



US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT TO CONGRESS

Issue 86 | April 1-September 30, 2021

The "Hand to Hand" quilt was produced by the Artists/Veterans Art Collaborative and Barbara Murak. It represents the diversity of its veteran and collaborating creators and the importance of reaching out to offer support and community.

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL



MISSION

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

VISION

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

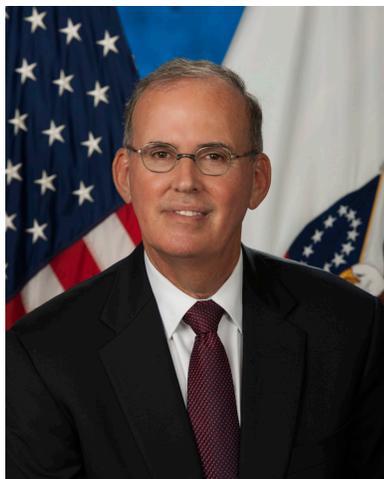
To achieve this vision, the Office of Inspector General (OIG) will

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

VALUES

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

A MESSAGE FROM THE INSPECTOR GENERAL



As I submit this Semiannual Report to Congress on the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the period from April 1 through September 30, 2021, I look back on these past six months as a time marked by tremendous resilience. VA personnel and the OIG staff who conduct oversight of VA's program and operations have forged ahead despite great personal, professional, and external challenges.

VA has continued to navigate the intense healthcare demands of not only veterans, but also those of community members whose hospitals were overrun or under-resourced. It has instituted alternative methods of care delivery, benefits processing and exams, and other services and strategies that have been necessary to adapt to current conditions. VA personnel should be lauded for having worked through exhaustion, natural disasters, and personal risks to provide needed care, services, and benefits to veterans, their families, and communities.

OIG personnel have had to modify our oversight activities in this environment. Virtual site visits, greater reliance on data analytics, and other measures have allowed oversight staff to carefully monitor VA in a stressful and ever-changing landscape. I thank the OIG staff for their outstanding dedication and commitment as they provide effective, fair, and timely oversight during these challenging times.

I had hoped that as we released this report, we would have been talking about recovery efforts and a return to some degree of prepandemic conditions. Although there are indicators we will get there soon, we need to continue to target the impact of the pandemic on VA's programs, operations, and services while also maintaining a focus on less affected functions. Accordingly, included in this report are the OIG's recent efforts to monitor the ongoing quality of VA health care, the timeliness and accuracy of benefits, the security and sufficiency of information technology and other systems, and other VA programs. The 849 OIG recommendations offered during this reporting period are meant to help position VA to minimize the effects of the pandemic on long-term operations while improving its core functions.

In this six-month period, the OIG identified over \$2.9 billion in monetary impact for a return on investment of \$29 for every dollar spent on oversight. For the full fiscal year, the OIG identified nearly \$4.9 billion in monetary impact for a return on investment of \$25 for every dollar spent on oversight. The OIG hotline received and triaged 15,104 contacts in this reporting period (29,233 for the fiscal year) to help identify wrongdoing and concerns with VA activities. Investigators opened 169 investigations and closed 207, with efforts leading to 113 arrests. Collectively, the OIG's work from April through September also resulted in 729 administrative sanctions and actions.

I greatly appreciate the constructive and positive approach VA leaders have shown in working with the OIG. Of particular note, VA Secretary Denis McDonough mandated OIG-developed training for

A MESSAGE FROM THE INSPECTOR GENERAL

all VA employees and new hires on reporting to and engaging with oversight personnel. Finally, I thank members of Congress, VA staff, veterans service organizations, and the veteran community for the unwavering support that is so critical to our work.

A handwritten signature in black ink, appearing to read "Michael J. Missal". The signature is fluid and cursive, with a large, stylized initial "M".

MICHAEL J. MISSAL

Inspector General

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ORGANIZATION PROFILE

THE DEPARTMENT OF VETERANS AFFAIRS



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

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

VA is the second-largest federal employer. For fiscal year (FY) 2021, VA is operating under a \$245.3 billion budget, with over 426,000 employees serving an estimated 19.5 million veterans. VA maintains facilities in every state, the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the US Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit www.va.gov.

THE OFFICE OF INSPECTOR GENERAL



MISSION

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

HISTORY AND STATUTORY AUTHORITY

The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) [Public Law (P.L.) 95-452, as amended]. This Act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of—and to prevent and detect criminal activity, waste, abuse, and mismanagement in—VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The Inspector General has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the Department. In addition, the Veterans Benefits and Services Act of 1988 (P.L. 100-322) charged the OIG with overseeing the quality of

ORGANIZATION PROFILE

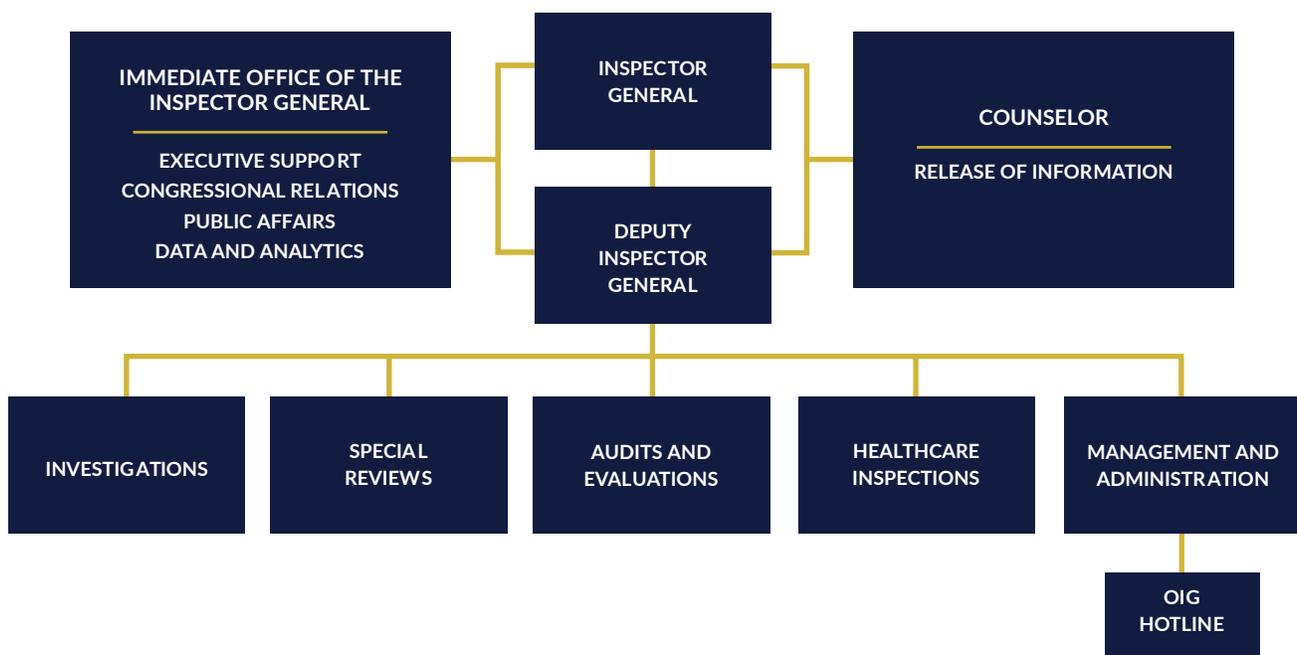
VA health care. Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has over 1,100 staff organized into five primary directorates: the Offices of Investigations, Special Reviews, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). The OIG also has offices for the Counselor to the Inspector General, congressional relations, and public affairs, as well as staff dedicated to executive support and to data modeling and services. The FY 2021 funding from ongoing appropriations provided \$228 million for OIG operations. Congress appropriated an additional \$10 million in supplemental funds as part of the American Rescue Plan to support the OIG's mission in response to the COVID-19 pandemic.

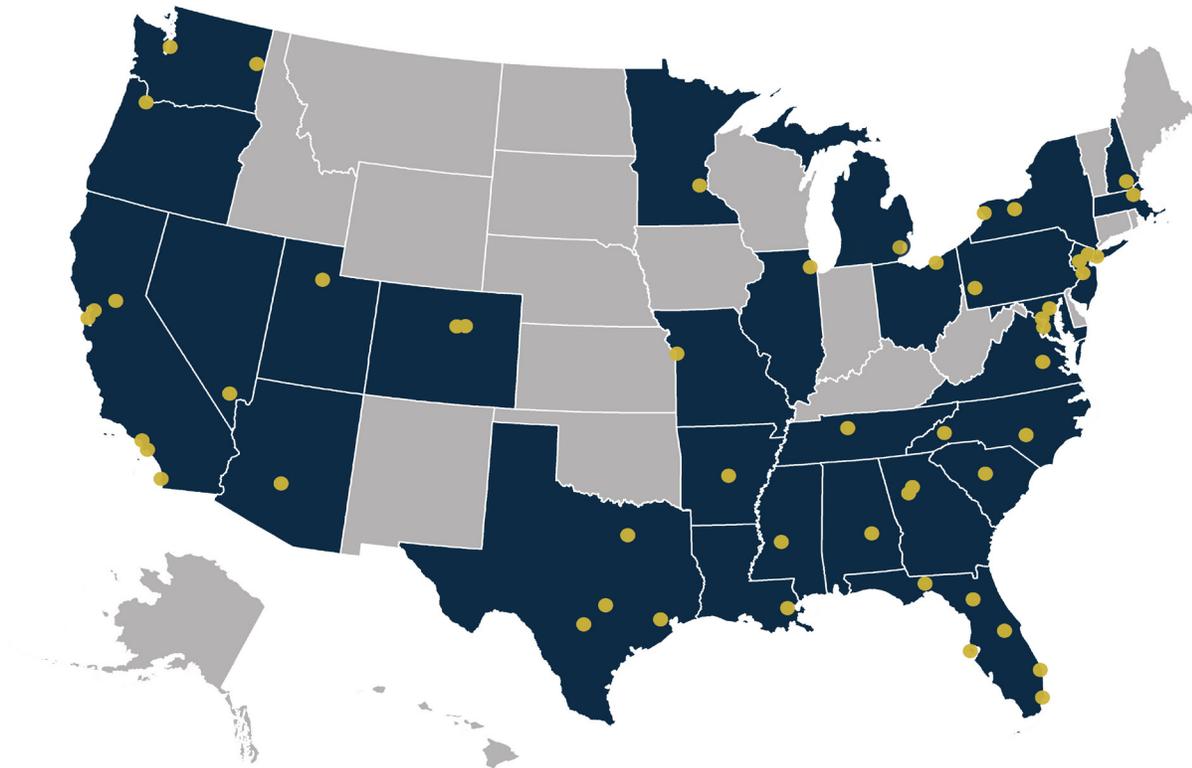
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff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

OIG ORGANIZATIONAL CHART



ORGANIZATION PROFILE

OIG FIELD OFFICES MAP



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

ORGANIZATION PROFILE

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

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

THE OFFICE OF AUDITS AND EVALUATIONS

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

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

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

THE OFFICE OF HEALTHCARE INSPECTIONS

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

ORGANIZATION PROFILE

THE OFFICE OF INVESTIGATIONS

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

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

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

THE OFFICE OF SPECIAL REVIEWS

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

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the IG Act, this Semiannual Report to Congress presents the OIG's accomplishments during the reporting period April 1–September 30, 2021. Highlighted below are some of the activities conducted during this period by the VA OIG's offices, followed by statistical tables that summarize key performance measures. Subsequent sections of the report then feature examples of each office's highly effective publications and priorities. This information is supplemented by appendixes that detail titles of OIG publications released, the monetary impact of OIG products, the status of VA's implementation of recommendations, and OIG reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

This office is staffed by the Inspector General, the Deputy Inspector General, and executive support personnel, including employees preparing reports for public distribution and following up on recommendations. It also includes personnel focused on special projects, congressional relations, data services and modeling, and public affairs. For example, the immediate office staff led an effort this reporting period to complete a mandated training course for all VA employees on how to engage with and properly report wrongdoing to the OIG. The one-time training was launched on September 22 for all VA employees to complete in FY 2022 per a directive from VA Secretary McDonough. A bill was also introduced to maintain the mandate going forward and confer additional authority for the OIG to access the VA's email system, which could be used for all-employee crime alerts, reminders of key resources for employees, and information on employee roles and responsibilities for working with the OIG.

CONGRESSIONAL RELATIONS

The VA OIG actively engages with Congress on critical issues affecting VA programs and operations. During the reporting period, the Inspector General and OIG personnel conducted 84 briefings with congressional members and their staff. Some of the OIG oversight work and recommendations for improvements discussed included

- reviews of VA's actions related to COVID-19 preparedness and responses,
- a healthcare inspection related to suspension of community care for patients being treated for depression,
- an audit of VHA's prescription drug return program,
- reviews related to VHA and VBA's handling of military sexual trauma treatment and claims,



HIGHLIGHTED ACTIVITIES AND FINDINGS

- a review of the failure to locate a missing veteran from a VA community living facility, and
- a review of the circumstances surrounding the death of a veteran residing in a contractor-operated housing program.

OIG staff also fielded 63 inquiries from congressional staff related to constituent matters for review or referral.

DATA MODELING

The Data Modeling Group applied advanced analytics, data visualization, and information synthesis techniques to support proactive oversight of VA programs and operations. During this reporting period, the Data Modeling Group had 63 ongoing projects, created eight new internal data monitoring tools, and made enhancements to several others. The new tools focused on retroactive benefit awards, the procurement of artificial limbs, prescription medications, hospital length of stay, behavioral and suicide risk, and contract cost overruns. The group's efforts included the following developments:

- Procurement-related data-monitoring tools addressing areas such as medications, contracts, and healthcare equipment
- Systems monitoring of transactions including those related to specific types of benefits
- Analytic tools monitoring VA's COVID-19-related activities, including vaccinations, veterans' access to health care, and infections in high-risk settings

PUBLIC AFFAIRS

The OIG is committed to maintaining transparency and to providing accurate and timely information to veterans and their families, the media, veterans service organizations, Congress, VA leaders and staff, and the public. To that end, public affairs staff disseminated report information, news releases, public statements, and congressional testimony to the OIG's many stakeholders. Staff also conducted internal communication projects to help facilitate its oversight work in a largely virtual work environment.

The OIG continued to reach a diverse audience, including expanding its presence on LinkedIn and Twitter by more than 12,500 followers (totaling more than 44,000) by the end of the fiscal year. Staff published 370 updates on reports, hiring activities, and other news that resulted in about 670,000 impressions, and also posted 245 tweets to about 6,000 followers with over 170,000 impressions. These were supplemented by 17 podcasts detailing oversight findings on VA activities.

Staff continue to work with US Attorneys' public affairs offices and other law enforcement partners to release statements and respond to requests for information on criminal investigations. The OIG's work was featured prominently by broadcast and print media outlets that included *Government Matters*, the *New York Times*, *Wall Street Journal*, *Washington Post*, *Military Times*, and *Stars and Stripes*. Among the issues covered were reports on the care and oversight deficiencies related to multiple homicides at a Clarksburg, West Virginia, medical facility and pathology oversight failures at a VA hospital in Fayetteville, Arkansas.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations (OAE) published 42 reports summarizing results from its oversight work, including three VA management advisory memoranda that highlighted concerns requiring VA's prompt attention. Contracting review teams also conducted 58 preaward and postaward contract reviews and six claim reviews to help VA obtain fair and reasonable pricing on products and services. OAE identified potential cost savings of nearly \$330 million and recovered over \$18 million in contract overcharges. Its published reports resulted in 184 recommendations with a potential monetary impact of about \$636 million for the reporting period.



Weaknesses in VA's governance and oversight were identified as affecting many aspects of program performance. OAE reports identified numerous erroneous payments to veterans and organizations that could have been avoided. For example, one report concluded that lack of oversight contributed to benefits-processing delays that led to about \$350 million in VA overpayments. Also, leaders missed opportunities to receive credits under its prescription drug return program, costing VA over \$14.9 million. Improved program oversight would help ensure VA uses taxpayer dollars to their greatest effect in support of eligible veterans' and other beneficiaries' care and services.

OAE also identified potential strategies to improve the management of several key systems at selected VA facilities through its recently initiated series of financial efficiency reviews and information technology (IT) security inspections. The financial review of two facilities identified issues in pharmacy cost management, purchase card use, and administrative labor expenditures. An IT security inspection of the Austin Outpatient Clinic found that VA's Office of Information and Technology did not detect over 85 percent of the clinic's high-severity vulnerabilities (such as risk of loss of data, incursions, data corruption, and threats to the VA system). These reviews and inspections included specific recommendations for corrective action.

Staff's continued work on validating the accuracy of VA's compensation claims processing flagged two areas warranting more attention: (1) a more comprehensive workload management system to complete required downward adjustments to veterans' disability compensation benefits that minimizes delays and overpayments and (2) improvements to the process VA uses to pay veterans to replace or repair clothing if they use a prescription skin medication, or wear or use a prosthetic or orthopedic appliance that damages clothing. The latter report identified that many veterans receiving the benefits no longer met entitlement requirements. VA leaders have revised the handbook on the clothing allowance benefit to include detailed roles, responsibilities, and procedures for determining and monitoring entitlement. This report estimated that VA could save over \$129.7 million over five years if recommendations are implemented. OAE's commitment to creating positive outcomes for the veteran community, VA personnel, and taxpayers drives the reports and recommendations it publishes.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The Counselor's office performed a wide range of activities that included working with the Office of Management and Administration (OMA) to interpret and apply presidential executive orders, guidance issued by the Safer Federal Workforce Task Force, and departmental policies to enhance the safety of VA patients, visitors, and federal employees and to limit the spread of COVID-19. Also, the Counselor's office reorganized itself into four specialized divisions to offer more focused, high-quality legal services to the OIG—information release, audits and investigations, administrative law, and employee relations and reasonable accommodation.

During this reporting period, the Counselor's office provided significant support to several teams from across the OIG as they evaluated various aspects of VA's Electronic Health Record Modernization (EHRM) program implementation. The Counselor's office also

- assisted OAE with several meaningful projects, including projects finding inadequate financial controls related to VA-affiliated nonprofit corporations and identifying improvements needed in military sexual trauma (MST) claims processing and VHA's oversight of COVID-19 supplemental funds;
- approved more than 160 subpoena requests submitted by special agents and worked with OIG criminal investigators and the Department of Justice (DOJ) to develop a memorandum of understanding through which the OIG would gain the services of a Special Assistant US Attorney to focus on prosecuting VA-related healthcare fraud cases;
- dedicated several attorneys to provide legal counsel to Office of Healthcare Inspections (OHI) during its reviews of serious clinical and administrative failures, including reports of events that resulted in the criminal prosecution of a VA healthcare provider for involuntary manslaughter; and
- analyzed VA's lease to an organization that operated a supportive housing program for veterans experiencing homelessness on a VA medical center campus, establishing that VA's Police Service failed in its responsibility to search a stairwell under VA control where a veteran had died (see Office of Special Reviews information below).

Also of note, the office responded to several litigation matters and worked closely with US Attorneys' Offices in federal court proceedings. Staff represented the OIG in matters before the Merit Systems Protection Board and the Equal Employment Opportunity Commission as well. Its Release of Information Office continued to review all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and processed and responded to nearly 500 requests from the public and other government agencies for OIG records. The Employee Relations and Reasonable Accommodation Division responded to 168 inquiries from OIG managers and employees on matters involving employee discipline, performance and grievances, and other day-to-day workforce issues, and responded to 74 requests for reasonable accommodation and 167 inquiries associated with leave administration. The division has also provided critical support to the OIG's efforts to comply with Executive Order 14043, establishing a COVID-19 vaccination requirement for federal employees.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF HEALTHCARE INSPECTIONS

During this reporting period, OHI focused on veterans' access to high quality care during the pandemic, including the continuity of that care. This required flexibility and innovation from OIG staff to conduct meaningful oversight work in a safe yet minimally disruptive manner. It is evident from OHI's published reports that despite the unwavering dedication of so many frontline VA healthcare providers and support staff, their leaders are struggling to create and promote a culture that prioritizes the safety of every veteran they serve.



Patient safety, while a shared responsibility among all who serve in a healthcare setting, is ultimately dependent on proactive and engaged leadership. OHI's CHIP reports focused on leadership stability as well as engagement with staff and patients, as noted during in-depth reviews and analyses of employee survey data and patient safety data trends. OHI's Veterans Integrated Service Network (VISN) reviews described the oversight conducted by VHA's regional leaders that demonstrated their level of support for and relationships with their assigned facilities, including potential gaps in communication. Several OIG hotline reports highlight the effect of VISN and facility leaders' failure to create an environment where staff at multiple levels felt empowered and safe to report on perceived compromises to patient safety. Two recently published reports illustrate the tragic outcome of missed opportunities for staff and leaders to intervene and ultimately prevent veteran deaths. In Fayetteville, Arkansas, an impaired provider misinterpreted pathological specimens for years, resulting in misdiagnoses, inappropriate treatment plans, or no treatment for life-threatening conditions. The dangerous practices persisted due to ineffective documentation and dated quality management practices combined with frustrated and complacent staff. In Clarksburg, West Virginia, compromises to safe hiring practices and quality management reviews, together with lack of collaborative patient care, allowed a nursing assistant to murder seven veterans over the course of eight months.

Mental healthcare services, particularly for high-risk veterans, remain a VHA priority and an ongoing area for OHI oversight work. During this reporting period, CHIP teams reviewed the completion of suicide safety plans for patients and annual suicide prevention training for VHA employees. OHI uncovered issues with the management of patients in acute alcohol withdrawal and those who reported intimate partner violence (IPV). Recognizing that isolation and fragmented mental healthcare delivery during a pandemic have been shown to exacerbate substance abuse and domestic violence, OHI has expanded its reviews of these topics systemwide to help ensure care and services are provided with the appropriate clinical, social, and legal supports. OHI has also expanded its cyclical inspections to include VHA's Readjustment Counseling Service (vet centers). The first several reports highlighted issues related to suicide prevention, care coordination for high-risk populations, staff training, and internal quality reviews.

OHI's review of VA's multibillion-dollar EHRM effort also continued with oversight of training, care coordination, medication management, access to care, medical informatics, and potential risks to patient safety.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF INVESTIGATIONS

Office of Investigations (OI) staff investigate a wide range of potential criminal activity and civil violations of law, including fraud related to VA benefits, construction, education, procurement, and health care; as well as drug offenses; crimes of violence; threats against VA employees or facilities; and cyberthreats to VA information systems. During this reporting period, investigative efforts resulted in 113 arrests, 124 convictions, and over \$1.96 billion in monetary benefits for VA.



OI remained focused on high-impact investigations and coordinated closely with other OIG directorates, external law enforcement entities, and DOJ to successfully address criminal and civil violations affecting VA. The office has worked to meet COVID-19 challenges by creating a stand-alone healthcare fraud division, hiring an investigative counsel to manage the False Claims Act/Program Fraud Civil Remedies Act (FCA/PFCRA) program, and as a member of the VA Health Care Fraud Task Force helping DOJ select a special prosecutor to focus on VA-specific cases. Investigative staff actively participated in DOJ's COVID-19 Fraud Enforcement Task Force, FBI's COVID-19 Fraud Response Working Group, DOJ's Procurement Collusion Strike Force, and the VA/OIG COVID-19 Working Group, all of which work to share information and pool resources to support and advance ongoing pandemic-related investigations.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OMA supports the OIG's overall mission by providing comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency. In this reporting period, OMA had major responsibilities for overseeing execution of the OIG's largest budget to date—\$228 million in ongoing appropriations—which was increased by an additional \$10 million in supplemental funding to further support the work of the OIG. In FY 2021, the office posted more than 270 vacancies, hired and onboarded over 190 external applicants, and promoted or reassigned nearly 85 OIG employees.



The OIG's IT function was restructured by creating four divisions: IT customer support, enterprise systems, information security, and web applications. This restructuring provides comprehensive IT support throughout the organization including

- addressing the day-to-day IT operational needs of OIG employees,
- ensuring systems are operational and meet the needs of users,

HIGHLIGHTED ACTIVITIES AND FINDINGS

- providing direction and support to ensure that OIG systems are secure and meet government standards, and
- assisting in maintaining and developing OIG-specific applications.

During the reporting period, OMA fulfilled 361 data requests to support oversight activities of VA's broad range of healthcare services and benefits programs involving disabilities, pensions, education, housing assistance, and burials. For all of FY 2021, OMA fulfilled a total of 836 data requests.

Finally, OMA is responsible for overseeing the OIG hotline. During FY 2021, the number of staff who support that function was expanded. The increased staffing allows the OIG to review and respond more quickly to the nearly 30,000 complaints received annually.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews (OSR) is staffed with a robust team of investigative attorneys, administrative investigators (including those with prior criminal investigation expertise), forensic auditors, and senior analysts. It focuses on significant incidents and administrative investigations, particularly involving senior VA officials. The office collaborates with other directorates to address complex issues of concern. Staff work on multiple review projects and administrative investigations pertaining to VA programs, operations, and personnel misconduct.

In this reporting period, the office published one report, *Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus*. The report detailed the widespread confusion among VA personnel and weaknesses in policy related to searching the physical area where the long-missing veteran was found dead. Following the OSR team's inquiries, among the changes made were a revised VA policy regarding any missing persons on VA property and plans to ensure responsibilities for other VA properties that are partially leased were properly communicated.

Additionally, the office has successfully worked with VA to close out all of the remaining 22 recommendations from OSR's 2019 report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*. OSR leaders continued to implement its operational plan, designed to focus oversight on VA programs and operations that have the greatest effect on veterans and the public interest. Finally, the office has reorganized and is in the process of hiring staff to add capacity for project supervision, data analysis, e-discovery support, and quality assurance. During this reporting period, staff have taken on several cases assigned by the Inspector General and Deputy Inspector General and continue to work collaboratively with other directorates and other OIGs to review topics and issues of interest that span multiple offices or agencies.

STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE FISCAL YEAR

337 
PUBLICATIONS

222
ARRESTS

214 
CONVICTIONS,
PRETRIAL DIVERSIONS, AND
DEFERRED PROSECUTIONS

8 CONGRESSIONAL
TESTIMONIES



1,381
ADMINISTRATIVE
SANCTIONS AND
CORRECTIVE ACTIONS*

29,233
HOTLINE CONTACTS



\$25:1
RETURN ON
INVESTMENT

1,238
RECOMMENDATIONS
TO VA

\$4,868,487,959
MONETARY IMPACT



 **29**
PODCASTS

*These include results from Hotline and Investigations cases.

STATISTICAL PERFORMANCE

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Better Use of Funds	\$502,238,441	\$290,713,105	\$792,951,546
Dollar Recoveries	\$4,024,712	\$3,514,188	\$7,538,900
Fines, Penalties, Restitution, and Civil Judgments ¹	\$386,609,916	\$755,232,601	\$1,141,842,517
Fugitive Felon Program	\$542,200,000	\$251,300,000	\$793,500,000
Savings and Cost Avoidance	\$1,028,035,415	\$15,058,733	\$1,043,094,148
Questioned Costs	\$481,962,421	\$607,598,427	\$1,089,560,848
Total Dollar Impact	\$2,945,070,905	\$1,923,417,054	\$4,868,487,959
Cost of OIG Operations ²	\$100,961,525	\$92,377,326	\$193,338,851
Return on Investment ³	\$29:1	\$21:1	\$25:1

SCAN HERE FOR
VA OIG HOTLINE



BEA
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VA Inspector General Hotline (53H)

810 Vermont Avenue, NW, Washington, DC 20420

1 This category includes both investigations conducted solely by the VA OIG and joint investigations conducted in partnership with other law enforcement agencies. The amount reported reflects the total monetary recovery to all government entities, nongovernment entities, and private individuals as a result of these investigations. Of the amount reported for this period, VA received \$49,638,141.

2 The six-month operating cost for OHI (\$23,038,075), 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.

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

STATISTICAL PERFORMANCE

TABLE 2: PUBLICATIONS

REPORT TYPE ⁴	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Administrative Investigations	1	3	4
Audits and Reviews	36	15	51
Claim Reviews	6	2	8
Comprehensive Healthcare Inspections	34	7	41
Financial Inspections	2	0	2
Hotline Healthcare Inspections	29	15	44
Information Technology Inspections	1	0	1
National Healthcare Reviews	8	6	14
Postaward Reviews	20	16	36
Preaward Reviews	38	35	73
Special Reviews	0	0	0
Vet Center Inspections	3	0	3
Subtotal	178	99	277
ALTERNATIVE WORK PRODUCTS	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Issue Statements	0	0	0
Management Advisory Memoranda	3	3	6
Subtotal	3	3	6
OTHER PUBLICATION TYPES	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Budget Request	1	0 ⁵	1
Congressional Testimonies	6	2	8
Major Management Challenges	1	0	1
Monthly Highlights	6	6	12
Peer Reviews Completed of Other OIGs	2	1	3
Podcasts	17	12	29
Press Releases	0	0	0
Subtotal	33	21	54
Total	214	123	337

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

⁵ Corrected figure.

STATISTICAL PERFORMANCE

TABLE 3: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	3	3	6
Clinical Consultations to Other Federal Entities ⁶	2	1	3
Hotline Referrals Reviewed	2,301	2,254	4,555

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	15,104	14,129	29,233
Cases Opened	683	527	1,210
Cases Closed	521	636	1,157
Administrative Sanctions and Corrective Actions ⁷	496	571	1,067
Substantiation of Allegations Percentage Rate	41%	39%	40%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	10	12	22
Individuals Provided Office of Special Counsel Contact Information	67	48	115
Individuals Provided Merit Systems Protection Board Contact Information	2	18	20
Individuals Provided Office of Resolution Management Contact Information	104	70	174

⁶ The number of Clinical Consultations to Other Federal Entities is reported separately for the first time in this Semiannual Report to Congress. Last reporting period all clinical consultations were reported under Clinical Consultations to Other VA OIG Offices.

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

STATISTICAL PERFORMANCE

TABLE 5: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE ⁸	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests ⁹	113	109	222
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance ¹⁰	19	5	24
Indictments ¹¹	93	94	187
Indictments and Informations Resulting from Prior Referrals to Authorities	28	41	69
Criminal Complaints	24	21	45
Convictions	124	71	195
Pretrial Diversions and Deferred Prosecutions	13	6	19
Case Referrals to Department of Justice for Criminal Prosecution ¹²	139	137	276
Case Referrals to State and Local Authorities for Criminal Prosecution ¹³	27	21	48
Administrative Sanctions and Corrective Actions	233	81	314
Cases Opened	169	165	334
Cases Closed ¹⁴	207	165	372

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

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

10 This calculation is based on the full list of fugitive felon referrals made to VBA and VHA. Future calculations will be adjusted to reflect the National Crime Information Center categories for which VBA and VHA are taking action.

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

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

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

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

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

OAE produced 42 publications during this reporting period. These focus on issues that have a meaningful impact on veterans' health care and benefits, the effective operations of VA programs and services, and the management of VA resources and taxpayer dollars. The list of all OAE report recommendations for corrective action made during the reporting period can be tracked on the OIG's dashboard at www.va.gov/oig/recommendation-dashboard.asp. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

42

Publications



184

Recommendations

\$636M

Monetary Benefits

FEATURED PUBLICATIONS

The following three publications provide examples of the type of work OAE staff conducts that focuses on identifying problems and making recommendations that can have a significant effect on VA and the veterans it serves. The first report reflects OAE's commitment to overseeing long-term VA efforts that can affect the quality of health care delivered to veterans, the planning for significant IT transitions, and investments of billions of taxpayer dollars. The second report examines preaward contract reviews that can have a significant monetary impact for VA in cost savings. The last highlighted publication underscores the importance of providing veterans with prompt and accurate benefit payments.

UNRELIABLE INFORMATION TECHNOLOGY INFRASTRUCTURE COST ESTIMATES FOR THE ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM

The EHRM program manages VA's transition to a new electronic health record (EHR) system that is interoperable with the Department of Defense's system, allowing care providers to access more comprehensive medical histories for the nine million-plus veterans enrolled in VA health care.

The OIG conducted this audit because of the importance of the modernization program and its extensive costs. The audit assesses whether the Office of Electronic Health Record Modernization (OEHRM) estimated IT infrastructure upgrade costs in accordance with VA standards and Government Accountability Office guidance. The OIG also examined whether OEHRM reported to Congress all costs needed to support the program, including future technology refreshment. This is the second OIG report this year examining VA's development and reporting of cost estimates for infrastructure upgrades needed to support the program.

