, hotline staff conducted activities such as the following:

- Directed complaints to OIG offices and directorates to determine if cases should be opened or other dispositions taken

11 Exec. Order No. 13,932, 3 C.F.R. 385 (2021).

- Referred 624 cases to and required a written response from applicable VA offices for OIG review 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 666 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 528 cases for which nearly 42 percent of allegations were substantiated, 447 administrative sanctions and corrective actions were taken, and $838,420 in monetary benefits were achieved
- Responded to more than 1,048 requests for senior personnel record reviews from VA staff offices prior to promotions, new jobs, and particular awards
- Issued 4,501 semicustom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope

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 directorates.

PATIENT AT WILMINGTON, DELAWARE, VA MEDICAL CENTER'S COMMUNITY LIVING CENTER EXPERIENCED HARMFUL COMPLICATIONS WHILE EATING AS A RESULT OF DIETARY ERRORS

An anonymous complainant alleged that a VA community living center (CLC) (nursing home) patient in Delaware experienced complications from improper care and subsequently died. Hotline staff requested the CLC leaders and staff review the matter and provide a response for OIG review. The CLC's independent review found the patient was initially on a special diet (minced and moist food) and was observed during all meals to avoid choking or aspiration. When the patient returned to the CLC following hospitalization (where a different diet was employed), the patient's special diet was not reinstated. The patient's roommate found the patient choking and alerted nursing staff, who responded and suctioned food from the patient's throat. Later the same day, the patient developed signs and symptoms of respiratory distress. The patient expired after developing aspiration pneumonia (a lung infection caused by inhaling food, liquid, and other matter) and oxygen deficiency. An institutional disclosure was made to the patient's family. The CLC also implemented corrective actions that included standardizing a process for promptly reassessing a veteran's care plan when returning to the CLC, implementing CLC staff annual training (with case studies and simulations) on patients with difficulty swallowing and feeding assistance, and requiring the nurses to complete the templated nursing transfer summary note in the electronic health record when sending a resident to the emergency department.

A PATIENT ATTEMPTED SUICIDE BY MEDICATION OVERDOSE AT THE VA MEDICAL CENTER IN WASHINGTON, DC

OIG hotline staff received a complaint alleging that a veteran attempted suicide in the emergency department of the Washington DC VA Medical Center after presenting with suicidal ideation. After the

allegation was referred to the facility for review, it was revealed the one-to-one sitter responsible for providing constant observation of the suicidal patient did not follow appropriate procedures, instead leaving the patient alone with their belongings in a triage room. Additionally, because no beds were immediately available in the main emergency department, the patient was not asked to wear a hospital gown nor have their belongings secured. This resulted in the patient taking an overdose of their prescribed amitriptyline. Following the suicide attempt, the veteran was transferred to the medical intensive care unit for stabilization and observation. The following corrective actions were implemented:

- A new process requiring emergency department leaders, or their designee, be notified when a one-to-one observation is instituted
- Improved environmental safety checklists and sitter documentation tools aligning with the Office of Nursing Services' recommended best practices
- Annual training for caring and managing patients deemed at high risk for suicide, including face-to-face education with simulations
- Vocera devices (secure integrated wireless voice communications) issued to emergency department sitters to help meet requirements for communicating hand-offs

POOR DOCUMENTATION AND INADEQUATE STAFF TRAINING OF PUGET SOUND'S COMMUNITY AND PRIMARY CARE CLINICS CAUSED A PATIENT'S DELAY IN CARE

A complainant reported a patient at the VA Puget Sound Health Care System had been waiting over a year for the facility's community care office to approve a consult (referral) for a follow-up positron emission tomography scan. The OIG hotline staff requested a response from the Puget Sound facility, which reviewed and substantiated the complaint. A chart review of the patient's treatment record revealed the care provider failed to document the patient's eligibility for care in the community and failed three times before correctly entering the standard episode of care (SEOC) notations using Consult Toolbox—the software that enables staff to track and manage consults. Per VA's Office of Community Care field guidebook, documentation of a patient's eligibility for care in the community and the SEOC are required before a consult is approved. The Puget Sound Health Care System provided additional training to the community care provider liaison and community care clinical reviewers on the proper use of Consult Toolbox to ensure community care eligibility is documented and the appropriate SEOC is selected to minimize delays in care. In addition, the Office of Community Care is now reviewing how healthcare providers are entering consults and conducting on-the-spot training when warranted.

VETERAN IMPROPERLY RECEIVED FULL VA DISABILITY COMPENSATION WHILE INCARCERATED

An anonymous complainant reported a veteran was collecting full VA disability compensation benefits while incarcerated for a felony conviction. The complainant provided information from the Federal Bureau of Prisons' inmate locator tool showing the veteran had been incarcerated at a federal corrections facility for the prior eight months. The matter was referred to the St. Paul Regional Office for further investigation. As a result of the findings, the veteran's VA disability compensation benefits were retroactively reduced, resulting in an overpayment of more than $15,000. The veteran did not dispute the incarceration but admitted to being unaware that incarceration for felony convictions affects VA disability compensation.

Investigations and Reports

The IG Act requires federal inspectors general to provide summaries of significant investigations closed during the reporting period, as well as specific information about the reports they publish and any associated monetary impact.[12] If, however, the office has previously published this information to its **website** or **oversight.gov,** the office may satisfy these reporting requirements by providing links to the relevant information.[13] The tables that follow identify OIG investigations and reports by type and date and include hyperlinks to their respective publications (when available).

