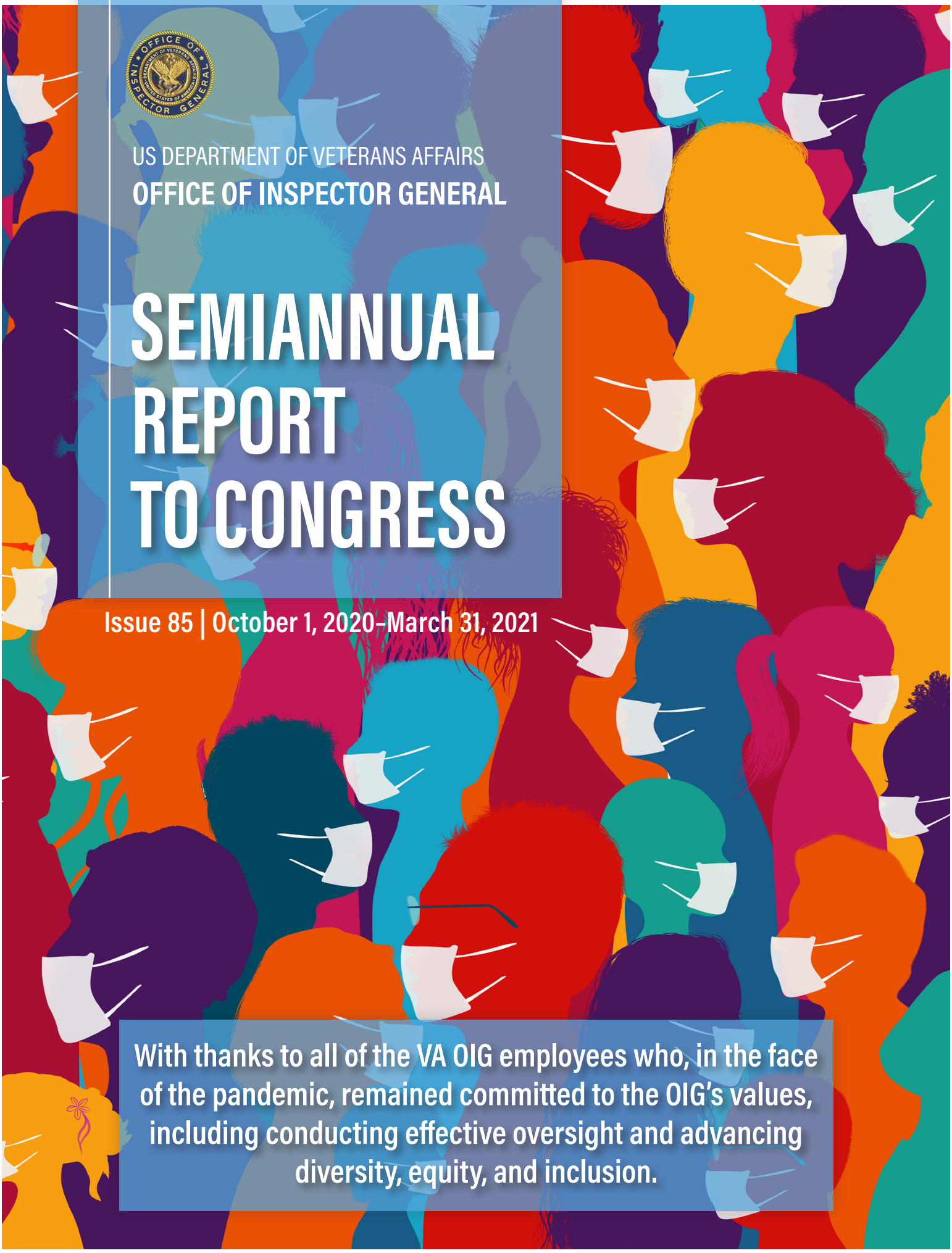
US DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT TO CONGRESS

Issue 85 | October 1, 2020–March 31, 2021



With thanks to all of the VA OIG employees who, in the face of the pandemic, remained committed to the OIG's values, including conducting effective oversight and advancing diversity, equity, and inclusion.

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

MISSION

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

VISION

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

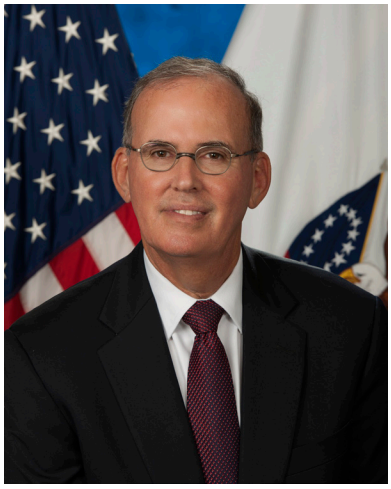
To achieve this vision, the Office of Inspector General (OIG) will

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

VALUES

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

A MESSAGE FROM THE INSPECTOR GENERAL



I am grateful for the opportunity to submit this *Semiannual Report to Congress* on the Department of Veterans Affairs (VA) Office of Inspector General (OIG) activities and accomplishments for October 1, 2020, through March 31, 2021. As we enter the second year of the COVID-19 pandemic, our thoughts are with the families of the more than 11,000 veterans who died as a result of the virus. The OIG lauds the efforts of the numerous VA employees who have worked to treat and comfort sick and dying veterans, their families, and caregivers. We also recognize the other efforts by VA personnel to address the many challenging situations caused by the pandemic, including working to assist communities in need across the nation. They have done so at significant personal risk. In addition, the OIG recognizes the many VA staff who have found innovative solutions to continue providing benefits and services during these challenging times.

Even as wide-scale vaccination and other progress have been made in this past reporting period, the effects of this pandemic will be felt throughout VA for years to come. The OIG has made COVID-19-related projects a priority so that effective and timely oversight can be provided. Included in this report are the OIG's efforts in this area, including reports on VA's backlogs in healthcare and disability benefit appointments, delays in the delivery of some services, and other fall-out from necessary protective measures. The OIG recommendations provided during this reporting period are meant to help mitigate the aftermath of the pandemic and provide a path forward for advancing systems and structures that need to be strengthened for VA to achieve its broader objectives, such as electronic health records, supply chain, and financial management systems.

Among the significant work by OIG staff, its criminal investigators worked vigorously to bring victims and their loved ones some measure of closure through the sentencing of two former VA doctors. One worked at the Beckley VA Medical Center in West Virginia and was convicted after sexually abusing patients, and the other was a pathologist whose substance use impairments and resulting misdiagnoses led to deaths and serious harm to scores of veterans.

As the cover of this report reflects, the OIG continues to advance its core values, including promoting diversity, equity, and inclusion. The core values of the OIG guide how our office operates and performs. They drive the achievements that all OIG directorates have realized, including positive staff engagement and high-quality work.

In this six-month period, the OIG identified more than $1.9 billion in monetary impact for a return on investment of $21 for every dollar spent on oversight. This work is detailed in the 124 publications issued for the first half of fiscal year 2021, in which the OIG made 389 recommendations. The OIG hotline received and triaged 14,129 contacts to help identify wrongdoing and concerns with VA programs and

A MESSAGE FROM THE INSPECTOR GENERAL

activities. Investigators opened 165 investigations and also closed 165, with efforts leading to 109 arrests. Collectively, the OIG's work resulted in 652 administrative sanctions and corrective actions.

I greatly appreciate the work of the OIG staff, who have shown tremendous flexibility and drive during this pandemic to help VA make significant improvements. I also want to thank those OIG employees who volunteered to help VA vaccinate veterans and others across the country.

Finally, I would like to thank members of Congress, VA staff, veterans service organizations, and the veteran community for their continued support that is so essential to our oversight efforts.

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 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 $246.2 billion budget, with over 425,000 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

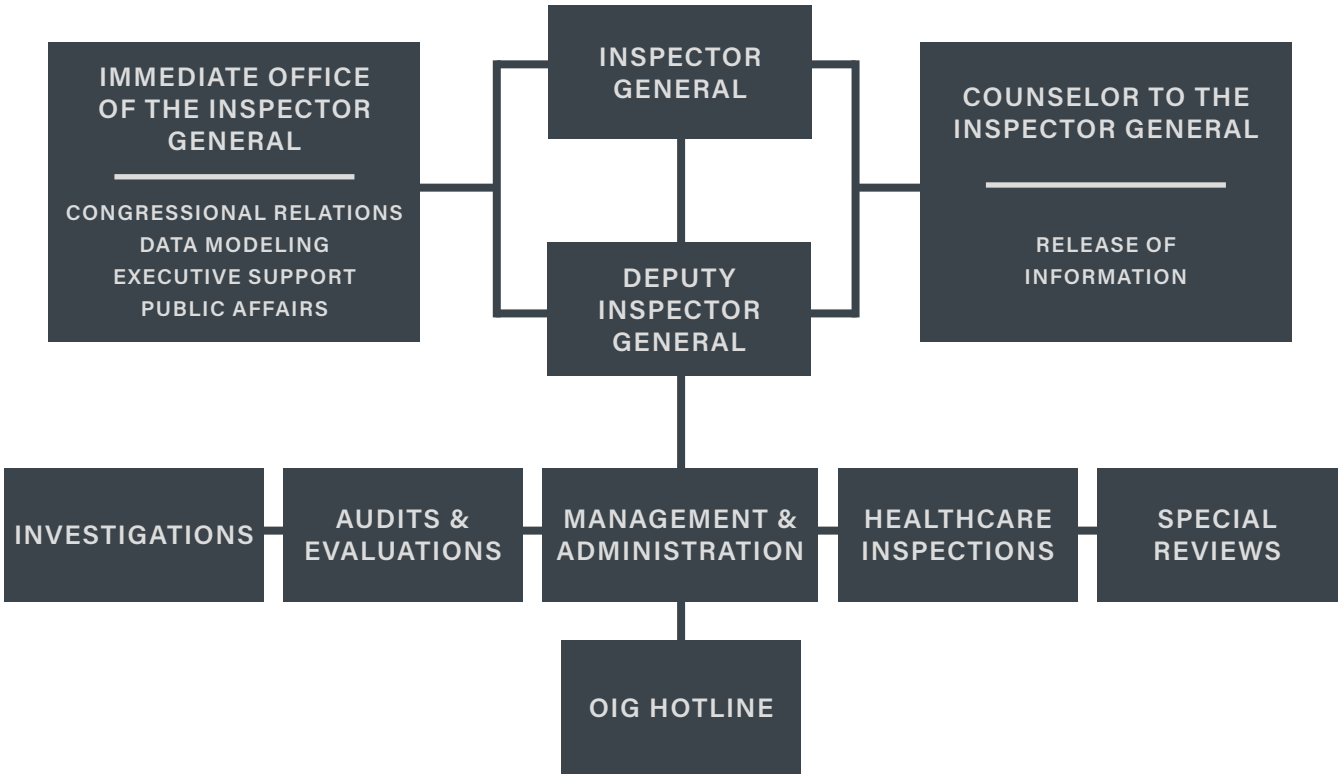
The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) [Public Law (P.L.) 95-452, as amended]. This Act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies 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 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 1,020 staff organized into five primary directorates: the Offices of Audits and Evaluations, Healthcare Inspections, Investigations, Management and Administration (including the OIG hotline), and Special Reviews. The OIG also has an office for congressional relations, public affairs, data modeling, and executive support, as well as an Office of the Counselor to the Inspector General. 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.

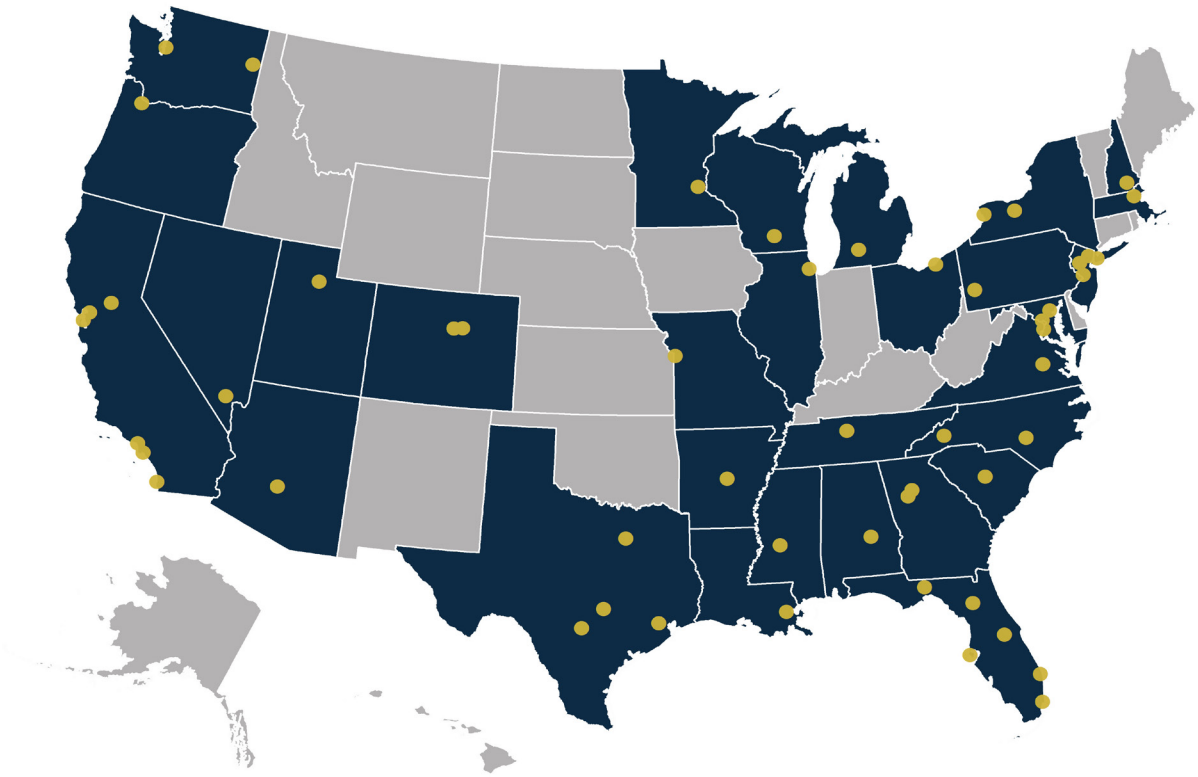
In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff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

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The office serves as the central coordination point for all executive correspondence, congressional testimony, and media inquiries, and has major responsibilities for data modeling and stakeholder engagement. The Inspector General and Deputy Inspector General provide leadership and set the strategic 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. The office includes congressional relations and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed, as well as a data modeling group that specializes in advanced analytics, information integration, and data visualization. In addition, through report follow-up, the office makes 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, 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 assesses 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 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.

THE OFFICE OF INVESTIGATIONS

This office investigates potential crimes and civil violations of law involving VA programs and operations involving 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, cyber-tools, 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

Staff provide comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, information technology, and data services to the organization. The office also oversees the OIG hotline, which receives, screens, and refers all allegations and complaints for additional action. Staff accept concerns selectively, prioritizing those having the most potential risk to veterans, VA programs and operations, or 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.

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period October 1, 2020–March 31, 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 including savings, cost avoidance, and dollar recoveries; 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 performing report distribution and following up on recommendations. It also includes personnel focused on congressional relations, data modeling, and public affairs.

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 41 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 of deficiencies in VA's Veterans Crisis Line in response to a veteran caller who died,
- information on VA's need for better internal communication and data sharing within its spina bifida program,
- a review of the mammography program at the Washington DC VA Medical Center, and
- the results of a comprehensive healthcare inspection of Veterans Integrated Service Network 7 (the VA Southeast Network in Duluth, Georgia).

OIG staff also fielded 65 inquiries from congressional staff related to constituent matters for review or referral.

HIGHLIGHTED ACTIVITIES AND FINDINGS

DATA MODELING

The Data Modeling Group applies 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 55 ongoing projects, created nine new internal data reports, and made enhancements to several other reports. New reports focused on Coronavirus Aid, Relief, and Economic Security (CARES) Act spending, vaccination plan implementation, accountability for veterans' remains, mental healthcare processes, and potential fraud within the VA Home Loan Guaranty program. These Data Modeling Group efforts included the following developments:

- Systems addressing VA's COVID-19-related activities, including vaccinations, supply and service purchasing, treatment actions, and emerging hotspots
- Mental health-related systems addressing institutional stays and discharges, risk flags in veterans' medical records, and veteran contact efforts
- A repository to properly record the date of death for veterans and beneficiaries and congruence with other systems, including purchased care and services, medical device procurement, and benefit claims processing

PUBLIC AFFAIRS

The OIG is committed to 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 general public. Communications staff disseminate report information, news releases, public statements, and congressional testimony to the OIG's many stakeholders. During this reporting period, the OIG also released an update to its strategic plan that accounts for the significant impact of the pandemic. Communications staff conducted internal communication projects to help facilitate coordinated and effective oversight in a largely virtual work environment as well.

The OIG continues to expand its presence on LinkedIn and Twitter to reach a diverse audience. During this reporting period, the OIG grew its LinkedIn base by 24 percent (7,800 unique followers) and now has a subscriber base of 41,000 followers. The OIG also published 159 updates to highlight oversight reports, hiring activities, and other news that resulted in about 350,000 impressions. In addition, the communications staff posted 80 tweets to 5,600 followers primarily on reports and investigations, resulting in over 73,000 impressions. The 12 podcasts released covered reports on VA activities, monthly investigative highlights, and other developments.

Communications 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 OIG investigations. The audit, inspection, and review work was featured prominently in wide-reaching media outlets, such as television and radio news programs and the *New York Times*, *Wall Street Journal*, *Washington Post*, *USA Today, Military Times*, and *Stars and Stripes*. Among the issues covered were reports on the former VA Secretary's handling of allegations of sexual assault at the Washington DC VA Medical Center and VA's COVID-19 responses and preparedness.

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations (OAE) published 18 reports summarizing results from its oversight work, including two management advisory memoranda that highlighted concerns requiring VA's immediate attention. Those memoranda prompted VA to strengthen fiduciary program management and described the potential repercussions of expedited hiring during the COVID-19 pandemic. OAE teams also conducted 51 preaward and postaward contract reviews and two claims reviews to help VA obtain fair and reasonable pricing on products and services. OAE identified potential cost savings of about $290 million and recovered over $8 million in contract overcharges. OAE's published reports resulted in 66 recommendations that could have a combined monetary impact of over $599 million.

OAE continues to improve VA's programs and processes by addressing long-standing challenges. For example, OAE initiated financial efficiency reviews to assess the oversight and stewardship of funds by VHA facilities and to identify potential cost efficiencies in medical center functions. The office also began conducting several information technology (IT) security inspections to evaluate controls that protect VA systems and data from unauthorized access, use, modification, or destruction. A new division was established to focus on reviewing VA's IT modernization efforts as well.

OAE is closely monitoring VBA's update of the official disabilities rating schedule (38 C.F.R., book C, Schedule for Rating Disabilities) to assess how the changes will affect the claims processing backlog, error rates, and the automated notification process. Staff are also evaluating whether these changes are being implemented according to VBA's established schedule.

As part of the OIG's continuing oversight of the COVID-19 pandemic response, OAE's work was recognized by the Pandemic Relief Accountability Committee for highlighting lessons learned in assessing personal protective equipment (PPE) inventory. Specifically, in a February 2021 report, OAE assessed how VA reported and monitored PPE and swiftly developed processes and tools to gather data that would help VA navigate facilities' surging demand for PPE. OAE continues to scrutinize VA's finances, acquisition processing, supply chains, and information networks as VA shifts from containing the virus and caring for patients to distributing vaccines and addressing backlogs and other after-effects. OAE's commitment to creating positive outcomes for the veteran community, VA personnel, and taxpayers drives the reports and recommendations it publishes.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The Counselor's office continues to provide extensive legal support and guidance to all components of the OIG. Its work helps ensure accuracy and effectiveness in conducting oversight in service to veterans.

HIGHLIGHTED ACTIVITIES AND FINDINGS

During this reporting period, the Counselor's office performed a wide range of activities that included working with criminal investigators to streamline the OIG's qui tam program (which involve False Claims Act suits filed by a private person, in the name of the government, to recover funds lost to fraud on government contracts) and coordinating with the Department of Justice (DOJ) on decisions to intervene. Coordination with the VA Office of General Counsel to complete a civil settlement in a False Claims Act case also yielded approximately $179 million. Office staff also developed refresher training on the use of force for investigators as required by the Council of the Inspectors General on Integrity and Efficiency and reviewed more than 120 subpoenas.