In this report, the OIG found weaknesses in how OEHRM developed and reported cost estimates. The two \$4.3 billion infrastructure upgrade estimates reported to Congress were not reliable and, because of incomplete documentation, determining the accuracy of the estimates was not possible. The OIG

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

also found VA did not report to Congress other IT upgrade costs of about \$2.5 billion because OEHRM did not include costs other VA agencies would bear. OEHRM also did not update the cost estimates it provided to Congress.

The OIG made six recommendations to help VA ensure an independent cost estimate is performed, reassess and refine the estimate to comply with standards, develop procedures consistent with guidance, disclose to Congress costs for all IT infrastructure upgrades and updates, and formalize agreements with OIT and VHA to identify expected funding contributions from each entity.

Note: OAE also published the EHRM-related report *Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*. See the summary in the section Publications on Acquisition and Procurement Administration and Oversight.

SUMMARY OF FISCAL YEAR 2020 PREAWARD REVIEWS OF HEALTHCARE RESOURCE PROPOSALS FROM AFFILIATES

The OIG reviewed 31 proposals for sole-source healthcare provider contracts in FY 2020 and provided information that VA contracting officers could use to help negotiate fair and reasonable prices. These contracts allow VA to fill, at a fixed price, positions for which it is unable to hire staff. The proposals typically come from VA-affiliated schools of medicine or their associated hospitals or physician practice groups.

The combined estimated contract value of the 31 proposals reviewed was \$209 million. The OIG identified a total of \$81 million in potential cost savings for 29 proposals. As of March 2021, VA contracting officers have awarded 25 of the 31 proposals and have sustained over \$16 million in cost savings.

OIG reviews of the individual contract proposals were not previously published because they contain clinical staff's sensitive personal data. This report summarizes the OIG's prior findings and recommendations in three areas:

- **Costs underlying proposed hourly rates.** For 25 of the 27 proposals reviewed that contained hourly rate pricing, the OIG determined that the prices offered to the government were higher than the supported amounts. Frequently occurring issues included unsupported provider salaries, administrative expenses, fringe benefit amounts, or malpractice insurance premiums.
- **Offered per procedure prices.** The OIG reviewed six proposals with per procedure pricing and determined that they all offered prices higher than the properly calculated Medicare rates.
- **Potential conflicts of interest.** The OIG found potential conflicts of interest for VA personnel for 24 of the 31 proposals reviewed. These personnel held faculty appointments at the affiliated institutions and potentially would also have responsibilities such as monitoring performance of the affiliate's services. In each instance, the OIG recommended the contracting officer request an opinion from VA's Office of General Counsel on whether these individuals would have a financial interest in the proposal.

VBA OVERPAID VETERANS DUE TO DELAYS IN REDUCING COMPENSATION BENEFITS

VBA oversees the disability compensation program, providing veterans with monthly payments because of disabilities that occurred during, or were aggravated by, their military service. VBA's Office of Field Operations (OFO) is responsible for ensuring these benefits are provided effectively and efficiently.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

Sometimes evidence is received that requires decreasing or discontinuing the benefits. These are called proposals to reduce benefits. Veterans are given time to challenge any proposed action while their benefits continue unchanged. Lengthy delays can waste taxpayer dollars in excessive payments that cannot be recouped. The OIG examined whether OFO managed proposals to reduce benefits by minimizing processing delays and excessive payments. The OIG estimated about 88 percent of claims completed during the review period involved processing delays. The delays occurred because the OFO workload distribution strategy prioritized claims involving the granting of benefits. The OIG acknowledges VBA's goal to ensure these claims are given priority over those that reduce or remove benefits. However, the proposed reductions cannot be allowed to increase in a way that results in excessive payments that could be directed to other eligible beneficiaries or allowable uses. If OFO does not develop an effective strategy to manage the workload, delays and excessive payments will continue, resulting in an estimated \$232 million in excessive payments over the next two years. Further, delays may cause unnecessary stress for veterans waiting for final decisions. VBA concurred with OIG recommendations to implement a workload management strategy to distribute and process proposals to reduce benefits that minimizes delays and excessive payments, along with a formal procedure to routinely monitor that strategy. VBA requested closure of the recommendations given changes made since the review, but the OIG will monitor implementation to ensure successful completion.

PUBLICATIONS ON HEALTHCARE ACCESS AND ADMINISTRATION

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

VHA MADE INACCURATE PAYMENTS TO PART-TIME PHYSICIANS ON ADJUSTABLE WORK SCHEDULES

In this report, the OIG examined whether VHA medical facilities managed time and attendance for part-time physicians on adjustable work schedules to ensure salary payments were accurate. Based on a review of 134 agreements ending in 2019, the OIG found VHA medical facilities did not adequately manage time and attendance to ensure physicians were paid correctly for an estimated 44 percent of agreements. This occurred because officials did not make certain that medical facilities complied with policies and procedures. Consequently, the OIG estimated VHA medical facilities had about \$8.3 million in questioned costs that year and an additional \$8.3 million in 2020. The OIG made nine recommendations to strengthen management controls, including completing overdue reconciliations, correcting inaccurate payments, and determining whether Antideficiency Act violations occurred. Recommendations also included ensuring time and attendance records are validated and certified and that physicians do not significantly deviate from their agreements.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

BETTER OVERSIGHT OF PROSTHETIC SPENDING NEEDED TO REDUCE UNREASONABLE PRICES PAID TO VENDORS

In FY 2019, VA provided veterans with about \$318.8 million in medically prescribed prosthetic and rehabilitative items such as artificial limbs, shoes, shoe inserts, and compression garments. The OIG audit was conducted to determine if VHA's oversight ensured medical facilities paid reasonable prices when reimbursing vendors for these items. The OIG found that, because VHA's oversight of prosthetic spending was ineffective, medical facilities sometimes reimbursed vendors at unreasonable rates. Medical facilities spent about \$10 million more than reasonable rates in the six-month period from October 2019 through March 2020. Furthermore, the OIG found that prosthetic spending data was unreliable—about 36,200 transactions in the National Prosthetics Patient Database from October 2019 through March 2020 contained at least one inaccurate data element, including the price paid. The OIG made four recommendations, including monitoring spending to make sure medical facilities reimburse vendors at reasonable prices.

INDEPENDENT REVIEW OF VA'S SPECIAL DISABILITIES CAPACITY REPORT FOR FISCAL YEAR 2019

VA must report annually to Congress on its capacity in five areas: (1) spinal cord injury and disorder, (2) traumatic brain injury (TBI), (3) blind rehabilitation, (4) prosthetics and sensory aids, and (5) mental health. The requirement was established to ensure that VA's capacity to serve disabled veterans does not fall below 1996 levels. The OIG is required to report to Congress on the accuracy of VA's report. The OIG found nothing that caused it to believe the capacity report was not fairly stated and accurate in all material respects, with some exceptions noted. As the OIG previously reported, VA cannot compare current mental health capacity with 1996 capacity because of changes in diagnosis and treatment, service provision, and data collection. The OIG believes that by modernizing reporting metrics, Congress would be better positioned to assess VA's capacity to provide care for today's disabled veterans.

INEFFECTIVE GOVERNANCE OF PRESCRIPTION DRUG RETURN PROGRAM CREATES RISK OF DIVERSION AND LIMITS VALUE TO VA

VHA pharmacies can return prescription drugs that become damaged or expire before use through a reverse distributor for credit or destruction. The audit examined whether VHA was effectively overseeing the drug return program to maximize benefits to taxpayers and ensure drugs waiting to be returned are not diverted or otherwise abused. The OIG found medical facility pharmacy chiefs did not effectively implement the program and did not follow requirements in VA's contract with the reverse distributor, Pharma Logistics. This increased the risk of drug diversion and ultimately put about \$18.1 million at risk. Pharmacy chiefs also did not fully understand the program's requirements. Responsible officials within VHA did not effectively oversee the contract, govern the program, or communicate requirements to medical facilities. The OIG made eight recommendations that included ensuring medical facilities are properly securing and accounting for drugs set aside for return.

OPPORTUNITIES EXIST TO IMPROVE MANAGEMENT OF NONINSTITUTIONAL CARE THROUGH THE VETERAN-DIRECTED CARE PROGRAM

The Veteran-Directed Care (VDC) program provides veterans with a budget to hire caregivers and purchase goods and services that will best meet their care needs and allow them to remain in their homes longer. This audit focused on whether VHA properly budgets and manages the VDC program. The OIG found the program generally addressed veterans' care needs. However, due to program management weaknesses, VHA lacks assurance that veterans are properly monitored, provider agencies are paid

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

correctly, and taxpayer dollars are appropriately spent. The report also identified opportunities to improve VHA medical facilities' management of the program. Recommendations included documenting quarterly monitoring of services veterans receive, improving the provider billing and payment process, and ensuring veterans do not receive the same services through the VDC and Family Caregiver Programs. VHA also should establish procedures to identify staffing needs and track demand for services.

CONTRACTED RESIDENCE PROGRAMS NEED STRONGER MONITORING TO ENSURE VETERANS EXPERIENCING HOMELESSNESS RECEIVE SERVICES

The OIG assessed whether VHA effectively monitored participants in the Contracted Residential Services program, which provides temporary housing and services to veterans experiencing homelessness. The audit team also examined how VHA administered program contracts to ensure veterans received needed services, contractors met the contract terms and conditions, and funds were used appropriately. Report findings include that medical facility staff did not consistently prepare case management documentation for veterans and monitor their progress in the program. Contracting officers also did not always properly delegate responsibilities to staff who functioned as contracting officer's representatives. Another identified issue was that some invoices lacked required supporting documentation. Based on its review of a statistical sample of 14 contracts, the audit team estimated that 107 of 119 contracts had monitoring and administration deficiencies, and that VHA made about \$35.3 million in improper payments. The OIG made five recommendations for corrective action.

INCONSISTENT DOCUMENTATION AND MANAGEMENT OF COVID-19 VACCINATIONS FOR COMMUNITY LIVING CENTER RESIDENTS

While reviewing VHA's plans to document receipt and distribution of the COVID-19 vaccine, the OIG found VHA facilities did not consistently document the COVID-19 vaccination status of veterans living in VA's community living centers (CLCs). The OIG determined in this management advisory memorandum that VHA could not know at a national level whether the vaccine was offered to some CLC residents, and if so, what their status was. Because those residents are in the highest COVID-19 vaccine priority group, they should be offered the vaccine, when possible, before other groups of veterans. With supplies limited, VHA should know which CLC residents still need to be vaccinated. The OIG will continue its oversight work on vaccinations within VHA and plans to issue a full report, including specific recommendations. In the meantime, the OIG requested updates on what action, if any, VHA takes to mitigate the potential risks identified and the outcome of those actions.

MEDICAL FACILITIES FORFEITED DRUG RETURN CREDITS THROUGH INADEQUATE MONITORING OF VENDOR

While auditing VHA's prescription drug return program, the VA OIG found VHA is at increased risk for not receiving all drug return credits. VA ended its contract with national drug return vendor Pharma Logistics in October 2020 but will continue to receive final invoices through at least April 2022. VHA lost at least an estimated \$2.1 million worth of drug return credits because pharmacy chiefs did not always monitor preliminary invoices, reconcile job settlement statements to identify outstanding credits, and request extensions to allow additional time for credit processing. The OIG will continue its oversight work on prescription drug returns within VHA and plans to issue a full report, including specific recommendations. The OIG requests to know what action, if any, VHA takes to mitigate the potential risks identified in this management advisory memorandum and the outcome of those actions.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

PUBLICATIONS ON BENEFITS DELIVERY AND ADMINISTRATION

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

ALLEGED UNAUTHORIZED CONTROL OVER A VA BENEFICIARY'S FUNDS

This review assessed the merits of an allegation made to the OIG hotline regarding misuse of a veteran's funds. The daughter of a now deceased veteran for whom no VA fiduciary was appointed alleged that staff of a state veterans home in California moved her father to a memory care unit without a diagnosis of impaired memory and took control of his funds. The OIG did not substantiate this allegation; a nurse practitioner attested to the veteran's cognitive decline—consistent with a cause of death. Furthermore, the state, not the home, took control of the veteran's assets to recover unreimbursed care costs. The OIG made no recommendations but determined the VBA had not finalized a decision regarding the veteran's ability to manage his benefits payments, which might have led VA to appoint a fiduciary. The OIG addressed this in a separate management advisory memorandum to VA.

ENTITLED VETERANS GENERALLY RECEIVED CLOTHING ALLOWANCE BUT STRONGER CONTROLS COULD DECREASE COSTS

In this audit, the OIG examined VA's annual clothing allowance benefit for veterans who use a prosthetic appliance or prescription skin medication that damages clothing and found VA generally ensured that entitled veterans received their benefits. However, the VHA clothing allowance handbook needs detailed guidance on administering the benefit, including the roles, responsibilities, and functions of all staff involved. The OIG also found that some veterans may no longer meet entitlement requirements. Although most veterans are required to apply each year for benefits, those given recurring status are automatically renewed. If those cases were reevaluated, VA could save an estimated \$129.7 million over the next five years. The OIG recommended the under secretary for health revise the VHA clothing allowance handbook to include detailed entitlement procedures. The under secretary, in collaboration with VBA, should also reevaluate veterans' entitlement to recurring clothing allowance benefits.

COMPENSATION AND PENSION PROCEEDS WERE GENERALLY HANDLED ACCURATELY BUT SOME WERE DELAYED

The OIG audited VBA's handling of proceeds to determine if they were completed accurately and timely. A proceed is an actionable item in the veteran's or beneficiary's record that is created when benefits payments are returned to VA for reasons such as a change of bank account number, a change of address, or a veteran's death. On December 18, 2019, VBA had more than 7,500 open proceeds totaling about \$13 million. The OIG determined that VBA generally handled proceeds accurately but sometimes took more than 90 days to close some proceeds. When a proceed remains open for an extended period of time, the veteran or beneficiary may undergo financial hardship. Proceeds open more than 90 days totaled an estimated \$2.1 million. VBA was called on to set a standard time for closing proceeds and develop oversight and monitoring procedures to ensure proceeds are closed promptly.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

THE OFFICE OF FIELD OPERATIONS DID NOT ADEQUATELY OVERSEE QUALITY ASSURANCE PROGRAM FINDINGS

In 2020, VBA processed about 1.2 million disability compensation claims and paid more than \$90.8 billion in total benefits to about five million veterans. To ensure claims decisions are accurate and consistent so veterans receive the benefits they deserve, VBA established a multifaceted quality assurance program. The OIG reviewed the program and identified a systemic weakness in oversight and accountability by OFO, one of two offices involved. While VBA's quality assurance program routinely identified claims-processing deficiencies and communicated results to stakeholders, OFO did not ensure regional office employees adequately address identified deficiencies. Until VBA leaders ensure improvements are made, veterans may not get the benefits they deserve. The OIG recommended the acting under secretary for benefits develop and implement a written plan to strengthen oversight of the quality assurance program and monitor the plan to ensure identified deficiencies are adequately addressed.

BLUE WATER NAVY OUTREACH REQUIREMENTS WERE MET, BUT CLAIMS PROCESSING AND PROCEDURES COULD IMPROVE

Since 1991, Vietnam veterans in a defined area are presumed to have been exposed to harmful herbicides such as Agent Orange. The Blue Water Navy Vietnam Veterans Act of 2019 extended this presumption to veterans who served within 12 nautical miles of Vietnam. This review examined whether VBA employees (1) notified Navy veterans of their potential eligibility for medical benefits under the act; (2) correctly determined claimants' eligibility for benefits; and (3) made accurate rating decisions on the veterans' claims. Although VBA met its outreach requirements and generally determined veterans' herbicide exposure correctly, VBA had not established procedures for resolving unlikely ship location search results used to help determine eligibility. In addition, approximately 46 percent of VBA's rating decisions were inaccurate from April through June 2020, resulting in about \$37.2 million in improper payments to veterans. The OIG made three recommendations for corrective action.

IMPROVEMENTS STILL NEEDED IN PROCESSING MILITARY SEXUAL TRAUMA CLAIMS

VBA has established special procedures to help veterans support claims for MST when they do not have the evidence usually required. In an August 2018 report, the OIG found that processors did not follow the proper procedures for about half of denied claims, resulting in premature denials. The OIG made six recommendations intended to help VBA fix claims processing deficiencies and better process claims in the future. This report examined whether VBA effectively implemented the OIG's 2018 recommendations and concluded that VBA was not properly implementing them. The acting under secretary for benefits should establish a formal procedure to correct all MST claims-processing errors identified by the OIG, correct continuing deficiencies, and strengthen controls to effectively implement and promote compliance with the OIG's 2018 recommendations. The OIG also recommended VBA strengthen communication, oversight, and accountability for the processing of MST claims.

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



RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

VBA'S FIDUCIARY PROGRAM NEEDS TO IMPROVE THE TIMELINESS OF DETERMINATIONS AND REIMBURSEMENTS OF MISUSED FUNDS

The purpose of the VA Fiduciary Program is to protect beneficiaries who are unable to manage their VA benefits as a result of injury, disease, or advanced age, or because they are under age 18. The OIG examined whether Fiduciary Program staff properly addressed allegations of benefit payments being misused and then reimbursed beneficiaries as required. From January 1, 2018, through September 30, 2019, VBA staff investigated approximately 12,000 allegations of misuse. The OIG did not find systemic issues related to VBA staff's review of allegations. However, the OIG team found instances of significant wait times for staff to determine misuse and negligence and to reimburse misused funds. The team also found that VBA did not adequately monitor all follow-up actions on reported misuse. The OIG made two recommendations to VBA to ensure prompt completion of determinations and reimbursements after December 31, 2017.

PUBLICATIONS ON MANAGEMENT OF FINANCIAL OPERATIONS AND SYSTEMS

Audits and reviews of VA's administrative support functions and financial management operations focus on the adequacy of infrastructure to provide program managers and leaders with the information needed to be good stewards of the funds entrusted to them by efficiently and effectively overseeing and safeguarding VA assets and resources. OIG oversight work satisfies the Chief Financial Officers Act of 1990 (P.L. 101-576) audit requirements for federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

ADAPTIVE SPORTS GRANTS MANAGEMENT NEEDS IMPROVEMENT

VA's Office of National Veterans Sports Programs and Special Events (NVSPSE) granted \$47 million for adaptive sports programs from FY 2017 to FY 2020. Acting on a hotline complaint, the OIG examined whether NVSPSE officials effectively managed the program to ensure compliance with applicable laws and regulations. The OIG found officials were not effectively managing the program and did not always reimburse grant recipients on time. By not closing out grants on time, the NVSPSE also failed to free up about \$346,000 that could have been used for other purposes. It also improperly let recipients spend \$328,000 in FY 2017 appropriations outside the approved period and improperly reimbursed 19 recipients about \$247,000, potentially violating both the Purpose Statute and the Antideficiency Act. The OIG made seven recommendations to improve management of the adaptive sports grants program and to determine whether Purpose Statute or Antideficiency Act violations occurred.

INADEQUATE FINANCIAL CONTROLS AND PAYMENTS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS

VA reimburses affiliated nonprofit corporations for all or part of the salaries and associated costs for research, education, and training. The audit team examined whether VA medical centers have adequate controls for, and provide sufficient oversight of, payments to affiliates. The OIG previously evaluated complaints involving affiliates with five VA medical centers. For this audit, the team also

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

added medical centers in Albuquerque, New Mexico, and Palo Alto, California. The Albuquerque and Palo Alto medical centers made about \$17.9 million in improper payments to affiliated nonprofit corporations. Procedures for approving invoices did not require verifying that the services were provided. The team also noted an absence of required periodic reviews by VA supervisors of approved invoices. Furthermore, VA's Nonprofit Program Office did not note these issues in its triennial reviews. The OIG made three recommendations.

VETERANS CEMETERY GRANTS PROGRAM DID NOT ALWAYS AWARD GRANTS TO CEMETERIES CORRECTLY AND HOLD STATES TO STANDARDS

The OIG audited NCA's governance and oversight of the Veterans Cemetery Grants Program and whether critical noncompliance issues at two Hawaii state cemeteries were addressed. Program staff did not prioritize some grants as regulations required but generally ensured cemeteries used grants for their intended purposes. However, NCA did not make certain cemeteries with grants met all national shrine standards for markers, maintenance, and safety. The audit team observed noncompliance issues at eight state cemeteries, including the Hilo and Makawao cemeteries in Hawaii. As a result, NCA lacks assurance that veterans and family members buried in those cemeteries have been appropriately honored. The OIG made 11 recommendations to the under secretary for memorial affairs to improve management of state cemetery grants and veterans cemeteries. They included NCA continuing to seek increased grant funding and working with Hawaii's government to correct longstanding problems at its eight state veterans cemeteries.

STRONGER FINANCIAL MANAGEMENT PRACTICES ARE NEEDED AT VA'S MARYLAND HEALTH CARE SYSTEM

This report examined whether VA's Maryland Health Care System effectively managed purchases and payments for medical equipment and supplies that support patient care. The team also reviewed fiscal oversight of purchase cards and internal controls governing the use of overtime. The OIG found ineffective processes, internal control weaknesses, and inadequate oversight in five areas. VA concurred with eight OIG recommendations, including implementing controls to ensure proper equipment request submissions and documentation in the enterprise equipment request portal before purchase and payment. The healthcare system's logistics service should also work with the prime vendor to make certain that estimated supply data are timely, accurate, and meet supply requirements, and should correct unit conversion errors to improve inventory accuracy. Purchase cardholders should also comply with record retention requirements, and all staff should be made aware of overtime policies and procedures. Supervisors are called on to effectively monitor overtime worked and to maintain supporting documentation.

INCONSISTENT HUMAN RESOURCES PRACTICES INHIBIT STAFFING AND VACANCY TRANSPARENCY

The audit examined how human resources processes affect VA's reporting of staffing and vacancy data on its public website. In this third legally mandated report, VA was found to have taken actions to address longstanding data integrity concerns with the primary system for reporting staffing and vacancy information. The report identified opportunities for VA to improve the transparency and governance of position data to improve the quality of reported information. The OIG also found VHA delegated much of its data reconciliation to its local facilities, which introduced variability in the process and did

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

not allow for the consistent creation, maintenance, and verification of information. Recommendations included validating inventory data; establishing standards to ensure positions are consistently approved, created, and maintained; and regularly monitoring position management. The OIG also recommended implementing policy and procedures for staffing level approvals and publishing detailed guidance that establishes authoritative position management documents.

REVIEW OF VHA'S FINANCIAL OVERSIGHT OF COVID-19 SUPPLEMENTAL FUNDS

In response to the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the OIG reviewed VHA's tracking and reporting of COVID-19 supplemental funding from pandemic relief legislation. VA met monthly reporting requirements to OMB and Congress on obligations and expenditures and reported weekly to OMB by program activity. The report noted where VA's reporting was not complete and accurate, indicating internal control weaknesses. The OIG concluded the variances affected the quality of reporting. Despite the risks identified, VA performed only a limited summary fund review of its COVID-19 obligations and expenditures before reporting. Given the inherent risks due to outdated financial information technology, VHA was prompted to develop a procedure to ensure information accurately represents the underlying source transactions. This procedure would advance proper accounting for all COVID-19 obligations and expenditures.

FISCAL YEAR 2020 RISK ASSESSMENT OF VA'S CHARGE CARD PROGRAM

The OIG conducted an annual risk assessment of VA's charge card program, evaluating the three types of charge cards—purchase cards (including convenience checks), travel cards, and fleet cards—for transactions during FY 2020. The OIG determined that the purchase card program remains at medium risk of illegal, improper, or erroneous purchases, as in FY 2019 and FY 2018. Data analytics identified potential misuse of purchase cards, and OIG investigations and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation and VA policies and procedures. As for VA's Travel Card Program and Fleet Card Program, the OIG found both remain at low risk for illegal, improper, or erroneous purchases primarily because they had no year-end spending surges but also because they accounted for 1.4 percent and 0.3 percent of VA's FY 2020 spending on charge card transactions.

FINANCIAL EFFICIENCY REVIEW OF THE MIAMI VA HEALTHCARE SYSTEM

The OIG assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Miami VA Healthcare System in Florida. The review focused on four areas: (1) use of the Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program, a collection of contracts that streamlines purchasing for certain medical supplies; (2) use of purchase cards, such as requirements for documenting transactions; (3) the number of administrative staff compared to similar facilities and the accurate recording of labor costs; and (4) efficiency in pharmacy operations, such as inventory management and the healthcare system's efforts to reduce costs. The OIG made 12 recommendations for improving cost efficiency to the healthcare system director. The number of recommendations should not be used, however, to gauge the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations in the areas reviewed.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

REVIEW OF VA'S COMPLIANCE WITH THE PAYMENT INTEGRITY INFORMATION ACT FOR FISCAL YEAR 2020

The OIG determined whether VA complied with the requirements of the Payment Integrity Information Act of 2019 (PIIA) for FY 2020. VA did not comply with PIIA because it did not satisfy two of six requirements

- to meet reduction targets for two programs—Pension and Purchased Long-Term Services and Supports—assessed to be at risk for improper payments, and
- to report an improper payment rate of less than 10 percent for five VA programs and activities that had improper payment estimates in the materials accompanying the annual financial statement.

VA satisfied the other four requirements. The OIG recommended the under secretary for benefits ensure the Pension Program meets its reduction target. The OIG also recommended the acting deputy under secretary for health ensure the Purchased Long-Term Services and Supports Program meets its reduction target and reduces improper payments for five VA programs to below 10 percent.

INADEQUATE BUSINESS INTELLIGENCE REPORTING CAPABILITIES IN THE INTEGRATED FINANCIAL AND ACQUISITION MANAGEMENT SYSTEM

The OIG is conducting an audit to determine whether VA's Financial Management Business Transformation Service identified and addressed issues with a new IT system following its initial deployment at the National Cemetery Administration. The Integrated Financial and Acquisition Management System will be used throughout VA to manage budgetary, financial, and contracting activities. The OIG issued a management advisory memorandum to share observations from the ongoing audit and expects to publish the final report in fiscal year 2022. The audit team found that the National Cemetery Administration was experiencing significant challenges with the system's business intelligence reporting capabilities—for example, reports that show the total funding available for the administration or allow staff to project the funding required to pay employee salaries throughout the year. The OIG requested that the Office of Management inform the OIG what action, if any, the Office of Management takes to address the issued identified.

FINANCIAL EFFICIENCY REVIEW OF THE SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM IN NEW ORLEANS

The OIG assessed the healthcare system's oversight of funds for FY 2019 and identified opportunities for cost efficiency. The review team found that the system (1) fell short of VA's recommended use of a contract program for medical supply purchases and did not always monitor its prime vendor's performance or report performance problems; (2) did not always follow policies and regulations concerning purchase card use, which resulted in possible cost inefficiencies, inadequate oversight of cardholders and transactions, and improper payments of \$140,016; (3) had over 250 more administrative employees than other systems of similar size but has implemented strategies to increase staffing efficiency; and (4) spent approximately \$9 million more on prescription drugs than similar systems but has begun improving efficiency and cost savings. The OIG made six recommendations to the healthcare system director to address the issues identified in this review.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

PUBLICATIONS ON MANAGEMENT OF INFORMATION TECHNOLOGY AND SECURITY

OAE personnel audit and review VA's IT systems and security operations. This work helps determine whether there are adequate policies in place and fully implemented that focus on protecting veterans and VA employees, facilities, and information. These audit reports present VA with recommendations to improve IT management and security. The OIG is also statutorily required to review VA's compliance with the Federal Information Security Modernization Act of 2014 (P.L. 113-283), as well as IT security evaluations conducted as part of the consolidated financial statements audit.

INADEQUATE OVERSIGHT OF CONTRACTORS' PERSONAL IDENTITY VERIFICATION CARDS PUTS VETERANS' SENSITIVE INFORMATION AND FACILITY SECURITY AT RISK

The OIG conducted this review to determine whether VHA contracting officers complied with mandates to ensure contractors account for and return their personnel's personal identity verification (PIV) cards as required, such as at the end of a contract or employment. PIV cards are federally issued credentials used by authorized individuals to gain access to federal facilities and information systems. The Federal Acquisition Regulation (FAR) establishes that it is the contracting officer's responsibility to ensure that contractor employees return all PIV cards they are issued. Unreturned cards increase risks for unauthorized access to VA facilities and information systems. The review team examined a random sample of 46 professional service and healthcare resource contracts. None of the reviewed contracts had adequate evidence to demonstrate FAR requirements were met. VHA contracting officers' noncompliance with PIV card requirements occurred because they were unaware of their responsibilities and the requirements. In addition, VHA did not have policies or procedures detailing supervisory oversight of contracting officers' duties regarding PIV cards, the internal audit office did not review compliance, and there was no automated tool for continuous tracking and monitoring of PIV cards issued to contractors' personnel. The OIG made 10 recommendations to the under secretary for health to address deficiencies related to compliance with requirements for PIV cards issued to contractors' personnel. Recommendations include ensuring all PIV cards are returned prior to contract closeout, outlining specific supervisory responsibilities for contracting officer oversight, and periodically reviewing contract compliance. The OIG also recommended VHA assess whether the existing and planned information systems could have the functionality to allow effective and routine monitoring of contractors' PIV cards or a new system is needed.

VHA NEEDS MORE RELIABLE DATA TO BETTER MONITOR THE TIMELINESS OF EMERGENCY CARE

VHA emergency departments measure timeliness using software that records how quickly patients move through a facility. The OIG audited this data because accurate recording is necessary to providing quality services for the 2.3 million patients who receive VA emergency care in a year. The report detailed that the data were inconsistently entered and contained inaccuracies, including possible data manipulation at the Baltimore VA Medical Center, which affected records of about 30 percent of total patient visits at that department. The OIG also found that data and evidence in health records indicated patients with the most critical needs did not always receive care within VHA timelines. The OIG made five recommendations to improve oversight of VHA's emergency departments, including ensuring the Baltimore facility reevaluates its corrective action plan, making certain that staff receive training on

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

recording triage times, strengthening reliability reviews to improve data accuracy, establishing routine oversight for data reliability, and monitoring the highest-risk patients.

INSPECTION OF INFORMATION TECHNOLOGY SECURITY AT THE VA OUTPATIENT CLINIC IN AUSTIN, TEXAS

The inspection focused on whether the VA Outpatient Clinic in Austin, Texas, was meeting federal guidance in four areas related to configuration management, physical security, security management, and access controls. The inspection team identified security deficiencies in the clinic's configuration management controls related to component inventory and vulnerability and patch management. VA's OIT did not detect 150 of the 246 vulnerabilities the team identified. The team also discovered media protection deficiencies when three hard drives that potentially held personally identifiable information and personal health information were not labeled or processed for sanitization. Without these controls, VA may be placing critical systems at unnecessary risk of unauthorized access, alteration, or destruction. The OIG recommended maintaining an accurate inventory, implementing a more effective patch and vulnerability management program, distributing the media protection standard operating procedure, and ensuring compliance with the procedure's labeling and sanitization provisions.

IMPROVEMENTS NEEDED IN ADDING NON-VA MEDICAL RECORDS TO VETERANS' ELECTRONIC HEALTH RECORDS

This report evaluated whether VA's community care staff accurately uploaded records for non-VA medical care to veterans' electronic health records. These records enable continuity of care by VHA providers and inform treatment decisions. The audit team found that the VHA medical facilities using community care staff to index or categorize non-VA medical records did not comply sufficiently with VHA requirements. Errors included using ambiguous or incorrect document titles, indexing records for non-VA care to the wrong referral or veteran, and entering duplicate records. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, and a lack of facility-level policies. Inaccurate indexing poses a risk to veteran care and increases the burden on the VHA staff who need to locate and correct the errors. The OIG made two recommendations to the under secretary for health to address the issues identified.

PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS: IT SYSTEM DEVELOPMENT CHALLENGES AFFECT EXPANSION

The Program of Comprehensive Assistance for Family Caregivers provides benefits for caregivers of eligible veterans. The VA MISSION Act of 2018 expanded program eligibility from veterans injured after 9/11 to include veterans injured in any conflict. A prerequisite to expansion is an IT system that fully supports the program. The OIG assessed VA's efforts to implement that system. Although the OIG recognizes VA's efforts and challenges as millions of veterans may now be considered for the program, VA did not meet the act's deadlines for implementing and reporting on the system. It lacked effective governance and leadership when upgrading and replacing the legacy system. The new IT system, the Caregiver Record Management Application (CARMA), was fully implemented on October 1, 2020. Although CARMA meets the act's requirements, VA did not establish its appropriate security risk category and fully assess privacy vulnerabilities. Four recommendations were made for VA corrective action.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

FEDERAL INFORMATION SECURITY MODERNIZATION ACT AUDIT FOR FISCAL YEAR 2020

The OIG contracted with CliftonLarsonAllen LLP (CLA) to evaluate VA's information security program compliance with the Federal Information Security Modernization Act for FY 2020. CLA evaluated 48 major applications and general support systems hosted at 24 VA sites. CLA concluded that VA continues to face significant challenges meeting requirements and made 26 recommendations. Two recommendations from previous years were closed and three new ones were added. CLA recommended VA address security-related issues that contributed to reported IT material weaknesses and improve deployment of security patches, system upgrades, and system configurations to reduce significant security vulnerabilities and enforce a consistent process across all field offices. CLA also recommended VA improve performance monitoring to ensure controls operate as intended at all facilities and communicate identified security deficiencies to mitigate significant risks. CLA will follow up on the outstanding recommendations in the FY 2021 audit of VA's information security program.

