Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 77 | October 1, 2016 - March 31, 2017

OIG MISSION

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

VISION

To meet our mission and enhance the trust and confidence of veterans and their families, Veterans Service Organizations, Congress, VA employees, and the public, we must:

- Ensure that our work is independent and avoid any appearance of impairment to our independence.
- Prevent and detect fraud, waste, and abuse in VA programs and operations.
- Be proactive and strategic in identifying impactful issues.
- Produce reports that are:
  - ◊ Accurate
  - ◊ Timely
  - ◊ Fair
  - ◊ Objective
  - ◊ Thorough
- Make meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations.
- Be fully transparent by promptly releasing reports that are not otherwise prohibited from disclosure.
- Promote accountability of VA employees if they fail to perform as expected.
- Attract, develop, and retain the highest quality staff in the Office of Inspector General (OIG).
- Treat whistleblowers and others who provide information to the OIG with respect and dignity and protect their identities if they so desire.

VALUES

Our conduct will be guided and informed by adherence to the following values:

- Meet the highest standards of professionalism, character, ethics, and integrity.
- Work as one organization by encouraging teamwork and collaboration across directorates and offices.
- Establish a positive and engaging work environment.
- Promote diversity, individual perspectives, and equal opportunity throughout the OIG.
- Respect the role and expertise that each staff member brings to the OIG.
- Continually improve our performance.
- Ensure equitable opportunities for professional growth and development.
- Accept responsibility for our behavior and performance.

Message from the Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to Public Law (P.L.) 95-452, *Inspector General Act of 1978*, as amended, this report presents our accomplishments during the reporting period October 1, 2016–March 31, 2017.

It is an honor and privilege to serve as the Inspector General. Since I was sworn in on May 2, 2016, we have made a number of enhancements to our practices, policies, and operation. Several of these initiatives represent concerted efforts by the Office of Inspector General (OIG) to focus on high-risk areas throughout VA with the goal of being more proactive in our oversight. I believe that these changes will enable us to perform more impactful work in a timelier manner. Among other initiatives, we established a Rapid Response Team to more consistently and timely respond to the highest-risk clinical allegations we receive concerning Veterans Health Administration (VHA) facilities or programs. We also established an Access to Care Division that will conduct focused oversight audits and reviews designed to evaluate wait times and other barriers to receiving care in VHA. Further, we have enhanced our healthcare inspection program, now called the Comprehensive Healthcare Inspection Program (CHIP), to make it more extensive and risk-based. Among other changes, we are placing greater attention on the effectiveness of leadership of individual medical centers and presenting a narrative of our findings. Moreover, we have established a Data Analytics Council, which will collaborate across OIG directorates to leverage existing VA data sources to identify strategically impactful and proactive matters, particularly in high-risk procurement and information technology (IT) programs and operations.

OIG issued 115 reports and work products on VA programs and operations during this reporting period. OIG investigations, inspections, audits, evaluations, and other reviews identifed over $974 million in monetary benefits, for a return on investment of $14 for every dollar expended on OIG oversight. The OIG Hotline received over 17,000 contacts from sources concerning VA programs and operations. OIG investigators closed 384 investigations and made 150 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, and personal and property crimes. OIG investigative and Hotline work resulted in 732 administrative sanctions and corrective actions. Highlighted below are some of the key findings and conclusions that were the result of our work during this reporting period.

The Office of Investigations continues to collaborate with other agencies to prevent and detect fraud. An Office of Investigations, Federal Bureau of Investigation, Health and Human Services OIG, and Defense Criminal Investigative Service investigation of an alleged illegal medical product marketing scheme, which relied on gratuity payments to VA and Medicare physicians, resulted in a $350 million civil P.L. 97-258, *False Claims Act* settlement agreement. The medical product was a biological skin substitute for the treatment of diabetic foot ulcers. The investigation determined that Advanced BioHealing (ABH), Inc., sales representatives provided a variety of financial inducements to VA physicians to include honorarium payments, concert tickets, and all-expense paid vacations in an effort to increase sales of their product to VA facilities. ABH sales to VA during the time the gratuities were paid to VA clinicians totaled approximately $147 million. To date, this settlement is

the largest P.L. 97-258, *False Claims Act* recovery by the U.S. involving a medical device. See page 51 for more details.

The Office of Healthcare Inspections (OHI) continues to report on VA's efforts to provide needed mental health care, timely access to health care, and quality medical care. Below are some examples of our reports in these critically important areas:

- In *Evaluation of Veterans Health Administration Veterans Crisis Line*, OHI commented on the administrative problems that need to be addressed to insure veterans who are calling the suicide crisis line receive the highest quality advice and compassion as they struggle with life threatening issues. See page 17 for more details on these findings and conclusions.

- In *Healthcare Inspection – Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri*, OHI made recommendations to improve the productivity and quality of mental health care provided at the St. Louis VA Medical Center. See page 19 for more details on these findings and conclusions.

- In *Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana*, OHI reported on the impact of delays on the health of veterans who depend on VA to provide seamlessly coordinated care between VA and contract providers. See page 20 for more details on these findings and conclusions.

- In *Healthcare Inspection – Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska*, OHI reported on the difficulty of providing veterans quality medical care where there are few providers in the local community. See page 20 for more details on these findings and conclusions.

- In *Healthcare Inspection – Review of Antimicrobial Stewardship Programs in VHA Facilities,* OHI made recommendations to support VA's effort to properly employ antibiotics against pathogens with the goal of effective medical treatment, while limiting the opportunity for microbes to become resistant to current antibiotics. See page 18 for more details on these findings and conclusions.

The Office of Audits and Evaluations (OAE) issued several high impact reports regarding veterans access to health care. These projects identified weaknesses in areas such as timely access to health care, reliability of wait times data, and implementation of the Veterans Choice Program (Choice). Below is a summary of two of our recent projects:

- In *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, OAE determined that veterans experience a significant delay to access health care in Veterans Integrated Service Network (VISN) 6. The audit found that 36 percent of appointments for new patients in VISN 6 had to wait longer than 30 days for an appointment during the first quarter of fiscal year (FY) 2016. The average wait for new patients was 59 days. This was notably higher than the 10 percent of appointments that VHA electronic scheduling system showed were scheduled greater than 30 days out. In addition to access to VA health care, the audit also examined access to care in the VA's Choice program. Under the Choice program, veterans who live more than 40 miles away from their VA medical center or have an appointment more than 30 days out may seek community health care that is reimbursed by VA. OAE found that those veterans who received their care through the Choice program during the first quarter of 2016 had an average wait time of 84 days. OAE found that VISN 6 did not consistently manage the timeliness of specialty care consults in its facilities,

and the audit also identified weaknesses in the wait time data captured in the VHA's electronic scheduling system. See page 26 for more details on findings and conclusions.

- OAE conducted a review of the Choice program at the request of Senator Johnny Isakson, Chairman of the Senate Committee on Veterans' Affairs, who expressed concerns about the implementation of Choice and the barriers facing veterans trying to access the program. The review focused on whether veterans were experiencing barriers accessing Choice during its first year of implementation. OAE determined several barriers exist in accessing care through Choice, to include cumbersome authorization and scheduling procedures, inadequate provider networks, and potential veteran liability for treatment costs. After being scheduled with a Choice provider, on average the veteran waited about 13 days to receive care. VHA identified approximately 1.2 million instances in which veterans could not receive VHA appointments from November 1, 2014 through September 30, 2015. During this period, about 283,500 eligible veterans opted into Choice, and 149,000 of these received an appointment with a Choice provider. OAE calculated a 13 percent rate of Choice utilization (based on appointments provided compared to veterans eligible to receive care). OAE was unable to determine why the other 87 percent did not access Choice. The Under Secretary for Health concurred with the findings and recommendations. See page 26 for more details.

In addition, OAE contracted with an independent public accounting firm to audit VA's FY 2015 and 2016 financial statements as required by P.L. 101-576, *Chief Financial Officers Act of 1990*. VA received an unmodified opinion meaning that its financial statements were materially accurate. However, the contractor identified six material weaknesses: information technology security controls; education benefits accrued liability; the control environment surrounding the compensation, pension, and burial actuarial estimates; community care obligations, reconciliations, and accrued expenses; financial reporting; and the Chief Financial Officer organizational structure for VA and VHA. The contractor further identified two significant deficiencies: procurement, undelivered orders, accrued expenses, and reconciliations; and the loan guaranty liability estimate. It also reported VA's substantial noncompliance with applicable Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under P.L. 104-208, *Federal Financial Management Improvement Act*. The contractor cited instances of noncompliance with section 5315, title 38, United States Code, pertaining to the charging of interest and administrative costs; noncompliance with section 3733, title 38, United States Code, pertaining to the vendee loan program; and six violations of P.L. 97-258, *Antideficiency Act,* identified by VA. See page 35 for more details on findings and conclusions.

During the reporting period, the Office of the Counselor to the Inspector General initiated a new model of providing legal assistance to our different Directorates. In the past, the Counselor's office typically only became involved in an audit, investigation, inspection, or healthcare review at the point a draft report was submitted for legal review. Under the new model, an attorney is assigned at the formative stages of a project as a member of the project team, where they are responsible for providing legal counsel during the entire lifecycle of the project. As a member of the team, the assigned attorney is better suited to assist in determining the proper project scope and identifying the appropriate criteria controlling the matter(s) under review. In addition, they are able to quickly recognize and address legal issues as they arise, thereby streamlining both the project completion and publication of a final report.

I continue to be enthusiastic and optimistic about the OIG's ability to conduct effective oversight of the programs and operations of VA. Our accomplishments are a reflection of the incredible dedication and commitment of OIG staff. I am very grateful to the staff for working tirelessly to fulfill our mission, vision, and values and to produce timely, fair, objective, thorough, and accurate reports and products of the highest quality. The OIG remains committed to being as transparent as possible to conduct ourselves with the highest levels of professionalism, character, and integrity.

I am also appreciative of the great support of veterans, the Congress, its staff, Veteran Service Organizations, and stakeholders. We also have strong collaborative relationships with the Secretary, Acting Deputy Secretary, other VA senior management, and employees. We have a shared purpose to serve our Nation's veterans, their families, and taxpayers.

MICHAEL J. MISSAL
Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month Total
Better Use of Funds	$167.9
Fines, Penalties, Restitutions, and Civil Judgments	$151.4
Fugitive Felon Program	$120.8
Savings and Cost Avoidance	$466.1
Questioned Costs	$38.5
Dollar Recoveries	$29.5
Total Dollar Impact	$974.2
Cost of OIG Operations[1]	$70.2
Return on Investment[2]	**14:1**

Investigative Activities[3]	6-Month Total
Arrests[4]	144
Fugitive Felon Arrests	6
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	9
Indictments[5]	125
Indictments and Informations Resulting from Prior Referrals to Authorities	98
Criminal Complaints	33
Convictions	160
Pretrial Diversions and Deferred Prosecutions	21
Case Referrals to Department of Justice for Criminal Prosecution[6]	226
Cases Accepted	54
Cases Declined	107
Cases Pending	65
Case Referrals to State and Local Authorities for Criminal Prosecution[7]	49
Cases Accepted	27
Cases Declined	11
Cases Pending	11

Investigative Activities[3]	6-Month Total
Administrative Investigations Opened	9
Administrative Investigations Closed	14
Administrative Sanctions and Corrective Actions	198
Cases Opened[8]	306
Cases Closed[9]	384
Administrative Summaries of Investigation[10]	18

Hotline Activities	6-Month Total
Contacts	17,251
Cases Opened (internal and external)	929
Cases Closed[11] (external only)	643
Administrative Sanctions and Corrective Actions[12]	534
Substantiation Percentage Rate[13]	39
Individuals Claiming Retaliation/ Seeking Whistleblower Protection	35
Individuals Provided Office of Special Counsel Contact Information	31
Individuals Provided Merit Systems Protection Board Contact Information	23
Individuals Provided Office of Resolution Management Contact Information	59

Statistical Highlights

Reports and Work Products	6-Month Total
Reports Issued	
Audits and Evaluations	23
National Healthcare Reviews	5
Hotline Healthcare Inspections	13
Clinical Assessment Program Reviews	10
Administrative Investigations	1
Preaward Contract Reviews	39
Postaward Contract Reviews	15
Claim Reviews	1
Subtotal	**107**
Work Products	
Administrative Investigation Advisories[14]	7
Administrative Investigation Closures[15]	0
Audit Work Products	1
Healthcare Closures	0
Subtotal	**8**
Total Reports and Work Products	**115**

Healthcare Inspections Activities	6-Month Total
Clinical Consultations	**6**

1. The 6-month operating cost for the Office of Healthcare Inspections ($12.5 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.
2. This figure is calculated by dividing Total Dollar Impact by Cost of OIG Operations.
3. All investigative data reported and analyzed was collected via OIG's case management system. Please note that OIG does not publish or issue investigative reports related to criminal investigations.
4. Does not include Fugitive Felon arrests by OIG or other agencies.
5. Figure is a result of referrals made to prosecutorial authorities prior to and during the current reporting period.
6 and 7. Due to the timing of the release of the new reporting requirements, OIG was unable to track the number of persons referred for criminal prosecution as the organization has historically tracked cases. However, OIG has modified its tracking process to ensure the number of persons referred is provided in the next reporting period.
8. Includes administrative investigations opened.
9. Includes administrative investigations closed. This total also includes cases which opened in previous FYs.
10. During this reporting period, OIG published 18 administrative summaries of investigation in response to allegations regarding patient wait times received since April 2014. These are listed in Appendix A.
11, 12, & 13. Includes cases which opened in previous FYs.
14. During this reporting period, OIG also published 34 administrative investigation advisories that had been issued prior to FY 2017. These are listed in Appendix A.
15. During the reporting period, OIG published 61 administrative investigation closures that had been issued prior to FY 2017. These are listed in Appendix A.

Glossary

3R	recruitment, relocation, and retention
ABH	Advanced BioHealing
AIB	Administrative Investigative Board
ASP	Antimicrobial Stewardship Program
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
BDP	Barnet Dulaney Perkins
CAP	Clinical Assessment Program
CBOC	Community Based Outpatient Clinic
CCU	critical care unit
CEO	chief executive officer
CFR	Code of Federal Regulations
CHAMPVA	Civilian Health and Medical Program of the VA
CHOICE	Veterans Choice Program
CID	Criminal Investigation Division
CLC	community living center
CMOP	Consolidated Mail Outpatient Pharmacy
COS	Chief of Staff
CPAC	Consolidated Patient Account Center
CPRS	Computerized Patient Record System
DAIG	Deputy Assistant Inspector General
DCIS	Defense Criminal Investigative Service
DD-214	Certificate of Release or Discharge from Active Duty
DEA	Drug Enforcement Administration
DFWP	Drug Free Workplace Program
DHS	Department of Homeland Security
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
EHR	electronic health record
ED	emergency department
EOC	Environment of Care
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FHCC	Federal Health Care Center
FSS	Federal Supply Schedule
FY	fiscal year
GAO	Government Accountability Office
GBON	Georgia Board of Nursing
GCMB	Georgia Composite Medical Board
GSA	General Services Administration
HCS	Health Care System
HHS	Health and Human Services
HIV	human immunodeficiency virus
HR	human resources
HT	home telehealth
ICU	intensive care unit
IED	improvised explosive device
IG	Inspector General
IRS	Internal Revenue Service
IT	information technology
ITF	intent to file
MFD	multifunctional devices
MH	mental health
NAVAHCS	Northern Arizona VA Health Care System
NCA	National Cemetery Administration
NCIS	Naval Criminal Investigative Service
NCO	network contracting office
NECC	New England Compounding Center
NP	nurse practitioner
NVC	non-VA care
NVCC	non-VA care coordination
NVVF	National Vietnam Veterans Foundation
NYHHS	New York Harbor Health Care System
OAE	Office of Audits and Evaluations

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OALC	Office of Acquisition, Logistics, and Construction
OAR	Office of Accountability Review
OCI	Office of Criminal Investigations
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHRA	Office of Human Resources and Administration
OI	Office of Investigations
OIG	Office of Inspector General
OIT	Office of Information and Technology
OM	Office of Management
ONDCP	Office of National Drug Control Policy
OPM	Office of Personnel Management
OSC	Office of Special Counsel
OSDBU	Office of Small and Disadvantaged Business Utilization
OSP	Office of Operations, Security, and Preparedness
OT	overtime
OWCP	Office of Workers' Compensation Program
P.L.	Public Law
PATS	Patient Advocate Tracking System
PBGC	Pension Benefit Guarantee Corporation
PC3	Patient-Centered Community Care
PCP	primary care physician
PII	personally identifiable information
PTSD	post-traumatic stress disorder
PVAHCS	Phoenix VA Health Care System
QM	quality management
RVSR	Rating Veterans Service Representative
SAOW	Service Area Office West
SAVAHCS	Southern Arizona VA Health Care System
SBA	Small Business Administration
SDV	service-disabled veteran
SDVOSB	Service-Disabled Veteran-Owned Small Business
SES	Senior Executive Service
SMC	special monthly compensation
SSA	Social Security Administration
UPS	United Parcel Service
USB	Under Secretary for Benefits
USH	Under Secretary for Health
USPIS	United States Postal Inspection Service
USPS	United States Postal Service
VAMC	VA Medical Center
VAPHS	VA Pittsburgh Healthcare System
VAPS	VA Police Service
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VCL	Veterans Crisis Line
VCS	Veterans Canteen Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Reporting Requirements

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

Reporting Requirements	Section(s)
§ 4 (a) (2) to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA.	Other Significant OIG Activities
§ 5 (a) (1) a description of significant problems, abuses, and deficiencies relating to the administration of VA programs and operations disclosed during the reporting period.	Office of Healthcare Inspections Office of Audits and Evaluations Office of Investigations Office of Management and Administration Office of Contract Review Other Significant OIG Activities
§ 5 (a) (2) a description of the recommendations for corrective action made during the reporting period.	Office of Healthcare Inspections Office of Audits and Evaluations Office of Investigations
§ 5 (a) (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed.	Appendix B
§ 5 (a) (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted.	Office of Investigations
§ 5 (a) (5) a summary of instances where information or assistance requested is refused or not provided.	Other Significant OIG Activities
§ 5 (a) (6) a listing, subdivided according to subject matter, of each audit report issued during the reporting period, including the total dollar value of questioned costs and the dollar value of recommendations that funds be put to better use.	Appendix A
§ 5 (a) (7) a summary of each particularly significant report.	Office of Healthcare Inspections Office of Audits and Evaluations Office of Investigations

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Reporting Requirements	Section(s)
§ 5 (a) (8) and (9) Statistical tables showing the total number of reports and the total dollar value of both questioned costs and recommendations that funds be put to better use by management.	Statistical Highlights Appendix A
§ 5 (a) (10) a summary of each audit report issued before the commencement of the reporting period for which no management decision has been made by the end of the reporting period, for which no establishment comment was returned within 60 days of providing the report to the establishment, and for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations.	Other Significant OIG Activities Appendix B
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period.	Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement.	Appendix A
§ 5 (a) (14) an appendix containing the results of any peer review conducted by another OIG during the reporting period or a statement identifying the date of the last peer review conducted by another OIG.	Other Significant OIG Activities
§ 5 (a) (15) a list of any outstanding recommendations from any peer review conducted by another OIG that have not been fully implemented.	Other Significant OIG Activities
§ 5 (a) (16) a list of any peer reviews conducted by the VA OIG of another OIG during the reporting period and a list of any recommendations made from any previous peer review that remain outstanding or have not been fully implemented.	Other Significant OIG Activities
§ 5 (a) (17) statisical tables showing the total number of investigative reports issued, the total number of persons referred to the Department of Justice for criminal prosecution, the total number of persons referred to State and local prosecuting authorities for criminal prosecution, the total number of indictments and criminal informations that resulted from any prior referral to prosecuting authorities, and a description of the metrics used for developing the data for the statistical tables.	Statistical Highlights

Reporting Requirements	Section(s)
§ 5 (a) (19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including a detailed description of the facts and circumstances of the investigation as well as the status and disposition of the matter.	Office of Investigations
§ 5 (a) (20) a detailed description of any instance of whistleblower retaliation.	Other Significant OIG Activities
§ 5 (a) (21) a detailed description of any attempt by the establishment to interfere with the independence of the OIG.	Other Significant OIG Activities
§ 5 (a) (22) detailed descriptions of the particular circumstances of each inspection, evaluation, and audit or investigation involving a senior Government employee that is closed and was not disclosed to the public.	Office of Investigations

VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

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 the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2017, VA is operating under a $180.5 billion budget, with over 379,000 employees serving an estimated 21 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

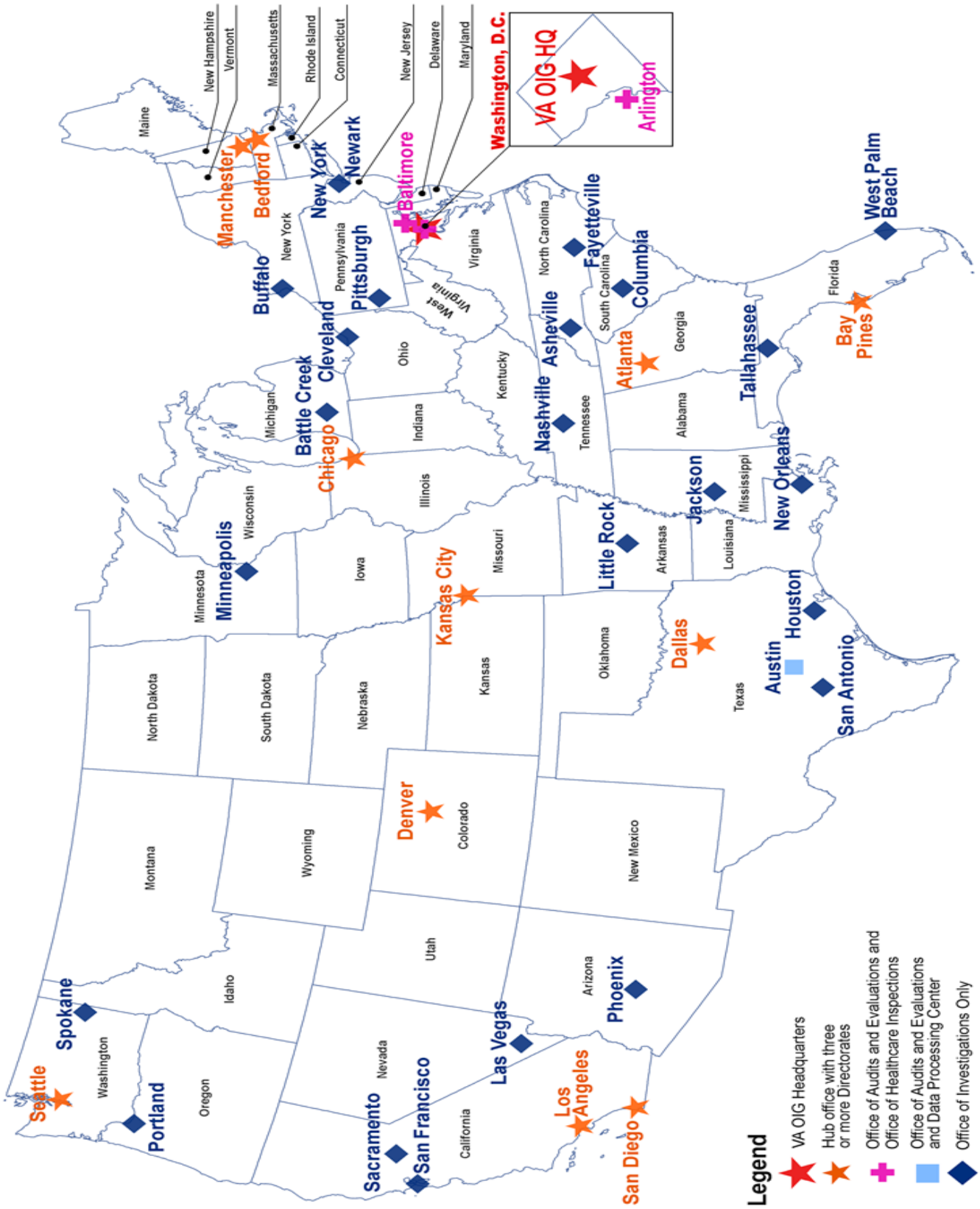
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information, please visit the VA internet home page at www.va.gov.

VA Office of Inspector General

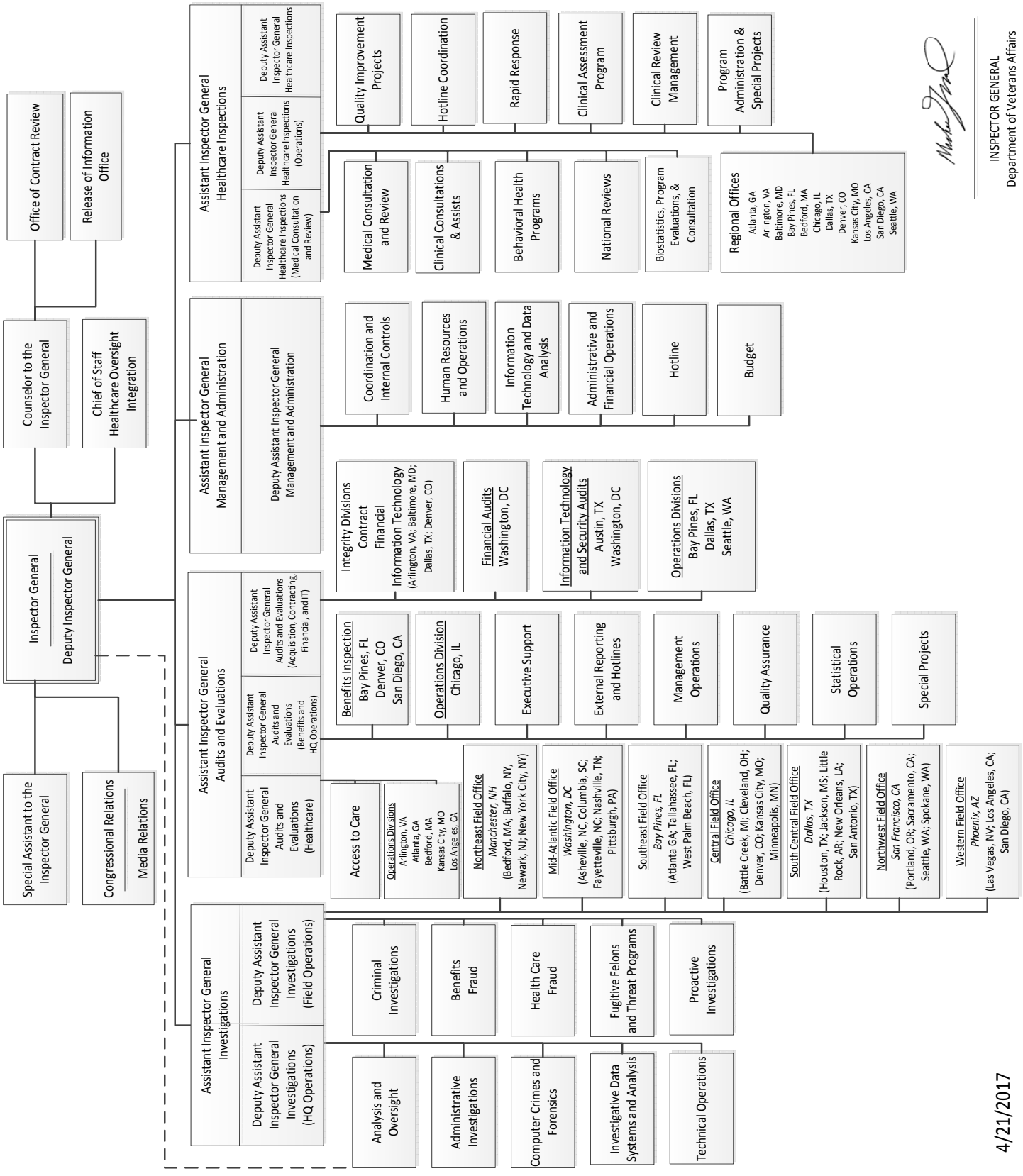
The Office of Inspector General's (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, and investigations. OIG was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, P.L. 95-452, *Inspector General Act*, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. In addition, P.L. 100-322, *Veterans Benefits and Services Act of 1988*, passed on May 20, 1988, charged OIG with the oversight of the quality of VA health care. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 790 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2017 funding for OIG operations provides $159.6 million from ongoing appropriations. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country. OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG internet home page at www.va.gov/oig.

OIG Field Offices Map



OIG Organizational Chart



Office of Healthcare Inspections

For many years, VHA has been a national leader in the quality of care provided to patients when compared with the major U.S. health care providers. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 5 national healthcare reviews; 13 Hotline healthcare inspections; and 10 Clinical Assessment Program (CAP) reviews to evaluate the quality of veteran care. All reports issued this reporting period are listed in Appendix A.

Clinical Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to veterans. CAP reviews provide cyclical oversight of VHA health care facilities. Their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 10 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 12 months. The topics covered this reporting period include: Quality, Safety, and Value; Environment of Care (EOC); Medication Management: Anticoagulation Therapy; Coordination of Care: Inter-Facility Transfers; Diagnostic Care: Point-of-Care Testing; Moderate Sedation; Community Nursing Home Oversight; and Management of Disruptive/Violent Behavior. When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of the evaluation of that specific topic. During this reporting period, OIG issued three CAP/ Community Based Outpatient Clinic (CBOC) summary reports, which are highlighted in the National Healthcare Reviews section.

National Healthcare Reviews

Evaluation of the VHA Veterans Crisis Line

OIG conducted a healthcare inspection of the Veterans Crisis Line (VCL) with four primary objectives: (1) to evaluate an allegation that VCL staff did not respond adequately to a veteran's urgent needs; (2) to perform a detailed review of VCL's governance structure, operations, and quality assurance functions; (3) to evaluate whether VHA completed planned actions in response to OIG's recommendations from a previously published OIG report; and (4) to address complaints received from the U.S. Office of Special Counsel (OSC). OIG determined that VCL staff did not respond adequately to a veteran's urgent needs. OIG found deficiencies in the VCL's processes for managing incoming telephone calls and in governance and oversight of VCL operations. OIG found substantial disagreement about key decisions in operations of the VCL between the VHA Suicide Prevention Office and VHA Member Services. OIG also found that VHA contracting staff and leaders lacked an understanding of the backup center contract terms and did not verify quality control aspects of contractor performance, resulting in deficient oversight. OIG found some backup call centers used a queuing process that may lead callers to perceive they were on hold, and that VCL leadership had not established expectations or targets for queued call times, or thresholds for taking action on queue times. OIG discovered deficiencies in the VCL Quality Management (QM) program. OIG found several challenges in VCL QM staff's ability to collect, analyze, and effectively review relevant QM data. VCL policies were not consistent with existing VHA policies for veteran safety or risk management and did not incorporate techniques for evaluating available data to improve quality, safety, or value for veterans. OIG found that the VCL had not completed actions to fully implement the seven recommendations from the prior report. OIG substantiated the OSC complainant's

allegations that Social Service Assistants were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that a newly trained Social Service Assistant contacted a caller in crisis by telephone to solicit the veteran's location; and a Social Service Assistant did not document when closing out a veteran's case.