In addition to assisting criminal investigators, the office provided advice on implementing the Families First Coronavirus Response Act and briefed employees and managers on a variety of legal issues. Staff also advised the Office of Healthcare Inspections in its reviews of allegations of delayed access or inadequate health care throughout VA, including the legal research and reviews of myriad publications released during this six-month period. Similarly, attorneys provided guidance to the Office of Audits and Evaluations on a wide range of projects and the resulting reports.

The Office of the Counselor responded to several litigation matters, including those involving the Privacy Act of 1974 and Federal Tort Claims Act, and continued to work closely with US Attorneys' Offices in federal court proceedings. Staff also represented the OIG in matters before the Merit Systems Protection Board and the Equal Employment Opportunity Commission. Through its Release of Information Office, the Counselor's office continued to review all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and processed and responded to more than 490 requests from the public and other government agencies for OIG records.

THE OFFICE OF HEALTHCARE INSPECTIONS

During this reporting period, the Office of Healthcare Inspections (OHI) continued to evaluate the delivery of quality health care amid the prolonged and significant challenges presented by COVID-19, while making operational changes to mitigate the spread of the virus. Routine inspection teams conducted most site visits virtually without compromising overall quality and with limited reductions in scope.

VHA leaders and frontline healthcare teams are responsible for meeting veterans' preventative and clinical care needs. COVID-19 practices have also placed significant demands on clinical staff, and VHA has identified providers' mental and physical wellness as a priority. As one aspect of its COVID-related oversight work, OHI reported on providers' use of virtual modalities to help ensure safe continuity of primary care and initiated work to evaluate VHA's programs and processes for supporting the psychological well-being and mental health recovery of frontline staff. As a member of the larger inspector general community, OHI clinical staff also continued to assist the Pandemic Response and Accountability Subcommittee on Health Care and contributed to

the publication *Federal COVID-19 Testing: Data Insights from Six Federal Health Care Programs* published January 14, 2021.

OHI remained committed to examining an array of veteran healthcare issues. During the six-month reporting period, OHI released 28 publications, including a pair of national reviews on the quality of colonoscopies provided in community-based outpatient clinics and the reprocessing of their colonoscopes. The quality of mental health care provided to veterans also remained an oversight priority for OHI. Veterans must be ensured of timely access to high-quality care provided by well-trained staff during times of crisis. OHI has reported situations where crisis interventions for veterans were compromised by inadequate responses by VA's Veterans Crisis Line, which is a critical resource to veterans and their families.

THE OFFICE OF INVESTIGATIONS

Office of Investigation (OI) staff investigate an extensive range of potential criminal activity—from drug offenses and crimes of violence to numerous types of fraud and cyber-threats to VA information systems. During the COVID-19 pandemic, investigators have been particularly vigilant and responsive to allegations of medical supply procurement fraud, theft, and other activities that put VA personnel, patients, and resources at risk. In this reporting period, investigators' efforts resulted in 109 arrests. Criminal and civil investigations yielded millions of dollars in recoveries for VA and resulted in significant judicial and administrative actions.

OI continues to focus on high-impact investigations and coordinates closely with other OIG directorates, external law enforcement entities, and DOJ in order to successfully address criminal and civil violations. The office also created a special agent in charge position to develop and lead the OIG's healthcare fraud program. Its agents are involved in the DOJ's COVID-19 response, which facilitates communications among agencies (including the FBI, Food and Drug Administration, and the Department of Health and Human Services) regarding emerging schemes. OI also participates in the FBI's COVID-19 Fraud Response Working Group, which focuses on ongoing pandemic-related investigations. Office staff have also joined DOJ's Procurement Collusion Strike Force and the VA/VA OIG COVID-19 Working Group, both of which have worked to identify counterfeit N95 respirators.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency and to support the OIG's overall mission. During the reporting period, OMA facilitated the 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. OMA also continued to lead the coordination of OIG's response to the COVID-19 pandemic and ensured proactive measures were taken to protect the health, safety, and overall well-being of all VA OIG employees.

The modernization of OIG's IT infrastructure continues to be a priority to support growth, strengthen security, and address the OIG's increasingly complex IT needs. Examples of these initiatives include

- restructuring IT functions to provide specialized support for a broad range of areas,
- initiating implementation of a new IT system that will better detect emerging issues,
- monitoring the OIG's virtual infrastructure to apply preemptive security and scalability measures, and
- preparing for the procurement of a new enterprise-level case management system and e-discovery platform to bolster resources for investigations, inspections, reviews, audits, and referrals.

OMA fulfilled 476 data requests to support oversight activities across VA's broad range of healthcare services and benefit programs involving disabilities, pensions, education, housing assistance, and burials. OMA also developed a new suite of tools to empower oversight staff to perform data exploration through the use of self-service dashboards populated with commonly requested data.

OMA is also responsible for overseeing the OIG's hotline. During this period, the hotline received and screened 14,129 contacts from complainants, including VA employees, veterans, and the public, and directed potential cases to the appropriate OIG directorate for further review. Throughout the pandemic, the hotline has developed procedures for the expedited review and processing of COVID-19-related complaints.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews (OSR) is staffed with a robust team of investigative attorneys, administrative investigators, criminal investigators, 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 also published three reports related to VA officials' misconduct, conflicts of interest, and irregularities regarding incentive compensation. In particular, the office focused

resources on investigating allegations that senior VA officials used government time and resources to undermine the credibility of a complainant. This resulted in the publication of a report involving the former Secretary and other VA leaders, *Senior VA Officials' Response to a Veteran's Sexual Assault Allegations*. As required under the Inspector General Act of 1978 §5(a)(5) to report to Congress in the *Semiannual Report to Congress* "incidents where the establishment has … restricted or significantly delayed access to information…," it should be noted that the investigation was hindered by the refusal of several senior VA officials to cooperate with requests for follow-up interviews to clarify and resolve conflicts that arose when additional information was gathered after their initial interviews.

As reported in the results for the Office of Investigations, OSR also concluded work on a multidirectorate investigation into a contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs. The contractor agreed to pay $179.7 million in settlement to resolve overpayment claims.

Additionally, the office has adopted an operational plan designed to focus its oversight on VA programs and operations that have the greatest effect on veterans and the public interest. These proactive reviews utilize the OIG's advanced data analytic capabilities. The office has also reorganized to improve project supervision, internal data analysis, e-discovery support, and quality assurance.

STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE REPORTING PERIOD

124 PUBLICATIONS

109 ARRESTS

79 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

2 CONGRESSIONAL TESTIMONIES

652 ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS*

14,129 HOTLINE CONTACTS

$21:1 RETURN ON INVESTMENT

389 RECOMMENDATIONS TO VA

$1,923,417,054 MONETARY IMPACT

12 PODCASTS

*Hotline and Investigations included

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD
Better Use of Funds	$290,713,105
Recoveries	$3,514,188
Fines, Penalties, Forfeitures, Restitution, and Civil Judgments[1]	$755,232,601
Fugitive Felon Program	$251,300,000
Savings and Cost Avoidance	$15,058,733
Questioned Costs	$607,598,427
Total Dollar Impact	**$1,923,417,054**
Cost of OIG Operations[2]	$92,377,326
Return on Investment[3]	**$21:1**

1. Fines, penalties, restitution, and civil judgments may result from investigations conducted solely by the VA OIG or in partnership with other law enforcement agencies. The total amount reported includes amounts received by other government entities as a result of VA OIG's investigative efforts. Of the total amount reported for this period, VA received $255,182,909.

2. The six-month operating cost for OHI ($21.6 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

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
Administrative Investigations	3
Audits and Reviews	15
Claim Reviews	2
Comprehensive Healthcare Inspections	7
Financial Inspections	0
Hotline Healthcare Inspections	15
Information Technology Inspections	0
National Healthcare Reviews	6
Postaward Reviews	16
Preaward Reviews	35
Special Reviews	0
Subtotal	**99**
ALTERNATIVE WORK PRODUCTS	**THIS PERIOD**
Issue Statements	0
Management Advisory Memoranda	3
Subtotal	**3**
OTHER PUBLICATION TYPES	**THIS PERIOD**
Budget Request	1
Congressional Testimonies	2
Major Management Challenges	0
Monthly Highlights	6
Peer Reviews Completed of Other OIGs	1
Podcasts	12
Press Releases	0
Subtotal	**22**
Total	**124**

4. 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).

TABLE 3: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	4
Hotline Referrals Reviewed	2,254

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD
Contacts	14,129
Cases Opened	527
Cases Closed	636
Administrative Sanctions and Corrective Actions*	571
Substantiation of Allegations Percentage Rate	39%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	12
Individuals Provided Office of Special Counsel Contact Information	48
Individuals Provided Merit Systems Protection Board Contact Information	18
Individuals Provided Office of Resolution Management Contact Information	70

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

STATISTICAL PERFORMANCE

TABLE 5: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[5]	THIS PERIOD
Arrests[6]	109
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	5
Indictments[7]	94
Indictments and Informations Resulting from Prior Referrals to Authorities	41
Criminal Complaints	21
Convictions	71
Pretrial Diversions and Deferred Prosecutions	6
Case Referrals to Department of Justice for Criminal Prosecution[8]	137
Case Referrals to State and Local Authorities for Criminal Prosecution[9]	21
Administrative Sanctions and Corrective Actions	81
Cases Opened	165
Cases Closed[10]	165

5. 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.

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

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

8. 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.

9. 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.

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

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

OAE had 18 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 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.

18
PUBLICATIONS

66
RECOMMENDATIONS

$599M
MONETARY BENEFITS

FEATURED PUBLICATIONS

The following three publications provide examples of the 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.

As part of OAE's mission to oversee specific, high-risk areas within VA, this reporting period OAE focused on programs providing veterans with timely medical care and benefits and VA's response to the ongoing pandemic. An example of a healthcare review was OAE's examination of the biologic implant program that identified deficiencies in purchasing, inventory management, and tracking. Poor inventory management can jeopardize prompt care, as medical providers may need to delay or cancel procedures if implants are unavailable. An inability to track implants can also affect patient notifications in the event of a recall. OAE found that VHA did not designate responsibility for overseeing biologic implant tracking or have a national policy or an accredited tracking system in place.

Congress has mandated that VA make notifications when individuals processing veteran and other beneficiary claims consistently fail skill tests. Mistakes in processing claims can result in financial hardships on beneficiaries or even deny benefits to which veterans are entitled. Competency is particularly important for processing claims that are complex or involve particularly vulnerable populations, such as veterans receiving posttraumatic stress-related benefits who were also the focus of an OAE report during this review period. OAE reviewed VBA's compliance with skills certification mandates for compensation and pension claims processors and concluded that VBA did not meet the congressionally mandated requirements for FY 2016 through FY 2019. Specifically, VBA did not administer a required test to all claims processors, nor did it provide individual training plans to the majority of processors who failed.

Among its pandemic oversight work (which also focused on the backlog of disability exams, exposure of veterans experiencing homelessness in transitional housing, and expedited hiring), OAE examined the reporting and monitoring of personal protective equipment (PPE) inventory. The spread of COVID-19

drastically increased the demand for PPE such as masks, gloves, and gowns, and significantly disrupted the global supply chain. As the nation's largest integrated healthcare system, VHA had to compete for PPE for its personnel and patients and then store and distribute it. While OAE found VHA quickly addressed known limitations in its inventory management system and reduced risks of supply outages by shifting supplies, it made recommendations to help VHA improve the accuracy and consistency of the data reported.

BIOLOGIC IMPLANT PURCHASING, INVENTORY MANAGEMENT, AND TRACKING NEED IMPROVEMENT

The OIG examined whether VHA had effective procedures for (1) purchasing, (2) inventorying, and (3) tracking biologic implants such as skin substitutes and corneal or dental implants. The OIG found deficiencies in all three areas at the four medical facilities visited. The audit team determined that purchasing agents did not always record implant purchases properly or use the appropriate funds. The purchasing agents did not record 2,931 of 10,305 purchased biologic implants in the appropriate system. Instead, agents documented the implants in various local spreadsheets, databases, and third-party systems. Purchasing agents sometimes improperly used logistics funds instead of prosthetic funds, making it difficult for VHA to fully account for biologic implant spending and effectively budget or use funds for other purposes. The OIG found that because of inadequate guidance, the facilities visited had an inaccurate inventory of biologic implants, did not use a standardized system, and did not consistently review inventory on hand. At these four facilities, staff could not locate 714 biologic implants in inventory, valued at almost $1.1 million. The audit team also found 288 unrecorded additional items, valued at almost $433,000, in storage locations. Finally, the facilities visited failed to track at least 45 percent of implants reported as used from October 2017 through March 2019. VHA concurred with the OIG's 11 recommendations to improve how it purchases, inventories, and tracks biologic implants.

VBA DID NOT CONSISTENTLY COMPLY WITH SKILLS CERTIFICATION MANDATES FOR COMPENSATION AND PENSION CLAIMS PROCESSORS

This review examined how effectively VBA managers fulfilled the plan VA was required to submit to Congress for a skills certification program for claims processors. The program includes a required test to ensure staff have the skills, knowledge, and abilities needed to accurately carry out their tasks. Based on a statistical sample, the OIG estimated 4,700 of 10,800 individuals required to take the exam were not tested. The program also did not provide individual training plans to about 1,900 of the 2,500 employees who failed the test or ensure that all staff who failed took the next scheduled test. Further, VBA did not take personnel actions against an estimated 98 percent of employees who failed consecutive tests after receiving remedial training. Several factors contributed to the identified issues, including an insufficient process for identifying and notifying those required to take the test and data limitations affecting tracking. In addition, VBA did not design tests for all employees cited in the plan. Testing was canceled in FY 2018 because of intranet technical issues and in FY 2019 to assess the effectiveness of testing. The OIG made six recommendations regarding written guidelines for individuals who are required to take or who are exempted from taking tests; a tracking mechanism for eligible test takers; updates to Congress

on why not all claims-processing positions are subject to testing; plans to train staff who failed tests; an oversight plan to ensure individuals who failed consecutive tests were retrained; and notifying Congress of plans to take personnel actions against individuals who fail consecutive tests after remediation, as required by law.

REPORTING AND MONITORING PERSONAL PROTECTIVE EQUIPMENT INVENTORY DURING THE PANDEMIC

The OIG received hotline allegations that VHA medical facilities could not acquire and maintain enough PPE to keep pace with escalating needs. The OIG assessed how VHA reported and monitored PPE supply levels during the pandemic. The review team also solicited information about whether facilities ran out of PPE or experienced significant shortages. Without reliable PPE inventory information, VHA cannot effectively assess demand, monitor stock levels, or identify supply shortages that require prompt action. In interviews of 22 people involved in logistics operations at 42 facilities, no one reported running out of PPE items. Some individuals reported running low, but risks of outages were mitigated by shifting supplies among facilities or acquiring additional PPE in time. Overall, the OIG found VHA took swift steps to work around known limitations in its inventory management system by developing new processes and tools, using near real-time information on PPE inventory to shift and order supplies, and otherwise ensuring its facilities would not run out of PPE. The OIG found, however, that VHA could improve the accuracy and consistency of the PPE data for reporting and monitoring. VHA concurred with the OIG's two recommendations to provide guidance for reporting expired quantities of PPE that may still be of use, and to more effectively verify facilities' self-reported information. Although not a formal recommendation, the OIG also called on VHA to report any data limitations until corrections can be made.

PUBLICATIONS ON HEALTHCARE ACCESS AND ADMINISTRATION

OIG audits and evaluations focus on the effectiveness of VA programs delivering healthcare services to veterans. Reports on these programs identify opportunities for VA leaders 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.

HOMEMAKER AND HOME HEALTH AIDE PROGRAM: MOST CLAIMS PAID CORRECTLY, BUT OPPORTUNITIES EXIST TO IMPROVE SERVICES TO VETERANS

The VHA Homemaker and Home Health Aide program offers personal care and related services to help frail or disabled veterans with daily activities. The OIG examined whether veterans received intended program services and whether VHA accurately processed program claims. VHA lacked assurance that veterans received services from licensed or certified agencies and, as a result, may have made up to $145.4 million in improper payments. Medical facilities were also inconsistent in how they applied program policies, prioritized veterans on program waiting lists, and addressed veterans who were difficult to place. VHA paid many claims on time and nearly always accurately, but improperly paid an estimated $8.5 million with at least $5.5 million potentially recoverable. Opportunities exist for reducing the risk of paying for inadequately supported or unauthorized claims. The OIG made eight

recommendations to VHA to address these issues, such as updating program policies and ensuring sufficient monitoring of claim payments.

MANAGEMENT AND OVERSIGHT OF THE ELECTRONIC WAIT LIST FOR HEALTHCARE SERVICES

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=76.

The OIG substantiated allegations that the VHA data on VA's website regarding the electronic wait list for patient appointments was inconsistent with internal data sources. The audit team confirmed the website data did not include entries older than two years or administrative entries, such as patients requesting care at a different facility. Because VHA addressed these issues, the OIG did not make related recommendations. The team did find that patients were not removed from the wait list when appropriate, indicating that VHA employees did not review entries daily and supervisors did not validate the list weekly. This lack of oversight increases the risk that patients will not receive care in a timely manner or at their preferred facility and could lead to the appearance that veterans waited longer than they did for care. Although VHA enhanced its wait list management, the OIG provided three recommendations for improvement.

ADDED MEASURES COULD REDUCE VETERANS' RISK OF COVID-19 EXPOSURE IN TRANSITIONAL HOUSING

The OIG reviewed measures taken by VHA's Homeless Program Office, medical facilities, and community service providers to mitigate COVID-19 risks in transitional housing programs for veterans experiencing homelessness. The review team found that transitional housing service providers at the 14 assessed facilities successfully implemented four of six Centers for Disease Control and Prevention measures but could have strengthened implementation of two others. These involved communicating precautions to high-risk veterans and social distancing. VHA and service provider staff said the Homeless Program Office allowed them the flexibility to isolate vulnerable veterans, facilitate telehealth exams, and coordinate the provision of medical care in the community. Some service providers and VA medical facilities also developed their own best practices for reducing risks. The OIG made four recommendations to the under secretary for health regarding additional measures to strengthen the implementation of Centers for Disease Control and Prevention guidelines at the service providers' facilities.

PUBLICATIONS ON BENEFITS DELIVERY AND ADMINISTRATION

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

ENHANCED STRATEGY NEEDED TO REDUCE DISABILITY EXAM INVENTORY DUE TO THE PANDEMIC AND ERRORS RELATED TO CANCELED EXAMS

The OIG assessed how VBA scheduled and conducted exams during the COVID-19 pandemic to limit veterans' exposure, minimize processing delays, and ensure claims were not prematurely denied due to missed or canceled in-person exams. VBA's strategy for addressing the inventory of delayed disability

exams was also examined. To protect veterans, VBA discontinued in-person exams and notified them of options such as telehealth exams, reviews of acceptable clinical evidence, or future in-person exams. VBA and the OIG identified claims prematurely or improperly denied based on canceled exams. In response, VBA clarified guidance and established additional controls for exam management. While the exam inventory had increased (about 1.5 million exams needed as of July 31), the percentage of errors appears to have decreased. The OIG made two recommendations to help reduce the exam inventory and increase telehealth exams, including ensuring contractors follow telehealth guidance.

POSTTRAUMATIC STRESS DISORDER CLAIMS PROCESSING TRAINING AND GUIDANCE NEED IMPROVEMENT

To decide that a veteran is eligible for disability benefits, VA claims processors must establish a connection between the disability and the veteran's military service. The OIG examined whether claims processors followed VA regulations and procedures when determining service connection for posttraumatic stress disorder (PTSD) claims that were not related to military sexual trauma. The review team found that claims processors inaccurately processed about 18,300 of 118,000 PTSD claims completed in fiscal year 2019. Most errors occurred because claims processors did not verify or ask veterans to provide the disorder's cause, known as an in-service stressor. The OIG recommended that VBA determine (1) the actions needed to ensure staff understand requirements for gathering evidence and verifying stressors for PTSD claims and (2) whether the adjudication procedures manual needs to be reorganized and amended to help staff process PTSD claims more accurately.