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

Table 7 lists significant investigations with judicial action this period, with hyperlinks that direct readers to the full case summary as published in the VA OIG's **Monthly Highlights**. Although the IG Act only requires that federal inspectors general provide information regarding significant *closed* investigations, table 7 includes judicial actions from significant closed *and open* criminal investigations to provide a more accurate representation of the VA OIG's efforts this reporting period. When applicable, investigations in the table marked with an asterisk (*) would indicate those with substantiated allegations of misconduct involving a senior government employee or official; however, the VA OIG has no investigations responsive to this reporting requirement this period.[14]

Table 8 lists VA OIG reports issued this period. Within this table, reports marked with an asterisk (*) are precluded from public release pursuant to federal law.[15] Those marked with a dagger (†) indicate instances where the VA OIG did not request or receive a VA management decision during the reporting period.[16] Reports marked with a double dagger (‡) indicate those with substantiated allegations of misconduct involving a senior government employee or official.[17] A key to these symbols is included where applicable.

12 5 U.S.C. § 405(b)(2) and § 405(b)(3) (as amended by Pub. L. No. 117-263).

13 5 U.S.C. § 405(h) (as amended by Pub. L. No. 117-263).

14 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

15 Preaward and postaward audits and 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. However, to improve transparency, the OIG does publish summaries of these reports.

Investigations of whistleblower reprisal allegations made by employees of VA contractors or grantees are protected from public release pursuant to 41 U.S.C. § 4712, which prohibits disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not published.

16 5 U.S.C. § 405(b)(5)(B) (as amended by Pub. L. No. 117-263).

17 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table 7. Significant Criminal Investigations with Judicial Actions this Period

DATE	TITLE
VHA INVESTIGATIONS	
CHAMPVA AND OTHER HEALTHCARE FRAUD	
10/11/2022	Owner of Compounding Pharmacy Pleaded Guilty in Connection with Compounding Pharmacy Fraud Scheme
11/16/2022	Three Defendants Plead Guilty in Compounding Pharmacy Scheme
12/1/2022	Former Compounding Pharmacy Executives Sentenced in Connection with 2012 Fungal Meningitis Outbreak
12/6/2022	Former VA Psychologist Indicted for Submitting False Claims
12/8/2022	Owner of Two Companies Indicted in Connection with Healthcare Fraud Scheme
12/20/2022	Cardiac Monitoring Companies Agreed to Pay More Than $44.8 Million to Resolve False Claims Act Allegations
12/20/2022	Healthcare Device Manufacturer Agreed to Pay $11.36 Million to Resolve False Claims Act Allegations
1/3/2023	Veteran Sentenced for Altering Military Documents to Obtain VA Benefits
1/10/2023	Defendant Pleaded Guilty to Fraudulent Receipt of VA Funds
1/25/2023	Fraudulent Nursing Diploma Scheme Led to Federal Charges against 25 Defendants
2/9/2023	Medical Equipment Manufacturer Agreed to Pay $2.5 Million to Resolve False Claims Act Allegations
2/23/2023	Acupuncture Clinic Also Entered into Civil Settlement for $300,000 to Resolve False Claims Act Allegations
THEFT OF GOVERNMENT PROPERTY, IDENTITY THEFT, BRIBERY, AND FALSE STATEMENTS	
11/17/2022	Two Former Dallas VA Medical Center Employees Pleaded Guilty to Theft of Government Funds
12/14/2022	Former Miami VA Medical Center Employee Was Sentenced in Connection with Bribery Scheme
1/11/2023	Former VA Employee Pleaded Guilty to Theft of Diabetic Test Strips
2/8/2023	Former Purchasing Agent at the VA Medical Center in Chicago, Illinois, Sentenced for Role in Bribery Scheme
2/28/2023	Former VA Supervisor Charged in Connection with Bribery Scheme
3/6/2023	Former Registered Nurses Pleaded Guilty to False Statements
3/14/2023	Former VA Social Worker Claiming to Be a Purple Heart and Bronze Star Recipient Sentenced for Stolen Valor Scheme That Included Stealing a Veteran's Identity to Gain Benefits

Table 7. Significant Criminal Investigations with Judicial Actions this Period (Continued)

DATE	TITLE
3/14/2023	Former Philadelphia VA Medical Center Employee Sentenced in Connection with Bribery Scheme
VBA INVESTIGATIONS	
EDUCATION BENEFITS FRAUD	
12/16/2022	Technology Company Sued for Submitting False Claims for Inflated Post-9/11 GI Bill Tuition Benefits
2/15/2023	Career School and Its Director Ordered to Pay Over $9 Million to Settle False Claims Act Allegations
2/22/2023	Two Defendants Indicted in Connection with Education Benefits Fraud Scheme
THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD	
10/26/2022	Former VA Employee Indicted for Theft of Government Funds
11/9/2022	Veteran Sentenced for Stealing Disability Benefits from VA and the Social Security Administration
11/14/2022	Former VA-Appointed Fiduciary Indicted for Stealing VA Benefits from Veteran
11/16/2022	Veteran and Spouse Indicted in Connection with Compensation Benefits Fraud Scheme
12/13/2022	Veteran Sentenced for Misrepresenting Symptoms to Obtain Compensation Benefits
12/22/2022	Veteran Pleaded Guilty to Theft of Government Funds
1/10/2023	Veteran Pleaded Guilty to Defrauding VA and Threatening a Federal Agent
1/19/2023	Veteran Sentenced for Fraudulently Obtaining VA Benefits in Deceased Mother's Name
2/3/2023	Defendant Sentenced in Connection with Compensation Benefits Fraud Scheme
2/28/2023	Rooming House Operator Sentenced in Connection with Theft Scheme
3/2/2023	Former VA Fiduciary Charged with Wire Fraud
3/23/2023	Spouse of Veteran Sentenced in Connection with Compensation Benefits Fraud Scheme
LIFE INSURANCE FRAUD AND FALSE STATEMENTS	
10/27/2022	Veteran Admits to Role in Life Insurance Fraud Scheme
12/07/2022	Veteran Convicted of Lying to the Federal Aviation Administration
3/28/2023	Navy Doctor Admits to Role in Life Insurance Fraud Scheme