Review of Antimicrobial Stewardship Programs in VHA Facilities

As directed by the Senate Appropriations Committee report to accompany H.R. 2029, Military Construction, Department of Veterans Affairs, and Related Agencies Appropriation Bill 2016, and at the request of Senator Dianne Feinstein, OIG reviewed VHA implementation of Antimicrobial Stewardship Programs (ASPs). The majority of VHA facilities had established ASPs; however, OIG identified variations with program implementation. A large majority of facilities had written policies and designated ASP champions; however, over one third did not timely complete program evaluation, and facilities reported less than 50 percent compliance with staff education on appropriate use of antibiotics. VHA made efforts to collect and analyze data on antibiotic use and resistance but did not endorse one standard data collection tool for inter-facility comparisons and consistency of data collection and reporting. Additionally, facilities did not consistently generate clinical outcome reports on antibiotic usage. Therefore, VHA cannot effectively measure positive or negative national trends on antibiotic use to guide improvement efforts. With standardization, individual facility and system-wide trends can be analyzed. Further, in order to achieve optimal ASPs, facility leaders need to provide dedicated staff, administrative support, and essential tools to develop and maintain such programs. OIG recommended that the Under Secretary for Health (USH) implement procedures to ensure that facilities comply with VHA Directive 1031 requirements, including the completion of annual evaluations, designation of provider and pharmacy champions, staff education, and the provision of adequate dedicated staffing and resources; require VHA facilities to track and generate clinical outcome reports on antibiotic use; and consider implementing standardized tools and definitions for antimicrobial stewardship data and a uniform reporting system to permit analysis of comparable information over time.

Evaluation of Human Immunodeficiency Virus Screening in VHA Outpatient Clinics

OIG conducted a systematic review of VHA outpatient clinics to evaluate for compliance with selected VHA requirements regarding human immunodeficiency virus (HIV) screening. The objectives were to determine whether outpatient clinics complied with the requirements to: (1) identify an HIV Lead Clinician; (2) establish local policies and procedures; (3) provide HIV screening as part of routine medical care; and (4) document informed consent for HIV testing. OIG performed this focused review at 56 VA facilities through a review of facility documents, evaluation of the electronic health records (EHR) of 1,990 outpatients, and discussion with facility staff. OIG estimated that 96.3 percent of facilities identified a Lead HIV Clinician, and 92.6 percent of facilities established policies, procedures, and guidelines for HIV screening. OIG estimated that clinicians offered screening to 66.4 percent of outpatients. OIG did not find documentation of the offer of screening in 28.9 percent of EHRs. OIG estimated that clinicians documented oral informed consent in 75.1 percent and written informed consent in 6.6 percent of records for outpatients screened for HIV. OIG also estimated that informed consent was not documented in 18.3 percent of records for outpatients screened for HIV. OIG recommended that the USH, in conjunction with Veterans Integrated Service Network (VISN) and facility senior managers, ensure that clinical staff offer HIV screening as part of routine medical care and document informed consent for HIV testing.

CAP Summary Report on the Evaluation of Inpatient Flow in VHA Facilities

OIG completed a healthcare evaluation of coordination of care in VHA facilities. The purpose of the review was to evaluate selected aspects of the VHA patient flow process over the inpatient continuum (admission through discharge). The objectives were to determine whether clinicians complied with requirements for admission

assessments, transfer notes, and discharge documentation and whether facilities had clinical Bed Flow Coordinators to coordinate patient flow activities throughout the facility. OIG conducted this review at 24 VHA medical facilities during CAP reviews performed across the country from October 1, 2015 through March 31, 2016. OIG observed many positive practices during our review, including that most facilities had committees that monitored patient flow and addressed identified problems or opportunities for improvement, most facilities had appointed clinical Bed Flow Coordinators, and clinicians documented providing patients with a copy of the discharge instructions the patients understood. However, OIG identified system weaknesses in discharge policy content, policies addressing overflow patients in temporary bed locations, and documentation of resident supervision for discharge notes or instructions.

Evaluation of the Quality, Safety, and Value Program in VHA Facilities FY 2016

OIG completed a healthcare evaluation of VHA medical facilities' quality, safety, and value programs. The purpose of the evaluation was to determine whether VHA facilities complied with selected requirements related to quality, safety, and value activities. OIG conducted this review at 28 VHA medical facilities during CAP reviews performed across the country from October 1, 2015 through March 31, 2016. All 28 facilities had established quality, safety, and value programs and performed ongoing reviews and analyses of mandatory areas. OIG identified system weaknesses in five areas and recommended that the USH, in conjunction with VISN managers and facility senior managers, reinforce requirements for: facility clinical managers to evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency established by facility policy; facility clinical managers to implement the improvement actions recommended by the Peer Review Committee; facility Utilization Managers to complete at least 75 percent of all required reviews and designated Physician Utilization Management Advisors to document their review decisions in the VHA's utilization management database; facility Patient Safety Managers to enter all patient incidents into the VHA's web-based patient incident database, complete the minimum number of root cause analyses each FY, provide feedback about the root cause analyses findings to the individuals or departments who reported the incidents, and submit patient safety reports to facility leaders at least annually; and facility committees and teams to consistently implement and evaluate corrective actions from quality, safety, and value activities.

Hotline Healthcare Inspections

Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri

OIG conducted an inspection pursuant to a June 2014 request from Senator Bernie Sanders, then Chairman of the Senate Veterans Affairs Committee, to assess allegations regarding deficiencies in Mental Health (MH) services clinical processes including productivity, data reporting, access, quality of assessments and care, and administrative processes at the VA St. Louis Health Care System (HCS), St. Louis, Missouri. Of 19 allegations, 6 were substantiated while 13 were not substantiated. OIG also identified 8 additional findings. OIG found that outpatient psychiatrists had fewer-than-expected appointment slots and encounters in FY 2013; outpatient psychiatrists' productivity data were inconsistent with the number of daily encounters; some outpatient psychiatrists' coding error rates exceeded VHA's minimum accuracy standards for the period May through August 2013 and VHA-required follow-up was not completed; inadequate consult management of ancillary group treatment referrals for two patients; outpatient MH and post-traumatic stress disorder (PTSD) clinics treatment delays averaged 3 days in FY 2013; an MH clinic nurse did not adequately assess an unscheduled patient's treatment needs; a former staff member did not provide timely military sexual trauma treatment or follow-up; outpatient PTSD staff failed to provide timely care to a walk-in patient or include a second patient in treatment planning involving transfer to the MH clinic; the "public" facsimile machine used for VBA, Vocational Rehabilitation and Employment referrals was not reliable or attended to properly; two Compensation

and Pension evaluators entered erroneous information in a veteran's EHR; and the facility management insufficiently investigated two of three MH patient deaths.

Consult Delays and Management Concerns, VA Montana HCS, Fort Harrison, Montana

OIG conducted a healthcare inspection at the request of Senators Jon Tester and Steve Daines to assess whether patients experienced delays in obtaining consults, and the impact of any consult delays on patient outcomes, at the VA Montana HCS (system), Fort Harrison, MT. OIG also evaluated the adequacy of internal feedback mechanisms related to consults. For consults ordered in FY 2015, OIG found apparent delays for 11,073 of 26,293 patients (42 percent) with at least one in-house consult; 11,863 of 21,221 patients (56 percent) with at least one non-VA care (NVC) consult; and 2,683 of 4,427 patients (61 percent) with at least one Veterans Choice Program (Choice) consult. Among the VA facilities reviewed for comparison, the system had the lowest or among the lowest percentage of patients with delayed in-house and Choice consults and the highest percentage of patients with delayed NVC consults. OIG found that delays among consults ordered in FY 2015 may have harmed four patients. In July 2015, system leadership initiated a focused effort to identify and resolve factors contributing to consult delays. Despite this effort, OIG found evidence of persistent issues with completing consults timely in FY 2016. System leadership initiated ongoing reviews to determine if patient harm occurred due to delays in care. OIG found the system had several mechanisms in place for staff to communicate concerns about consult delays to system leadership. Despite available mechanisms, staff expressed concerns about communication with system leadership. OIG recommended the System Director ensure the care of the potentially harmed patients be reviewed by an external source, confer with the Office of Chief Counsel as necessary regarding the potentially harmed patients and take action as appropriate, and continue efforts to improve consult timeliness.

Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA HCS, Anchorage, Alaska

OIG conducted a healthcare inspection at the request of Senator Lisa Murkowski to follow up on recommendations made in a previous report, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska* (Report No. 14-04077-405, issued July 7, 2015). OIG evaluated selected aspects of the progress the Alaska VA HCS (system) made in implementing the action plans and reviewed access to care data for patients at all system CBOCs. OIG found that a permanent provider had been in place at the Mat-Su VA CBOC since September 2014 and system leaders had developed a recruitment and retention plan. Improvements were made to contingency plans for ensuring continuity and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events. Training requirements regarding care coordination were implemented in all CBOCs and primary care settings. OIG determined overall access to care throughout the system met VHA performance measure targets based on data maintained by VHA and provider recommendations for new and established primary care patients. The system made improvements to the peer review process and completed planned actions for the patient cases identified in the 2015 report. OIG found that managers continued to monitor provider evaluations and implement enhancements needed for committee reporting. System leaders continued to implement actions to improve culture and morale throughout the system. Based on actions already implemented, recommendations 3 and 6 from the 2015 report are considered closed. The remaining seven recommendations will remain open for continued monitoring of actions by OIG Follow-Up Staff. OIG made no new recommendations. OIG Update: OIG received updated information in May 2016 and determined the planned actions have been completed for the remaining seven recommendations and consider all nine original recommendations closed.

Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg HCS, Roseburg, Oregon

OIG conducted an inspection at the request of Congressman Peter A. DeFazio in response to allegations about inadequate nurse staffing in the Community Living Center (CLC) and patient safety reporting at the VA Roseburg HCS (system), Roseburg, OR. OIG did not substantiate the allegation that the system's CLC nurse staffing was inadequate and not in compliance with VHA policy. System leadership implemented VHA's staffing methodology. OIG did not substantiate the allegation that failure to correctly staff the CLC units resulted in patient falls or employee injuries. The system, including the CLC, had a comprehensive approach to identifying high risk patients and managing fall prevention, although staffing levels were not consistently analyzed after a fall occurred. OIG did not substantiate the allegation that the CLC had no working alarms. Nurse call and elopement prevention system alarms functioned as required. OIG did not substantiate the allegation that patient safety concerns were not reported. Patient safety issues were communicated to leadership and incident reports completed. OIG repeatedly heard complaints of low staff morale; however, OIG determined leadership at both the system and VISN level continued to take action regarding improving workplace culture.

Teleradiology Concerns, VA Roseburg HCS, Roseburg, Oregon

OIG conducted an inspection to assess the merit of allegations made by a confidential complainant regarding radiology services at the VA Roseburg HCS (system), Roseburg, OR, and teleradiology services with the Alaska VA HCS, Anchorage, AK, and the Jonathan M. Wainwright Memorial, VA Medical Center (VAMC), Walla Walla, WA. OIG substantiated the allegation that the reading of teleradiology studies for Anchorage patients by system radiologists occurred prior to both sites signing a Memorandum of Understanding. OIG found no evidence of delays in radiologic interpretation, misinterpretation of studies, or reports of patient harm. OIG did not substantiate that delays in radiologic readings occurred for Roseburg patients as a result of providing teleradiology services to Anchorage and Walla Walla. OIG substantiated that the system lacked an integrated peer review process for radiology. The system's Radiology Service level peer review program was not an integrated part of the system's overall peer review program for QM. This could hinder the system's ability to detect misinterpretations of radiologic studies if they occurred. OIG did not substantiate that the system improperly credentialed and privileged teleradiology providers. All four of the system's staff radiologists providing teleradiology services were appropriately credentialed and privileged.

MH-Related Concerns at the W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

OIG conducted a review to assess allegations of inadequate MH care of a specific patient and poor utilization of MH beds at the W. G. (Bill) Hefner VA Medical Center (facility) Salisbury, NC. OIG did not substantiate that a patient was discharged prematurely, denied readmission due to a lack of acute MH beds, and subsequently committed suicide. After being hospitalized for a week on the acute MH unit, the patient was evaluated by a psychiatrist who completed a suicide risk assessment, noted the patient was at low risk for suicidal behaviors, did not meet criteria for involuntary commitment, and could not be held against his will. The patient requested to be discharged and was discharged. A few weeks later, the patient presented to the emergency department (ED) with suicidal ideation and was admitted to the hospital for a second time. As the acute MH unit was full, the patient was admitted to a medicine unit on one-to-one observation. An acute MH unit bed became available, but the patient declined transfer and requested discharge. A second psychiatrist determined the patient was at low risk for suicidal behaviors and not appropriate for admission. The patient was discharged. OIG did not substantiate the patient committed suicide. The autopsy report attributed the cause of death to combined drug toxicity and classified the manner of death as accidental. OIG found a lack of communication and coordination between ED staff, medical unit staff, the psychiatrist, and the suicide prevention team during the patient's second hospital stay. The Suicide Prevention Team was not routinely notified by staff when a patient designated high risk was being treated in the ED or inpatient unit and some team members were not fully aware of their role and responsibilities. While OIG confirmed that the acute MH was frequently near capacity and the chronic MH

unit did not accept "overflow" patients, OIG did not substantiate the implied inappropriateness of the condition. Facility leaders were aware of the problem and actively recruiting for inpatient psychiatrists which would permit full conversion of some chronic MH beds to acute MH beds.

Review of Robotic Assisted General Surgery at the Southern Arizona HCS, Tucson, Arizona

OIG conducted an inspection in response to a complainant's allegations regarding robotic assisted surgery performed by General Surgery physicians at the Southern Arizona VA HCS in Tucson, Arizona. OIG did not substantiate that a surgeon selected a poor candidate for robotic-assisted low anterior resection surgery though the patient was medically complex and surgically challenging. While the type of surgical management may vary among surgeons, the decision to utilize robotic technique in the patient was within the discretion of the surgeon's clinical judgment. OIG did not substantiate that a surgeon provided sub-standard surgical care for a patient. The patient experienced complications after surgery, but these same complications could have occurred if the patient had undergone a laparoscopic or open type procedure. OIG did not substantiate that a surgeon is a poor laparoscopic surgeon and needs additional training before performing robotic-assisted surgery. Facility surgeons who perform robotic-assisted low anterior resection surgery at the facility completed the requisite training, including being proctored for six surgical cases, and attended advanced courses for additional training. OIG did not substantiate the facility lacks Intensive Care Unit (ICU) bed availability for post-operative recovery, but OIG determined bed flow issues may result in a physical bed shortage in the ICU at times. Four Rapid Process Improvement Workshops related to bed flow issues were completed and process improvement recommendations that were implemented have helped to move patients to appropriate levels of care and open ICU beds.

Echocardiography Scheduling and Quality of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection in response to allegations concerning echocardiography scheduling and quality of care concerns at the Edwards Hines, Jr., VA Hospital (facility) in Hines, IL. OIG substantiated the allegation of scheduling delays for 1,226 echocardiography studies during 2014. OIG found that 1,176 requests were performed between 31–120 days, and 50 requests were performed greater than 121 days from requests. For one of the patients whose imaging study was performed greater than 121 days, the scheduling delay resulted in a delay in diagnosing a condition requiring surgery. This scheduling delay had the potential to cause harm, but no apparent adverse effects occurred. To assess the quality of the echocardiography images, OIG reviewed 50 routine echocardiography studies randomly selected from 1,122 studies completed July 1, 2014, through January 12, 2015. In all 50 studies, OIG's findings were consistent with, or had only minor deviations from, the final written reports documented in each patient's EHR and none of the deviations were clinically significant. All of the studies were sufficient for clinical decision making. However, OIG found the quality of the majority of the images reviewed was poor and may have been due to the technicians' competency. OIG found no documented evidence of performance improvement activities for the echocardiography technicians. The Chief of Cardiology informed us that a formal performance improvement process was not in place for the echocardiography technicians. OIG recommended that the Facility Director ensure routine echocardiographic studies are scheduled according to VHA policy; confer with counsel about a possible patient disclosure and take appropriate action, if any; ensure echocardiography technicians are provided training and continuing education opportunities; and that managers establish performance improvement activities for echocardiography technicians.

Alleged Violations of Nurse Practitioner Requirements, Carl Vinson VA Medical Center, Dublin, Georgia

OIG conducted a healthcare inspection at the request of Senator Johnny Isakson, Chair of the Senate Committee on Veterans' Affairs, to assess allegations that nurse practitioners (NPs) lacked appropriate oversight and

were operating beyond their scopes of practice in violation of Georgia Board of Nursing (GBON) licensure requirements at the Carl Vinson VA Medical Center (facility) in Dublin, GA. OIG substantiated that prior to OIG's visit in 2015, the facility was not in compliance with GBON and Georgia Composite Medical Board (GCMB) requirements for NPs. However, at the time of OIG's visit, all NPs were licensed through the GBON. OIG substantiated that facility leadership made a concentrated effort to get protocol agreements in place for 12 NPs; however, OIG determined these actions were appropriate. OIG did not substantiate that facility leadership misled the GBON into believing that the requested protocol agreements were for newly hired NPs, because the application forms did not inquire as to NPs' length of service at the facility. OIG substantiated that a certified Family Medicine NP assigned to the MH Clinic was treating MH patients and prescribing psychotropic medications in collaboration with a MH physician. Because the American Academy of Nurse Practitioners permitted this practice and the NP was in the position prior to the requirement that NPs be certified in their fields of practice, this was acceptable. OIG did not substantiate that an NP was acting in the role of a physician and prescribing medications outside his/her scope of practice. OIG found that the NP's scope of practice reflected expected practices and he/she fully complied with prescribing requirements for medications and abided by all limitations on his/her prescription authority. OIG did not substantiate that the facility Chief of Staff knew that NPs were prescribing medications and failed to report it to GCMB.

Documentation of Patient Enrollment Concerns in Home Telehealth, John D. Dingell VA Medical Center, Detroit, Michigan

OIG conducted an inspection in response to allegations concerning the documentation of patient enrollment in home telehealth (HT) at the John D. Dingell VA Medical Center, (facility) Detroit, MI. OIG substantiated that from September 14, 2013, until October 1, 2013, HT program staff entered documentation of monthly HT monitoring for 836 patients. OIG found that 828 of the 836 patients were not properly enrolled in HT. OIG substantiated that HT staff worked overtime (OT) from September 14, 2013, until October 1, 2013, for the purpose of initiating the enrollment process for new HT patients. The documentation included screening notes and monthly monitor notes that met the criteria for patient care encounters (workload) that contributed to the ability of the Associate Chief of Nursing Service for Specialty Services to meet one of two FY 2013 performance measures for telehealth services. OIG substantiated that during the OT hours that HT staff worked on Sunday, September 29, 2013, and after regular working hours on Monday, September 30, 2013, they entered a total of 634 monthly monitor notes. However, OIG found that HT staff were not required to work OT for several weeks to produce documentation on the enrollment of patients in HT program. Rather, they voluntarily worked OT to complete patient enrollment and clean up missing notes. OIG found that without the use of OT during the last 2 days of FY 2013, the facility would not have reached or surpassed its performance goal of 11,724 HT encounters. OIG recommended that the Facility Director ensure HT staff are retrained and that HT documentation accurately reflects enrollment status, review the circumstances surrounding the entry of monthly monitor notes with the Office of Human Resources and Administration (OHRA) and the Office of General Counsel (OGC), and take appropriate action as necessary.

Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center, Augusta, Georgia

OIG conducted an inspection to evaluate allegations involving improper completion of consults, false documentation, inappropriate scheduling practices, and Non-VA Care Coordination (NVCC) document scanning errors at the Charlie Norwood VA Medical Center (VAMC), Augusta, GA. OIG did not substantiate that senior managers instructed clerks to delete consults for all clinics. OIG substantiated a physician was completing consults prior to seeing patients and a supervisor instructed some employees to improperly complete NVCC consults and document "Services provided or patient refused services." OIG also substantiated that a clinic scheduler manipulated patients' desired appointment dates in an effort to correct scheduling errors and that managers directed a clerk not to schedule new patients if they could not be scheduled within 14 days [of

desired date]. OIG found the facility identified 3,776 "errors" that prevented uploading of NVCC documentation because a software option had not been enabled. OIG learned that the employees who had been instructed to improperly close consults had completed an additional 1,212 NVCC consults. In support of an OIG criminal investigation, we reviewed all 2,726 consults. The false documentation aspect of this review was under criminal investigation for more than 18 months, and OIG delayed publication of this report pending completion of the investigation. OIG recommended the Interim USH ensure that VA facilities certify the use of appropriate DocManager™ software settings, the VISN Director review the circumstances surrounding improperly completed consults and managers' failures to promptly and fully evaluate the improperly completed urology consults, and confer with appropriate VA offices to determine the need for administrative action, if any. OIG also recommended that the Facility Director clinically evaluate the improperly completed urology consults, monitor the status of the improperly completed NVCC consults, and ensure that all clinic schedulers are trained on correct scheduling practices.

Opioid Prescribing Practice Concerns, VA Illiana HCS, Danville, Illinois

OIG conducted a healthcare inspection to assess an alleged unsafe opioid prescribing practice of a primary care physician (PCP) at VA Illiana HCS, Danville, IL. The specific allegation related to the initiation of a fentanyl patch to treat pain in a patient with a complex MH history who subsequently died of fentanyl toxicity. OIG found the PCP considered the use of non-steroidal anti-inflammatory medications for pain but was concerned about an interaction with one of the patient's other medications. Fentanyl is typically prescribed to alleviate severe pain and not indicated for the management of acute pain or in opioid naïve patients. This patient had received opioid medications in the past for chronic pain issues and would be considered opioid tolerant. The PCP had safety concerns regarding oral opioid analgesics and prescribed a low dose fentanyl patch in a small supply. The autopsy report showed pieces of fentanyl patches in the patient's gastric contents, indicating that the patient likely ingested one or more patches. The patient also had two patches on his back; one of which he obtained outside the VA as the dose on one of the patches was approximately eight times the dose the VA PCP had ordered. Facility pharmacy staff performed an opioid medications audit and confirmed that each fentanyl patch ordered by the VA PCP had been dispensed to the patient with the prescribed lower dose. OIG did not substantiate that the PCP engaged in unsafe opioid prescribing practices, specifically regarding initiation of a fentanyl patch to treat pain in a patient with a complex MH history who subsequently died of fentanyl toxicity. The provider followed the 2010 VA/Department of Defense (DoD) Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain recommendations when initiating the patient's pain management. If used appropriately, the low dose fentanyl patches would not likely have resulted in fentanyl toxicity or death. OIG made no recommendations.

Alleged Quality of Care Concerns, VA Greater Los Angeles HCS, Los Angeles, California

At the request of the then-Congresswoman Lois Capps, OIG conducted a healthcare inspection to assess quality of care concerns in the management of a patient at the VA Greater Los Angeles HCS (system), Los Angeles, CA, and from a home health agency contracted by the system. OIG did not substantiate that the patient received poor care while an inpatient at the system. OIG determined that the patient received appropriate care in response to his medical needs. Throughout his almost 3-week stay, the patient had 12 consultations from various clinical services and 2 gastrointestinal procedures. OIG could not substantiate that the patient had maggots in his underwear the day after he left the system because it could not be proven if or when the presence of maggots occurred. OIG found no documentation regarding maggots prior to the patient leaving the system or by the ED staff who examined the patient at a local community hospital a few hours after the patient left the system and again the following day. OIG could not substantiate that the home health agency provided poor care to the patient once he was in his own home because the office that provided services had since closed, the staff who cared for him were no longer employed by the agency, and no agency treatment records could be located. OIG identified inconsistent compliance with the nursing documentation requirements in the EHR

of the patient's pressure ulcers regarding wound location, drainage information, improvement, and wound characteristics, as required. OIG also found inconsistent documentation of collaboration and participation by providers/physicians related to the patient's pressure ulcer. OIG recommended that nursing staff comply with pressure ulcer documentation requirements and that physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, reviews, and inspections of VA programs, functions, and facilities. This work addresses the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, veterans' eligibility for benefits and benefits administration, resource utilization, financial and contract management, forensic auditing, fraud prevention, and information security. During the reporting period, OAE published 23 audits and evaluations of VA programs and operations and published one additional work product. These are listed in Appendix A.

Veterans Health Administration Audits and Evaluations

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

Review of the Implementation of the Veterans Choice Program

OIG conducted this review at the request of Senator Johnny Isakson, Chairman of the Senate Committee on Veterans' Affairs, who expressed concerns about the implementation of Choice and the barriers facing veterans trying to access it. OIG's review focused on whether veterans were experiencing barriers accessing Choice during its first year of implementation. Choice, as part of the Patient Centered Community Care Program, provides care for eligible veterans when the local VHA medical facilities lack available specialists, have long wait times, or are geographically inaccessible. OIG reviewed monthly reports to identify average wait times for multiple stages of the Choice process, including the authorization of care, scheduling, and the delivery of health care to veterans. OIG determined several barriers exist in accessing care through Choice, to include cumbersome authorization and scheduling procedures, inadequate provider networks, and potential veteran liability for treatment costs. After being scheduled with a Choice provider, on average the veteran waited about 13 days to receive care. VHA identified approximately 1.2 million instances in which veterans could not receive VHA appointments from November 1, 2014 through September 30, 2015. During this period, approximately 283,500 eligible veterans opted into Choice, and 149,000 of these received an appointment with a Choice provider. OIG calculated a 13 percent rate of Choice utilization (based on appointments provided compared to veterans eligible to receive care). OIG was unable to determine why the other 87 percent did not access Choice. OIG recommended the USH streamline procedures for accessing care, develop accurate forecasts of demand for care in the community, reduce providers' administrative burdens, ensure veterans are not liable for authorized care, and ensure provider payments are made in a timely manner. The USH concurred with OIG's findings and recommendations.

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6

OIG evaluated whether VISN 6 provided new veterans timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. VISN 6 did not consistently have timely access to health care for new patients at its VA medical facilities and through Choice. Wait times were significantly higher than the wait time data that VHA's electronic scheduling system showed. This occurred because VISN 6 and medical facility management did not ensure staff consistently implemented VHA's scheduling requirements. Inaccurate wait time data resulted in a significant number of veterans not

being eligible for treatment through Choice. With respect to those veterans in VISN 6 who received their care through Choice, OIG estimated that 82 percent of the appointments during the relevant time period had wait times longer than 30 days. This occurred primarily because medical facilities did not ensure they had sufficient staffing resources to provide timely access to Choice care. VISN 6 also did not consistently manage the timeliness of specialty care consults. OIG concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Access to health care has been a recurring issue in VHA. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in 2016. OIG made 10 recommendations regarding monitoring controls over scheduling requirements, wait time data, Choice, and consult management. The then-USH concurred with four recommendations and concurred in principle with six recommendations. VHA's planned corrective actions are acceptable and OIG will monitor VHA's progress until all proposed actions are completed.

Review of Alleged Consult Mismanagement at the Phoenix VA HCS

OIG initiated this review to look into allegations made in 2015 by a confidential complainant and reported to OIG by the House Committee on Veterans' Affairs. OIG's review substantiated that the Phoenix VA Health Care System (PVAHCS) inappropriately discontinued consults for patients. In August 2014, OIG previously reported on numerous allegations regarding patient deaths, patient wait times, and scheduling practices at PVAHCS. That report recommended that the VA Secretary ensure PVAHCS follow VA consult guidance and appropriately review consults before closing them to ensure veterans receive necessary medical care. Although VHA made efforts to improve the care provided at PVAHCS, OIG found that consult management issues continue at PVAHCS. The current review determined that because consults were inappropriately discontinued, some patients did not receive the care requested or they experienced delays in receiving care. The review found that during calendar year 2015, PVAHCS staff inappropriately discontinued and canceled consults and were generally unclear about following specific consult management procedures. Procedures and consult management responsibilities varied in different specialties throughout the system, which further led to staff confusion and, in some cases, canceled consults. OIG's recommendations focused on improving the consult procedures at PVAHCS to ensure veterans receive the necessary follow-up medical care.

Review of Alleged Wait-Time Manipulation at the Southern Arizona VA HCS

OSC referred allegations concerning the Southern Arizona VA Health Care System (SAVAHCS) Ocotillo Primary Care Clinic to the VA Secretary in October 2014. These allegations were brought to the OSC by a former SAVAHCS employee who served in the Ocotillo Clinic. The complainant alleged that managers improperly directed scheduling staff to "zero out" patient wait times; Ocotillo Clinic physicians were awarded bonuses based in part on wait times; the complainant was excluded from a meeting with the hospital director; and the failure to adhere to agency scheduling directives endangered veterans' health. OIG substantiated the OSC complainant's allegation that managers improperly directed scheduling staff to zero outpatient wait times at the Ocotillo Clinic in violation of the agency's scheduling directive. A review of scheduling data showed 76 percent of appointments in the Ocotillo Clinic had a zero-day wait time from December 2013 through August 2014. According to a nursing supervisor, as well as several of her nursing staff, SAVAHCS scheduler training taught methods that violated VA's national scheduling policy. OIG partially substantiated that, in FY 2013, physicians were awarded bonuses based, to some extent, on appointment availability, including the percentage of patients scheduled within 14 days of their requested date. OIG found no evidence that Ocotillo Clinic physician performance pay in FY 2014, FY 2015, or FY 2016 was based on wait-time performance. OIG did not substantiate that the complainant had been excluded from a meeting with the hospital director because the complainant criticized scheduling procedures. OIG's review of patient care records found one patient who experienced a delay in care that led to a poor outcome. However, OIG determined that the poor outcome resulted from a lack of communication regarding the need for medical intervention, and not from

SAVAHCS's failure to adhere to agency scheduling directives. OIG recommended that the VA Southwest Health Care Network Director review the training records of all SAVAHCS schedulers to ensure their training is compliant with VHA's scheduling policy and ensure that SAVAHCS schedulers comply with current VHA policy regarding scheduling policies and practices. The Director of VISN 22 concurred with OIG's findings and recommendations, and submitted acceptable corrective action plans. OIG will follow up on the recommendations to ensure full implementation of all corrective actions.