PUBLICATIONS ON ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT

The OIG audits and reviews VA's acquisition processes and oversight operations. These reports provide insight into the challenges of a large, decentralized purchasing system, in which a variety of offices play significant roles. Compliance with the FAR (as well as title 48 C.F.R.) and VA's internal acquisition regulations ensures VA staff and veterans receive the best supplies and services in a timely manner. The recommendations in these reports present VA with constructive means to improve the acquisition and procurement processes.

DEFICIENCIES IN REPORTING RELIABLE PHYSICAL INFRASTRUCTURE COST ESTIMATES FOR THE ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM

VA is spending billions of dollars to replace its aging EHR system to capture more comprehensive medical histories for millions of veterans. The new system requires medical facility physical infrastructure upgrades, including electrical and cabling. This report details OIG findings that VHA's cost estimates for these upgrades did not fully meet VA standards for being comprehensive, well-documented, accurate, and credible. The OIG projected that VHA's June and November 2019 estimates were potentially underestimated by as much as \$1 billion and \$2.6 billion, respectively. The OEHRM also did not include VHA physical infrastructure cost estimates in statutorily mandated reports to Congress, stating it was not within OEHRM's responsibility to report. VA concurred with the OIG's five recommendations and in its comments to the report agreed that the costs associated with these upgrades will be transparently disclosed to Congress.

VA'S MANAGEMENT OF LAND USE UNDER THE WEST LOS ANGELES LEASING ACT OF 2016: FIVE-YEAR REPORT

The West Los Angeles Leasing Act of 2016 requires land use of the West Los Angeles campus to principally benefit veterans and families. The OIG found that VA has made little progress in implementing the draft master plan that would provide housing for 1,200 veterans due to required environmental impact studies, needed infrastructure upgrades, difficulties establishing a principal developer

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

enhanced-use lease, and fundraising challenges. As of July 2021, VA had only 55 of the 480 housing units available—11 percent of the four-year target. Additionally, the OIG identified seven noncompliant land-use agreements. While a 2018 OIG audit identified two of these seven agreements, VA has not yet taken sufficient corrective action. The OIG recommended VA implement a plan to bring the five new land-use agreements into compliance and ensure its capital asset inventory accurately reflects all land-use agreements lasting six months or longer.

CONTRACTING OFFICER WARRANTING PROGRAM MEETS FEDERAL REQUIREMENTS BUT COULD BE STRENGTHENED

In FY 2020, VA's contracting officers obligated approximately \$36.9 billion for goods and services required for veteran care and support. A warrant gives federal contracting officers the authority to obligate taxpayer dollars for procuring goods and services. While VA's contracting officer warrant program complies with FAR requirements, it may not fully mitigate the risks associated with contracting officer warrants. VA needs to thoroughly justify warrants, gather data to effectively distribute contracting officers' workload, and institute guidance to help determine when and how to reinstate warrants to individuals with past performance issues. Finally, VA should improve consistency for how warrant boards conduct their activities. The OIG made three recommendations to strengthen VA's warrant program, to include assessing the warrant justification template, determining whether additional procedures to monitor contracting officer workload should be implemented, and identifying updates to policies to increase consistency.

EXCESS PURCHASE OF SURGICAL SUPPLIES AND IMPROPER PURCHASE CARD TRANSACTIONS AT THE NEW ORLEANS VA MEDICAL CENTER IN LOUISIANA

The OIG evaluated an August 2019 hotline complaint alleging mismanagement of supplies, equipment, and operating rooms while activating the New Orleans VA Medical Center in Louisiana. The OIG substantiated that the medical center purchased about \$1.85 million in excess surgical supplies. Employees also violated VA policies by not properly accounting for or advertising the excess supplies to other facilities. Employees violated the FAR and VA financial policy when they used purchase cards instead of contracts to obtain supplies. The OIG recommended the Southeast Louisiana Veterans Health Care System director account for undocumented excess supplies, determine if action should be taken on some \$675,000 in missing supplies listed in a report of survey, and ensure identified FAR violations are reported and appropriately ratified. The director should also make certain that employees obtain guidance when they are uncertain about proper use of government purchase cards.

MEDICAL/SURGICAL PRIME VENDOR CONTRACT EMERGENCY SUPPLY STRATEGIES AVAILABLE BEFORE THE COVID-19 PANDEMIC

VA's demand for personal protective equipment (PPE) increased dramatically during the COVID-19 pandemic. The OIG reviewed emergency contingency supply plans by the MSPV-NG program's prime vendors and whether medical facilities took advantage of those options. All four prime vendors developed contingency plans that included an advance-order list. Three also offered options to purchase and store medical supplies in advance. However, the OIG found none of the 16 medical facilities assessed used those emergency strategies. Most facility leaders did not know those plans existed. Most facilities reported maintaining their own contingency stocks; however, staff eventually had to buy supplies on the open market where they paid higher prices. Recommendations included educating chief logistics officers on prime vendors' contingency plans, and ensuring they understand how those plans can help mitigate

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

supply shortages. The OIG also recommended clarifying the intent of the emergency and continuous supply provisions in the MSPV-NG contracts.

USE AND OVERSIGHT OF THE EMERGENCY CACHES WERE LIMITED DURING THE FIRST WAVE OF THE COVID-19 PANDEMIC

The OIG assessed how effectively VA managed its emergency caches during the first wave of the COVID-19 pandemic in early 2020. These caches contain a standard supply of drugs and medical supplies, including personal protective equipment, for use during a pandemic. The review team found that only nine of 144 medical facilities activated their emergency caches from February through June 2020. Medical facility directors reported that they did not need the supplies or that the quantity was not sufficient for a pandemic. In addition, VHA changed the process for mobilizing caches during the pandemic but did not communicate this clearly to medical facility directors. The review team also identified problems with cache maintenance and monitoring, such as expired or missing personal protective equipment and incomplete documentation on cache activations. The OIG made three recommendations to the undersecretary for health to improve the use and oversight of the emergency caches.

REVIEWS OF VA CONTRACTS AND VENDOR PROPOSALS

The OIG also provides VA's Office of Acquisition, Logistics, and Construction (OALC) with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for OALC contracting activities and conducts healthcare preaward reviews for VHA. OIG issued 64 of these types of unpublished reports during this reporting period. These reports are released only to the contracting officer because of the proprietary and privacy information they contain. However, in the interest of transparency, OIG published two reports summarizing the issues identified in some of these unpublished reviews, one for FSS pharmaceutical preaward reviews (below) and another for healthcare services preaward reviews (described in the Featured Publications section on page 14).

A SUMMARY OF PREAWARD REVIEWS OF VA FEDERAL SUPPLY SCHEDULE PHARMACEUTICAL PROPOSALS ISSUED IN FISCAL YEAR 2020

The OIG reviews proposals submitted to VA for FSS pharmaceutical contracts valued annually at \$5 million or greater. These reviews help VA contract specialists negotiate fair and reasonable prices for the government and taxpayers. Individual reviews are not published because they contain sensitive commercial information. To promote transparency, the OIG issued a report summarizing the reviews of pharmaceutical contract proposals conducted in FY 2020. The 15 proposals had a cumulative 10-year estimated contract value of approximately \$10 billion and included a total of 515 offered drug items. This OIG report detailed how many proposals were accurate, complete, and current, and summarized pricing and prior recommendations for those that were not. It did not include additional recommendations for VA response. Contract specialists have completed negotiations on the proposals, and the OIG's recommendations collectively resulted in approximately \$42 million in savings for VA.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

Preaward Reviews

As mentioned earlier, 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-eight preaward reviews identified over \$329 million in potential cost savings during this reporting period. In addition to FSS and Architect/Engineer Services proposals, preaward reviews during this reporting period included 14 healthcare provider proposals, accounting for approximately \$38.3 million of the identified potential savings.

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the Veterans Health Care Act of 1992 (P.L. 102-585) for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over \$18.5 million, including approximately \$2.7 million related to compliance with the Veterans Health Care Act's pricing requirements, recalculation of federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 20 postaward reviews performed, 13 involved voluntary disclosures. In nine of the 13 voluntary disclosure reviews, OIG identified additional funds due. VA recouped 100 percent of the recommended recoveries for postaward contract reviews. Because these reports contain proprietary and privacy information, they are released only to the contracting officer.

Claim Reviews

The OIG assists contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, the OIG reviewed six claims and determined that \$557,781 of claimed costs were unsupported and should be disallowed.

Government Audit Contract Findings

The IG Act, as amended by the National Defense Authorization Act for FY 2008 (P.L. 110-181), requires each Inspector General to submit an appendix on final, completed contract audit reports issued to the contracting activity (agency component) that contain significant audit findings—unsupported, questioned, or disallowed costs in excess of \$10 million, or other significant findings—as part of the semiannual report. The following report is exempt from publication but highlights the VA OIG's work in this area.

REPORT NUMBER	NATURE OF REVIEW	ISSUE DATE	MONETARY IMPACT
20-02933-238	Vendor's Compliance with Medical Disability Examination Billing Requirements	8/17/2021	\$11,724,146

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, OHI published eight national healthcare reviews and 29 inspection reports responsive to OIG hotline complaints on topics that are related to VHA operations and the access to and quality of care provided to patients. They addressed a broad range of topics such as mental health care, pharmacy deficiencies, care coordination, CLCs, and leadership. The office also published 34 CHIP reports, which resulted from unannounced OIG inspections of VA facilities' key clinical and administrative processes that are associated with promoting positive healthcare outcomes for veterans. Additionally, the office published three Vet Center Inspection Program (VCIP) reports, which are examinations of community-based clinics that provide a range of services to veterans and active-duty service members. OHI recommendations for corrective action are detailed at www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

74

Publications



2,301

Hotline Referrals Reviewed

5

In-Depth Clinical Consultations

FEATURED PUBLICATIONS

Highlighted below are four OHI publications that focus on issues and recommendations that can have a significant impact on VA programs and processes, and veterans' timely access to quality care delivered with compassion and respect.

The first of the highlighted publications details the misconduct of a former VA pathology and laboratory medicine chief, as well as the failure of facility leaders to address signs of his alcohol impairment and promote a culture of accountability. The second report evaluates the quality of care delivered at four vet centers and the third report focuses on inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System. The second report represents a new cyclical inspection program started in fiscal year 2021 that focuses on vet centers, while the third report is an example of OHI's comprehensive inspections completed at each VHA facility about every three years. The final featured publication addresses the challenges faced by MST coordinators at VHA facilities and the culture of safety for patients requesting MST-related care.

PATHOLOGY OVERSIGHT FAILURES AT THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS IN FAYETTEVILLE, ARKANSAS

The OIG initiated a healthcare inspection in spring 2018 after receiving allegations that former pathology and laboratory medicine service chief Dr. Robert Levy misdiagnosed pathological specimens and altered quality management documents to conceal errors at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas. The OIG substantiated the allegations. After a comprehensive, retrospective

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

review of cases, Dr. Levy interpreted over his 12-year tenure (almost 34,000 cases), clinical reviewers identified more than 3,000 diagnostic errors. The need for disclosures of errors causing serious injury was identified for 34 patients. As service chief of a specialty care department with only one other pathologist and as chairperson of three pathology quality management committees, Dr. Levy had the opportunity to subvert the quality process. Facility leaders failed to recognize his manipulation of quality data. Dr. Levy admitted to long-term alcohol use. The OIG found that facility leaders missed opportunities to address signs of an impairment. The failure of facility leaders to promote a culture of accountability likely led to minimal reporting of Dr. Levy's signs of impaired behaviors. The OIG made 10 recommendations to the under secretary for health related to competency and pathology quality management processes, pathology reports, and the consulting process with external pathologists. The OIG also recommended the Office of General Counsel and the Office of Human Resources and Administration/Operations, Security, and Preparedness be consulted about administrative actions for VHA leaders, as appropriate. Two recommendations focused on alcohol testing and management of impaired healthcare workers. Two recommendations to the facility director addressed lack of peer references during reappraisal and evaluation of the facility's psychological safety climate. The inspection was completed after the OIG Office of Investigations conducted a criminal investigation. As of January 2021, Dr. Levy was sentenced to 20 years in prison for manslaughter and mail fraud.

VET CENTER INSPECTION OF SOUTHEAST DISTRICT 2 ZONE 2 AND SELECTED VET CENTERS

The OIG VCIP provides a focused evaluation of aspects of the quality of care delivered at vet centers. This report focuses on Southeast district 2 zone 2 leadership and operations at four selected vet centers: Clearwater, Ocala, and Sarasota in Florida; and Ponce in Puerto Rico. The OIG inspection focused on six review areas: leadership and organizational risks; quality reviews; COVID-19 response; suicide prevention; consultation, supervision, and training; and environment of care. Generally, district leaders had a good understanding of quality improvement principles and implemented district-wide quality improvement programs in response to the VA all-employee survey results. District 2 zone 2 Vet Center Service customer feedback survey results exceeded national scores. The inspection team conducted an analysis of vet center quality reviews required to ensure compliance with policy and procedures. The OIG made four recommendations for clinical and administrative quality reviews and two recommendations for critical incident quality reviews. The COVID-19 response review showed that, although initially feeling ill-equipped, district leaders enacted emergency plan procedures and vet centers remained operational. Employees' response to an OIG questionnaire indicated the pandemic response was well managed by district leaders and vet center directors. The suicide prevention review included a zone-wide evaluation of electronic client records, and a focused review of the four selected vet centers. The OIG issued 10 recommendations—four specific to client records and six for selected vet centers' suicide prevention and intervention processes. The consultation, supervision, and training review evaluated the four vet centers. The inspection team identified concerns with external clinical consultation, supervision, and training that led to four recommendations. The environment of care review evaluated the four vet centers and resulted in two recommendations. The OIG issued a total of 22 recommendations for improvement, including three to the under secretary for health and 19 to the district director.

COMPREHENSIVE HEALTHCARE INSPECTION OF THE EASTERN OKLAHOMA VA HEALTH CARE SYSTEM IN MUSKOGEE

This CHIP report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System. The inspection covered key clinical and administrative processes that are associated with promoting quality care. It focused on leadership

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

and organizational risks; COVID-19 pandemic readiness and response; quality, safety, and value; registered nurse credentialing; medication management, specifically remdesivir use in VHA; mental health with a focus on suicide risk; screening and evaluation; care coordination, specifically interfacility transfers; and high-risk processes that apply to management of disruptive and violent behavior. At the time of the OIG virtual review, all leadership positions were permanently filled. Survey data revealed opportunities to improve employee perceptions of leadership, reduce feelings of moral distress at work, and reduce fears of retaliation. Patient experience survey data highlighted a need to address outpatient care experiences. The OIG identified concerns with institutional disclosures for sentinel events and issued nine recommendations for improvement in four areas.

CHALLENGES FOR MILITARY SEXUAL TRAUMA COORDINATORS AND CULTURE OF SAFETY CONSIDERATIONS

The VA OIG conducted a review of select activities and challenges facing MST coordinators and VISN points of contact in response to a request from Congressman Chris Pappas, Chairman of the House Veterans' Affairs' Subcommittee on Oversight and Investigations, and Congresswoman Julia Brownley, Chairwoman of the Women Veterans Task Force. The OIG also reviewed the culture of safety for patients requesting MST-related care. Sexual trauma experienced while serving in the military affects both women and men with potentially serious and long-term consequences. Psychological trauma, such as MST, also increases risk of physical health conditions such as cardiovascular disease, stroke, and diabetes. VHA requires that each facility have a designated MST coordinator with at least 20 percent of their time dedicated to protected administrative time. The OIG conducted a national survey and interviews to evaluate MST coordinators' duties and perceived challenges. Approximately 80 percent of the respondents reported having been assigned at least 20 percent or more of protected time. Thirty-nine percent reported inadequate resources to fulfill MST coordinator administrative responsibilities. Based on an analysis of survey results and interview information, the OIG found that insufficient protected administrative time, role demands, understaffing of support personnel, and inadequate funding and outreach materials challenged MST coordinators' ability to fulfill role responsibilities. Additionally, the OIG found that MST coordinators who reported more dedicated time than other MST coordinators did not necessarily serve at facilities with higher numbers of patients in MST-related care. The OIG made one recommendation to the under secretary for health to evaluate the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of MST coordinators' responsibilities, and take action as warranted.



Listen to the OIG's [companion podcast](#) for this report.

NATIONAL HEALTHCARE REVIEWS

National healthcare reviews focus on VHA programs, activities, or functions from a systemwide perspective. Such reviews may be used to provide factual and analytical information, monitor compliance with established criteria and standards, measure performance, assess the efficiency and effectiveness of programs and operations, or identify and share best practices within VHA facilities. National reviews may be mandated or requested by Congress or initiated by the OIG.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

REVIEW OF COMMUNITY-BASED OUTPATIENT CLINICS CLOSED DUE TO THE COVID-19 PANDEMIC

This report reviewed VHA community-based outpatient clinic (CBOC) closures that occurred due to the COVID-19 pandemic to evaluate the impact of these closures on patient care. Of VHA's 1,031 CBOCs, 173 were closed to face-to-face visits on or after February 1, 2020. Reasons for closure fell into four categories, including (1) safety of patients and staff due to community spread, (2) need for consolidation of resources to support larger CBOCs or facilities, (3) lack of staff and PPE, and (4) small size of the CBOC or proximity to other CBOCs or facilities. The OIG concluded that, generally, patient care needs were not interrupted due to CBOC closures. Clinicians triaged patients and offered other care delivery options such as telephone visits; VA Video Connect, which allows veterans and caregivers to meet with VA healthcare providers through live video on any electronic device with an internet connection; rescheduled appointments for a later date; or outpatient visits at the parent facility. The OIG made no recommendations.

DEFICIENCIES IN EMERGENCY PREPAREDNESS FOR VETERANS HEALTH ADMINISTRATION TELEMENTAL HEALTH CARE AT VA CLINIC LOCATIONS PRIOR TO THE PANDEMIC

The OIG reviewed 58 VHA outpatient clinics' emergency preparedness and evaluated the delivery of telemental health care as of November 1, 2019. The review focused on clinic-specific emergency procedures, defined emergency procedure roles and responsibilities, staff emergency contact information, and patient safety reporting methods. This review excluded telemental health delivered in patients' homes and in non-VA clinic settings. The OIG identified issues related to (1) missing telehealth emergency plans and procedures; (2) emergency procedures not specific to telehealth care or patients' clinic locations; (3) lack of a process for annual updates to telehealth emergency procedures; (4) undefined emergency procedure roles and responsibilities for telehealth staff; (5) insufficient emergency contact information; (6) lack of a process to verify and communicate emergency contact information; and (7) lack of a consistent process to designate the telehealth setting in patient safety reporting methods. Five recommendations were made.



Listen to the OIG's
[companion podcast](#)
for this report.

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

This CHIP report provides a focused evaluation of VISN 19 facilities' COVID-19 pandemic readiness and response. This evaluation focused on emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; CLC patient care and operations; facility staff feedback; and VA and VISN 19 vaccination efforts. The OIG has aggregated findings on COVID-19 preparedness and responsiveness from routine inspections to ensure prompt dissemination of information given the quickly changing landscape as infection rates and demands on facilities continually shift. Findings of inspected medical facilities are grouped by VISN, which are regional offices that provide oversight of medical centers in their area. This report, the second in a series, describes findings on COVID-19 practices from healthcare inspections performed within VISN 19 during the weeks of November 30 and December 7, 2020. It also provides a more recent snapshot of the pandemic's demands on these facilities' operations based on data compiled as of April 2021. Interviews and survey results provide additional context on lessons learned and perceptions of both preparedness and response. This report also provides data that illustrate the tremendous COVID-19-related demands on VA healthcare services. It describes leader and staff experiences, assessments, shared sentiments, and best practices to help improve operations and clinical

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

care during public health crises. At the time of the inspections, VHA and the VISN were experiencing the highest number of cases since the beginning of the pandemic and had valuable information to share about their experiences.

REVIEW OF VETERANS HEALTH ADMINISTRATION STAFFING MODELS

Congress directed the OIG to review VHA progress in developing a comprehensive staffing model. While VHA reported that staffing models exist for all occupations, VA plans to develop the first iteration of staffing models that will determine staffing requirements by FY 2022. VA and VHA define staffing models differently, and the associated program office directors reported inconsistent staffing model roles and responsibilities. Limited personnel capacity was reported as a barrier to the development, validation, and implementation of staffing models. The OIG made three recommendations to the VHA under secretary for health to coordinate with VA to review roles, responsibilities, and number of staff required to develop, validate, and implement VHA staffing models; evaluate the status and provide a timeline to develop, validate, and implement staffing models; and evaluate the status and provide a timeline to implement in policy the requirements related to HR Smart, VA's human capital system of record for positions.

OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES FISCAL YEAR 2021

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and nonclinical occupations experiencing staffing shortages within VHA. In this eighth staffing report, the OIG evaluated severe occupational staffing shortages and compared this information to the previous three years. The OIG found 98 percent of facilities identified one or more severe occupational staffing shortages. Every year since 2014, medical officer and nurse occupations were identified as severe shortages. Within the medical officer occupational series, psychiatry was the most frequently identified clinical severe staffing shortage. Medical support assistance was the most frequently identified nonclinical severe staffing shortage. Since FY 2018, the overall number of severe occupational staffing shortages decreased from 3,068 to 2,152. Similarly, the number of occupations reported by at least 20 percent of facilities decreased from 30 to 19. The OIG made no recommendations.

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT: EVALUATION OF QUALITY, SAFETY, AND VALUE IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

This report on VHA facilities provides a focused evaluation of their quality, safety, and value (QSV) programs. The evaluation examined committee processes for QSV oversight functions, protected peer reviews of clinical care, utilization management, and patient safety. QSV-related findings are presented from healthcare inspections performed at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The OIG reviewers evaluated meeting minutes, protected peer reviews, root cause analyses, annual patient safety reports, and other relevant documents. The results in this report are a snapshot of VHA performance at the time of the FY 2020 reviews. Facilities generally complied with many of the selected requirements. However, the OIG identified weaknesses in various key QSV functions, noted repeat deficiencies from FY 2018 and 2019 QSV evaluations, and issued four recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT: EVALUATION OF HIGH-RISK PROCESSES IN VETERANS HEALTH ADMINISTRATION FACILITIES, FISCAL YEAR 2020

Another summary CHIP report on VHA facilities evaluated their reusable medical equipment (RME) programs. This evaluation focused on facility sterile processing services (SPS) work with RME related to administration, quality assurance, and staff training. The report describes RME-related findings from healthcare inspections performed at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The OIG reviewers examined relevant documents and training records, observed reprocessing and storage areas, and interviewed key managers and staff. The results in this report provide a snapshot of VHA performance at the time of the FY 2020 reviews. The report details general compliance with many of the selected requirements. However, the OIG identified weaknesses in various key RME-related processes and issued seven recommendations.

HEALTHCARE INSPECTIONS

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

INSUFFICIENT VETERANS CRISIS LINE MANAGEMENT OF TWO CALLERS WITH HOMICIDAL IDEATION, AND AN INADEQUATE PRIMARY CARE ASSESSMENT AT THE MONTANA VA HEALTH CARE SYSTEM IN FORT HARRISON

This inspection evaluated Veterans Crisis Line (VCL) responses to a caller (caller 1) with homicidal ideation and another caller (caller 2) with suicidal and homicidal ideation, and caller 1's primary care at the VHA facility. The OIG substantiated that a VCL responder failed to assess caller 1's homicidal risk factors, address lethal means, complete an adequate safety plan, communicate critical information to a supervisor, and take actions to prevent a family member's death. The OIG also substantiated that two VCL social service assistants failed to dispatch emergency services for caller 2 following a rescue request. The OIG identified deficiencies in social service assistant oversight. A facility provider failed to include caller 1's mental health diagnosis in the assessment and did not submit caller 1's non-VA medical records for scanning or document a review. The OIG made 11 recommendations regarding quality management, review of the callers' contacts, administrative investigation boards, responders' communication, social service assistant oversight, and non-VA health records documentation policy compliance.

DEFICIENCIES IN LEADERS' RESPONSES TO LAPSES IN REUSABLE MEDICAL EQUIPMENT REPROCESSING AT THE CHILlicothe VA MEDICAL CENTER IN OHIO

An inspection at the Chillicothe VA Medical Center in Ohio focused on allegations regarding an SPS employee's failure to follow endoscope reprocessing procedures, potentially placing patients at risk. The OIG determined the facility director did not develop and implement an adequate plan to monitor the employee's compliance with SPS reprocessing procedures. Because multiple patients were potentially

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

affected, facility and VISN leaders notified the VHA Clinical Episode Review Team (CERT). The CERT concluded that the risk to patients was minimal and a large-scale disclosure was not warranted; however, the determination may have been based on an inaccurate understanding of the reprocessing equipment capabilities. The OIG made two recommendations—one to the facility director regarding oversight of the employee's performance and one to the under secretary for health that the CERT review the reprocessing equipment manufacturer's information provided by the OIG to determine if it altered the determination of patient risk or the need for a large-scale disclosure.

DEFICIENCIES IN COMMUNITY LIVING CENTER PRACTICES AND THE DEATH OF A PATIENT FOLLOWING ELOPEMENT FROM THE CHILLICOTHE VA MEDICAL CENTER IN OHIO

Another report on the Chillicothe VA Medical Center in Ohio concerned aspects of care provided to a patient who was struck and killed by a vehicle near facility grounds following elopement from the CLC. The OIG determined that the patient's admission to the CLC was inappropriate, interventions were inadequate to mitigate the patient's risk for elopement, staff were inadequately trained, and patient safety reports were not completed as required. On the day of the patient's death, staff failed to detect that the patient, who was involuntarily civilly committed to the CLC, was missing for nearly three hours. Once the patient's absence was noted, facility staff failed to follow policy to locate the patient. The OIG also expressed concern that the CLC may not have been utilized as intended. The OIG made 12 recommendations to the VISN and facility directors regarding reviews of the patient's care, the use of the CLC, and staff training.

CARE AND OVERSIGHT DEFICIENCIES RELATED TO MULTIPLE HOMICIDES AT THE LOUIS A. JOHNSON VA MEDICAL CENTER IN CLARKSBURG, WEST VIRGINIA

The OIG conducted a healthcare inspection to review events involving patients with profound hypoglycemic (low blood sugar) episodes at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, after an OIG criminal investigation was completed. On July 14, 2020, Reta Mays, a former nursing assistant, pleaded guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder of an eighth patient. The OIG found that the facility had serious clinical and administrative failures that contributed to Ms. Mays's criminal actions not being identified and stopped earlier. Healthcare inspectors assessed Ms. Mays's hiring and performance, medication management and security, clinical evaluations of hypoglycemic events, reporting and responding to the events, quality programs, and leaders' responses and corrective actions. The OIG made 15 recommendations.

INADEQUATE RESIDENT SUPERVISION AND DOCUMENTATION OF AN OPHTHALMOLOGY PROCEDURE AT THE OKLAHOMA CITY VA HEALTH CARE SYSTEM

This inspection evaluated an attending ophthalmologist's quality of care and whether ophthalmology residents received appropriate supervision. The OIG substantiated that the subject ophthalmologist failed to provide adequate resident supervision and entered inaccurate documentation related to supervision for a single patient case. The ophthalmology residents were unable to reach the ophthalmologist during an eye injection procedure when the patient experienced a complication. A note in the patient's EHR incorrectly documented supervision by the ophthalmologist, who did not directly participate in and was not present during the care of the patient. Facility leaders identified documented evidence of resident supervision and determined that the ophthalmologist documented proper patient care. The OIG made three recommendations related to documentation of resident supervision and the hand-off process for covering attending ophthalmologists.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

DRUG INTERACTIONS RELATED TO A PATIENT DEATH, MARION VA MEDICAL CENTER IN ILLINOIS

The OIG's healthcare inspection at the Marion VA Medical Center in Illinois evaluated an allegation that a patient died due to complications from high cholesterol. The OIG substantiated that high cholesterol contributed to the patient's death but the primary cause of death was accidental acute multidrug intoxication. The psychiatrist and staff failed to document whether they provided the patient with education during a telephone encounter regarding potential side effects or adverse drug-drug interactions of medication changes. The psychiatrist prescribed long-term benzodiazepine use for a posttraumatic stress disorder (PTSD) diagnosis and failed to address both positive and negative drug screens with the patient. The facility failed to launch the psychotropic drug safety initiative phase four plan. The primary care provider did not comply with facility policy by failing to enter a return-to-clinic order following an appointment. Primary care and behavioral health staff did not comply with facility policy to contact the patient after a missed appointment. The OIG made five recommendations.



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DELAY IN A PATIENT'S EMERGENCY DEPARTMENT CARE AT THE MALCOM RANDALL VA MEDICAL CENTER IN GAINESVILLE, FLORIDA

The OIG assessed allegations that a patient's care was delayed and mismanaged in the facility's emergency department resulting in the patient's death, and there were inadequate emergency department nurse staffing levels. Two recommendations were made for corrective action based on the findings. No pandemic-related scheduling and quality deficiencies were identified in the patient's surgical care. The OIG did substantiate deficient and mismanaged emergency department care, which may have resulted in a delay in care. The inspection team was unable to determine if more expeditious care would have affected the patient's mortality. VHA requires registered nurses performing triage in VA emergency departments to use the five-tier Emergency Severity Index (ESI) system, a structured tool for assigning a severity level to patients. The facility lacked a policy that prohibited ESI 2 patients from remaining in the waiting room, which conflicted with guidance from the Emergency Nurses Association. The OIG did not substantiate inadequate levels of nursing staff in the emergency department during the week of the patient's death or that facility leaders received complaints.

IMPROPER FEEDING OF A COMMUNITY LIVING CENTER PATIENT WHO DIED AND INADEQUATE REVIEW OF THE PATIENT'S CARE, VA NEW YORK HARBOR HEALTHCARE SYSTEM IN QUEENS

This healthcare inspection assessed an allegation that improper feeding contributed to a patient's death at the New York Harbor Health Care System's CLC. The OIG substantiated that improper feeding during lunch by a registered nurse contributed to the patient's death. Approximately five hours after being fed lunch, a piece of chicken was removed from the patient's airway during intubation. The inspection team was unable to determine the exact size of the chicken but concluded that the chicken was larger than appropriate to feed to the patient. The cardiopulmonary resuscitation subcommittee completed an insufficient review of the code. No staff member submitted an incident report, and while a clinical disclosure was completed, an institutional disclosure was not. The OIG made seven recommendations to the facility director related to nursing competencies and training, documentation, review of the patient's care, committee oversight, incident reports, and institutional disclosures.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

TRAUMATIC BRAIN INJURY SERVICES AND LEADERS' OVERSIGHT AT THE SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM IN NEW ORLEANS

The inspection did not substantiate allegations that clinicians failed to adequately evaluate and treat TBI for patients who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn. The inspection team reviewed data from the VHA support service center and found the facility screening rate generally met or exceeded VHA's national benchmark. The team independently reviewed 327 EHRs to determine if patients who had a positive initial TBI screen received a timely comprehensive evaluation and if clinical services were initiated, if indicated. Clinical services were indicated for 96.69 percent of patients who received a TBI diagnosis and were initiated for 92.57 percent. The OIG found that care plans were thorough and found several areas in which facility staff exceeded VHA standards. No adverse clinical outcomes were identified and the OIG made no recommendations.

FAILURE OF A PRIMARY CARE PROVIDER TO COMPLETE ELECTRONIC HEALTH RECORD DOCUMENTATION AND INADEQUATE OVERSIGHT AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

An allegation that a provider's documentation deficiencies and accumulated "view alerts" may have resulted in patients' adverse clinical outcomes prompted this inspection at the Charlie Norwood VA Medical Center in Augusta, Georgia, and a review of facility leaders' actions. The OIG did not identify adverse clinical outcomes related to the provider's delinquent EHR documentation and was unable to determine if patients experienced adverse clinical outcomes from the provider's 4,000 accumulated view alerts because the alerts were addressed and no longer viewable. Facility leaders implemented actions to address and monitor the provider's documentation deficiencies and found no accumulated view alert-related adverse clinical outcomes. However, leaders need to develop and implement strategies to manage view alerts and assess retrospective reviews related to their accumulation. The facility also did not monitor EHRs for patients' episodes of care without associated progress notes or define the required view alert response time for providers. The OIG made three recommendations related to providers' view alert time frames and EHR and view alert monitoring.