Table 7. Significant Criminal Investigations with Judicial Actions this Period (Continued)

DATE	TITLE
OTHER INVESTIGATIONS	
FRAUD RELATED TO COVID-19	
10/13/2022	Two Defendants Charged in Connection with COVID-19 Fraud Scheme
11/1/2022	Federal Contractor Pleaded Guilty to Bribery Charge
12/19/2022	Business Owner Sentenced for Multimillion-Dollar COVID-19 Scam
2/21/2023	VA Employee Indicted in Connection with Paycheck Protection Program Loan Fraud Scheme
3/22/2023	Pharmaceutical Executive Pleaded Guilty to Conspiring to Sell Excessively Priced COVID-19 Personal Protective Equipment to VA
DRUG DISTRIBUTION	
10/7/2022	Nonveteran Sentenced for Drug Delivery Resulting in a Veteran's Death
11/2/2022	Two Defendants Indicted for Conspiring to Distribute Fentanyl at the Bedford, Massachusetts, VA Medical Center
11/29/2022	Defendant Sentenced for Drug Diversion Scheme
1/9/2023	Two Defendants Sentenced for Drug Distribution
SEXUALLY-BASED OFFENSES	
10/26/2022	Former VA Accounting Technician Sentenced for Producing and Possessing Child Sexual Abuse Material
12/6/2022	Former Physician at the Chula Vista VA Clinic Sentenced for Invasion of Privacy
2/1/2023	Former VA Psychiatrist Charged with Sexual Battery by Fraudulent Representation
2/9/2023	VA Registered Nurse Charged with Committing a Lewd and Lascivious Act on a Dependent Person
SDVOSB FRAUD AND WORKERS' COMPENSATION PROGRAM FRAUD	
12/15/2022	Three Defendants Indicted in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme
1/18/2023	Nonveteran Sentenced for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme
2/9/2023	Former VA Nurse Pleaded Guilty in Connection with Workers' Compensation Fraud Scheme
3/3/2023	Defendants Sentenced in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

Table 7. Significant Criminal Investigations with Judicial Actions this Period (Continued)

DATE	TITLE
THREATS AND ASSAULTS AGAINST VA EMPLOYEES	
11/1/2022	**Veteran Indicted for Threatening the Chief of Police at the Clarksburg, West Virginia, VA Medical Center**
11/17/2022	**Former VA Employee Charged with Threatening a Public Official**
2/2/2023	**Incarcerated Veteran Sentenced for Threatening VA Employees**
2/8/2023	**Veteran Sentenced for Making Threats against VA Doctors**
2/10/2023	**Veteran Sentenced for Assault on a Federal Officer**
2/27/2023	**Veteran Pleaded Guilty to Destruction of Property at Bath VA Medical Center**
2/27/2023	**Son of a Veteran Sentenced for Assaulting a VA Registered Nurse**
3/1/2023	**Veteran Pleaded Guilty to Threatening VA Employees**

Table 8. Reports Issued this Period

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
10/27/2022	**Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative**	21-03924-234	—	—
10/31/2022	**Review of VA's Staffing and Vacancy Reporting under the MISSION Act of 2018**	22-01440-254	—	—
11/3/2022	**VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics**	21-03777-218	—	—
12/7/2022	**Inappropriate Community Care Consult Edits Unsubstantiated at the VA Puget Sound Health Care System in Seattle, Washington**	22-01853-09	—	—
12/7/2022	**Audit of VA's Financial Statements for Fiscal Years 2022 and 2021**	22-01155-14	—	—
12/8/2022	**VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments**	21-03063-04	—	—
12/8/2022	**Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services**	21-03630-250	—	$15,700

Note: Numbers may not sum due to rounding.
* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.
‡ Denotes products with substantiated allegations of misconduct involving a senior government employee or official.

Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
2/22/2023	Security and Incident Preparedness at VA Medical Facilities	22-03770-49	—	—
2/23/2023	Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia	21-03718-47	—	—
3/7/2023	Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2021	22-03217-59	—	—
3/9/2023	VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff	22-01814-36	—	—
3/16/2023	Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits	22-01503-65	—	—
3/21/2023	VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023	22-00879-79	—	—
3/28/2023	Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met	21-01997-69	—	—
FINANCIAL INSPECTIONS				
2/2/2023	Financial Efficiency Inspection of the VA Palo Alto Health Care System in California	22-01565-29	$3,102	$26,900,000

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† Denotes products for which the VA OIG did not request or receive a VA management decision.
‡ Denotes products with substantiated allegations of misconduct involving a senior government employee or official.

Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
2/8/2023	**Financial Efficiency Inspection of the Northern Arizona VA Health Care System**	22-01721-35	$82,600	$54,000
INFORMATION SECURITY INSPECTIONS				
1/18/2023	**Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics**	22-01836-12	—	—
1/18/2023	**Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama**	22-01854-13	—	—
MANAGEMENT ADVISORY MEMORANDA				
12/8/2022	**VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs**	22-01290-237	—	—
POSTAWARD CONTRACT AUDITS AND REVIEWS*†				
11/10/2022	**Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract**	22-02252-16	—	$21,139
11/10/2022	**Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract**	22-02253-17	—	$305,866
11/17/2022	**Review of Noncompliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts**	22-00774-05	—	$6,477,028

Note: Numbers may not sum due to rounding.
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† Denotes products for which the VA OIG did not request or receive a VA management decision.
‡ Denotes products with substantiated allegations of misconduct involving a senior government employee or official.

Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
11/17/2022	**Review of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	22-00767-06	—	$10,323,500
11/17/2022	**Independent Audit Report of a Federal Supply Schedule Contract**	22-02990-18	—	—
12/1/2022	**Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract**	22-01399-22	—	$25,647
1/10/2023	**Report of a Settlement Agreement**	18-01689-42	—	$12,547,347
2/8/2023	**Review of Noncompliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts**	22-00775-51	—	$639,032
2/9/2023	**Independent Audit Report on a Subcontractor Proposal for a Change Order Request Submitted under a VA Contract**	22-03036-62	$2,538,924	—
2/23/2023	**Review of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	22-00773-46	—	$1,833,889
3/2/2023	**Report of Settlement Agreement**	20-03111-76		$1,286,650
3/17/2023	**Independent Audit Report on a Subcontractor Proposal for a Change Order Request Submitted under a VA Contract**	22-02706-84	$1,671,094	—

Note: Numbers may not sum due to rounding.
* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.
‡ Denotes products with substantiated allegations of misconduct involving a senior government employee or official.

Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
3/24/2023	**Independent Audit Report of an Underpayment Request under a Federal Supply Schedule Contract**	23-00090-89	—	—
3/29/2023	**Independent Audit Report of a Voluntary Disclosure of Price Reductions under a Federal Supply Schedule Contract**	23-00149-88	—	$297,963
PREAWARD CONTRACT AUDITS AND REVIEWS*†				
10/24/2022	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03319-01	$395,387	—
10/24/2022	**Review of a Federal Supply Schedule Proposal Submitted under a Solicitation**	22-00567-02	$14,328,772	—
11/3/2022	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03562-10	$7,788,999	—
11/3/2022	**Review of a Federal Supply Schedule Proposal Submitted under a Solicitation**	22-03605-11	—	—
11/22/2022	**Independent Audit Report of a Proposal Submitted under an Offer Number**	22-02389-20	$20,698,120	—
12/2/2022	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03210-25	—	—
12/22/2022	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00315-30	$36	—
1/9/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00580-41	$4,397,203	—

Note: Numbers may not sum due to rounding.
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† Denotes products for which the VA OIG did not request or receive a VA management decision.
‡ Denotes products with substantiated allegations of misconduct involving a senior government employee or official.

Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
1/12/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03688-33	—	—
1/24/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-02805-57	$2,078,480	—
2/1/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00707-56	$803,500	—
2/1/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Solicitation**	22-02591-61	—	—
2/8/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00445-58	$6,561,936	—
2/10/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-02335-60	—	—
2/10/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-04036-64	—	—
2/23/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00810-63	$3,272,387	—
3/8/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00860-75	$530,650	—

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Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
3/24/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01031-83	$222,157	—
OFFICE OF HEALTHCARE INSPECTIONS				
CARE IN THE COMMUNITY INSPECTIONS				
11/1/2022	**Care in the Community Healthcare Inspection of VA Heartland Network (VISN 15)**	21-01821-08	—	—
1/12/2023	**Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)**	21-01823-31	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (NATIONAL-LEVEL)				
10/20/2022	**Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00811-07	—	—
10/20/2022	**Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00813-253	—	—
10/25/2022	**Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00818-03	—	—
10/25/2022	**Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00817-255	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL)				
11/21/2022	**Mountain Home VA Healthcare System in Tennessee**	21-03311-15	—	—

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Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
12/6/2022	Louisville VA Medical Center in Kentucky	21-03309-23	—	—
12/13/2022	Lexington VA Health Care System in Kentucky	21-03308-24	—	—
1/12/2023	El Paso VA Health Care System in Texas	22-00043-39	—	—
2/14/2023	Memphis VA Medical Center in Tennessee	21-03310-54	—	—
3/15/2023	Amarillo VA Health Care System in Texas	22-00036-68	—	—
3/30/2023	VA Texas Valley Coastal Bend Health Care System in Harlingen	22-00042-91	—	—
HEALTHCARE INSPECTIONS				
1/17/2023	Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	22-00029-40	—	—
1/19/2023	Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana	21-02511-28	—	—
1/24/2023	Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California	21-03734-32	—	—

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Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
1/25/2023	**Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada**	22-00707-44	—	—
1/25/2023	**Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland**	22-01668-45	—	—
1/26/2023	**Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison**	22-01341-43	—	—
1/31/2023	**Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System**	21-03864-34	—	—
2/1/2023	**Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana**	21-02612-53	—	—
2/2/2023	**Inadequate Outpatient Mental Health Triage and Care of a Patient at the Chico Community-Based Outpatient Clinic in California**	22-01363-52	—	—
2/27/2023	**Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama**	22-00031-67	—	—

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Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
3/8/2023	Opioid Safety at the VA Northern California Health Care System in Mather	22-00901-78	—	—
3/9/2023	Deficiencies in the Implementation and Leadership Oversight of Ketamine at the Eastern Oklahoma VA Health Care System in Muskogee	21-01836-66	—	—
3/29/2023	Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	21-03680-80	—	—
3/30/2023	Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida	22-01594-86	—	—
NATIONAL HEALTHCARE REVIEWS				
11/17/2022	Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearms	21-00175-19	—	—
1/31/2023	Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs	21-01711-50	—	—
VET CENTER INSPECTIONS				

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Table 8. Reports Issued this Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
1/12/2023	Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	21-03232-37	—	—
1/19/2023	Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers	21-03231-38	—	—
OFFICE OF AUDITS AND EVALUATIONS AND OFFICE OF HEALTHCARE INSPECTIONS				
JOINT REVIEW				
12/1/2022	Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic	21-03579-27	—	—
OFFICE OF SPECIAL REVIEWS				
ADMINISTRATIVE INVESTIGATIONS				
3/14/2023	Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA	22-02721-77	—	—
WHISTLEBLOWER REPRISAL INVESTIGATIONS (CONTRACTORS AND GRANTEES)				
1/30/2023	**Nonpublic Report of Investigation of Whistleblower Retaliation Claim Under 41 U.S.C. § 4712**	2022-02521-SR-0003	—	—
OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL				
INTERNAL INVESTIGATION SUMMARIES				
11/21/2022	Summary of Internal Investigations regarding Misconduct by a Former VA OIG Special Agent in Charge‡	23-00524-21	—	—
Total			**$65,373,347**	**$60,727,761**

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Open Recommendations

The IG Act requires federal inspectors general to identify each recommendation made during a prior reporting period for which corrective action has not been completed by the Department, including any potential cost savings associated with the recommendation.[18] **Table 9** identifies recommendations made prior to this reporting period that are open as of March 31, 2023.