Review of an Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VAMC in Salisbury, North Carolina

The VA Secretary forwarded to OIG allegations received from the OSC regarding access to care at the W.G. (Bill) Hefner VAMC, Salisbury, NC. The complainant made six allegations related to the existence of a large backlog of radiology exams at the VAMC. These allegations are in addition to the allegations investigated and published October 4, 2016, in the *Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times–VA Medical Center in Salisbury, North Carolina*, by OIG's Office of Investigations (OI). OIG substantiated the allegation that the VAMC had a backlog of about 3,300 pending orders for radiology exams, but did not substantiate the other five allegations. OIG confirmed the existence of a backlog of over 3,000 pending orders for radiology exams at a specific point in time in 2014 near the date identified by the complainant. However, Salisbury VAMC Imaging Service decreased the over 3,000 pending exams and the number of pending orders. The facility averaged 1,358 pending orders from January 1, 2014 through March 31, 2016, but was unable to eliminate the backlog. Furthermore, OIG review found the Imaging Service was not effectively managing its pending radiology exam workload to ensure patients received timely exams. Some patients experienced significant delays in the completion of ordered exams. OIG reviewed the records of 15 patients who died before the completion of a total of 16 ordered exams, but did not determine that any of the deaths or adverse clinical outcomes resulted from the delays. OIG recommended the VAMC Director require staff review all unscheduled radiology exam orders that are 30 days past the clinically indicated date and either cancel the orders if the exams are not needed or ensure the exams are scheduled. OIG also recommended the Director make unscheduled urgent and STAT orders a priority in the staff's review of unscheduled radiology orders and identify whether potential harm has occurred to patients due to delays in care. Finally, OIG recommended the VA Mid-Atlantic Health Care Network Director ensure the VAMC develops a plan to address existing demand for radiology exams and ensure future patients receive access to exams in accordance with VHA policy. The VA Mid-Atlantic Health Care Network Director and the VAMC Salisbury Director concurred with OIG findings and recommendations and provided an appropriate corrective action plan.

Audit of VHA's Consolidated Mail Outpatient Pharmacy Program

In September 2015, OIG received a congressional request to conduct an audit of the prescription processing and delivery timeliness for VHA's Consolidated Mail Outpatient Pharmacy (CMOP) Program. VHA's CMOP facilities had automated controls and pharmacists in place to ensure pharmaceuticals were secure and safely processed. However, at one of seven CMOPs, the Logistics Officer and Director or Associate Director did not review and approve inventory adjustments from the individual pill dispensing system as required by national policy. Although VA had implemented policy controls to minimize the risk for potential loss, theft, and diversion of pharmaceuticals, the Director believed there was a minimal risk for theft and thus did not follow the policy. OIG determined that more than 99 percent of veterans received their prescription packages within this CMOP's 10 day timeliness goal. This is calculated from the time the CMOP receives the prescription order to delivery of the package to the veteran. OIG also found that prescription-tracking information on VA's My HealtheVet allowed veterans who are VA patients to access their prescription information and track prescriptions filled by CMOPs. Finally, the CMOP Program had quality metrics in place to monitor and address its performance. The Program met the core quality metrics during the period of July 1 through

December 31, 2015. However, there were discrepancies with the accuracy of the data reported by the CMOPs to the National Office. OIG recommended the USH ensure the CMOP Logistics Officer and Director or Associate Director review and sign all inventory adjustment documentation monthly and the CMOP National Office implement a mechanism to validate self reported data to help ensure the reliability of its core quality metrics. The USH concurred with OIG's findings and requested closure of the recommendations based upon the actions taken as a result of the audit. The documentation provided was sufficient to close the recommendations.

Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses

In November 2015, OIG received an allegation that employees at the Consolidated Patient Account Centers (CPACs) were required to use two Windows enterprise licenses when thin clients were converted to computers. According to the complaint, CPACs operated within a virtual desktop infrastructure environment that required CPAC employees to log onto a virtual machine that had its own Windows enterprise license to perform their work-related functions. Allegedly, employees were using computers that required Windows enterprise licenses only as a gateway to access a virtual machine that also required a license. The complaint further alleged that the Windows enterprise licenses on the computers were not necessary because the computers were being underutilized. OIG substantiated the allegation that the VA Office of Information and Technology (OIT) wasted VA funds at CPACs to purchase underutilized computers that also required Windows enterprise licenses to operate. Specifically, CPAC employees used these computers only as gateways to access virtual machines on the network server that had individual Windows enterprise licenses. This occurred because OIT mandated that CPACs replace thin clients which depend on networked resources to operate with computers. However, OIT did not consider the CPACs' operating framework before purchasing the computers or mandating the replacement. Because CPACs did not change their operating framework when they converted from thin clients and only used computers as gateways, OIT paid for underutilized computers and avoidable licenses. As a result, OIT wasted approximately $7.2 million in VA funds converting CPACs from thin clients to computers. OIG recommended the Assistant Secretary for OIT implement policies and procedures to ensure cost effective utilization of information technology (IT) equipment, installed software, and services, and ensure the coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions. The Assistant Secretary for OIT concurred with the OIG recommendation and provided plans for the corrective action. OIG will monitor the planned actions and follow up on their implementation.

Review of Alleged Misuse of VA Funds at the VA Pittsburgh HCS

OIG substantiated an allegation that VA Pittsburgh Healthcare System (VAPHS) staff provided free meals for medical residents without the required meal plan. The VAPHS Director could have authorized the meals under an approved meal plan for residents comparable to those at the facility's index hospital, the University of Pittsburgh Medical Center. However, the Chief of Staff, who is responsible for reviewing this activity annually, overlooked the requirement for an approved meal plan. As a result, the VAPHS used approximately $441,000 in appropriated funds to purchase catered meals for medical residents from April 2013 through March 2015 without such a plan. In addition, OIG did not substantiate the assertion that the meals were lavish, but the cost of these commercial meals was more than the cost of similar catered meals potentially available from the Veterans Canteen Service (VCS). The VAPHS missed the opportunity to acquire potentially less expensive meals from VCS, rather than using this competitively selected commercial caterer. In January 2016, in response to OIG's review, the VAPHS Director established a meal plan for residents.

Review of Alleged Improper Non-VA Community Care Consult Practices at the Ralph H. Johnson VAMC, Charleston, South Carolina

On April 14, 2015, the OSC forwarded to the VA Secretary allegations of wrongdoing that occurred at the Ralph H. Johnson VAMC in Charleston, SC, in early FY 2014. A multidisciplinary team of auditors and health care inspectors began to address the allegations. These allegations were that management at the VAMC directed claims assistants to discontinue pending consult requests that were "aged out," a phrase previously unfamiliar to the complainants; Fee Basis clerks were directed to discontinue consults by marking them as completed when they were incomplete; and management interfered in the consult request process, including directing care for ineligible patients and allowing the Fee Basis Unit chief to direct his own care. OIG partially substantiated the allegation that management directed claims assistants to discontinue consults, but found that practice to be consistent with the VAMC's administrative policy. OIG substantiated the allegation that the Fee Basis clerks did not properly discontinue consults; identifying three that had been marked completed prior to medical documentation being uploaded into the patient's EHR. OIG did not substantiate the allegation that management directed care for ineligible patients and allowed the Fee Basis Unit chief to direct his own care. OIG recommended the VAMC Director initiate an independent review regarding one patient that experienced a delay in receiving specialty care and that the Director ensures that consults that were not acted on within seven days can be tracked and managed in accordance with national policy. The VAMC Director subsequently had the one patient's case reviewed by three outside experts who determined that the delay did not change the outcome for the patient.

Review of Alleged Human Resources Delays at the Atlanta VAMC

OIG received and substantiated allegations that the Atlanta VAMC had a backlog of over 300 unadjudicated background investigations and that mandatory drug testing of new hires did not occur for 6 months. VA officials confirmed the VAMC had a backlog of unadjudicated background investigations by mid FY 2015. The Director of VA Central Office's Personnel Security and Suitability Service said the VAMC had a backlog of approximately 200 of these investigations as of July 2015. Atlanta Human Resources (HR) personnel acknowledged a backlog dating as far back as 2012. Even though the lack of available records limited OIG's ability to quantify the extent of the backlog, OIG substantiated that backlogs were occurring by determining that the average adjudication processing time at the VAMC was about 170 days. OIG also substantiated that the Drug Free Workplace Program (DFWP) was not administered from November 2014 to May 2015. These lapses occurred because records within the personnel security program were inadequate, policies were not implemented as required, and HR staff were not adequately trained. VAMC management did not ensure the continuity of the DFWP when the former coordinator left the position in September 2014. Without proper controls over these functions, the VAMC cannot reliably attest to the suitability of its staff, exposing veterans and employees to individuals who have not been properly vetted. The facility lacks assurance that employees in Testing Designated Positions remain suitable for employment. OIG recommended the Medical Center Director assess the HR program and ensure staff receive appropriate background investigations, provide training on the requirements of the personnel security program, and monitor the DFWP. The Director concurred with OIG's recommendations. OIG considers the corrective action plans the facility submitted acceptable and will follow up on their implementation.

Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the PVAHCS

OIG reviewed this complaint alleging that the PVAHCS improperly sole-sourced ophthalmology contracts to Barnet Dulaney Perkins (BDP), and the Chief of Staff and Interim Associate Director had a conflict of interest with BDP. OIG did not substantiate that the PVAHCS improperly sole-sourced ophthalmology service contracts to BDP, but found that the PVAHCS and Network Contracting Office (NCO) 18 used full and open competition to award BDP three ophthalmology service contracts valued at just over $30.4 million, respectively, on February 1, 2006, and October 1, 2009. However, the NCO 18 contracting officer(s) did not properly maintain

contract documentation in the Electronic Contract Management System for two contracts. The PVACHS's issuance of just over $12.4 million in unauthorized commitments to BDP and the lack of recruitment of VA ophthalmologists may have made it appear that these contracts had been sole-sourced. OIG did not substantiate the allegation of a conflict of interest between the named PVACHS officials and BDP because OIG found no evidence that a business, financial, and/or personal relationship existed between them and BDP. The PVAHCS officials had pressured the contracting officer to sole-source additional contracts to BDP because of concerns over possible delays in care and lapses in the continuity of care, but the contracting staff did not give in to the pressure, and the PVAHCS began using VA's Patient-Centered Community Care (PC3) contracts in March 2015. OIG recommended the Service Area Office West (SAOW) Director ensure the proper maintenance of contracting files and the PVAHCS Director ratify the unauthorized commitments and develop a business case for the provision of ophthalmology services. The NCO 18 provided contract documents almost one year after the start of the review that showed NCO 18 properly awarded the contracts and that the first allegation was unsubstantiated. The PVAHCS and SAOW Directors agreed with the recommendations and provided responsive action plans.

Audit of Hurricane Sandy Major Construction Relief Funds for the VA New York Harbor HCS

OIG performed this audit to determine if the VA New York Harbor HCS (NYHHS) received the goods, services, and deliverables VA paid for in accordance with P.L. 113-2, *Disaster Relief Appropriations Act*, 2013 (the Act), for Hurricane Sandy recovery. OIG found that the goods, services, and deliverables paid for through March 2016, with funds designated for Hurricane Sandy major construction, were received by NYHHS in accordance with the Act. Because NYHHS received the goods, services, and deliverables paid for by the *Disaster Relief Appropriations Act*, 2013 through March 2016 in accordance with P.L. 113-2, OIG made no recommendations.

Audit of Alleged Misuse of VHA Funds at the Northern Arizona VA HCS

OIG did not substantiate an allegation that the Northern Arizona VA HCS (NAVAHCS) inappropriately used VHA appropriations to purchase IT items. From September 2012 through March 2014, the NCO for the VISN overseeing NAVAHCS awarded six contracts to obtain various IT items for this and other medical facilities. NAVAHCS paid about $368,000 for multifunctional devices (MFD) with printing functionality and other expenses using VHA appropriations. Although VA's 2006 policy memo stated that VA should use the IT systems appropriations for MFDs with printer functionality, OIG did not fault NAVAHCS for its decision to use VHA appropriations because of inconsistent guidance on the correct use of funds for similar copier machines connected to a network that could also serve as printers. OIG also determined that NAVAHCS appropriately used VHA funds on the remaining five contracts to purchase commercial software supporting patient care. Because VA issued guidance to clarify VA's 2006 policy memo during the audit, OIG made no recommendations.

Review of Alleged Mismanagement of Construction Projects at the VAMC in Clarksburg, West Virginia

OIG substantiated a Hotline allegation of improper management and oversight of minor, nonrecurring maintenance, and clinical specific initiative construction projects at the Louis A. Johnson VAMC in Clarksburg, WV. The complainant alleged eight construction projects were mismanaged, which led to project cost overruns, delays, cancellations, unnecessary change orders, and additional work. Most significant was a parking garage planned for at a cost of approximately $9.7 million that was reduced from approximately 430 new spaces to approximately 25 new spaces before the project was canceled in March 2016. The VAMC also had to reduce other construction projects in scope because of inadequate planning and delayed project completion. The VAMC has completed only three of the eight projects; all three cost significantly more than planned. This occurred because of inaccurate cost estimates, untimely performance of site surveys, and failure to ensure project designs were within funding limitations. In total, OIG identified approximately $2.8 million in unnecessary costs and delays in completing projects needed to serve veterans. Accordingly, OIG recommended

the VISN 5 Director ensure the Louis A. Johnson VAMC implements a plan to use or repurpose the heating and air conditioning system identified by this review, train staff on developing cost estimates and funding requests, and ensure timely performance of site surveys.

Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths

In September 2015, OIG received an allegation that VHA paid NVC providers for services that could not have been rendered to about 4,200 deceased veterans listed in the Social Security Administration's (SSA) Death Master File. To investigate the allegation, OIG reviewed payment records documenting outpatient and inpatient claims worth about $15.5 million to determine whether, and to what extent, improper payments were made from FYs 2011–2015. OIG substantiated the allegation and found VHA improperly paid for 12 of the 25 billed NVC outpatient services reviewed, totaling about $810 in improper payments. These improper payments occurred because NVC authorization clerks failed to update the end dates on veterans' NVC authorizations to reflect their dates of death, as required by VHA policy. However, OIG did not substantiate that VHA made improper payments for inpatient services because the services had been rendered before the veterans' dates of death. For the 60 billed NVC inpatient services reviewed, OIG determined the veterans' dates of death in the Death Master File were incorrect and/or the payment records did not reflect the last dates the veterans received care. Although OIG did not find a systemic issue, we estimated VHA annually makes about $101,000 in improper payments to NVC providers for deceased veterans. VHA could improperly pay NVC providers about $505,000 for outpatient services over the next 5 years unless it ensures NVC authorizations for deceased veterans are updated in accordance with VHA policy. OIG recommended that the USH recover the improper payments identified and ensure VA medical facilities update NVC authorizations for deceased veterans as required by VHA policy. The USH concurred with OIG's report and provided an acceptable action plan.

Audit of VHA's Patient Advocacy Program

The Patient Advocacy Program is intended to identify systemic problems in VA health care with veterans experiencing unsatisfactory service. This audit was conducted to determine whether VHA responded to FY 2015 patient complaints timely and appropriately. VHA did not adequately capture FY 2015 patient complaint information and identify complaint trends. OIG reviewed responses made as recently as May 2016 to FY 2015 complaints. OIG projected more than one-third of approximately 135,000 of VHA's serious patient complaints in the Patient Advocate Tracking System (PATS) lacked key information and were closed erroneously. Serious complaints included issues such as delays in accessing care or services, problems with clinical care, and pain management. In addition, OIG estimated about 11,000 patient complaints at five of the eight sites visited were not recorded in PATS, and VA medical facilities and VISNs in OIG's fieldwork performed limited or no formal complaint trending. VHA missed opportunities to achieve its intended program goals because the Patient Advocacy Program had material weaknesses in internal control areas, such as policies, quality control, information technology, and human capital. As a result, lapses in collecting, monitoring, and trending patient complaints reduced the potential effectiveness of the Patient Advocacy Program and affected VA's progress in becoming more veteran-centric, including identifying systemic issues for improving the quality of veterans' health care. PATS did not have important security controls in place. Approximately 4,000 of about 7,900 users had inappropriate access to PATS due to VHA's untimely review of user privileges and access rights. PATS also lacked audit logs for significant user actions. These conditions occurred and persisted, in part, because OIT did not adequately assess PATS security and operational risks. As a result, PATS data were vulnerable to unauthorized access and alteration, and records were not available to monitor modifications to sensitive patient information. OIG recommended the USH implement operational controls to ensure the effectiveness of the program and reliability of its patient complaint data. OIG also recommended the USH and the Assistant Secretary for OIT address PATS security and authorization issues. The USH and Acting Assistant Secretary for OIT concurred with OIG's recommendations. OIG considers their corrective action plans acceptable and will follow up on their implementation.

Veterans Benefits Administration Audits and Evaluations

OIG performs audits and evaluations of veterans' benefits programs focusing on the effectiveness of benefits delivery to veterans, dependents, and survivors. These audits and evaluations identify opportunities for enhancing the management of program operations and provide VA with constructive recommendations to improve the delivery of benefits.

Audit of VBA's Automated Burial Payments

In October 2014, OIG received an allegation that VBA's automated burial benefits system was authorizing improper burial payments. OIG evaluated the effectiveness of VBA controls ensuring proper automated burial payments. VBA controls ensured that the majority of automated burial payments were made to living spouses for deceased veterans in accordance with the Code of Federal Regulations (CFR). However, controls did not consistently ensure proper automated burial payments. OIG found VBA improperly authorized 4,525 of 16,406 automated burial payments (about $2.8 million) from August 2014 through January 2015, including payments to spouses who weren't on veterans' records at the date of death or who were deceased, the processing of multiple payments, and payments to veterans who were still living. This occurred because VBA lacked controls, policies, procedures, and sufficient quality assurance reviews. If VBA does not implement adequate controls, OIG estimated VBA will continue authorizing improper automated burial payments of about $5.6 million annually and approximately $28 million over the next five years. VBA improperly discontinued 68 living veterans' monthly disability benefit payments totaling $190,267 because VBA had erroneously recorded the veterans as deceased, possibly causing financial hardship to veterans and their families. OIG recommended the Principal Deputy Under Secretary for Benefits, performing the duties of the Under Secretary for Benefits (USB), review the improper payments identified during OIG's audit, take appropriate corrective actions when warranted, and strengthen burial payment controls. OIG also recommended he initiate actions to ensure policies and procedures are consistent with the CFR and perform quality assurance reviews. The Principal Deputy Under Secretary for Benefits concurred with four of five recommendations and provided acceptable corrective actions plans, but didn't agree to enforce the requirement that proof of death be submitted prior to the release of automated burial payments. He also provided additional comments which OIG addressed in this report.

Review of Alleged Use of Incorrect Effective Dates at VBA's VA Regional Office in Chicago, Illinois

OIG assessed the merits of a December 2015 OIG Hotline allegation that claims processors at the Chicago VA Regional Office (VARO) assigned incorrect effective dates when processing claims associated with "intent to file" (ITF) submissions. An ITF provides claimants the opportunity to submit minimal information related to their claim for benefits and allows up to one year for the claimant to provide additional information and evidence necessary to complete the claim. If benefits are subsequently established, VA may use the date the VARO received the ITF as the basis for an earlier effective date for benefits payments. OIG substantiated the allegation that Rating Veterans Service Representatives (RVSRs) at the Chicago VARO did not always assign the correct effective dates when they received an ITF. Overall, RVSRs established incorrect effective dates for 15 of the 30 disability claims (50 percent) OIG sampled from a universe of 616 claims. Five of the errors resulted in 15 improper benefits payments totaling approximately $5,700; 10 of the errors had incorrect effective dates but did not affect benefits payments. The majority of effective date errors occurred when the claimant submitted an ITF electronically. In these cases, VBA automatically updates the corporate database; however, there is no standardized form within the electronic claims folder, which increases the likelihood the VARO overlooks the ITF. Although a notification letter is generated, it is stored in a separate VBA system. Generally, OIG attributed the errors to a lack of guidance within VBA policy on how to identify ITF filings and insufficient analysis of effective date errors, which led to weaknesses in training. Using incorrect effective dates may result in incorrect

benefits payments. However, subsequent to OIG's review, VBA updated its policy to include instructions on identifying ITFs and made additional ITF training available nationwide. OIG recommended the Chicago VARO Director conduct a review and take appropriate actions on the 586 claims associated with ITFs remaining from OIG's universe. In addition, OIG recommended the Director implement a plan to ensure sufficient analysis is completed to identify effective date errors related to ITFs. Furthermore, OIG recommended the VARO Director ensure claims processors receive training on how to identify ITFs. The VARO Director concurred with the recommendations and provided sufficient evidence to close the recommendations.

Other Audits and Evaluations

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

OIG performs audits of IT and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and safeguarding veterans and VA employees, facilities, and information. OIG's audit reports present VA with constructive recommendations needed to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with P.L. 107-347, *Federal Information Security Management Act of 2002*, as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit. These evaluations have led OIG to report information security and security of data and data systems as a major management challenge for VA.

Audit of VA's Recruitment, Relocation, and Retention Incentives

OIG assessed how VA used recruitment, relocation, and retention (3R) incentives to develop and maintain its workforce in FY 2014. OIG conducted this audit following a complaint alleging VA awarded its Senior Executive Service (SES) employees recruitment and relocation incentives without adequate justification and retention incentives without determining the employee's intent to leave VA. OIG substantiated part of the allegation, finding VA's Office of Corporate Senior Executive Management did not ensure SES recruitment and relocation incentives were properly authorized before making award recommendations to VA. OIG did not substantiate that VA awarded SES employees retention incentives without determining the employee's intent to leave. VHA didn't properly authorize 33 percent of the recruitment and 64 percent of the relocation incentives awarded to non-SES employees. Most retention incentives awarded to SES employees and non-SES VHA employees and half of retention incentives awarded to non-SES VACO employees lacked adequate workforce and succession plans. VA needs to improve efforts to recoup payments when employees do not meet the recruitment or relocation service agreement terms. VA's inadequate controls over its 3R incentives represent an estimated $158.7 million in unsupported spending and approximately $3.9 million in repayment liabilities projected for FYs 2015 through 2019. OIG recommended the Assistant Secretary for OHRA review and update procedures for VA Administrations to ensure recruitment and relocation incentives are justified and properly authorized and develop internal controls for VA Administrations to monitor facilities' compliance with developing succession plans to reduce VA's reliance on retention incentives.

Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract

In January 2015, OIG received an anonymous Hotline complaint alleging that OIT spent over $2 million on a cloud brokerage service contract that provided only limited brokerage functionality and that VA's actions did not ensure adequate system performance or return on investment. Substantiating the allegations, OIG

determined total project costs exceeded $5 million, that the system's limited brokerage service functionality prevented it from being used in a production environment, and that VA's actions did not ensure adequate system performance or return on investment. The project manager did not ensure that formal testing and acceptance were conducted on project deliverables. Project management was not performed in accordance with established procedures and the Project Management Accountability System was not used to hold project managers accountable for meeting project goals. These deficiencies occurred because of a lack of executive oversight and ineffective project management. Without enforcement of oversight controls, project leadership cannot ensure the value of contract deliverables or demonstrate an adequate return on investment for the project. OIG recommended that the Assistant Secretary for OIT implement improved controls to ensure effective oversight of IT projects and compliance with IT project management procedures. Additionally, the Assistant Secretary should enforce the use of the Veteran-focused Integration Process on all software development projects and ensure all VA developed software costs are funded with IT systems appropriations.

Independent Review of VA's FY 2016 Performance Summary Report on Drug Control Funds to the Office of National Drug Control Policy

As required by the Office of National Drug Control Policy (ONDCP) Drug Control Accounting Circular, OIG reviewed VA's FY 2016 Performance Summary Report to ONDCP. OIG attested to VA's ability to capture performance information accurately and whether the current system was properly applied to generate the performance data reported in the Performance Summary Report. Based upon OIG's review and the criteria of the Circular, nothing came to OIG's attention that caused us to believe that VA does not have a system to meet its FY 2016 targets for the continuity of care performance measure (Patient Care) and the substance abuse disorder ongoing studies performance measure (Research and Development) in all material respects.

Independent Review of VA's FY 2016 Detailed Accounting Submission to the ONDCP

OIG is required to review VA's FY 2016 Detailed Accounting Submission to the ONDCP. The Submission concerns assertions on VA's drug methodology, reprogrammings and transfers, and fund control notices. Based upon OIG's review, nothing came to OIG's attention that caused us to believe that management's assertions included in VA's Submission are not fairly stated in all material respects based on the set criteria.

Chief Financial Officers Act of 1990 Compliance

OIG contracted with an independent public accounting firm to audit VA's FY 2016 financial statements as required by P.L. 101-576, *Chief Financial Officers Act of 1990*. VA received an unmodified opinion meaning that its financial statements were materially accurate. The contractor identified six material weaknesses: IT security controls; education benefits accrued liability; the control environment surrounding the compensation, pension, and burial actuarial estimates; community care obligations, reconciliations, and accrued expenses; financial reporting; and the Chief Financial Officer organizational structure for VA and VHA. The contractor further identified two significant deficiencies: procurement, undelivered orders, accrued expenses, and reconciliations; and the loan guaranty liability estimate. It also reported VA's substantial noncompliance with applicable Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under P.L. 104-208, *Federal Financial Management Improvement Act*. It noted improvements were needed in complying with P.L. 97-255, *Federal Managers' Financial Integrity Act*. The contractor cited instances of noncompliance with section 5315, title 38, United States Code, pertaining to the charging of interest and administrative costs; noncompliance with section 3733, title 38, United States Code, pertaining to the vendee loan program; and six violations of P.L., 97-258, *Antideficiency Act,* identified by VA.

Office of Investigations

Veterans Health Administration Investigations

The Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 111 cases; made 60 arrests; obtained over $125 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $3 million in savings, efficiencies, and cost avoidance; and recovered over $91,000.

During this reporting period, OIG opened 25 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 19 individuals were arrested for various crimes relating to drug diversion. These investigations resulted in nearly $18,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and over $1.2 million in savings, efficiencies, cost avoidance, and dollar recoveries. In addition, a compound pharmacy investigation which defrauded the Civilian Health and Medical Program of the VA (CHAMPVA) resulted in a total of 3 arrests and approximately $67 million in fines and penalties.

OI initiated 10 investigations related to the fraudulent receipt of health benefits, which resulted in 2 arrests for various related crimes. These investigations resulted in approximately $51,000 in fines, restitution, penalties, and civil judgments; and over $270,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OI opened 27 investigations regarding criminal activities carried out by VHA employees (excluding crimes related to drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from veterans, and theft of VA property or funds. As a result of OIG work in this area, 12 individuals were arrested which resulted in more than $58 million in court ordered payments of fines, restitution, penalties, and civil judgements; and over $326,000 achieved in savings, efficiencies, cost avoidance, and dollar recoveries.

The case summaries that follow provide a representative sample of the type of VHA investigations conducted during this reporting period.

Alexandria, Louisiana, Nursing Assistant Indicted for Negligent Homicide

An Alexandria, LA, nursing assistant was indicted for negligent homicide. The indictment alleges that the defendant assaulted an inpatient veteran by slamming the veteran's head into a wall while the veteran was in a special observation day room. The veteran died several weeks later. According to the forensic report, the death was the result of blunt force trauma to the head.

Augusta, Georgia, VAMC Nurse Arrested for Elder Exploitation

An Augusta, GA, VAMC registered nurse was indicted and subsequently arrested for elder exploitation. An OIG investigation revealed that the defendant, assigned to the Critical Care Unit (CCU) as a night shift nurse, allegedly punched an intubated CCU patient in the face and head area and concealed the physical assault by covering the telehealth camera lens in the patient's room with medical tape. The patient sustained injuries from the assault. The defendant was removed from patient care pending the result of the investigation and the medical center is now proposing termination.

Former Sacramento, California, VAMC Chief of Podiatry and Vendor Indicted for Fraud

The former chief of podiatry for the Sacramento, CA, VAMC and a long time VA vendor were both indicted for health care fraud, conspiracy to violate the anti-kickback statute, and conspiracy to commit wire fraud. The vendor held local and national contracts to supply prosthetic and orthotic devices to VA. OIG, VA Police Service (VAPS), and Department of Homeland Security (DHS) Investigations investigated allegations that the chief willfully wrote consults for substandard orthotic footwear provided to veterans. The vendor then billed VA for the substandard footwear at inflated rates and paid the chief's spouse $60,000 for patient referrals. In addition, the defendants conspired to falsely claim to VA where the vendor's products were manufactured. VA was informed that the vendor's products were domestically produced when they were actually made in China. These false statements subsequently helped the vendor land lucrative Government contracts. A senior employee working for the vendor recently pled guilty to Conspiracy to Commit Wire Fraud. The loss to VA is approximately $2 million.

Former Augusta, Georgia, VAMC Chief of Fee Basis Sentenced for Making False Statements

A former Augusta, GA, VAMC Chief of Fee Basis was sentenced to 27 months' incarceration, 3 years' supervised release, and was ordered to pay a $5,100 special assessment and a $1,500 fine after being found guilty at trial of making false statements in relation to health care and making a false statement to a Federal agent. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 NVCC consults at the medical center. Specifically, the defendant directed his subordinates to falsely document "services provided or patient refused services" in the patients' VA electronic medical records even though employees had not reviewed the records or contacted the patients. OHI conducted a review of approximately 2,700 patient records and determined that over 450 patients never received care and/or refused services.