FIDUCIARY PROGRAM: SOME INCOMPETENCY DECISIONS NOT COMPLETED, PUTTING THOSE BENEFICIARIES' FUNDS AT RISK

An OAE team assessed the merits of an August 2019 hotline allegation that a deceased veteran's VA funds had been misused while he was living at a California nursing home. As part of this assessment, which is the subject of another report, the team discovered that VBA had not finalized the veteran's incompetency proposal, which had been initiated three years before his death. This delay conflicts with VBA guidance that the decision be made and a fiduciary appointed within 141 days. The team expanded its review and found VBA had not finalized incompetency proposals for 221 beneficiaries from 2016 through 2019. A statistical analysis of 55 of these proposals showed nearly all had incomplete decisions—that is, had stalled. The OIG shared the 221 records with VBA so that it could determine whether further action is needed to ensure incompetency proposals are finalized.

VA NEEDS BETTER INTERNAL COMMUNICATION AND DATA SHARING TO STRENGTHEN THE ADMINISTRATION OF SPINA BIFIDA BENEFITS

The OIG reviewed VA's spina bifida program to assess concerns that eligible individuals may not be receiving all their benefits. Children born with spina bifida may receive VA benefits if a biological parent is a veteran presumed to have been exposed to herbicides during the Vietnam War. VBA determines benefit eligibility and issues monthly payments, while VHA covers all medically necessary health care. The OAE team determined that VBA staff generally decided spina bifida benefits claims accurately. However, VBA and VHA program offices did not adequately communicate or share data, contributing to improper payments, payments made after deaths, and delays in healthcare enrollments. VA also did not consistently reach out to eligible individuals or accurately provide benefits information. The OIG recommended improving coordination between VBA and VHA, and ensuring beneficiaries are promptly enrolled in health care and consistently provided accurate and comprehensive information. Enhancements were also recommended for engaging beneficiaries unaware of or not using services.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

HANDLING ADMINISTRATIVE ERRORS AT THE CHICAGO VA REGIONAL BENEFITS OFFICE IN ILLINOIS

A March 2019 allegation was made that employees at the Chicago, Illinois, VA regional benefits office were not following VBA procedures for correcting administrative errors. The OIG substantiated the allegation based on procedures in place at the time each error was corrected. VBA modified its procedures for correcting administrative errors three times after the review team began its work in October 2019. Claims processors did not properly correct administrative errors in 88 percent of cases reviewed. Those errors resulted in improper underpayments of about $59,100 to six veterans, improper overpayments of $18,900 to two veterans, and $5,900 in debts VA had inappropriately collected from eight veterans through January 2020. The OIG recommended the director of the Chicago VA regional office ensure the errors identified by the OAE review team are corrected, monitor the effectiveness of actions taken to improve the accuracy of corrections, and determine whether additional measures are needed.

POST-9/11 GI BILL NON-COLLEGE DEGREE ENTITLEMENT CALCULATIONS LEAD TO DIFFERENCES IN HOUSING ALLOWANCE PAYMENTS

The OIG analyzed data on housing allowances for Post-9/11 GI Bill students attending non-college degree schools. These schools offer training programs, such as those for truck drivers and emergency medical technicians. Generally, the education program entitlement for these schools is 36 months. However, VBA could allocate to students from less than one month to almost six years of housing allowance because of how it is required to calculate the amounts. This management advisory memorandum provided details on the calculations and the OAE team's analysis of housing allowances during a five-year period. VBA's response indicated it would use this analysis to help determine whether to request a legislative change to how entitlements and housing allowance payments are calculated for Post-9/11 GI Bill benefits. The OIG requested that VBA inform the OIG of any actions taken in response to the memorandum and the outcome of those actions.

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. OAE 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.

INADEQUATE OVERSIGHT OF THE MEDICAL/SURGICAL PRIME VENDOR PROGRAM'S DISTRIBUTION FEE INVOICING

An OAE team assessed VA's oversight of the Medical/Surgical Prime Vendor-Next Generation program (MSPV-NG), under which prime vendors maintain inventories of medical and surgical supplies and restock medical facilities when needed. VA controls were found to be insufficient to ensure medical facility staff accurately reviewed, verified, or certified distribution fee invoices for the program. VA also

did not ensure staff at medical facilities accurately established and applied the on-site representative rates and paid fees based on annual facility purchases. The MSPV-NG pricing schedule establishes fee rates for on-site representatives based on annual facility purchase amounts. VA establishing a flat fee rate will help mitigate on-site representative fee rate disparities, but in the interim VA still needs to ensure facilities reconcile prior and ongoing rate disparities. The OIG made 10 recommendations to improve oversight of verification and certification of distribution fee invoices and ensure the accuracy of on-site representative fees.

INSUFFICIENT OVERSIGHT FOR ISSUING PROSTHETIC SUPPLIES AND DEVICES

This report examined VHA oversight of prosthetic supplies and devices issued to veterans (including artificial limbs and devices that support or replace a body part or function, as well as sensory aids for hearing, vision, mobility, or speech and communication). VA's Prosthetic and Sensory Aids Service (PSAS) costs have increased from over $2.9 billion in fiscal year (FY) 2016 to nearly $3.5 billion in FY 2019. Oversight weaknesses were identified that contributed to PSAS staff cloning (copying) consults improperly. Consequently, VHA improperly issued an estimated $15.8 million in prosthetic supplies in 2017—also affecting the tracking of fulfillment times. While most transactions related to deceased veterans were proper, the OIG found that 6 percent of these transactions were improper. The OIG did not identify evidence of fraud with respect to these errors. VHA also adequately oversaw duplicate supply issuance. VHA concurred with the OIG's four recommendations to improve oversight of the clone consult function to prevent the improper issuance of prosthetic supplies.

AUDIT OF VA'S FINANCIAL STATEMENTS FOR FISCAL YEARS 2020 AND 2019

To fulfill an annual legislative requirement, the OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's financial statements. CLA provided an unmodified opinion on VA's FY 2020 and FY 2019 financial statements. It identified five material weaknesses in internal controls in the following areas: (1) significant accounting estimates; (2) obligations, undelivered orders, and accrued expenses; (3) financial systems and reporting; (4) IT security controls; (5) entity-level controls including the the chief financial officer organizational structure. The information technology security controls material weakness has been reported for more than 10 years. VA also did not substantially comply with certain requirements of the Federal Financial Management Improvement Act due to its disjointed legacy financial management system architecture, which no longer supports stringent financial management and reporting requirements. CLA made recommendations for addressing these material weaknesses and is responsible for its November 2020 audit report and conclusions.

THE FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT OF 1996[1]

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires all Chief Financial Officer Act agencies to implement financial management systems that substantially comply with three essential requirements: (1) federal financial management systems requirements, (2) federal accounting standards, and (3) the United States Standard General Ledger at the transaction level. The law further requires that

1 This annual report is not counted as a published report during this reporting period, but is summarized here to satisfy the reporting requirement under section 5(a)(13) of the IG Act. See appendix C for more information.

the head of the agency annually assesses and the agency auditor reports whether the agency's financial management systems substantially comply with the law's essential requirements.

Accordingly, the OIG is required to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The Audit of VA's Financial Statements for Fiscal Years 2020 and 2019 reported the following:

- VA's financial management system is not complying with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under the FFMIA, which has been reported in part for more than 10 years.
- Improvements are needed by VA in order to fully comply with the intent of the Federal Managers' Financial Integrity Act, which has been reported since 2015.
- There are instances of noncompliance with Title 38 of the United States Code, section 5315, pertaining to the charging of interest and administrative costs, which has been reported for more than 10 years.
- VA reported one violation of the Antideficiency Act, Title 31 of the United States Code, section 1341 (a), in November 2020 and is examining whether another violation may have occurred. Five other potential violations, which are carried forward from prior years, are under further discussion with the Office of Management and Budget. CLA has reported actual or potential violations of the Antideficiency Act since FY 2012.
- VA is not complying with the Improper Payments Elimination and Recovery Act for FY 2019, which has been reported by the OIG since 2012.

These conditions are primarily due to VA's complex and disjointed legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continues to be challenged in its efforts to apply consistent enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

PUBLICATIONS ON MANAGEMENT OF INFORMATION TECHNOLOGY AND SECURITY

OAE personnel audits and reviews VA's IT systems and security operations. This work helps ensure the policies focusing on the adequacy of managing and protecting veterans and VA employees, facilities, and information are in place and fully implemented. OIG audit reports present VA with recommendations to improve IT management and security. The OIG is also statutorily required to review annually 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.

VA NEEDS TO COMPLY FULLY WITH THE GEOSPATIAL DATA ACT OF 2018

This audit examined whether VA complied with the requirements of the "Covered Agency Responsibilities" section of the Geospatial Data Act of 2018. VA did not meet three of the 13 responsibilities. First, VA did not promote geospatial data activities, although the OIG found VA did not have the necessary criteria from the Federal Geographic Data Committee to develop and implement a strategy to comply with this requirement. Second, VA did not promote geospatial data integration and, third, did not ensure that geospatial information was included on agency record schedules that have been approved by the National Archives and Records Administration (NARA), as required by the act. The OIG recommended that VA establish mandatory policies and responsibilities to promote the integration of geospatial data and establish a process that ensures geospatial data and activities are included on VA record schedules that have been NARA-approved.

PUBLICATION ON LEADERSHIP AND HUMAN CAPITAL ADMINISTRATION AND OVERSIGHT

Audits and evaluations of VA's human capital asset management and leadership include the administration and oversight of people managing vital programs. The OIG identifies potential risks to veterans' programs associated with the poor or lack of implementation of VA or other governing policies on staffing and recruiting, awards and recognition, and compliance with federal personnel management criteria. OAE staff examine the effectiveness, timeliness, and accuracy of policy implementation that can affect patients' access to health care, benefits delivery, and programs needed to support veterans, eligible family members, and their caregivers. In addition to the report previously highlighted on skills certification mandates for compensation and pension claims processors, OAE released the following advisory.

POTENTIAL RISKS ASSOCIATED WITH EXPEDITED HIRING IN RESPONSE TO COVID-19

This management advisory memorandum identifies potential risks associated with VHA's efforts to quickly add new staff to meet increased demand for healthcare services caused by the COVID-19 pandemic. The OIG recognizes the tremendous pressure to quickly hire staff to meet unprecedented needs. To achieve VHA's goal of bringing all new employees on duty within three days of making a tentative offer, VHA has been modifying or deferring tasks such as fingerprinting, background investigations, drug testing, credentialing, and preplacement physicals. Because the associated risks, if realized, could damage the trust veterans have in VA keeping their information secure and ensuring care providers are suitably qualified, this memorandum raises issues for VHA to consider in determining whether vulnerabilities and related processes warrant further review. These include possible changes to centralize governance of deferred actions to improve oversight.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

PUBLICATIONS ON ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT

Reports on VA's acquisition processes and oversight operations provide insight into the challenges of a large, decentralized purchasing system, in which a variety of offices play significant roles. Compliance with the Federal Acquisition Regulation (as well as Title 48 of the C.F.R.) and VA's internal acquisition regulations facilitates VA staff and veterans receiving the best and most timely supplies and services. The recommendations in these reports present VA with constructive means to improve the acquisition and procurement processes.

OAE published three reports, two of which were highlighted at the start of this section related to PPE inventory and biologic implant purchasing and tracking. The third focuses on the administration of claims for care that veterans received in the community:

THE OFFICE OF COMMUNITY CARE'S OVERSIGHT OF NON-VA HEALTHCARE CLAIMS PROCESSED BY ITS CONTRACTOR

This audit was conducted to determine whether a VHA contractor's employees accurately processed claims for non-VA care. VA authorizes care from non-VA providers based on eligibility requirements, availability of VA care, and the circumstances of individual veterans. VA contracted with Signature Performance to help process claims for such care, but the contract did not require Signature employees to follow VA's claims-processing guidance. It also did not include standardized criteria to use when processing claims. The OIG found 13 percent of the contractor's claims decisions did not align with Office of Community Care's (OCC) guidance, increasing the risk that veterans were unnecessarily billed. VA agreed that oversight of the contractor's performance was not robust. OIG recommendations to the under secretary included providing additional training and guidance, enhancing quality surveillance, and ensuring contract requirements specify that contractor employees must follow OCC's guidance for processing non-VA care claims.

OTHER ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT ACTIVITIES

The OIG also provides VA's Office of Acquisition, Logistics, and Construction with preaward, postaward, and other reviews of vendors' proposals and contracts such as claims reviews. In addition, the OIG provides advisory services to that office on contracting activities and conducts healthcare preaward reviews for VHA. OAE issued 53 of these types of reports to VA during this reporting period. The majority of these reports are released only to the contracting officer because of the proprietary and privacy information they contain. The OIG does publish summaries periodically to provide more information on the impact of these reviews.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Thirty-five preaward reviews identified over $286 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews included 18 healthcare provider proposals, accounting for approximately $64 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. Sixteen postaward reviews resulted in VA recovering contract overcharges totaling over $8 million, including approximately $7 million related to compliance with the 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 16 postaward reviews performed, 13 involved voluntary disclosures. In 11 of the 13 voluntary disclosure reviews, OAE identified additional funds due. VA recouped 100 percent of the recommended recoveries for postaward contract reviews.

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 whether the claimed amount is supported by accounting and other financial records. During this period, OAE reviewed two claims and determined that $4.2 million 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 Fiscal Year 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 contains significant audit findings—unsupported, questioned, or disallowed costs in excess of $10 million, or other significant findings—as part of the SAR. During this reporting period, the VA OIG did not issue any reports meeting these requirements.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, OHI published six national healthcare reviews and 15 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, community living centers, and leadership. The office also published seven Comprehensive Healthcare Inspection Program (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. 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.

28
PUBLICATIONS

2,254
HOTLINE REFERRALS REVIEWED

4
IN-DEPTH CLINICAL CONSULTATIONS

FEATURED PUBLICATIONS

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

Two of the three selected publications focus on issues related to the ongoing VHA requirement that facilities ensure providers have the clinical skills required to perform their job and, equally important, that providers treat their patients and fellow employees with respect. The OIG has continually reported on the incongruity of required provider skills and desired clinical performance. The first of the highlighted publications reports on the misconduct of a gynecological provider, the deficiencies in quality of care, and unprofessional interactions between staff and patients. The second report emphasizes the need to have appropriately trained clinical staff in the catheterization lab and the need for VHA national specialty leaders to support medical center leaders as they make critical decisions for specialty services. The third report is one in a recent series that highlights how VA, at the Veterans Integrated Service Network (VISN) level, addressed many of the challenges presented with the COVID-19 pandemic.

MISCONDUCT BY A GYNECOLOGICAL PROVIDER AT THE GULF COAST VETERANS HEALTH CARE SYSTEM IN BILOXI, MISSISSIPPI

OHI evaluated allegations related to inappropriate language and conduct toward women veterans by a gynecological provider; a nurse chaperone's failure to provide patient support; and three additional

concerns related to compliance with patient complaint processes, facility leaders' response to the gynecological provider's misconduct, and deficiencies in reporting misconduct to state licensing board(s) and the National Practitioner Data Bank. The OIG substantiated that the gynecological provider's conduct was unprofessional, unethical, and insensitive. The nurse chaperone did not provide support to, or advocate on behalf of, the patients. The OIG found VHA has not incorporated key best practice strategies, such as trauma-informed care and sensitive examination policies, into training, policy, and practice. Further, VHA policies fall short in outlining expected chaperone responsibilities, duties, training, or competencies. Although facility patient advocates and quality management leaders tracked and trended patient complaints, the data were incomplete, limiting the accuracy and value of identified trends. Facility leaders had prior knowledge of the gynecological provider's misconduct; however, leaders failed to effectively address misconduct for years by not timely performing informal or formal investigations and not reporting the provider to state licensing board(s) or the National Practitioner Data Bank despite evidence that the conduct may have met the reporting standards. The OIG made two recommendations to the under secretary for health related to the role and training of providers and chaperones who conduct or provide support to patients during sensitive exams. One recommendation was directed to the VISN director related to facility processes for recording and tracking patient complaints. The remaining three recommendations were made to the facility director regarding staff education on misconduct policies, administrative investigation policies, and review of the subject gynecologist's conduct and quality of care provided.

VHA'S RESPONSE FOLLOWING CARDIAC CATHETERIZATION LAB CLOSURE AT THE SAMUEL S. STRATTON VA MEDICAL CENTER IN ALBANY, NEW YORK

This inspection assessed an allegation that the cardiac catheterization lab (CCL) was closed due to concerns of risk to patients at the Samuel S. Stratton VA Medical Center (facility) in Albany, New York. The OIG did not receive a response from VISN 2 staff following an inquiry and subsequently opened the healthcare inspection. The OIG substantiated that the CCL was closed due to concerns of risk to patients and determined the closure was in response to issues including use of improper clinical procedural techniques, personnel disputes, and a hostile work environment. A facility fact-finding review identified concerns with communication and team dynamics among staff and suspended CCL procedures. The OIG found that VISN and facility leaders acted promptly to obtain unbiased assessments when they arranged for an external review of the CCL by the National Cardiology Program Office (NCPO). The NCPO made recommendations addressing the clinical judgment and technical skills of the CCL cardiologists. Facility leaders convened an administrative investigation board and initiated management reviews. Clinicians independent of the facility and well versed in interventional cardiology assessed the CCL cardiologists' clinical competence. VISN and facility leaders decided that the CCL should remain closed indefinitely. According to the NCPO, its role is typically confined to advising VHA and facilities on policy matters. In this instance, the offering of recommendations by NCPO extended beyond policy matters and addressed operations, including the safe resumption of interventional cardiology at the facility. The OIG made three recommendations: two recommendations to the under secretary for health regarding the designation of a VHA specialty leader in interventional cardiology and one recommendation to the VISN director to review the circumstances that led to the failure to respond to an OIG inquiry.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTION OF FACILITIES' COVID-19 PANDEMIC READINESS AND RESPONSE IN VETERANS INTEGRATED SERVICE NETWORKS 10 AND 20

This CHIP report provides a focused evaluation of VISNs 10 and 20 facilities' COVID-19 pandemic readiness and response. This evaluation focused on emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; community living center patient care and operations; and facility staff feedback. OHI 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 describes findings on COVID-19 practices from healthcare inspections performed within VISNs 10 and 20 from July 1 through September 30, 2020. The report also provided a more recent snapshot of the pandemic's demands on these facilities' operations based on data compiled as of December 31, 2020. Interviews and survey results offered additional context on lessons learned and perceptions of both preparedness and response. This report also includes 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 care during public health crises. At the time of the inspections, VHA and the VISNs had not yet experienced the full force of the pandemic peaks in November and December 2020 but had valuable information to share about their experiences.

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, requested by Congress, or initiated by the OIG.

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT FOR FISCAL YEAR 2019

In this annual Comprehensive Health Inspection Program (CHIP) summary report, the OIG evaluated the quality of care delivered by VHA facilities. The report covers key processes that are associated with promoting quality care, and focuses on leadership and organizational risks; quality, safety, and value; medical staff privileging; environment of care; medication management, specifically controlled substances inspections; mental health, with a focus on military sexual trauma follow-up and staff training; geriatric care, examining antidepressant use among the elderly; women's health, targeting abnormal cervical pathology results notification and follow-up; and high-risk processes that apply to operations and management of emergency departments and urgent care centers. The OIG noted that 88 percent of facility leaders were assigned permanently at the 43 VA facilities visited in fiscal year 2019. These facility leaders generally appeared engaged in quality activities, felt supported by network leaders, were aware of employee and patient satisfaction efforts, and actively addressed recommendations for improvement. However, the OIG found opportunities for some facilities to enhance their performance. The OIG issued 32 recommendations for advancements across eight areas.

REVIEW OF VETERANS HEALTH ADMINISTRATION'S EMERGENCY DEPARTMENT AND URGENT CARE CENTER OPERATIONS DURING THE COVID-19 PANDEMIC

An OHI team reviewed VHA's response to the anticipated demand for emergency department and urgent care center services during the COVID-19 pandemic. They deployed a survey and interviewed 63 emergency department and urgent care center directors. Identified issues included VHA having a small number of negative pressure rooms and small waiting rooms, making it difficult to isolate patients. Several directors reported a loss of staff due to providers' testing positive, transfers, or retirements. Testing was generally available. Some directors reported a lack of or need to ration certain items of PPE. Data related to supplies, clinical treatment, COVID-19 epidemiology, and hospital utilization were helpful for directors' decision making. The directors reported closely monitoring staff for burnout. Lessons learned included rethinking how emergency or urgent care can be delivered in a pandemic and continuing to provide care to non-COVID-19 patients while attending to the special care needs of patients with COVID-19.