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

The IG Act also requires federal inspectors general to report information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a *previous* reporting period.[19] The VA OIG has no information responsive to this requirement. However, **table 10** identifies instances where VA management did not concur with VA OIG recommendations issued this reporting period. Additional context for each instance is provided below the table.

Table 9. Open Recommendations from Prior Reporting Periods

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
7/11/2014	**Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments**	13-01452-214	5	$205,000,000
9/28/2018	**VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016**	18-00474-300	1	—
12/13/2018	**Inadequate Governance of the VA Police Program at Medical Facilities**	17-01007-01	1, 4	—
9/5/2019	**Accuracy of Claims Decisions Involving Conditions of the Spine**	18-05663-189	2	$64,800,000
10/10/2019	**Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018**	19-07040-243	3–4, 9–10, 13	—

18 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

19 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
12/17/2019	Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers	17-03718-240	1, 7–8	$84,000,000
4/27/2020	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	19-09447-136	1, 4	—
5/19/2020	Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina	19-08256-124	3	—
6/18/2020	Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka	19-06870-175	14	—
7/21/2020	Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia	18-01622-207	1	—
8/12/2020	Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri	19-06873-210	7	—
9/2/2020	Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources	18-03800-232	1	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
11/18/2020	Comprehensive Healthcare Inspection of the Atlanta VA Health Care System in Decatur, Georgia	20-00129-09	10	—
11/24/2020	Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019	20-01994-18	27	—
2/10/2021	Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	20-01036-70	2	—
2/25/2021	Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement	19-07053-51	6–7, 9–11	—
3/3/2021	VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors	20-00421-63	1–6	—
3/4/2021	Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing	19-06147-50	1–4, 9–10	$3,700,000
5/19/2021	Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio	20-01276-131	5, 9	—
5/25/2021	Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03178-116	5	—
6/2/2021	Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	18-02496-157	1, 9–10	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
6/9/2021	Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic	20-03326-124	2	—
6/10/2021	Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency	20-00541-133	1–5	—
6/15/2021	Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs	20-01487-142	1–2	$129,709,810
6/16/2021	Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System	19-07719-113	1, 6, 8	$5,420,000
6/17/2021	Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records	19-08658-153	1–2	—
6/24/2021	Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards	20-00176-125	5, 10–11	—
6/29/2021	Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk	20-00345-77	1–10	—
7/1/2021	VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules	20-01646-139	1–7	$16,600,000

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
7/7/2021	Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03185-151	2–6	—
7/13/2021	Adaptive Sports Grants Management Needs Improvement	20-01807-173	1, 3–7	$247,000
7/13/2021	Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon	20-01257-180	11	—
8/2/2021	Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020	21-00519-192	3	—
8/4/2021	Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program	20-02828-174	1, 7	—
8/5/2021	Improvements Still Needed in Processing Military Sexual Trauma Claims	20-00041-163	2	—
8/19/2021	Review of Veterans Health Administration Staffing Models	20-01508-214	1–3	—
8/25/2021	Comprehensive Healthcare Inspection of the VA Eastern Colorado Health Care System in Aurora	21-00246-228	7	—
9/1/2021	Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island	21-00265-231	3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
9/2/2021	Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System in Muskogee	21-00251-212	6–7, 9	—
9/9/2021	Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus	20-03465-243	1, 3–4	—
9/9/2021	Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts	21-00260-232	2–4, 6	—
9/14/2021	Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	21-00263-246	4	—
9/15/2021	Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont	21-00258-230	2	—
9/23/2021	Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors	20-01802-234	1–4	$20,000,000
9/23/2021	Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta	21-00257-252	6	—
9/24/2021	Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts	21-00261-266	5–8	—
9/27/2021	Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened	20-01910-244	1–3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
9/27/2021	Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina	21-01304-275	4–5	—
9/29/2021	VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report	20-03407-253	1	—
9/29/2021	Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven	21-00266-281	8	—
9/30/2021	Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers	20-04051-287	7	—
9/30/2021	Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida	21-00268-273	3, 5	—
10/21/2021	Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance	19-06004-225	7	—
10/26/2021	Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico	21-00270-04	7, 10	—
11/8/2021	Audit of VA's Compliance under the DATA Act of 2014	20-04237-09	1, 3–4, 6–7, 9, 11	—
11/10/2021	Deficiencies in Select Community Care Consult (Stat) Processes during the COVID-19 Pandemic	20-03437-26	5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
11/10/2021	New Patient Scheduling System Needs Improvement as VA Expands Its Implementation	21-00434-233	2–3, 6–7	—
11/23/2021	Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico	20-03700-35	2	—
12/2/2021	VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements	20-00426-02	1	—
12/7/2021	Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health Care in Veterans Health Administration Facilities, Fiscal Year 2020	21-01508-32	1–3	—
12/8/2021	VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services	20-01099-249	3	$341,700,000
12/8/2021	VHA Risks Overpaying Community Care Providers for Evaluation and Management Services	21-01807-251	1	$59,600,000
12/9/2021	Comprehensive Healthcare Inspection of the Fayetteville VA Coastal Health Care System in North Carolina	21-00277-41	3, 6	—
12/15/2021	Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains	19-09592-262	1, 3, 6, 9	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
12/15/2021	Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits	20-04219-07	6	$136,000,000
12/15/2021	Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma VA Health Care System in Muskogee	21-01801-45	1	—
12/16/2021	Inadequate Oversight of VHA's Home Oxygen Program	19-07812-29	3–5	—
12/16/2021	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	21-01038-49	2–3	—
12/20/2021	MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data	20-03351-08	1	—
12/20/2021	Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	21-01804-56	4, 6, 16	—
1/11/2022	Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina	21-00279-54	2	—
1/13/2022	VA's Use of the Defense Logistics Agency's Electronic Catalog for Medical Items	20-00552-30	2–6	$4,420,878