Former Portland, Oregon, VA Social Worker Sentenced for Attempted Coercion and Initiating a False Police Report

A former Portland, OR, VA social worker was sentenced to 2 days' incarceration and 24 months' probation and was ordered to receive MH counseling and pay $16,536 in restitution after pleading guilty to attempted coercion and initiating a false police report. The defendant falsely reported that her veteran patient had threatened to kill her. This threat prompted the medical center to shut down the MH clinic for the remainder of the day. Further investigation revealed that the defendant engaged in a personal relationship with the veteran who was 100 percent service-connected and rated incompetent by VA. The defendant exchanged over 4,000 personal text messages with the veteran asking him to marry her, raise an adoptive child, and spend personal time together outside of their therapy sessions. The defendant also threatened to report the veteran to VA police as dangerous and to have him arrested if he reported their personal relationship.

Former Atlanta, Georgia, VAMC Physician's Assistant Sentenced for Acts Affecting a Personal Financial Interest

A former Atlanta, GA, VAMC physician's assistant was sentenced to 1 year of probation and 90 days' home confinement after being found guilty at trial of acts affecting a personal financial interest. An OIG investigation revealed that from July 2009 to January 2010 the defendant, while employed with VA, accepted $500 per month from a medical supply distributor to promote a wound care product to fellow medical providers. The defendant continuously placed a large amount of orders for the same product, which was paid for by the medical center. The defendant did not disclose to anyone at the medical center that she received compensation based on the sales of the medical product. Further investigation revealed that the defendant also compiled protected health information and personally identifiable information (PII) from veteran/patients she treated on her personal computer to compare the effectiveness of wound care treatment options while using the wound care product. The defendant subsequently resigned from VA and accepted a position with the manufacturer of the wound

care product as the company's Director of Clinical Education. The co-defendant, a medical supply distributor, previously pled guilty to Aiding and Abetting Acts Affecting a Personal Financial Interest and was sentenced to 2 months' probation.

Former Coatesville, Pennsylvania, VAMC Health Technician Pleads Guilty to Tax Fraud

A former Coatesville, PA, VAMC health technician pled guilty to fraudulently preparing approximately 176 Federal income tax returns for other individuals, including his co-workers, during the years 2010 through 2013. The returns sought tax refunds of approximately $610,526. In addition to charging his co-workers a fee for preparing their tax returns, the defendant stole a portion of the refunds that he generated by having a portion of the tax refunds deposited into his personal bank account. The investigation revealed that the subject accessed tax preparation websites using his VA computer and some of the fraudulent tax returns were submitted through the VA network.

Former VA CBOC Contract Employee Sentenced for Assault

A former VA CBOC contract employee was sentenced to 24 months' probation and ordered to participate in an MH treatment program after pleading guilty to assault. An OIG investigation revealed that the defendant was terminated from the CBOC pursuant to an inappropriate relationship with one of his female veteran patients. After his termination, the employee returned to the CBOC and made threatening statements. The following day, the employee came back to the facility armed with a handgun and paraded outside the front of the building.

East Orange, New Jersey, VAMC Employee Charged With Assault and Possession of Weapons

An East Orange, NJ, VAMC employee was charged with assault and possession of weapons. An OIG and VAPS investigation resulted in the defendant being charged after allegedly attacking and assaulting his VA supervisor with a wooden "billy" club at the medical center. Consensual searches of the employee's locker and car yielded three illegal knives. The altercation was sparked by a prior incident in which the supervisor allegedly sexually assaulted the employee. OIG is currently investigating the allegation of sexual assault.

West Los Angeles, California, VAMC Employee Charged With Assault

A West Los Angeles, CA, VAMC employee was charged with assaulting another employee with a deadly weapon. An OIG investigation revealed that two employees got into an argument and one employee allegedly used his VA-issued utility knife to stab the other employee. The incident was witnessed by another VA employee. The victim received an 8-inch laceration on his torso and another stab wound, resulting in 13 stitches. The defendant subsequently admitted to stabbing the victim.

Seattle, Washington, VAMC Employee Arrested for Possession of a Firearm

A Seattle, WA, VAMC employee was arrested for possession of a firearm by a felon. An OIG, Federal Bureau of Investigation (FBI), Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), and VAPS investigation was initiated after an anonymous tip alleged that the employee was stealing chemicals from the medical center in an effort to develop concentrated hydrogen peroxide for unknown reasons. The defendant had also been involved in several workplace altercations in the past year. The investigation further revealed that the employee, a convicted felon, possessed weapons and also sold narcotics. A search of the defendant's vehicle parked at the medical center resulted in the seizure of a loaded pistol and methamphetamine. The defendant is being held pending further judicial action.

Long Beach, California, VAMC Employee Sentenced for Criminal Threats

A Long Beach, CA, VAMC employee was sentenced to 6 days in jail and 3 years' probation after pleading guilty to criminal threats. An OIG and VAPS investigation resulted in the defendant being charged after texting pictures of his genitals to a subordinate employee. The defendant was also accused of sexually assaulting another employee. During the investigation, the employee allegedly threatened to kill a witness.

Veteran Sentenced for Weapons Violation

A veteran was sentenced to 4 years' incarceration and 3 years' probation after pleading guilty to unlawfully converting a firearm into a machine gun and then selling the weapon. During an OIG and VAPS investigation involving illicit drug sales at the Long Beach, CA, VAMC, the defendant sold a fully automatic SKS rifle, two 20-round magazines, and ammunition to an undercover VA police officer.

Veteran Arrested for Sexual Abuse at the Lexington, Kentucky, VAMC

A veteran was indicted and arrested for sexual abuse. An OIG, VAPS, and local police investigation resulted in the defendant being charged with the sexual abuse of another inpatient at the Lexington, KY, VAMC. The defendant is alleged to have gone into the victim's room and sexually abused the victim after she had been administered sleep medication. The defendant admitted to the sexual abuse.

Veteran Sentenced for Unlawful Sexual Contact with a Minor

A veteran participating in compensated work therapy at the Chillicothe, OH, VAMC was sentenced to 3 years' incarceration after pleading guilty to unlawful sexual contact with a minor and gross sexual imposition. The veteran was also adjudicated a Tier 2 Sex Offender/Child Victim Offender Registrant. An OIG and local police investigation resulted in the defendant being charged with the sexual contact of a 14-year-old disabled daughter of a VA volunteer on VA property.

Former Murfreesboro, Tennessee, VAMC Nurse Sentenced for Drug Diversion

A former Murfreesboro, TN, VAMC staff nurse was sentenced to 2 years' probation after pleading no contest to obtaining a controlled substance by fraud pursuant to a judicial diversion agreement. An OIG investigation revealed that on at least 18 occasions between April 2014 and March 2015 the defendant diverted oxycodone, hydrocodone, morphine, and lorazepam intended for CLC geriatric patients. The defendant admitted to diverting the drugs for personal use and subsequently resigned from her position at the medical center.

Former Salt Lake City, Utah, VAMC Associate Chief of Pharmacy Sentenced for Drug Diversion

A former Salt Lake City, UT, VAMC associate chief of pharmacy was sentenced to 3 years' probation after pleading guilty to acquiring possession of a controlled substance by fraud. An OIG investigation revealed that between October 2011 and March 2015 the defendant diverted approximately 25,000 pills of oxycodone, hydromorphone, Adderall, buprenorphine, Ritalin, and tramadol from the inpatient pharmacy. The defendant admitted to diverting the drugs for personal use and subsequently resigned from his position at the medical center.

Former Palo Alto, California, HCS Physician Pleads Guilty to Prescription Fraud

A former Palo Alto, CA, HCS physician pled guilty to prescription fraud. For over 2 months, the physician prescribed oxycodone tablets to multiple patients that had no need for this medication. The physician then explained to these patients that he had made a mistake and retrieved the tablets either directly from the patient or by making arrangements to recover them from the United Parcel Service (UPS) during the shipping process. The defendant claimed that a dependence on pain medication led him to divert the oxycodone tablets. The physician's VA employment was terminated.

Two Little Rock, Arkansas, VAMC Pharmacy Technicians and a Pharmacy Technician Student Trainee Indicted for Drug Diversion

Two Little Rock, AR, VAMC pharmacy technicians and a pharmacy technician student trainee were indicted for charges to include conspiracy to defraud, theft of Government funds, possession with intent to distribute, conspiracy to distribute, and possession with intent to distribute. An OIG investigation resulted in the defendants being charged with diverting and distributing 4,000 oxycodone, 3,300 hydrocodone, 308 ounces of

promethazine with codeine syrup, and over 14,000 Viagra and Cialis tablets. Three additional VA employees were identified as part of the drug diversion, resulting in a resignation and reassignments. The monetary loss to VA is over $77,000.

Former Minneapolis, Minnesota, VAMC Nurse Charged with Drug Diversion

A former Minneapolis, MN, VAMC nurse was charged with unlawfully procuring, attempting to procure, possessing or having control over a controlled substance by fraud, deceit, misrepresentation, or subterfuge. An OIG investigation resulted in the defendant being charged with entering false patient information into the medical center Pyxis machine in order to obtain hydrocodone and oxycodone for personal use.

Former Wilkes-Barre, Pennsylvania, VAMC Nurse Sentenced for Drug Diversion

A former Wilkes-Barre, PA, VAMC registered nurse was sentenced to 3 years' probation after having previously pled guilty to knowingly and intentionally obtaining a controlled substance by fraud. The defendant diverted "wasted" morphine and hydromorphone for personal use from the hospice unit from 2014 to 2015.

Former Livermore, California, VAMC Employee Sentenced for Drug Theft

A former Livermore, CA, VAMC employee was sentenced to 3 years' probation, time served (1 day), and was ordered to attend and successfully complete a 4-month drug treatment program after pleading "no contest" to possession of a controlled substance. During an OIG and VAPS investigation involving the theft of prescription medication packages, the defendant was observed at his work desk smashing pills into a powder form that he subsequently inhaled. The defendant admitted to stealing narcotics from United States Postal Service (USPS) packages.

Portland, Oregon, VAMC Fee-Based Physician Enters into a Pretrial Diversion Agreement

A Portland, OR VAMC fee-based physician entered into a Pretrial Diversion agreement with the Government. A VA OIG and Office of Personnel Management (OPM) OIG investigation revealed that the fee-based physician prescribed controlled substances for her husband, who was a full-time VA surgeon at the same facility, and then diverted the controlled substances for her own use. The two physicians did not share the same last name, and the husband was unaware of the diversion. The physician's employment was terminated by the facility.

Former St. Joseph, Missouri, CBOC Employee Pleads Guilty to Drug Diversion

A former St. Joseph, MO, CBOC employee received a suspended imposition of sentence and was placed on 3 years' probation after pleading guilty to fraudulently attempting to obtain a controlled substance. An OIG and local police investigation resulted in the defendant being charged after he wrote VA prescriptions for a non-veteran. The physician wrote the fraudulent prescriptions from August 2015 to April 2016 in order to obtain the controlled substances for his personal use.

Former Richmond, VA, VAMC Nurse Sentenced for Drug Diversion

A former Richmond, VA, VAMC registered nurse was sentenced to 4 months' home detention and 3 years' probation after pleading guilty to obtaining controlled substances by misrepresentation, fraud, or deception. During an OIG and VAPS investigation, the defendant confessed to diverting for personal use approximately 20 to 30 oxycodone 5mg tablets and 8 to 10 fentanyl patches (varying in strength from 25 to 100 micrograms) from two Omnicell medication dispensers. The defendant also confessed to occasionally shorting patients that were under her care by giving them a limited dose of their prescribed pain medication in order to satisfy her addiction. The defendant resigned her position as a result of this investigation.

Long Beach, California, VAMC Employee Sentenced for Selling Heroin

A VA employee was sentenced to 3 years' incarceration for selling heroin to an undercover officer at the Long Beach, CA, VAMC on multiple occasions. An OIG, VAPS, Los Angeles High Intensity Drug Trafficking Areas,

Los Angeles Sheriff's Department, Drug Enforcement Administration (DEA), and ATF investigation revealed that 24 subjects, including veterans and two VA employees, sold heroin, methamphetamine, marijuana, crack cocaine, oxycodone, Percocet, Tylenol with Codeine, morphine, hydrocodone, fentanyl, and Tramadol at the medical center. A handgun and a fully automatic SKS rifle were also sold to undercover officers.

Former St. Louis, Missouri, VAMC Employee Pleads Guilty to Conspiracy to Steal Government Funds

A former St. Louis, MO, VAMC employee pled guilty to conspiracy to steal Government funds. A VA OIG and Federal Deposit Insurance Company OIG investigation revealed that, from October 2012 to February 2014, the defendant was an outside contractor and received purchase orders from the medical center for maintenance work totaling $144,629. During this time, the defendant allegedly kicked back payments of approximately $41,250 to a VA official. The defendant later became a VA employee and arranged for his unqualified stepson to receive purchase orders for maintenance work. From April 2014 to April 2015, the defendant's stepson received $125,549 for maintenance work. During this time, the stepson allegedly kicked back payments of approximately $39,000 to the same VA official and approximately $20,800 to the defendant. This investigation is ongoing and there is an anticipated loss of $451,853.

Former West Los Angeles, California, VAMC Payroll Technician Arrested for Wire Fraud and Theft of Government Funds

A former West Los Angeles, CA, VAMC payroll technician was arrested for wire fraud and theft of Government funds. An OIG investigation resulted in the defendant being charged with two separate schemes to divert funds at the facility. The first scheme involved diverting 136 payroll allotments, totaling $4,689, from the pay of other employees to the defendant's own bank account. The defendant is also alleged to have generated fraudulent vendor forms and sent them to the Financial Service Center in order to redirect VA suspense payments to bank accounts under his control. The loss associated with this second scheme is $110,424. The employee confessed to the thefts and subsequently resigned.

Northport, New York, VAMC Union President Pleads Guilty to Petit Larceny

A Northport, NY, VAMC employee and former American Federation of Government Employees president pled guilty to petit larceny. In furtherance of this plea deal, the defendant agreed to make full restitution. The defendant also agreed to serve a 60-day jail sentence or to perform 280 hours' community service in lieu of jail, followed by 3 years' probation. An OIG, Department of Labor (DOL) Office of Labor Management Standards, and Attorney General's Office investigation revealed that the defendant embezzled approximately $45,000 from the union's bank account and used the funds for personal expenditures.

Non-Veteran Pleads Guilty to Theft of Government Funds

A non-veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant, who never served in the military, was able to obtain medical benefits as well as VA grant benefits by submitting falsified documents to VA claiming he served in the Marine Corps. The loss to VA is $130,121.

Ann Arbor, Michigan, VAMC Patient Arrested for the Distribution of an Illegal Substance that Resulted in the Death of Another Veteran

An Ann Arbor, MI, VAMC patient was indicted and arrested for the distribution of an illegal substance that resulted in the death of another veteran. An OIG and FBI investigation resulted in the defendant being charged with introducing a mixture of heroin and fentanyl into the medical center and providing a portion to the victim that resulted in his death.

Veteran Pleads Guilty to Possession With Intent to Deliver Narcotics

A veteran pled guilty to possession with intent to deliver narcotics. An OIG, state police, and VAPS investigation was initiated in 2013 when a patient seeking drug addiction treatment reported being approached on several occasions to buy narcotics from individuals at the Philadelphia, Pennsylvania, VAMC. Through several undercover operations, 12 other subjects were identified as selling narcotics at the medical center and have also been charged as part of this investigation.

Veteran Pleads Guilty to Possession of a Schedule II Controlled Substance

A veteran pled guilty to felony possession of a schedule II controlled substance (oxycodone) and as part of a Deferred Prosecution Agreement, was sentenced to 12 months' supervised probation, 48 hours' community service, and was ordered to attend and complete a drug education program. The veteran's co-defendant, a former VA physician, previously received a similar sentence. An OIG, local police, North Carolina Medical Board, and DEA Diversion investigation revealed that the VA physician had a personal relationship with the veteran that continued after she left VA employment and that she continued to prescribe controlled medications to the veteran using VA prescriptions. Forensic evidence analysis determined that the former VA physician had authored the illegal prescriptions. Both the physician and the veteran received pills from the prescriptions that were filled at outside pharmacies. The physician surrendered her medical license and DEA number as a result of this investigation.

Veteran Indicted on Multiple Drug Charges

A veteran was indicted on multiple felony drug charges. An OIG investigation revealed that the defendant obtained opioids from VA and his non-VA medical provider from 2014 to 2016, which resulted in the defendant receiving approximately 1,260 tablets by deception. The defendant admitted to distributing the extra controlled substances he obtained to other individuals.

Veteran Sentenced for Obtaining a Controlled Substance by Fraud or Forgery

A veteran was sentenced to 3 to 13 months' incarceration, 18 months' supervised probation, and was ordered to pay $2,907 in fines/cost after pleading guilty to obtaining a controlled substance by fraud or forgery. An OIG and local police investigation revealed that the veteran went to multiple VAMCs, military installations, and private pharmacies in three states presenting forged prescriptions for controlled narcotics. The veteran then sold or used the fraudulently obtained narcotics. After being charged, the veteran absconded and was a fugitive for over a year.

Son of a Deceased Veteran Indicted for Unlawful Possession of Oxycodone and Identity Theft

The son of a deceased veteran was indicted for unlawful possession of oxycodone and identity theft. An OIG investigation resulted in the defendant being charged with posing as his deceased father and contacting VA to refill his father's oxycodone prescription. For over 9 months, VA shipped 4,500 oxycodone tablets to the son's home.

Non-Veteran Arrested for Weapon and Drug Violation at San Francisco, California, VAMC

A non-veteran was arrested for possession of a controlled substance while armed and possession of high capacity magazines. An OIG and VAPS investigation resulted in the defendant being charged with possession of loaded firearms and illegal drugs while at the San Francisco, CA, VAMC. An AR-15 rifle, a shotgun with a folding stock, a Sig Sauer P229 pistol, nine magazines, and crystal methamphetamine were seized from the defendant's vehicle.

Veteran Arrested for Travel Benefit Fraud

A veteran was indicted and arrested for theft of Government funds. An OIG and VAPS investigation resulted in the defendant being charged with submitting fraudulent travel benefit claims to the San Francisco, CA, VAMC.

The defendant claimed to drive over 500 miles a day roundtrip to the medical center, 4 to 5 days per week for several years. In actuality, the defendant was living in a mobile RV trailer park not far from the medical center. The loss to VA is approximately $159,000.

Veterans Sentenced for Travel Benefit Fraud

A veteran was sentenced to 3 years' probation and was ordered to pay $19,079 in restitution after pleading guilty to grand larceny relating to beneficiary travel fraud. A VA OIG, New York State Medicaid OIG, and NY District Attorney's Office investigation revealed that on 747 occasions the defendant claimed and received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also being reimbursed for travel by VA. The loss to VA was $19,079.

In a separate case, a veteran was sentenced to time served (30 days), 3 years' supervised probation, and was ordered to pay VA $10,225 in restitution after pleading guilty to presenting a false, fictitious, or fraudulent claim to a Department of the United States. An OIG investigation revealed that for nearly 2 years the defendant claimed an address 128 miles from the Asheville, NC, VAMC. In actuality, the defendant was living in Housing and Urban Development-VA Supportive Housing only 14 miles from the facility. This defendant was part of a larger investigation involving multiple beneficiary travel fraud suspects that led to the arrest of 13 veterans and restitution of more than $100,000 being ordered paid back to the facility.

Veterans Benefits Administration Investigations

VBA administers a number of financial benefits programs for eligible veterans and certain family members, including VA guaranteed home loans, education, insurance, and monetary benefits. Investigations routinely concentrate on payments made to ineligible individuals. For example, a veteran may deliberately feign a medical disability to defraud the VA compensation program. With respect to VA guaranteed home loans, OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. VA appoints fiduciaries for veterans in receipt of VA benefits who are deemed incompetent and for minor children who are receiving VA benefits. OIG investigates allegations of fraud committed by these fiduciaries.

OIG's IT and Data Analysis Division, in coordination with OI conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. During this reporting period, OIG opened 75 investigations, which resulted in 37 arrests and $4 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,535 possible cases with over 4,340 investigative cases opened. Investigations have resulted in the actual recovery of $105 million, with an additional $35 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $209 million. To date, there have been 823 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OI opened 138 investigations involving the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. Various criminal charges were filed which led to 64 arrests for these types of investigations. OIG obtained over $14.7 million in court ordered payment of fines, restitution, penalties, and civil judgements; achieved over $4.5 million in savings, efficiencies, and cost avoidance; and recovered more than $3.1 million.

Former VA Field Examiner Arrested for Mail Fraud

A former VA field examiner was indicted and arrested for mail fraud. An OIG investigation resulted in allegations that the defendant drafted a Last Will and Testament for an incompetent veteran and listed himself as the sole beneficiary of the veteran's financial assets, valued at approximately $680,000. The defendant then used USPS to place the fraudulent document on file with the veteran's fiduciary, Regions Bank. The defendant resigned from VA employment in lieu of termination.

VA-Appointed Fiduciary Charged with Exploitation of Veteran

A VA-appointed fiduciary, who is the brother of a disabled veteran, was charged with abuse, neglect, or exploitation of a vulnerable adult and unlawful dealing of property by a fiduciary. An OIG and Utah State Attorney General's Office investigation resulted in the fiduciary being charged with misusing approximately $246,475 of VA and Social Security funds intended for the disabled veteran. The loss of VA funds is approximately $197,200.

Fiduciary Pleads Guilty to Theft of Government Funds

The sister of a veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant assumed responsibility for more than $148,000 of her brother's funds at the time she was appointed his fiduciary. The defendant then failed to provide her required annual accounting and ignored repeated attempts by VA to contact her. By the time the defendant was replaced by a professional fiduciary, more than $100,000 in additional VA funds had been deposited. The defendant allegedly used more than $95,000 of the VA funds to pay off her personal loans and to purchase a new BMW vehicle.

VA Fiduciary Indicted for Misappropriation by a Fiduciary and Wire Fraud

A VA fiduciary was arrested after being indicted for misappropriation by a fiduciary and wire fraud. An OIG investigation revealed that the defendant charged a veteran for room/board fees and caregiver fees during 33 months when the veteran was residing in a VA-contracted nursing home. The defendant spent more than $119,000 of the veteran's funds on personal living expenses.

Former VA Fiduciary Arrested for Misappropriation

A former VA fiduciary was indicted and arrested for theft of Government funds and misappropriation by a fiduciary. An OIG investigation resulted in the defendant being charged with making numerous cash withdrawals and purchases from a veteran's bank account from October 2014 to July 2015. The veteran had recently received a large sum of back pay from VA. The defendant allegedly misappropriated approximately $37,197 in VA benefits.

Former Fiduciary Sentenced for Embezzlement

A former VA fiduciary was sentenced to 6 months' incarceration, 6 months' home confinement, 24 months' supervised release, and was ordered to pay $36,000 in restitution to the veteran. The defendant, an attorney, previously pled guilty to stealing VA benefits from the veteran's bank account from October 2009 to March 2011 while acting as the veteran's appointed guardian. The defendant used the embezzled funds for personal expenses.

VA Appointed Fiduciary Indicted for Theft of Government Funds

A VA-appointed fiduciary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with misusing a veteran's VA benefits. The defendant allegedly used the veteran's funds for personal use after making general withdrawals, writing checks to cash, and making automated teller machine (ATM) withdrawals. The loss to the veteran is $24,937.

Muskogee, Oklahoma, VARO Employee Sentenced for Theft of Government Funds

A Muskogee, OK, VARO employee was sentenced to 5 years' probation and was ordered to pay $39,606 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant used his position in the education benefits office to send funds, using the accounts of two separate veterans, to a Green Dot debit card account he opened in his brother's name.

Defendant Pleads Guilty to Theft of Government Funds

A defendant pled guilty to theft of Government funds. An OIG investigation determined that a former VBA employee fraudulently used the identities of multiple veterans to prepare special monetary payments that were directly deposited by VA into multiple bank accounts held either by the VBA employee or the defendant. As a result of this scheme, this defendant fraudulently received VA funds of approximately $45,900. The loss to VA as a result of the former VBA employee's actions was approximately $66,996.

Veteran Pleads Guilty to Wire Fraud and Spouse Pleads Guilty to Misprision of a Felony

A veteran pled guilty to wire fraud and his spouse pled guilty to misprision of a felony. A VA OIG, USPS OIG, DOL OIG, and VAPS investigation revealed that the veteran, who was rated 100 percent disabled and receiving special monthly compensation (SMC) for loss of use of both feet and major depressive disorder, was able to ambulate and carry out daily tasks with a clear ability to use both of his feet. Additionally, the veteran was receiving Federal Workers' Compensation benefits from a fraudulent injury he claimed to have suffered through his previous employment with the USPS. The veteran's spouse was charged in relation to her assistance in furthering the fraud by pushing her husband in his wheelchair to his VA appointments and benefitting financially from the proceeds. The loss to VA is $922,137.

Veteran Sentenced for the Fraudulent Receipt of VA Compensation Benefits

A veteran was sentenced to 24 months' incarceration, 3 years' supervised release, and was ordered to pay VA $789,472 in restitution after being found guilty at trial of health care fraud. An OIG and FBI investigation revealed that from March 1995 through June 2013 the defendant misrepresented his vision loss to VA. The defendant was granted a 100 percent service connection for vision loss, SMC, and other program benefits to which he was not entitled. The defendant was observed walking without assistance and driving. The defendant also maintained a valid driver's license and received a speeding ticket. In addition to receiving approximately $700,000 in VA compensation benefits, the defendant also received a $10,000 VA grant to purchase an automobile (intended for another person to drive the defendant), and an $11,000 VA grant towards the installation of an in-ground swimming pool at his residence. The defendant also received over $75,000 in VA health care benefits to which he was not entitled, to include CHAMPVA, dental services, beneficiary travel pay, blind rehabilitation training, and prosthetics equipment and devices.

Veteran Sentenced for Theft of VA Compensation Benefits

A veteran was sentenced to 6 months' incarceration, 6 months' home confinement, 2 years' supervised release, and was ordered to pay VA restitution of $150,164 after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with claiming false PTSD stressors in order to fraudulently collect VA compensation benefits for approximately 10 years. Examples of stressors the veteran fraudulently claimed included his participation in a "dead body detail" during Operation Desert Storm and his involvement in an incident in which a fellow soldier's Humvee was fired upon causing the vehicle to crash and kill the soldier. The investigation determined that from July 1991 to January 1992 the veteran served as an administrative clerk in Saudi Arabia and Kuwait and did not serve in a combat role during his tour of duty overseas. Additionally, the defendant was not involved in a Humvee accident or "dead body detail." The defendant was previously convicted in 1996 as the result of an OIG investigation involving the VA Home Loan Program.

Veterans Indicted for VA Compensation Fraud

A veteran was indicted for false statements pertaining to health care matters. An OIG investigation resulted in the defendant being charged with misrepresenting to VA his ability to walk and fraudulently receiving approximately $570,000 in VA benefits based on his reported loss of use of both feet.

In a second case, a veteran was indicted for theft of Government funds. The defendant is alleged to have altered his Certificate of Release or Discharge from Active Duty (DD-214) in order to fraudulently receive VA compensation benefits. The loss to VA is $142,284.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 30 months' supervised probation and was ordered to pay $19,950 in criminal restitution towards a $270,575 civil debt the defendant incurred with VA. The defendant previously pled guilty to making false statements. An OIG investigation revealed that the defendant falsely claimed to suffer from symptoms of narcolepsy and received a medical discharge from the Navy in 1997. The defendant subsequently applied for VA compensation benefits for service-connected narcolepsy, claiming the condition rendered him homebound and unable to work, which was granted at 100 percent. The defendant later became a Federal employee for the U.S. Army Corps of Engineers and utilized his Federal Employee Health Benefits to obtain treatment and medication for the fraudulently claimed condition in furtherance of his scheme to defraud VA. The defendant also provided material false statements to OIG agents, a VA physician, and an RVSR about his condition and symptoms. As a result of this investigation, the defendant was also terminated from his position with the U.S. Army Corps of Engineers.

Veteran Pleads Guilty to Theft of Government Funds and Social Security Fraud

A veteran pled guilty to theft of Government funds and SSA fraud. A VA OIG and SSA OIG investigation revealed that the defendant served in the military and received VA pension benefits under one Social Security number, but earned income under a separate Social Security number. The defendant's earned income, if reported, would have made him ineligible for a VA pension benefit. The loss to VA is $205,534.

Veteran Convicted of Theft of Government Funds and False Statements

A veteran was found guilty at trial of theft of Government funds and false statements. A VA OIG, SSA OIG, and Health and Human Services (HHS) OIG investigation revealed that the defendant fraudulently applied for and received VA, SSA, and HHS disability benefits, claiming loss of use of her right hand since January 2009 when in fact she had full use of both hands. During the course of the investigation, the defendant also provided false statements to VHA and SSA medical staff regarding the extent of her disabilities. The loss to the Government is over $300,000, to include a loss to VA of $187,656.

Veteran and Wife Arrested for Conspiracy and Theft of Government Funds

A veteran and his wife were indicted and arrested for conspiracy and theft of Government funds. An OIG investigation resulted in charges that alleged the veteran provided false information to VA regarding his vision loss. The veteran had been granted Special Monthly Pension based on the need for Aid and Attendance for blindness. The investigation revealed that the veteran has a valid driver's license, drives himself, and performs normal daily activities without the assistance of another person or low vision aids. The loss to VA is $63,352.

Veterans Sentenced for Theft of Government Funds

A veteran was sentenced to 5 years' probation and was ordered to pay $313,276 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that in 1998 the defendant provided VA with a medical report from a non-VA ophthalmologist reporting that his visual acuity was "hand motion only," his vision would not get better, and that his vision could not be corrected by surgery. Based on this information, the defendant was rated 100 percent service connection for blindness. The investigation further revealed that the

defendant possessed a valid driver's license, rode a motorcycle, and worked for 6 years as a mail clerk at a private business. A VA ophthalmologist examined the defendant and determined that he was not and could never have been blind. The loss to VA is $518,486, with $205,210 being recovered administratively.

In a second case, a veteran was sentenced to 2 years' probation and was ordered to pay restitution of $100,096 after pleading guilty to theft of Government funds. An OIG investigation revealed that from 2008 to 2014 the defendant received individual unemployment benefits while self employed as a structural engineer and as the owner of a local tavern.

In a third case, a veteran was sentenced to 3 years' probation, 250 hours' community service, and was ordered to pay VA restitution of $56,740 after pleading guilty to theft of Government funds. An OIG investigation revealed that from 2012 to 2015 the defendant received individual unemployability benefits while employed by a local district attorney's office and the Oregon Department of Justice.