COLONOSCOPE REPROCESSING AT MULTISPECIALTY COMMUNITY-BASED OUTPATIENT CLINICS

This national review evaluates specific elements of colonoscope reprocessing at 10 multispecialty community-based outpatient clinics (CBOCs) that performed colonoscopies on site. The OIG reviewed training oversight and documentation, colonoscope reprocessing, and environmental monitoring in sterile processing areas. The OIG determined that CBOC sterile processing services (SPS) staff reprocessed and tracked colonoscopes according to VHA requirements and met requirements for environmental monitoring. The OIG found that 50 percent of SPS employees who were required to complete initial training within 90 days did not complete it in the required time frame. Service chiefs at 70 percent of the CBOCs did not ensure that training documentation was complete, and supervisors did not make certain that SPS staff received continuing education at 20 percent of the sites. The OIG issued two recommendations related to initial SPS training and continued education to the undersecretary for health.

QUALITY OF COLONOSCOPIES IN MULTISPECIALTY COMMUNITY-BASED OUTPATIENT CLINICS

An OHI team also conducted a second national colonoscopy project that reviewed colonoscopies performed in VHA multispecialty CBOCs, focusing on the CBOC colonoscopy providers' professional practice evaluations, national quality assurance monitoring, colonoscopy quality monitoring, and emergency care preparations. The OIG determined that (1) VHA, facility, and CBOC leaders lacked standardized monitoring processes preventing them from identifying colonoscopy quality gaps; (2) CBOC colonoscopy quality indicator data were not comprehensively monitored; (3) VHA's colorectal cancer screening directive lacked colonoscopy quality indicator compliance monitoring requirements; (4) lack of consistency in endoscopy software and variations in data collection limited the VHA National Gastroenterology Program Office's ability to monitor quality assurance; and (5) CBOC staff monitored patients during colonoscopies, managed potential risks, and had policies for managing after-hours medical emergencies. The OIG issued three recommendations related to colonoscopy provider professional practice evaluations, colonoscopy quality assurance monitoring, and standardization of endoscopy software.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

REVIEW OF VETERANS HEALTH ADMINISTRATION'S VIRTUAL PRIMARY CARE RESPONSE TO THE COVID-19 PANDEMIC

This review assessed VHA's virtual primary care response between February 7 and June 16, 2020. One strategy initiated by VHA, in accordance with the Centers for Disease Control and Prevention's recommendation to social distance, was the expansion of virtual care. Virtual care options during the pandemic included videoconferencing through the VA Video Connect (VVC) and third-party applications as well as telephone appointments. Face-to-face primary care encounters decreased by 75 percent and virtual encounters increased, with contact by telephone representing 81 percent of all primary care encounters. Additionally, primary care providers reported via questionnaire that virtual care scheduling was challenging and that VVC training and support were lacking for veterans, as was equipment and internet connectivity. The OIG made two recommendations to the under secretary for health related to access, equipment, and VVC training and support.

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=81

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. These inspections typically focus on allegations of 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.

VETERANS CRISIS LINE CHALLENGES, CONTINGENCY PLANS, AND SUCCESSES DURING THE COVID-19 PANDEMIC

This review focused on Veterans Crisis Line (VCL) operations during the COVID-19 pandemic. VCL's communal call center model posed a safety risk to staff, so VCL was challenged to equip and transition nearly 800 employees to telework-based operations. Over the course of six weeks, VA's Office of Information and Technology issued computers, monitors, and iPhones to staff. Regional information technology staff ensured that VCL employees had connectivity and access to needed programs. VCL employees were provided with training, guidance, and resources, and precautionary safety measures were implemented in the call centers for on-site staff. The VCL continued to meet performance targets for key indicators. VCL leaders reported the VCL could benefit from a broader technology and equipment plan, its own information technology staff, and managing its own contracts; better succession planning; and maintaining an inventory of items such as headsets, keyboards, and cell phones. The OIG made no recommendations.

MANAGEMENT OF THE OPHTHALMOLOGY CLINIC AND PATIENT SAFETY REPORTING CONCERNS AT THE VA CENTRAL IOWA HEALTH CARE SYSTEM IN DES MOINES

OHI conducted an inspection in response to multiple allegations related to ophthalmology clinic management, quality of care, oversight, medication management and facility leaders' failures at the VA Central Iowa Health Care System in Des Moines. The OIG found many of the allegations to be

unsubstantiated; however, the team identified deficits in ophthalmology clinic staff members' knowledge and use of the required patient safety event reporting system. There were also identified issues with the management and adverse impact of ongoing personnel conflicts within the ophthalmology clinic that leaders at multiple levels had difficulty managing. The OIG made four recommendations related to staff training and their use of the Joint Patient Safety Reporting system, addressing the ophthalmology clinic culture, and the oversight and management of the ophthalmology clinic.

Visit the OIG's Recommendation Dashboard at www.va.gov/oig/recommendation-dashboard.asp to track VA's progress in implementing OIG recommendations.

DEFICIENCIES IN THE VETERANS CRISIS LINE RESPONSE TO A VETERAN CALLER WHO DIED

This inspection assessed an allegation regarding VCL staff's management of a veteran caller who died the same day as contacting the crisis line. VCL staff did not initiate an emergency dispatch for the caller who reported using alcohol and over-the-counter medications that cause drowsiness. VCL policies did not address call management or safety planning with intoxicated callers or accidental overdose risk assessments. VCL leaders implemented aggregated data review criteria to oversee the quality of responders' telephone calls but only for consecutive calls, which may have contributed to inadequate quality assurance initiatives. The caller's lethality risk should have been considered high, and VCL staff should have initiated other actions including requesting an urgent consult by a suicide prevention coordinator. The OIG made eight recommendations regarding lethal means training, supervisory documentation, substance abuse and overdose risk assessment, safety planning, internal reviews, suicide prevention strategies, and a review of the caller's contacts with the VCL.

DEFICIENCIES IN AMBULATORY CARE CENTER AND EMERGENCY DEPARTMENT PROCESSES AT THE VA LOMA LINDA HEALTHCARE SYSTEM IN CALIFORNIA

OHI staff did not substantiate an allegation that a patient died in the emergency department waiting room at the facility. The patient was unarousable in the waiting room and died after being transported to an emergency department room where a physician noted no heart sounds or pulse. The family declined intervention. The OIG was not able to determine if the failure to complete and document an assessment and lack of hand-off communication with the emergency department by ambulatory care center staff affected the patient's outcome. The facility conducted a fact-finding review and identified a plan to address deficiencies. The facility revised the "first look" nurse policy (which requires that the first look nurse obtain or direct staff to obtain and document the patient's initial vital signs within 10 minutes of the patient's arrival to the emergency department). However, staff did not fully comply with the revised policy. The OIG made recommendations that the facility provide documentation training, review the hand-off communication policy, and ensure compliance with the revised policy.

SURGICAL SERVICE CARE DEFICIENCIES IN THE CRITICAL CARE UNIT AT THE CHARLIE NORWOOD VA MEDICAL CENTER IN AUGUSTA, GEORGIA

A healthcare inspection was conducted to assess allegations that deficiencies in care coordination between facility staff and remote telemedicine intensive care unit (tele-ICU) staff resulted in deaths, injuries, or poor outcomes for patients in the critical care unit after general surgery residents were withdrawn. While the OIG was unable to determine whether the withdrawal resulted in poor patient outcomes, the OIG found the lack of a common understanding of the tele-ICU program and insufficient

engagement between facility and tele-ICU staff contributed to challenging and impaired communication processes, including for reporting patient safety events. Six recommendations were made to the facility director related to communication and coordination, on-call processes, medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, and orientation and competency training. Two recommendations were made to the VISN 10 tele-ICU medical director related to patient safety reporting training and coordination of patient care reviews.

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

A healthcare team reviewed a patient's mental health care prior to death by suicide. The OIG substantiated that the patient died by suicide within three days of discharge and inpatient staff initiated medication and provided discharge instructions that included suicide prevention materials. Inpatient staff did not include vet center staff in discharge planning and failed to complete the comprehensive suicide risk evaluation. Facility leaders did not establish a mental health treatment coordinator policy and staff did not assign a coordinator or report a positive suicide risk screening result in an issue brief. VISN and National Center for Patient Safety leaders did not know vet center representation was required during VHA root cause analyses for shared patients. The OIG made one recommendation to the under secretary for health and six recommendations to the facility director.

DEFICIENCIES IN PRIVILEGING A UROLOGIST TO PRACTICE AND MEDICATION MANAGEMENT PROCESSES AT THE VA CENTRAL IOWA HEALTH CARE SYSTEM IN DES MOINES

An OHI team conducted an inspection in response to a referral regarding a urologist who practiced, was privileged, and ordered controlled substances without a Drug Enforcement Administration (DEA) registration. The urologist practiced and was privileged without DEA credentials because facility leaders did not promptly implement a directive requiring controlled substance ordering providers to possess an individual DEA registration. Upon recognizing the urologist's noncompliance, facility leaders acted, and the urologist obtained the required DEA registration. The failure of the urologist to promptly obtain a DEA registration was not related to clinical competency. The OIG was concerned, however, that the facility's operating room practice permitted surgeons to issue verbal orders for nonurgent medications without entering the medication orders in the computer. The practice bypassed quality controls and prevented pharmacists and controlled substance inspectors from reviewing medication orders. The OIG made five recommendations to the facility director.

THORACIC SURGERY QUALITY OF CARE ISSUES AND FACILITY LEADERS' RESPONSE AT THE C.W. BILL YOUNG VA MEDICAL CENTER IN BAY PINES, FLORIDA

OHI staff evaluated allegations related to a thoracic surgeon's surgical complications including patient deaths, operative note misrepresentations, and inappropriate reporting of the surgeon's complication rate. A non-VA consultant identified quality of care concerns in 16 of 24 patient cases reviewed. Facility external management reviews found concerns with five patient cases. The surgeon was reassigned to a nonclinical care setting. A VHA panel of cardiothoracic surgeons reviewed 22 of the 24 cases as well as additional cases. In December 2019, the panel determined that the surgeon delivered surgical care within quality expectations and the surgeon resumed patient care. Five recommendations related to a thoracic specialty leader, operative documentation, the National Surgery Office's assessments, and peer review processes were submitted to the under secretary for health. Five recommendations were made to

the facility director related to operative documentation, professional communications, the surgical work group, privileging, and institutional disclosures.

MEDICATION DELIVERY DELAYS PRIOR TO AND DURING THE COVID-19 PANDEMIC AT THE VA MANILLA OUTPATIENT CLINIC IN PASAY CITY, PHILIPPINES

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=80

The OIG found that a patient experienced a medication delay in late 2019 due to a stock shortage. The OIG was unable to substantiate if a second patient experienced medication refill delays because the inspectors could not determine when the refills were requested. Clinic leaders identified an increased pharmacy processing time in October 2019, and the chief of pharmacy services initiated an action plan that decreased that time. In March 2020, the President of the Philippines declared a COVID-19 emergency and implemented a quarantine that imposed travel limitations. As a result, four patients experienced medication delivery delays in March and April 2020. The OIG substantiated pharmacists could not dispense insulin to a patient as the clinic had no stock of the perishable medication after April 2020. The OIG determined none of these delays resulted in adverse clinical outcomes. Two recommendations were made related to pharmacy stock shortages and processing delays.

COMMUNICATION OF TEST RESULTS AND ONCOLOGY SCHEDULING CONCERNS AT THE BECKLEY VA MEDICAL CENTER IN WEST VIRGINIA

Conducted in response to a congressional request, this inspection assessed allegations that a patient received delayed and poor-quality care in the emergency department and oncology service. The OIG did not substantiate these allegations. On two occasions, there was no documentation that a primary care provider communicated test results with the patient. The OIG found deficits in an oncologist's use of scheduling orders and lack of adherence to the primary care and oncology service agreement wait times. The OIG was unable to determine whether compliance with the return to clinic policy would have altered the patient's course. Facility leaders performed comprehensive reviews of the patient's care. The OIG made two recommendations to communicate and document laboratory results and comply with clinic scheduling and ordering policies.

MAMMOGRAPHY PROGRAM DEFICIENCIES AND PATIENT RESULTS COMMUNICATION AT THE WASHINGTON DC VA MEDICAL CENTER

Pursuant to a congressional request, the OIG conducted an inspection at the Washington DC VA Medical Center after learning some patients did not receive mammography exam results. After the discovery of unsent mammography result letters, the facility completed reviews and identified four patients with breast cancer. Though the four patients did not receive letters, they received timely notification from the ordering provider and follow-up. Ordering providers did not consistently document patient notification of abnormal mammography results. At the time of the review, the facility did not have a mammography program due to staff loss and had not fully implemented National Radiology Program Office (NRPO) recommendations. The OIG made seven recommendations related to documentation and notification processes, action plans, standard operating procedures, staff training, and NRPO reviews and requirements.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

VIEW ALERT PROCESS FAILURES AND THE IMPACT ON PATIENT CARE AT THE CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM IN MONTGOMERY

This inspection was conducted in response to allegations that significant failures related to the management of "view alert notifications" placed patients at risk. A view alert is an automated notification to providers of abnormal test results. The OIG substantiated that nine of 12 reviewed providers had each accumulated more than 5,000 view alerts at some point between July 23 and December 2, 2019. The OIG substantiated that of the patients reviewed, some of their care was compromised because abnormal laboratory and imaging results were either not managed or not managed within the required timeframe. Some patients were at risk for delayed cancer diagnoses because of the lack of timely provider follow-up. The OIG also found ordering providers did not consistently take appropriate actions to edit and resubmit canceled consults. The OIG made one recommendation to the under secretary for health, one to the VA Southeast Network director, and nine to the system director.

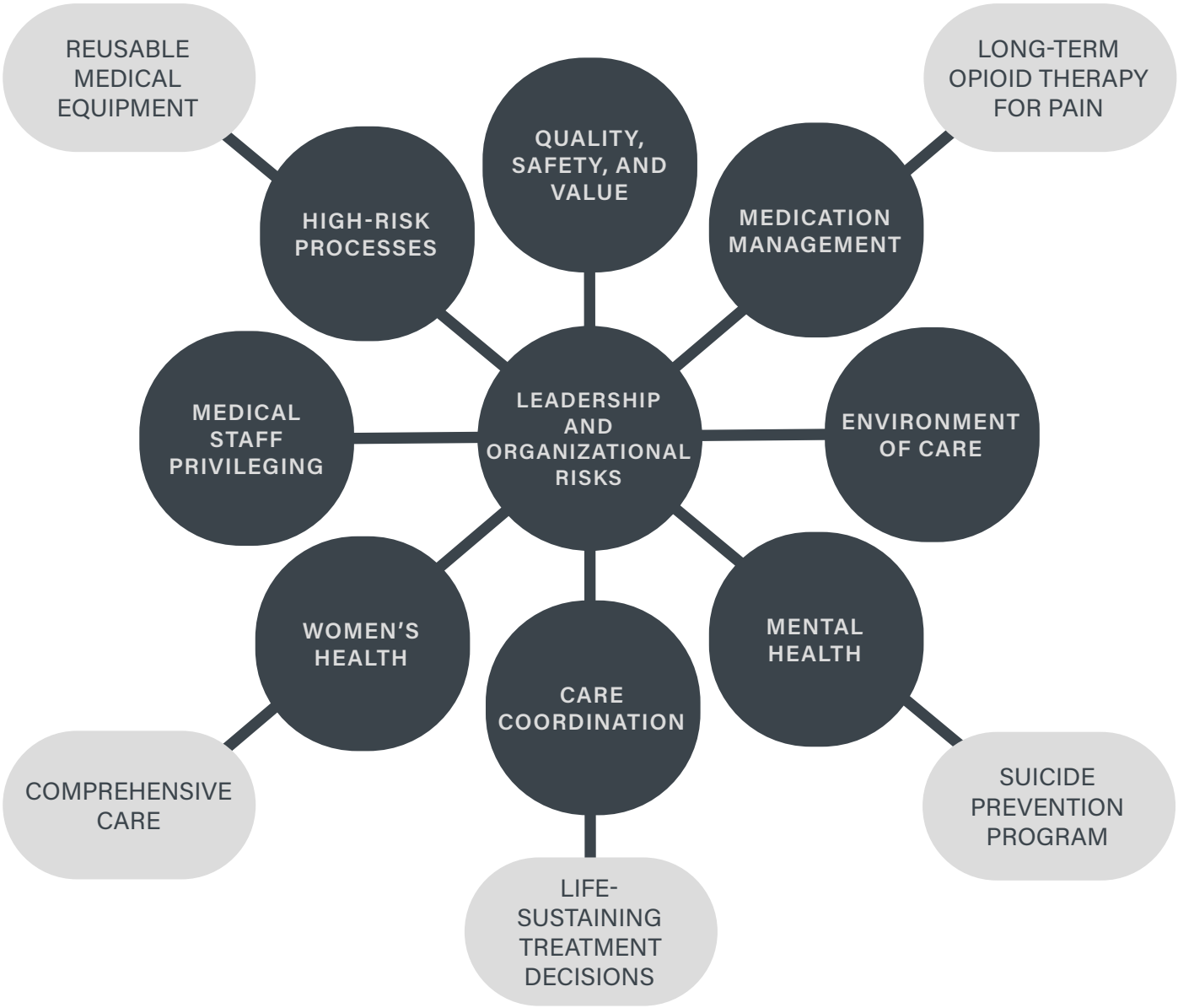
DEFICIENCIES IN CARE AND ADMINISTRATIVE PROCESSES FOR A PATIENT WHO DIED BY SUICIDE, PHOENIX VA HEALTH CARE SYSTEM, ARIZONA

This inspection assessed concerns regarding mental health care provided to a patient who died by suicide. While the patient awaited psychological diagnostic testing, facility staff failed to offer mental health treatment, and a social worker relied on an eight-month-old prior suicide risk assessment. The social worker did not document that a voicemail message provided notification of the patient's death, and a suicide prevention coordinator failed to complete timely family outreach documentation. A mental health delegate did not timely approve the patient's consult, and a third-party administrator scheduled the patient for therapy rather than testing. Primary care scheduling staff did not complete required missed appointment outreach, and the suicide prevention coordinator did not promptly complete a behavioral health autopsy. The OIG made seven recommendations related to the patient's care, suicide risk assessment, documentation, timely community care authorization, missed appointment procedures, community care scheduling, and prompt behavioral health autopsies.

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 seven comprehensive healthcare inspection, 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 six medical centers and healthcare systems and one VISN published in the six-month reporting period.

**COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM
AREAS OF FOCUS FISCAL YEAR 2020**



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 425,000 employees and contractors; and offenses affecting the Department's assets, programs, and operations.

109
ARRESTS

71
CONVICTIONS

$1.02B
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, including those who depend on VA's fiduciary program to safeguard their benefits. Finally, the sexual assault case involving a former physician (which is one of two egregious cases in this reporting period involving providers charged with patient care) underscores the need for vigilance and vigorous action to identify and bring to justice any individual who violates their position of trust by putting veterans' health and lives at risk.

TECHNICAL TRAINING SCHOOL OWNER AND WIFE SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

A VA OIG and FBI investigation revealed a school's owner submitted fraudulent documents to VA for several years. The owner and his wife admitted to falsifying student enrollment documents and employer verification information dating back to 2015, which caused VA to pay over $29 million in tuition, books, fees, and monthly student housing allowances. The owner of the technical training school and his wife were sentenced in the Southern District of California in connection with this education benefits fraud scheme. The owner was sentenced to 45 months' incarceration, three years' supervised release, and was ordered to pay restitution to VA in the amount of more than $29 million and to forfeit approximately $3 million. The owner's wife was sentenced to two years' probation.

HOME HEALTHCARE COMPANY OWNER SENTENCED FOR FIDUCIARY FRAUD

Another VA OIG and FBI investigation uncovered that while claiming to offer home healthcare and fiduciary services to veterans and surviving spouses, the owner of a home healthcare company

submitted fraudulent applications for pension, survivor's pension, and aid and attendance benefits to VA on behalf of elderly veterans and surviving spouses. On the applications, the owner included inflated home healthcare expenses that were not actually paid. The home healthcare expenses reduced the veterans' and surviving spouses' incomes to make it appear as if they qualified for the benefits. The owner also altered medical records so that the beneficiaries would appear to be eligible for the benefits. Without informing the beneficiaries, the owner then fraudulently directed their benefit payments to bank accounts that she controlled. The owner was sentenced in the District of Nevada to 41 months' incarceration, three years' supervised release, restitution of approximately $1.7 million and forfeiture of approximately $1.7 million.