DEFICIENCIES IN THE COMPLETION OF COMMUNITY CARE CONSULTS AND LEADERS' OVERSIGHT AT THE NEW MEXICO VA HEALTH CARE SYSTEM IN ALBUQUERQUE

This inspection evaluated allegations that (1) community care consults were completed without scanning and attaching available clinical results to patients' EHRs; (2) consult completion triggered view alerts indicating that consult results were available for review when they were not; and (3) VISN 22 and facility leaders were aware of the first practice and did not take action. The OIG substantiated that community care nurses completed consults without scanning and attaching clinical documentation to patients' EHRs. Community care nurses lacked a comprehensive orientation and training program to provide the required knowledge and skills to correctly perform their duties. The chief of community care did not verify adherence to consult-related VHA requirements or conduct regular reviews to identify areas for improvements. The OIG made five recommendations related to the community care consult completion process, nursing competencies and training, committee oversight and monitoring, facility leaders' oversight, and community care organizational structure and leaders' expertise.

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TRAINING DEFICIENCIES WITH VA'S NEW ELECTRONIC HEALTH RECORD SYSTEM AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON

The OIG identified multiple, broad deficiencies related to training content and delivery for VA's transition to a new EHR system at the Mann-Grandstaff VA Medical Center (facility) in Spokane, Washington. Weaknesses were also found in VA OEHRM's attempt to evaluate training, contractor performance of work on training, and EHRM governance concerns. The inspection team observed that facility employees demonstrated a commitment to the EHR transition while prioritizing patient care during a global pandemic. The OIG made 11 recommendations related to training content and delivery, evaluating contractor performance, evaluating training, reviewing the governance of the EHRM effort, tracking EHR patient complaints, and assessing employee morale.

DEFICIENCIES IN THE MENTAL HEALTH CARE OF A PATIENT WHO DIED BY SUICIDE AND FAILURE TO COMPLETE AN INSTITUTIONAL DISCLOSURE, VA SOUTHERN NEVADA HEALTHCARE SYSTEM IN LAS VEGAS

The OIG substantiated that a patient died by suicide the day of discharge from the inpatient mental health unit, and that facility leaders failed to complete an institutional disclosure. Outpatient providers did not complete required comprehensive evaluations. Staff did not assign the patient a high-risk-for-suicide flag, adequately assess the patient's substance use, incorporate history into the treatment plan, or address changes in demeanor. The discharge safety plan had not been modified for approximately eight months. Leaders had not established a mental health treatment coordinator policy and did not effectively address the patient's complaints. The OIG made a total of 10 recommendations.

AUDIOLOGY LEADERS' DEFICIENCIES RESPONDING TO POOR CARE AND MONITORING PERFORMANCE AT THE EASTERN OKLAHOMA VA HEALTH CARE SYSTEM IN MUSKOGEE

This healthcare inspection focused on actions that audiology leaders at the Eastern Oklahoma VA Health Care System in Muskogee took after discovering an audiologist provided poor clinical care. The OIG found that audiology leaders failed to evaluate whether patients needed clinical follow-up, additional patients were affected, and disclosures were required. The instances of poor care were not reported to the patient safety manager. In addition, performance monitoring of facility audiologists was not conducted as required. Moreover, annual competency assessments and performance appraisals were not consistently completed and did not contain adequate performance standards. The audiology leaders misunderstood the requirements for state licensing board reporting and failed to inform the facility director of the need to initiate a state licensing board review. The OIG made 10 recommendations to the facility director related to ensuring patient follow-up, making disclosures, overseeing audiologists, and ensuring audiology leaders' compliance with policies regarding disclosure, adverse events, and state licensing board reporting.

FAILURES IN CARE COORDINATION AND REVIEWING A PATIENT'S DEATH AT THE VA SALT LAKE CITY HEALTHCARE SYSTEM IN UTAH

The inspection considered allegations of a lack of care coordination, delay in care, refusal to hire a pharmacist, relocation delays, and busing patients to the facility for care. The OIG substantiated a nurse delayed care by not returning the patient's call. The nurse did not discuss with the covering provider that the patient was off anticoagulant medications or that the patient was requesting



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assistance in getting an anticoagulant medication filled. The facility's internal review was incomplete and included inaccurate information, and leaders were unable to determine if an institutional disclosure was warranted. The OIG substantiated the Orem CBOC's relocation was delayed; however, the facility implemented a contingency plan to address the delay. The matters not substantiated were a lack of care coordination; the chief of pharmacy's refusal to hire a pharmacist, which affected the patient's ability to obtain medication; and the busing of patients to the main facility for care. The OIG made three recommendations.

DEFICIENCIES IN MENTAL HEALTH CARE COORDINATION AND ADMINISTRATIVE PROCESSES FOR A PATIENT WHO DIED BY SUICIDE, RALPH H. JOHNSON VA MEDICAL CENTER, CHARLESTON, SOUTH CAROLINA

This report reviewed allegations referred by Chairman Mark Takano of the House Committee on Veterans' Affairs regarding the mental health care provided at the Ralph H. Johnson VA Medical Center to a patient at high risk for suicide who later died by suicide. The OIG did not substantiate inadequate monitoring or delayed care related to service agreement procedures or delayed identification of the patient's high-risk status. However, facility staff did not adequately evaluate the patient when reviewing high-risk status and did not assign a mental health treatment coordinator prior to discharge. Facility staff also did not complete required outreach to the patient, comply with VHA suicide risk assessment procedures, or notify facility leaders of the patient's death by suicide. The OIG made five recommendations.

DEFICIENCIES IN THE MANAGEMENT OF A PATIENT'S REPORTED INTIMATE PARTNER VIOLENCE AT THE RALPH H. JOHNSON VA MEDICAL CENTER, IN CHARLESTON, SOUTH CAROLINA

The inspection team evaluated concerns related to the Ralph H. Johnson VA Medical Center staff's management of a patient's reported perpetration of IPV and IPV Assistance Program (IPVAP) implementation at the facility. The OIG found that despite reports of IPV, inpatient and outpatient staff did not consult with the IPVAP point of contact and inpatient staff did not ensure the spouse felt safe with the patient returning home upon discharge. The inpatient psychiatry resident did not timely complete a progress note addendum that included critical IPV-related information. Facility staff failed to consult with the Office of Chief Counsel. The facility director did not ensure development of an IPVAP protocol; facility staff and leaders did not accurately identify the assigned IPVAP coordinator as a resource; and VHA guidance about IPV training responsibilities was unclear.

DEFICIENCIES IN COVID-19 SCREENING AND FACILITY RESPONSE FOR A PATIENT WHO DIED AT THE MICHAEL E. DEBAKEY VA MEDICAL CENTER IN HOUSTON, TEXAS

This inspection assessed the COVID-19 screening and treatment of a patient with serious mental illness. Facility staff did not complete the patient's COVID-19 temperature screening and failed to medically manage the symptomatic patient. The patient disappeared, was found nonresponsive off-site four days later, taken to the facility, and died the following day. Mental health staff failed to address surrogacy documentation discrepancies and educate the family on COVID-19 screening and the visitor policy. Facility staff did not comply with the missing patient policy, report an adverse event, or ensure a timely review of the patient's care. Facility leaders did not timely or accurately disclose to the patient's family the medical mismanagement that led to the patient's adverse clinical outcome and eventual death.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

The OIG made nine recommendations related to COVID-19 screening, visitor policy, mental health care coordination, surrogacy, missing and at-risk patients, adverse events, issue briefs, root cause analyses, and institutional disclosures.

DEFICIENCIES IN THE ASSESSMENT AND CARE OF A PATIENT SEEKING GERIATRIC SERVICES AT THE FAYETTEVILLE VA MEDICAL CENTER IN NORTH CAROLINA

The OIG assessed allegations that staff at the Fayetteville VA Medical Center in North Carolina failed to coordinate appropriate care for a patient seeking VA CLC placement and respite care, and did not provide medications for the patient while at a community-based assisted living center. The OIG did not substantiate that the facility failed to coordinate CLC placement or provide medications for the patient while at the community's assisted living center. However, the facility failed to coordinate respite services due to an improper determination of the patient's eligibility. In addition, the psychiatrist used the involuntary commitment process in a manner inconsistent with the state's parameters and failed to adequately assess the patient's decision-making capacity and determine whether the patient had a healthcare agent. Providers also missed opportunities to coordinate the patient's specialty care needs. The OIG made seven recommendations.

DEFICIENCIES IN COORDINATION OF CARE FOR PATIENTS WITH TREATMENT-RESISTANT DEPRESSION AT THE VA SAN DIEGO HEALTHCARE SYSTEM IN CALIFORNIA

Chairman Mark Takano and Representatives Julia Brownley, Chris Pappas, and Mike Levin of the House Committee on Veterans' Affairs shared allegations related to patients receiving ketamine for treatment-resistant depression in the community after authorizations for the care lapsed in September 2019 at the VA San Diego Healthcare System in California. The OIG substantiated that the facility ended authorizations for community care for patients receiving ketamine for treatment-resistant depression on two occasions and identified deficiencies in facility processes. The report includes two recommendations to the under secretary for health related to community care providers' review of VA's protocol for ordering ketamine and related research. Four recommendations were made to the facility director on community care processes for coordination of non-VA care and ensuring coordinated transitions for patients returning to care at the facility.

MISMANAGEMENT OF A PATIENT AT THE TOMAH VA MEDICAL CENTER IN WISCONSIN

The inspection team reviewed allegations referred by Congressman Ron Kind regarding the care of a patient at the facility who subsequently died from a presumed anoxic (complete lack of oxygen-related) brain injury. The OIG did not substantiate staff oversedated the patient. There were failures to provide adequate benzodiazepine dosing, review the patient's electrocardiogram, and transfer the patient earlier, which likely contributed to the patient's deterioration and ultimate death. A non-VA paramedic documented that the oxygen flow was not active. Leaders and staff reported lack of knowledge about the oxygen failure. Nurses did not complete all alcohol withdrawal assessments. A physician improperly ordered restraints, and nurses failed to obtain full vital signs and lacked restraint training. Staff did not communicate emergency detention with the patient's family; however, notification is not required. Leaders did not conduct a timely institutional disclosure with the patient's family, in person, or provide updates. The OIG made 10 recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

DEFICIENCIES IN ADMINISTRATIVE ACTIONS FOR A PATIENT'S INPATIENT MENTAL HEALTH UNIT AND COMMUNITY LIVING CENTER ADMISSIONS AT THE TUSCALOOSA VA MEDICAL CENTER IN ALABAMA

This report assessed allegations that staff at the facility denied a patient's discharge requests and did not ensure access to a patient advocate. The OIG substantiated that staff denied the patient's discharge requests. Staff also failed to follow informed consent procedures and did not conduct a sufficient or timely decision-making capacity evaluation. The patient remained on voluntary admission for nearly two years and 11 months. Facility staff did not adequately assess the patient's admission status and did not follow commitment requirements. They also did not comply with against-medical-advice requirements. Additionally, staff did not properly identify a surrogate decision-maker and did not address ethical concerns regarding the appropriateness of the patient's surrogate decision-maker. The OIG substantiated that staff failed to ensure the patient's access to the patient advocate and did not properly manage a letter from the patient to a public official. There are seven recommendations for corrective action.

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FACILITY LEADERS' RESPONSE TO LEVEL 2 AND LEVEL 3 PATHOLOGY READING ERRORS AT THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS IN FAYETTEVILLE, ARKANSAS

The OIG evaluated facility progress in responding to pathology reading errors identified during a look-back review of cases interpreted by former facility pathologist Dr. Robert Levy (whose actions and oversight are highlighted in the Featured Publications section on page 30). The OIG found facility processes for disclosures of pathological errors and EHR amendment met VHA requirements. However, opportunities for improved tracking of clinical disclosure completion existed, and a process was lacking for clinical providers to communicate subsequent health changes to the clinical review team for reconsideration of institutional disclosure needs. Although amended pathology reports were completed for patients identified with level 3 diagnostic errors (major diagnostic discrepancies with potential negative impact on patient care/treatment), fewer than 5 percent of the amended pathology reports were entered into EHRs of patients identified with level 2 diagnostic errors (disagreement in diagnosis with minimal or no patient care impact) at the time of the OIG site visit. The three recommendations relate to processes for documentation of clinical disclosures, communication to the clinical review team, and completion of EHR amendments.

FACILITY LEADERS PROVIDED OVERSIGHT OF A PHYSICIAN IN FELLOWSHIP TRAINING AT VA SIERRA NEVADA HEALTH CARE SYSTEM IN RENO

The inspection team examined the oversight and performance of a physician in fellowship training at the VA Sierra Nevada Health Care System. The physician, arrested by Canadian authorities for the alleged murder of a patient, participated in a geriatric fellowship at the facility from early fall 2018 through early fall 2019. No deficiencies were found in the quality of care and no statistical significance between the subject physician's rotations and patient deaths. The physician was onboarded and received supervision and evaluation per VHA requirements. Facility leaders initiated an issue brief and EHR review, although the review was not inclusive of all relevant patient deaths. Upon OIG request, the VISN (the facility's regional oversight office) further reviewed an additional seven patients and noted no clinical deficits in care that could have contributed to patient deaths. The OIG made no recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

DEFICIENCIES IN MENTAL HEALTH CARE AND FACILITY RESPONSE TO A PATIENT'S SUICIDE, VA PORTLAND HEALTH CARE SYSTEM IN OREGON AND TREATMENT PROGRAM REFERRAL PROCESSES AT THE PALO ALTO HEALTH CARE SYSTEM IN CALIFORNIA

The OIG evaluated a patient's care at the facility, including referral to the VA Palo Alto PTSD residential rehabilitation treatment program (RRTP). Portland staff made efforts to accommodate the patient's preferences, completed safety planning, and conducted MST screening. Leaders and staff did not assign a mental health treatment coordinator or establish policy. Portland staff did not adequately manage the high-risk-for-suicide patient record flag or gain approval for inactivation of the flag from the appropriate committee as required by facility policy. VHA policy and suicide behavior reporting guidance was inconsistent and leaders did not follow VHA staff-specific guidance. Portland staff did not complete a timely behavioral health autopsy. Palo Alto RRTP staff did not promptly screen the patient or accept self-referrals. Inconsistent with VHA policy, RRTP policy included additional admission requirements for the patient's service animal. The OIG made two recommendations to the under secretary for health, three recommendations to the facility director, and two recommendations to the VA Palo Alto director.

CLINICALLY APPROPRIATE ANEMIA CARE AND TIMING OF A COLONOSCOPY PROCEDURE FOR A PATIENT AT THE VA CARRIBEAN HEALTHCARE SYSTEM IN SAN JUAN, PUERTO RICO

A healthcare inspection was conducted to assess concerns about the diagnosis and treatment of anemia and coordination of a colonoscopy for a patient who subsequently died. The patient had iron-deficiency anemia. The OIG found that the primary care provider evaluated and treated the anemia effectively. In 2017, the patient developed a blood clot, requiring anticoagulant treatment. In 2018, the patient developed an abnormal heart rhythm and remained on an anticoagulant. The anticoagulant treatment was managed appropriately. In 2020, the patient was admitted to the facility on two occasions. During the second hospitalization, the patient was evaluated by cardiology staff for a possible heart attack. Prior to undergoing a cardiac catheterization, the patient underwent a colonoscopy and was treated for rectal bleeding. At the end of a cardiac catheterization, the patient developed cardiac arrest and could not be resuscitated. The OIG found the timing of the patient's colonoscopy to be clinically appropriate. No recommendations were made.

CARE CONCERNS AND THE IMPACT OF COVID-19 ON A PATIENT AT THE FAYETTEVILLE VA COASTAL HEALTH CARE SYSTEM IN NORTH CAROLINA

The healthcare team assessed concerns of quality, coordination, and timeliness of care, and the impact of COVID-19 on a patient with unintentional weight loss who was later diagnosed with oral cancer and died at another VA medical center. The OIG substantiated that a primary care provider and dietitians did not provide quality care. The primary care provider did not order a test, and dietitians did not conduct comprehensive nutritional assessments. The OIG also substantiated that the patient's nurse and dietitians did not coordinate care with the patient's primary care provider. The nurse did not facilitate a requested face-to-face visit, and dietitians did not communicate the patient's progressively worsening nutritional status. A scheduling error delayed a follow-up dietitian appointment, and a delay occurred in scheduling a non-VA dental appointment. The report details six recommendations related to nutritional assessments, care coordination, appointment scheduling, and COVID-19 scheduling practices and their impact on patient care.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

FAILURE TO MITIGATE RISK OF AND MANAGE A COVID-19 OUTBREAK AT A COMMUNITY LIVING CENTER AT VA ILLIANA HEALTH CARE SYSTEM IN DANVILLE, ILLINOIS

Allegations were made that during a COVID-19 outbreak, CLC staff and leaders at the Illiana VA Medical Center failed to observe infection control practices specific to respiratory PPE; minimize risk of exposure to COVID-19; perform ongoing COVID-19 testing; and notify residents, families, and staff of positive test results. The OIG substantiated that the facility failed to observe general infection control practices and minimize the risk of exposure to COVID-19. The OIG did not substantiate a failure to notify residents, families, and staff of test results, but did substantiate a lack of a post-baseline testing plan and a failure to test all staff after potential exposure. Actions taken by leaders following the CLC outbreak lacked input from frontline staff to identify corrective actions and opportunities for improvement. The OIG made 14 recommendations.

COMPREHENSIVE HEALTHCARE INSPECTIONS

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. During the reporting period, the OIG issued 34 comprehensive healthcare inspections, which are listed in appendix A, table A.2. Comprehensive healthcare inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus are depicted in the illustration on the next page. There were reports on 31 medical centers and healthcare systems and three VISNs published in the six-month reporting period.

VET CENTER INSPECTIONS

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

1. Leadership and organizational risks
2. Quality reviews
3. COVID-19 response
4. Suicide prevention
5. Consultation, supervision, and training
6. Environment of care

During the reporting period, the OIG issued three VCIP reports, which are listed in appendix A, table A.2. These reports include the review of 69 vet centers across three zones.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS FISCAL YEAR 2021



RESULTS FROM THE OFFICE OF INVESTIGATIONS

OVERVIEW

OI focuses on a wide range of criminal and civil cases, prioritizing those that have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect VA patient care and safety, the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 426,000 employees and contractors; and offenses affecting the Department's assets, programs, and operations.

113

Arrests



124

Convictions

\$1.96B

Monetary Benefits

FEATURED INVESTIGATIONS

The investigations highlighted in this section illustrate OI's emphasis on cases that involve harm to VA patients; result in monetary recoveries for VA that can be reinvested in programs, services, and benefits; address fraud, waste, and abuse by VA employees in positions of trust; help ensure benefits and services meant for veterans and other eligible beneficiaries are being received by the individuals for whom they were intended; and give some measure of relief to victims of crime and their loved ones.

The first of the three highlighted cases below spotlights the millions of dollars at risk when fraud schemes, such as the education case, go undetected. The second case reflects OI's commitment to protecting the most vulnerable veterans from financial exploitation. The third case details the attempts of an individual to profit from the COVID-19 pandemic by defrauding VA, state governments, and private entities.

FOR-PROFIT TRADE SCHOOL OWNER SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

An investigation by the VA OIG, Federal Bureau of Investigation (FBI), and US Postal Inspection Service (USPIS) revealed that a school's owner fraudulently obtained state and VA approval for his for-profit heating, ventilation, and air conditioning trade school. He then used the approval status to entice veterans to attend the school, which resulted in the fraudulent collection of VA education benefits. The owner was found guilty by a federal jury of seven counts of wire fraud and four counts of money laundering. He was sentenced in the Northern District of Texas to 235 months' incarceration, three years' supervised release, and restitution of approximately \$65.2 million. The loss to VA is approximately \$71 million.

DEFENDANT SENTENCED FOR FRAUD SCHEMES TARGETING VETERANS

A VA OIG and FBI investigation found that from 2016 through 2020, a fraudulent service provider operated an entity that purported to provide caregiving, contracting, and rental assistance services. She victimized at least 29 individuals, most of whom were elderly and vulnerable veterans. One elderly

RESULTS FROM THE OFFICE OF INVESTIGATIONS

veteran lost over \$262,000 through embezzled retirement savings, diverted VA benefits payments, and the proceeds of a loan the service provider fraudulently obtained using the veteran's name. The service provider caused several veterans to apply for VA grants designated for home improvement but failed to perform the promised work, and also engaged in a rental fraud scheme in which she purported to assist veterans with housing but diverted the rental and security deposit payments for her own benefit. The defendant was sentenced in the Eastern District of Virginia to 114 months' imprisonment and restitution of \$431,004 after pleading guilty to wire fraud and aggravated identity theft.

DEFENDANT PLEADS GUILTY IN CONNECTION WITH MULTIMILLION DOLLAR COVID-19 SCAM

A business owner made fraudulent misrepresentations in an attempt to secure orders from VA for 125 million face masks and other PPE that would have totaled over \$806 million. This individual promised that he could obtain millions of genuine 3M masks from domestic factories when he knew that fulfilling the orders would not be possible. He attempted to obtain an upfront payment from VA of over \$3 million, and obtained approximately \$7.4 million from state governments and private entities by making similar false representations of his ability to obtain PPE. Following an investigation by the VA OIG and Homeland Security Investigations, he pleaded guilty in the Western District of New York to wire fraud in connection with this scam.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this reporting period, OI opened 69 cases; made 70 arrests; obtained over \$119.1 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved nearly \$2.2 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period.

Cases Resulting in Settlements

VA CHOICE CONTRACTOR PAID \$3.5 MILLION IN INTEREST FOR OVERPAYMENTS

A contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs entered into a final settlement agreement with the Eastern District of California to resolve allegations that it submitted duplicate invoices to VA and failed to reduce billings to VA to reflect negotiated discounts it received from private healthcare providers for services rendered. Pursuant to this agreement, the contractor made an interest payment of over \$3.5 million. This settlement was the culmination of a three-year investigation conducted by the VA OIG, VA, and DOJ. Over the course of this investigation, this contractor returned approximately \$92.5 million in overpayments by VA due to duplicate invoice submissions.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Public Corruption by VHA Employees

DEFENDANT PLEADS GUILTY IN CONNECTION WITH THEFT SCHEME

A VA OIG, FBI, and VA Police Service investigation resulted in charges alleging that an individual conspired with a former pharmacy technician at the East Orange VA Medical Center in New Jersey to steal prescription human immunodeficiency virus (HIV) medication from the facility for several years. The total loss to VA is approximately \$8.2 million. The individual pleaded guilty in the District of New Jersey to conspiracy to steal government property. The former pharmacy technician was also indicted on charges of conspiracy to steal preretail medical products belonging to the United States, theft of government property, and theft of government medical products.

FORMER ANCHORAGE VA MEDICAL CENTER EMPLOYEE SENTENCED AND BUSINESS OWNER PLEADED GUILTY IN CONNECTION WITH BRIBERY SCHEME

A former business owner paid nearly \$30,000 in bribery payments to a former contracting officer representative at the Anchorage VA Medical Center in exchange for preferential treatment. As a result, the business, which was a service-disabled veteran-owned small business, obtained more than \$5 million in set-aside snow removal and housekeeping contracts at the medical center. The former contracting officer representative was sentenced to one year and one day of imprisonment and restitution of \$347,000. The former business owner pleaded guilty to bribery of a public official. Both court proceedings occurred in the District of Alaska. The investigation was conducted by the VA OIG, FBI, Small Business Administration (SBA) OIG, and General Services Administration (GSA) OIG.

FORMER EMPLOYEE OF THE FAYETTEVILLE VA MEDICAL CENTER SENTENCED IN CONNECTION WITH BRIBERY SCHEME

A VA OIG investigation uncovered that a former agent for specially adapted housing at the Fayetteville VA Medical Center received over \$20,000 in bribes from a business partner in exchange for directing more than \$1 million in grants intended for the modifications of veterans' homes to his partner's company. The former VA employee was sentenced in the Eastern District of North Carolina to two years' incarceration, three years' supervised probation, and restitution of \$21,520.

Other COVID-19-Related Schemes

VIRGINIA BUSINESSMAN SENTENCED IN CONNECTION WITH MULTIPLE FRAUD SCHEMES

The chief executive officer of a government service provider made false statements to both VA and the Federal Emergency Management Agency to obtain contracts to provide large quantities of PPE, such as N95 masks. The contracts were valued at approximately \$38 million. In addition, he electronically submitted applications containing false information for Paycheck Protection Program and Emergency Injury Disaster Loans, which resulted in his receipt of approximately \$1 million, and also submitted a

Visit the OIG's news release page for case summaries and related DOJ releases.



RESULTS FROM THE OFFICE OF INVESTIGATIONS

fraudulent DD Form 214 (certifying release or discharge from active duty) to VA, falsely reflecting that he served in the US Marine Corps, which resulted in the fraudulent receipt of VA compensation benefits. He was sentenced in the Eastern District of Virginia to 21 months' imprisonment and three years' supervised release. Prior to sentencing, the defendant paid full restitution of approximately \$349,000. The loss to SBA is approximately \$261,000 and the loss to VA is approximately \$74,000. The VA OIG, FBI, SBA OIG, and GSA OIG conducted the investigation.

BILOXI, MISSISSIPPI, VA MEDICAL CENTER EMPLOYEE PLEADED GUILTY IN CONNECTION WITH THEFT SCHEME

A VA OIG, FBI, and USPIS investigation found that an employee of the Biloxi VA Medical Center in Mississippi stole 3M N95 masks, electronics, and medical devices from the facility and resold these items to second-hand retailers during the COVID-19 pandemic. The employee made close to \$74,000 for the stolen VA property, reselling the 3M N95 masks for an average of \$18.36 per mask, which is 35 times their procured value of \$0.53. The employee pleaded guilty in the Southern District of Mississippi to theft of government property.

FEDERAL CONTRACTOR CHARGED WITH BRIBERY

A VA OIG investigation resulted in charges against a federal contractor who allegedly offered bribes to a VA contracting officer in return for steering contracts for PPE to his company. The federal contractor was arrested after being charged in the Northern District of New York with bribery.

DETROIT, MICHIGAN, VA MEDICAL CENTER REGISTERED NURSE CHARGED IN COVID-19 VACCINATION CARD FRAUD SCHEME

A registered nurse at the John D. Dingell VA Medical Center in Detroit, Michigan, was charged with stealing authentic COVID-19 vaccination record cards from the facility and the vaccine lot numbers necessary to make the cards appear legitimate. She allegedly resold the cards for \$150 to \$200 each to individuals within the metro Detroit community. The nurse was charged in the Eastern District of Michigan with theft of government property and theft or embezzlement related to a healthcare program. The VA OIG, Department of Health and Human Services (HHS) OIG, and VA Police Service investigated the matter.

FORMER WEST HAVEN VA MEDICAL CENTER EMPLOYEE SENTENCED FOR LARCENY

An investigation by the VA OIG, VA Police Service, and West Haven Police Department revealed that a former housekeeper stole a box of masks and face shields from the West Haven VA Medical Center in Connecticut. The defendant then resold the items to employees at a nearby gas station. The former housekeeper, who retired from VA while under investigation, was sentenced in Connecticut Superior Court to 90 days' imprisonment and one year of supervised release after pleading guilty to larceny.

[Fraud Against the Civilian Health and Medical Program of the Department of Veterans Affairs \(CHAMPVA\)](#)

SEVEN DEFENDANTS INDICTED IN CONNECTION WITH COMPOUND PHARMACY SCHEME

Charges were filed alleging that seven defendants conspired to fraudulently bill federal and private healthcare insurance programs for compounded medication. The seven defendants were indicted in the

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Southern District of Texas for their roles in this fraud and kickback scheme, which totaled approximately \$110 million. The loss to VA is over \$2.8 million. The investigation was carried out by the VA OIG, US Postal Service OIG, Department of Labor (DOL) OIG, FBI, HHS OIG, Defense Criminal Investigative Service (DCIS), and Texas Health and Human Services.

SEVEN INDIVIDUALS AND FOUR COMPANIES PLEADED GUILTY IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

The US District Court for the District of South Carolina unsealed various judicial actions pertaining to one of the largest healthcare fraud schemes in US history. The owner of over a dozen durable medical equipment companies, six business associates, and four companies participated in a scheme in which telemedicine companies contracted with telemedicine doctors to prescribe orthotic braces for patients with whom there was no doctor-patient relationship. The durable medical equipment companies then submitted grossly inflated claims to federal agencies for payment. The total loss to the government is approximately \$1.2 billion. Of this amount, the total loss to CHAMPVA is over \$2.1 million. The defendants pleaded guilty to charges in connection with this investigation, which was conducted by the VA OIG, FBI, HHS OIG, and Internal Revenue Service (IRS) Criminal Investigation.

DEFENDANT SENTENCED IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

An individual paid recruiters to convince beneficiaries to fill prescriptions for unnecessary, expensive, and supposedly tailor-made compounded medications from the Department of Defense's TRICARE program and CHAMPVA. The defendant then paid doctors to approve preprinted prescriptions for large amounts of these medications. It is alleged that the doctors did not see the beneficiaries or consider their medical needs before approving the prescriptions. The defendant allegedly steered the beneficiaries to fill their prescriptions at a codefendant's compounding pharmacy, which then billed the Department of Defense and VA for the expensive drug formulations. The investigation was undertaken by the VA OIG, DCIS, Food and Drug Administration Office of Criminal Investigations, and FBI. The defendant was sentenced in the Southern District of Florida to over 11 years' incarceration, three years' supervised release, restitution of \$11.8 million, and forfeiture of approximately \$7.6 million. The loss to VA is \$757,044.

DEFENDANT INDICTED IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

A multiagency investigation resulted in charges alleging that a defendant's role as a marketer was instrumental in a fraud scheme in which the Department of Defense's TRICARE and CHAMPVA were billed approximately \$4 million for unnecessary laboratory testing. Of this amount, approximately \$655,000 was billed to CHAMPVA. The VA OIG, HHS OIG, DOL OIG, DCIS, Office of Personnel Management OIG, and FBI were engaged in the investigation. The defendant was indicted in the Northern District of Texas for conspiracy to commit healthcare fraud.

FIVE INDIVIDUALS ARRESTED AND TWO INDIVIDUALS PLEADED GUILTY IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

An investigation by the VA OIG, DCIS, FBI, and HHS OIG resulted in the arrest of five defendants who were charged in the District of New Jersey in connection with a nationwide healthcare fraud scheme, and an additional two defendants pleaded guilty to conspiracy to violate the anti-kickback statute and conspiracy to commit healthcare fraud. The investigators found that the defendants participated in a scheme that solicited durable medical equipment and cancer genetic screening tests to prospective patients and used telemarketers and telemedicine doctors to generate prescriptions. It is alleged that

RESULTS FROM THE OFFICE OF INVESTIGATIONS

the telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the testing laboratory. Many of the target companies identified in the scheme submitted claims for payment to CHAMPVA. To date, investigative efforts have led to 17 arrests and 10 convictions. The total loss to VA is approximately \$330,000.

Other Healthcare Fraud

TWO FORMER COMPOUNDING PHARMACY EMPLOYEES RESENTENCED IN CONNECTION WITH 2012 FUNGAL MENINGITIS

A defunct compounding pharmacy's former owner, who also served as head pharmacist, and a former supervisory pharmacist were resentenced in the District of Massachusetts in connection with a 2012 nationwide fungal meningitis outbreak that killed 64 and caused infections in 793 patients. An investigation by the VA OIG, Food and Drug Administration Office of Criminal Investigations, DCIS, USPIS, and FBI revealed the defendants committed fraud by introducing adulterated drugs and misbranded drugs into interstate commerce. Although no known VA patients died or became ill, VA purchased approximately \$516,000 of these products that were produced in unsanitary conditions and in an unsafe manner. The defendants were resentenced because the First Circuit Court of Appeals vacated their initial sentencing in July 2020, after appeal by the government, finding that the sentencing court failed to impose applicable sentencing enhancements and erred in its forfeiture rulings. The former owner was resentenced to 174 months' incarceration, three years' supervised release, and a forfeiture of \$1.4 million. The former supervisory pharmacist was resentenced to 126 months' incarceration, two years' supervised release, and a forfeiture of approximately \$473,000. The defendants were also ordered to pay combined restitution of \$82 million.