Veteran's Widow Sentenced for Making False Statements

A widow receiving Dependency and Indemnity Compensation (DIC) benefits was sentenced to 18 months' incarceration, 3 years' supervised release, and was ordered to pay $254,272 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant failed to disclose her remarriage to VA and subsequently made material false statements concerning her marital status in order to continue to receive VA benefits.

Veteran Charged with Stolen Valor

A veteran was charged with wire fraud and stolen valor. The veteran alleged that while serving in the United States Marine Corps he was awarded a Combat Action Ribbon along with two Purple Heart medals. The veteran claimed to have been injured by an improvised explosive device (IED) while serving in Iraq. As a result of his claims, the veteran fraudulently obtained VA compensation benefits, in addition to receiving a mortgage-free house from the Military Warrior Support Foundation. An OIG and FBI investigation resulted in the defendant being charged with falsely claiming the Combat Action Ribbon and Purple Heart medals. The investigation also revealed that the veteran was not injured by an IED and did not engage in combat. The loss to VA is $243,436.

Friends of Deceased VA Beneficiaries Sentenced for Theft of Government Funds

The friend of a deceased VA beneficiary was sentenced to 21 months' incarceration, 2 years' supervised release, and was ordered to pay $396,057 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after the beneficiary's death in September 2005.

In a separate case, a friend of a deceased VA beneficiary was sentenced to 21 months' incarceration, 24 months' supervised release, and was ordered to pay VA $101,250 in restitution. An OIG investigation revealed that the defendant failed to report the beneficiary's death to VA and stole VA benefits that were direct deposited after her death in February 2008.

Grandson of Deceased Veteran Sentenced for Theft of Government Funds

The grandson of a deceased veteran was sentenced to 15 months' incarceration, 3 years' supervised release, and was ordered to pay VA $304,415 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the veteran's death in July 2007.

Nephews of Deceased VA Beneficiaries Indicted for Theft

The nephew of a deceased VA beneficiary was indicted for theft of Government funds and social security fraud by concealment. A VA OIG, SSA OIG, and OPM OIG investigation resulted in the defendant being charged with stealing his aunt's VA, SSA, and OPM benefits that were direct deposited to a joint account after her death in September 1995. The loss to the Government was $363,924, to include a loss to VA of $209,274.

In another case, the nephew of a deceased VA beneficiary was indicted for theft of Government funds, bank fraud, and aggravated identity theft. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his aunt's death in August 2007. The defendant also allegedly changed the mailing address on the beneficiary's checking account and made cash withdrawals from the account using a debit card. The loss to VA is $102,622.

Son of Deceased VA Beneficiary Charged With Theft of Government Funds

The son of a deceased VA beneficiary was charged with theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into his deceased mother's bank account after her death in June 2003. The defendant's attorney told agents that the defendant knew he wasn't entitled to the benefits and was willing to repay the funds. Full restitution of $188,406 was subsequently received by the Government.

Stepson of Deceased Beneficiary Charged with Concealing Veteran's Death and Stealing Government Benefits

The stepson of a deceased VA beneficiary was arrested for fraud schemes, theft, taking the identity of another, money laundering, and concealment of a dead body. A VA OIG, SSA OIG, and local law enforcement investigation resulted in the defendant being charged with burying his stepfather in the backyard in order to conceal his death and steal his VA and SSA benefits. As a result of this deception, VA and SSA benefits continued to be direct deposited to the beneficiary's account after his death in December 2011. The loss to the Government is $300,000, to include a loss to VA of $175,000.

Daughter of Deceased VA Beneficiary Given Pretrial Diversion

The daughter of a deceased VA beneficiary entered a pretrial diversion program after an OIG investigation revealed that she stole VA funds that were direct deposited after her mother's death in November 2003. The defendant subsequently reimbursed VA and a local bank the entire outstanding overpayment of $166,289 as part of the program requirements.

Grandson of Deceased VA Beneficiary Indicted for Theft of Government Funds

The grandson of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the veteran's death in May 2008. The loss to VA is $143,106.

Daughter of Deceased VA Beneficiary Arrested for Bank Fraud and Aggravated Identity Theft

The daughter of a deceased VA beneficiary was indicted and subsequently arrested for bank fraud and aggravated identity theft. An OIG investigation resulted in the defendant being charged with using an ATM card to steal VA benefits that were direct deposited after her mother's death in August 2009. When the defendant no longer had access to the ATM card, she wrote personal checks to herself and forged her mother's signature. The loss to VA is $119,389.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA DIC beneficiary was sentenced to 1 day of incarceration, 12 months' supervised release, and was ordered to pay VA $114,048 in restitution after pleading guilty to theft of Government funds. A

VA OIG and Pension Benefit Guarantee Corporation (PBGC) OIG investigation resulted in the defendant being charged with stealing VA and PBGC benefits that were direct deposited after her mother's death in March 2005. The defendant maintained a post office box in her deceased mother's name and submitted correspondence to VA bearing her deceased mother's forged signature in order to continue to receive benefits.

Daughter-in-Laws of Deceased VA Beneficiaries Sentenced for Theft of Government Funds

The daughter-in-law of a deceased VA DIC beneficiary was sentenced to 1 year of probation and was ordered to pay VA $109,518 in restitution after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the beneficiary's death in October 2007. The defendant also forged her deceased mother-in-law's name on a VA marital status questionnaire in 2010 reporting that she had not remarried. In addition, the defendant's husband, who admitted that he also used the VA funds, entered into a pre-trial diversion agreement.

In another case, the former daughter-in-law of a deceased VA beneficiary, who was also the Power of Attorney, was sentenced to 3 months' incarceration, 3 years' supervised release, and was ordered to pay $93,588 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds (checks and direct deposits) issued after the beneficiary's death in November 2005. The defendant used the funds for personal expenses. The defendant also defrauded the deceased beneficiary's private pension fund.

Relative of Deceased VA Beneficiary Sentenced for Theft of Government Funds

A relative of a deceased VA beneficiary was sentenced to 3 years' probation, 300 hours' community service, and was ordered to attend mental health and alcohol treatment programs and to pay $109,292 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA DIC benefits that were direct deposited after the beneficiary's death in November 2009. The defendant admitted to using the stolen funds for personal use.

Sons of Deceased VA Beneficiaries Plead Guilty to Theft of Government Funds

The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother's death in June 2009. The defendant stole most of the VA funds by making checks payable to himself. The loss to VA is $108,690.

In a second case, the son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing $106,583 in VA benefits that were direct deposited into his mother's bank account after her death in February 2009. The investigation also resulted in the commencement of forfeiture proceedings on a recreational boat partially owned by the defendant.

Daughter of Deceased VA Beneficiary Convicted of Theft of Government Funds

The daughter of a deceased VA beneficiary was convicted at trial of theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in January 2007. The loss to VA is $101,459.

Sons of Deceased VA Beneficiaries Sentenced for Theft of Government Funds

The son of a deceased VA beneficiary was sentenced to 14 months' incarceration, 3 years' supervised release, and was ordered to pay $101,060 in restitution after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother's death in April 2005.

In a separate case, the son of a deceased VA beneficiary was sentenced to 11 months' incarceration, 3 years' supervised release, and was ordered to pay restitution of $86,516 after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA DIC benefits that were direct deposited into a joint account after his mother's death in December 2005. The defendant admitted to using the stolen funds for personal use.

Friend of Deceased Beneficiary Found Guilty of Theft of Government Funds

A friend of a deceased beneficiary was found guilty at trial of theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the beneficiary's death in February 2008. The loss to VA is $100,610.

Daughter of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after her mother's death in December 2009. The defendant is also alleged to have submitted falsified documents to VA on several occasions after her mother's death in order to continue receiving the VA benefit payments. The defendant allegedly changed mailing addresses and bank accounts multiple times in order to avoid detection. The loss to VA is $99,006.

Son of Deceased VA Beneficiary Pleads Guilty to Making a False Statement

The son of a deceased VA beneficiary pled guilty to making a false statement. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother's death in May 2008. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA in order to make it appear that his mother was still alive. The loss to VA is $97,660.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased VA beneficiary was arrested by the U.S. Marshals Service in Spokane, WA, for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits from her deceased mother's account after her mother's death in December 2009. The defendant is also alleged to have submitted two forged Marital Status Questionnaires after her mother's death. The defendant is currently pending extradition to Texas. The loss to VA is approximately $93,000.

Daughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased beneficiary was sentenced to 3 years' probation and was ordered to pay $77,184 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with the theft of VA DIC benefits that were direct deposited after the beneficiary's death in July 2009. The defendant admitted to using the stolen funds for personal use.

Other Investigations

OI investigates a wide array of criminal offenses in addition to those listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography; allegations of bribery and kickbacks; bid rigging and antitrust violations; false claims submitted by contractors; and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices, OI opened 29 cases and made 20 arrests. These investigations resulted in over $11.3 million in court ordered payment of fines, restitution, penalties, and civil judgments; over $36,000 in savings, efficiencies, cost avoidance; and more than $380,000 in dollar recoveries.

False Claims Act Settlement Agreement

A VA OIG, FBI, HHS OIG, and Defense Criminal Investigative Service (DCIS) investigation of an alleged illegal medical product marketing scheme, which relied on gratuity payments to VA and Medicare physicians, resulted in a $350 million civil P.L. 97-258, *False Claims Act* settlement agreement. The medical product was a biological skin substitute for the treatment of diabetic foot ulcers. The investigation determined that Advanced BioHealing (ABH), Inc., sales representatives provided a variety of financial inducements to VA physicians to include honorarium payments, concert tickets, and all-expense paid vacations in an effort to increase sales of their product to VA facilities. ABH sales to VA during the time the gratuities were paid to VA clinicians totaled approximately $147 million. To date, this settlement is the largest P.L. 97-258, *False Claims Act* recovery by the U.S. involving a medical device. VA's portion of this settlement agreement totaled $58 million, which is captured in the VHA section on page 36.

Civil Settlement in Medical Products Case

The Department of Justice (DOJ) announced that a Government contractor based in St. Louis, MO, signed a civil settlement agreement and paid $4 million to resolve allegations that they submitted false claims for medical items sold to VA and DoD. The civil settlement was the result of a VA OIG, General Services Administration (GSA) OIG, and DCIS investigation and resolved allegations that the contractor made false disclosures to VA and DoD regarding the discounts and prices it was providing to other commercial customers for assorted medical products. The agreement also resolves allegations that the contractor made false statements to VA and DoD about the country of origin for some products, and as a result, sold products that were not from approved countries as required by P.L 96-39, *Trade Agreements Act*. VA's portion of the settlement is approximately $2.1 million.

Veteran and Business Associate Plead Guilty to Misprision of a Felony

A service-connected disabled veteran and a business associate, who owned a separate minority-owned small business, pled guilty to misprision of a felony. In addition, the owner of a small business pled guilty, and also pled guilty on behalf of his company, to conspiracy. A multi-agency investigation revealed that over $350 million in set-aside (veteran-owned, minority-owned, women-owned) construction contracts were fraudulently obtained by the defendants, who conspired in creating companies for the sole purpose of obtaining set-aside Government contracts, all while providing false information to VA and the Small Business Administration (SBA) in order to qualify for the contracts.

Civil Settlement Agreement Involving Service-Disabled Veteran-Owned Small Business

As part of a Civil Settlement Agreement between the Government and the two owners of a Service-Disabled Veteran-Owned Small Business (SDVOSB), $132,000 was transferred to the U.S. Treasury. This transfer of funds represents all remaining assets for the company and brings the total recovered to $1,132,000. An OIG investigation revealed that the defendants secured approximately $30 million in VA SDVOSB set-aside contracts at VA National Cemeteries. The veteran owner admitted that he was not in control of the company and that the co-owner ran the business. The non-veteran co-owner's family business had been awarded contracts at the cemeteries prior to 2007 before the VA National Cemetery contracts started being designated as SDVOSB set-aside contracts.

Kansas City, Missouri, Construction Company and Former Owners Indicted on Charges Related to SDVOSB Fraud

A Kansas City, MO, construction company and two of its former owners were indicted for various charges to include wire fraud conspiracy, major program fraud, wire fraud, and money laundering. A VA OIG investigation, with assistance from GSA OIG, resulted in the indictment that alleges that the defendants obtained

$13.8 million in Federal Government contracts for work in nine states by using a veteran's service-disabled veteran (SDV) status to create a "pass-through" company for the purpose of obtaining 20 set-aside veteran-owned small business and SDVOSB contracts. The work was then allegedly subcontracted to a non-SDV-owned company. The SDV owner maintained full-time work as a Government employee and did not control the day-to-day management, daily operation, or long-term decision making of the SDVOSB. Warrants have led to the seizure of $2.5 million from various financial accounts associated with this scheme.

Civil Complaint Alleging SDVOSB Fraud Filed Against Construction Companies and Officers

A U.S. Attorney's Office filed a civil complaint against a construction company contracted by VA as an SDVOSB, its three officers, and another construction company as the result of a VA OIG and SBA OIG investigation. The civil action was based on an SDVOSB fraud allegation that involved several VA construction contracts at VA facilities in New Jersey. The amounts of the contracts totaled over $7 million, most of which were funded by P.L. 111-5, *American Recovery and Reinvestment Act*. The complaint seeks monetary damages for violations of P.L. 97-258, *False Claims Act*, fraud, and other deceptive actions allegedly committed by the subjects. The construction company contracted by VA was allegedly created to act as a pass-through SDVOSB company for a non-SDVOSB company so it could qualify and bid on set-aside contracts.

Non-Veteran Owner Ordered to Forfeit Over $6.7 Million in Assets

A Federal judge ordered a non-veteran owner of an SDVOSB to forfeit over $6.7 million in assets. A jury previously found the owner guilty at trial of conspiracy to defraud the United States and wire fraud. A VA OIG, SBA OIG, GSA OIG, Army Criminal Investigations Division, and Navy Criminal Investigation Service (NCIS) investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those SDVs, the company was awarded more than $112 million in Federal contracts between 2006 and 2010, of which $110 million were VA contracts.

Husband and Wife Sentenced for SDVOSB Fraud

A husband and wife were sentenced to 48 months' and 30 months' incarceration respectively, and 36 months' supervised release after previously being convicted at trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. The defendants also forfeited over $170,000 in cash and five rental properties that were acquired using proceeds from the fraudulently obtained Government contracts. A VA OIG, Department Of Interior OIG, and SBA OIG investigation revealed that the defendants used a "pass-through" scheme to create an SDVOSB in order to qualify for and obtain set-aside construction contracts in multiple states. The defendants used an SDV who was a full-time truck driver and had no construction experience or equipment to establish a construction business and provided fraudulent references to VA and other Government agencies in order to obtain the work. The defendants also created another business to obtain SBA 8(a) set-aside contracts with the two businesses sharing employees, financial assets, and then subcontracting out the work on most projects. The $4 million VA loss includes P.L. 111-5, *American Recovery and Reinvestment Act* funds. The total loss to the Government is $15 million.

Two Non-Veteran Corporate Officers Charged with SDVOSB Fraud

Two non-veteran corporate officers of an SDVOSB were indicted for conspiracy to defraud the United States, major fraud against the United States, and wire fraud. One of the corporate officers was also indicted for false statements. A multi-agency investigation resulted in the defendants being charged with recruiting a veteran and establishing a "pass-through" SDVOSB for the purpose of obtaining Federal construction contracts for their legitimate businesses. The company, which falsely self-certified the "pass-through" as an SDVOSB, was awarded almost $16 million in Federal contracts between 2008 and 2014, of which over $12 million were VA contracts.

VA Loan Guaranty Program Beneficiary Sentenced for False Statement

A VA loan guaranty program beneficiary was sentenced to 27 months' incarceration, 60 months' supervised release, and was ordered to pay $107,000 in restitution after pleading guilty to making a false statement to obtain a loan. A VA OIG, United States Postal Inspection Service (USPIS), SSA OIG, and local police investigation resulted in the defendant being charged with using allegedly falsified information (including employment and income information) to obtain a $423,000 home loan guaranteed by VA, and then subsequently defaulting on the loan. The defendant was also alleged to have provided false information to obtain multiple vehicle loans, and then manufactured a scheme to remove the first liens from the vehicle titles in order to resell the vehicles to legitimate dealers.

Former Tucson, Arizona, CMOP Chief IT Specialist Pleads Guilty to Possession of Child Pornography

The former Tucson, AZ, CMOP chief IT specialist pled guilty to possession of child pornography. DHS agents executed a search warrant at the VA employee's residence which resulted in the seizure of approximately 40 GB of child pornography video from the employee's personal computer. Subsequently, OIG seized the employee's VA-issued laptop, which was sent to the OIG Forensic Laboratory. The result of their examination revealed pornographic images as well as internet word searches associated with child pornography. The VA employee resigned from VA while under investigation.

Former Des Moines, Iowa, VAMC Employee Sentenced for Possession of Child Pornography

A former Des Moines, IA, VAMC employee was sentenced to 135 months' incarceration and 15 years' supervised release after pleading guilty to possession of child pornography. An OIG and DHS Investigations investigation revealed that while the defendant was working at the medical center he searched for child pornography using a shared VA computer.

Defendant Convicted of Identity Theft Charges

A defendant was convicted at trial of aggravated identity theft, access device fraud, conspiracy to commit identity theft, and conspiracy to commit access device fraud. A VA OIG and Federal Housing Finance Authority OIG investigation revealed that the defendant obtained the PII of dozens of VA employees from a former VA employee. The defendant used the PII of the VA employees and of Freddie Mac pension plan participants to run credit reports, to open credit accounts, to make fraudulent purchases at high-end retailers, and to pay for plastic surgery in Miami, FL.

Thirty-Three Non-Veterans Plead Guilty to Conspiracy to Defraud the Government with Respect to Claims

Thirty-three non-veterans, including three former Battle Creek, MI, VAMC employees, pled guilty to conspiracy to defraud the Government with respect to claims. A multi-agency investigation revealed that from 2008 to 2016 the defendants utilized other individuals' PII, obtained in part from patients and employees of the medical center and inmates of the Michigan Department of Corrections, to file false tax returns totaling over $22 million. For his part, the leader of the conspiracy was sentenced to 10 years' incarceration and was ordered to pay $16 million in restitution. Additionally, this defendant was sentenced to an additional and consecutive 37 months' incarceration related to a weapon recovered during the execution of a search warrant of his residence. The three former VAMC employees are scheduled to be sentenced later this year.

Contract USPS Driver Arrested for Mail Theft

A contract USPS driver was arrested for theft and mail theft. A VA OIG and USPS OIG investigation resulted in the defendant being charged with stealing VA packages containing controlled substances. Hydrocodone pills were also recovered from the defendant's residence.

Two Defendants Found Guilty of Major Fraud Against the United States

Two non-veteran defendants were found guilty of major fraud against the United States. Additionally, one of the defendants was also found guilty of conspiracy and wire fraud. A VA OIG, Housing and Urban Development OIG, USPIS, and North Carolina Department of Insurance investigation revealed an interstate fraudulent construction bond scheme, affecting multiple Federal agencies over the course of several years. The loss to VA is approximately $4 million.

Former Goodwill Supportive Service for Veteran Families VA Grant Manager Pleads Guilty to Conspiracy and Wire Fraud

A former Goodwill Supportive Service for Veteran Families VA grant manager pled guilty to conspiracy to commit wire fraud and wire fraud. A co-conspirator was found guilty at trial of the same charges. An OIG investigation revealed that the two defendants created false businesses purporting to house homeless veterans and then siphoned VA grant money by depositing Goodwill checks into small business bank accounts they had opened. The loss to VA is approximately $325,000.

Veteran Sentenced for Surety Bond Fraud

A veteran was sentenced to 150 months' incarceration, 3 years' supervised release, and was ordered to pay $4.1 million in restitution. A multi-agency investigation revealed an extensive surety bond fraud scheme that affected multiple Federal agencies and over $935 million in Government construction contracts. The defendant, along with other co-conspirators, used Government-owned lands or bogus trusts as assets to back bid, payment, and performance bonds while accepting approximately $10 million in bonding fees. The impacted VA contracts totaled over $97 million, including P.L. 111-5, *American Recovery and Reinvestment Act* funds.

Former Sales Representative Sentenced for Purchase Card Fraud

A former sales representative for a VA vendor was sentenced to 25 months' incarceration, 3 years' supervised release, 100 hours' community service, and was ordered to pay $1,141 in restitution and a $600 special assessment. An OIG investigation revealed that the defendant used her position to gain access to multiple VA purchase card numbers and then used the cards to fraudulently purchased tickets to sporting events.

Veteran Sentenced for Mail Fraud and Structuring Currency Transactions

A veteran was sentenced to 18 months' incarceration, 3 years' probation, and was ordered to pay restitution of $525,521 after pleading guilty to mail fraud and structuring currency transactions. An OIG and Internal Revenue Service (IRS) Criminal Investigation Division (CID) investigation determined that the defendant fraudulently posed as a representative of VA and took payments from 16 veterans with the promise of getting the veterans VA compensation benefits at a 100 percent rating. The payments made to the defendant were to be used to pay an attorney to do research and file the veterans' claims. The defendant subsequently stole the payments from his victims and never filed a single claim on their behalf.

Company Owner Pleads Guilty to Conspiracy to Commit Mail Fraud

The owner of three companies, who contracted with various Government agencies, pled guilty to conspiracy to commit mail fraud. A multi-agency investigation revealed that beginning as early as February 2010 the defendant received numerous contracts from the Government, to include a VA contract, through FedBid.com. Once the companies secured a contract from the Government, they arranged for victim-vendors to provide the goods to the Government. To induce the victim-vendors to agree to provide the goods and extend credit to the companies, the defendant made fraudulent representations regarding his companies' creditworthiness and association with the Government. As part of the conspiracy, the defendant falsely promised to pay the victim-vendors for the goods. The defendant subsequently failed to pay dozens of victim-vendors over $1 million for goods provided to the various Government agencies.

New England Compounding Center Owner Convicted of Multiple Charges

The owner and head pharmacist of the New England Compounding Center (NECC) was convicted at trial of racketeering, racketeering conspiracy, mail fraud, and introduction of misbranded drugs into interstate commerce with the intent to defraud and mislead in connection with a 2012 nationwide fungal meningitis outbreak. An OIG, Federal Drug Administration (FDA) Office of Criminal Investigation (OCI), FBI, DCIS, and USPS investigation revealed that the defendant directed and authorized the shipping of contaminated methylprednisolone acetate to NECC customers nationwide. In addition, the defendant authorized the shipping of drugs before test results confirming their sterility were returned, never notified customers of nonsterile results, and shipped compounded drugs with expired ingredients. Furthermore, certain batches of drugs were manufactured, in part, by an unlicensed pharmacy technician at NECC. The defendant also repeatedly took steps to shield NECC's operations from regulatory oversight by the FDA by claiming to be a pharmacy dispensing drugs pursuant to valid, patient-specific prescriptions. The investigation further revealed that VA purchased approximately $516,000 worth of various pharmaceutical products from NECC. The Government contended that all products compounded and sold to NECC customers, including VA, were made in an unsafe manner and under unsanitary conditions.

Eight Subjects Arrested for Conspiracy to Commit Health Care Fraud and Conspiracy to Launder Money

Eight subjects were indicted and arrested for conspiracy to commit health care fraud and conspiracy to launder money related to their alleged participation in a massive health care fraud and kickback scheme involving compound pharmacy prescriptions. Approximately $158 million in alleged false and fraudulent claims were submitted through DOL's Office of Workers' Compensation Program (OWCP) with approximately $82 million of the fraudulent claims being paid by the Government. This amount includes $14 million in alleged fraudulent charges to VA with approximately $7.5 million paid out. The Government has seized over $58 million in bank and stock accounts related to the alleged criminal conduct.

Six Former Insys Therapeutics, Inc., Pharmaceutical Executives and Managers Arrested for Bribery and Defrauding Health Insurers

As the result of a multi-agency investigation, six pharmaceutical executives and managers, formerly employed by Insys Therapeutics, Inc., were indicted and arrested on charges that they allegedly led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe a fentanyl-based pain medication and defraud health care insurers. The medication, called "Subsys," is a powerful narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for bribes and kickbacks, the practitioners allegedly wrote large numbers of prescriptions for the patients, most of who were not diagnosed with cancer. The indictment also alleges that the defendants conspired to mislead and defraud health insurance providers who were reluctant to approve payment for the drug when it was prescribed for non-cancer patients. CHAMPVA paid the company approximately $3.3 million for Subsys.

Former Mind Spa Inc., Employee Sentenced for Workers' Compensation Program Fraud

A former employee of Mind Spa Inc., was sentenced to 18 months' incarceration and 2 years' supervised release. Twenty-eight defendants, to include OWCP claimants, former USPS and VA employees, doctors, medical provider employees, a DOL Claims Examiner, and a claims representative were charged with various crimes related to their roles in a health care fraud scheme. A VA OIG, USPS OIG, DOL OIG, IRS CID, Treasury Inspector General for Tax Administration, and SSA OIG investigation revealed that the defendants' actions caused more than $9.5 million to be fraudulently billed to the DOL OWCP.

Three Defendants Found Guilty of Workers' Compensation Fraud

Three defendants were found guilty at trial of conspiracy, health care fraud, wire fraud, and money laundering relating to their ownership and operation of multiple workers' compensation clinics throughout the United States. A VA OIG, USPIS, DOL OIG, DHS OIG, and IRS Criminal Investigator investigation resulted in the defendant being charged with conspiring since January 2011 to unlawfully bill multiple Federal agencies for false and fraudulent claims and for services not rendered. The investigation also revealed that in July 2013, shortly after the execution of a Federal search warrant on the business, two of the defendants "laundered" $700,000 in an attempt to conceal the money's location from law enforcement. The loss to the Government is approximately $9 million.

Former Medical Clinic Operator Sentenced for Paying an Illegal Remuneration and Conspiracy

The former operator of a medical clinic was sentenced to 30 months' incarceration and 3 years' supervised release after pleading guilty to paying an illegal remuneration and conspiracy. A VA OIG, USPS OIG, DOL OIG, and DHS OIG investigation was initiated after allegations that the clinic was defrauding VA and other Federal agencies by billing for services not provided. In addition, it was also determined that the defendant had paid more than $1 million in kickbacks for the referral of Federal workers' compensation claimants. The judge incorporated into the defendant's sentence a previously entered forfeiture money judgment of $2,122,543.

Health Care Executive Charged with Health Care Fraud, Conspiracy, and Money Laundering

A health care executive was charged with health care fraud, conspiracy, and money laundering relating to his ownership and operation of OWCP companies that provided durable medical equipment and muscle and range of motion test and reports. A VA OIG, USPS OIG, DOL OIG, DHS OIG, and IRS CID investigation revealed that from September 2011 to November 2013 the defendant allegedly conspired to fraudulently charge Federal agencies for health care items and services that were the result of kickback payments and were not medically necessary. The investigation also revealed that the defendant allegedly conspired to unlawfully bill for services not performed as described in each invoice. The loss to the Government is approximately $2 million.

Former Chief Executive Officer Pleads Guilty to Obstructing a Health Care Crime Investigation

The former chief executive officer (CEO) of a medical clinic was sentenced to 3 years' probation and a $4,000 fine after pleading guilty to obstructing a health care crime investigation. A VA OIG, USPS OIG, DOL OIG, and DHS OIG investigation was initiated into allegations that the clinic was defrauding VA and other Federal agencies by billing for services not provided. It was subsequently determined that the clinic's operators were paying kickbacks for the referral of Federal workers' compensation claimants. When interviewed, the CEO made false material statements and failed to disclose that she had played an active role in helping her co-conspirators launder approximately $2.5 million in illicit proceeds by allowing them to purchase real estate in her name.

Two Nursing Home Operators Agree to Pay $4.7 Million

The Department of Justice announced that two nursing home operators agreed to pay $4.7 million to resolve allegations concerning inflated therapy claims by their contracted rehabilitation therapy company. This civil settlement was the result of a VA OIG, HHS OIG, and FBI investigation into allegations that the company utilized numerous schemes to inflate the amount of therapy that they actually provided to patients, including veterans placed by VA at these nursing homes. A criminal investigation regarding the company is still ongoing.

Former Physician Pleads Guilty to Health Care Fraud

A former physician, who had previously lost his medical license, pled guilty to health care fraud after being charged for his part in a health care fraud scheme. The defendant was employed as a medical consultant at

a Kansas City, MO, clinic that was subcontracted by a VA contractor to provide VA disability examinations for local veterans. The examinations were performed in violation of the prime contractor's contract with VA, which required that the examinations be conducted by a licensed and credentialed provider who has a clear and unrestricted license and has not been excluded from participating in Federal health care programs. The investigation revealed that a total of 209 examinations were submitted for 53 veterans utilizing another doctor's name and license without his permission. The investigation is ongoing.

Ohio Home Health Care Provider and Son Convicted of Health Care Fraud and Conspiracy to Commit Health Care Fraud

The owner of a northeast Ohio home health care provider and her son were convicted at trial of health care fraud and conspiracy to commit health care fraud. The owner was also convicted of money laundering. A multi-agency health care fraud task force investigation revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information or stolen identities on every annual provider agreement approved by the Cleveland, OH, VAMC. Five defendants were originally charged; however, one died and the other two previously pled guilty. The State and Federal loss is approximately $7 million, to include a loss to VA of approximately $429,600.

Three Former Pharmaceutical Company Managers Sentenced for Health Care Fraud

The former district manager of a pharmaceutical company was sentenced to 8 months' probation with home confinement, 128 hours' community service, and was ordered to pay $21,500 in asset forfeiture after previously pleading guilty to conspiracy to commit health care fraud. A second former district manager, who had previously pled guilty to conspiracy to commit health care fraud, was sentenced to 8 months' probation with home confinement and was ordered to pay a $10,000 criminal fine and $28,237 in asset forfeiture. A third former district manager, who had previously pled guilty to wrongful disclosure of identifiable health information, was sentenced to 12 months' probation and a $10,000 criminal fine. All of these sentences were part of a larger multi-agency investigation into allegations of kickbacks, off-label marketing, and the submission of false claims in the form of prior authorizations.