FORMER DOCTOR AT THE BECKLEY VA MEDICAL CENTER IN WEST VIRGINIA SENTENCED AFTER SEXUALLY ABUSING PATIENTS

A VA OIG, FBI, and VA Police Service investigation found that a former doctor specializing in osteopathic manipulation therapy sexually abused three VA patients who sought chronic pain treatment during examinations at the facility. The former doctor was sentenced in the Southern District of West Virginia to 25 years' incarceration and three years' probation after pleading guilty to the deprivation of rights under the color of law (civil rights).

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 52 cases; made 67 arrests; obtained almost $296.4 million in court-ordered payments of fines, restitution, forfeiture, penalties, and civil judgments; and achieved nearly $735,000 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 Involving Patient Harm

FORMER CHIEF OF PATHOLOGY AT THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS IN FAYETTEVILLE, ARKANSAS, SENTENCED FOR INVOLUNTARY MANSLAUGHTER AND MAIL FRAUD

In addition to the sexual assault case previously highlighted, a former chief of pathology was sentenced to 20 years' incarceration, three years' probation, and approximately $497,000 in restitution after pleading guilty to involuntary manslaughter and mail fraud. The VA OIG investigation found the defendant misdiagnosed thousands of VA patients while under the influence of a potent substance that causes a lengthy intoxication period and is undetectable using routine drug and alcohol testing methods. The defendant's misdiagnoses included that of lung cancer in a veteran who would later die without treatment. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency. The defendant was sentenced in the Western District of Arkansas.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

DEFENDANT SENTENCED FOR DRUG DISTRIBUTION

An investigation by the VA OIG and Drug Enforcement Administration revealed that the defendant sold fentanyl to the friend of a veteran. The friend later provided the fentanyl to the veteran, who fatally overdosed at a VA residential facility in Lowell, Massachusetts. During the investigation, the defendant sold over 100 grams of fentanyl to an undercover agent. The defendant was sentenced in the District of Massachusetts to 10 years' incarceration and eight years' supervised release after previously pleading guilty to the distribution of fentanyl, the distribution of 40 grams or more of fentanyl, and possession with intent to distribute 28 grams or more of crack cocaine.

Cases Resulting in Settlements

CONTRACTOR AGREES TO PAY $179.7 MILLION TO RESOLVE OVERPAYMENT CLAIMS

A contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs entered into a settlement agreement with the DOJ Civil Division's Commercial Litigation Branch and the US Attorney's Office for the District of Arizona to resolve allegations that it retained overpayments received from VA. The two programs enabled veterans to obtain medical care from private-sector providers in their communities. As an administrator of these programs, the contractor was paid by VA to coordinate medical appointments and make payments to community healthcare providers. The alleged overpayments included duplicate payments VA made to the contractor for the same services as well as payments for services for which the contractor received full or partial reimbursement. Pursuant to the settlement agreement, the contractor will pay $179.7 million to the government. Of this amount, VA will receive approximately $158 million. This VA OIG cross-directorate investigation also involved staff from the OSR, OAE, OMA, and the Office of the Counselor to the Inspector General.

See monthly criminal case summaries at www.va.gov/oig/publications/monthly-highlights.asp and subscribe to email alerts at www.va.gov/oig.

Public Corruption by VHA Employee

FORMER PHARMACY TECHNICIAN AT THE EAST ORANGE VA MEDICAL CENTER IN NEW JERSEY AND COCONSPIRATOR CHARGED IN CONNECTION WITH THEFT SCHEME

A former pharmacy technician at the VA medical center in East Orange, New Jersey, was arrested after being charged with theft of government medical products and a second defendant was arrested after being charged with conspiracy to commit theft of government property. An investigation by the VA OIG, FBI, and VA Police Service resulted in charges alleging the defendants conspired to steal prescription HIV medication from the facility for several years. The loss to VA is approximately $7.8 million. Both defendants were charged in the District of New Jersey.

FORMER ANCHORAGE VA MEDICAL CENTER CONTRACTING OFFICER'S REPRESENTATIVE PLEADS GUILTY IN CONNECTION WITH BRIBERY SCHEME

A former contracting officer's representative at the Anchorage VA Medical Center pleaded guilty in the District of Alaska for his participation in a bribery scheme. An investigation by the VA OIG, Small Business Administration OIG, General Services Administration OIG, and FBI resulted in charges alleging the defendant gave preferential treatment to the owner of a service-disabled veteran-owned small business in return for nearly $30,000 in bribery payments. Consequently, the business obtained more than $5 million in set-aside snow removal and housekeeping contracts at the medical center. Two other individuals were also charged in connection with the scheme.

FORMER VA MEDICAL CENTER SURGICAL SERVICE SUPERVISOR PLEADS GUILTY IN CONNECTION WITH FRAUD SCHEME

A former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center in Ohio pleaded guilty to theft of government property, "honest services" wire fraud, wire fraud, and false statements relating to healthcare matters. A VA OIG and FBI investigation resulted in charges alleging the defendant received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. It is alleged that to justify the purchase of implants from the vendor, the defendant falsified some patient records to make it appear as if patients had implants that did not correlate to any actual surgical or medical procedure. The defendant is accused of defrauding VA of nearly $2.2 million. It is alleged that in a separate scheme, the defendant fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to make purchases from a company that he controlled for an additional loss of over $1 million. The defendant pleaded guilty in the Northern District of Ohio.

FORMER VA SUPPLY SUPERVISOR AND MEDICAL SUPPLY COMPANY PRESIDENT INDICTED IN CONNECTION WITH FRAUD SCHEME

A former central supply department supervisor at the Jesse Brown VA Medical Center in Chicago, Illinois, and a medical supply company president were indicted for wire fraud. A VA OIG investigation resulted in charges alleging that the former employee received monetary kickbacks in exchange for initiating VA orders from the medical supply company for medical products, many of which were never delivered to VA. The former employee was also indicted on additional counts of wire fraud, attempted witness tampering, and obstruction. The defendants are accused of defrauding VA of approximately $1.7 million. The defendants were indicted in the Northern District of Illinois.

FORMER WEST PALM BEACH VA MEDICAL CENTER EMPLOYEE SENTENCED IN CONNECTION WITH BRIBERY SCHEME

A VA OIG investigation, which was based on a hotline complaint, led to charges alleging that a terminated employee and 17 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach, Miami, and Philadelphia. The charges allege that VA employees placed orders for supplies in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. The defendant worked as an inventory management specialist, where he placed over $1.4 million in orders with the vendors charged in this case in exchange for cash kickbacks. The defendant also recruited other VA employees and vendors to participate in the scheme. To date, 15 individuals have pleaded guilty in connection with this investigation. The defendant

who was the terminated employee of the West Palm Beach VA Medical Center in Florida was sentenced in the Southern District of Florida to 27 months' incarceration, 24 months' probation, and restitution of $1.4 million.

DEFENDANT SENTENCED IN THEFT SCHEME

A VA OIG investigation revealed that a former VA maintenance and operations supervisor for the Central Texas Veterans Health Care System in Temple, his wife, and a former VA vendor used the wife's company to steal funds from VA. The former supervisor and his wife provided the vendor with fraudulent invoices from her company for services that were not actually provided to the vendor. The vendor paid the former supervisor, and then fabricated his own set of invoices used to bill VA for goods and services that were never provided. The amount of these invoices equaled the amount the vendor paid to the former supervisor plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The loss to VA is approximately $1,145,000. The former VA vendor was sentenced in the Western District of Texas to five years' probation and restitution of $714,000.

FORMER TRANSPORTATION ASSISTANT AT THE VILLAGES, FLORIDA, VA OUTPATIENT CLINIC SENTENCED IN CONNECTION WITH FRAUD SCHEME

A former transportation assistant at VA's Outpatient Clinic in The Villages, Florida, was sentenced to 18 months' incarceration and forfeiture of $382,254. A VA OIG investigation revealed that the former transportation assistant, who had the authority to award transportation assignments to vendors, conspired with his daughter and ex-wife to create and control two companies to which he steered VA transportation assignments. As a result, VA paid a total of $305,673 to these companies. The former transportation assistant also solicited and received approximately $76,000 in kickbacks from two other transportation vendors. The former transportation assistant's ex-wife and daughter were also criminally prosecuted in connection with this investigation. The defendant was sentenced in the Middle District of Florida.

FORMER EMPLOYEE AT THE VA PUGET SOUND HEALTHCARE SYSTEM SENTENCED FOR THEFT OF GOVERNMENT PROPERTY

VA OIG investigators revealed that a terminated employee of the VA Puget Sound Healthcare System in Seattle, Washington, stole several pieces of medical equipment, to include ventilators and bronchoscopes during the pandemic, and then sold the stolen items online. The defendant was sentenced in the Western District of Washington to three months' incarceration, nine months' home confinement with electronic monitoring, and three years' supervised release after pleading guilty to theft of government property. The defendant was also ordered to pay restitution to VA in the amount of $132,291.

Drug Diversion by VA Employee

FORMER VA HOSPICE NURSE SENTENCED FOR DRUG DIVERSION

VA OIG investigators learned a former hospice unit nurse at the VA Bedford Healthcare System in Massachusetts used tap water to dilute liquid morphine and subsequently administered the diluted substance to hospice patients. The defendant then ingested the diluted amount of the remaining drug. To conceal her drug diversion, the defendant falsified medical records by reporting that the patients had received more pain medication than they did. The former nurse was sentenced to 40 months'

incarceration and three years' supervised release in the District of Massachusetts after previously pleading guilty to tampering with a consumer product and obtaining a controlled substance by misrepresentation, fraud, deception, and subterfuge.

Fraud Against the Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA)

SIX DEFENDANTS CHARGED IN CIVIL COMPLAINT IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

The owners of a compounding pharmacy, two physicians, and two third-party marketers were charged with submitting false claims for compounded prescriptions to the Department of Defense's healthcare program TRICARE and CHAMPVA. It is alleged that the owners of the compounding pharmacy paid substantial kickbacks to third-party marketers in exchange for the referral of prescriptions for compounded drugs. The compounded prescriptions were fraudulently dispensed by doctors who were geographically located in different states than the patients, and for whom no doctor-patient relationship existed. The overall loss to the government is approximately $5.65 million. Of this amount, the loss to VA is approximately $1.9 million. The investigation was conducted by the VA OIG, FBI, Defense Criminal Investigative Service, and Air Force Office of Special Investigations with charges made through a civil complaint in the District of Nevada for violations of the False Claims Act.

TELEMARKETING COMPANY OWNER PLEADED GUILTY TO CONSPIRACY TO COMMIT HEALTHCARE FRAUD

The owner of a telemarketing company pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. An investigation by the VA OIG, Internal Revenue Service Criminal Investigation, Department of Health and Human Services OIG, and FBI led to charges alleging the defendant's company targeted the Medicare-aged population using offshore call centers that employed aggressive tactics to generate orders for durable medical equipment companies. The defendant's company subsequently bribed doctors to sign the orders. The defendant's company received more than $12 million from the durable medical equipment companies through the sale of the illegally signed doctors' orders, which were used in support of fraudulent claims submitted to Medicare and VA's Civilian Health and Medical Program. The loss to VA is approximately $800,000.

DEFENDANT PLEADED GUILTY IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT FRAUD SCHEME

In another durable medical equipment case, a business owner established numerous durable medical equipment companies and placed them in the names of straw owners. They then submitted over $400 million in fraudulent durable medical equipment claims to Medicare and CHAMPVA. The business owner and coconspirators allegedly purchased thousands of doctors' orders for braces from marketers who bribed doctors to sign under the guise of telemedicine. The business owner admitted to using the fraud proceeds to purchase numerous personal items and pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud and filing a false tax return. This was a VA OIG, Internal Revenue Service Criminal Investigation, Department of Health and Human Services OIG, and FBI investigation. The total loss to VA is approximately $500,000.

SEVEN DEFENDANTS INDICTED IN CONNECTION WITH COMPOUNDING PHARMACY SCHEME

Seven defendants were indicted in the Southern District of Florida for conspiracy to commit wire fraud; mail fraud; conspiracy to pay, and payment of, healthcare kickbacks. The defendants were charged with submitting false claims for compounded prescriptions totaling over $110.8 million to TRICARE, CHAMPVA, and private insurance companies. It is alleged that the compounded prescriptions were fraudulently dispensed by doctors who were located in different states than the patients and for whom no doctor-patient relationship existed. The compounded prescriptions were also alleged to be fraudulently dispensed by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or were billed for but never provided. The overall estimated loss to the government and private insurance is approximately $29.3 million. Of this amount, the loss to VA is approximately $450,000. This multiagency inspection included the VA OIG, Food and Drug Administration Office of Criminal Investigations, Army Criminal Investigation Command, Department of Labor Employee Benefits Security Administration, and Defense Criminal Investigative Service.

PHYSICIAN SENTENCED FOR OBSTRUCTION OF A HEALTHCARE INVESTIGATION

A VA OIG, FBI, Defense Criminal Investigative Service, and Department of Health and Human Services OIG investigation revealed that a physician used telemedicine to fraudulently prescribe compounded medication that resulted in over $5 million paid by government healthcare insurance programs, to include CHAMPVA. The investigation further revealed that the physician did not speak to many of the patients for whom she wrote prescriptions. The defendant also misled agents during an interview that was conducted in connection with this investigation. The loss to VA is $305,430. The physician was sentenced in the Eastern District of Arkansas to three years' probation, a fine of $180,000, and restitution of $33,150.

THREE DEFENDANTS PLEADED GUILTY TO DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

Three defendants pleaded guilty in the District of New Jersey to conspiracy to violate the Anti-Kickback Statute and conspiracy to commit healthcare fraud. The defendants participated in a telemarketing scheme to solicit durable medical equipment and cancer genetic screening tests to prospective patients and then used telemedicine doctors to generate prescriptions for these patients regardless of medical necessity. It is alleged that the telemedicine doctors had no relationship with the patients, and that the telemarketers then sold the completed orders to a testing laboratory. Many of the companies participating in the scheme engaged CHAMPVA. The loss to the government exceeds $1 billion. Of this amount, the loss to VA is approximately $330,000. To date, investigative efforts by the VA OIG, Defense Criminal Investigative Service, Internal Revenue Service Criminal Investigation, Department of Health and Human Services OIG, and FBI have led to nine arrests and six convictions.

Other Healthcare Fraud

OWNER OF WHOLESALE PHARMACEUTICAL COMPANY CHARGED IN SCHEME TO HOARD PERSONAL PROTECTIVE EQUIPMENT AND PRICE GOUGE HEALTHCARE PROVIDERS

The owner of a wholesale pharmaceutical company participated in a scheme to defraud healthcare providers, to include VA, of more than $1.8 million by acquiring and hoarding personal protective equipment during the pandemic. It is alleged that the owner directed sales representatives to solicit

healthcare providers, including VA, to purchase personal protective equipment and other designated materials at excessively inflated prices through high-pressure sales tactics and through misrepresenting sourcing and actual costs. The company owner allegedly sold N95 masks to VA and other healthcare providers for as much as $25 per mask, despite acquiring such masks at much lower prices. The total amount of designated scarce materials billed to VA by the vendor was approximately $334,300. The owner was indicted in the Southern District of Mississippi on charges of conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials. The investigation was conducted by the VA OIG, US Immigration and Customs Enforcement's Homeland Security Investigations, and FBI.

NONVETERAN SENTENCED IN CONNECTION WITH HEALTHCARE FRAUD SCHEME

An individual falsely claimed to have served in the US Marine Corps and to have been awarded the Purple Heart after being wounded in combat. After enrolling for VA healthcare benefits, the defendant received 692 outpatient treatments between December 2012 and March 2016. The nonveteran also received housing benefits that were intended for homeless veterans through the Department of Housing and Urban Development-VA Supportive Housing Program. The loss to the government was $167,234. Of this amount, the loss to VA is $162,900. Following the investigation by the VA OIG and Department of Housing and Urban Development OIG, the nonveteran was sentenced in the Central District of California to 16 months' imprisonment and to pay restitution of $167,234.

VIRGINIA BUSINESSMAN PLEADED GUILTY IN CONNECTION WITH MULTIPLE FRAUD SCHEMES

The chief executive officer of a government service provider pleaded guilty in the Eastern District of Virginia to false statements, wire fraud, and theft of government funds. A VA OIG, Department of Homeland Security OIG, and FBI investigation found that the defendant made false statements to both VA and the Federal Emergency Management Agency to obtain contracts, which were valued at approximately $38 million, to provide personal protective equipment during the pandemic. The defendant falsely claimed to VA and the Federal Emergency Management Agency that he possessed large quantities of personal protective equipment, to include N95 masks. The defendant also electronically submitted applications containing false information for Paycheck Protection Program and Emergency Injury Disaster Loans, which resulted in his receipt of approximately $1 million in loans. The investigation also revealed that the defendant submitted a fraudulent DD Form 214 (certifying release or discharge from active military duty) to VA, which falsely reflected that he served in the US Marine Corps. As a result, the defendant fraudulently received VA compensation benefits. The loss to the Small Business Administration is approximately $261,000 and the loss to VA is approximately $74,000.

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

VBA implements a number of programs for eligible veterans and family members, including education, insurance, and monetary benefits, as well as VA guaranteed home loans. Investigations routinely concentrate on benefits provided to ineligible individuals. With respect to home loans, the OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management

of foreclosed loans or properties. The OIG also investigates allegations of fraud committed by VA-appointed fiduciaries and caregivers.

OIG's IT and Data Analysis Division, 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 personnel to process and work cases resulting in the arrest of one individual, recoveries of $124,210, and a projected five-year savings to VA estimated at $1.3 million.

OI opened 70 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 25 arrests. OI obtained over $45.7 million in court-ordered fines, restitution, forfeiture, penalties, and civil judgments; achieved more than $13.5 million in savings, efficiencies, and cost avoidance; and recovered more than $3.4 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

Education Benefits Fraud

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

The owner of a heating, ventilation, and air conditioning school fraudulently obtained state and VA approval for his for-profit school. The defendant then allegedly used the fraudulently obtained approval status to entice students to attend the school, which resulted in the unlawful collection of VA education benefits. The loss to VA is approximately $71 million. The school owner was indicted in the Northern District of Texas on charges of wire fraud, money laundering, and aggravated identity theft following a VA OIG, US Postal Inspection Service, and FBI investigation.

TRUCKING SCHOOL OWNER SENTENCED FOR WIRE FRAUD

An investigation by the VA OIG, DOJ OIG, and FBI resulted in charges alleging that the owner of a trucking school conspired with employees and veteran students of his trucking school to fraudulently enroll veterans at the school from 2011 to 2015. The loss to VA is approximately $4.1 million. The school owner was sentenced in the Central District of California to four years' imprisonment, three years' supervised release, and restitution of over $4.1 million after previously pleading guilty to wire fraud.

Life Insurance Fraud

TWO VETERANS SENTENCED IN CONNECTION WITH LIFE INSURANCE FRAUD SCHEME

Two Navy veterans were sentenced in the Southern District of California for their involvement in a Traumatic Servicemembers Group Life Insurance (TSGLI) fraud scheme. An investigation by the VA OIG, Naval Criminal Investigative Service, and FBI led to charges alleging these two veterans, and at least 16 others, submitted numerous TSGLI claims that reflected fraudulent 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. To date, 11 individuals have been charged in the connection with this scheme. The first defendant was sentenced to four months' imprisonment, four

months' home confinement, and three years' supervised release. The second defendant was sentenced to four months' home confinement to be served as part of three years' probation. The loss to the TSGLI program is approximately $2 million.

Fiduciary Fraud

FORMER VA FIDUCIARY INDICTED FOR MISAPPROPRIATION

A former VA-appointed fiduciary was indicted in the Western District of Pennsylvania for misappropriation following a VA OIG investigation. The defendant allegedly 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. It is also alleged that some of the purchases included a diamond ring, a pickup truck, and two motorcycles.

Compensation Benefits Fraud

VETERAN INDICTED IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

A veteran is alleged to have fraudulently received VA compensation benefits for blindness. The veteran was rated as having "light perception only" and a visual acuity of 5/200 for approximately 30 years following his discharge from the Army. Allegations include that he maintained a driver's license in multiple states while claiming blindness. Furthermore, that during a 15-year period, the defendant and his wife purchased approximately 33 automobiles that he routinely drove, including on long-distance trips, to perform errands, and to VA medical appointments. The loss to VA is approximately $978,000. The veteran was indicted in the Western District of North Carolina on charges of theft of government funds, false statements, and false claims as a result of the VA OIG investigation.

VETERAN PLEADED GUILTY IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

A VA OIG investigation revealed that the defendant lied about his military service history, to include submitting a fraudulent record that listed the receipt of a Combat Infantryman Badge and a combat 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 and healthcare benefits. The loss to VA is $318,423. The veteran pleaded guilty in the Southern District of Florida to theft of government funds.