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
1/20/2022	**Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020**	21-01507-61	1–4, 6–7	—
1/31/2022	**Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia**	21-00292-73	5	—
2/3/2022	**Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina**	21-00276-67	8	—
2/9/2022	**Lack of Care Coordination and Hepatocellular Carcinoma Surveillance of a Patient at the VA Eastern Colorado Health Care System in Aurora**	21-02492-77	6	—
2/17/2022	**First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions**	20-03086-70	1–3	—
2/17/2022	**Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020**	21-01506-76	3	—
3/3/2022	**Comprehensive Healthcare Inspection of the James J. Peters VA Medical Center in Bronx, New York**	21-00289-90	5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
3/8/2022	Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia	21-00280-89	7	—
3/9/2022	Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened	21-02750-63	5	$88,700
3/16/2022	Comprehensive Healthcare Inspection of the Salem VA Medical Center in Virginia	21-00281-100	1	—
3/17/2022	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	21-00781-108	3	—
3/17/2022	Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-00781-109	1	—
3/17/2022	Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-00656-110	1	—
3/23/2022	Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	21-00282-111	4	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
3/24/2022	Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints	21-00510-105	1–3	—
3/28/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020	21-01503-112	1–5	—
4/6/2022	Comprehensive Healthcare Inspection of the VA Western New York Healthcare System in Buffalo	21-00290-116	6	—
4/7/2022	Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities	20-00827-126	1–4	—
4/13/2022	Federal Information Security Modernization Act Audit for Fiscal Year 2021	21-01309-74	1–26	—
4/14/2022	Quality of Care Concerns and Leaders' Responses at the Amarillo VA Health Care System in Texas	21-02491-129	1	—
4/19/2022	Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York	21-00294-128	7	—
4/25/2022	The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule	21-02889-134	1–5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
4/27/2022	Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims	21-03916-103	2	—
5/3/2022	Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement	21-02437-120	5	$624,000
5/3/2022	Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania	21-01712-144	4	—
5/4/2022	Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York	21-00291-136	5	—
5/5/2022	Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York	21-00300-130	5	—
5/10/2022	The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic	21-00533-157	1	—
5/19/2022	Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23)	21-01820-159	2–3	—
5/24/2022	VHA Continues to Face Challenges with Billing Private Insurers for Community Care	21-00846-104	1–3	$805,200,000

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
5/25/2022	Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York	21-00295-161	8, 10	—
5/26/2022	Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York	21-00299-162	5, 8	—
6/1/2022	Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls	21-01123-97	1–2	—
6/1/2022	Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona	21-02453-99	4	—
6/1/2022	Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas	21-03305-139	5	—
6/1/2022	Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-03020-168	1–2	—
6/2/2022	Comprehensive Healthcare Inspection of the Beckley VA Medical Center in West Virginia	21-00286-163	4	—
6/2/2022	Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia	21-00293-170	2, 5–6	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
6/6/2022	Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight	20-02186-78	1–5	—
6/8/2022	Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions	21-01237-127	2–3	—
6/14/2022	Financial Efficiency Review of the VA El Paso Healthcare System in Texas and New Mexico	21-02197-165	2, 10, 12	$159,000
6/14/2022	Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore	21-00283-173	4–8	—
6/16/2022	Comprehensive Healthcare Inspection of the Washington DC VA Medical Center	21-00288-175	6, 9	—
6/22/2022	Mission Accountability Support Tracker Lacked Sufficient Security Controls	21-03080-142	2–3	—
6/28/2022	Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia	21-03349-186	1–7	—
6/28/2022	Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2021	22-00576-178	1	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
6/30/2022	Pharmacists' Practices Delayed Buprenorphine Refills for Patients with Opioid Use Disorder at the New Mexico VA Health Care System in Albuquerque	21-03195-189	1–2	—
7/7/2022	Financial Efficiency Review of the VA Boston Healthcare System in Massachusetts	21-03853-174	6–7	—
7/13/2022	Contract Closeout Compliance Needs Improvement at Regional Procurement Offices Central and West	21-02599-156	1	$4,400,000
7/13/2022	Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia	21-00287-194	5–6, 9	—
7/14/2022	Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland	21-00239-180	1	—
7/14/2022	Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training	21-02201-200	3	—
7/20/2022	Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Led to $12.8 Million in Questioned Costs	21-01081-155	3–5	$12,800,000
7/21/2022	Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure	21-02704-135	2–3, 6	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
7/21/2022	Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement	21-02732-153	1–3, 6–7	—
7/27/2022	Financial Efficiency Review of the VA Black Hills Health Care System in South Dakota	22-00066-184	1, 5, 7	$174,468
7/28/2022	VBA Improperly Created Debts When Reducing Veterans' Disability Levels	21-01351-151	1–4	—
8/3/2022	The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring	21-02401-190	3	—
8/3/2022	VA Needs to Improve Governance of Identity, Credential, and Access Management Processes	22-00210-191	1–4	—
8/4/2022	Digital Divide Consults and Devices for VA Video Connect Appointments	21-02668-182	1–2, 4–8, 10	$14,478,000
8/9/2022	The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing	21-01361-192	1, 5–6	—
8/25/2022	Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune	21-03061-209	1–2	$13,800,000
9/7/2022	VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims	22-00404-207	1, 3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
9/12/2022	Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	21-02326-233	1–3	—
9/15/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021	22-00815-232	1–4	—
9/19/2022	New York/New Jersey VA Health Care Network (VISN 2) Should Improve Boiler Maintenance to Reduce Safety Risks and Prevent Care Disruptions	21-00887-211	5	—
9/22/2022	Home Improvements and Structural Alterations Program Needs Greater Oversight	21-03906-226	1–2, 4–5	$13,798,444
9/22/2022	Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana	22-00971-217	4–5	—
9/27/2022	Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	21-03203-239	1–2, 4–7	—
9/27/2022	Alleged Failures to Adequately Equip Executive Protection Personnel Are Substantiated in Part	21-02145-243	1–5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
9/27/2022	**Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas**	22-00973-215	1–2, 5	—
9/28/2022	**Buy American Act Compliance Deficiencies at Regional Procurement Office Central**	21-02641-229	1–2	—
9/28/2022	**Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance**	21-00797-248	1–7	—
Total				**$1,936,720,300**