Beauty School Owners Sentenced for VA Education Fraud

The owner of a beauty school was sentenced to 63 months' incarceration, 36 months' supervised release, 150 hours' community service, and was ordered to pay $4,526,653 in restitution after pleading guilty to conspiracy to commit wire fraud and engaging in monetary transactions in property derived from specified unlawful activity. A second owner was sentenced to 60 months' incarceration, 36 months' supervised release, 400 hours' community service, and was ordered to pay $4,526,653 in restitution after pleading guilty to conspiracy to commit wire fraud. An OIG, IRS CID, and NCIS investigation revealed that the owners of the school provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to the enrolled veterans whose tuition was paid by VA. In reality, the enrolled veterans rarely, if ever, received instruction from employees at the school. The owners required the enrolled veterans to sign in and out at the school each day in order to create the appearance that they were attending the required number of hours, but permitted the veterans to leave the school during the hours they were ostensibly attending class. As a result, VA paid $4,526,653 to the school in tuition funds and over $10.5 million to veterans to cover housing costs and other educational expenses.

Former CEO of a Non-Profit Sentenced for Obstruction of a Federal Audit

A former CEO of a non-profit was sentenced to 3 years' probation and 18 weeks' community service after pleading guilty to obstruction of a Federal audit. An OIG investigation determined that the defendant defrauded VA's Homeless Providers Grant and Per Diem Program and made false statements to a VA auditor. The defendant orchestrated the purchase of two properties by the non-profit for $86,000 above the fair market value price in order to obtain excess VA grant funds. After the close of escrow on the properties, the seller made a

$50,000 donation to the non-profit. A Federal civil case is pending against the defendant, the non-profit, and the seller of the properties.

Majority Owner of the NECC Sentenced for Structuring Withdrawals

The majority owner of the NECC was sentenced to 1 year of probation and was ordered to forfeit $4,600. The defendant's husband was sentenced to 2 years' probation and was ordered to forfeit $119,647. Both defendants were also ordered to pay criminal fines totaling $59,600. The defendants previously pled guilty to making structured withdrawals totaling approximately $124,000 following the initiation of an OIG, FBI, FDA OCI, USPIS, and DCIS investigation that ultimately determined that NECC products caused the deaths of 64 people and caused fungal infections in approximately 700 others. Although no known VA patients died or became ill as a result of receiving an NECC product, VA did purchase approximately $516,000 of NECC products that were allegedly produced in unsanitary conditions and in an unsafe manner. Neither defendant had an active role in the operations or management of NECC.

Six Non-Veterans Sentenced for Redirecting Benefit Payments

Six non-veterans were sentenced to a combined 336 months' incarceration, 216 months' of supervised release, and were ordered to pay $2,105,318 in restitution. An additional defendant pled guilty to conspiracy to commit wire fraud. Two additional defendants are still awaiting sentencing and two subjects are fugitives. An OIG, DHS Investigations, and USPIS investigation resulted in the discovery of defendants in Jamaica redirecting the monthly benefit payments of veterans and SSA recipients. Subsequently, pre-paid credit cards containing the benefit payments were mailed to co-defendants in the U.S. (Miami) where the funds were removed, a portion kept, and the remainder sent back to Jamaica. Additionally, the investigation identified that the co-defendants were allegedly involved in lottery scams which target elderly, vulnerable victims. The defendants' guilty pleas and cooperation led to the discovery of several additional co-conspirators in Jamaica. The loss to VA, SSA, and the lottery scam victims is approximately $3 million. This investigation began as a proactive, nationwide effort to combat the growing problem of veterans' benefits redirections.

Non-Veteran Sentenced for Theft of VA Property

A non-veteran was sentenced to 3 years' probation after pleading guilty to unlawful conversion of Government property. An OIG and VAPS investigation revealed that the defendant assisted in selling VA-owned property stolen from the Manchester, NH, VAMC, via eBay. The defendant's co-conspirator stole over $10,000 worth of tools and equipment and over $300 worth of scrap metal from the medical center. Many of the stolen items were subsequently recovered.

Assaults and Threats Made Against VA Employees

During this reporting period, OI initiated 16 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 12 individuals. Investigations resulted in nearly $1,800 in court ordered payment of fines, restitution, penalties, and civil judgments; and approximately $435,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Veteran Arrested for Assaulting a Federal Law Enforcement Officer

A veteran was indicted and arrested for assaulting a Federal law enforcement officer. An OIG investigation resulted in the defendant being charged with assaulting a VA police officer after being admitted to the Mountain Home, TN, VAMC. After admittance, the defendant allegedly made threatening remarks towards the staff. A VA police officer responded and while speaking with the defendant the officer was subsequently assaulted by the defendant. The officer suffered multiple serious injuries.

Veteran Arrested for Assaulting a Lyons, New Jersey, VAMC Physician

A veteran was arrested for assaulting a Lyons, NJ, VAMC physician. An OIG and VAPS investigation disclosed that the defendant allegedly assaulted his VA physician by throwing a cup of hot coffee at her face and throwing a water pitcher at her back after he was told he was going to be discharged from the medical center. The VA physician sustained injuries, including burns to her face and an injury to her eye.

Veteran Involuntarily Committed After Assaulting Phoenix, Arizona, VAMC Employee

A Federal judge involuntarily committed a veteran indefinitely to the permanent care and custody of the Federal Government at the Federal Medical Center in Butner, NC. The court determined that the defendant's release to the public would create a substantial risk of bodily injury to another person. An OIG investigation determined that the defendant physically assaulted and attempted to sexually assault a VA employee at the Phoenix, AZ, VAMC. During the assault, the defendant stripped off his clothing and barricaded himself and the victim in an office.

Veteran Sentenced for Assault of Topeka, Kansas, VAMC Police Chief

A veteran was sentenced to 48 months' supervised probation after pleading guilty to assaulting a Federal law enforcement officer. An OIG investigation resulted in the defendant being charged with assaulting the VA chief of police at the Topeka, KS, VAMC. After responding to an emergency call by VA medical staff due to the defendant making threats, the chief was assaulted by the defendant and suffered minor injuries.

Veteran Arrested for Making Threat to Lebanon, Pennsylvania, VAMC

A veteran was arrested for communicating a threat which caused the evacuation of a building at the Lebanon, PA, VAMC. An OIG and VAPS investigation resulted in an allegation that the defendant used a pre-paid cell phone to communicate a threat to a county dispatcher in PA leading to the disruption of patient services at the medical center for several hours while the building was searched for explosives by law enforcement officers. The veteran was identified after a review of the pre-paid cell phone's call logs found an outgoing telephone number matching a "next of kin" phone number in the veteran's VA record.

Veteran Sentenced for Communicating Threats

A veteran was sentenced to 4 months' incarceration, 1 year of supervised probation, and was ordered to attend mental health and substance abuse counseling for communicating threats. The defendant originally had been given the opportunity to enter into a pretrial diversion agreement with the U.S. Attorney's Office; however, he failed to follow the conditions of the agreement. An OIG investigation revealed that in June 2013 the defendant made threats to use an explosive device and a firearm to kill VA employees and his VA fiduciary.

Veteran Enters into Pretrial Agreement after Making Threats

A veteran entered into a pretrial agreement after being charged with making threats. The pretrial agreement places the defendant on 18 months' supervised probation. An OIG investigation revealed that the veteran made a direct threat to kill a VA employee at the Fayetteville, AR, VAMC. After a 10-month mental evaluation, the defendant was determined to be competent.

Veteran Arrested for Firearm Violations

A veteran was arrested for unlawful possession of a firearm by a felon, possession of a firearm on Federal property, and false statements. An OIG, ATF, and VAPS investigation revealed that the defendant was a felon in possession of a firearm who allegedly committed an armed robbery of another veteran while at a West Palm Beach, FL, VAMC. Additionally, on a different date, the defendant displayed a firearm to another veteran and made threatening statements that he was going to blow up VA with a grenade because VA owed the defendant money. OIG obtained voluntary consent to search the defendant's home after the defendant denied possessing

firearms. A loaded .45 caliber pistol, UZI carbine, and ammunition were found and seized from the defendant's home.

Veteran Pleads No Contest to Making Threats to the Palo Alto, California, VAMC

A veteran pled no contest to making threats to commit a crime resulting in death or great bodily injury. As part of the plea, the veteran was sentenced to 1 year incarceration and 3 years' probation. An OIG and VAPS investigation revealed that the veteran made several threats, both telephonic and via text message, indicating that he had purchased a gun and that there would be a mass shooting at the Palo Alto, CA, VAMC. The veteran also threatened one specific VA employee indicating that he had a gun and that she was on his "hit list."

Veteran Sentenced for Making Threat to VA

A veteran was sentenced to 6 months' incarceration and 3 years' supervised release after pleading guilty to an interstate communication of a threat to injure another. An OIG investigation revealed that the defendant called the VA National Suicide Hotline and communicated a plan to purchase a firearm once he received his Social Security check and travel to a VARO and "kill as many people as possible," before committing suicide. During a subsequent interview, the defendant admitted to making the threat because he was extremely agitated due to VA's repeated denials of his benefits for PTSD.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 69.5 million felony warrants have been received from the National Crime Information Center and participating states resulting in 81,838 investigative leads being referred to law enforcement agencies. Over 2,580 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.34 billion in estimated overpayments with an estimated cost avoidance of $1.69 billion. During this reporting period, OIG opened 16 and closed 11 fugitive felon investigations, identifying $120.8 million in estimated overpayments. OIG investigative work resulted in the arrest of 6 fugitive felons. Based on the information provided by OIG, at least 9 additional arrests were made by other law enforcement agencies.

- A veteran, wanted for bank robbery and unlawful flight to avoid prosecution, was taken into custody without incident at the Seattle, WA, VAMC with the assistance of OIG.
- A fugitive veteran was arrested at the East Orange, NJ, VAMC by U.S. Marshals Task Force members with the assistance of OIG. The fugitive was wanted for a parole violation related to a bank robbery conviction. During a search incident to arrest, the fugitive was found to be in possession of heroin.
- A veteran was arrested by the New York Police Department Warrant Squad with the assistance of OIG; the FBI; Boise, ID, Police; and the VAPS at the New York, NY, VAMC. The veteran was wanted for the kidnapping, rape, and homicide of an 18-year-old woman in Boise, Idaho.
- A veteran was arrested by the United States Marshals Service with the assistance of OIG at the Vet Center in South Burlington, VT. The veteran was wanted for charges of child pornography.
- OIG provided assistance that led to the arrest of a veteran by the U.S. Marshals Service and local law enforcement. The fugitive was wanted for attempted murder and arson.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. During this reporting period, OIG opened 9 administrative investigations and closed 14 administrative investigations. The work resulted in the issuance of 1 report. This report is listed in Appendix A.

The Administrative Investigations Division also issues advisory memoranda when an allegation has been substantiated and OIG suggests VA take some action based on the investigation, but where the violation does not rise to the level of a formal recommendation. During this reporting period, the Administrative Investigations Division issued 7 advisory memorandums.

Conduct Prejudicial to the Government and Misuse of Position in the VA Office of General Counsel, Washington, DC

On April 29, 2016, OGC asked OIG to investigate allegations that Mr. John Thomas Burch, Jr., a GS-14 General Attorney and Deputy Director of OGC's Homeland Security and Operations Division, used his official position for private gain, misused Government property, and misused official time in connection with his outside employment as President of a non-profit charity organization, National Vietnam Veterans Foundation, Inc. (NVVF). This request came after Cable News Network (CNN) contacted VA and inquired about Mr. Burch's employment status as an attorney, and disclosed that they were researching a story involving Mr. Burch and NVVF. OIG found that Mr. Burch engaged in conduct prejudicial to the Government, used his public office for private gain, and misused Government resources.

Closed Senior Government Employee Investigations Not Disclosed to the Public

OIG often reviews allegations and conducts administrative and criminal investigations concerning high-ranking senior officials. However, if allegations in these investigations are unsubstantiated, or if investigations are referred to another office such as OSC, OIG may close these investigations and take no action. Below is a list detailing those investigations of senior Government officials that were closed and not disclosed to the public during the reporting period.

Alleged Privacy Act Violation by Former Associate Director of a VAMC

VA Regional Counsel and VA management out of a VAMC contacted OIG regarding a possible Privacy Act violation by a VAMC Associate Director. VAMC management received information from an employee who alleged the Associate Director accessed the medical record of a former employee who is also a veteran. It was further alleged the Associate Director made a comment to the former employee that contained information only the former employee disclosed to their behavioral health provider. The potential victim and timeframe when this may have occurred were unknown. At the end of the investigation, OIG informed the VAMC that the allegations were unsubstantiated. As a result, VAMC management determined they would not take administrative action against the Associate Director. This case was not referred to the United States Attorney's Office as the alleged misconduct was out of statute near the initiation of this investigation.

Alleged Conflict of Interest in VA's Office of Small and Disadvantaged Business Utilization

VA OIG received a Hotline referral which alleged that the Executive Director, VA Office of Small and Disadvantaged Business Utilization (OSDBU), was aware of and attempted to cover up an organizational conflict of interest (OCI) between himself and Monterey Consultants Inc. (Monterey). The complainant alleged that the

Executive Director steered a contract to Monterey, was dishonest about his knowledge of the OCI, attempted to cancel the SDVOSB status of Monterey's competitor (Loch Harbour Group), and allowed Monterey access to litigation and procurement sensitive information. The complainant further alleged that OSDBU employees had emails showing the Executive Director had knowledge of Monterey's actions and that he prompted his directors not to answer the contracting officer's questions during an OCI investigation. In its investigation, OIG did not find any evidence to indicate the existence of a criminal conflict (or any other felony crime) involving the Executive Director. As a result, this case was not referred to the U.S. Attorney's Office for criminal prosecution.

Four Administrative Investigations Referred to OSC

OIG conducted four separate administrative investigations of VA senior leadership to include VA's Chief of Staff, the Assistant Secretary for OHRA, the Deputy Assistant Secretary for Administration in OHRA, the MyVA Executive Director, and the Executive Director of the Human Resources Enterprise Integration Office. These investigations pertained to alleged prohibited personnel practices. As a result of OIG's investigations, each of the four cases was closed and evidence was referred to OSC for their consideration and action as deemed appropriate.

Two Administrative Investigations Referred to OGC

OIG conducted an investigation of a Program Manager in OIT and another investigation of a Program Analyst in VHA's Health Informatics office for an alleged conflict of interest. As a result of OIG's investigations, both cases were closed and evidence was referred to OGC for their assessment and any administrative action they deemed appropriate.

Office of Management and Administration

The Office of Management and Administration provides comprehensive support services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support, and through products and services that promote the overall mission and goals of OIG.

Coordination and Internal Controls Division

The Coordination and Internal Controls Division has primary responsibilities in three distinct areas: coordination of training across OIG, operating OIG's own internal controls program, and OIG records management. In addition, the division handles broad coordination of policy and external administrative and management coordination with VA and other Federal agencies.

Human Resources and Operations Division

The HR and Operations Division conducts follow-up reporting and tracking of OIG report recommendations; provides strategic, operational, and performance planning; prepares and publishes OIG-wide reports, such as the Semiannual Report to Congress; develops OIG policies and procedures; and electronically distributes all OIG oversight reports. The Operations Division also promotes organizational effectiveness and efficiency by managing all OIG contracting and providing consistent, prompt HR management, and related support services.

Information Technology and Data Analysis Division

IT staff promote organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to VA databases and email by all authorized employees; providing internet document management and control; and providing support to all OIG components.

Data Analysis staff provide automated data processing technical support of OIG and other Federal and Governmental agencies requiring information from VA files. Data Analysis Division products facilitate the identification of fraud-related activities and support OIG comprehensive initiatives that result in solutions beneficial to VA.

Proactive Review Leads to Identification of Improper Payments to Providers After Veterans' Reported Deaths

A proactive review by the IT and Data Analysis Division revealed that VHA paid NVC providers for services that could not have been rendered because the veterans had already died. A subsequent audit substantiated these findings and estimated that the corrective actions recommended as part of the audit could result in a cost-savings of $505,000 over the next 5 years.

Administrative and Financial Operations Division

The Administrative and Financial Operations Division promotes OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support services in such areas as employee travel, logistical coordination, purchase card coordination, and space and property management.

Budget Division

The Budget Division promotes organizational effectiveness by providing a full complement of budgetary formulation and execution services to management and organizational components, including formulation of submissions and operating plans; monitoring allocations, expenditures, and reserves; conducting financial analyses; and developing internal budget policies.

Hotline Division

The Hotline Division is the focal point for contacts made to OIG, operating a toll-free telephone service 5 days a week, Monday through Friday, from 9:00 AM to 4:00 PM Eastern Time. OIG receives web submissions, emails, letters, phone calls, and faxes from employees, veterans, the general public, Congress, and other Federal agencies reporting allegations of criminal activity, fraud, waste, abuse, and mismanagement of VA programs and operations. The Hotline also houses the Whistleblower Protection Ombudsman, who provides education about protections provided under Federal law for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation.

During this reporting period, the Hotline received 17,251 contacts. Each contact to the Hotline is reviewed initially by OIG staff. Of these contacts, 823 became external Hotline cases, while an additional 569 of the contacts became Hotline non-case referrals. The Hotline makes non-case referrals to the appropriate VA organization if the allegation does not rise to the level of a case but appears to warrant VA action. The Hotline also closed 773 cases (internal and external), substantiating allegations 39 percent of the time. External Hotline cases resulted in 534 administrative sanctions and corrective actions and $1.36 million in monetary benefits. In addition, the Hotline responded to more than 700 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Delay in Diagnosis and Missed Cancer Diagnosis

Following allegations that the James Lovell Federal Health Care Center (FHCC) missed a patient's cancer diagnosis, the VISN determined that there was a delay in diagnosis of the patient, other patient's cancer diagnoses were missed, and that policies and procedures for surgery and women's health care were lacking. As a result, the FHCC implemented 10 corrective actions, including the creation of a new coordinator position for women's health cancer screening/diagnosis/treatment/tracking to address the deficiencies identified.

Fee-Basis Claims Processing

Allegations were reported that the Washington DC VAMC was suspending and denying NVC claims in order to meet the performance measures set by the VISN. As a result of the allegations, VISN 5 conducted a review of the Purchased Care Program at the VAMC. They determined that the Purchase Care Payment Package contained software glitches that supported miscalculations and rejections due to a lack of appropriate data in claims records. This problem allowed a particular employee to manipulate data for artificial outcomes. To address these issues, the VISN mandated three corrective actions to include quarterly audits of the work of all fee-basis employees.

Inadequate Care Resulting in Death

After a former patient of the Salem VAMC died at home, it was alleged that his previous care for several open wounds was improper, that he was prematurely discharged, and that both of these events directly contributed to his death. Because the patient was being treated as an inpatient for MH issues, the Chief of MH with the assistance of other staff reviewed his overall care. They determined that he was not discharged inappropriately,

his wound care was less than optimal, there was inaccurate documentation of his wounds while he was an inpatient, and there was a lack of follow-up by the Dermal Nurse before his discharge. As a result, 13 corrective actions were identified in the areas pertaining to the Dermal Wound Nurse, Acute MH Nursing, and the MH Chief.

Inappropriate Opioids Prescriptions

The Peru, IN, CBOC was alleged to have issued narcotics to veterans that failed drug screening and that the policy contributed to the death of a veteran. The Director of the Indiana HCS reviewed the allegations and determined that there were instances where the facility did not follow the pain management procedures and did prescribe opioids for veterans that had positive drug tests. The review did not find that the identified veteran died as a result, but rather that the veteran was still alive and receiving treatment. The Director identified two corrective actions covering both physician behavior and required frequency for drug screening.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's Office of Acquisition, Logistics, and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 55 reviews in this reporting period. The tables that follow provide an overview of OIG performance during this reporting period.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Thirty-nine preaward reviews identified approximately $447.2 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included 17 health care provider proposals which accounted for approximately $26.4 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2016–March 31, 2017	39	$447,245,411

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with P.L. 102-585, *Veterans Health Care Act of 1992*, for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over $25.8 million, including approximately $21.5 million related to P.L. 102-585, *Veterans Health Care Act,* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 15 postaward reviews performed, 9 involved voluntary disclosures. In three of the nine voluntary disclosure reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2016–March 31, 2017	15	$25,804,128

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, OIG reviewed one claim and determined that approximately $9.9 million of claimed costs were unsupported and should be disallowed.

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2016–March 31, 2017	1	$9,894,257

Other Significant OIG Activities

Congressional Testimony

IG Testifies on VA Health Care's Placement on Government Accountability Office High Risk List

The Honorable Michael J. Missal testified before the Committee on Homeland Security and Governmental Affairs, United States Senate, at a hearing on select Federal programs placed on the Government Accountability Office's (GAO) 2017 High Risk list. GAO initially designated VA Health Care as a high risk area in its 2015 report, and it remains on the list in 2017. Mr. Missal explained that OIG and GAO share analogous missions. He highlighted a number of recent OIG reports that complement the five broad areas of concern noted by GAO and underscore the decision to place VA Health Care on its High Risk list. Mr. Missal emphasized the OIG's commitment to undertake impactful work that will assist VA in providing appropriate and timely services and benefits to veterans and ensuring the proper expenditure of taxpayer funds.

IG Testimony Highlights OIG Work Parallel to GAO Concerns on VA Health Care

The Honorable Michael J. Missal testified before the Committee on Veterans' Affairs, United States Senate, on how the OIG's oversight of VA programs and operations corresponds with the GAO decision to place VA Health Care on its biennial High Risk List beginning in 2015 and again in 2017. Mr. Missal highlighted a number of OIG reports with findings related to the five broad areas of concern noted by GAO in placing VA Health Care on its High Risk List: ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities. Mr. Missal noted that GAO and the OIG communicate regularly to promote coordination, avoid duplication of effort, and maximize oversight of VA. He also reaffirmed the OIG's commitment to continuing to produce impactful reports that provide VA, Congress, and the public with information about our recommendations to improve the delivery of services and benefits to veterans and the judicious expenditure of taxpayer money. Mr. Missal was accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for OHI.

IG Delivers Testimony on Importance, Value of OIG Oversight

The Honorable Michael J. Missal testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, on the oversight OIG provides to VA programs and operations. Mr. Missal highlighted the more significant aspects of the OIG's mission, vision, and values and discussed a number of recent or planned operational enhancements initiated since becoming IG that are intended to better focus OIG efforts on high-risk areas throughout VA in a more proactive and timelier manner. Additionally, he discussed the OIG's FY 2017 operating budget, the FY 2018 request, and the anticipated effects of the Federal hiring freeze on the OIG's operation. Lastly, he highlighted a number of recent OIG reports demonstrating VA's susceptibility to fraud, waste, abuse, and mismanagement in its programs and operations. Given the historical average of a return on investment of $30 for every $1 expended on OIG oversight, Mr. Missal emphasized the need for the OIG to be positioned to conduct effective oversight.

IG Testifies on Historical Challenges Facing VA Community Care, Warns That Adequate Controls Must be in Place to Mitigate Significant Risks

The Honorable Michael J. Missal testified before the Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work concerning VA's Choice Program and the future of VA's Community Care Program. He explained that the OIG's audits, reviews, and inspections have highlighted VA's history of challenges in administering its purchased care programs. Specifically, OIG's work has demonstrated that

veterans' access to care, proper expenditure of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lacks adequate processes to manage funds and oversee program execution. Mr. Missal emphasized that while purchasing health care services from community providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. He also indicated that the OIG plans to conduct significant oversight of VA's Community Care programs over the next 3 years.

OIG Tells Congress VA Must Strengthen DFWP Controls

Nicholas Dahl, Deputy Assistant Inspector General (DAIG) for OAE, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work related to oversight of controlled substances and DFWPs at VA facilities. This oversight is necessary to ensure that VA takes the necessary steps to reduce risks to the safety and well-being of veterans and VA employees by having and following the proper program controls. He explained that OIG's March 2015 report, *Audit of VA's Drug-Free Workplace Program*, identified program weaknesses and determined VA's Program was not accomplishing its primary goal of ensuring illegal drug use was eliminated and VA's workplace was safe. He also discussed the results of a January 2017 OIG review of the Atlanta VAMC, Decatur, Georgia, that substantiated allegations of a backlog of unadjudicated background investigations and that mandatory drug testing for new hires in certain positions did not occur for a period of at least 6 months between 2014 and 2015. Mr. Dahl was accompanied by Emorfia (Amy) Valkanos, Registered Pharmacist, from the Manchester OHI.

Audit Officials Testify on Identified Deficiencies in Administration of Select VA Human Capital Programs

Mr. Nicholas Dahl, DAIG, testified before the Subcommittee on National Security, Committee on Oversight and Government Reform, United States House of Representatives, on VA's human capital management risks. Specifically, Mr. Dahl discussed the results of OIG's reviews of 3R incentive programs and the DFWP. Both OIG reports identified needs to strengthen controls over the respective programs in order to ensure (1) the strategic and prudent use of taxpayer dollars to recruit and retain highly qualified employees in hard-to-fill positions, and (2) the effective use of pre-employment, random, and reasonable suspicion drug testing to maintain a workplace that is free from illegal drug use. Mr. Dahl also noted that the OIG substantiated allegations that there were delays in processing background investigations and mandatory drug testing for new hires in certain positions at the Atlanta VAMC in Decatur, Georgia. He discussed the recommendations made by the OIG to improve the identified conditions in each report. Mr. Dahl was accompanied by Irene Barnett, Ph.D., Director, Bedford OAE.

False Claims Act Settlements

For this reporting period, VA received payments totaling $128,977 from settlement agreements in complaints filed under the *qui tam* provisions of P.L. 97-258, *False Claims Act*. This amount represents VA's single damages in this case. This amount is separate from the *False Claims Act* settlement agreement that totaled $58 million, which is captured in the Other Investigations section on page 51.

Peer and Qualitative Assessment Reviews

P.L. 111-203, *Restoring American Financial Stability Act of 2010,* requires VA OIG to report the results of any peer review conducted of VA OIG's audit operation by another OIG during the reporting period or to identify the date of the last peer review conducted by another OIG, in addition to any outstanding recommendations that have not been fully implemented. During this reporting period, DOJ OIG completed a peer review of

VA OIG's audit operations, focusing on the system of quality controls that were in effect for the year ending September 30, 2015. In their review, DOJ OIG found that VA OIG's system of quality controls was suitably designed and that audit organizations complied with this system. As a result, DOJ OIG concluded VA OIG's system of quality controls provides reasonable assurance of audit organizations performing and reporting in conformity with applicable standards in all material respects. Therefore, VA OIG received a rating of pass.

The Act also requires VA OIG to report the results of any peer review it conducted of another OIG's audit operations during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period. VA OIG did not complete any peer reviews during this reporting period.

Government Contractor Audit Findings

P.L. 110-181, *National Defense Authorization Act for Fiscal Year 2008*, requires each IG appointed under P.L. 95-452, *Inspector General Act of 1978*, as amended, to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG did not issue any reports meeting these requirements.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 149 proposals and made 6 comments.

Refusals To Provide Information or Assistance

P.L. 95-452, *Inspector General Act of 1978*, as amended, authorizes OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes OIG to request information or assistance from any Federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to OIG in the Act. OIG is required to provide a summary of instances when such information or assistance is refused. OIG reports no such instances occurring during this reporting period.

Attempts by the Establishment To Interfere with the Independence of OIG

P.L. 95-452, *Inspector General Act of 1978*, as amended, also requires OIG to report on instances where VA imposes budget constraints designed to limit OIG capabilities. Additionally, the Act requires OIG to report incidents where VA has resisted OIG oversight or delayed OIG access to information. During this reporting period, OIG reports no such instances.

Instances of Whistleblower Retaliation

P.L. 95-452, *Inspector General Act of 1978*, as amended, requires OIG to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires OIG to detail the consequences imposed by the Department to hold the official accountable. However, OIG's current practice is to forward allegations of whistleblower reprisal to OSC. As a result, OIG cannot provide information regarding whistleblower retaliation at this time.

Agency Comments Not Received Within 60 Days

As part of the report production process, OIG transmits its draft report to VA for review, comment, and concurrence to implement recommendations. OIG's goal is to receive substantive feedback from the Department within 60 days of transmitting the draft report. During this reporting period, there were no instances of OIG receiving agency comments more than 60 days after draft report transmittal.

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

P.L. 95-452, *Inspector General Act of 1978*, as amended, mandates OIG to list reports issued before the commencement of the reporting period in which there was no management decision by the end of the current reporting period and where VA did not provide substantive comments within 60 days of receipt of the draft report. In both cases, there were no instances to report.

Employee Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

We extend our thanks to OIG employees listed below who are on active military duty or returned from active military duty.

- Kenneth Sardegna, an OAE Director at OIG Headquarters, returned from duty from the U.S. Army in October 2016.
- John Moore, a Program Specialist at OIG Headquarters, was activated by the U.S. Army National Guard in March 2013.
- Ricardo Wallace-Jimenez, a Criminal Investigator in Spokane, WA, returned from duty from the U.S. Army National Guard in October 2016 and was reactivated in November 2016.
- Dana Epperson, a Criminal Investigator in Seattle, WA, returned from duty from the U.S. Army in October 2016 and was reactivated in November 2016.
- Randall Snow, an OHI Director in Arlington, VA, was activated by the U.S. Air Force in March 2017.