VETERAN SENTENCED IN CONNECTION WITH COMPENSATION BENEFITS FRAUD SCHEME

A veteran was sentenced in the Western District of Texas to 366 days' incarceration, three years' probation, and payment of $198,907 in restitution. A VA OIG investigation, which was based on a hotline complaint, demonstrated the defendant lied to VA to obtain a 100 percent service-connected disability rating related to partial leg and arm paralysis and other neurological ailments. The investigation uncovered that the defendant maintained a physically active lifestyle, to include running, participating in daily vigorous exercise classes at her gym, and mowing her lawn. The loss to VA is approximately $198,900.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

Theft of Government Funds

FORMER BANK MANAGER SENTENCED FOR THEFT OF GOVERNMENT FUNDS

An investigation by the VA OIG and Social Security Administration OIG revealed that a former bank manager in Las Vegas, Nevada, used his position as a bank manager to access VA and social security benefit payments that were made to two deceased beneficiaries. The manager then used the funds for personal expenses. He was sentenced in the District of Nevada to 30 months' imprisonment, three years' supervised release, and ordered to pay restitution of nearly $1.2 million. Of the restitution, VA will receive approximately $757,900.

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 30 cases and made 11 arrests. These investigations resulted in over $413 million in court-ordered payments of fines, restitution, forfeiture, penalties, and civil judgments, as well as $106,655 in savings, efficiencies, and cost avoidance.

Service-Disabled Veteran-Owned Small Business (SDVOSB) Fraud

TWO DEFENDANTS PLEADED GUILTY IN CONNECTION WITH SDVOSB FRAUD SCHEME

The owner of a construction company and a nonveteran pleaded guilty in the Western District of Texas to conspiracy to defraud the United States. The defendants and another individual conspired to defraud VA by fraudulently obtaining a SDVOSB set-aside construction contract valued at more than $20 million. This was a VA OIG, General Services Administration OIG, Army Criminal Investigation Command, Small Business Administration OIG, and Defense Criminal Investigative Service investigation.

TWO NONVETERANS PLEADED GUILTY IN CONNECTION WITH SDVOSB FRAUD SCHEME

A multiagency investigation resulted in charges alleging that two nonveterans falsely claimed that a joint venture was eligible to receive SDVOSB set-aside contracts from the government. The total value of these set-aside government contracts is approximately $16.1 million. Of this amount, the total value of the VA set-aside contracts was approximately $4.3 million. This case was investigated by the VA OIG, Air Force Office of Special Investigations, Department of Transportation OIG, Department of Agriculture OIG, Small Business Administration OIG, Army Criminal Investigation Division, General Services Administration OIG, and FBI. The two nonveterans pleaded guilty in the District of Utah in connection with this SDVOSB fraud scheme.

Procurement Cases Resulting in Settlements

CONTRACTOR AGREED TO PAY $11 MILLION TO RESOLVE CRIMINAL AND CIVIL PROBES

A government contractor that provides electricity solutions for buildings and data centers entered into a nonprosecution and civil agreement with the Department of Justice Civil Division's Commercial Litigation Branch and the US Attorney's Office for the District of Vermont. As part of the agreement, the contractor will pay $1.7 million in criminal forfeiture and admitted that its conduct constituted wire fraud. The contractor also agreed to pay $9.3 million to resolve False Claims Act and Anti-Kickback Statute liability for a former employee's scheme, which involved inflating estimates and assessing improper costs in proposals and overcharging federal agencies, including VA. This investigation was conducted by the VA OIG, Naval Criminal Investigative Service, Department of Agriculture OIG, Coast Guard Investigative Service, General Services Administration OIG, and the FBI.

FURNITURE VENDOR AGREES TO PAY $7.1 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

Pursuant to a settlement related to allegations that included falsifying or not lowering prices for the federal government as required, a General Services Administration-contracted furniture vendor will pay $7.1 million to the United States. Of this amount, VA will receive approximately $560,000. The vendor entered into the settlement agreement with the US Attorney's Office for the Northern District of California and DOJ's Civil Division's Consumer Litigation Branch to resolve allegations that the company violated the False Claims Act. A VA OIG, Department of State OIG, Defense Contract Audit Agency, General Services Administration OIG, and Defense Criminal Investigative Service investigation addressed allegations that the company provided false information to the General Services Administration about its commercial pricing practices during contract negotiations. The settlement also resolves allegations that the company did not extend lower prices to government customers as required by the General Services Administration contract's price reduction clause.

DURABLE MEDICAL EQUIPMENT MANUFACTURER AGREED TO PAY $1.5 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A manufacturer of range-of-motion therapy devices entered into a settlement agreement with the US Attorney's Office for the District of Massachusetts to resolve allegations that the company violated the False Claims Act by improperly charging the government for custom-fabricated orthotics. A VA OIG and Department of Health and Human Services OIG investigation addressed allegations that the company overcharged VA for its devices under the terms of their contract. This contract required the company to sell its devices to VA at a substantially better price than was offered to any commercial customer. Despite the contract's terms, the company did not disclose to VA that it continued to offer much deeper discounts to certain customers. As a result, the company charged VA medical centers nationwide up to 300 percent more for its devices than the contract required. Pursuant to the settlement, the company will pay $1.5 million, of which $797,267 is restitution. Of this restitution amount, VA will receive $452,553.

Workers' Compensation Program Fraud

DEFENDANT SENTENCED IN CONNECTION WITH WORKERS' COMPENSATION FRAUD SCHEME

An investigation by the VA OIG, Department of Labor OIG, US Postal Service OIG, and Department of Homeland Security OIG resulted in charges alleging the defendant sold the personally identifiable

information of government employees to other conspirators, who subsequently used the information to fraudulently bill the Department of Labor's Office of Workers' Compensation Program. The loss to the federal government is approximately $6.5 million. Of this amount, the loss to VA is approximately $2.5 million. The defendant was sentenced in the Northern District of Texas to 12 months' imprisonment, two years' supervised release, and restitution of approximately $190,623, of which VA will receive approximately $72,436.

Off-Label Marketing

MEDICAL DEVICE MANUFACTURER'S FORMER CHIEF EXECUTIVE OFFICER AND FORMER VICE PRESIDENT OF SALES SENTENCED IN CONNECTION WITH OFF-LABEL MARKETING SCHEME

A medical device manufacturer's former chief executive officer and former vice president of sales were sentenced in the District of Massachusetts for their roles in the marketing and distribution of a device for use outside of the Food and Drug Administration's approval. The former chief executive officer was sentenced to pay a criminal fine of $1 million, and the former vice president of sales was sentenced to pay a criminal fine of $500,000. The company previously entered into a global settlement with the government to pay a fine of $18 million, of which VA's portion of the settlement was $372,382. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, US Food and Drug Administration Office of Criminal Investigations, and the FBI.

THREATS AND ASSAULTS MADE AGAINST VA EMPLOYEES

During this reporting period, OI initiated 12 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against eight individuals.

Investigations resulted in $427,328 in savings, efficiencies, cost avoidance, and dollar recoveries.

Assaults Against VA Employee

DEFENDANT PLEADED GUILTY IN CONNECTION WITH CARJACKING

A VA OIG and VA Police Service investigation revealed that the defendant brandished a firearm as he confronted an employee of the VA Puget Sound Healthcare System in Seattle, who was getting into her vehicle in the facility's parking lot. The defendant then stole the employee's vehicle, purse, and other personal items. The victim's credit card was subsequently used to make 24 unauthorized purchases in the local area. The nonveteran pleaded guilty in King County District Court in Washington to unlawful possession of a firearm, escape, assault, and violation of the Uniformed Controlled Substances Act.

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, 91.1 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 105,524 investigative leads being referred

to law enforcement agencies. More than 2,652 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 $1.7 billion in estimated overpayments and cost avoidance of more than $2.38 billion. Overpayments are all benefits veterans received from VBA and VHA while having active felony warrants. Cost avoidance is the estimated amount of money veterans with an active felony warrants would have received if the VA OIG did not have the Fugitive Felon Program. During this reporting period, OI made six arrests of fugitive felons, assisted other federal and state agencies in the apprehension of five additional fugitive felons, and identified $251.3 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 whether (1) 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 one criminal investigation with substantiated allegations against senior government employees.

ALLEGED SEXUAL ASSAULT BY A PODIATRIST AT THE VA CENTRAL IOWA HEALTH CARE SYSTEM IN DES MOINES

The OIG received a referral alleging that a podiatrist at the VA Central Iowa Health Care System in Des Moines sexually assaulted a female employee while on duty at the facility. The investigation confirmed that the podiatrist touched the breast of the female employee. On October 8, 2020, this matter was referred for prosecution to, and declined by, the US Attorney's Office for the Southern District of Iowa. The facility terminated the podiatrist on November 4, 2020.

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 investigations with unsubstantiated allegations against a senior government employee.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FORMER VA ACTING UNDER SECRETARY FOR BENEFITS ALLEGED CONTRACT IRREGULARITIES

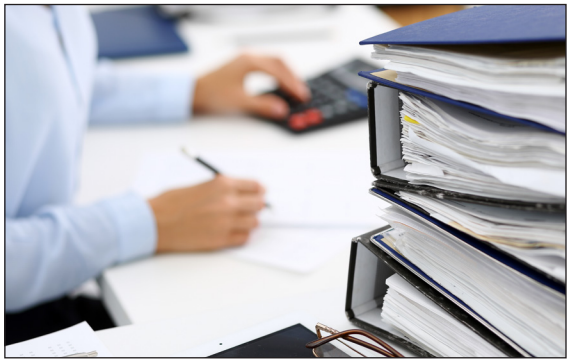
The OIG received a referral alleging that a former acting under secretary for benefits attempted to steer a portion of a VA contract which involved the Transition Assistance Program's dashboard component for his own personal benefit. It was alleged that the former acting under secretary for benefits requested that the prime contractor hire a particular individual as a subcontractor. During numerous interviews and document reviews, no evidence was identified that substantiated the allegations that the former acting under secretary for benefits attempted to or did steer any government contracts. This matter was not referred to the Department of Justice because no criminal conduct was identified. The investigation was closed on October 19, 2020.

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.
- The Hotline Division receives, screens, and refers OIG mission-related complaints as appropriate. It also analyzes and synthesizes information to inform decisions to accept cases on a select basis with priority given to issues having the most 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 OIG space plans and manages more than 60 OIG offices across the country.
- The Training and Development Division coordinates centralized instruction and staff professional development activities.



RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERSIGHT ACTIVITIES

OMA provides comprehensive services that promote reliable and timely management and administrative support of the organization. In addition to providing essential services to advance the OIG's overall mission and goals, OMA has noteworthy oversight responsibilities related to the operation of the Hotline Division. Hotline personnel receive, screen, and act in response to complaints regarding VA programs and services. The hotline director also serves as the Whistleblower Protection Coordinator. The coordinator 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 14,129 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 527 cases to and required a written response from applicable VA offices 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 658 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 636 cases for which nearly 39 percent of allegations were substantiated, 571 administrative sanctions and corrective actions were taken, and $725,375 in monetary benefits were achieved
- Responded to more than 948 requests for record reviews from VA staff offices
- Issued 4,261 semi-custom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope

FEATURED HOTLINE CASES

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

DISABILITY BENEFITS CHANGE

Hotline personnel received allegations that a veteran had attempted suicide due to a prolonged disability claim appeal related to a diagnosis of multiple sclerosis. At the time, the veteran was found to be ineligible for benefits because of the nature of the veteran's discharge from the military. Upon receipt of the complaint, hotline personnel alerted the VCL staff, who in turn contacted the veteran to check on the veteran's well-being. Simultaneously, the VA regional office responsible for benefit review undertook an examination of the veteran's record and found that a recent administrative decision had been made

in the veteran's favor. As a result, the veteran was awarded retroactive disability compensation in the amount of $40,216.

POOR DOCUMENTATION, WAITLISTS, AND STERILE PROCESSING AT CINCINNATI VA MEDICAL CENTER

The hotline received a multi-issue complaint regarding operations at the Cincinnati VA Medical Center clinic. The complainant alleged significant delays with coordination of care for veterans in the community due to secret wait lists, providers not using appropriate justifications for non-VA care, patient safety issues involving reuse of unsterile equipment, cataract surgery protocols not being followed leading to poor patient outcomes, and theft of government equipment by clinic staff. The hotline staff sent the case to the Office of Accountability and Whistleblower Protection. OAWP substantiated the allegations related to the reuse of unsterile equipment as well as theft and misuse of government equipment by a provider. As a result, the facility took action against a specific provider and required support personnel to complete training required for their position.

UNEARNED INDIVIDUAL UNEMPLOYABILITY BENEFITS

A complainant reported that a veteran receiving individual unemployability benefits had been working as a tattoo artist since 2016, making between $2,000 and $4,000 per month after expenses. Based on the allegations, pertinent documents from the veteran's benefits file, and documents submitted by the complainant, hotline staff opened a case and engaged the VA Regional Office (VARO). In response, the VARO queried both alleged employers and the IRS and, as part of due process, requested that the veteran respond to an employment questionnaire so that they could determine qualifying criteria for marginal employment. The veteran failed to return the required paperwork and the VARO took action to discontinue both individual unemployability and Dependents' Educational Assistance. However, since there was no definitive proof of long-term receipt of unearned benefits, no overpayment was established and the effective date for revised benefits was set as October 1, 2020. With a decrease from $3,492 to $1,696 per month in monthly benefits payments, the five-year projected cost savings totaled $107,755.

ALLEGED IMPROPER BEHAVIOR BY VA READJUSTMENT COUNSELING VETERAN CALL CENTER FOR MENTAL HEALTH

A confidential complainant reported that mental health providers were hanging up on veterans who called the VA Readjustment Counseling Veteran Call Center. In response, OIG hotline staff tasked the VA program office to review the allegations submitted and determine any appropriate corrective actions. The deputy chief officer of the call center conducted in-depth fact finding and determined that although interviews revealed that staff believed that some staff inappropriately hung up on callers, there was insufficient evidence that call center leaders ignored allegations of wrongdoing. To address the findings, VA initiated five corrective actions, including providing additional staff training, quality call monitoring, and enhancing supervision.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

DELAY IN CARE AT HAMPTON VA MEDICAL CENTER

A complainant submitted allegations that a veteran was trying to receive physical therapy in a community care setting but that over the course of eight months none of the four consults (referrals) submitted by the primary care provider resulted in treatment. The complainant further alleged that the veteran was treated rudely and hung up on when he attempted to resolve the problem by contacting the community care department. Upon review of the allegations, hotline staff sent a request for action to the facility and tasked them with reviewing the circumstances of the patient's care. The facility found that the initial consult was never processed due to a backlog. As a result, the Office of Community Care submitted the required paperwork and the veteran was seen without further delay. The Office of Community Care also made additional contacts with the veteran to ensure he was pleased with his treatment. Subsequent to this issue being reported, the Office of Community Care underwent a leadership change and within two months the backlogged consults decreased by 22 percent.

DELAYED DIAGNOSIS AT BIRMINGHAM VA MEDICAL CENTER

A complainant alleged that a veteran received a magnetic resonance image (MRI) in 2019 that was not read until July 2020 when it was determined that the veteran had a benign tumor. Although a treatment plan was established and carried out, the diagnosis came seven months after the test results were available. The hotline staff sent a request to the facility that a review of the veteran's care be provided to the OIG. The facility substantiated the complainant's allegations and implemented seven corrective actions to include restructuring the clinic to improve continuity of care and follow-up of results, establishing remote access for medical residents to check test results and contact patients, and auditing medical records for the neurology clinic to ensure lab and imaging results were communicated to patients and other follow-up was completed.

FEATURED DATA-DRIVEN INITIATIVES

The Data Analysis Division, in collaboration with cross-directorate stakeholders, continues 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. Examples of these data-driven initiatives include the following:

- Community Care Analysis Tool Suite, which provides OIG personnel with immediate access to community care claims details and enhances their ability to compare providers to help identify potential fraud, waste, and abuse. The tools include demographic information and descriptive statistics for each community care providers.
- Procurement Tool Suite, which allows OIG personnel to synthesize and review data related to the VA procurement process. The tools include a dashboard that displays VA contracts and associated payment data, and VA expenditures through contracts or purchase cards.

RESULTS FROM THE OFFICE OF SPECIAL REVIEWS

OVERVIEW

OSR issued three publications in this reporting period. Staff reviewed and triaged matters for further review that will be the subject of future reports as well. The reports listed below reflect OSR's commitment to identify senior officials' wrongdoing and 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.

3
PUBLICATIONS

3
RECOMMENDATIONS

FEATURED PUBLICATION

The report that best highlights the type of work OSR conducts involves its review of allegations of improper conduct at the highest levels of VA in response to a complainant who made a sexual assault complaint at a VA medical facility. The report garnered extensive national media and congressional attention, as well as responses from veterans service organizations.

SENIOR VA OFFICIALS' RESPONSE TO A VETERAN'S SEXUAL ASSAULT ALLEGATIONS

To address congressional requests, the OIG investigated VA's response to a veteran's complaint that she was sexually assaulted at the Washington DC VA Medical Center, including whether the VA Secretary or other senior officials investigated or sought to undermine the veteran's credibility. The OIG lacked conclusive evidence to reconcile conflicting testimony regarding whether former VA Secretary Robert Wilkie investigated or asked others to investigate the veteran. Six senior officials testified, however, that the Secretary stated the veteran had made, or may have made, prior similar complaints—which some understood meant prior complaints were unfounded. Officials' questioning of the veteran's credibility affected responses, including VA police conducting a background check on the veteran who made the complaint before the individual she identified as well as the public affairs staff engaging media to scrutinize the veteran. Despite the inspector general confirming VA could take action, leaders failed to follow up on available information regarding the individual the veteran accused or to address inhospitable conditions at the facility.

ADMINISTRATIVE INVESTIGATIONS

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 conduct investigations generally

concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders.

Under §5(a)(19) of the IG Act, OIGs must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) where allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether the matter was referred to the DOJ, the date of such referral, and, if applicable, the date of declination by the DOJ Section 5(a)(22)(B) of the IG Act also 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. The OIG publishes all closed administrative investigations, whether or not the allegations were substantiated. In addition to the featured publication above, the OIG published two administrative investigations.

Visit the OIG's Recommendation Dashboard at www.va.gov/oig/recommendation-dashboard.asp to track VA's progress in implementing OIG recommendations.

FALSE STATEMENTS AND CONCEALMENT OF MATERIAL INFORMATION BY VA INFORMATION TECHNOLOGY STAFF

OSR investigated an allegation that certain VA employees had a conflict of interest regarding VA's establishment of a 2016 cooperative research and development agreement (CRADA). The CRADA contemplated VA sharing with a private company the health data of all veterans who had ever received VA health care The CRADA was cancelled before any data disclosures were made. The OIG found no evidence of conflict of interest but substantiated that two VA employees who created the CRADA made multiple false statements to the approving official in advocating that he execute the CRADA while failing to disclose that VA privacy experts had raised significant unresolved concerns. The approving official relied on the information received from the two employees and was led to approve the CRADA under false pretenses. As prosecution was declined in 2018, investigators recommended VA determine what administrative action, if any, to take with respect to the two employees' conduct.

ALLEGED IRREGULARITIES REGARDING PHYSICIAN INCENTIVE COMPENSATION WERE NOT SUBSTANTIATED

OSR simultaneously investigated two separate complaints of potential irregularities regarding incentive compensation earned by VA physicians and dentists at two different healthcare facilities. The first complainant alleged that the director of a cardiac catheterization lab misused his government position for personal gain by restricting other cardiologists' access to the lab to satisfy a new productivity incentive; however, an OIG analysis of physician productivity did not substantiate the allegation. The second complainant alleged that the medical center dental service chief inappropriately miscoded numerous patient encounters to increase his performance pay. The OIG determined that, while the dental service chief incorrectly coded several patient encounters, the coding errors were due to his inexperience with coding procedures and had an insignificant impact on his overall performance pay. The OIG recommended an audit of the performance pay received to ensure the errors did not result in any improper payments.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

CONGRESSIONAL RELATIONS

During this reporting period, OIG leaders testified at two congressional hearings on the pandemic's impact on VA 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.