NONVETERAN SENTENCED IN CONNECTION WITH FRAUD SCHEME

A VA OIG and Social Security Administration (SSA) OIG investigation revealed that from approximately April 2010 to September 2019, a nonveteran defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits. The defendant falsely claimed to be a decorated veteran—specifically, a US Navy SEAL, a prisoner of war, and Silver Star recipient. After the defendant was arrested, additional investigation by the Bureau of Alcohol, Tobacco, Firearms and Explosives revealed that the defendant participated in the straw purchase of two firearms. He was sentenced in the Eastern District of Pennsylvania District Court to 40 months' imprisonment, 36 months' supervised release, and restitution of \$302,121 after previously pleading guilty to charges of stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, aiding and abetting straw purchases of firearms, and false statements to the SSA. The loss to VA is approximately \$302,121.

TWO SPINAL DEVICE COMPANY EXECUTIVES INDICTED IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

The founder/chief executive officer and the chief financial officer of a spinal device company were arrested after an investigation by the VA OIG, USPIS, FBI, and HHS OIG. The charges alleged the executives paid millions of dollars in kickbacks to surgeons in exchange for their utilization of the company's surgical products. Six surgeons, including a physician at the VA medical center in the Bronx and a non-VA surgeon who was paid through VA's CHOICE program, previously entered into civil settlements with the US Attorney's Office in which they acknowledged receiving kickbacks from

RESULTS FROM THE OFFICE OF INVESTIGATIONS

the company. The VA physician's specific settlement totaled \$330,668, of which \$103,785 is allocated to VA. The two executives were indicted in the District of Massachusetts on charges that include violating the Anti-Kickback Statute, conspiracy to violate the Anti-Kickback Statute, and conspiracy to commit money laundering.

Grant Fraud

TWO DEFENDANTS SENTENCED IN CONNECTION WITH THEFT SCHEME

An investigation by the VA OIG and Department of Housing and Urban Development (HUD) OIG found that a former case manager for a nonprofit organization dedicated to combatting homelessness and a property agent schemed to steal VA Support Services for Veterans Families (SSVF) and HUD-VA Supportive Housing (HUD-VASH) funds. From October 2014 through November 2015, the defendants received housing vouchers from the SSVF and HUD-VASH programs in support of housing homeless veterans. Instead of using these funds to make the appropriate rental payments on behalf of the veterans, the defendants kept the funds for themselves. As a result, 25 veterans were evicted from their residences. The former case manager was sentenced to one year and one day of incarceration, three years' supervised release, and restitution of \$112,202. The property agent was sentenced to 21 months' incarceration, three years' supervised release, and restitution of \$105,698. Both defendants were sentenced in the Northern District of Georgia.

Caregiver Support Program Fraud

TWO DEFENDANTS PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

A VA OIG investigation revealed that from October 2015 through April 2020, a veteran and his spouse made numerous false statements to VA that indicated that the veteran was unemployed and in need of a full-time caregiver. During this same time period, the veteran worked full-time as a veteran service representative at the VA regional office in San Diego, California. The loss to VA is approximately \$183,000. Both defendants pleaded guilty in the Southern District of California to theft of government funds.

Healthcare Identity Theft

NONVETERAN SENTENCED IN CONNECTION WITH IDENTITY THEFT SCHEME

The VA OIG and VA Police Service investigated an individual who assumed the identity of a veteran that was a family friend to gain admittance to the Mountain Home VA Healthcare System in Tennessee. Further investigation revealed the defendant used the veteran's identity when admitted to several Knoxville area hospitals that subsequently attempted to bill VA for services provided, but were denied. The defendant was sentenced in the Eastern District of Tennessee to 27 months' imprisonment and restitution of \$25,502 after previously pleading guilty to aggravated identity theft and theft of medical services.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Drug Diversion by VA Employees

FORMER VA ANN ARBOR HEALTHCARE SYSTEM CERTIFIED NURSE ANESTHETIST PLEADED GUILTY IN CONNECTION WITH DRUG DIVERSION SCHEME

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

FORMER KERRVILLE VA MEDICAL CENTER PHARMACY TECHNICIAN AND TWO ACCOMPLICES INDICTED IN CONNECTION WITH DRUG DIVERSION SCHEME

An investigation by the VA OIG, DEA, USPIS, and Kerr County Sheriff's Office resulted in charges alleging that since December 2020, a former pharmacy technician at the Kerrville VA Medical Center stole in excess of 40 packages containing controlled substances intended for veterans from the mail stream in and around Kerrville, which he subsequently sold to two accomplices for further distribution. The former pharmacy technician and the two accomplices were indicted in the Western District of Texas on numerous charges in connection with a drug diversion and distribution scheme. The two accomplices were subsequently arrested pursuant to the indictment.

Kidnapping

TWO DEFENDANTS INDICTED IN KIDNAPPING OF ELDERLY WOMAN WITH DEMENTIA

A VA OIG and FBI investigation resulted in charges alleging that two individuals kidnapped an elderly female with dementia in a parking lot at the West Los Angeles VA Medical Center and subsequently obtained approximately \$17,000 from the victim's checking account without her consent. The two individuals were indicted in the Central District of California on charges of kidnapping and extortion.

Sexual Assault

FORMER COMMUNITY-BASED OUTPATIENT CLINIC NURSE PRACTITIONER PLEADED GUILTY TO SODOMY AND SEXUAL ABUSE

A VA OIG and VA Police Service investigation revealed that in 2019, a former VA nurse practitioner sexually assaulted two female veteran patients at the CBOC in Florissant, Missouri. The defendant pleaded guilty in the Circuit Court of St. Louis County, Missouri, to felony sodomy and misdemeanor sexual abuse.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FORMER NORTHPORT, NEW YORK, VA MEDICAL CENTER EMPLOYEE INDICTED FOR AGGRAVATED SEXUAL ABUSE, SEXUAL ABUSE, AND FALSE STATEMENTS

A VA OIG, FBI, and VA Police Service investigation led to charges alleging that a former employee of the Northport VA Medical Center in New York forcibly committed a sexual act against a coworker while on duty and later made false statements to VA OIG agents when interviewed regarding the act. The defendant was arrested after being indicted in the Eastern District of New York for aggravated sexual abuse, sexual abuse, and false statements, and was also terminated from his VA employment as a result of these allegations.

Voyeurism

VA EMPLOYEE PLEADED GUILTY TO VIDEO VOYEURISM AND DISORDERLY CONDUCT

An investigation by the VA OIG and VA Police Service determined that on approximately 17 occasions, an employee at the VA Joint Ambulatory Care Center in Pensacola, Florida, illegally placed a recording device that resembled a cellular phone charger in a unisex employee restroom. The defendant admitted that he placed the device in the restroom to record individuals and then later watch the footage. He pleaded guilty in the Northern District of Florida to charges of video voyeurism and disorderly conduct.

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

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

OIG's data analysis personnel, in coordination with OI, conducts an ongoing "Death Match" project to proactively identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. Within this reporting period, field personnel (including investigative assistants and special agents) teamed with headquarters staff to process and work cases resulting in the arrest of one individual, recoveries of \$551,986, and a projected five-year savings to VA estimated at over \$2 million.

OI opened 63 investigations involving the fraudulent receipt of VA monetary benefits including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 26 arrests. OI obtained over \$21.3 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than \$23.4 million in savings, efficiencies, and cost avoidance; and recovered more than \$3.8 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Education Benefits Fraud

OWNER OF A DOG-HANDLING SCHOOL SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

An investigation by the VA OIG, IRS Criminal Investigation, and FBI concluded that the owner of a canine training school fraudulently obtained VA approval through the submission of multiple materially false statements regarding the school's certifications and on-staff instructors. Similarly, the defendant submitted falsified certification materials to receive licensure to operate in the state of Texas. The defendant was sentenced in the Western District of Texas to over nine years' imprisonment, three years' supervised release, and restitution of approximately \$1.5 million. The loss to VA is over \$1.5 million.

OWNER OF A BARBER SCHOOL PLEADED GUILTY IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

VA OIG investigators determined that the former owner of a barber school submitted false course enrollments to VA on behalf of veterans who were eligible for Chapter 33, Post 9/11 GI Bill benefits. The total loss to VA is approximately \$410,000. The defendant pleaded guilty in the Southern District of Mississippi to wire fraud.

SECURITY TRAINING SCHOOL OWNER SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

The VA OIG and FBI found that the owner of a security training school (approved for VA benefits under the Vocational Rehabilitation and Employment program) obtained funds by providing false information to VA. That information related to the number of hours of instruction and the manner and quality of the instruction provided to veterans whose tuition was paid by VA. The investigation revealed that enrolled veterans rarely, if ever, received instruction from school employees. The defendant was sentenced in the District of Columbia to 30 months' imprisonment and restitution of \$150,000. The loss to VA is approximately \$150,000.

Life Insurance Fraud

DEFENDANT PLEADED GUILTY IN CONNECTION WITH LIFE INSURANCE FRAUD SCHEME

A multiagency investigation resulted in charges alleging that a Navy servicemember, along with at least 16 others, submitted numerous fraudulent Traumatic Servicemembers' Group Life Insurance (TSGLI) claims. Those claims contained false narratives of catastrophic injuries and exaggerated the loss of activities of daily living to generate payouts of \$25,000 to \$100,000 per claim. VA supervises the administration of the TSGLI program. The servicemember pleaded guilty in the Southern District of California for his involvement in the fraud scheme. To date, 11 individuals have been charged in the connection with this scheme. The loss to the TSGLI program is approximately \$2 million. The investigation was carried out by the VA OIG, Naval Criminal Investigative Service (NCIS), and FBI.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Compensation Benefits Fraud

VETERAN PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

A veteran fraudulently received compensation benefits for blindness. The veteran was rated as having "light perception only" and 5/200 vision for approximately 30 years upon his discharge from the Army. This VA OIG investigation revealed that the defendant maintained a driver's license in multiple states while claiming blindness. During a 15-year period, the defendant and his wife purchased over 30 automobiles that he routinely drove, including on long-distance trips, to run errands, and to attend VA medical appointments. The veteran pleaded guilty in the Western District of North Carolina to theft of government funds. The loss to VA is approximately \$978,000.

VETERAN INDICTED FOR THEFT OF PUBLIC FUNDS

Another VA OIG proactive investigation led to charges alleging a veteran had been rated as 100 percent service-connected disabled for bilateral blindness since 2000, despite maintaining a valid driver's license. The veteran was observed driving nearly daily and mowing his lawn. He was indicted in the Eastern District of Missouri for theft of public funds. The loss to VA is approximately \$880,000.

VETERAN SENTENCED IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

VA OIG investigators revealed that a veteran lied about his military service history, to include submitting a fraudulent record that listed the receipt of a Combat Infantryman Badge earned during deployment to Panama, when he actually had no active-duty periods other than for training. The fraudulent record enabled the defendant to receive VA compensation benefits and healthcare benefits. He was sentenced in the Southern District of Florida to six months' imprisonment, three years' supervised release with nine months' home confinement, and restitution of \$318,423. The total loss to VA is \$318,423.

VETERAN INDICTED IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

A veteran was charged with lying about his physical disabilities and manufacturing combat stories to VA examiners to obtain a 100 percent permanent and total VA disability rating. It is alleged that while he was a competitive bodybuilder, the defendant attended examinations using a cane and faked difficulty walking and moving his extremities. The VA OIG's investigation of the initial hotline complaint resulted in the defendant being arrested (after being indicted in the Southern District of Florida) for theft of government funds and false statements. The total loss to VA is \$245,286.

VETERAN AND SPOUSE PLEADED GUILTY TO THEFT OF GOVERNMENT PROPERTY

The VA OIG and SSA OIG confirmed that a veteran, with assistance from his wife, fraudulently led VA and the SSA to believe that he was completely blind, which qualified him for special monthly compensation and other VA benefits. The investigation determined that the veteran was able to drive, operate machinery, and perform other daily activities without the assistance of another person or low-vision aids. The veteran and his spouse pleaded guilty in the District of Kansas to theft of government property. The total loss to the government is \$243,483. Of this amount, the total loss to VA is \$131,973.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Fiduciary Fraud

TWO DEFENDANTS SENTENCED IN CONNECTION WITH FIDUCIARY FRAUD SCHEME

From November 2006 to July 2017, the owner of a former VA-appointed fiduciary corporation and the owner's spouse engaged in a sophisticated financial scheme with two other individuals to defraud victims of their VA and SSA beneficiary funds. The defendants used funds that were unlawfully transferred from their clients' accounts to purchase homes, motor vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately \$3.3 million. After previously pleading guilty to the fraud scheme, both defendants were sentenced in the District of New Mexico—the owner to 47 years' imprisonment and three years' supervised release, and the spouse to 15 years' imprisonment and three years' supervised release. Both defendants are required to pay the entire amount of stolen funds as restitution to their victims. The VA OIG, SSA OIG, IRS Criminal Investigation, and FBI conducted the investigation.

FORMER VA FIDUCIARY AND HIS BUSINESS INDICTED FOR THEFT OF GOVERNMENT FUNDS AND MISUSE OF FUNDS BY A FIDUCIARY

A VA OIG investigation resulted in charges alleging that a former VA-appointed fiduciary misappropriated over \$315,000 in VA benefits that were intended for 13 of their veteran clients. The former fiduciary and his business were indicted in the District of South Carolina for theft of government funds and misuse of funds by a fiduciary.

FORMER VA FIDUCIARY PLEADED GUILTY TO MISAPPROPRIATION

VA OIG investigators concluded that a former VA-appointed fiduciary embezzled VA funds intended for his veteran brother, including over \$130,000 in unauthorized money transfers, over \$25,000 in ATM cash withdrawals, and numerous purchases for his own personal use. Some of the purchases included a diamond ring, a pickup truck, and two motorcycles. The defendant pleaded guilty in the Western District of Pennsylvania to misappropriation by a fiduciary.

Theft of Government Funds

DEFENDANT PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

A VA OIG and SSA OIG investigation revealed that from October 2002 until December 2019, a nonveteran unlawfully negotiated VA and SSA benefit checks intended for her veteran boyfriend who died in 2002. The defendant also accessed two different bank accounts held in the deceased veteran's name into which the VA and SSA benefits were being electronically deposited. The defendant pleaded guilty in the Eastern District of Pennsylvania to theft of government funds. The total loss to the government is \$673,584, of which VA lost \$548,459.

DEFENDANT SENTENCED IN CONNECTION WITH THEFT SCHEME

From August 2003 until September 2019, the ex-daughter-in-law of a deceased VA beneficiary unlawfully used dependency and indemnity compensation benefits intended for the deceased beneficiary. Following the VA OIG investigation, the defendant was sentenced in the District of Arizona to 60 months' supervised probation and restitution of approximately \$232,000. The total loss to VA is approximately \$232,000.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

SON OF DECEASED BENEFICIARY PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

VA OIG investigators found that from September 2006 until June 2018, the son of a deceased VA beneficiary repeatedly conducted withdrawals of VA survivor's pension benefits from his deceased mother's bank account. The defendant pleaded guilty in the District of New Jersey to theft of government funds. The loss to VA is \$201,166.

DAUGHTER OF DECEASED VA BENEFICIARY SENTENCED FOR THEFT OF PUBLIC FUNDS

A VA OIG investigation determined that the daughter of a deceased VA beneficiary stole monthly VA dependency and indemnity compensation benefits intended for her mother, who died in March 2009. The defendant was sentenced in the Eastern District of Virginia to two years' probation and restitution of approximately \$188,000.

Benefits Identity Theft

FORMER VETERANS BENEFITS ADMINISTRATION DATABASE MANAGER SENTENCED FOR ATTEMPTING TO SELL THE PERSONAL INFORMATION OF VETERANS AND VA EMPLOYEES

A VA OIG and US Secret Service investigation identified a former VBA database manager attempting to sell the personal data of veterans, their dependents, and VA employees for \$100,000 to a confidential source working with law enforcement. The defendant was sentenced in the Eastern District of Arkansas to 46 months' imprisonment and two years' supervised release.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. OI also investigates allegations of bribery and kickbacks; bid rigging and antitrust violations; false claims submitted by contractors; and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices alone, OI opened 29 cases and made 10 arrests. These investigations resulted in over \$246 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over \$1 billion in savings, efficiencies, and cost avoidance.

SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD

NONVETERAN CONSTRUCTION COMPANY OWNER PLEADED GUILTY IN CONNECTION WITH SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A multiagency investigation revealed that between 2009 and 2018, a nonveteran owner of a construction company and his coconspirators controlled and operated a service-disabled veteran-owned small business (SDVOSB) that was also certified by the SBAs 8(a) business development program. The defendant furthered the conspiracy through the submission of false invoicing, false past performance questionnaires, and false references on behalf of this SDVOSB/8(a) construction company. The SDVOSB was awarded approximately \$335 million in set-aside contracts, of which approximately \$118 million

RESULTS FROM THE OFFICE OF INVESTIGATIONS

came from VA. When the company was growing too large to compete for small business contracts, the defendant and his coconspirators used the minority status of another to set up a second 8(a) certified company, which was awarded an additional \$11 million in set-aside contracts. The defendant pleaded guilty in the Western District of Missouri to conspiracy to commit wire and major program fraud and filing a false tax return. To date, all defendants have pleaded guilty and are awaiting sentencing. The investigation was conducted by the VA OIG, DCIS, Army Criminal Investigation Command, Department of Agriculture OIG, GSA OIG, IRS Criminal Investigation, Air Force Office of Special Investigations, NCIS, Defense Contract Audit Agency – Operations Investigative Support, US Secret Service, SBA OIG, DOL OIG, and DOL Employee Benefits Security Administration.

SDVOSB Cases Resulting in Settlements

CONSTRUCTION FIRM PAID \$2.5 MILLION TO RESOLVE CRIMINAL AND CIVIL INVESTIGATIONS

An investigation by the VA OIG and SBA OIG resolved allegations that from August 2007 to October 2013, a now-defunct construction company certified to VA that it qualified for SDVOSB set-aside and sole-source contracts. The defunct company submitted invoices to VA for multiple SDVOSB contracts, even though it was ineligible for that status because the service-disabled owner did not control the firm on a day-to-day basis. The US Attorney's Office for the Central District of California announced that a construction firm closely affiliated with the defunct company, which worked on that company's SDVOSB contracts, agreed to a civil settlement and nonprosecution agreement of \$2.5 million. This settled allegations that it violated federal law through its involvement in the defunct company's federal construction contracts. Of this amount, VA will receive \$1.4 million.

Workers' Compensation Program Fraud

DEFENDANT SENTENCED IN CONNECTION WITH WORKERS' COMPENSATION FRAUD SCHEME

A multiagency investigation revealed that over a three-year period a defendant submitted fraudulent claims for durable medical equipment to DOL's Office of Workers' Compensation Program. The total loss to the government is approximately \$6 million. Of this amount, the loss to VA is approximately \$2.5 million. The VA OIG, DOL OIG, Department of Homeland Security OIG, and US Postal Service OIG pursued this investigation. The defendant was sentenced in the Northern District of Texas to over seven years' incarceration, 36 months' supervised release, and restitution of over \$6 million after previously pleading guilty to conspiracy to commit healthcare fraud.

THREATS AND ASSAULTS MADE AGAINST VA EMPLOYEES

During this reporting period, OI personnel initiated 22 criminal investigations resulting from assaults and threats involving VA facilities and employees. This work resulted in charges filed against 13 individuals. Investigations resulted in \$146,524 in savings, efficiencies, cost avoidance, and dollar recoveries.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FORMER VA PUGET SOUND HEALTHCARE SYSTEM PHARMACIST SENTENCED FOR MAKING THREATS AGAINST VA EMPLOYEES

A group of investigative agencies determined that a former VA Puget Sound Healthcare System pharmacist attempted to acquire an AR-15 rifle and threatened in text messages to kill two VA employees. The defendant was previously charged in the Superior Court of King County, Washington, with cyberstalking. The state charges were dismissed so that this matter could be pursued in federal court. The former pharmacist was sentenced in the Western District of Washington to one year of imprisonment (time served) and three years' supervised release. This investigation, which was initiated based upon a VA OIG hotline complaint, was conducted by VA OIG investigators, the VA Police Service, Kent Police Department, Seattle Police Department, and Albuquerque Police Department, with assistance from the Bureau of Alcohol, Tobacco, Firearms and Explosives, USPIS, and FBI.

VETERAN PLEADED GUILTY TO MAKING THREATS TO KILL SOCIAL WORKER'S FAMILY

A veteran sent a threatening text message to his VA social worker's government-issued cell phone after he was discharged from housing provided through the HUD-VA Supportive Housing Program due to misconduct. The defendant threatened to kill the social worker's family members because he blamed the social worker for his removal from the program. Following the VA OIG investigation, he pleaded guilty in the Northern District of Ohio to influencing, impeding, or retaliating against a federal employee by threatening a family member.

VETERAN PLEADED GUILTY TO AGGRAVATED HARASSMENT OF VA STAFF

Another veteran left threatening and harassing voicemail messages for multiple employees at the Albany Stratton VA Medical Center in New York. The defendant was previously convicted for making threats against the VA medical centers in Albany and Canandaigua, New York. The defendant pleaded guilty in the Northern District of New York to aggravated harassment. The investigation was carried out by the VA OIG and VA Police Service.

VETERAN ARRESTED FOR MAKING THREATS AGAINST VA EMPLOYEES

An investigation by the VA OIG and FBI resulted in charges alleging that between November 2020 and May 2021, a veteran sent more than 100 text messages in which he threatened to use explosives to injure or kill various Bay Pines VA Healthcare System employees. The defendant was arrested after being charged in the Middle District of Florida with the interstate transmission of threats to kidnap or injure.

VETERAN ARRESTED FOR MAKING THREATS TO BLOW UP MEDICAL CENTER

A VA OIG and VA Police Service investigation led to charges alleging that a veteran made numerous statements on multiple occasions to various VA call center employees in which he threatened to blow up the VA medical center in Buffalo, New York, and to kill facility staff. The defendant was arrested in the Western District of New York after being charged with making threatening interstate communications.

FORMER COATESVILLE VA MEDICAL CENTER EMPLOYEE INDICTED FOR MAKING THREATS

A former employee of the Coatesville VA Medical Center in Pennsylvania faced multiple charges following a VA OIG investigation. The defendant allegedly sent sexually explicit, harassing, and threatening interstate communications and mail packages to various former coworkers. He also allegedly targeted the family members of his former coworkers with similarly vulgar communications. The defendant was indicted in the Eastern District of Pennsylvania for threatening and cyberstalking his former coworkers.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FUGITIVE FELON PROGRAM

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since 2002, 95.4 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 110,624 investigative leads being referred to law enforcement agencies. More than 2,678 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified nearly \$2 billion in estimated overpayments and cost avoidance of more than \$2.62 billion. During this reporting period, OI made 7 arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of 19 additional fugitive felons, and identified \$542.2 million in estimated overpayments.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES

SUBSTANTIATED ALLEGATIONS OF MISCONDUCT AGAINST SENIOR GOVERNMENT OFFICIALS

Under §5(a)(19) of the IG Act, inspectors general must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) in which allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including (1) whether the matter was referred to the DOJ, (2) the date of such referral, and (3) if applicable, the date of declination by the DOJ. During this reporting period, OI closed no criminal investigations with substantiated allegations against senior government employees.

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

Section 5(a)(22)(B) of the IG Act requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed one criminal investigation with unsubstantiated allegations against a senior government employee, as described below.

ALLEGED ACTS BY A VA CLINICAL TRIAL NETWORK DIRECTOR AFFECTING A PERSONAL FINANCIAL INTEREST

The OIG received an allegation that a VA Clinical Trial Network Director might have violated federal law and VA ethical rules by conducting presentations to VA staff regarding the benefits of a drug without disclosing that he received financial compensation from the same pharmaceutical company that manufactured the medication. The investigation determined that the VA Clinical Trial Network Director notified his supervisors of work that he was performing for the pharmaceutical company. The findings of this investigation were presented to the VA Office of General Counsel, who determined that the VA Clinical Trial Network Director's actions did not warrant any adverse administrative action. On June 21, 2021, this matter was referred for prosecution to, and declined by, the US Attorney's Office for the District of Massachusetts. The investigation was closed on July 6, 2021.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

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

- The Human Resources Division works to recruit and retain qualified and committed staff.
- The Budget Division provides a broad range of formulation and execution services to make certain that OIG expends funds appropriately and to the greatest effect.
- IT Divisions provide nationwide support, systems development, integration, and undertake continuous monitoring to fully secure OIG systems and data.
- The Data Analysis Division manages requests for access to secure information, helps identify fraud-related activities both real-time and through predictive analytics, and supports the OIG's comprehensive oversight initiatives.¹⁵
- The Hotline Division receives, screens, and refers OIG mission-related complaints as appropriate. It also analyzes and synthesizes information to inform decisions on selecting cases with priority given to issues having the greatest potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress.
- The Operations Division oversees the internal controls and records management programs, manages the senior executive services program, and is responsible for writing and publishing organizational policies.
- The Procurement and Financial Operations Division has fully warranted contracting officers and is responsible for the OIG's acquisition-related functions, as well as a range of financial services, including payment of invoices, and administration of the employee travel and purchase card programs.
- The Space and Facility Management Division develops space plans and manages more than 50 OIG offices across the country.
- The Training and Development Division coordinates centralized instruction and staff professional development activities.

¹⁵ This division will merge in the next reporting period with the Data Modeling Group within the Immediate Office of the Inspector General to provide more integrated OIG-wide support. The group will be called the Office of Data and Analytics.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERSIGHT ACTIVITIES

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

- Received and screened 15,104 contacts from complainants, including VA employees, veterans, and the public, and then directed potential cases to the appropriate OIG directorate for further review
- Referred 683 cases to and required a written response from applicable VA offices as appropriate and after determining that allegations pertained to higher-risk topics, but where insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 754 non-case referrals to appropriate VA offices after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 521 cases for which nearly 40 percent of allegations were substantiated, 496 administrative sanctions and corrective actions were taken, and \$481,182 in monetary benefits were achieved
- Responded to more than 430 requests for record reviews from VA staff offices
- Issued 4,588 semi-custom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope, and finalized a contract to significantly increase the volume of semi-custom responses in the future

FEATURED HOTLINE CASES

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

DELAY IN DIAGNOSIS AND POOR COMMUNICATIONS INVOLVING A PATIENT SEEKING VA CARE IN HATTIESBURG, MISSISSIPPI

After several failed attempts for care and diagnostic tests at the Hattiesburg VA Clinic, a veteran contacted the OIG for assistance. Based on a review of the veteran's records, the OIG sent a case to the clinic's parent medical center, which determined that the veteran waited three months for a primary care appointment at the clinic. Additionally, the medical center found that the veteran's primary care provider

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

failed to provide timely follow-up care and did not promptly correct a returned request for scheduling an MRI due to insufficient information. As a result of the case, the clinic connected the patient to a community care provider for the MRI, contacted the patient to apologize for the delay, and reminded all care providers to review patient records, complete all services, and provide a list of medications to patients transferring to other facilities.

COMMUNITY CARE PAYMENT ISSUES AT THE WM. JENNINGS BRYAN DORN VA MEDICAL CENTER IN COLUMBIA, SOUTH CAROLINA

A provider of a community residential care facility alleged that VA did not pay the facility for services provided to four veterans. The allegation attributed this to the responsible VA medical center billing office's failure to collect payments from the veterans. Based on a review of the documents and responses from the Office of Community Care, the OIG determined that the company was owed nearly \$130,000 for services rendered and also for ongoing services for two of the four veterans still residing at the facility. To resolve the identified problems, the facility was paid \$163,000 and the Office of Community Care created a new system to ensure that all claims submitted for care under the Geriatrics and Extended Care Program were promptly reviewed and then uploaded into their payment system.

PATIENT CARE CONCERNS IN THE RADIOLOGY DEPARTMENT AT THE VA HUDSON VALLEY HEALTH CARE SYSTEM IN MONTROSE, NEW YORK

A confidential complainant contacted the OIG hotline alleging quality of care issues in the radiology department that included X-rays being misread or deleted, and orders being improperly cancelled. After receiving documentation related to specific patients, the OIG requested the medical center respond to the allegations. The facility completed its fact finding and determined that a technician had lost films, failed to process orders, and falsified medical documentation to hide his mistakes. The VA reviewers further determined that another technician and a physician had some knowledge of the issues. As a result, the medical center instituted eight corrective actions to strengthen oversight of the radiological unit and screening of technicians. Additionally, the two technicians and the physician were referred for disciplinary action.

DELAYED PATIENT CARE AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON

The OIG received allegations that a veteran was unable to receive a follow-up cardiology appointment and that the facility had a huge backlog of appointments, which led to patients not being seen promptly and surgeries being outsourced. In response, the OIG tasked the VISN (the regional office charged with overseeing the medical center) to review the issues and determine the underlying problem. Upon investigation, it was determined that the veteran's cardiology appointment at the medical center was cancelled, but care was being provided in the community. The veteran confirmed that the arrangement was satisfactory. The larger issue of a substantial backlog of appointments was confirmed—the root cause being a combination of the rollout of a new EHR system and prior COVID-related appointment cancellations. To address the problem, the medical center formed a scheduling team, which successfully cleared the backlog in a little over three months. Additionally, to ensure the problem did not reoccur, medical center leaders brought in help from a neighboring medical center while the facility continued to transition to the new record system.

Visit the
OIG's hotline
page for more
information.



RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

VETERAN IN CRISIS AFTER PROBLEMS WITH FILLING A PRESCRIPTION

A veteran contacted the hotline indicating that he was having issues filling a prescription from a non-VA care provider at his VA medical center and, as a result, intended to harm himself. OIG staff took immediate action and implemented its emergency protocol used for complainants in crisis. Contact was made with the VCL to ensure they engaged with the veteran and a case was sent to the medical center to address the veteran's underlying concern. Within 15 minutes, VCL staff contacted the veteran and verified that he was with local law enforcement and was safe. Shortly thereafter, the medical center staff worked quickly to review the veteran's complaint. They confirmed that his prescription had been filled and they clarified with pharmacy technicians the proper protocol for processing outside prescriptions.

FEATURED DATA-DRIVEN INITIATIVE

The Data Analysis Division, in collaboration with cross-directorate stakeholders, continued to leverage data to proactively identify new areas for impactful oversight and to create and refine user-friendly, self-service dashboards to empower all OIG staff to advance their work using just-in-time information. The team has also continued to train OIG personnel to effectively leverage data tools and other services. Recent examples of these data-driven initiatives include the following:

- Created internal tools to inform and advance internal dialogue regarding high-priority issues. For example, in response to recommendations from the OIG's Diversity, Equity, and Inclusion Committee, staff developed and deployed an interactive dashboard that summarizes employee demographics, including gender, race, age, disability, and veteran status. This tool is accessible by all OIG staff. Another tool allows senior executives to examine the extent to which there is variation in performance ratings and awards based on staff demographics. Both tools are central to the OIG's ongoing efforts to enhance the agency's culture.
- Facilitated *Big Data Win Workshops* showcasing data-driven, cross-directorate projects. For example, in September 2021, the team collaborated with stakeholders from OAE on a workshop to highlight survey-based data collection methodologies, the use of survey data in published reports, and tips to designing and building a successful data collection tool. The session also featured a case study involving the recent surveys conducted for the Council of the Inspectors General on Integrity and Efficiency (CIGIE) and the VA OIG's External Peer Review of the US Postal Service OIG.
- Introduced "Thursday Three," a weekly communication message to the OIG workforce used to disseminate project snapshots, stakeholder spotlights, and field guides to self-service tools and advanced analytic techniques, including machine learning.

RESULTS FROM THE OFFICE OF SPECIAL REVIEWS

OVERVIEW

OSR issued one publication in this reporting period. Staff reviewed and triaged matters for further review that will be the subject of future reports as well. The report listed below reflects OSR's commitment to help VA make changes that can increase the trust of the veteran community and advance efforts to hold all VA employees to high standards of professional and ethical conduct. As with other OIG published reports, OSR recommendations for corrective action are detailed at www.va.gov/oig/recommendation-dashboard.asp. Dashboard users can track the status of report recommendations published since October 2012.

1

Publication



7

Recommendations

ADMINISTRATIVE INVESTIGATION

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

FAILURE TO LOCATE MISSING VETERAN FOUND DEAD AT A FACILITY ON THE BEDFORD VA HOSPITAL CAMPUS

This administrative investigation focused on the circumstances of a veteran's death on the Edith Nourse Rogers Memorial Veterans Hospital campus in Bedford, Massachusetts. The veteran resided at an independent living facility operated by a private company in space leased through VA's enhanced-use lease program. A month after the veteran was reported missing, another resident found his body in an emergency exit stairwell down the hall from his room. The VA

police department's failure to locate the veteran resulted in part because VHA policy requires extensive searches for missing patients but not for missing residents. The then police chief also improperly ceased routine patrols of the building in which the veteran was found. Inadequate oversight of the lease terms resulted in stairwells not being cleaned. Routine patrols or cleanings likely would have found him earlier. VA concurred with the OIG's seven recommendations to improve policies and procedures.