Appendix A: Reports and Work Products Issued During Reporting Period

Table 1: List of Reports and Work Products Issued by Type

Office of Audits and Evaluations | Audits, Evaluations, and Reviews

Issue Date and Report Number	Report Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
10/4/2016 15-04672-342	Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System			
10/4/2016 14-02890-425	Review of an Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VAMC in Salisbury, NC			
11/2/2016 15-05255-422	Audit of VHA's Consolidated Mail Outpatient Pharmacy Program			
11/9/2016 14-02890-72	Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System			
11/15/2016 16-01484-82	Audit of VA's Financial Statements for Fiscal Years 2016 and 2015			
12/6/2016 16-00790-417	Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses			$7,200,00
12/15/2016 15-02278-415	Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System			
12/20/2016 14-02890-352	Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina			
1/5/2017 14-04578-371	Audit of VA's Recruitment, Relocation, and Retention Incentives	$162,600,000	$162,600,000	
1/30/2017 15-03401-76	Review of Alleged Human Resources Delays at the Atlanta VA Medical Center			
1/30/2017 15-04673-333	Review of the Implementation of the Veterans Choice Program			
1/31/2017 15-02189-336	Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract	$5,300,000	$5,300,000	

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Report Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
2/1/2017 15-01818-213	Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System			
2/7/2017 15-02932-98	Audit of Hurricane Sandy Major Construction Relief Funds for VA New York Harbor Healthcare System			
2/8/2017 15-01436-456	Audit of VBA's Automated Burial Payments			$28,000,000
2/28/2017 16-01418-136	Audit of Alleged Misuse of VHA Funds at the Northern Arizona VA Health Care System			
3/2/2017 16-02618-424	Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6			
3/24/2017 15-03231-319	Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia			$2,785,000
3/27/2017 16-00252-137	Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths			$505,000
3/31/2017 15-05379-146	Audit of VHA's Patient Advocacy Program			
3/31/2017 17-00976-176	Independent Review of VA's FY 2016 Detailed Accounting Submission to the Office of National Drug Control Policy			
3/31/2017 17-01000-177	Independent Review of VA's FY 2016 Performance Summary Report on Drug Control Funds to the Office of National Drug Control Policy			
3/31/2017 16-02806-182	Review of Alleged Use of Incorrect Effective Dates at VBA's VARO in Chicago, Illinois			
	Total Monetary Impact	**$167,900,000**	**$167,900,000**	**$38,490,000**

Office of Audits and Evaluations | Work Products		
Issue Date	**Number**	**Title**
3/6/2017	16-02138-149	FY 2016 Risk Assessment of VA's Charge Card Programs

Office of Healthcare Inspections | Clinical Assessment Program Reviews		
Issue Date	**Number**	**Facility**
1/18/2017	15-00075-449	VA St. Louis Health Care System, St. Louis, Missouri
2/16/2017	16-00574-151	Overton Brooks VA Medical Center, Shreveport, Louisiana
3/8/2017	16-00551-128	VA Caribbean Healthcare System, San Juan, Puerto Rico
3/8/2017	16-00557-134	Boise VA Medical Center, Boise, Idaho
3/8/2017	16-00550-145	Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
3/13/2017	16-00553-135	Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio
3/13/2017	16-00554-148	Southern Arizona VA Health Care System, Tucson, Arizona
3/16/2017	16-00547-156	VA Portland Health Care System, Portland, Oregon
3/27/2017	16-00575-147	Canandaigua VA Medical Center, Canandaigua, New York
3/31/2017	16-00572-179	VA Salt Lake City Health Care System, Salt Lake City, Utah

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Report Title**
12/15/2016	15-04247-111	Review of Antimicrobial Stewardship Programs in VHA Facilities
2/28/2017	15-04925-469	Evaluation of Human Immunodeficiency Virus Screening in Veterans Health Administration Outpatient Clinics
3/7/2017	16-03805-20	Evaluation of Inpatient Flow in Veterans Health Administration Facilities
3/20/2017	16-03985-181	Evaluation of the Veterans Health Administration Veterans Crisis Line
3/31/2017	16-03743-193	Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
10/12/2016	14-04898-290	Teleradiology Concerns, VA Roseburg Healthcare System, Roseburg, Oregon
10/12/2016	15-00506-420	Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon
11/9/2016	15-05180-75	Mental Health-Related Concerns, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
11/14/2016	15-04651-81	Review of Robotic Assisted General Surgery, Southern Arizona Health Care System, Tucson, Arizona

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
12/13/2016	14-03434-102	Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri
2/2/2017	15-01900-142	Echocardiography Scheduling and Quality of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois
2/9/2017	14-00750-143	Documentation of Patient Enrollment Concerns in Home Telehealth, John D. Dingell VA Medical Center, Detroit, Michigan
2/16/2017	15-01901-160	Alleged Violations of Nurse Practitioner Requirements, Carl Vinson VA Medical Center, Dublin, Georgia
3/9/2017	15-05249-162	Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska
3/10/2017	14-02890-168	Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center, Augusta, Georgia
3/10/2017	16-00621-175	Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana
3/30/2017	16-00462-192	Opioid Prescribing Practice Concerns, VA Illiana Health Care System, Danville, Illinois
3/31/2017	15-04976-191	Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

Office of Investigations | Administrative Investigations		
Issue Date	**Number**	**Report Title**
11/10/2016	16-03330-91	Conduct Prejudicial to the Government and Misuse of Position in the VA Office of General Counsel, Washington, DC

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
10/17/2016	16-05259-27	Review of Proposal Submitted under a Solicitation	$164,016
10/18/2016	16-02724-73	Review of Request for Modification under a Federal Supply Schedule Contract	$0
10/25/2016	16-04247-80	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$22,104,123
10/26/2016	16-05305-79	Review of Proposal Submitted under a Solicitation	$704,740
11/3/2016	16-05117-85	Review of Proposal Submitted under a Federal Supply Schedule Contract	$877,338
11/3/2016	16-04244-84	Review of Request for Modification under a Federal Supply Schedule Contract	$105,279

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
11/10/2016	16-04397-90	Review of Proposal Submitted under a Solicitation	$339,961
11/15/2016	16-05096-89	Review of Proposal Submitted under a Solicitation	$15,939,781
11/16/2016	16-04757-86	Review of Proposal Submitted under a Solicitation	$487,769
11/16/2016	17-00246-92	Review of Proposal Submitted under a Solicitation	$2,945,536
11/18/2016	16-04127-94	Review of Proposal Submitted under a Solicitation	$19,204,183
11/29/2016	16-02748-100	Review of Proposal Submitted under a Solicitation	$27,090,404
12/1/2016	16-04319-101	Review of Proposal Submitted under a Solicitation	$71,494,814
12/5/2016	16-05067-106	Review of Proposal Submitted under a Solicitation	$0
12/5/2016	16-04179-107	Review of Proposal Submitted under a Solicitation	$3,258,985
12/14/2016	17-00779-113	Review of Proposal Submitted under a Solicitation	$1,278,365
12/14/2016	17-00725-115	Review of Proposal Submitted under a Solicitation	$1,417,233
12/19/2016	16-05070-119	Review of Proposal Submitted under a Solicitation	$0
12/20/2016	16-05453-125	Review of Request for Modification under a Federal Supply Schedule Contract	$0
12/21/2016	16-05426-123	Review of Proposal Submitted under a Solicitation	$1,993,975
12/22/2016	17-00540-124	Review of Proposal Submitted under a Solicitation	$1,327,765
12/23/2016	16-05100-117	Review of Proposal Submitted under a Solicitation	$421,829
1/11/2017	17-01185-138	Review of Proposal Submitted under a Solicitation	$217,470
1/17/2016	17-00778-144	Review of Proposal Submitted under a Solicitation	$9,170,625
1/25/2017	17-00247-150	Review of Proposal Submitted under a Solicitation	$4,470,207
2/1/2017	17-00323-153	Review of Request for Modification under a Federal Supply Schedule Contract	$8,880,757
2/2/2017	16-05271-152	Review of Proposal Submitted under a Solicitation	$241,491,873
2/2/2017	17-01463-155	Review of Proposal Submitted under a Solicitation	$657,102
2/7/2017	17-00325-157	Review of Proposal Submitted under a Solicitation	$1,897,302
2/16/2017	16-05355-167	Review of Request for Modification under a Federal Supply Schedule Contract	$3,898,020
2/22/2017	17-00807-164	Review of Request for Modification under a Federal Supply Schedule Contract	$35,726
2/28/2017	17-00696-173	Review of Proposal Submitted under a Federal Supply Schedule Contract	$0
3/21/2017	16-05320-186	Review of Request for Modification under a Federal Supply Schedule Contract	$2,236,346
3/21/2017	17-01352-183	Review of Proposal Submitted under a Solicitation	$647,914

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
3/21/2017	17-01859-184	Review of Proposal Submitted under a Solicitation	$387,265
3/21/2017	17-00774-185	Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract	$1,351,327
3/23/2017	17-02556-187	Review of Proposal Submitted under a Solicitation	$0
3/29/2017	17-02046-194	Review of Proposal Submitted under a Solicitation	$511,617
3/29/2017	17-02076-195	Review of Proposal Submitted under a Solicitation	$235,764
		Total Monetary Impact	**$447,245,411**

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
10/12/2016	16-00871-48	Review of Proposal Submitted under a Federal Supply Schedule Contract	$19,832
12/6/2016	15-04342-108	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$492,623
12/13/2016	16-03396-105	Review of Compliance under a Federal Supply Schedule Contract	$436,650
12/14/2016	16-00469-114	Review of Compliance under a Federal Supply Schedule Contract	$59,030
12/19/2016	16-01098-120	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$112,082
2/7/2017	16-04290-158	Review of Compliance under a Federal Supply Schedule Contract	$947,084
2/8/2017	17-00015-118	Review of Contractor's Failure to follow Good Manufacturing Practices under a Federal Supply Schedule Contract	$1,078,840
2/9/2017	15-04001-159	Review of a Monetary Recovery from Federal Supply Schedule Contract	$2,112,111
2/9/2017	16-04492-161	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$12,348
2/14/2017	16-02961-163	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$3,004
2/16/2017	16-04317-165	Review of Compliance under a Federal Supply Schedule Contract	$4,507
2/23/2017	17-00357-171	Review of Compliance under a Federal Supply Schedule Contract	$115,611

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
2/23/2017	16-00670-172	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$8,270
3/14/2017	17-00002-178	Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract	$533,942
3/31/2017	12-03149-198	Review of Federal Ceiling Price Calculation Errors under a Federal Supply Schedule Contract	$19,868,194
		Total Monetary Impact	**$25,804,128**

Office of Contract Review | Claims Review			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
3/31/2017	17-01002-199	Review of Claim Submitted Under a Federal Supply Schedule Contract	$9,894,257
		Total Monetary Impact	**$9,894,257**

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$167,900,000	$38,490,000		
Preaward Reviews			$447,245,411	
Postaward Reviews				$25,804,128
Claim Reviews			$9,894,257	
	$167,900,000	$38,490,000	$457,139,668	$25,804,128

Table 2: Resolution Status of Reports with Questioned Costs		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	4	$38,490,000
Total inventory this period	4	$38,490,000
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	4	$38,490,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	4	$38,490,000
Total carried over to next period	**0**	**$0**

Table 3: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	2	$167,900,000
Total inventory this period	2	$167,900,000
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	2	$167,900,000
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	2	$167,900,000
Total carried over to next period	**0**	**$0**

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

Office of Investigations | Administrative Summaries of Investigation		
Issue Date	**Number**	**Facility**
10/4/2016	14-02890-255	W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
11/8/2016	14-02890-353	Southern Arizona VA Health Care System, Tucson, Arizona
11/8/2016	14-02890-412	VA Portland Health Care System, Portland, Oregon
11/10/2016	14-02890-413	VA Oxnard Outpatient Clinic, Oxnard, California
11/29/2016	14-02890-400	Washington DC VA Medical Center, Washington, DC
11/29/2016	14-02890-405	Malcom Randall VA Medical Center, Gainesville, Florida
12/20/2016	14-02967-83	VA Greater Los Angeles Health Care System, Los Angeles, California
12/20/2016	14-02890-87	Phoenix VA Health Care System, Phoenix, Arizona
12/20/2016	14-02890-88	VA Loma Linda Health Care System, Loma Linda, California
12/20/2016	14-02890-122	Ralph H. Johnson VA Medical Center, Charleston, South Carolina
12/20/2016	14-02890-404	William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
12/20/2016	14-02890-406	James A. Haley Veterans' Hospital, Tampa, Florida
12/20/2016	14-02890-407	VA North Texas Health Care System, Dallas, Texas
12/20/2016	14-02890-408	VA Medical Center-Fort Harrison, Fort Harrison, Montana
12/20/2016	14-02890-410	VA Southern Nevada Health Care System, Las Vegas, Nevada
12/20/2016	14-02890-411	Central Texas Veterans Health Care System, Temple, Texas
12/20/2016	14-02890-416	Louis Stokes VA Canton Outpatient Clinic, Canton, Ohio
2/23/2017	14-03340-103	G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi

Office of Investigations | Administrative Investigation Advisories		
Issue Date	**Number**	**Advisory Title**
11/18/2016	10-00299-459	Prohibited Personnel Practices, Preferential Treatment, Nepotism, Office of Informatics and Analytics
11/18/2016	10-02858-462	Alleged Preferential Treatment and Misuse of Position, Office of Quality, Performance, and Oversight, OI&T, VACO
11/18/2016	11-00198-04	Alleged Prohibited Personnel Practices, Other Improper Hiring Practices, and Conduct Prejudicial to the Government, Office of Human Resources and Administration, VACO
11/18/2016	11-00210-06	Staffing Irregularities, VA Central Office Human Resources Service
11/18/2016	11-00651-08	Failure to Follow VA Performance Policy, Office of Diversity and Inclusion, VA Central Office, Washington, DC
11/18/2016	11-01165-09	Advisory Memorandum
11/18/2016	11-01682-12	Conflict of Interest, West Palm Beach VA Medical Center, Florida
11/18/2016	11-03461-14	False Statements, VHA Office of Research and Development, Technology Transfer Program, Washington, DC
11/18/2016	11-04536-17	Appearance of Preferential Treatment, VHA Office of Informatics and Analytics, St. Peterburg, Florida
11/18/2016	11-00211-33	Improper Use of Veterans Recruitment Appointment Authority, VBA Regional Office and Insurance Center, Philadelphia, Pennsylvania
11/18/2016	11-04189-34	Improperly Managed Detail, St. Louis Health Care System, St. Louis, Missouri
11/18/2016	11-02766-438	Appearance of a Conflict of Interest, Overton Brooks VA Medical Center, Shreveport, Louisiana
11/18/2016	11-02460-439	Federal and VA Acquisition Regulations Violation, VA Office of Information and Technology, Veterans Integrated Service Network 5
11/18/2016	11-02935-440	Misuse of Time and Resources, VA Ambulatory Surgery Unit, United States Air Force Academy, Colorado Springs, Colorado
11/18/2016	11-03313-442	Alleged Improper Relocation Incentives, Central Alabama Veterans Health Care System
11/18/2016	11-03398-443	Misuse of Position, Preferential Treatment, and Failure to Follow VA Policy, Veterans Integrated Service Network 11, Ann Arbor, Michigan, and Saginaw VA Medical Center
11/18/2016	11-03720-445	Failure of Management to Ensure that Possible Felony Criminal Activity was Promptly Referred to OIG, VA Medical Center, Washington, DC
11/18/2016	12-00570-35	Travel Irregularities, Board of Veterans Appeals, VA Central Office, Washington, DC
11/18/2016	12-00570-36	Improper Time and Attendance, Board of Veterans Appeals, VA Central Office
11/18/2016	12-01841-38	Failure to Obtain Federal Acquisition Certification in Contracting Program, Service Area West, Desert Pacific Health Care Network, Long Beach, California
11/18/2016	12-02355-39	Prohibited Personnel Practices, Interference With A Civil Service Examination, and False Statements, VHA Readjustment Counseling Service, Washington, DC

Office of Investigations | Administrative Investigation Advisories		
Issue Date	**Number**	**Advisory Title**
11/18/2016	12-02359-40	Improper Incentive Awards Program, VA Hudson Valley Health Care System, Montrose, New York
11/18/2016	12-02525-41	Misuse of Position, VA Central Office
11/18/2016	12-03735-42	Violation of VA Policy, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
11/18/2016	12-00570-57	Alleged Preferential Treatment and Misuse of Sick Leave, Board of Veterans Appeal, VACO
11/18/2016	12-00396-60	Appearance of Preferential Treatment, Veterans Relationship Management, OI&T, Washington, DC
11/18/2016	12-02448-63	Travel Irregularities, Office of Human Resources and Administration, VA Central Office
11/18/2016	13-00609-43	Failure to Notify OIG of Possible Felony Criminal Activity and Reprisal, National Cemetery Administration, Washington, DC
11/18/2016	13-00647-44	Alleged Preferential Treatment
11/18/2016	13-00996-46	Appearance of Preferential Treatment, VA Loma Linda Health Care System, Loma Linda, California
11/18/2016	14-01737-23	Alleged Misuse of Government Resources, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
11/18/2016	14-03651-28	Management Implication Notification - Occupational Safety and Health, Philadelphia, Pennsylvania
11/18/2016	15-03474-01	Alleged Misuse of Travel Funds, Misconduct, and False Statements, Office of Intergovernmental Affairs, VACO
11/18/2016	15-01376-47	Misuse of Travel Funds and Position, VA Southern Nevada Health Care System, Las Vegas, Nevada
12/14/2016	15-01879-109	Alleged Conflict of Interest, Veterans Benefits Administration, Office of Economic Opportunity, Washington, DC
1/31/2017	14-04097-139	Alleged Improper Use of Relocation Program and Incentives, Veterans Health Administration
1/31/2017	14-04690-140	Alleged Improper Telework and Ineffective Supervision, Nebraska-Western Iowa Health Care System, Omaha, Nebraska
1/31/2017	14-01418-141	Alleged Preferential Treatment in Hiring, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
3/7/2017	15-01328-166	Alleged Misuse of Official Time, Falsified Documents, Conflict of Interest, and Quality of Care, Birmingham VA Medical Center
3/29/2017	17-00730-174	Alleged Misuse of Travel Funds, VA Central Office, Washington, DC
3/30/2017	17-01003-189	Alleged Misuse of Travel Funds, VA Eastern Kansas Health Care System, Colmery-O'Neil VA Medical Center, Topeka, Kansas

Office of Investigations | Administrative Investigation Closures		
Issue Date	**Number**	**Closure Title**
11/18/2016	09-02125-457	Alleged Conflict of Interest, VA Medical Center, Birmingham, Alabama
11/18/2016	10-02858-74	Alleged Misuse of Travel Funds, Office of Information & Technology
11/18/2016	10-02328-460	Alleged Improper Contracts, Conflict of Interest, and Misuse of Position, VHA, Chief Business Office, Denver, Colorado
11/18/2016	10-02814-461	Alleged Preferential Treatment and Improper Supervision, South Texas Veterans Health Care System, San Antonio, Texas
11/18/2016	10-02858-463	Alleged Prohibited Personnel Practices, Abuse of Authority, and Misuse of Position, OI&T, VACO
11/18/2016	10-02858-465	Alleged Abuse of Authority and Misuse of Position, OI&T Field Security Operations
11/18/2016	10-03291-466	Alleged Nepotism and Preferential Treatment, Jesse Brown VA Medical Center, Chicago, Illinois
11/18/2016	10-03530-467	Alleged Preferential Treatment and Prohibited Personnel Practices, Brooklyn Campus of the VA NY Harbor Healthcare System
11/18/2016	10-03822-468	Alleged Improper Hiring, Misuse of Grant Funds, and False Statements, VISN 17, Waco, Texas
11/18/2016	11-00147-02	Alleged Prohibited Personnel Practices and Preferential Treatment, OI&T, VA Central Office, Washington, DC
11/18/2016	11-00198-03	Alleged Threats, Office of Human Resources and Administration
11/18/2016	11-00210-05	Alleged Prohibited Personnel Practices, Office of Human Resources Management, Washington, DC
11/18/2016	11-00211-07	Alleged Prohibited Personnel Practices and Conflict of Interest, VBA Regional Office and Insurance Center, Philadelphia, Pennsylvania
11/18/2016	11-01620-10	Alleged Security Violation, VISN 1, VA New England Healthcare System, Bedford, Massachusetts
11/18/2016	11-01682-11	Alleged Improper Leave Approval, West Palm Beach VA Medical Center, Florida
11/18/2016	11-01711-13	Alleged Misuse of Official Time, VA New Jersey Health Care System, East Orange, New Jersey
11/18/2016	11-04189-15	Alleged Misuse of Travel Funds, St. Louis VA Medical Center, St. Louis, Missouri
11/18/2016	11-04285-16	Alleged Misuse of Funds, Conflict of Interest, and Acceptance of a Gift, OI&T, Washington, DC
11/18/2016	11-04502-18	Alleged Misuse of Position and Improper Pay, VA Great Lakes Health Care System, Hines, Illinois
11/18/2016	11-04536-19	Alleged Misuse of Government Resources, VHA Office of Informatics and Analytics, Washington, DC
11/18/2016	11-00084-69	Alleged Misuse of Official Time, El Paso VA Health Care System, El Paso, Texas
11/18/2016	11-01783-432	Alleged Misuse of Time, Position, and Resources, Malcom Randall VA Medical Center, Gainsville, Florida
11/18/2016	11-01897-433	Alleged Misuse of Government Resources, VA Medical Center, Washington, DC

Office of Investigations | Administrative Investigation Closures		
Issue Date	**Number**	**Closure Title**
11/18/2016	11-02312-434	Alleged Conflict of Interest and Research Program Irregularities, Tennesee Valley Healthcare System, Nashville Campus, Tennessee
11/18/2016	11-02610-435	Alleged Misuse of Government Resources, VA Pacific Island Healthcare System, Honolulu, Hawaii
11/18/2016	11-02460-436	Alleged Ethical, Acquisition, and Information Security Violations; Misuse of Government Resources; and Prohibited Personnel Practices, VISN 5, Linthicum, Maryland
11/18/2016	11-02766-437	Alleged Preferential Treatment and Prohibited Personnel Practices, Overton Brooks VA Medical Center, Shreveport, Louisiana
11/18/2016	11-03313-441	Alleged Prohibited Personnel Practices, Central Alabama Veterans Health Care System, Montgomery, Alabama
11/18/2016	11-03461-444	Alleged Misuse of Government Resources and Preferential Treatment, VHA Office of Research & Development
11/18/2016	11-02258-446	Alleged Prohibited Personnel Practice and Misuse of Government Resources, Office of Business Oversight, Austin, Texas
11/18/2016	12-01841-37	Alleged Contracting Personnel Operated Without Warrants, Service Area Office West, Desert Pacific Health Care Network, Long Beach, California
11/18/2016	12-01697-51	Alleged Misuse of Official Time, Board of Veterans' Appeals, Washington, DC
11/18/2016	12-00568-52	Alleged Contract/Procurement Irregularities, El Paso VA Health Care System, El Paso, Texas
11/18/2016	12-01978-53	Alleged Mismanagement of Health Care Resource Contracts and Conflict of Interest (Self-Referrals) by Contract Physicians
11/18/2016	12-00963-55	Alleged Nepotism, Abuse of Authority, Favoritism, and Reprisal, Philadelphia VA Regional Office and Insurance Center
11/18/2016	12-04586-56	Alleged Conflict of Interest and Misuse of Government Resources, VA Mid-South Health Care Network, Nashville, Tennessee
11/18/2016	12-01841-58	Alleged Misuse of Time, Service Area Office West, Network 22 Contracting Office, Long Beach, California
11/18/2016	12-00449-59	Alleged Conflict of Interest, Dayton VA Medical Center, Dayton, Ohio
11/18/2016	12-04629-61	Alleged Misuse of Resources and Prohibited Personnel Practices, VA Caribbean Health Care System, San Juan, Puerto Rico
11/18/2016	12-02359-67	Alleged Fraudulent My HealtheVet Activity, VA Hudson Valley Health Care System, Montrose, New York
11/18/2016	12-03735-68	Alleged Misuse of Government Resources, Oklahoma City VA Medical Center, Oklahoma
11/18/2016	12-00570-70	Alleged Improper Salary Increase, Misuse of Travel Card, and Improper Time and Attendance, BVA, Washington, DC
11/18/2016	12-00396-71	Alleged Conflict of Interest, Misuse of Position, and Unauthorized Disclosure of Proprietary Information, Veterans Relationship Management, OI&T, Washington, DC

Office of Investigations | Administrative Investigation Closures		
Issue Date	**Number**	**Closure Title**
11/18/2016	12-02355-77	Alleged Prohibited Personnel Practice VHA Readjustment Counseling Service, Baltimore, Maryland
11/18/2016	13-02784-49	Alleged Improper Speaking Engagement and Acceptance of Gifts, VA Acquisition Academy, Frederick, Maryland
11/18/2016	13-01419-50	Alleged Hostile Work Environment, VA OI&T
11/18/2016	13-00784-54	Alleged Prohibited Personnel Practices, Misuse of Position, and Hiring Irregularities, VHA, Department of Veterans Affairs, Overton Brooks VA Medical Center, Shreveport, Lousiana
11/18/2016	13-02287-62	Alleged Misuse of Position and Resources, OI&T, Washington, DC
11/18/2016	13-00235-64	Alleged Misrepresentation of Cost, Inteference with an OIG Investigation, and Improper Disclosure of Confidential Information
11/18/2016	13-03899-65	Alleged Mismanagement and Preferential Treatment, National Cemetery Administration, VA Central Office, Washington, DC
11/18/2016	13-02649-66	Alleged Improper Management Directive, Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana
11/18/2016	14-00730-21	Alleged Prohibited Personnel Practices and Preferential Treatment, Chief Business Office, Purchased Care, Denver, Colorado
11/18/2016	14-01144-22	Alleged Misuse of Position, Greater Los Angeles Healthcare System, California
11/18/2016	14-02170-24	Alleged Misuse of Government Resources, Travel Irregularities, and Creating a Hostile Work Environment, VA Central Office, Washington, DC
11/18/2016	14-03276-25	Misuse of Government Resources, VA Office of Construction and Facilities Management, Mare Island, California
11/18/2016	14-02603-26	Alleged Consult Delays at Phoenix VAMC, Phoenix VAMC, Phoenix, Arizona
11/18/2016	14-03837-29	Alleged Preferential Treatment and Misuse of Funds, VA Pacific Islands Health Care System, Honolulu, Hawaii
11/18/2016	14-04373-30	Alleged Preferential Treatment, VHA, VA Central Office, Washington, DC
11/18/2016	14-01429-45	Alleged Ethics Violations, Office of VA Secretary, VA Central Office
11/18/2016	15-00106-31	Alleged Use of Public Office for Private Gain, VA New York Harbor Health Care System, New York, New York
11/18/2016	16-00010-78	Sexual Harassment and Improper Conduct

Appendix B: Unimplemented Reports and Recommendations

The follow-up reporting and tracking of OIG report recommendations is required by P.L. 103-355, *Federal Acquisition Streamlining Act of 1994*, as amended by P.L. 104-106, *National Defense Authorization Act of 1996*. The Acts require agencies to complete final action on each management decision required with regard to a recommendation in an OIG's report within 12 months of its issuance/publication. If the agency fails to complete final action within the 12-month period, OIG is required to identify the matter in each Semiannual Report to Congress until final action on the management decision is completed.

Table 1 identifies the number of open OIG reports and recommendations with results sorted by action office. As of March 31, 2017, there are 126 total open reports and 483 total open recommendations. However, 7 reports and 7 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 79 reports and 351 recommendations that, as of March 31, 2017, have been open less than 1 year. The total monetary benefit attached to the reports open less than 1 year is $2,854,635,555. Table 3, on the other hand, identifies the 47 reports and 132 recommendations that, as of March 31, 2017, remain open for more than 1 year. Titles that are italicized represent reports that OIG has suspended until OIG can conduct a follow-up visit to assess the recommendations for closure. The total monetary benefit attached to the reports open greater than 1 year is $1,133,400,000.