INSPECTOR GENERAL MISSAL TESTIFIES BEFORE HOUSE VETERANS' AFFAIRS OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE ON VA'S SUPPLY CHAIN IN THE PANDEMIC AND MODERNIZATION EFFORTS

Inspector General Missal testified on March 24, 2021, on VA's medical and surgical supply chain during the pandemic as well as oversight conducted by the OIG and the Government Accountability Office. The Inspector General discussed how OIG staff have worked to report promptly on VA's logistics during the pandemic and develop impactful recommendations. The testimony also discussed recent reports that focus on long-standing VA supply chain issues and modernization efforts, illustrating prior programmatic weaknesses. In response to questions, Inspector General Missal discussed an OIG review of mismanagement of equipment and supplies at the Hampton VA Medical Center in Virginia, the OIG's need for testimonial subpoena authority, and the common themes that underlie many OIG oversight reports such as poor governance structures, deficient IT systems, and lack of steady leadership.

DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS TESTIFIES BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

Deputy Assistant Inspector General for Audits and Evaluations Brent Arronte testified at a hearing on March 23, 2021, regarding the increase in VA's disability exam inventory caused by the pandemic. Because VA canceled in-person disability exams as a protective measure, a backlog of exams mounted quickly. In addition, some claims were improperly denied due to canceled appointments during the pandemic. Mr. Arronte's testimony discussed these and other issues drawn from the OIG's November 2020 report *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*. The OIG's findings focused on VBA's failure to create a documented plan to reduce the exam inventory to prepandemic levels.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

TABLE 6. OIG CONGRESSIONAL TESTIMONY (OCTOBER 1, 2020–MARCH 31, 2021)

WITNESS	COMMITTEE	TOPIC	DATE
Inspector General Michael Missal	House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations	The Pandemic and VA's Medical Supply Chain: Evaluating the Year-Long Response and Modernization	3/24/2021
Deputy Assistant Inspector General for Audits and Evaluations Brent Arronte	House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs	VA Compensation and Pension Exams During the COVID-19 Pandemic: A Path Forward	3/23/2021

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 (OCTOBER 1, 2020–MARCH 31, 2021)

TITLE	ISSUE DATE
VA OIG August 2020 Highlights	10/02/2020
VA OIG September 2020 Highlights	10/19/2020
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2020	10/19/2020
VA OIG October 2020 Highlights	11/24/2020
Semiannual Report to Congress #84	11/25/2020
VA OIG November 2020 Highlights	12/14/2020
Healthcare Inspection: Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans	1/14/2021
VA OIG December 2020 Highlights	1/25/2021
Management and Oversight of the Electronic Wait List for Healthcare Services	1/27/2021
Nurse Staffing Shortages at the Community Living Center within the San Francisco VA Health Care System	1/28/2021
VA OIG January 2021 Highlights	2/23/2021
VA OIG February 2021 Highlights	3/16/2021

REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors general are required by §4(a)(2) of the Inspector General Act of 1978 (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 16 legislative or regulatory proposals and made four comments. The OIG also reviewed 13 internal VA directives and handbooks that guide the work of VA employees and provided three 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	2/4/2020	HHS OIG	Pass	None
Investigations	12/10/2018	NASA OIG	Pass	None

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	11/23/2020	Department of Homeland Security	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 occuring 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.

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:

- Matthew Clark, an auditor in Dallas, Texas, was activated by the United States Army in July 2019.
- Danielle Head, a procurement analyst in Arlington, Virginia, was activated by the United States Army in October 2019.
- Damian Donahoe, a training management coordinator in Kansas City, Missouri, was activated by the United States Army in January 2020.
- Katherine Bostick, a health systems specialist in Aurora, Colorado, was activated by the United States Army in March 2020.
- Ricardo Wallace-Jimenez, a criminal investigator in Spokane, Washington, was activated by the United States Army in April 2020.
- Christopher Dong, an attorney in Washington, DC, was activated by the United States Air Force in March 2020 and returned from duty in October 2020.
- Trevor Rogers, a management and program analyst in Decatur, Georgia, was activated by the United States Army in December of 2020.
- Matthew Baker, a health systems specialist in Buffalo, New York, was activated by the Army National Guard in January 2021.

US ATTORNEY'S OFFICE INVESTIGATIVE EXCELLENCE AWARD

The US Attorney's Office for the Southern District of California presented Assistant Special Agent in Charge David Senness with a Case of the Year award for his investigation of U.S. v. Andrew Otero, et al. during the "Excellence in the Pursuit of Justice" awards. This annual award is designed to recognize the federal, state, and local law enforcement partners who have made extraordinary contributions to the DOJ's mission. Assistant Special Agent in Charge Senness was recognized for helping protect contracts intended for veterans and creating a model playbook for procurement fraud prosecutions.

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.

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
Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams *Issued 11/19/2020 | Report Number 20-02826-07*	—	—
Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans *Issued 11/23/2020 | Report Number 19-07316-262*	—	$153,897,817
Management and Oversight of the Electronic Wait List for Healthcare Services *Issued 12/1/2020 | Report Number 19-09161-02*	—	—
Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement *Issued 12/9/2020 | Report Number 20-00608-29*	—	$362,500,000
Audit of VA's Financial Statements for Fiscal Years 2020 and 2019 *Issued 12/14/2020 | Report Number 20-01408-19*	—	—
Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing *Issued 12/18/2020 | Report Number 20-02774-26*	—	—
VA Needs to Comply Fully with the Geospatial Data Act of 2018 *Issued 1/26/2021 | Report Number 20-02339-35*	—	—
Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk *Issued 1/27/2021 | Report Number 20-02071-49*	—	—
Insufficient Oversight for Issuing Prosthetic Supplies and Devices *Issued 2/11/2021 | Report Number 18-00972-38*	—	$79,200,000
VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits *Issued 2/23/2021 | Report Number 20-00295-61*	—	—

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

AUDITS, FINANCIAL INSPECTIONS, IT INSPECTIONS, AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic *Issued 2/24/2021 | Report Number 20-02959-62*	—	—
Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement *Issued 2/25/2021 | Report Number 19-07053-51*	—	—
The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor *Issued 3/2/2021 | Report Number 19-06902-23*	—	—
VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors *Issued 3/3/2021 | Report Number 20-00421-63*	—	—
Handling Administrative Errors at the Chicago VA Regional Benefits Office in Illinois *Issued 3/4/2021 | Report Number 20-00102-73*	—	$67,000
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing *Issued 3/4/2021 | Report Number 19-06147-50*	—	$3,700,000
Potential Risks Associated with Expedited Hiring in Response to COVID-19 *Issued 3/11/2021 | Report Number 20-00541-34*	—	—
Post-9/11 GI Bill Non-College Degree Entitlement Calculations Lead to Differences in Housing Allowance Payments *Issued 3/17/2021 | Report Number 20-03210-83*	—	—
Total	**$0**	**$599,364,817**

PREAWARD REVIEWS	BETTER USE OF FUNDS
Review of a Request for Modification for Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 10/8/2020 | Report Number 20-02356-01*	$258,688
Review of a Proposal Submitted Under a Solicitation *Issued 10/30/2020 | Report Number 20-03378-10*	$2,356,891

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 11/2/2020 | Report Number 20-04162-13*	—
Review of a Proposal Submitted Under a Solicitation *Issued 11/3/2020 | Report Number 20-04253-14*	$426,446
Review of a Request for Modification for Product Additions Submitted Under a Federal Supply Schedule Contract *Issued 11/4/2020 | Report Number 20-03274-17*	$130,943
Review of a Proposal Submitted Under a Solicitation *Issued 11/10/2020 | Report Number 21-00014-15*	$868,404
Review of a Proposal Submitted Under a Solicitation *Issued 11/17/2020 | Report Number 20-04252-20*	$2,381,638
Review of a Proposal Submitted Under a Solicitation *Issued 11/24/2020 | Report Number 21-00564-22*	$76,484
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 12/4/2020 | Report Number 20-02405-32*	—
Review of a Proposal Submitted Under a Solicitation *Issued 12/14/2020 | Report Number 21-00143-33*	$1,703,094
Review of a Proposal Submitted Under a Solicitation *Issued 12/14/2020 | Report Number 21-00330-39*	$780,047
Review of a Request for a Contract Extension Submitted Under a Federal Supply Schedule Contract *Issued 12/15/2020 | Report Number 20-04074-37*	—
Review of a Proposal Submitted Under a Solicitation *Issued 12/21/2020 | Report Number 20-04441-44*	$3,811,160
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 12/28/2020 | Report Number 20-02873-42*	$2,472,751
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 1/4/2021 | Report Number 20-04058-55*	$59,940

PREAWARD REVIEWS (CONTINUED)	BETTER USE OF FUNDS
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 1/7/2021 | Report Number 20-04118-58*	$33,999,100
Review of a Proposal Submitted Under a Solicitation *Issued 1/13/2021 | Report Number 21-00653-57*	—
Review of a Proposal Submitted Under a Solicitation *Issued 1/15/2021 | Report Number 21-00752-60*	$6,865,045
Review of a Proposal Submitted Under a Solicitation *Issued 1/27/2021 | Report Number 21-00634-67*	$126,941
Review of a Proposal Submitted Under a Solicitation *Issued 1/29/2021 | Report Number 21-01217-74*	$682,434
Review of a Proposal Submitted Under a Solicitation *Issued 2/3/2021 | Report Number 21-00775-78*	$3,214,880
Review of a Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 2/4/2021 | Report Number 21-00345-80*	—
Review of a Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 2/4/2021 | Report Number 20-02558-81*	$3,408,990
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 2/8/2021 | Report Number 20-04450-82*	$28,641,760
Review of a Proposal Submitted Under a Solicitation *Issued 2/10/2021 | Report Number 20-01086-75*	$8,866,846
Review of a Proposal Submitted Under a Solicitation *Issued 2/16/2021 | Report Number 21-00855-84*	$973,213
Review of a Proposal Submitted Under a Solicitation *Issued 2/17/2021 | Report Number 21-01389-87*	—
Review of a Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 2/23/2021 | Report Number 20-04225-88*	$2,188,500
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 2/25/2021 | Report Number 20-02816-90*	$114,437,781

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 Number *Issued 3/8/2021 | Report Number 20-04154-96*	$22,561,340
Review of Proposal Submitted Under a Solicitation *Issued 3/22/2021 | Report Number 21-01011-95*	$30,654,465
Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract *Issued 3/24/2021 | Report Number 21-00730-106*	$3,905,820
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation Number *Issued 3/25/2021 | Report Number 20-04110-101*	—
Review of a Proposal Submitted Under a Solicitation Number *Issued 3/25/2021 | Report Number 21-01371-99*	$387,629
Review of a Federal Supply Schedule Proposal Submitted Under a Solicitation *Issued 3/26/2021 | Report Number 20-04362-97*	$10,193,827
Total	**$286,435,057**

Note: Numbers may not sum due to rounding.

POSTAWARD REVIEWS	QUESTIONED COSTS
Review of Compliance with Public Law 102-585 Section 603 Under Federal Supply Schedule Contracts *Issued 10/22/2020 | Report Number 19-07849-03*	$144,556
Review of Voluntary Disclosures of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract *Issued 12/2/2020 | Report Number 20-01208-16*	$1,186,952
Review of a Voluntary Disclosure Due to Price Reductions Clause Violations Under a Federal Supply Schedule Contract *Issued 12/2/2020 | Report Number 20-03095-30*	$215,834
Review of a Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 12/15/2020 | Report Number 19-08275-45*	$6,907
Review of a Voluntary Disclosure and Refund Offer Due to Price Reductions Clause Violations Under a Federal Supply Schedule Contract *Issued 12/15/2020 | Report Number 20-02851-46*	$114,853

POSTAWARD REVIEWS (CONTINUED)	QUESTIONED COSTS
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract *Issued 12/15/2020 | Report Number 20-01328-41*	$308,822
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract *Issued 12/21/2020 | Report Number 20-03317-43*	$109,376
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Interim Agreement *Issued 12/28/2020 | Report Number 20-04358-47*	$55,912
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 Under a Federal Supply Schedule Contract *Issued 12/29/2020 | Report Number 20-03315-53*	$19,483
Review of a Voluntary Disclosure of Noncompliance with Public Law 102-585 Section 603 *Issued 1/6/2021 | Report Number 19-07087-54*	$5,448,151
Review of a Voluntary Disclosure Due to Price Reductions Clause Violations Under a Federal Supply Schedule Contract *Issued 1/21/2021 | Report Number 20-01818-65*	$54,882
Review of a Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract *Issued 1/21/2021 | Report Number 20-00675-66*	$245,766
Review of a Voluntary Disclosure Due to Price Reductions Clause Violations Under a Federal Supply Schedule Contract *Issued 1/27/2021 | Report Number 20-03531-72*	$321,202
Review of Federal Supply Schedule Contract V797D-2001D *Issued 3/18/2021 | Report Number 20-03967-103*	$81
Review of a Federal Supply Schedule Contract *Issued 3/26/2021 | Report Number 20-04057-105*	—
Review of a Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract *Issued 3/31/2021 | Report Number 20-03246-71*	$830
Total	**$8,233,607**

Note: Numbers may not sum due to rounding.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

CLAIM REVIEWS	BETTER USE OF FUNDS
Review of a Certified Claim Submitted Under a Contract *Issued 11/20/2020 | Report Number 20-03592-21*	$350,669
Review of a Certified Claim under a VA Contract *Issued 3/4/2021 | Report Number 20-04294-94*	$3,927,379
Total	**$4,278,048**

Note: Numbers may not sum due to rounding.

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

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Ralph H. Johnson VA Medical Center in Charleston, South Carolina	11/5/2020	20-00132-04
Carl Vinson VA Medical Center in Dublin, Georgia	1/12/2020	20-00130-06
Atlanta VA Health Care System in Decatur, Georgia	11/18/2020	20-00129-09
Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina	12/15/2020	20-00130-25
Charlie Norwood VA Medical Center in Augusta, Georgia	12/16/2020	20-00132-28
Dayton VA Medical Center in Ohio	2/3/2021	20-01271-64
Veterans Integrated Service Network 7: VA Southeast Network in Duluth, Georgia	3/3/2021	20-00130-86

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Veterans Crisis Line Challenges, Contingency Plans, and Successes During the COVID-19 Pandemic	10/28/2020	20-02830-05
Management of the Ophthalmology Clinic and Patient Safety Reporting Concerns at the VA Central Iowa Health Care System in Des Moines	11/3/2020	20-01326-08
Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died	11/17/2020	19-08542-11
Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California	11/19/2020	19-08411-12
Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia	12/16/2020	20-01480-31

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
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	1/5/2021	20-01521-48
Deficiencies in Privileging a Urologist to Practice and Medication Management Processes at the VA Central Iowa Health Care System in Des Moines	1/12/2021	20-02359-52
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida	1/13/2021	18-01321-56
Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines	1/28/2021	20-02779-59
Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	2/10/2021	20-01036-70
Communication of Test Results and Oncology Scheduling Concerns at the Beckley VA Medical Center in West Virginia	2/11/2021	20-00339-69
VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York	2/17/2021	19-09129-76
Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center	2/25/2021	20-00563-68
View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery	3/11/2021	20-00427-92
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona	3/23/2021	20-02667-93

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019	11/24/2020	20-01994-18
Review of Veterans Health Administration's Emergency Department and Urgent Care Center Operations During the COVID-19 Pandemic	12/17/2020	20-01106-40
Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics	3/4/2021	20-01387-89
Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic	3/11/2021	20-02717-85
Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20	3/16/2021	21-01116-98
Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics	3/31/2021	20-01386-107

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

ADMINISTRATIVE INVESTIGATIONS	ISSUE DATE	REPORT NUMBER
Senior VA Officials' Response to a Veteran's Sexual Assault Allegations	12/10/2020	20-01766-36
False Statements and Concealment of Material Information by VA Information Technology Staff	1/28/2021	17-01980-201
Alleged Irregularities Regarding Physician Incentive Compensation Were Not Substantiated	3/17/2021	19-00652-79

TABLE A.4. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$607,598,427
Better Use of Funds	$290,713,105
Total	**$898,311,532**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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	20	$607,598,427
Total inventory this reporting period	**20**	**$**607,598,427
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	20	$607,598,427
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**20**	$607,598,427
Total carried over to next reporting period	**0**	**$0**

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with recommended funds to be put to better use issued during the reporting period	30	$290,713,105
Total inventory this reporting period	**30**	$290,713,105
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	30	$290,713,105
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**30**	$290,713,105
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 March 31, 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 at www.va.gov/oig/recommendation-dashboard.asp 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 March 31, 2021, there were 165 total open reports, with 59 open more than a year and 106 open less than a year. However, table B.1 shows a total of 174 open reports, with 63 open more than a year and 111 open less than a year. This is because nine 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	46	89	135
Veterans Benefits Administration	6	11	17
Office of Acquisition, Logistics, and Construction	3	2	5
Office of General Counsel	1	2	3
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	3	1	4
Office of Information and Technology	1	4	5
Office of Management	2	0	2
Office of Accountability and Whistleblower Protection	1	0	1
Office of Electronic Health Record Modernization	0	1	1
Office of Enterprise Integration	0	1	1
Totals	**63**	**111**	**174**

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 March 31, 2021, there are 802 total open recommendations, with 188 open more than a year and 614 open less than a year. However, table B.2 shows a total of 808 open recommendations, with 192 open more than a year and 616 open less than a year. This is because six 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	116	558	674
Veterans Benefits Administration	11	34	45
Office of Acquisition, Logistics, and Construction	6	5	11
Office of General Counsel	1	3	4
Office of Human Resources and Administration/ Office of Operations, Security, and Preparedness	14	5	19
Office of Information and Technology	26	5	31
Office of Management	16	0	16
Office of Accountability and Whistleblower Protection	2	0	2
Office of Electronic Health Record Modernization	0	5	5
Office of Enterprise Integration	0	1	1
Totals	**192**	**616**	**808**