The Boston Globe

Bedford VA violated federal law by failing to search for missing veteran later found dead, federal watchdog finds

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

CONGRESSIONAL RELATIONS

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

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

Counselor to the Inspector General Christopher Wilber testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee on April 21, 2021, on pending legislation including H.R. 2428, the Strengthening Oversight for Veterans Act of 2021. Mr. Wilber testified in support of the bill, which would give the VA OIG testimonial subpoena authority. He explained how it would strengthen the OIG's work, discussed examples of inspections and investigations where the OIG could not interview former VA employees, and noted safeguards for witnesses. Mr. Wilber also commented on other legislation that related to findings in OIG reports.

COUNSELOR TO INSPECTOR GENERAL TESTIFIES BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, US HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS

Counselor to the Inspector General Christopher Wilber also testified before the Subcommittee on Oversight and Investigations, US House of Representatives Committee on Veterans' Affairs on May 19, 2021. The hearing focused on VA's progress toward improving its Office of Accountability and Whistleblower Protection since issuance of the OIG's 2019 report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, and ensuring whistleblowers at the Department are protected and engaged. Mr. Wilber discussed how OIG staff interact with whistleblowers and complainants as well as provided an update on VA's efforts to close out the report's 22 recommendations. In response to questions, Mr. Wilber discussed the importance of OIG independence and independent legal counsel and explained that the OIG's impression is that the Office of Accountability and Whistleblower Protection has improved its work under recent VA leaders.

DIRECTOR OF INFORMATION TECHNOLOGY AND SECURITY AUDITS TESTIFIES BEFORE THE SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION, US HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS

Michael Bowman, director of the Information Technology and Security Audit Division for the Office of Audits and Evaluations, testified before the Subcommittee on Technology Modernization, US House of Representatives Committee on Veterans' Affairs on May 20, 2021. He discussed VA's ongoing cybersecurity challenges and the results of the OIG's April 2021 report, *Federal Information Security Modernization Act Audit for Fiscal Year 2020*. He shared the OIG's findings and repeated recommendations made in recent Federal Information Security Modernization Act audits and how that underscores VA's inability to make major improvements and impactful change in their security program.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS TESTIFIES BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Deputy Assistant Inspector General for Audits and Evaluations Leigh Ann Searight testified before the House Veteran's Affairs Subcommittee on Oversight and Investigations on July 13, 2021. She discussed the status of recommendations from two OIG oversight reports of VA's police program that identified governance and information management systems challenges. The findings of the December 2018 report have not been addressed, and VA still does not have adequate or coordinated governance over its police program. The June 2020 report concluded that VA did not have an effective strategy to update its police information system. The OIG made seven recommendations in its 2020 report, and VA has taken sufficient action to close two of the recommendations (5 and 7). Ms. Searight stated that an effective governance structure is critically important to the functioning of any program. Moreover, an effective police program governance is dependent on access to accurate and timely information to provide strategic direction, make informed decisions, and maintain accountability.

DEPUTY INSPECTOR GENERAL TESTIFIES BEFORE TWO CONGRESSIONAL COMMITTEES ON VA'S ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM

Deputy Inspector General David Case testified before the Senate Veterans' Affairs Committee on July 14, 2021, and the House Veterans' Affairs Subcommittee on Technology Modernization on July 21, 2021, on VA's progress deploying the new EHR system. He focused on the OIG's recent audits on unreliable cost estimates for various infrastructure upgrades as well as a healthcare inspection that reviewed the training given to VA staff at the first deployment site, Mann-Grandstaff VA Medical Center in Spokane, Washington. Mr. Case discussed the work that VA needs to do to be more transparent and accountable to Congress to comply with existing statutes. He answered questions regarding VA's need for a revised governance structure that actively involves VHA users, and he provided an update on the review of allegations that VA staff withheld and altered information from OIG staff.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

**TABLE 6. OIG CONGRESSIONAL TESTIMONY
(APRIL 1-SEPTEMBER 30, 2021)**

WITNESS	COMMITTEE	TOPIC	DATE
Counselor to the Inspector General Christopher A. Wilber	Subcommittee on Oversight and Investigations Committee on Veterans' Affairs, US House of Representatives	Legislative Hearing on H.R. 2428 and other Pending Legislation	4/21/2021
Counselor to the Inspector General Christopher A. Wilber	Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives	Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?	5/19/2021
Director of Information Technology and Security Division for the Office of Audits and Evaluations Michael Bowman	Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives	Cybersecurity and Risk Management at VA: Addressing Ongoing Challenges and Moving Forward	5/20/2021
Deputy Assistant Inspector General for Audits and Evaluations Leigh Ann Searight	Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, US House of Representatives	Modernizing the VA Police Force: Ensuring Accountability	7/13/2021
Deputy Inspector General David Case	U.S. Senate Committee on Veterans' Affairs, US Senate	VA Electronic Health Records: Modernization and the Path Ahead	7/14/2021
Deputy Inspector General David Case	Subcommittee on Technology Modernization, Committee on Veterans' Affairs, US House of Representatives,	Moving Forward: Evaluating Next Steps for the Department of Veterans Affairs Electronic Health Record Modernization Program	7/21/2021

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

PUBLIC AFFAIRS

In addition to the activities discussed earlier, public affairs projects include podcasts of monthly highlights and other activities of the OIG. The podcast program is intended to complement other communications outreach. All podcasts and their transcripts are available at www.va.gov/oig/podcasts/default.asp.

**TABLE 7. OIG PODCASTS
(APRIL 1-SEPTEMBER 30, 2021)**

TITLE	ISSUE DATE
Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines	4/05/2021
VHA's Virtual Primary Care Response to the COVID-19 Pandemic	4/06/2021
Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia	4/08/2021
VA OIG March 2021 Highlights	4/19/2021
PRAC Healthcare Subgroup Work	5/12/2021
VA OIG April 2021 Highlights	5/13/2021
Drug Interactions Related to a Patient Death at the Marion VA Medical Center in Illinois	6/16/2021
VA OIG May 2021 Highlights	6/24/2021
VA OIG June 2021 Highlights	7/15/2021
Emergency Preparedness for VHA Telemental Health Care	7/29/2021
Use and Oversight of the Emergency Caches Were Limited During the First Wave of the COVID-19 Pandemic	8/10/2021
VA OIG July 2021 Highlights	8/19/2021
Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Health Care System, Utah	9/02/2021
Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations	9/13/2021
VA OIG August 2021 Highlights	9/21/2021
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix, VA Health Care System, Arizona	9/27/2021
Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri	9/30/2021

REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors general are required by §4(a)(2) of the IG Act (P.L. 95-452) to review existing and proposed legislation and regulations and make recommendations in the *Semiannual Report to Congress* concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, the OIG reviewed four legislative or regulatory proposals and made two comments. The OIG also reviewed 23 internal VA directives and handbooks that guide the work of VA employees and provided nine comments.



PEER AND QUALITATIVE ASSESSMENT REVIEWS

Under §5(a)(14) and (15) of the IG Act, as amended by the Dodd–Frank Wall Street Reform and Consumer Protection Act (P.L. 111-203), inspectors general must report the results of any peer review conducted of its operations by another office of inspector general during the reporting period or identify the date of the last peer review conducted by another office of inspector general, in addition to any outstanding recommendations that have not been fully implemented. The VA OIG’s offices of Audits and Evaluations, Healthcare Inspections, Investigations, and Special Reviews are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards.

The IG Act also requires inspectors general, under §5(a)(16), to report the results of any peer review they completed of another office of inspector general’s audit operations during the reporting period, as well as any outstanding recommendations that have not been fully implemented from any peer review completed during or prior to the reporting period.

Tables 8 and 9 list the results of the most recent peer reviews conducted by and of the VA OIG.

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

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

REPORTING REQUIREMENTS

TABLE 9. MOST RECENT PEER REVIEWS CONDUCTED BY THE VA OIG

TYPE	DATE COMPLETED	OIG REVIEWED	RATING	OUTSTANDING RECOMMENDATIONS
Audits	8/8/2018	SSA OIG	Pass	None
Inspections and Evaluations	09/14/2021	DoD OIG	Pass	None
Investigations	12/13/2018	Department of Education OIG	Pass	None

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

The IG Act authorizes federal inspectors general to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. OIGs are required under §5(a)(5) of the Act to provide a summary of instances when such information or assistance is refused. The VA OIG reports no such instances occurring during this reporting period.

INSTANCES OF WHISTLEBLOWER RETALIATION

Inspectors general are required by §5(a)(20) of the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires inspectors general to detail the consequences imposed by the Department to hold those officials accountable. However, the VA OIG’s current practice is to refer VA employees alleging whistleblower reprisal to either the VA Office of Accountability and Whistleblower Protection or the US Office of Special Counsel, as each of those offices has specific statutory authority to address reprisal claims that the OIG does not. The OIG does investigate allegations of whistleblower reprisal made by employees of VA contractors, but did not complete any such investigations during this SAR period. Accordingly, the VA OIG has no findings of whistleblower retaliation to report.

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

Section 5(21) of the IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information. During this reporting period, there were no such incidents.

REPORTING REQUIREMENTS

CLOSED OFFICE OF INSPECTOR GENERAL WORK NOT DISCLOSED TO THE PUBLIC

The VA OIG is required by §5(a)(22)(A) of the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, and audit conducted by the OIG that is closed and was not disclosed to the public. The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

AWARDS AND RECOGNITION

EMPLOYEE RECOGNITION OF MILITARY PERSONNEL

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

- Trevor Rogers, a management and program analyst in Decatur, Georgia, was activated by the United States Army in December 2020.
- Danielle Head, a procurement analyst in Arlington, Virginia, was activated by the United States Army in January 2021.
- Ricardo Wallace-Jimenez, a criminal investigator in Spokane, Washington, was activated by the United States Army in January 2021.
- Jennifer Siegel, a management and program analyst in Bay Pines, Florida, was activated by the United States Army in February 2021.
- Jose Flores-Marrero, an auditor in Washington, DC, was activated by the United States Air Force in March 2021.
- Matthew Clark, an auditor in Dallas, Texas, was activated by the United States Army in May 2021.

2021 COUNCIL OF THE INSPECTORS GENERAL ON INTEGRITY AND EFFICIENCY AWARDS

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

- An Award for Excellence in Investigation will be awarded to OI's investigative team for their personal sacrifice, exceptional investigative work, and unwavering dedication demonstrated in successfully investigating the murders committed by a nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.
- An Award for Excellence in Investigation will be awarded to OI's investigative team for their investigatory efforts to seek justice for victims harmed by a physician at the Beckley VA Medical Center in West Virginia.
- An Award for Excellence in Audit will be awarded to the OAE audit team responsible for the report, [Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager](#), which identified substantial internal control weaknesses leading to overpayments.

AWARDS AND RECOGNITION

- An Award for Excellence in Information Technology will be awarded to the OAE audit team that produced the report, *Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Record System*, which identified significant technical weaknesses with physical and IT infrastructure prior to the EHR go-live at VA's first deployment site.
- An Award for Excellence in Evaluations will be awarded to the OAE review team for their work on the report, *Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement*, which determined that VBA inaccurately processed thousands of PTSD claims, resulting in improper payments totaling \$90.6 million.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

Federal inspectors general are required to provide information on the reports they publish and any associated monetary impact. Tables A.1 through A.3 provide a listing of VA OIG publications issued this period with results sorted according to the authoring directorate. If applicable, the total dollar value of questioned costs and recommendations that funds be put to better use are identified. Table A.4 summarizes all monetary benefits for OIG reports issued this reporting period. This information is required by §5(a)(6) of the IG Act.

Under §5(a)(8) and (9) of the Act, offices of inspector general must provide statistical tables showing the total number of reports issued during the reporting period with questioned costs or recommendations that funds be put to better use (1) for which no management decision had been made by the commencement of the reporting period, (2) which were issued during the reporting period, (3) for which a management decision was made during the reporting period, and (4) for which no management decision was made by the end of the current reporting period. This information is provided in tables A.5 and A.6.

Sections 5(a)(10)(A) and (B) of the IG Act require that offices of inspector general provide a summary of each report issued before the commencement of the reporting period for which no management decision had been made by the end of the current reporting period and for which VA did not provide substantive comments within 60 days of receipt of the draft report. In each case, there were no instances to report. As part of the report production process, the VA OIG transmits its draft report to VA for review, comment, and concurrence to implement recommendations. The OIG's goal is to receive substantive feedback from the Department within 30 days of transmitting the draft report. The reporting requirement under §5(a)(10)(C) is presented in appendix B.

Federal inspectors general are also required under §5(a)(11) and (12) of the IG Act to provide a description and explanation of the reasons for any significant revised management decision made during the reporting period, as well as information concerning any significant management decisions with which the Inspector General is in disagreement. The VA OIG reports that there were no significant revised management decisions made during the reporting period.

While VA OIG reports that there were no significant revised management decisions made during the reporting period, there were significant management decisions in two reports with which the Inspector General is in disagreement:

- In the report *Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk*, the acting under secretary agreed with the OIG's findings; however, he did not concur with many of the OIG's recommendations on the basis that VHA is not the appropriate responsible office to establish PIV-related roles, responsibilities, and processes for the Department's contracting officers. Specifically, the acting under secretary concurred with recommendation 5, concurred in principle with recommendations 4 and 10, and nonconcurred with recommendations 1 through 3 and 6 through 9. Appendix C of the report includes the full text of VHA's comments. The OIG disagrees and believes that its recommendations fall within VHA's purview for action.
- In the report *Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center in Charleston, South Carolina*, the VISN and facility directors nonconcurred with recommendation 3 that asked the facility director to review the patient's care for program adherence and appropriate outreach and take

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

action as warranted. The OIG disagrees with the facility director who did not concur with the recommendation to review staff's failure to seize an opportunity to work collaboratively with a high-risk patient who was difficult to engage in treatment.

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

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

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

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
<p>Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents</p> <p><i>Issued 4/14/2021 Report Number 21-00913-91</i></p>	—	—
<p>Federal Information Security Modernization Act Audit for Fiscal Year 2020</p> <p><i>Issued 4/29/2021 Report Number 20-01927-104</i></p>	—	—
<p>The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings</p> <p><i>Issued 5/18/2021 Report Number 20-00049-122</i></p>	—	—
<p>Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</p> <p><i>Issued 5/25/2021 Report Number 20-03178-116</i></p>	—	—
<p>Compensation and Pension Proceeds Were Generally Handled Accurately but Some Were Delayed</p> <p><i>Issued 5/27/2021 Report Number 20-00817-123</i></p>	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
<p>Program of Comprehensive Assistance for Family Caregivers: IT System Development Challenges Affect Expansion</p> <p><i>Issued 6/8/2021 Report Number 20-00178-24</i></p>	—	—
<p>Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic</p> <p><i>Issued 6/9/2021 Report Number 20-03326-124</i></p>	—	—
<p>Review of VHA's Financial Oversight of COVID-19 Supplemental Funds</p> <p><i>Issued 6/10/2021 Report Number 20-02967-121</i></p>	—	—
<p>Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency</p> <p><i>Issued 6/10/2021 Report Number 20-00541-133</i></p>	—	—
<p>Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available Before the COVID-19 Pandemic</p> <p><i>Issued 6/14/2021 Report Number 20-03075-138</i></p>	—	—
<p>Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs</p> <p><i>Issued 6/15/2021 Report Number 20-01487-142</i></p>	\$129,700,000	\$9,810
<p>Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System</p> <p><i>Issued 6/16/2021 Report Number 19-07719-113</i></p>	\$132,000	\$5,420,000
<p>Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records</p> <p><i>Issued 6/17/2021 Report Number 19-08658-153</i></p>	—	—
<p>Inspection of Information Technology Security at the VA Outpatient Clinic in Austin, Texas</p> <p><i>Issued 6/22/2021 Report Number 20-01485-114</i></p>	—	—
<p>VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care</p> <p><i>Issued 6/23/2021 Report Number 20-01141-145</i></p>	—	—
<p>Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards</p> <p><i>Issued 6/24/2021 Report Number 20-00176-125</i></p>	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
<p>Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk</p> <p><i>Issued 6/29/2021 Report Number 20-00345-77</i></p>	—	—
<p>VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules</p> <p><i>Issued 7/1/2021 Report Number 20-01646-139</i></p>	—	\$16,600,000
<p>Alleged Unauthorized Control over a VA Beneficiary's Funds</p> <p><i>Issued 7/6/2021 Report Number 20-02071-167</i></p>	—	—
<p>Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</p> <p><i>Issued 7/7/2021 Report Number 20-03185-151</i></p>	—	—
<p>Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations</p> <p><i>Issued 7/8/2021 Report Number 20-03704-165</i></p>	—	\$17,900,000
<p>VBA Overpaid Veterans Due to Delays in Reducing Compensation Benefits</p> <p><i>Issued 7/8/2021 Report Number 20-03229-155</i></p>	—	\$348,000,000
<p>Adaptive Sports Grants Management Needs Improvement</p> <p><i>Issued 7/13/2021 Report Number 20-01807-173</i></p>	—	\$247,000
<p>VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds</p> <p><i>Issued 7/21/2021 Report Number 20-00433-168</i></p>	—	—
<p>Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services</p> <p><i>Issued 7/22/2021 Report Number 19-08267-147</i></p>	—	\$35,300,000
<p>Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020</p> <p><i>Issued 8/2/2021 Report Number 21-00519-192</i></p>	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program <i>Issued 8/4/2021 Report Number 20-02828-174</i>	\$6,570,395	—
Improvements Still Needed in Processing Military Sexual Trauma Claims <i>Issued 8/5/2021 Report Number 20-00041-163</i>	—	—
Financial Efficiency Review of the Miami VA Healthcare System <i>Issued 8/11/2021 Report Number 20-01796-195</i>	\$41,000	\$287,000
Medical Facilities Forfeited Drug Return Credits through Inadequate Monitoring of Vendor Invoices <i>Issued 8/12/2021 Report Number 20-00418-190</i>	—	—
Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA <i>Issued 8/12/2021 Report Number 20-00418-166</i>	\$14,600,000	\$307,365
Fiscal Year 2020 Risk Assessment of VA's Charge Card Program <i>Issued 8/18/2021 Report Number 21-00350-201</i>	—	—
Blue Water Navy Outreach Requirements Were Met, but Claims Processing and Procedures Could Improve <i>Issued 9/2/2021 Report Number 20-03938-208</i>	—	\$37,200,000
Inadequate Business Intelligence Reporting Capabilities in the Integrated Financial and Acquisition Management System <i>Issued 9/8/2021 Report Number 21-02609-229</i>	—	—
Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2019 <i>Issued 9/13/2021 Report Number 21-00612-189</i>	—	—
Excess Purchase of Surgical Supplies and Improper Purchase Card Transactions at the New Orleans VA Medical Center in Louisiana <i>Issued 9/14/2021 Report Number 20-00395-224</i>	\$1,245,291	\$1,900,000
Summary of Fiscal Year 2020 Preward Reviews of Healthcare Resource Proposals from Affiliates <i>Issued 9/15/2021 Report Number 21-00044-219</i>	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans <i>Issued 9/20/2021 Report Number 20-00971-235</i>	—	\$192,070
Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors <i>Issued 9/23/2021 Report Number 20-01802-234</i>	\$20,000,000	—
Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened <i>Issued 9/27/2021 Report Number 20-01910-244</i>	—	—
A Summary of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2020 <i>Issued 9/28/2021 Report Number 21-00041-250</i>	—	—
VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report <i>Issued 9/29/2021 Report Number 20-03407-253</i>	—	—
TOTAL	\$172,288,686	\$463,363,245

PREAWARD REVIEWS	BETTER USE OF FUNDS
Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract <i>Issued 4/2/2021 Report Number 21-00249-109</i>	—
Review of Proposal Submitted under a Solicitation <i>Issued 4/9/2021 Report Number 21-01585-111</i>	\$2,361,918
Review of Product Addition Proposal Submitted under a Federal Supply Schedule Contract <i>Issued 4/27/2021 Report Number 21-01584-120</i>	—
Review of a Proposal Submitted under a Solicitation <i>Issued 4/27/2021 Report Number 21-01641-126</i>	\$5,693,480
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 4/28/2021 Report Number 21-00771-130</i>	\$8,157,600
Review of Proposal Submitted under a Solicitation <i>Issued 5/3/2021 Report Number 21-02128-128</i>	\$362,417

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 5/3/2021 Report Number 21-00581-127</i>	—
Review of Request for Contract Extension Proposal Submitted under a Federal Supply Schedule Contract <i>Issued 5/5/2021 Report Number 21-00989-134</i>	\$231,230
Review of Proposal Submitted under a Solicitation <i>Issued 5/27/2021 Report Number 21-02387-150</i>	\$2,074,185
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 5/28/2021 Report Number 20-03940-152</i>	\$83,251,853
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 6/2/2021 Report Number 21-01338-156</i>	—
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 6/2/2021 Report Number 21-00959-158</i>	\$11,720,440
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 6/2/2021 Report Number 21-00792-159</i>	\$6,975,340
Review of Proposal Submitted under a Solicitation <i>Issued 6/14/2021 Report Number 21-02273-164</i>	\$340,911
Review of Proposal Submitted under a Solicitation <i>Issued 7/15/2021 Report Number 21-02218-186</i>	—
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 7/28/2021 Report Number 21-01811-187</i>	\$12,017,550
Review of a Proposal Submitted under a Solicitation <i>Issued 7/29/2021 Report Number 21-02829-204</i>	\$9,725,173
Review of a Proposal Submitted under a Solicitation <i>Issued 7/29/2021 Report Number 21-02937-203</i>	\$4,474,045
Review of a Request for Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 7/30/2021 Report Number 21-02313-206</i>	\$58,302,876

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation <i>Issued 8/2/2021 Report Number 21-01015-198</i>	\$86,097,886
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract <i>Issued 8/10/2021 Report Number 21-01567-216</i>	—
Review of a Request for a Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 8/12/2021 Report Number 21-01759-221</i>	—
Review of a Request for Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 8/13/2021 Report Number 21-02216-211</i>	—
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 8/13/2021 Report Number 21-01985-227</i>	\$3,321,080
Review of a Proposal Submitted under a Solicitation <i>Issued 8/30/2021 Report Number 21-02941-223</i>	\$4,013,764
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 8/31/2021 Report Number 21-03014-245</i>	—
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract <i>Issued 9/7/2021 Report Number 21-01984-248</i>	—
Review of a Proposal Submitted under a Solicitation <i>Issued 9/8/2021 Report Number 21-02965-241</i>	\$2,548,657
Review of a Proposal Submitted under a Solicitation <i>Issued 9/15/2021 Report Number 21-03425-260</i>	\$1,790,545
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 9/20/2021 Report Number 21-00328-279</i>	\$130,166
Review of a Proposal Submitted under a Solicitation <i>Issued 9/27/2021 Report Number 21-03307-272</i>	\$478,707
Review of a Request for Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 9/27/2021 Report Number 21-03246-282</i>	\$600,174

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of a Request for Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 9/27/2021 Report Number 21-01533-284</i>	\$58,848
Review of a Proposal Submitted under a Solicitation <i>Issued 9/28/2021 Report Number 21-03357-274</i>	\$1,511,697
Review of Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 9/28/2021 Report Number 21-01471-276</i>	\$226,370
Review of a Proposal Submitted under a Solicitation <i>Issued 9/29/2021 Report Number 21-03577-277</i>	\$2,950,277
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation <i>Issued 9/29/2021 Report Number 21-01632-288</i>	\$19,956,275
Review of a Request for Modification for Product Additions Submitted under a Federal Supply Schedule Contract <i>Issued 9/29/2021 Report Number 21-01934-291</i>	\$18,510
TOTAL	\$329,391,974

Note: Numbers may not sum due to rounding.

POSTAWARD REVIEWS	QUESTIONED COSTS
Review of a Voluntary Disclosure and Refund Offer due to Late Filing of Permanent FCPs under a Federal Supply Schedule Contract <i>Issued 4/1/2021 Report Number 20-03962-110</i>	\$254
Review of a Voluntary Disclosure and Refund Offer due to Unreported Sales and Unpaid IFF under Federal Supply Schedule Contracts <i>Issued 4/20/2021 Report Number 21-01043-118</i>	\$119,353
Review of Voluntary Disclosures Submitted Under Federal Supply Schedule Contracts <i>Issued 4/21/2021 Report Number 20-01329-112</i>	\$1,284,307
Settlement Agreement <i>Issued 4/23/2021 Report Number 20-01562-119</i>	\$438,976
Review of Voluntary Disclosures of Noncompliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts <i>Issued 5/3/2021 Report Number 19-07086-132</i>	\$4,951

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)	QUESTIONED COSTS
Review of Unreported Sales under a Federal Supply Schedule Interim Agreement <i>Issued 6/7/2021 Report Number 21-01041-161</i>	\$882
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract <i>Issued 6/14/2021 Report Number 20-03314-149</i>	\$811,420
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract <i>Issued 7/27/2021 Report Number 21-00873-193</i>	\$664,785
Review of a Voluntary Disclosure Submitted Under a Federal Supply Schedule Interim Agreement and Contract <i>Issued 7/30/2021 Report Number 21-01388-184</i>	\$46,920
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract <i>Issued 8/2/2021 Report Number 20-02089-137</i>	\$423,430
Review of a Contract Closeout Proposal under a VA Contract <i>Issued 8/6/2021 Report Number 21-00690-209</i>	\$1,056,861
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract <i>Issued 8/12/2021 Report Number 21-02069-226</i>	\$464
Review of Compliance with Billing Requirements <i>Issued 8/17/2021 Report Number 20-02933-238</i>	\$11,724,146
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract <i>Issued 8/20/2021 Report Number 19-07085-218</i>	\$20,735
Review of a Voluntary Disclosure Submitted by an Affiliate <i>Issued 9/9/2021 Report Number 20-03283-261</i>	\$1,052,384
Review of Compliance Requirements under a Federal Supply Schedule Contract <i>Issued 9/15/2021 Report Number 21-02997-255</i>	\$489
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract <i>Issued 9/15/2021 Report Number 20-03176-263</i>	\$352,781

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)	QUESTIONED COSTS
Review of Price Reduction Clause Violations under a Federal Supply Schedule Contract <i>Issued 9/29/2021 Report Number 21-01861-292</i>	\$5,184
Review of a Federal Supply Schedule Contract due to Price Reductions Clause Violations <i>Issued 9/30/2021 Report Number 20-02092-293</i>	\$68,913
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract <i>Issued 9/30/2021 Report Number 20-04360-280</i>	\$521,940
Total	\$18,599,176

Note: Numbers may not sum due to rounding.

CLAIM REVIEWS	BETTER USE OF FUNDS
Certified Claim under a Federal Supply Schedule Program <i>Issued 4/30/2021 Report Number 21-00244-135</i>	—
Certified Claim under a VA Contract <i>Issued 5/28/2021 Report Number 21-00187-144</i>	—
Review of a Settlement Proposal Submitted under a VA Contract <i>Issued 6/2/2021 Report Number 21-01391-160</i>	\$188,658
Review of a Termination Settlement Proposal Submitted under a VA Contract <i>Issued 6/22/2021 Report Number 21-01299-169</i>	\$62,526
Review of a Settlement Proposal Submitted under a VA Contract <i>Issued 7/15/2021 Report Number 21-01393-188</i>	\$256,216
Review of Termination Settlement Proposal Submitted under A VA Contract <i>Issued 8/18/2021 Report Number 20-04160-237</i>	\$50,381
TOTAL	\$557,781

Note: Numbers may not sum due to rounding.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Ann Arbor VA Medical Center in Michigan	4/22/2021	20-01266-117
Aleda E. Lutz VA Medical Center in Saginaw, Michigan	5/5/2021	20-01272-129
Cincinnati VA Medical Center in Ohio	5/19/2021	20-01276-131
Chillicothe VA Medical Center in Ohio	5/27/2021	20-01268-143
Battle Creek VA Medical Center in Michigan	6/1/2021	20-01267-148
VA Northern Indiana Health Care System in Marion	6/15/2021	20-01270-154
John D. Dingell VA Medical Center in Detroit, Michigan	6/23/2021	20-01273-162
Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati	7/1/2021	20-01265-172
Boise VA Medical Center in Idaho	7/12/2021	20-01256-179
VA Portland Health Care System in Oregon	7/13/2021	20-01257-180
VA Puget Sound Health Care System in Seattle, Washington	7/28/2021	20-01261-194
Roseburg VA Health Care System in Oregon	8/2/2021	20-01259-196
Mann-Grandstaff VA Medical Center in Spokane, Washington	8/4/2021	20-01262-191
Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington	8/4/2021	20-01254-185
Sheridan VA Medical Center in Wyoming	8/9/2021	21-00255-200
VA Western Colorado Health Care System in Grand Junction	8/17/2021	21-00247-210
Montana VA Health Care System in Fort Harrison	8/19/2021	21-00232-205
VA Eastern Colorado Health Care System in Aurora	8/25/2021	21-00246-228
VA Salt Lake City Health Care System in Utah	8/31/2021	21-00254-213
Providence VA Medical Center in Rhode Island	9/1/2021	21-00265-231
Oklahoma City VA Health Care System in Oklahoma	9/2/2021	21-00253-239
Eastern Oklahoma VA Health Care System in Muskogee	9/2/2021	21-00251-212
Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts	9/9/2021	21-00260-232
VA Central Western Massachusetts Healthcare System in Leeds	9/14/2021	21-00263-246
Manchester VA Medical Center in New Hampshire	9/15/2021	21-00262-247
White River Junction VA Medical Center in Vermont	9/15/2021	21-00258-230

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Cheyenne VA Medical Center in Wyoming	9/20/2021	21-00245-256
Veterans Integrated Service Network 19: VA Rocky Mountain Network in Glendale, Colorado	9/21/2021	21-00233-257
VA Maine Healthcare System in Augusta	9/23/2021	21-00257-252
North Florida/South Georgia Veterans Health System in Gainesville, Florida	9/24/2021	21-00269-268
VA Boston Healthcare System in Massachusetts	9/24/2021	21-00261-266
West Palm Beach VA Medical Center in Florida	9/29/2021	21-00272-283
VA Connecticut Healthcare System in West Haven	9/29/2021	21-00266-281
Miami VA Healthcare System in Florida	9/30/2021	21-00268-273

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison	4/15/2021	20-00545-115
Deficiencies in Leaders' Responses to Lapses in Reusable Medical Equipment Reprocessing at the Chillicothe VA Medical Center in Ohio	5/6/2021	20-02265-100
Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio	5/6/2021	20-01523-102
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia	5/11/2021	20-03593-140
Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma	5/18/2021	20-03886-141
Drug Interactions Related to a Patient Death, Marion VA Medical Center in Illinois	5/20/2021	20-03380-136
Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	6/2/2021	18-02496-157
Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida	6/3/2021	20-03535-146
Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens	6/22/2021	20-02968-170
Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans	6/30/2021	21-00669-176

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia	7/1/2021	20-00354-178
Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque	7/8/2021	20-00716-177
Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington	7/8/2021	20-01930-183
Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas	7/15/2021	20-02993-181
Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee	7/21/2021	20-04341-182
Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Healthcare System in Utah	7/29/2021	21-00657-197
Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center, in Charleston, South Carolina	8/3/2021	20-03763-207
Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center, Charleston, South Carolina	8/3/2021	20-02368-202
Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas	8/18/2021	20-03635-217
Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina	8/24/2021	21-00371-222
Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California	8/24/2021	20-03359-220
Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin	8/26/2021	20-01917-242
Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama	9/15/2021	20-02907-254
Facility Leaders' Response to Level 2 and Level 3 Pathology Reading Errors at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas	9/21/2021	21-01677-259

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Facility Leaders Provided Oversight of a Physician in Fellowship Training at VA Sierra Nevada Health Care System in Reno	9/22/2021	21-02070-265
Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California	9/23/2021	21-00271-258
Clinically Appropriate Anemia Care and Timing of a Colonoscopy Procedure for a Patient at the VA Caribbean Healthcare System in San Juan, Puerto Rico	9/27/2021	21-01334-269
Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina	9/27/2021	21-01304-275
Failure to Mitigate Risk of and Manage a COVID-19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois	9/28/2021	21-00553-285
NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Review of Community-Based Outpatient Clinics Closed Due to the COVID-19 Pandemic	4/6/2021	20-03002-108
Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic	6/24/2021	19-09808-171
Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19	7/7/2021	21-01699-175
Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations	8/5/2021	20-01979-199
Review of Veterans Health Administration Staffing Models	8/19/2021	20-01508-214
Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2020	8/26/2021	21-01502-240
Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020	9/22/2021	21-01509-264
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2021	9/28/2021	21-01357-271

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

VET CENTER INSPECTIONS	ISSUE DATE	REPORT NUMBER
Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers	9/30/2021	21-01805-286
Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers	9/30/2021	20-04051-287
Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers	9/30/2021	20-02014-270

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

ADMINISTRATIVE INVESTIGATIONS	ISSUE DATE	REPORT NUMBER
Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus	9/9/2021	20-03465-243

TABLE A.4. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	\$481,962,421
Better Use of Funds	\$502,238,441
Total	\$984,200,862

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	\$0
Reports with questioned costs issued during the reporting period	45	\$481,962,421
Total inventory this reporting period	45	\$481,962,421
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	NUMBER	DOLLAR VALUE
Reports with disallowed costs (agreed to by management)	45	\$481,962,421
Reports with allowed costs (not agreed to by management)	0	\$0
Total management decisions this period	45	\$481,962,421
Total carried over to next reporting period	0	\$0

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	\$0
Reports with recommended funds to be put to better use issued during the reporting period	39	\$502,238,441
Total inventory this reporting period	39	\$502,238,441
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	NUMBER	DOLLAR VALUE
Reports with disallowed costs (agreed to by management)	39	\$502,238,441
Reports with allowed costs (not agreed to by management)	0	\$0
Total management decisions this period	39	\$502,238,441
Total carried over to next reporting period	0	\$0

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

Follow-up reporting and tracking of federal inspector general recommendations are required by the Federal Acquisition Streamlining Act of 1994 (P.L. 103-355), as amended by the National Defense Authorization Act of 1996 (P.L. 104-106). The acts require agencies to complete final action on each management decision required with regard to a recommendation in any federal office of inspector general report within 12 months of the report's issuance/publication. If the agency fails to complete final action within the 12-month period, federal inspectors general are required by §5(a) (3) of the IG Act to identify the matter in each semiannual report to congress until final action on the management decision is completed. The tables that follow identify all unimplemented VA OIG reports and recommendation. All data in the tables are current as of September 30, 2021. Real-time information on the status of VA OIG recommendations is available through the OIG's Recommendation Dashboard.