Table 10. Instances Where VA Management Did Not Concur with VA OIG Recommendations Issued This Reporting Period

DATE	TITLE	NUMBER	REC. NUMBER(S)	MONETARY IMPACT
1/18/2023	**Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics**	22-01836-12	4	—
1/18/2023	**Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama**	22-01854-13	3	—

- In the report *Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics*, OIT concurred with eight of the VA OIG's nine recommendations but did not concur with recommendation 4, which was to verify that access control lists have been applied to network segments that contain medical systems. The assistant secretary for information and technology and chief information officer disagreed that the network segments the VA OIG identified contain sensitive devices requiring isolation using access control lists. The assistant secretary further stated that the devices identified by the VA OIG do not meet the definition of devices requiring isolation as defined by VA's Office of Information Security. The VA OIG disagrees. The eight network segments noted by the OIG were identified by the facility as containing medical systems, including VistA Imaging, Telehealth, medical devices, and equipment used for sterile processing. Per VA policy, these devices would fall under the medical device isolation architecture guidance and should have access control lists applied. VA policy covers these medical devices that are on the VA network and store sensitive patient information. Beginning on **page 29** of the report, appendix D includes the full text of OIT's comments, and the VA OIG's response is on **page 17**. The OIG stands by this recommendation and considers it open.
- In the report *Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama*, OIT concurred with seven of the VA OIG's eight recommendations but did not concur with recommendation 3, which was to ensure all databases at the medical center are part of the periodic database scan process. Specifically, the assistant secretary for information and technology and chief information officer stated that although VA was initially unable to provide historical vulnerability scan results for specific devices, the Cybersecurity Operations Center later provided the requested evidence to the OIG. The VA OIG disagrees. The evidence provided by the Cybersecurity Operations Center, which was meant to demonstrate that all databases at the medical center are included in the scanning process, does not include the specific devices missing from the original response to the OIG's request for scan results. Further, prior to this report's publication, the OIG accessed OIT's most recent scan results and the devices still were not present at that time. Consequently, the OIG was unable to validate the claim that all databases are included in the medical center's scanning process. Beginning on **page 29** of the report, appendix D includes the full text of OIT's comments and the VA OIG's response is on **page 11**. The OIG stands by this recommendation and considers it open.

Other Disclosures

OIG Reviews of Proposed Legislation and Regulations

Inspectors general are required by the IG Act to review existing and proposed legislation and regulations relating to VA programs and operations and to make recommendations, including 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.[20] During this reporting period, the OIG reviewed six legislative or regulatory proposals and made five comments. The OIG also reviewed nine internal VA directives and handbooks that guide the work of VA employees and provided one comment.

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.[21] 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.[22] The act also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority. The VA OIG reports the following information with respect to the use of its testimonial subpoena authority during this reporting period:

- Inspector General Missal issued one testimonial subpoena and OIG staff interviewed one individual.
- The US Attorney General did not object to any proposed subpoenas.
- The OIG sought to take testimony from a former VA employee who was served with a testimonial subpoena in September 2022. Counsel for the former employee accepted service of the subpoena, and the former employee appeared at the specified date and time but refused to testify. After efforts to resolve the issue with the former employee's counsel proved unsuccessful, the OIG engaged the US Attorney's Office for the District of Montana. In December 2022, an

20 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

21 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

22 Pub. L. No. 117-136 § 2(a).

Assistant United States Attorney filed a subpoena enforcement action in federal district court in Montana. The former employee opposed the government's petition. As of March 31, 2023, the matter is pending a decision from the court.

- There are no other matters to report.

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.[23] The VA OIG reports no such instances occurring during this reporting period.

Instances of Whistleblower Retaliation

Inspectors general are required by the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers as well as any consequences imposed by the Department to hold those officials accountable.[24] The VA 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. Therefore, the VA OIG has no information responsive to this reporting requirement.

The VA OIG does however investigate allegations of whistleblower reprisal made by employees of VA contractors or grantees.[25] Federal law prohibits inspectors general from disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not publicly released. In the spirit of transparency, the VA OIG can report that it reviewed four complaints of alleged whistleblower reprisal by VA contractors or grantees during this reporting period, and did not substantiate any. Consistent with the statutory requirements for these cases, the OIG refers the findings of completed investigations to the VA Secretary, who is responsible for granting or denying relief to the complainant.[26]

Closed 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, or audit, or any investigation involving a senior government employee, conducted by the OIG that is closed and was not disclosed to the public.[27] The VA OIG's practice is

23 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

24 5 U.S.C. § 405(b)(14)(A) and §405(b)(14)(B) (as amended by Pub. L. No. 117-263).

25 41 U.S.C. § 4712 (b)(2).

26 41 U.S.C. § 4712(c).