Table 1: Number of Unimplemented OIG Reports and Recommendations by Office

	Reports Open More Than 1 Year	Reports Open Less Than 1 Year	Total Reports Open	Recommendations Open More Than 1 Year	Recommendations Open Less Than 1 Year	Total Recommendations Open
Veterans Health Administration	27	63	90	50	297	347
Veterans Benefits Administration	11	6	17	25	25	50
National Cemetery Administration	0	1	1	0	3	3
Office of Acquisition, Logistics, and Construction	3	2	5	9	6	15
Office of Management (OM)	2	1	3	4	1	5
Office of Information and Technology	5	6	11	43	12	55
Office of Human Resources and Administration	1	1	2	1	7	8
Office of Operations, Security, and Preparedness (OSP)	1	0	1	1	0	1
Office of General Counsel	1	1	2	3	1	4
Chief of Staff (COS)	1	1	2	1	1	2
Total	**52**	**82**	**134**	**137**	**353**	**490**

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
4/7/2016 15-02781-153	Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act onMyCareer@VA Web Site	OIT	1	$34,011
4/8/2016 16-00110-246	Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming	VHA	1	
4/13/2016 16-00102-253	Combined Assessment Program Review of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma	VHA	2	
4/14/2016 15-04652-146	Review of Claims-Related Documents Pending Destruction at VA Regional Offices	VBA	6	
4/14/2016 16-00019-249	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Cheyenne VA Medical Center, Cheyenne, Wyoming	VHA	3	
4/14/2016 16-00023-252	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Fargo VA Health Care System, Fargo, North Dakota	VHA	1	
4/20/2016 16-00017-245	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Tuscaloosa VA Medical Center, Tuscaloosa, Alabama	VHA	1	
4/21/2016 15-05154-271	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Sheridan VA Healthcare System, Sheridan, Wyoming	VHA	4	
4/26/2016 11-00826-261	Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System	VHA	3	$8,900,000
4/28/2016 15-03802-222	Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System	VBA/OIT	2	
4/28/2016 16-00108-274	Combined Assessment Program Review of the Tuscaloosa VA Medical Center Tuscaloosa, Alabama	VHA	2	
5/3/2016 14-02890-286	Healthcare Inspection – Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina	VHA	2	
5/9/2016 15-02459-260	Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard	OIT	4	

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
5/11/2016 16-00010-302	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Greater Los Angeles Healthcare System, Los Angeles, California	VHA	1	
5/11/2016 16-00101-300	Combined Assessment Program Review of the VA Greater Los Angeles Healthcare System, Los Angeles, California	VHA	9	
5/12/2016 15-04252-284	Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015	VHA	2	
5/12/2016 15-04704-297	Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, Arizona	VHA	7	
5/12/2016 16-00025-301	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Carl Vinson VA Medical Center, Dublin, Georgia	VHA	3	
5/17/2016 15-02747-314	Alleged Prohibited Personnel Practice, Board of Veterans Appeals, Washington, DC	COS	1	
5/19/2016 16-00111-310	Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana	VHA	3	
6/7/2016 14-04435-265	Mental Health Service Concerns at the Knoxville VA Outpatient Clinic James H. Quillen VA Medical Center Mountain Home, Tennessee	VHA	2	
6/9/2016 16-00029-322	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Jesse Brown VA Medical Center Chicago, Illinois	VHA	1	
6/9/2016 16-00121-320	Combined Assessment Program Review of the Jesse Brown VA Medical Center, Chicago, Illinois	VHA	4	
6/10/2016 16-00027-318	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Connecticut Healthcare System, West Haven, Connecticut	VHA	2	
6/14/2016 16-00118-321	Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas	VHA	2	
6/16/2016 15-03700-283	Review of VA's Guidance on Protecting Religious Beliefs	VHA/NCA	4	

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
6/20/2016 15-03073-275	Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, Texas	VHA	1	
6/23/2016 15-01296-203	Community Based Outpatient Clinics Summary Report – Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics	VHA	5	
6/23/2016 16-00028-337	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Amarillo VA Health Care System, Amarillo, Texas	VHA	3	
6/23/2016 16-00116-323	Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut	VHA	1	
6/28/2016 13-02255-276	Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans	VBA	5	$307,900,000
8/3/2016 15-03688-304	Audit of VA's Green Management Program Solar Panel Projects	OM	1	
8/9/2016 16-02729-350	Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan	VHA	2	$311,544
8/11/2016 15-05490-367	Healthcare Inspection – Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota	VHA	1	
9/21/2016 15-03706-330	Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System	OALC	2	
9/22/2016 15-01396-525	Review of VA's Award of the PC3 Contracts	OALC	4	$16,800,000
9/27/2016 15-00018-349	Lack of Follow-Up Care for Positive Colorectal Cancer Screening New Mexico VA Health Care System Albuquerque, New Mexico	VHA	2	
9/27/2016 16-03960-428	Combined Assessment Program Summary Report – Evaluation of Advance Directives in Veterans Health Administration Facilities	VHA	2	
9/28/2016 16-00351-453	OIG Determination of VHA Occupational Staffing Shortages	VHA	4	

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
9/29/2016 15-02707-277	Review of VBA's Special Monthly Compensation Housebound Benefits	VBA	3	$44,300,000
9/30/2016 14-00875-325	Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona	VHA	4	
9/30/2016 14-05118-147	Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments	VBA	6	$2,270,000,000
9/30/2016 15-00084-370	Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina	VHA	4	
9/30/2016 15-00650-423	Review of Alleged Waste of Funds at the VA Medical Center in Madison, Wisconsin	VHA	1	
10/4/2016 15-04672-342	Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System	VHA	8	
10/12/2016 15-00506-420	Healthcare Inspection – Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon	VHA	1	
11/9/2016 14-02890-72	Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System	VHA	3	
11/9/2016 15-05180-75	Healthcare Inspection – Mental Health-Related Concerns, W.G. Bill Hefner VA Medical Center, Salisbury, North Carolina	VHA	1	
11/10/2016 16-03330-91	Administrative Investigation – Conduct Prejudicial to the Government and Misuse of Position in the VA Office of General Counsel, Washington, DC	OGC	1	
12/6/2016 16-00790-417	Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses	OIT	1	$7,200,000
12/13/2016 14-03434-102	Healthcare Inspection – Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri	VHA	5	
12/15/2016 15-04247-111	Healthcare Inspection – Review of Antimicrobial Stewardship Programs in VHA Facilities	VHA	2	

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
12/15/2016 15-02278-415	Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System	VHA	2	
1/5/2017 14-04578-371	Audit of Recruitment, Relocation, and Retention Inventives	OHRA	7	$162,600,000
1/18/2017 15-00075-449	Combined Assessment Program Follow-Up Review of Environment of Care at the VA St. Louis Health Care System, St. Louis, Missouri	VHA	1	
1/30/2017 15-03401-76	Review of Alleged Human Resources Delays at the Atlanta VA Medical Center	VHA	5	
1/30/2017 15-04673-333	Review of the Implementation of the Veterans Choice Program	VHA	6	
1/31/2017 15-02189-336	Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract	OIT	3	$5,300,000
2/8/2017 15-01436-456	Audit of VBA's Automated Burial Payments	VBA	4	$28,000,000
2/9/2017 14-00750-143	Healthcare Inspection – Documentation of Patient Enrollment Concerns in Home Telehealth, John D. Dingell VA Medical Center, Detroit, Michigan	VHA	2	
2/16/2017 16-00574-151	Clinical Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, Louisiana	VHA	20	
2/28/2017 15-04925-469	Evaluation of Human Immunodeficiency Virus Screening in Veterans Health Administration Outpatient Clinics	VHA	2	
3/2/2017 16-02618-424	Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6	VHA	10	
3/7/2017 16-03805-20	Combined Assessment Program Summary Report – Evaluation of Inpatient Flow in Veterans Health Administration Facilities	VHA	3	
3/8/2017 16-00551-128	Clinical Assessment Program Review of the VA Caribbean Healthcare System, San Juan, Puerto Rico	VHA	12	
3/8/2017 16-00557-134	Clinical Assessment Program Review of the Boise VA Medical Center, Boise, Idaho	VHA	4	

Table 2: Unimplemented OIG Reports and Recommendations Less Than 1 Year Old

Issue Date and Report Number	Report Title	Responsible Organization(s)	Number of Open Recommendations	Monetary Impact of Open Recommendations
3/8/2017 16-00550-145	Clinical Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri	VHA	13	
3/10/2017 16-00621-175	Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana	VHA	3	
3/13/2017 16-00553-135	Clinical Assessment Program Review of the Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio	VHA	16	
3/13/2017 16-00554-148	Clinical Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona	VHA	14	
3/16/2017 16-00547-156	Clinical Assessment Program Review of the VA Portland Health Care System, Portland, Oregon	VHA	14	
3/20/2017 16-03985-181	Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line	VHA	16	
3/24/2017 15-03231-319	Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia	VHA	5	$2,785,000
3/27/2017 16-00252-137	Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths	VHA	2	$505,000
3/27/2017 16-00575-147	Clinical Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York	VHA	7	
3/31/2017 15-05379-146	Audit of VHA's Patient Advocacy Program	VHA/OIT	8	
3/31/2017 16-00572-179	Clinical Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah	VHA	20	
3/31/2017 15-04976-191	Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California	VHA	1	
3/31/2017 16-03743-193	Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities Fiscal Year 2016	VHA	5	
Total				**$2,854,635,555**

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
06/07/10	08-02969-165	Review of Federal Supply Schedule 621 I--Professional and Allied Healthcare Staffing Services	OALC	None
Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL [Office of Acquisition and Logistics] direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable. *Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC [most favored customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).* *Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.* *Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.* *Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.*			
02/18/11	09-03850-99	Audit of the Veterans Service Network	OIT	$35,000,000
Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.				
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 11: We recommend the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
05/30/12	10-03166-75	Audit of VA Regional Offices' Appeals Management Processes	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals. *Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.* *Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.* *Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.*			
09/28/12	12-00375-290	Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC	OM/OGC	None
Recommendation 4: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville EUL [Enhanced Use Lease] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage. *Recommendation 5: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem.* *Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer immediately determine what services VOA [Volunteers of America] is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.*			

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
09/28/12	12-01012-298	***Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation***	VHA/OALC	None
Recommendation 7: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices. *Recommendation 8: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts.* *Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.*				
09/30/12	12-00165-277	Review of Alleged Delays in VA Contractor Background Investigations	OIT/OSP	None
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.				
03/06/13	12-02802-111	Review of Alleged Transmission of Sensitive VA Data Over Internet Connections	OIT	None
Recommendation 1: We recommend the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements.				
09/04/13	12-00181-299	Audit of VBA's Pension Payments	VBA	$502,000,000
Recommendation 1: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements procedures that ensure continued veteran and beneficiary eligibility.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
05/28/14	13-03018-159	Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub	VBA	None
Recommendation 5: We recommended the Under Secretary for Benefits ensures the Eastern Area Fiduciary Hub implements a plan to expedite completion of their backlog of field examinations to meet performance standards.				
07/11/14	13-01452-214	Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments	VBA	$205,000,000
Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.				
07/14/14	13-03699-209	Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to identify all provisionally-rated claims and ensure the proper controls are entered in the electronic system to track, manage, and complete them. *Recommendation 2: We recommended the Under Secretary for Benefits implement actions to include provisionally-rated claims in the rating inventory and correct the aging of provisional claims in pending workload statistics.* *Recommendation 3: We recommended the Under Secretary for Benefits implement a plan to expedite final decisions on all issues in provisionally-rated claims.*				
08/28/14	14-00657-261	Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits improve monitoring to ensure Veterans Affairs Regional Office staff establish claims in the Veteran Benefits Administration's data systems within 7 days of receipt. *Recommendation 2: We recommended the Under Secretary for Benefits develop a timeliness standard for Veterans Affairs Regional Office staff making initial requests for service treatment records.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
12/04/14	14-00930-14	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of the Central Alabama Veterans Health Care System, Montgomery, Alabama	VHA	None
Recommendation 14: We recommended that CBOC/Primary Care Clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care. *Recommendation 15: We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.*				
01/20/15	14-04214-70	Combined Assessment Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi	VHA	None
Recommendation 8: We recommended that requestors consistently include "inpatient" in the consult title and that facility managers monitor compliance.				
01/22/15	13-03324-85	Follow-up Audit of the Information Technology Project Management Accountability System	OIT	$6,400,000
Recommendation 2: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure personnel performing Compliance Reviews assess the accuracy and reasonableness of cost information reported on the Project Management Accountability System Dashboard (repeat recommendation from the 2011 VA Office of Inspector General audit report). *Recommendation 3: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure hiring actions are completed by acquiring the vacant Federal employee positions in the Project Management Accountability System Business Office (repeat recommendation from the 2011 VA Office of Inspector General audit report).* *Recommendation 6: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, complete development and implementation of a sound methodology to capture and report planned and actual total project and increment level costs (repeat recommendation from the 2011 VA Office of Inspector General audit report).*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 7: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, ensure project managers capture and report reliable cost data and maintain adequate audit trails to support how the cost information reported on the Project Management Accountability System Dashboard was derived in the interim until actions to automate budget traceability and shift VA's IT projects to increment-based contracts are completed (repeat recommendation from the 2011 VA Office of Inspector General audit report). *Recommendation 8: We recommended the Executive in Charge and Chief Information Officer, Office of Information and Technology, clearly define the term "enhancement of an existing system or its infrastructure" and require Service Delivery and Engineering project teams to track and report costs associated with enhancements on the Project Management Accountability System Dashboard.*				
02/17/15	**14-04386-124**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA North Texas Health Care System, Dallas, Texas**	**VHA**	**None**
Recommendation 4: We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training and that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.				
03/04/15	**14-04222-141**	**Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon**	**VHA**	**None**
Recommendation 39: We recommended that facility managers ensure patient notification of diagnostic test results within the required timeframe and that clinicians document notification.				
03/30/15	**14-02383-175**	**Audit of VA's Drug-Free Workplace Program**	**OHRA**	**None**
Recommendation 3: We recommended the Deputy Assistant Secretary for Human Resources Management develop procedures to ensure the Drug Testing coding of employees in Testing Designated Positions is accurate and complete in the Personnel and Accounting Integrated Data system.				
4/15/2015	**14-03651-203**	**Review of Alleged Data Manipulation and Mismanagement at the VA Regional Office, Philadelphia, Pennsylvania**	**VBA**	**None**
Recommendation 24: We recommended the Under Secretary for Benefits develop and implement a timeliness goal for VA Regional Offices to process returned mail.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 31: We recommended the Under Secretary for Benefits develop and implement a plan that includes a timeliness goal to ensure mail is associated with electronic or paper claims folders prior to claims processing actions. *Recommendation 35: We recommended the Under Secretary for Benefits conduct an independent review of production standards for Pension Call Center staff to determine if the timeliness standard is reasonable and obtainable without compromising the quality of customer service to callers.*				
5/5/2015	**15-00129-339**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Roseburg Healthcare System, Roseburg, Oregon**	**VHA**	**None**
Recommendation 4: We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.				
6/1/2015	**14-01883-371**	**Audit of Fiduciary Program's Management of Field Examinations**	**VBA**	**None**
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to ensure field examination workload is completed in compliance with timeliness standards. *Recommendation 2: We recommended the Under Secretary for Benefits use the percentage of untimely field examinations in addition to the average days pending performance measure to better evaluate completion of field examinations.* *Recommendation 3: We recommended the Under Secretary for Benefits require hub managers to use Beneficiary and Fiduciary Field System reports to identify and correct unscheduled field examinations at least once per quarter.*				
6/4/2015	**14-04220-363**	**Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, Arizona**	**VHA**	**None**
Recommendation 5: We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance. *Recommendation 6: We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.* *Recommendation 7: We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
6/17/2015	14-05158-377	***Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine***	VHA	None
Recommendation 2: We recommended the Facility Director reevaluate and make the appropriate changes to the methods for referring patients for mental health care, including the extent to which the consult package is being used appropriately. *Recommendation 3: We recommended the Facility Director ensure that mental health consults are reviewed and closed in accordance with Veterans Health Administration policy.* *Recommendation 4: We recommended the Facility Director ensure that Veterans Health Administration appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate.*				
6/29/2015	14-01991-387	Audit of Homeless Providers Grant and Per Diem Case Management Oversight	VHA	None
Recommendation 2: We recommended the Interim Under Secretary for Health revise policies, if necessary, when a definitive legal position is provided on Grant and Per Diem Program eligibility. *Recommendation 3: We recommended the Interim Under Secretary for Health implement controls to ensure grant applications comply with the definitive legal position on Grant and Per Diem Program eligibility.*				
7/29/2015	14-04530-414	Healthcare Inspection – Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness Central Alabama VA Health Care System, Montgomery, Alabama	VHA	None
Recommendation 11: We recommended that the Central Alabama VA Health Care System Director ensure that mental health providers adequately document their clinical reasoning when their treatment decisions do not comply with VA/DoD guidelines for medication management in Post-Traumatic Stress Disorder and Substance Use Disorder patients. *Recommendation 13: We recommended that the Central Alabama VA Health Care System Director ensure assignment of Mental Health Treatment Coordinators for all appropriate patients.* *Recommendation 14: We recommended that the Central Alabama VA Health Care System Director monitor to ensure the Dothan Primary Care contractor complies with staffing and care specifications as outlined in the contract.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
7/29/2015	14-04530-452	Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama	VHA	None
Recommendation 2: We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.				
8/27/2015	13-03922-453	Audit of Fiduciary Program Controls Addressing Beneficiary Fund Misuse	VBA	None
Recommendation 4: We recommended the Under Secretary for Benefits ensure the processing of all misuse actions are incorporated into quality reviews of Fiduciary Program operations.				
8/31/2015	15-00606-495	Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan	VHA	None
Recommendation 8: We recommended that facility managers comply with Veterans Health Administration directive requirements for exempted facilities, or if facility managers plan emergency intubation responses with onsite employees, they comply with Veterans Health Administration requirements for non-exempted facilities.				
9/14/2015	13-00690-455	Follow-up Review of VA's Veterans Benefits Management System	VBA/OIT	$27,000,000
Recommendation 4: We recommended the Executive in Charge for the Office of Information and Technology, in conjunction with the Under Secretary for Benefits, establish a clear strategy and plan to decommission legacy systems, eliminate redundant systems operations, and reduce system maintenance costs.				
9/28/2015	15-02997-526	Administrative Investigation, Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA	COS	None
Recommendation 4: We recommended the Deputy Secretary strengthen the approval process to include requiring an independent review of the Department's Permanent Change of Station program to ensure moves and expenses are appropriate and justified.				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
9/30/2015	14-04598-461	Review of Allegations Regarding Quality of Care, Professional Conduct, and Contractual Issues for Cardiothoracic Surgery and Perfusion Services at the VA North Texas Health Care System Provided by the University of Texas—Southwestern Medical Center	VHA	None
Recommendation 1: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS [VA North Texas Health Care System] take immediate steps to prioritize awarding a long-term contract for CT [cardiothoracic] surgery and perfusion services that is fully compliant with VA Directive 1663. *Recommendation 2: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a full-time or part-time CT surgeon(s).* *Recommendation 3: We recommend that the Director, VA Heart of Texas Health Care Network (VISN 17) and the Director, VANTHS take immediate steps to recruit a VA perfusionist(s).*				
9/30/2015	15-00180-538	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Pacific Islands Health Care System, Honolulu, Hawaii	VHA	None
Recommendation 14: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.				
11/12/2015	14-04756-32	Audit of the Seismic Safety of VA's Facilities	VHA/OALC/OM	None
Recommendation 1: We recommended the Principal Executive Director for the Office of Acquisition, Logistics, and Construction establish policy requiring medical facilities to conduct detailed seismic studies for all critical and essential buildings located in high and very high seismic zones that have not already undergone detailed seismic studies. *Recommendation 8: We recommended the Acting Assistant Secretary for Management revise VA Directive 7415 to mandate that enhanced use lease agreements require developers to certify the seismic safety of buildings or to have a plan for mitigating identified seismic deficiencies prior to renewal or execution of new facility use agreements with VA organizations.* *Recommendation 9: We recommended the Under Secretary for Health develop policies and procedures requiring VHA medical facilities to develop and test Continuity of Operations Plans, to include documenting the testing performed, in accordance with Federal Continuity Directive 1 requirements.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
1/12/2016	14-02465-47	Audit of VHA's Non-VA Medical Care Obligations	VHA	$358,000,000
Recommendation 1: We recommended that the Under Secretary for Health improve cost estimation tools to ensure adequate Non-VA Care cost estimates are produced consistently. *Recommendation 3: We recommended that the Under Secretary for Health update Fee Basis Claims System software to ensure inpatient authorizations can be periodically adjusted when the scope of patient care is fully known.* *Recommendation 4: We recommended that the Under Secretary for Health update Fee Basis Claims System software to allow the system to automatically deobligate unused funds when Non-VA Care staff indicate payments for the authorized services are complete.*				
1/12/2016	15-05158-74	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Edward Hines, Jr. VA Hospital, Hines, Illinois	VHA	None
Recommendation 3: We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.				
1/13/2016	15-05151-81	Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio	VHA	None
Recommendation 5: We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA. *Recommendation 7: We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.*				
1/14/2016	14-04530-41	Healthcare Inspection – Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama	VHA	None
Recommendation 1: We recommended that the Central Alabama Veterans Health Care System Director charter a systems redesign team to improve the timeliness of care delivery in the Emergency Department. *Recommendation 3: We recommended that the Central Alabama Veterans Health Care System Director ensure that adequate staffing is available in the Emergency Department to assure safe special observation to mental health patients.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
1/14/2016	15-04693-79	Combined Assessment Program Review of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania	VHA	None
Recommendation 12: We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.				
1/14/2016	15-04694-80	Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio	VHA	None
Recommendation 10: We recommended that pharmacy managers ensure employees who prepare compounded sterile products don all required personal protective equipment in the ante area prior to entering the IV [intravenous] Prep Room and monitor compliance. *Recommendation 11: We recommended that pharmacy managers ensure the IV Prep Room has sterile chemotherapy-type gloves available for compounding hazardous medications and monitor compliance.*				
2/10/2016	15-04697-105	Combined Assessment Program Review of the Sheridan VA Healthcare System, Sheridan, Wyoming	VHA	None
Recommendation 2: We recommended that Physician Utilization Management Advisors document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance. *Recommendation 11: We recommended that clinicians include the identification of assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.*				
2/11/2016	14-03540-123	Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York	VHA	None
Recommendation 1: We recommended that the Office of Mental Health Operations Executive Director ensure that issues regarding response hold times when callers are routed to backup crisis centers are addressed and that data is collected, analyzed, tracked, and trended on an ongoing basis to identify system issues. *Recommendation 2: We recommended that the Office of Mental Health Operations Executive Director ensure that orientation and ongoing training for all Veterans Crisis Line staff is completed and documented.*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 3: We recommended that the Office of Mental Health Operations Executive Director ensure that silent monitoring frequency meets the Veterans Crisis Line and American Association of Suicidology requirements and that compliance is monitored. *Recommendation 4: We recommended that the Office of Mental Health Operations Executive Director establish a formal quality assurance process, as required by the Veterans Health Administration, to identify system issues by collecting, analyzing, tracking, and trending data from the Veterans Crisis Line routing system and backup centers and that subsequent actions are implemented and tracked to resolution.* *Recommendation 5: We recommended that the Office of Mental Health Operations Executive Director consider the development of a Veterans Health Administration directive or handbook for the Veterans Crisis Line.* *Recommendation 6: We recommended that the Office of Mental Health Operations Executive Director ensure that contractual arrangements concerning the Veterans Crisis Line include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.* *Recommendation 7: We recommended that the Office of Mental Health Operations Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.*				
2/24/2016	**15-04700-119**	**Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital, Hines, Illinois**	**VHA**	**None**
Recommendation 1: We recommended that designated employees maintain a log of individuals entering the facility between 9:00 p.m. and 5:00 a.m. and that facility managers monitor compliance.				
2/25/2016	**14-02384-45**	**Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires**	**VBA**	**None**
Recommendation 1: We recommended the Acting Under Secretary for Benefits evaluate options for electronically capturing and analyzing information contained on completed Disability Benefits Questionnaires and implement the most cost effective option. (Similar to recommendation from 2012 Office of Inspector General audit report.) *Recommendation 4: We recommended the Acting Under Secretary for Benefits revise policies and procedures to include steps for obtaining missing public-use Disability Benefits Questionnaires clinician information and verifying clinicians have an active medical license. (Similar to recommendation from 2012 Office of Inspector General audit report.)*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 9: We recommended the Acting Under Secretary for Benefits establish procedures requiring Veterans Affairs Regional Office staff to receive recurring training on systemic issues identified during analyses of local quality assurance review results related to compliance with Disability Benefits Questionnaires' special issue indicator and clinician information completeness requirements. *Recommendation 10: We recommended the Acting Under Secretary for Benefits require Veterans Benefits Administration's Compensation Service Disability Examination Management staff to conduct annual validation reviews that select samples from a complete universe of claims with public-use Disability Benefits Questionnaires and focuses on public-use Disability Benefits Questionnaires that pose an increased risk of fraud. (Similar to recommendation from 2012 Office of Inspector General audit report.)* *Recommendation 14: We recommended the Acting Under Secretary for Benefits establish procedures requiring Veterans Affairs Regional Office staff to receive recurring training on systemic issues identified during analyses of local quality assurance review results related to public-use Disability Benefits Questionnaires, including unnecessary Veterans Health Administration compensation and pension examinations.*			
3/9/2016	**15-05160-161**	**Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona**	**VHA**	**None**
Recommendation 16: We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. *Recommendation 17: We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.*				
3/15/2016	**15-01957-100**	**Federal Information Security Modernization Act Audit for Fiscal Year 2015**	**OIT**	**None**
Recommendation 1: We recommended the Assistant Secretary for Information and Technology fully implement an agency-wide risk management governance structure, along with mechanisms to identify, monitor, and manage risks across the enterprise. (This is a modified repeat recommendation from prior years.) *Recommendation 2: We recommended the Assistant Secretary for Information and Technology formally authorize Health Eligibility Center systems to operate in accordance with VA information security standards. (This is a new recommendation.)* *Recommendation 3: We recommended the Assistant Secretary for Information and Technology implement clear roles, responsibilities, and accountability for developing, maintaining, completing, and reporting Plans of Action and Milestones. (This is a repeat recommendation from prior years.)*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 4: We recommended the Assistant Secretary for Information and Technology implement mechanisms to ensure Plans of Action and Milestones are updated to accurately reflect current status information. (This is a repeat recommendation from prior years.) *Recommendation 5: We recommended the Assistant Secretary for Information and Technology implement mechanisms to ensure sufficient supporting documentation is captured in the central Governance Risk and Compliance tool to justify closure of Plans of Action and Milestones. (This is a repeat recommendation from last year.)* *Recommendation 6: We recommended the Assistant Secretary for Information and Technology implement improved processes to ensure that all identified weakness are incorporated into Governance Risk and Compliance tool, in a timely manner, and corresponding POA&Ms are developed to track corrective actions and remediation. (This is a new recommendation.)* *Recommendation 7: We recommended the Assistant Secretary for Information and Technology implement system enhancements to the Governance Risk and Compliance tool to prevent the automatic re-opening of closed Plans of Action and Milestones and update Enterprise Operation's version of the tool to reflect NIST 800-53 Revision 4 controls. (This is a new recommendation.)* *Recommendation 8: We recommended the Assistant Secretary for Information and Technology develop mechanisms to ensure system security plans reflect current operational environments, including accurate system interconnections, boundary, control, and ownership information. (This is a repeat recommendation from last year.)* *Recommendation 9: We recommended the Assistant Secretary for Information and Technology implement improved processes for reviewing and updating key security documents such as risk assessments, privacy impact assessments, and security control assessments on an annual basis and ensure all required information accurately reflects the current environment. (This is a repeat recommendation from last year.)* *Recommendation 10: We recommended the Assistant Secretary for Information and Technology implement mechanisms to enforce VA password policies and standards on all operating systems, databases, applications, and network devices. (This is a repeat recommendation from prior years.)* *Recommendation 11: We recommended the Assistant Secretary for Information and Technology implement periodic access reviews to minimize access by system users with incompatible roles, permissions in excess of required functional responsibilities, and unauthorized accounts. (This is a repeat recommendation from prior years.)* *Recommendation 12: We recommended the Assistant Secretary for Information and Technology enable system audit logs and conduct centralized reviews of security violations on mission-critical systems. (This is a repeat recommendation from prior years.)*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 13: We recommended the Assistant Secretary for Information and Technology fully implement two-factor authentication for all local and remote access methods throughout the agency. (This is a repeat recommendation from prior years.) *Recommendation 14: We recommended the Assistant Secretary for Information and Technology implement mechanisms to ensure all remote access computers have updated security patches and antivirus definitions prior to connecting to VA information systems. (This is a repeat recommendation from prior years.)* *Recommendation 15: We recommended the Assistant Secretary for Information and Technology implement more effective automated mechanisms to continuously identify and remedy security deficiencies on VA's network infrastructure, database platforms, and Web application servers. (This is a repeat recommendation from last year.)* *Recommendation 16: We recommended the Assistant Secretary for Information and Technology implement a more effective patch and vulnerability management program to address security deficiencies identified during our assessments of VA's Web applications, database platforms, network infrastructure, and work stations. (This is a repeat recommendation from last year.)* *Recommendation 17: We recommended the Assistant Secretary for Information and Technology maintain complete and accurate baseline configurations and ensure all baselines are appropriately implemented and checked for compliance with established VA security standards. (This is a modified repeat recommendation from last year.)* *Recommendation 18: We recommended the Assistant Secretary for Information and Technology implement improved network access controls to ensure medical devices and non-OI&T managed networks are appropriately segregated from general networks and mission-critical systems. (This is a repeat recommendation from last year.)* *Recommendation 19: We recommended the Assistant Secretary for Information and Technology consolidate the security responsibilities for non-OI&T networks present under a common control for each site and ensure vulnerabilities are remedied in a timely manner. (This is a modified repeat recommendation from last year.)* *Recommendation 20: We recommended the Assistant Secretary for Information and Technology implement procedures to enforce a standardized system development and change control framework that integrates information security throughout the life cycle of each system. (This is a repeat recommendation from last year.)* *Recommendation 21: We recommended the Assistant Secretary for Information and Technology implement processes to ensure information system contingency plans are updated with the required information. (This is a repeat recommendation from last year.)*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 22: We recommended the Assistant Secretary for Information and Technology develop and implement a process for ensuring the encryption of backup data prior to transferring the data offsite for storage. (This is a repeat recommendation from prior years.) *Recommendation 23: We recommended the Assistant Secretary for Information and Technology implement improved processes for the testing of contingency plans and failover capabilities for major applications and general support systems to ensure that critical components can be recovered at an alternate site in the event of a system failure or disaster. (This is a new recommendation.)* *Recommendation 24: We recommended the Assistant Secretary for Information and Technology perform and document a Business Impact Analysis for all systems and incorporate the results into an overall strategy development effort for contingency planning. (This is a new recommendation.)* *Recommendation 25: We recommended the Assistant Secretary for Information and Technology implement more effective agency-wide incident response procedures to ensure timely resolution of computer security incidents in accordance with VA set standards. (This is a repeat recommendation from prior years.)* *Recommendation 26: We recommended the Assistant Secretary for Information and Technology identify all external network interconnections and implement improved processes for monitoring all VA internal networks, systems, and exchanges for unauthorized activity. (This is a repeat recommendation from last year.)* *Recommendation 27: We recommended the Assistant Secretary for Information and Technology implement improved safeguards to prevent data exfiltration from VA networks. (This is a new recommendation.)* *Recommendation 28: We recommended the Assistant Secretary for Information and Technology fully develop a comprehensive list of approved and unapproved software and implement continuous monitoring processes to identify and prevent the use of unauthorized software on agency devices. (This is a repeat recommendation from prior years.)* *Recommendation 29. We recommended the Assistant Secretary for Information and Technology develop a comprehensive software inventory process to identify major and minor software applications used to support VA programs and operations. (This is a repeat recommendation from prior years.)* *Recommendation 30: We recommended the Assistant Secretary for Information and Technology implement procedures for overseeing contractor-managed cloud-based systems and ensuring information security controls adequately protect VA sensitive systems and data. (This is a repeat recommendation from last year.)*				

Table 3: Unimplemented OIG Reports and Recommendations More Than 1 Year Old

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 31: We recommended the Assistant Secretary for Information and Technology implement mechanisms for updating the Federal Information Security Modernization Act systems inventory, including contractor-managed systems and interfaces, and annually review the systems inventory for accuracy. (This is a repeat recommendation from last year.) *Recommendation 2006-03: We recommended the Assistant Secretary for Information and Technology update all applicable position descriptions to better describe position sensitivity levels, and improve documentation of personnel records of "Rules of Behavior" and annual privacy training certifications.* *Recommendation 2006-04: We recommended the Assistant Secretary for Information and Technology ensure appropriate levels of background investigations be completed for all personnel in a timely manner, implement processes to monitor and ensure timely reinvestigations on all applicable employees and contractors, and monitor the status of the requested investigations.* *Recommendation 2006-08: We recommended the Assistant Secretary for Information and Technology reduce wireless security vulnerabilities by ensuring sites have up-to-date mechanisms to protect against interception of wireless signals and unauthorized access to the network, and ensure the wireless network is segmented from the general network.* *Recommendation 2006-09: We recommended the Assistant Secretary for Information and Technology identify and deploy solutions to encrypt sensitive data and resolve clear text protocol vulnerabilities.*				
3/28/2016	**16-00106-211**	**Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia**	**VHA**	**None**
Recommendation 7: We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.				
Total				**$1,133,400,000**

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On the Cover

The original Star-Spangled Banner, which flew over Baltimore's Fort McHenry during bombardment by the Royal Navy in 1814 and inspired the words of our National Anthem, hangs in Flag Hall of the National Museum of American History. September 14, 2014, marks the 100-year anniversary of Francis Scott Key's poem, "Defence of Fort McHenry," which later became the lyrics for "The Star-Spangled Banner." Photo courtesy of the Smithsonian Institution Archives (siarchives.si.edu).

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