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



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

Table B.1 identifies the number of VA OIG reports with at least one unimplemented recommendation, with results sorted by action office. As of September 30, 2021, there were 200 total open reports, with 65 open more than a year and 135 open less than a year. However, table B.1 shows a total of 212 open reports, with 67 open more than a year and 145 open less than a year. This is because 12 reports are counted multiple times in the table, as they have open recommendations for more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	50	120	170
Veterans Benefits Administration	8	9	17
National Cemetery Administration	0	1	1
Office of Acquisition, Logistics, and Construction	2	4	6
Office of Management	1	2	3
Office of Information and Technology	2	4	6
Office of Human Resources and Administration/ Office of Operations, Security and Preparedness	3	2	5
Office of Electronic Health Record Modernization	1	2	3
Office of Asset Enterprise Management	0	1	1
Total	67	145	212

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

Table B.2 identifies the number of open VA OIG recommendations with results sorted by action office. As of September 30, 2021, there are 975 total open recommendations, with 173 open more than a year and 802 open less than a year. However, table B.2 shows a total of 980 open recommendations, with 177 open more than a year and 803 open less than a year. This is because five recommendations are counted multiple times in the table as they have actions pending for more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	124	712	836
Veterans Benefits Administration	16	19	35
National Cemetery Administration	0	11	11
Office of Acquisition, Logistics, and Construction	5	9	14
Office of Management	16	3	19
Office of Information and Technology	4	34	38
Office of Human Resources and Administration/ Office of Operations, Security and Preparedness	9	4	13
Office of Electronic Health Record Modernization	3	8	11
Office of Asset Enterprise Management	0	3	3
Total	177	803	980

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

Table B.3 identifies the 135 reports and 802 recommendations that, as of September 30, 2021, have been open less than one year. The total monetary benefit attached to these recommendations is \$1,081,051,931.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina <i>Issued 11/05/2020 Report Number 20-00132-04</i>	VHA	3-4	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center in Dublin, Georgia <i>Issued 11/12/2020 Report Number 20-00130-06</i>	VHA	2, 6-9	—
Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died <i>Issued 11/17/2020 Report Number 19-08542-11</i>	VHA	4	—
Comprehensive Healthcare Inspection of the Atlanta VA Health Care System in Decatur, Georgia <i>Issued 11/18/2020 Report Number 20-00129-09</i>	VHA	4, 7-8, 10, 15	—
Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California <i>Issued 11/19/2020 Report Number 19-08411-12</i>	VHA	1-2	—
Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans <i>Issued 11/23/2020 Report Number 19-07316-262</i>	VHA	1, 3-5	—
Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019 <i>Issued 11/24/2020 Report Number 20-01994-18</i>	VHA	1, 4, 8, 11-20, 23-25, 27-32	—
Management and Oversight of the Electronic Wait List for Healthcare Services <i>Issued 12/01/2020 Report Number 19-09161-02</i>	VHA	1-3	—
Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement <i>Issued 12/09/2020 Report Number 20-00608-29</i>	VBA	1	\$362,500,000
Comprehensive Healthcare Inspection of the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina <i>Issued 12/15/2020 Report Number 20-00130-25</i>	VHA	8-9	—
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia <i>Issued 12/16/2020 Report Number 20-00132-28</i>	VHA	5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing <i>Issued 12/18/2020 Report Number 20-02774-26</i>	VHA	2-4	—
Deficiencies in Privileging a Urologist to Practice and Medication Management Processes at the VA Central Iowa Health Care System in Des Moines <i>Issued 01/12/2021 Report Number 20-02359-52</i>	VHA	2, 5	—
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida <i>Issued 01/13/2021 Report Number 18-01321-56</i>	VHA	3, 10	—
VA Needs to Comply Fully with the Geospatial Data Act of 2018 <i>Issued 01/26/2021 Report Number 20-02339-35</i>	OIT	2	—
Comprehensive Healthcare Inspection of the Dayton VA Medical Center in Ohio <i>Issued 02/03/2021 Report Number 20-01271-64</i>	VHA	4, 7, 9	—
Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi <i>Issued 02/10/2021 Report Number 20-01036-70</i>	VHA	1-2, 5	—
Insufficient Oversight for Issuing Prosthetic Supplies and Devices <i>Issued 02/11/2021 Report Number 18-00972-38</i>	VHA	1-4	\$79,200,000
VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York <i>Issued 02/17/2021 Report Number 19-09129-76</i>	VHA	1-2	—
VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits <i>Issued 02/23/2021 Report Number 20-00295-61</i>	VHA	4	—
Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic <i>Issued 02/24/2021 Report Number 20-02959-62</i>	VHA	2	—
Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement <i>Issued 02/25/2021 Report Number 19-07053-51</i>	VHA	1-11	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center <i>Issued 02/25/2021 Report Number 20-00563-68</i>	VHA	1-3, 5-7	—
The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor <i>Issued 03/02/2021 Report Number 19-06902-23</i>	VHA	1-3	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 7: VA Southeast Network in Duluth, Georgia <i>Issued 03/03/2021 Report Number 20-00130-86</i>	VHA	3-5	—
VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors <i>Issued 03/03/2021 Report Number 20-00421-63</i>	VBA	1-6	—
Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics <i>Issued 03/04/2021 Report Number 20-01387-89</i>	VHA	1-2	—
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing <i>Issued 03/04/2021 Report Number 19-06147-50</i>	OALC VHA	OALC: 5-8 VHA: 1-4, 9-10	\$3,700,000
Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic <i>Issued 03/11/2021 Report Number 20-02717-85</i>	VHA	1-2	—
View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery <i>Issued 03/11/2021 Report Number 20-00427-92</i>	VHA	2, 4-9	—
Alleged Irregularities Regarding Physician Incentive Compensation Were Not Substantiated <i>Issued 03/17/2021 Report Number 19-00652-79</i>	VHA	1	—
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona <i>Issued 03/23/2021 Report Number 20-02667-93</i>	VHA	2-6	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics <i>Issued 03/31/2021 Report Number 20-01386-107</i>	VHA	1-3	—
Comprehensive Healthcare Inspection of the Ann Arbor VA Medical Center in Michigan <i>Issued 04/22/2021 Report Number 20-01266-117</i>	VHA	1-9	—
Federal Information Security Modernization Act Audit for Fiscal Year 2020 <i>Issued 04/29/2021 Report Number 20-01927-104</i>	OIT	1-26	—
Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan <i>Issued 05/05/2021 Report Number 20-01272-129</i>	VHA	3	—
Deficiencies in Leaders' Responses to Lapses in Reusable Medical Equipment Reprocessing at the Chillicothe VA Medical Center in Ohio <i>Issued 05/06/2021 Report Number 20-02265-100</i>	VHA	1	—
Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio <i>Issued 05/06/2021 Report Number 20-01523-102</i>	VHA	1-12	—
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia <i>Issued 05/11/2021 Report Number 20-03593-140</i>	VHA	1-2, 4-15	—
Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma <i>Issued 05/18/2021 Report Number 20-03886-141</i>	VHA	2-3	—
The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings <i>Issued 05/18/2021 Report Number 20-00049-122</i>	VBA	1	—
Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio <i>Issued 05/19/2021 Report Number 20-01276-131</i>	VHA	4-10, 12-16	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
<p>Drug Interactions Related to a Patient Death, Marion VA Medical Center in Illinois</p> <p><i>Issued 05/20/2021 Report Number 20-03380-136</i></p>	VHA	1-5	—
<p>Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</p> <p><i>Issued 05/25/2021 Report Number 20-03178-116</i></p>	OEHRM OM VHA	OEHRM: 1, 5 OM: 2 VHA: 3-4	—
<p>Comprehensive Healthcare Inspection of the Chillicothe VA Medical Center in Ohio</p> <p><i>Issued 05/27/2021 Report Number 20-01268-143</i></p>	VHA	1-12	—
<p>Compensation and Pension Proceeds Were Generally Handled Accurately but Some Were Delayed</p> <p><i>Issued 05/27/2021 Report Number 20-00817-123</i></p>	VBA	1	—
<p>Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan</p> <p><i>Issued 06/01/2021 Report Number 20-01267-148</i></p>	VHA	1-6, 9-11	—
<p>Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas</p> <p><i>Issued 06/02/2021 Report Number 18-02496-157</i></p>	VHA	1-12	—
<p>Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida</p> <p><i>Issued 06/03/2021 Report Number 20-03535-146</i></p>	VHA	1-2	—
<p>Program of Comprehensive Assistance for Family Caregivers: IT System Development Challenges Affect Expansion</p> <p><i>Issued 06/08/2021 Report Number 20-00178-24</i></p>	OIT	1-4	—
<p>Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic</p> <p><i>Issued 06/09/2021 Report Number 20-03326-124</i></p>	VHA	1-3	—
<p>Review of VHA's Financial Oversight of COVID-19 Supplemental Funds</p> <p><i>Issued 06/10/2021 Report Number 20-02967-121</i></p>	VHA	1-2	—
<p>Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency</p> <p><i>Issued 06/10/2021 Report Number 20-00541-133</i></p>	OHRA/ OSP VHA	OHRA/OSP: 1-3 VHA: 4-5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
<p>Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available Before the COVID-19 Pandemic</p> <p><i>Issued 06/14/2021 Report Number 20-03075-138</i></p>	OALC VHA	OALC: 1 VHA: 2	—
<p>Comprehensive Healthcare Inspection of the VA Northern Indiana Health Care System in Marion</p> <p><i>Issued 06/15/2021 Report Number 20-01270-154</i></p>	VHA	1-13, 15, 18	—
<p>Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs</p> <p><i>Issued 06/15/2021 Report Number 20-01487-142</i></p>	VHA	1-2	\$129,709,810
<p>Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System</p> <p><i>Issued 06/16/2021 Report Number 19-07719-113</i></p>	VHA	1-8	\$5,552,000
<p>Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records</p> <p><i>Issued 06/17/2021 Report Number 19-08658-153</i></p>	VHA	1-2	—
<p>Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens</p> <p><i>Issued 06/22/2021 Report Number 20-02968-170</i></p>	VHA	1-7	—
<p>Inspection of Information Technology Security at the VA Outpatient Clinic in Austin, Texas</p> <p><i>Issued 06/22/2021 Report Number 20-01485-114</i></p>	OIT	1-3	—
<p>Comprehensive Healthcare Inspection of the John D. Dingell VA Medical Center in Detroit, Michigan</p> <p><i>Issued 06/23/2021 Report Number 20-01273-162</i></p>	VHA	1-5	—
<p>VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care</p> <p><i>Issued 06/23/2021 Report Number 20-01141-145</i></p>	VHA	1-5	—
<p>Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic</p> <p><i>Issued 06/24/2021 Report Number 19-09808-171</i></p>	VHA	1-5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
<p>Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards</p> <p><i>Issued 06/24/2021 Report Number 20-00176-125</i></p>	NCA	1-11	—
<p>Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk</p> <p><i>Issued 06/29/2021 Report Number 20-00345-77</i></p>	VHA	1-10	—
<p>Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia</p> <p><i>Issued 07/01/2021 Report Number 20-00354-178</i></p>	VHA	1-3	—
<p>Comprehensive Healthcare Inspection of Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati</p> <p><i>Issued 07/01/2021 Report Number 20-01265-172</i></p>	VHA	3-7	—
<p>VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules</p> <p><i>Issued 07/01/2021 Report Number 20-01646-139</i></p>	OM VHA	OM: 8-9 VHA: 1-7	\$16,600,000
<p>Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</p> <p><i>Issued 07/07/2021 Report Number 20-03185-151</i></p>	OEHRM	1-6	—
<p>Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque</p> <p><i>Issued 07/08/2021 Report Number 20-00716-177</i></p>	VHA	1-5	—
<p>VBA Overpaid Veterans Due to Delays in Reducing Compensation Benefits</p> <p><i>Issued 07/08/2021 Report Number 20-03229-155</i></p>	VBA	1-2	\$348,000,000
<p>Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington</p> <p><i>Issued 07/08/2021 Report Number 20-01930-183</i></p>	VHA	1-11	—
<p>Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations</p> <p><i>Issued 07/08/2021 Report Number 20-03704-165</i></p>	VHA	1-3	\$17,900,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Boise VA Medical Center in Idaho <i>Issued 07/12/2021 Report Number 20-01256-179</i>	VHA	1-8, 10	—
Adaptive Sports Grants Management Needs Improvement <i>Issued 07/13/2021 Report Number 20-01807-173</i>	VHA	1-7	\$247,000
Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon <i>Issued 07/13/2021 Report Number 20-01257-180</i>	VHA	1, 2, 5-13, 15, 17	—
Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas <i>Issued 07/15/2021 Report Number 20-02993-181</i>	VHA	1-10	—
Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee <i>Issued 07/21/2021 Report Number 20-04341-182</i>	VHA	1-10	—
VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds <i>Issued 07/21/2021 Report Number 20-00433-168</i>	VBA	2	—
Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services <i>Issued 07/22/2021 Report Number 19-08267-147</i>	VHA	1-5	\$35,300,000
Comprehensive Healthcare Inspection of the VA Puget Sound Health Care System in Seattle, Washington <i>Issued 07/28/2021 Report Number 20-01261-194</i>	VHA	1, 3-6, 8-21	—
Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Healthcare System in Utah <i>Issued 07/29/2021 Report Number 21-00657-197</i>	VHA	1-3	—
Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon <i>Issued 08/02/2021 Report Number 20-01259-196</i>	VHA	1-13	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020 <i>Issued 08/02/2021 Report Number 21-00519-192</i>	VBA VHA	VBA: 1 VHA: 2-3	—
Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center, Charleston, South Carolina <i>Issued 08/03/2021 Report Number 20-02368-202</i>	VHA	1, 3-4	—
Deficiencies in the Management of a Patient's Reported Intimate Partner Violence at the Ralph H. Johnson VA Medical Center, in Charleston, South Carolina <i>Issued 08/03/2021 Report Number 20-03763-207</i>	VHA	4	—
Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington <i>Issued 08/04/2021 Report Number 20-01262-191</i>	VHA	1-2, 4-10, 13	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington <i>Issued 08/04/2021 Report Number 20-01254-185</i>	VHA	1-4	—
Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program <i>Issued 08/04/2021 Report Number 20-02828-174</i>	VHA	1-8	\$6,570,395
Improvements Still Needed in Processing Military Sexual Trauma Claims <i>Issued 08/05/2021 Report Number 20-00041-163</i>	VBA	1-4	—
Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations <i>Issued 08/05/2021 Report Number 20-01979-199</i>	VHA	1	—
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center in Wyoming <i>Issued 08/09/2021 Report Number 21-00255-200</i>	VHA	1-3	—
Financial Efficiency Review of the Miami VA Healthcare System <i>Issued 08/11/2021 Report Number 20-01796-195</i>	VHA	1-12	\$328,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
<p>Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA</p> <p><i>Issued 08/12/2021 Report Number 20-00418-166</i></p>	VHA	1-8	\$14,907,365
<p>Comprehensive Healthcare Inspection of the VA Western Colorado Health Care System in Grand Junction</p> <p><i>Issued 08/17/2021 Report Number 21-00247-210</i></p>	VHA	3-4	—
<p>Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas</p> <p><i>Issued 08/18/2021 Report Number 20-03635-217</i></p>	VHA	1-9	—
<p>Comprehensive Healthcare Inspection of the Montana VA Health Care System in Fort Harrison</p> <p><i>Issued 08/19/2021 Report Number 21-00232-205</i></p>	VHA	4, 8	—
<p>Review of Veterans Health Administration Staffing Models</p> <p><i>Issued 08/19/2021 Report Number 20-01508-214</i></p>	VHA	1-3	—
<p>Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California</p> <p><i>Issued 08/24/2021 Report Number 20-03359-220</i></p>	VHA	1-5	—
<p>Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina</p> <p><i>Issued 08/24/2021 Report Number 21-00371-222</i></p>	VHA	1-7	—
<p>Comprehensive Healthcare Inspection of the VA Eastern Colorado Health Care System in Aurora</p> <p><i>Issued 08/25/2021 Report Number 21-00246-228</i></p>	VHA	4-7	—
<p>Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2020</p> <p><i>Issued 08/26/2021 Report Number 21-01502-240</i></p>	VHA	1-4	—
<p>Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin</p> <p><i>Issued 08/26/2021 Report Number 20-01917-242</i></p>	VHA	1-10	—
<p>Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah</p> <p><i>Issued 08/31/2021 Report Number 21-00254-213</i></p>	VHA	1-6	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Providence VA Medical Center in Rhode Island <i>Issued 09/01/2021 Report Number 21-00265-231</i>	VHA	1-3	—
Blue Water Navy Outreach Requirements Were Met, but Claims Processing and Procedures Could Improve <i>Issued 09/02/2021 Report Number 20-03938-208</i>	VBA	2-3	\$37,200,000
Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma <i>Issued 09/02/2021 Report Number 21-00253-239</i>	VHA	2-3, 5	—
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System in Muskogee <i>Issued 09/02/2021 Report Number 21-00251-212</i>	VHA	1-9	—
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts <i>Issued 09/09/2021 Report Number 21-00260-232</i>	VHA	1-7	—
Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus <i>Issued 09/09/2021 Report Number 20-03465-243</i>	OAEM OHRA/ OSP VHA	OAEM: 5-7 OHRA/OSP: 2 VHA: 1, 3-4	—
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds <i>Issued 09/14/2021 Report Number 21-00263-246</i>	VHA	1-5	—
Excess Purchase of Surgical Supplies and Improper Purchase Card Transactions at the New Orleans VA Medical Center in Louisiana <i>Issued 09/14/2021 Report Number 20-00395-224</i>	VHA	1-6	\$3,145,291
Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont <i>Issued 09/15/2021 Report Number 21-00258-230</i>	VHA	1-2	—
Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama <i>Issued 09/15/2021 Report Number 20-02907-254</i>	VHA	1-7	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
<p>Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire</p> <p><i>Issued 09/15/2021 Report Number 21-00262-247</i></p>	VHA	2-7	—
<p>Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming</p> <p><i>Issued 09/20/2021 Report Number 21-00245-256</i></p>	VHA	6-7	—
<p>Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans</p> <p><i>Issued 09/20/2021 Report Number 20-00971-235</i></p>	VHA	1-6	\$192,070
<p>Comprehensive Healthcare Inspection of Veterans Integrated Service Network 19: VA Rocky Mountain Network in Glendale, Colorado</p> <p><i>Issued 09/21/2021 Report Number 21-00233-257</i></p>	VHA	4	—
<p>Facility Leaders' Response to Level 2 and Level 3 Pathology Reading Errors at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas</p> <p><i>Issued 09/21/2021 Report Number 21-01677-259</i></p>	VHA	1-3	—
<p>Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020</p> <p><i>Issued 09/22/2021 Report Number 21-01509-264</i></p>	VHA	1-7	—
<p>Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta</p> <p><i>Issued 09/23/2021 Report Number 21-00257-252</i></p>	VHA	1-3, 5-11	—
<p>Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California</p> <p><i>Issued 09/23/2021 Report Number 21-00271-258</i></p>	VHA	1-7	—
<p>Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors</p> <p><i>Issued 09/23/2021 Report Number 20-01802-234</i></p>	VHA	1-4	\$20,000,000
<p>Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts</p> <p><i>Issued 09/24/2021 Report Number 21-00261-266</i></p>	VHA	1-8	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida <i>Issued 09/24/2021 Report Number 21-00269-268</i>	VHA	1-6	—
Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina <i>Issued 09/27/2021 Report Number 21-01304-275</i>	VHA	1-6	—
Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened <i>Issued 09/27/2021 Report Number 20-01910-244</i>	OALC	1-3	—
Failure to Mitigate Risk of and Manage a COVID-19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois <i>Issued 09/28/2021 Report Number 21-00553-285</i>	VHA	1-15	—
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven <i>Issued 09/29/2021 Report Number 21-00266-281</i>	VHA	1-8	—
Comprehensive Healthcare Inspection of the West Palm Beach VA Medical Center in Florida <i>Issued 09/29/2021 Report Number 21-00272-283</i>	VHA	1-2	—
VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report <i>Issued 09/29/2021 Report Number 20-03407-253</i>	OALC VHA	OALC, VHA: 1 VHA: 2	—
Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida <i>Issued 09/30/2021 Report Number 21-00268-273</i>	VHA	1-5	—
Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers <i>Issued 09/30/2021 Report Number 21-01805-286</i>	VHA	1-23	—
Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers <i>Issued 09/30/2021 Report Number 20-02014-270</i>	VHA	1-22	—
Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers <i>Issued 09/30/2021 Report Number 20-04051-287</i>	VHA	1-20	—
Total			\$1,081,051,931

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

Table B.4 identifies the 65 reports and 173 recommendations that, as of September 30, 2021, remain open for more than one year. The total monetary benefit attached to these reports is \$1,136,041,400.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments</p> <p><i>Issued 7/11/2014 Report Number 13-01452-214</i></p> <p>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.</p>	VBA	\$205,000,000
<p>Audit of the Personnel Suitability Program</p> <p><i>Issued 03/26/2018 Report Number 17-00753-78</i></p> <p>Recommendation 2: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.</p>	OHRA/ OSP	—
<p>Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls</p> <p><i>Issued 05/07/2018 Report Number 15-00022-139</i></p> <p>Recommendation 5: The OIG recommended the Under Secretary for Health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).</p>	VHA	\$173,829,000
<p>Unwarranted Medical Reexaminations for Disability Benefits</p> <p><i>Issued 07/17/2018 Report Number 17-04966-201</i></p> <p>Recommendation 1: The Under Secretary for Benefits establishes internal controls sufficient to ensure that a reexamination is necessary prior to employees ordering it, and modifies VBA procedures as appropriate to reflect these improved business processes.</p> <p>Recommendation 4: The Under Secretary for Benefits conducts a special focused quality improvement review of cases with unwarranted reexaminations to develop data sufficient to understand and redress the causes of any avoidable errors.</p>	VBA	\$100,600,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana</p> <p><i>Issued 08/08/2018 Report Number 17-04156-234</i></p> <p>Recommendation 3: The Principal Deputy Under Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Employee 3.</p>	VHA	—
<p>VA’s Management of Land Use Under the West Los Angeles Leasing Act of 2016</p> <p><i>Issued 09/28/2018 Report Number 18-00474-300</i></p> <p>Recommendation 1: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System implement a plan that puts the West LA campus in compliance with the West Los Angeles Leasing Act of 2016, the Draft Master Plan, and other federal laws, including reasonable time periods to correct deficiencies noted in this report.</p> <p>Recommendation 2: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure all non-VA entities operating on the West LA campus with expired or undocumented land use agreements establish new agreements compliant with the West Los Angeles Leasing Act.</p>	OALC, VHA	—
<p>Inadequate Governance of the VA Police Program at Medical Facilities</p> <p><i>Issued 12/13/2018 Report Number 17-01007-01</i></p> <p>Recommendation 1: Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.</p> <p>Recommendation 2: Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.</p> <p>Recommendation 4: Assess the staffing levels for the Office of Security and Law Enforcement police inspection program, and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.</p> <p>Recommendation 5: Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders.</p>	OHRA/ OSP, VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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VA’s Administration of the Transformation Twenty-One Total Technology Next Generation Contract	OALC	\$37,500,000
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Issued 06/13/2019 | Report Number 17-04178-46

Recommendation 1: The Technology Acquisition Center associate executive director provide written requirements, in designation memoranda or other written medium, that identify the method and level of detail required for program office contracting officers’ representatives to adequately document their review of contractor deliverables and determination of acceptability.

Recommendation 2: The Technology Acquisition Center associate executive director develop procedures for Technology Acquisition Center contracting officers to ensure review and acceptability of contractor deliverables is adequately documented in contract files to help prevent improper payments.

Recommendation 7: The Technology Acquisition Center associate executive director enhance written procedures by providing Technology Acquisition Center contracting officers with standards that define higher-risk financial stability risk scores and subsequent actions that should be taken when these scores are identified.

Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities	VHA	—
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Issued 06/27/2019 | Report Number 18-00037-154

Recommendation 06: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews and provides input into the patient referral process to mental health clinical pharmacists with consideration for ensuring that accurate diagnoses can be reliably identified by and conveyed to the mental health clinical pharmacists.

Recommendation 07: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews the patient referral process to mental health clinical pharmacists and provides input with consideration for clinical settings or scenarios in which a review of the clinical complexity of the referral by a licensed independent practitioner with prescribing authority would be appropriate, prior to treatment.

Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming	VHA	—
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Issued 07/24/2019 | Report Number 18-04680-162

Recommendation 15: The chief of staff confirms that clinicians provide and document patient/ caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians’ compliance.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Health Information Management Medical Documentation Backlog</p> <p><i>Issued 08/21/2019 Report Number 18-01214-157</i></p> <p>Recommendation 5: Assess the scanning process, including staffing and productivity levels, within each facility to ensure authorized staffing levels can support future workload.</p> <p>Recommendation 6: Ensure facility directors act on staffing level assessments and obtain the necessary resources within scanning departments.</p>	VHA	—
<p>Accuracy of Claims Decisions Involving Conditions of the Spine</p> <p><i>Issued 09/05/2019 Report Number 18-05663-189</i></p> <p>Recommendation 1: Implement a plan to conduct a focused analysis of claims processor compliance with the requirements set forth by recent court decisions regarding examiner opinions and formulate a plan to review and take corrective action on affected claims if deemed necessary based on the results of that review.</p> <p>Recommendation 2: Develop a plan to update the rating schedule to establish more objective criteria for each level of evaluation for peripheral nerves.</p> <p>Recommendation 3: Review all sections of the procedures manual related to peripheral nerve disability evaluations and develop a plan to make updates and clarifications where applicable.</p> <p>Recommendation 5: Update the Evaluation Builder tool to help users provide more accurate, comprehensive, and consistent information for claims decisions involving the spine and peripheral nerves.</p>	VBA	\$64,800,000
<p>State Prescription Drug Monitoring Programs Need Increased Use and Oversight</p> <p><i>Issued 09/23/2019 Report Number 18-02830-164</i></p> <p>Recommendation 3: Ensure VA clinicians who prescribe opioids take the Pain Management and Opioid Safety training once, with annual refresher training.</p>	VHA	—
<p>Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma</p> <p><i>Issued 09/24/2019 Report Number 18-06510-222</i></p> <p>Recommendation 10: The facility director confirms that the Women Veterans Health Committee includes required core members and monitors the committee's compliance</p>	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming VHA —

Issued 09/26/2019 | Report Number 18-04681-228

Recommendation 8: The associate director ensures flooring that provides cushioning is installed in the mental health seclusion rooms.

Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida VHA —

Issued 09/27/2019 | Report Number 19-00010-237

Recommendation 4: The chief of staff ensures that clinical managers clearly define focused professional practice evaluation criteria in advance with providers and monitors clinical managers' compliance.

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 VHA —

Issued 10/10/2019 | Report Number 19-07040-243

Recommendation 3: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that an interdisciplinary group or committee, that includes all required representatives, consistently reviews utilization management data and monitor committees' compliance.

Recommendation 4: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that clinical managers provide feedback about root cause analysis actions to the individuals or departments who reported the incidents and monitor clinical managers' compliance.

Recommendation 9: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that managers maintain a clean and safe environment throughout the facilities and monitor managers' compliance.

Recommendation 10: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that VA Police test panic alarms and document response times to alarm testing in locked mental health units and high-risk outpatient clinic areas and monitor VA Police compliance.

Recommendation 13: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, confirm that facility managers correct identified deficiencies from annual physical security surveys and monitor facility managers' compliance.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 14: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, verify that controlled substances coordinators reconcile one-day's dispensing from the pharmacy to every automated dispensing cabinet and returns to pharmacy stock from each dispensing area during controlled substances inspections and monitor controlled substances coordinators' compliance.

Recommendation 15: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, make certain that controlled substances coordinators refrain from routinely conducting monthly controlled substances inspections and monitor controlled substances coordinators' compliance.

Recommendation 16: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network Directors and facility senior leaders, ensure that facility managers conduct and report geriatric evaluation program performance improvement activities to an appropriate leadership board and monitor facility managers' compliance.

Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives	OIT	—
<i>Issued 10/17/2019 Report Number 19-06125-218</i>		

Recommendation 3: The assistant secretary for information and technology implements improved oversight procedures, including specific facility-level procedures, to ensure that sensitive personal information is not being stored on shared network drives.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>FY 2019 Audit of VA's Compliance under the DATA Act of 2014</p> <p><i>Issued 11/08/2019 Report Number 19-07247-251</i></p>	OM	—

Recommendation 1: We recommend the Assistant Secretary for Management and Chief Financial Officer continue the system modernization efforts that provide VA with the capability to generate the required DATA Act reporting files containing the necessary elements to meet compliance with the DATA Act. Ensure the modernization will provide the following:

- a. Accurate reporting of object class, program activity codes, program activity names and all other elements required by the DATA Act.
- b. Store award identification to allow VA to be able to develop a File C and reconcile the File C to both summary level data (Files A and B) and award level data (File D). The reconciliations should be performed prior to the quarterly certification.
- c. Report reconciliation with its subsidiary systems.
- d. A mechanism to ensure transactions are reported that currently may be excluded due to the use of 1358s.
- e. Standardize data field use to allow for management to record an award ID across financial and supporting systems.

Recommendation 2: We recommend the Assistant Secretary for Management and Chief Financial Officer ensure a DQP is finalized and implemented for future DATA Act submissions which meets the requirements for DATA Act reporting. In addition, the Office of Management, Office of Internal Control, and the Office of Enterprise Risk Management should ensure that the DQP supports the annual assurance statement and quarterly certification.

Recommendation 3: We recommend the Assistant Secretary for Management and Chief Financial Officer implement a grants management solution that will be either integrated with the new financial system or interface into it once completed. The VA should identify a grants management solution that can be implemented across all of VA's grant programs.

Recommendation 4: We recommend the Assistant Secretary for Management and Chief Financial Officer work with the SAO and component level SAO's to ensure that all certifications are signed, dated by the component SAO and received prior to the submission date.

Recommendation 5: We recommend the Assistant Secretary for Management and Chief Financial Officer ensure that the four CFDA programs (64.014, 64.015, 64.026, and 64.024) report obligations according to the definitions established for FABS reporting or obtain OMB and Treasury's approval for any deviations.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 6: We recommend the Assistant Secretary for Management and Chief Financial Officer ensure the Office of Budget implements monitoring controls over CFDA numbers to ensure any CFDA numbers that require activation are identified and activated promptly to avoid interruptions in expenditure reporting.