27 5 U.S.C. § 405(b)(16)(A) and § 405(b)(16)(B) (as amended by Pub. L. No. 117-263).

to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

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 Board of Veterans' Appeals administrative law judge committed criminal acts including possession of child pornography, engaging in other illicit sexual behavior, improperly disposing of non-VA government documents, and committing retaliation. The OIG used numerous investigative techniques including forensic reviews of the judge's government-issued laptop and email account but did not find any evidence that substantiated the allegations. During an interview with investigators, the judge denied all of the allegations. This matter was not referred to the Department of Justice because no criminal conduct was identified. This investigation was closed on October 11, 2022.
- The OIG received an allegation that a former VHA associate director may have created a conflict of interest when accepting a vice president position with a particular company upon his retirement from government service. The allegation also stated that this individual pressured VA staff to award a contract to the company while he was still a VA employee. This investigation determined that approximately 16 months prior to the former associate director's retirement, VA awarded a set-aside contract to the company worth approximately $2.9 million. The contract was awarded as an emergency authorization to upgrade and repair a continuous monitoring temperature control system in response to a negative finding during a Joint Commission inspection. Prior to his retirement, the VA Office of General Counsel also issued an ethics advisory to the associate director pertaining to his future employment with this company. VA's Office of General Counsel determined that although he was a GS-15 employee, the associate director was not classified as a "senior employee" and was not personally and substantially involved in any VA contracts during his VA employment. As a result, there were no government ethics rules prohibiting his employment by the company after his retirement. The OIG found no evidence of any quid pro quo discussions or other improper communications with the company during the associate director's VA employment. This matter was also not referred to the Department of Justice because no criminal conduct was identified. This investigation was closed on January 9, 2023.

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.[28] This information is presented in **table 11**. 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.[29] This information is presented in **table 12**. If the VA OIG did not complete any peer reviews of another office this period, then the table lists the most recent peer review completed.

TABLE 11. MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

DATE COMPLETED	TYPE	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
4/26/2022	Audits	DOJ OIG	Pass	None
6/25/2020	Inspections and Evaluations	HHS OIG (Lead), HUD OIG, DOI OIG, SBA OIG	Pass	None
12/10/2018*	Investigations	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.

TABLE 12. MOST RECENT PEER REVIEWS COMPLETED BY THE VA OIG

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

28 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

29 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

Awards and Recognition

Employee Recognition of Military Personnel

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

- Keith Cook, a criminal investigator in San Antonio, Texas, was activated by the Texas Air National Guard in May 2022 through October 2022.
- Christopher Sizemore, an auditor in Bay Pines, Florida, was activated by the US Air Force in June 2022 and returned in March 2023.

Appendix: Reporting Requirements

As Required by the IG Act (5 U.S.C. § 405(b))

§ 404. DUTIES AND RESPONSIBILITIES

(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 relating to programs and operations of such establishment and to make recommendations, including in the semiannual reports required by section 5(a), 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;

See: Other Disclosures

§ 405. REPORTS

(b) 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 programs and operations of such establishment and associated reports and recommendations for corrective action made by the Office;

See: Investigations and Reports

(2) an identification of each recommendation made before the reporting period, for which corrective action has not been completed, including the potential cost savings associated with the recommendation;

See: Open Recommendations

(3) a summary of significant investigations closed during the reporting period;

See: Investigations and Reports

(4) an identification of the total number of convictions during the reporting period resulting from investigations;

See: Statistical Performance

(5) information regarding each audit, inspection, or evaluation report issued during the reporting period, including—

(A) a listing of each audit, inspection, or evaluation;

Appendix: Reporting Requirements

(B) if 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, including whether a management decision has been made by the end of the reporting period;

See: Investigations and Reports

(6) information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a previous reporting period;

See: Open Recommendations

(7) the information described under section 804(b) of the **Federal Financial Management Improvement Act of 1996**;

See: Investigations and Reports (October–March issue only)

(8)(A) an appendix containing the results of any peer review conducted by another Office of Inspector General 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 Office of Inspector General;

See: Other Disclosures

(9) 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;

See: Other Disclosures

(10) 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;

See: Other Disclosures

(11) 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;

See: Statistical Performance

(12) a description of the metrics used for developing the data for the statistical tables under paragraph (17)[30];

See: Statistical Performance

(13) a report on each investigation conducted by the Office where allegations of misconduct were substantiated involving a senior Government employee or senior official (as defined by the Office) if the establishment does not have senior Government employees, which shall include—

(A) the name of the senior Government employee, if already made public by the Office; and

(B) a detailed description of—

(i) the facts and circumstances of the investigation; and

(ii) 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;

See: Investigations and Reports

(14)(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;

See: Other Disclosures

(15) information related to interference by the establishment, including—

(A) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including—

(i) with budget constraints designed to limit the capabilities of the Office; and

(ii) 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

(B) a summary of each report made to the head of the establishment under section 6(c)(2) during the reporting period;

See: Other Disclosures

(16) 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

30 As so in original. Probably should be (11).

(B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.

See: Other Disclosures

(h) if an Office has published any portion of the report or information required under subsection (a) to the website of the Office or on **oversight.gov**, the Office may elect to provide links to the relevant webpage or website in the report of the Office under subsection (a) in lieu of including the information in that report.

As Required by the Strengthening Oversight for Veterans Act of 2021 (38 U.S.C. § 312(d))

§ 2. TESTIMONIAL SUBPOENA AUTHORITY OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF VETERANS AFFAIRS

(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. § 405(b)), the Inspector General shall include a report on the exercise of the authority provided by 38 U.S.C. § 312(d)(1).

(B) Time period. 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.

See: Other Disclosures

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;

Appendix: Reporting Requirements

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

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

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

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

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

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

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

(F) any other savings which are specifically identified;

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

Final action means—

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

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

Senior government employee means—

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

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

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ISSUE 89 | October 1, 2022–March 31, 2023