Recommendation 7: We recommend the Assistant Secretary for Management and Chief Financial Officer research the basis for the delays in reporting expenditure data for FABS for the VHA Veterans Prescription Service program (CFDA # 64.012) and implement a corrective action plan for timely reporting going forward. The VA PMO should also seek an exemption from OMB and Treasury regarding the reporting delays for the program if no viable solutions are identified to mitigate the timing delays.

Recommendation 8: We recommend the Assistant Secretary for Management and Chief Financial Officer obtain and document guidance from Treasury and OMB on the proper treatment of payments to contractors for VA's Veterans Choice Program as either contract award (File D1) or financial assistance (File D2).

Recommendation 9: We recommend the Assistant Secretary for Management and Chief Financial Officer obtain and document guidance from Treasury and OMB regarding inclusion of payroll and contract costs in the FABS (File D2) and the duplication of the same contract costs in the FPDS-NG (File D1).

Recommendation 10: We recommend the Assistant Secretary for Management and Chief Financial Officer implement internal controls and update policies and procedures to improve the accuracy of and completeness of the information submitted for FABS reporting. The internal controls should ensure the following:

- a. Excluded payments not reported due to zip code issues are researched, cleared, and reported in VBA's sub certification.
- b. The default code "90" for Congressional District is not used when the county or zip code are unknown; instead, perform research to obtain the required data.
- c. Support from Treasury and OMB on the proper reporting of face amount of insurance in its FABS submissions.
- d. The information submitted for each data element is adequately supported and readily available.
- e. All data elements are reported in compliance with the definitions established by the DAIMS.

Recommendation 11: We recommend the Assistant Secretary for Management and Chief Financial Officer improve review procedures prior to submission to identify errors and ensure all transactions are included in procurement and financial assistance data.

Recommendation 12: We recommend the Assistant Secretary for Management and Chief Financial Officer perform research to determine the extent to which 1358 transactions are not reported for File D1 and develop solutions.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 13: We recommend the Assistant Secretary for Management and Chief Financial Officer develop solutions and continue system modernization efforts to reduce the use of the default object class. Research and develop program activity crosswalk for medical services.

Recommendation 14: We recommend the Assistant Secretary for Management and Chief Financial Officer strengthen procedures over the process to report all program activity names and program activity codes that are reported in the quarterly OMB MAX Collect Exercise in accordance with the latest Budget Data request requirements.

Recommendation 15: We recommend the Assistant Secretary for Management and Chief Financial Officer reinforce guidance for Contracting Officers concerning areas where exceptions were noted in DATA Act reporting.

Recommendation 16: We recommend the Assistant Secretary for Management and Chief Financial Officer obtain OMB and Treasury approval for aggregating and reporting transactions based on beneficiary address. Ensure controls around the aggregation process are implemented and operating effectively.

Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut	VHA	—
<i>Issued 11/20/2019 Report Number 19-00075-14</i>		

Recommendation 5: The VA Connecticut Healthcare System Director provides oversight for the timely completion of the projects impacting Sterile Processing Services and Surgical Services that remain pending.

Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut	VHA	—
<i>Issued 11/20/2019 Report Number 18-04675-23</i>		

Recommendation 1: The chief of staff ensures that service chiefs clearly define and share in advance the expectations for the focused professional practice evaluation process with providers and monitors the service chiefs' compliance.

Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia	VHA	—
<i>Issued 11/21/2019 Report Number 19-00013-15</i>		

Recommendation 5: The chief of staff makes certain that service chiefs define and communicate expectations for focused professional practice evaluation criteria in advance and maintain appropriate documentation of the processes and monitors service chiefs' compliance.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire</p> <p><i>Issued 11/25/2019 Report Number 19-00040-10</i></p> <p>Recommendation 2: The chief of staff ensures that clinical managers document in practitioners' profiles the focused professional practice evaluation criteria defined in advance and monitors clinical managers' compliance.</p> <p>Recommendation 10: The facility director confirms that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.</p>	VHA	—
<p>Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland</p> <p><i>Issued 11/26/2019 Report Number 19-05916-24</i></p> <p>Recommendation 4: The VA Maryland Health Care System Director strengthens the process for tracking code blue/rapid response events to include timely completion of the required documentation and accountability for delinquent documentation.</p>	VHA	—
<p>Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California</p> <p><i>Issued 12/02/2019 Report Number 18-04671-25</i></p> <p>Recommendation 15: The facility director ensures that controlled substances inspectors verify controlled substances orders for five random dispensing activities during monthly inspections and monitors inspectors' compliance.</p> <p>Recommendation 18: The facility director ensures that controlled substances inspectors verify that drugs held for destruction are secured and documented during monthly pharmacy inspections and monitors inspectors' compliance.</p>	VHA	—
<p>Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, Arizona</p> <p><i>Issued 12/05/2019 Report Number 19-00014-33</i></p> <p>Recommendation 14: The chief of staff makes certain that clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.</p>	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Inadequate Oversight of the Medical/Surgical Prime Vendor Program’s Order Fulfillment and Performance Reporting for Eastern Area Medical Centers

VHA

\$84,000,000

Issued 12/17/2019 | Report Number 17-03718-240

Recommendation 1: The executive in charge, office of under secretary for health, and the principal executive director, office of acquisition, logistics, and construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to develop a formal process to validate correct order fulfillment reporting by the prime vendors, ensure the correct algorithms are used, and help prevent missed opportunities to identify and mitigate issues.

Recommendation 4: The executive in charge, office of under secretary for health, and the principal executive director, office of acquisition, logistics, and construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to strengthen processes and procedures so that staff use the Medical/Surgical Prime Vendor Next Generation formulary to change unit of issuance and product pricing information in the item master files.

Recommendation 7: The executive in charge, office of under secretary for health, and the principal executive director, Office of Acquisition, Logistics, and Construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to monitor the Integrated Product Team’s development and implementation of a process to validate performance metric reporting such as on unadjusted fill rates.

Recommendation 8: The executive in charge, office of under secretary for health, requires the Procurement and Logistics Office to strengthen controls, monitor the Healthcare Commodities Program Office monthly, and ensure adherence to the established Medical/Surgical Prime Vendor Next Generation program control plan.

Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland

VHA

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Issued 01/09/2020 | Report Number 19-00016-61

Recommendation 14: The associate director confirms that damaged furniture and wheelchairs are repaired or removed from service and monitors compliance.

Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts

VHA

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Issued 01/13/2020 | Report Number 19-00043-66

Recommendation 1: The facility director makes certain that required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives’ compliance.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 6: The chief of staff ensures that ongoing professional practice evaluations are completed by a provider with similar training and privileges and monitors compliance.

Recommendation 17: The facility director confirms that the Women Veterans Health Committee is comprised of required core members and monitors the committee's compliance.

Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts

VHA

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Issued 01/13/2020 | Report Number 19-00038-63

Recommendation 17: The chief of staff certifies that clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and evaluate understanding when education is provided, and monitors clinicians' compliance.

Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes

VHA

\$261,300,000

Issued 01/14/2020 | Report Number 19-00021-41

Recommendation 2: Ensure the Veterans Health Administration is leveraging existing technologies to make sure medical facilities are routinely monitoring veteran use of sleep apnea devices in a consistent and effective manner to more promptly identify individuals at risk of noncompliance with recommended therapies.

Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System

VHA

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Issued 01/23/2020 | Report Number 19-06378-73

Recommendation 8: The VA North Texas Health Care System Director ensures implementation of an effective tracking mechanism to ensure VA providers receive results for women veterans referred to care in the community and monitors for compliance with Veterans Health Administration policy.

Recommendation 9: The VA North Texas Health Care System Director verifies review of the electronic health records of women veterans referred to Care in the Community whose medical records have not been obtained and takes action if indicated.

Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments

VBA

\$56,900,000

Issued 02/11/2020 | Report Number 18-05738-56

Recommendation 1: The OIG recommended the under secretary for benefits conduct a review of automatically and manually completed fiscal year 2016 drill pay adjustments that involved active duty military periods during that fiscal year, and take corrective actions as necessary.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 2: The OIG recommended the under secretary for benefits conduct a review of automatically and manually completed fiscal year 2016 drill pay adjustments that involved a response to the proposal letter, and take corrective actions as necessary.

<p>Review of Access to Care and Capabilities during VA’s Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington</p> <p><i>Issued 04/27/2020 Report Number 19-09447-136</i></p>	VHA	—
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Recommendation 1: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, evaluates the impact of the new electronic health record implementation on productivity and provides operational guidance and required resources to facilities prior to go-live.

Recommendation 2: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, identifies the impact of the mitigation strategies on user and patient experience at go-live and takes action, as needed.

Recommendation 4: The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, reevaluates the electronic health record modernization deployment timeline to minimize the number of required mitigation strategies at go-live.

<p>Deficiencies in Infrastructure Readiness for Deploying VA’s New Electronic Health Record System</p> <p><i>Issued 04/27/2020 Report Number 19-08980-95</i></p>	OEHRM	—
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Recommendation 5: Evaluate physical infrastructure for consistency with OEHRM requirements and monitor completion of those evaluations.

Recommendation 6: Fill infrastructure-readiness team vacancies until optimal staffing levels are attained.

Recommendation 7: Ensure physical security assessments are completed and addressed at future electronic health record deployment sites.

<p>Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina</p> <p><i>Issued 05/19/2020 Report Number 19-08256-124</i></p>	VHA	—
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Recommendation 3: The Fayetteville VA Medical Center Director ensures that facility Community Care staff process Community Care consults according to the Veterans Health Administration policy.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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VA’s Implementation of the FITARA Chief Information Officer Authority Enhancements

OIT

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Issued 06/09/2020 | Report Number 18-04800-122

Recommendation 5: The OIG recommends the Chief of Staff for Veterans Affairs ensures the Chief Information Officer, in conjunction with VA administration and staff offices revise VA Directive 6008 to clarify the Chief Information Officer’s authority and roles in the planning, programming, budgeting, and execution of all information technology resources.

Recommendation 7: The OIG recommends the Chief of Staff for Veterans Affairs ensures the Chief Information Officer, in conjunction with VA administration and staff offices establish policies and procedures for all VA administration and staff offices to work with the Chief Information Officer for planning, programming, budgeting, and execution of all information technology resources and to manage VA’s overall information technology portfolio with resources that effectively achieve program and business objectives.

Recommendation 8: The OIG recommends the Chief of Staff for Veterans Affairs ensures the Chief Information Officer, in conjunction with VA administration and staff offices establish and implement department-level information technology governance and oversight processes to ensure that the Chief Information Officer is a member of VA governance boards that inform decisions on all information technology resources across the agency, regardless of funding appropriation.

Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center in Baltimore, Maryland

VHA

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Issued 06/11/2020 | Report Number 19-08857-171

Recommendation 5: The VA Maryland Health Care System Director reviews the current process for medication delivery, to include the effectiveness of recently initiated actions as described in the report, from the Baltimore VA Medical Center pharmacy to the Loch Raven Community Living Center and implements an action plan to address identified vulnerabilities.

VA Police Information Management System Needs Improvement

OHRA/
OSP

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Issued 06/17/2020 | Report Number 19-05798-107

Recommendation 1: The OIG recommends that the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness in consultation with the Under Secretary for Health evaluate the appropriateness of having the Law Enforcement Training Center serve as the manager of the records management systems for VA police.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 3: The OIG recommended the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness in consultation with the Principal executive Director for the Office of Acquisition, Logistics and Construction; the Assistant Secretary for Information and Technology; and the Under Secretary for Health develop and implement a plan describing how, when, and to whom information about issues for the police records management system will be disseminated and resolved.

Recommendation 4: The OIG recommended the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness, in consultation with the Under Secretary for Health, update security and law enforcement program procedures to ensure they meet information management needs and requirements.

Recommendation 6: The OIG recommended the Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness in consultation with the General Counsel and the Assistant Secretary for Office of Accountability and Whistleblower Protection determine the appropriate administrative action to take, if any, against personnel involved in bypassing the requirement that the Report Exec system be hosted at the Austin Information Technology Center and the VA information security process be completed before operation.

<p>Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka</p> <p><i>Issued 06/18/2020 Report Number 19-06870-175</i></p>	VHA	—
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Recommendation 6: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that physician utilization management advisors consistently document their decisions in the National Utilization Management Integration database.

Recommendation 14: The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals' departing the healthcare system and include the signature of the first- or second-line supervisor in the properly designated area.

Recommendation 19: The Assistant Director evaluates and determines any additional reasons for noncompliance and makes certain that panic alarms are tested and that deficiencies identified from the testing are addressed, including staff education.

Recommendation 23: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that healthcare providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

Recommendation 24: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that healthcare providers obtain and document informed consent consistently for patients who are initiating long-term opioid therapy.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 30: The System Director evaluates and determines any additional reasons for noncompliance and ensures that each CBOC has at least two designated women’s health primary care providers or arrangements for leave coverage when CBOCs have only one designated provider.

Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care VHA —

Issued 07/07/2020 | Report Number 19-00017-191

Recommendation 1: The Under Secretary for Health completes a specialty care needs assessment for highly rural community-based outpatient clinics to include internet bandwidth and telehealth equipment and develops op-tions for the delivery of safe patient care.

Recommendation 4: The Under Secretary for Health completes an assessment to determine whether highly rural community-based outpatient clinics that are located in a non-VA community hospital or health care center are fully utilizing the resources available at the non-VA facilities and takes action as indicated.

Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veteran’s Hospital in Columbia, Missouri VHA —

Issued 07/09/2020 | Report Number 19-06864-183

Recommendation 5: The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs complete provider exit review forms within seven calendar days of licensed health care professionals’ departure from the medical center.

Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri VHA —

Issued 07/09/2020 | Report Number 19-09416-186

Recommendation 3: The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that first- or second-line supervisors complete provider exit review forms within seven calendar days of a provider’s departure from the medical center.

Recommendation 4: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that providers complete a behavior risk assessment that includes a history of substance abuse, psychological factors, and aberrant drug-related behaviors on all patients prior to initiating long-term opioid therapy.

Recommendation 6: The Chief of Staff determines the reason for noncompliance and make certain that healthcare providers consistently conduct urine drug testing as required for patients on long-term opioid therapy.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 7: The Chief of Staff determines the reasons for noncompliance and makes certain that healthcare providers obtain and document informed consent consistently for patients prior to initiating long-term opioid therapy.

Recommendation 8: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers follow up with patients within the required time frame after initiating long-term opioid therapy.

Recommendation 9: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that providers' follow-up of patients receiving long-term opioid therapy includes an assessment of pain management care plan adherence and intervention effectiveness.

Recommendation 10: The Interim Medical Center Director determines the reasons for noncompliance and ensures that the Pain Management Sub-Committee monitors the quality of pain assessment and the effectiveness of pain management interventions.

Recommendation 14: The Interim Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that the Women Veterans Health Committee is comprised of the required core members.

The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research

VHA

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Issued 07/14/2020 | Report Number 19-06451-165

Recommendation 2: The Under Secretary for Health develop and implement processes for documenting and maintaining records of the VA Secretary's approval of canine research studies, including the study at the Richmond VAMC that was not included in the Secretary's August 30, 2019, approval document.

Recommendation 4: The Under Secretary for Health review local accounting records and cost allocations to determine the total amount of FY 2018 and 2019 funds spent on canine research before the VA Secretary approved the studies and report this information to the House and Senate appropriations committees.

Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia

VHA

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Issued 07/21/2020 | Report Number 18-01622-207

Recommendation 1: The Atlanta VA Health Care System Director reviews the process for non-VA community care consult performance measurements, evaluates compliance with Veterans Health Administration policy, and implements an action plan as needed.

Recommendation 2: The Atlanta VA Health Care System Director ensures managers review the backlog of open non-VA community care consults and implements an action plan as needed.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies</p> <p><i>Issued 07/22/2020 Report Number 19-07059-169</i></p> <p>Recommendation 4: Implement a plan to ensure STAR analysts place more emphasis on and assess all procedural deficiency elements included on the quality review checklist.</p>	VBA	—
<p>Deficiencies in the Quality Review Team Program</p> <p><i>Issued 07/22/2020 Report Number 19-07054-174</i></p> <p>Recommendation 4: The OIG recommends that the under secretary for benefits revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures.</p>	VBA	—
<p>Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri</p> <p><i>Issued 07/23/2020 Report Number 19-06850-208</i></p> <p>Recommendation 5: The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.</p>	VHA	—
<p>Improving VA Patients and Select Community Care Health Information Exchanges</p> <p><i>Issued 08/06/2020 Report Number 20-01129-220</i></p> <p>Recommendation 1: The Under Secretary for Health reviews the barriers related to the utilization of VA Direct and ensures the Veterans Health Information Exchange Program Office increases the number of facilities using VA Direct as a secure option to share health information.</p> <p>Recommendation 2: The Under Secretary for Health ensures the Veterans Health Information Exchange Program Office evaluates the VA Exchange and VA Direct training and education programs and increases accessibility to Veterans Health Administration staff, community partners, and veterans.</p> <p>Recommendation 3: The Under Secretary for Health ensures the Veterans Health Information Exchange Program Office increases the number of community partners, including more state exchanges and other Health Information Exchange stakeholders, to facilitate the expansion of bidirectional health information exchange.</p>	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri VHA —

Issued 08/12/2020 | Report Number 19-06873-210

Recommendation 1: The System Director evaluates and determines any additional reasons for noncompliance and ensures improvement actions recommended by the Quality Executive Board are fully implemented and improvement changes are monitored.

Recommendation 3: The System Director evaluates and determines any additional reasons for noncompliance and ensures that the Patient Safety Manager or designee consistently implements improvement actions arising from root cause analysis activities.

Recommendation 4: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that service chiefs include service-specific criteria for ongoing professional practice evaluations of licensed independent practitioners.

Recommendation 5: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that service chiefs' reprivileging recommendations are based on ongoing professional practice evaluation activities.

Recommendation 6: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Medical Executive Board's decision to recommend continuation of privileges is based on ongoing professional practice evaluation results.

Recommendation 7: The System Director evaluates and determines any additional reasons for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the healthcare system.

Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois VHA —

Issued 08/13/2020 | Report Number 20-00077-211

Recommendation 4: The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that first- or second-line supervisors complete provider exit review forms within seven calendar days of providers' departure from the medical center.

Recommendation 5: The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that service leaders immediately report a provider's failure to meet generally accepted standards of practice to state licensing boards.

Recommendation 12: The Medical Center Director determines the reasons for noncompliance and makes certain that the Pain Committee monitors the quality of pain assessment and effectiveness of pain management interventions.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 13: The Chief of Staff determines the reasons for noncompliance and ensures that mental health providers consistently contact or attempt to contact high-risk patients who miss mental health or substance abuse appointments and properly document those efforts.

Recommendation 14: The Chief of Staff evaluates and determines any additional reasons for noncompliance and verifies that providers complete safety plans within the required time frame for patients with High Risk for Suicide Patient Record Flags.

Recommendation 15: The Chief of Staff evaluate and determines any additional reason for noncompliance and makes certain that suicide prevention safety plans include all required elements.

Recommendation 17: The Medical Center Director determines the reasons for noncompliance and makes certain that a multidisciplinary life-sustaining treatment decisions committee is established to review all proposed plans.

Recommendation 19: The Medical Center Director evaluates and determines any additional reasons for noncompliance and makes certain that required members consistently attend the Women Veterans Health Committee meetings.

Recommendation 22: The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures that Sterile Processing Services staff receive properly completed competency assessments for reprocessing reusable medical equipment.

Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas	VHA	—
<i>Issued 08/18/2020 Report Number 19-06872-199</i>		

Recommendation 5: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures clinical managers define in advance, communicate, and document expectations for focused professional practice evaluations in provider profiles.

Recommendation 10: The Chief of Staff determines reason(s) for noncompliance and makes certain that provider exit review forms are completed within seven calendar days of licensed healthcare professionals departing the medical center.

Recommendation 15: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures that clinicians complete a behavioral risk assessment that includes a history of substance abuse, psychological disease, and aberrant drug-related behaviors on patients prior to initiating long-term opioid therapy.

Recommendation 16: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and makes certain that healthcare providers consistently obtain and document informed consent for patients who are initiating long-term opioid therapy.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Recommendation 17: The Chief of Staff evaluates and determines any additional reason(s) for noncompliance and ensures healthcare providers follow up with patients within three months after initiating long-term opioid therapy.

<p>Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois</p> <p><i>Issued 08/25/2020 Report Number 20-00069-222</i></p>	VHA	—
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Recommendation 1: The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures specific action items are monitored and documented in the Quality Board minutes when problems or opportunities are identified.

Recommendation 6: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that service chiefs include the minimum pathology and radiation oncology specific criteria for ongoing professional practice evaluations of licensed independent practitioners.

Recommendation 7: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures service chiefs collect, review, and use ongoing professional practice evaluation data in determinations to continue current privileges.

Recommendation 8: The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain that the Medical Executive Board’s decisions to recommend initial and continuation of privileges are based on focused and ongoing professional practice evaluation results.

Recommendation 11: The Associate Director evaluates and determines any additional reasons for noncompliance and ensures clinical areas are in good repair and that a safe and clean environment is maintained throughout the medical center.

Recommendation 17: The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures staff receive annual suicide prevention refresher training.

Recommendation 22: The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that the Sterile Processing Services Chief complete competency assessments for staff reprocessing reusable medical equipment.

Recommendation 23: The Associate Director for Patient Care Services determines the reasons for noncompliance and ensures Sterile Processing Services staff receive monthly continuing education.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois</p> <p><i>Issued 08/27/2020 Report Number 20-00064-238</i></p> <p>Recommendation 6: The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures that repriviliging decisions are based on service-specific ongoing professional practice evaluation criteria.</p> <p>Recommendation 7: The Chief Medical Executive evaluates and determines any additional reasons for noncompliance and ensures that providers with similar training and privileges complete licensed independent practitioners' ongoing professional practice evaluations.</p>	VHA	—
<p>Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources</p> <p><i>Issued 09/02/2020 Report Number 18-03800-232</i></p> <p>Recommendation 1: The OIG recommended the executive in charge, Office of the Under Secretary for Health, establish financial controls, such as key performance indicators, that align with medical center operations and can be used to assess the efficient use of operating funds.</p> <p>Recommendation 3: The OIG recommended the executive in charge, Office of the Under Secretary for Health, require the Veterans Health Administration to establish and publish organizational charts that identify the appropriate financial management reporting lines of authority and to develop familiarization training on the reporting lines of authority at the VISN and medical center levels, as appropriate.</p>	VHA	—
<p>Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee</p> <p><i>Issued 09/03/2020 Report Number 19-09493-249</i></p> <p>Recommendation 3: The Memphis VA Medical Center Director evaluates the current process for Emergency Department physicians to refer patients to the Emergency Department mental health provider for a mental health assessment and verifies that patients who require mental health provider assessment receive the care needed.</p> <p>Recommendation 9: The Memphis VA Medical Center Director evaluates the process for timely retrieval of medical records from community care providers, verifies the medical records are uploaded into patients' electronic health records, and takes action as necessary.</p>	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery

VHA

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Issued 09/10/2020 | Report Number 20-00131-243

Recommendation 11: The Associate Director evaluates and determines any additional reasons for noncompliance and ensures that healthcare system managers maintain a safe and clean environment by identifying and resolving environmental deficiencies found during environment of care rounds.

Recommendation 21: The System Director evaluates and determines any additional reasons for noncompliance and ensures clinical and nonclinical staff complete annual suicide prevention refresher training.

Recommendation 22: The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures providers complete and document goals of care conversations prior to hospice referrals.

Recommendation 28: The Associate Director for Patient Care Services evaluates and determines any additional reasons for noncompliance and ensures that all new Sterile Processing Services employees complete Level 1 training within 90 days of hire.

The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions

VBA

\$122,000,000

Issued 09/10/2020 | Report Number 19-00227-226

Recommendation 1: The under secretary for benefits ensures the adjudication procedures manual is updated for consistency with all applicable laws, regulations, and policies related to permanent and total determinations in consultation with the office of general counsel.

Recommendation 2: The under secretary for benefits ensures decision-making staff support their permanent and total status decisions in the Reasons for Decision section of the rating decision by describing the evidence used to support their conclusions.

Recommendation 3: The under secretary for benefits replaces the title and standardized language of "Dependents' Educational Assistance under 38 U.S.C. Chapter 35" in rating decisions to clearly state that permanent and total status is being considered.

Recommendation 4: The under secretary for benefits ensures appropriate training is provided to decision-making staff based on the changes made to permanent and total procedures related to Recommendations 1, 2 and 3, and monitor the effectiveness of that training.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency	VBA	—
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Issued 09/17/2020 | Report Number 20-02825-242

Recommendation 2: Conduct a review to ensure claims received and completed from March 1, 2020, had the correct date of entitlement applied.

Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care	VHA	\$30,000,000
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Issued 09/17/2020 | Report Number 18-06039-229

Recommendation 5: The OIG recommended the Under Secretary for Health consider identifying surgical support element best practices used by efficient facilities and ensure less efficient medical facilities, where appropriate, implement these practices to address problems, reduce surgical cancellations and delays, and minimize patient risks.

Financial Controls Related to VA-Affiliated Nonprofit Corporations: Idaho Veterans Research and Education Foundation	VHA	\$112,400
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Issued 09/24/2020 | Report Number 18-00711-251

Recommendation 2: The Boise VAMC director makes certain the Idaho Veterans Research and Education Foundation board of directors implements controls requiring two or more responsible officials to provide oversight of all salary and pay rate changes.

Recommendation 3: The Boise VAMC director ensures the Idaho Veterans Research and Education Foundation board of directors implements controls for the use of credit cards and the receipt, review, and reconciliation of credit card statements.

Recommendation 4: The Boise VAMC director establishes procedures that require the Research and Development Budget Office staff to review VA-affiliated nonprofit corporation invoices to confirm services were performed or goods were received in accordance with Intergovernmental Personnel Act agreements before approving invoices for payment.

Recommendation 5: The Boise VAMC director institutes procedures to make certain the Research and Development Budget Office supervisor conducts periodic reviews of the VA-affiliated nonprofit corporation invoices authorized for payment by staff as required by VA Financial Policies and Procedures, Volume VIII, Chapter 1A.

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>The Veterans Health Administration’s Governance of Robotic Surgical System Investments Needs Improvement</p> <p><i>Issued 09/25/2020 Report Number 19-07103-252</i></p>	VHA	—
<p>Recommendation 1: The OIG recommended the under secretary for health update the high cost, high tech medical equipment application to provide clearer instructions on preparing requests and providing supporting documentation for robotic surgical systems. The application and instructions should be disseminated to medical facilities, Veterans Integrated Service Networks, and responsible central office organizations.</p> <p>Recommendation 2: The OIG recommended the under secretary for health establish controls to ensure information in high cost, high tech medical equipment applications is reviewed and validated before recommending final approval to the assistant deputy under secretary for health for administrative operations.</p> <p>Recommendation 3: The OIG recommended the under secretary for health evaluate the need and justification of the 10 robotic surgical systems at VA medical facilities that were acquired without approval by the assistant deputy under secretary for health for administrative operations.</p>		
<p>Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia</p> <p><i>Issued 09/28/2020 Report Number 19-07828-265</i></p>	VHA	—
<p>Recommendation 2: The Veterans Integrated Service Network 7 Director ensures Carl Vinson VA Medical Center leaders, in permanent or acting roles, are knowledgeable about and compliant with privileging policies.</p>		
<p>Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans</p> <p><i>Issued 09/29/2020 Report Number 19-07854-272</i></p>	VHA	—
<p>Recommendation 2: The Southeast Louisiana Veterans Health Care System Director ensures that the intensive care unit nursing staff comply with the five rights of medication administration prior to administering medications.</p>		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
<p>Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia</p> <p><i>Issued 09/30/2020 Report Number 19-08106-273</i></p> <p>Recommendation 11: The Charlie Norwood VA Medical Center Director ensures staff adhere to inter-facility transfer policies and procedures, including accurate communication of patients' restraint management status, and monitors compliance.</p> <p>Recommendation 18: The Charlie Norwood VA Medical Center Director ensures that the Disruptive Behavior Committee provides oversight of the code gray team activities, as required by Charlie Norwood VA Medical Center policy, and monitors compliance.</p>	VHA	—
Total		\$1,136,041,400

APPENDIX C: REPORTING REQUIREMENTS

TABLE C.1. REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
<p>(8) statistical tables showing the total number of audit, inspection, and evaluation reports and the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs), for reports—</p> <ul style="list-style-type: none"> (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— <ul style="list-style-type: none"> (i) the dollar value of disallowed costs; and (ii) the dollar value of costs not disallowed; and (D) for which no management decision has been made by the end of the reporting period; 	<p>Appendix A</p>
<p>(9) statistical tables showing the total number of audit, inspection, and evaluation reports and the dollar value of recommendations that funds be put to better use by management, for reports—</p> <ul style="list-style-type: none"> (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— <ul style="list-style-type: none"> (i) the dollar value of recommendations that were agreed to by management; and (ii) the dollar value of recommendations that were not agreed to by management; and (D) for which no management decision has been made by the end of the reporting period; 	<p>Appendix A</p>

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
<p>(10) a summary of each audit, inspection, and evaluation report issued before the commencement of the reporting period—</p> <p style="padding-left: 20px;">(A) for which no management decision has been made by the end of the reporting period (including the date and title of each such report), an explanation of the reasons such management decision has not been made, and a statement concerning the desired timetable for achieving a management decision on each such report;</p> <p style="padding-left: 20px;">(B) for which no establishment comment was returned within 60 days of providing the report to the establishment; and</p> <p style="padding-left: 20px;">(C) for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations;</p>	<p>(10)(A): Appendix A</p> <p>(10)(B): Appendix A</p> <p>(10)(C): Appendix B</p>
<p>(11) a description and explanation of the reasons for any significant revised management decision made during the reporting period;</p>	Appendix A
<p>(12) information concerning any significant management decision with which the Inspector General is in disagreement;</p>	Appendix A
<p>(13) the information described under section 804(b) of the Federal Financial Management Improvement Act of 1996;</p>	Results from the Office of Audits and Evaluations (October–March issue only)
<p>(14)(A) an appendix containing the results of any peer review conducted by another OIG during the reporting period; or</p> <p style="padding-left: 20px;">(B) if no peer review was conducted within that reporting period, a statement identifying the date of the last peer review conducted by another OIG;</p>	Other Reporting Requirements
<p>(15) a list of any outstanding recommendations from any peer review conducted by another Office of Inspector General that have not been fully implemented, including a statement describing the status of the implementation and why implementation is not complete;</p>	Other Reporting Requirements

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
<p>(16) a list of any peer reviews conducted by the Inspector General of another Office of the Inspector General during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review conducted before the reporting period) that remain outstanding or have not been fully implemented;</p>	<p>Other Reporting Requirements</p>
<p>(17) statistical tables showing—</p> <ul style="list-style-type: none"> (A) the total number of investigative reports issued during the reporting period; (B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period; (C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and (D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities; 	<p>Statistical Performance</p>
<p>(18) a description of the metrics used for developing the data for the statistical tables under paragraph (17);</p>	<p>Statistical Performance</p>
<p>(19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including the name of the senior government official (as defined by the department or agency) if already made public by the Office, and a detailed description of—</p> <ul style="list-style-type: none"> (A) the facts and circumstances of the investigation; and (B) the status and disposition of the matter, including— <ul style="list-style-type: none"> (i) if the matter was referred to the Department of Justice, the date of the referral; and (ii) if the Department of Justice declined the referral, the date of the declination; 	<p>Results from the Office of Investigations</p> <p>Results from the Office of Special Reviews</p>

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

DEFINITIONS

As defined in the IG Act:

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

- (A) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds;
- (B) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or
- (C) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable;

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

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

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

- (A) reductions in outlays;
- (B) deobligation of funds from programs or operations;
- (C) withdrawal of interest subsidy costs on loans or loan guarantees, insurance, or bonds;
- (D) costs not incurred by implementing recommended improvements related to the operations of the establishment, a contractor or grantee;
- (E) avoidance of unnecessary expenditures noted in preaward reviews of contract or grant agreements; or
- (F) any other savings which are specifically identified;

Management decision means the evaluation by the management of an establishment of the findings and recommendations included in an audit report and the issuance of a final decision by management

APPENDIX C: REPORTING REQUIREMENTS

concerning its response to such findings and recommendations, including actions concluded to be necessary;

Final action means—

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

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

Senior government employee means—

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

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

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