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

Table B.3 identifies the 106 reports and 614 recommendations that, as of March 31, 2021, have been open less than one year. The total monetary benefit attached to these recommendations is $888,108,224.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System *Issued 4/27/2020 | Report Number 19-08980-95*	OEHRM	3–7	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington *Issued 4/27/2020 | Report Number 19-09447-136*	VHA	1-2, 4-5, 7-8	—
Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 5/12/2020 | Report Number 19-08296-118*	VHA	4	—
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2019 *Issued 5/14/2020 | Report Number 19-09563-142*	VHA	1	—
Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina *Issued 5/19/2020 | Report Number 19-08256-124*	VHA	3, 5-6	—
VA's Implementation of the FITARA Chief Information Officer Authority Enhancements *Issued 6/9/2020 | Report Number 18-04800-122*	OIT	5, 7-8	—
Disability Compensation Benefit Adjustments for Hospitalization Need Improvement *Issued 6/10/2020 | Report Number 19-06249-94*	VBA	6	$40,000,000
Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center, Pennsylvania *Issued 6/11/2020 | Report Number 19-06391-119*	VHA	1-2, 4-5	—
Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center in Baltimore, Maryland *Issued 6/11/2020 | Report Number 19-08857-171*	VHA	1, 3-5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Financial Controls and Payments Related to VA-Affiliated NPCs: Middle Tennessee Research Institute *Issued 6/16/2020 | Report Number 18-00711-106*	VHA	1–3	$1,900,000
Financial Controls Related to VA-Affiliated Nonprofit Corporations: Deficient for Northern California Institute for Research and Education *Issued 6/16/2020 | Report Number 18-00711-141*	VHA	1-2	$25,940,000
VA Police Information Management System Needs Improvement *Issued 6/17/2020 | Report Number 19-05798-107*	OHRA/ OSP	1–4, 6	—
Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka *Issued 6/18/2020 | Report Number 19-06870-175*	VHA	5-6, 14-25, 30-31	—
Deficiencies in Virtual Pharmacy Services in the Care of a Patient *Issued 6/18/2020 | Report Number 19-07827-182*	VHA	2	—
Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel *Issued 6/25/2020 | Report Number 18-06501-158*	OGC	4–7	—
Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania *Issued 7/1/2020 | Report Number 19-09436-185*	VHA	2, 5	—
Inadequate Care by a Clinical Pharmacy Specialist and a Primary Care Provider at the Tennessee Valley Healthcare System in Nashville *Issued 7/2/2020 | Report Number 19-07543-178*	VHA	1-2	—
Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina *Issued 7/2/2020| Report Number 19-09377-192*	VHA	3	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Review of Highly Rural Community-Based Outpatient Clinics Limited Access to Select Specialty Care *Issued 7/7/2020 | Report Number 19-00017-191*	VHA	1, 4	—
Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin *Issued 7/7/2020 | Report Number 20-00082-189*	VHA	2-3	—
Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration *Issued 7/8/2020 | Report Number 19-00230-190*	OALC	1	$4,999,500
Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veteran's Hospital in Columbia, Missouri *Issued 7/9/2020 | Report Number 19-06864-183*	VHA	5, 11, 14	—
Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri *Issued 7/9/2020 | Report Number 19-09416-186*	VHA	2-11, 13-14	—
The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research *Issued 7/14/2020 | Report Number 19-06451-165*	VHA	2–5	—
Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas *Issued 7/14/2020 | Report Number 19-09410-203*	VHA	4–6	—
Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois *Issued 7/15/2020 | Report Number 20-00206-180*	VHA	1, 16, 21, 26	—
Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia *Issued 7/21/2020 | Report Number 18-01622-207*	VHA	1–3	—
Deficiencies in the Quality Review Team Program *Issued 7/22/2020 | Report Number 19-07054-174*	VBA	1–5	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies *Issued 7/22/2020 | Report Number 19-07059-169*	VBA	1-2, 4-6	—
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri *Issued 7/23/2020 | Report Number 19-06850-208*	VHA	3-5, 9-15	—
Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center *Issued 7/28/2020 | Report Number 19-07507-214*	VHA	4, 9	—
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia *Issued 7/29/2020 | Report Number 19-07600-215*	VHA	10	—
Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois *Issued 7/29/2020 | Report Number 20-00062-205*	VHA	1-7, 9, 11, 13	—
Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin *Issued 8/4/2020 | Report Number 20-00068-206*	VHA	7-10, 15	—
Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center, Louisville, Kentucky *Issued 8/5/2020 | Report Number 19-08666-212*	VHA	1-4, 10	—
Improving VA Patients and Select Community Care Health Information Exchanges *Issued 8/6/2020 | Report Number 20-01129-220*	VHA	1–3	—
Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri *Issued 8/12/2020 | Report Number 19-06873-210*	VHA	1, 3-16, 19-20	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois *Issued 8/13/2020 | Report Number 20-00077-211*	VHA	3-5, 9, 12-20, 22	—
Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas *Issued 8/18/2020 | Report Number 19-06872-199*	VHA	2-3, 5, 10, 15-17, 21	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri *Issued 8/19/2020 | Report Number 19-06848-209*	VHA	2	—
Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds *Issued 8/20/2020 | Report Number 19-09669-236*	VHA	2-6	—
Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital in Hines, Illinois *Issued 8/25/2020 | Report Number 20-00069-222*	VHA	1–18, 20, 22, 23	—
Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin *Issued 8/26/2020 | Report Number 20-00075-225*	VHA	4-11, 13, 17-21, 28	—
Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois *Issued 8/27/2020 | Report Number 20-00064-238*	VHA	2-3, 6-8, 10, 13-14, 17-20, 22-24, 26-27	—
Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon *Issued 8/27/2020 | Report Number 20-02240-248*	VHA	1	—
Appointment Management During the COVID-19 Pandemic *Issued 9/1/2020 | Report Number 20-02794-218*	VHA	1–3	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources *Issued 9/2/2020 | Report Number 18-03800-232*	VHA	1, 3	—
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama *Issued 9/2/2020 | Report Number 20-00130-194*	VHA	8, 10	—
Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee *Issued 9/3/2020 | Report Number 19-09493-249*	VHA	1–11, 14–16	—
The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions *Issued 9/10/2020 | Report Number 19-00227-226*	VBA	1–4	$122,000,000
Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery *Issued 9/10/2020 | Report Number 20-00131-243*	VHA	2-4, 8-9, 11–26, 28–30	—
Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care *Issued 9/17/2020 | Report Number 18-06039-229*	VHA	5	$30,000,000
Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency *Issued 9/17/2020 | Report Number 20-02825-242*	VBA	2	—
Mismanagement of Emergency Department Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas *Issued 9/23/2020 | Report Number 20-01318-258*	VHA	3-5, 8-10	—
Financial Controls Related to VA-Affiliated Nonprofit Corporations: Idaho Veterans Research and Education Foundation *Issued 9/24/2020 | Report Number 18-00711-251*	VHA	1–5	$112,400

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia *Issued 9/24/2020 | Report Number 20-01102-266*	VHA	1, 4	
The Veterans Health Administration's Governance of Robotic Surgical System Investments Needs Improvement *Issued 9/25/2020 | Report Number 19-07103-252*	VHA	1–5	—
Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia *Issued 9/28/2020 | Report Number 19-07828-265*	VHA	1–3, 5	—
Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide *Issued 9/29/2020 | Report Number 19-07062-255*	VBA	2–4	—
Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans *Issued 9/29/2020 | Report Number 19-07854-272*	VHA	2-6	—
Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California *Issued 9/29/2020 | Report Number 20-00005-271*	VHA	5	—
VA's Noncompliance with Preaward Review Requirements for Sole-Source Proposals for Healthcare Services *Issued 9/30/2020 | Report Number 18-04150-261*	VHA	1	$4,101,555
Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System *Issued 9/30/2020 | Report Number 19-00226-245*	VHA	1–8	205,100,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia *Issued 9/30/2020 | Report Number 19-08106-273*	VHA	1-3, 5-6, 8-9, 11-12, 14, 17-18	—
Management of the Ophthalmology Clinic and Patient Safety Reporting Concerns at the VA Central Iowa Health Care System in Des Moines *Issued 11/3/2020 | Report Number 20-01326-08*	VHA	1-4	—
Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina *Issued 11/5/2020 | Report Number 20-00132-04*	VHA	1-4, 6-7, 11	—
Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center in Dublin, Georgia *Issued 11/12/2020 | Report Number 20-00130-06*	VHA	1-17	—
Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died *Issued 11/17/2020 | Report Number 19-08542-11*	VHA	1-8	—
Comprehensive Healthcare Inspection of the Atlanta VA Health Care System in Decatur, Georgia *Issued 11/18/2020 | Report Number 20-00129-09*	VHA	1-5, 7-8, 10-17, 19-20, 23	—
Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California *Issued 11/19/2020 | Report Number 19-08411-12*	VHA	1-3	—
Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams *Issued 11/19/2020 | Report Number 20-02826-07*	VBA	1-2	—
Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans *Issued 11/23/2020 | Report Number 19-07316-262*	VHA	1, 3-8	$8,487,769

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019 *Issued 11/24/2020 | Report Number 20-01994-18*	VHA	1-20, 23-32	—
Management and Oversight of the Electronic Wait List for Healthcare Services *Issued 12/1/2020 | Report Number 19-09161-02*	VHA	1-3	—
Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement *Issued 12/9/2020 | Report Number 20-00608-29*	VBA	1-2	$362,500,000
Senior VA Officials' Response to a Veteran's Sexual Assault Allegations *Issued 12/10/2020 | Report Number 20-01766-36*	VHA	1 PROPOSED ACTION	—
Comprehensive Healthcare Inspection of the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina *Issued 12/14/2020 | Report Number 20-00130-25*	VHA	1-5, 7-10, 13-14	—
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia *Issued 12/16/2020 | Report Number 20-00132-28*	VHA	1-11, 15-20	—
Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia *Issued 12/16/2020 | Report Number 20-01480-31*	VHA	1-8	—
Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing *Issued 12/18/2020 | Report Number 20-02774-26*	VHA	1-4	—
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 *Issued 1/5/2021 | Report Number 20-01521-48*	VHA	1-7	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in Privileging a Urologist to Practice and Medication Management Processes at the VA Central Iowa Health Care System in Des Moines *Issued 1/12/2021 | Report Number 20-02359-52*	VHA	1-5	—
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida *Issued 1/13/2021 | Report Number 18-01321-56*	VHA	1-10	—
VA Needs to Comply Fully with the Geospatial Data Act of 2018 *Issued 1/26/2021 | Report Number 20-02339-35*	OEI OIT	OEI: 1 OIT: 2	—
False Statements and Concealment of Material Information by VA Information Technology Staff *Issued 1/28/2021 | Report Number 17-01980-201*	OIT VHA	OIT: 1 VHA: 2	—
Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines *Issued 1/28/2021 | Report Number 20-02779-59*	VHA	1-2	—
Comprehensive Healthcare Inspection of the Dayton VA Medical Center in Ohio *Issued 2/3/2021 | Report Number 20-01271-64*	VHA	1-10	—
Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi *Issued 2/10/2021 | Report Number 20-01036-70*	VHA	1-6	—
Insufficient Oversight for Issuing Prosthetic Supplies and Devices *Issued 2/11/2021 | Report Number 18-00972-38*	VHA	1-4	$79,200,000
Communication of Test Results and Oncology Scheduling Concerns at the Beckley VA Medical Center in West Virginia *Issued 2/11/2021 | Report Number 20-00339-69*	VHA	1-2	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York *Issued 2/17/2021 | Report Number 19-09129-76*	VHA	1-3	—
VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits *Issued 2/23/2021 | Report Number 20-00295-61*	VBA VHA	VBA/VHA: 1-2 VBA: 3 VHA: 4	—
Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic *Issued 2/24/2021 | Report Number 20-02959-62*	VHA	1-2	—
Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement *Issued 2/25/2021 | Report Number 19-07053-51*	VHA	1-11	—
Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center *Issued 2/25/2021 | Report Number 20-00563-68*	VHA	1-7	—
The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor *Issued 3/2/2021 | Report Number 19-06902-23*	VHA	1-5	—
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 7: VA Southeast Network in Duluth, Georgia *Issued 3/3/2021 | Report Number 20-00130-86*	VHA	2-7	—
VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors *Issued 3/3/2021 | Report Number 20-00421-63*	VBA	1-6	—
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing *Issued 3/4/2021 | Report Number 19-06147-50*	OALC VHA	VHA: 1-4, 9-10 OALC: 5-8	$3,700,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Handling Administrative Errors at the Chicago VA Regional Benefits Office in Illinois *Issued 3/4/2021 | Report Number 20-00102-73*	VBA	1-2	$67,000
Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics *Issued 3/4/2021 | Report Number 20-01387-89*	VHA	1-2	—
View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery *Issued 3/11/2021 | Report Number 20-00427-92*	VHA	1-11	—
Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic *Issued 3/11/2021 | Report Number 20-02717-85*	VHA	1-2	—
Alleged Irregularities Regarding Physician Incentive Compensation Were Not Substantiated *Issued 3/17/2021 | Report Number 19-00652-79*	VHA	1	—
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona *Issued 3/23/2021 | Report Number 20-02667-93*	VHA	1-7	—
Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics *Issued 3/31/2021 | Report Number 20-01386-107*	VHA	1-3	—
Total			**$888,108,224**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

Table B.4 identifies the 59 reports and 188 recommendations that, as of March 31, 2021, remain open for more than one year. The total monetary benefit attached to these reports is $1,662,711,000.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 7/11/2014 | Report Number 13-01452-214*	VBA	$205,000,000
Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.		
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	—
Recommendation 5: We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.		
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	—
Recommendation 3: We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.		
Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through FBCS *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	—
Recommendation 1: We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators, as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.		
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	VHA OHRA/ OSP	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
Recommendation 4: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage the background investigation workload.		
Recommendation 8: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.		
Recommendation 9: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.		
Recommendation 10: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.		
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	$34,500,000
Recommendation 5: The OIG recommended the Under Secretary for Health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).		
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	$100,600,000
Recommendation 1: The Under Secretary for Benefits establishes internal controls sufficient to ensure that a reexamination is necessary prior to employees ordering it, and modifies VBA procedures as appropriate to reflect these improved business processes.		
Recommendation 4: The Under Secretary for Benefits conducts a special focused quality improvement review of cases with unwarranted reexaminations to develop data sufficient to understand and redress the causes of any avoidable errors.		
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
Review of Pain Management Services in Veterans Health Administration Facilities *Issued 9/17/2018 | Report Number 16-00538-282*	VHA	—
Recommendation 3: The Under Secretary for Health evaluates and determines the adequacy of the number of pain specialists at each facility through formalized assessments and takes action as appropriate.		
Recommendation 4: The Under Secretary for Health ensures that VA facilities without pain specialists have formalized designated resources of pain care provided by providers.		
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*	VHA OALC	—
Recommendation 1: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System implement a plan that puts the West LA campus in compliance with the West Los Angeles Leasing Act of 2016, the Draft Master Plan, and other federal laws, including reasonable time periods to correct deficiencies noted in this report.		
Recommendation 2: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure all non-VA entities operating on the West LA campus with expired or undocumented land use agreements establish new agreements compliant with the West Los Angeles Leasing Act.		
Recommendation 3: The Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System create a process to allow the Veterans Community Oversight and Engagement Board an opportunity to provide input to the executive leadership on West LA campus land use.		
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	VHA OHRA/ OSP	—
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.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.		
Recommendation 3: Make certain medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives.		
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.		
Recommendation 5: Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders.		
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 | Report Number 17-03499-20*	OHRA/ OSP	—
Recommendation 2: The Acting Assistant Secretary for Human Resources and Administration makes certain that an adequate threat assessment is developed and kept current for each principal secured by the Executive Protection Division.		
Recommendation 7: The Acting Assistant Secretary for Human Resources and Administration establishes written procedures for documenting the review and approval of employee overtime within the Executive Protection Division and ensures compliance.		
Recommendation 8: The Acting Assistant Secretary for Human Resources and Administration assesses and takes remedial action, if necessary, to make certain that Executive Protection Division staff use parking and transit benefits in accordance with VA policy.		
Recommendation 9: The Acting Assistant Secretary for Human Resources and Administration confers with the Offices of General Counsel and Accountability and Whistleblower Protection to determine whether any agents inappropriately accepted transit benefits while using VA parking spaces, and if so, determine the appropriate administrative action to take, if any.		
Recommendation 10: The Acting Assistant Secretary for Human Resources and Administration works with the Offices of General Counsel and Accountability and Whistleblower Protection to institute procedures for an ombudsman or similar function that will enable the Executive Protection Division agents to address management disputes without needing to involve the VA Secretary.		
Recommendation 12: The Acting Assistant Secretary for Human Resources and Administration consults with the Offices of General Counsel and Accountability and Whistleblower Protection to provide adequate mechanisms and training for all staff within the Office of Operations, Security, and Preparedness, including the Executive Protection Division, that ensure allegations of perceived misconduct by the VA Secretary can be appropriately addressed without the threat of retaliation.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center *Issued 1/28/2019 | Report Number 17-01757-50*	VHA	—
Recommendation 6: The Associate Director ensures that safety and infection prevention processes are in place at construction sites and monitors compliance.		
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package *Issued 5/1/2019 | Report Number 17-05246-98*	VHA	—
Recommendation 3: The Executive in Charge, Office of the Under Secretary for Health, strengthens procedures for VA medical centers to sufficiently conduct and document physical inventory results and retain documentation as required by VHA policy.		
Recommendation 4: The Executive in Charge, Office of the Under Secretary for Health, strengthens controls at VA medical centers to ensure supplies are consistently secured.		
Recommendation 5: The Executive in Charge, Office of the Under Secretary for Health, ensures VA medical centers affix barcode labels for all expendable supplies at the locations where the inventory items are stored.		
Recommendation 6: The Executive in Charge, Office of the Under Secretary for Health, strengthens procedures for the Veteran Integrated Service Network Quality Control Review process, ensuring a thorough review is conducted and action plans are developed and executed to address identified deficiencies at the VAMCs. In addition, update the Quality Control Review document regarding VA medical center security, access requirements, and improper distribution of supplies.		
Inadequate Oversight of Contracted Disability Exam Cancellations *Issued 6/10/2019 | Report Number 18-04266-115*	VBA	—
Recommendation 1: The Under Secretary for Benefits improve the exam management systems to ensure visibility of the information needed to conduct adequate oversight of contracted disability exam cancellations.		
VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract *Issued 6/13/2019 | Report Number 17-04178-46*	OALC	$ 37,500,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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 *Issued 6/27/2019 | Report Number 18-00037-154*	VHA	—
Recommendation 6: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews and provides input into the patient referral process to mental health clinical pharmacists with consideration for ensuring that accurate diagnoses can be reliably identified by and conveyed to the mental health clinical pharmacists.		
Recommendation 7: The Under Secretary for Health ensures the Veterans Health Administration Office of Mental Health and Suicide Prevention Director reviews the patient referral process to mental health clinical pharmacists and provides input with consideration for clinical settings or scenarios in which a review of the clinical complexity of the referral by a licensed independent practitioner with prescribing authority would be appropriate, prior to treatment.		
Management of Major Medical Leases Needs Improvement *Issued 7/2/2019 | Report Number 17-05859-131*	OALC	$ 152,300,000
Recommendation 6: The Deputy Under Secretary for Health for Operations and Management and the Executive Director, Office of Construction Facilities Management, ensure VA uses appropriate security measure requirements when acquiring VA major medical leases by performing Interagency Security Committee risk evaluations prior to solicitation.		
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 7/11/2019 | Report Number 19-00497-161*	VHA	—
Recommendation 20: The Charlie Norwood VA Medical Center Director ensures that the emergency department security system is upgraded to meet current security requirements and to provide a safe environment for patients and staff.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 24: The Charlie Norwood VA Medical Center Director ensures the Contracting Officer's Representative responsible for the technical administration of the transportation contract conducts surveillance of the contractor's performance and provides oversight of the contractual agreements.		
Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 7/23/2019 | Report Number 17-05572-170*	VHA	—
Recommendation 3: The New Mexico VA Health Care System Director reviews open and completed consult data as well as new patient data and develops action plans to address identified issues.		
Recommendation 5: The New Mexico VA Health Care System Director ensures that patients with outpatient mental health consults and return-to-clinic orders, including telemental health, are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult/return-to-clinic timeframe and that the scheduling process is monitored for compliance.		
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming *Issued 7/24/2019 | Report Number 18-04680-162*	VHA	—
Recommendation 15: The chief of staff confirms that clinicians provide and document patient/caregiver education and assess understanding of education provided about newly prescribed medications and monitors clinicians' compliance.		
Non VA Emergency Care Claims Inappropriately Denied and Rejected *Issued 8/6/2019 | Report Number 18-00469-150*	VHA	533,000,000
Recommendation 1: The Under Secretary for Health reevaluates all claims denied after April 8, 2016, for the reason of "other health insurance" for appropriate corrective action.		
Health Information Management Medical Documentation Backlog *Issued 8/21/2019 | Report Number 18-01214-157*	VHA	—
Recommendation 1: Establish a policy that formally defines "medical document backlog"—specifically, the age of unscanned and unindexed medical documentation.		
Recommendation 4: Implement policy to require chiefs of Health Information Management to notify facility directors when a medical document backlog exists and to take appropriate action.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 5: Assess the scanning process, including staffing and productivity levels, within each facility to ensure authorized staffing levels can support future workload.		
Recommendation 6: Ensure facility directors act on staffing level assessments and obtain the necessary resources within scanning departments.		
Recommendation 7: Implement standardized quality assurance monitoring procedures to improve accurate updating of patients' electronic health records and completion of corrective actions when errors are identified.		
Recommendation 8: Ensure original documents are retained until the scanning supervisor or designee verifies that scanning staff have met quality assurance monitoring standards established in Recommendation 7.		
Recommendation 9: Develop procedures to ensure facility directors provide adequate document scanning/indexing training, consistent with Veterans Health Administration Handbook 1907.07, prior to allowing employees to scan/index documents without direct supervision and as needed for corrective actions.		
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/5/2019 | Report Number 18-05663-189*	VBA	$64,800,000
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.		
Recommendation 2: Develop a plan to update the rating schedule to establish more objective criteria for each level of evaluation for peripheral nerves.		
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.		
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.		
State Prescription Drug Monitoring Programs Need Increased Use and Oversight *Issued 9/23/2019 | Report Number 18-02830-164*	VHA	—
Recommendation 2: Update the Pain Management and Opioid Safety training course to specifically address VHA Directive 1306, Querying State Prescription Drug Monitoring Programs, query requirements and recommendations.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: Ensure VA clinicians who prescribe opioids take the Pain Management and Opioid Safety training once, with annual refresher training.		
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 9/24/2019 | Report Number 18-06510-222*	VHA	—
Recommendation 1: The chief of staff makes certain that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors compliance. Recommendation 10: The facility director confirms that the Women Veterans Health Committee includes required core members and monitors the committee's compliance.		
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming *Issued 9/26/2019 | Report Number 18-04681-228*	VHA	—
Recommendation 8: The associate director ensures flooring that provides cushioning is installed in the mental health seclusion rooms. Recommendation 16: The facility director ensures the Women Veterans Health Committee includes required core members and monitors the committee's compliance.		
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida *Issued 9/27/2019 | Report Number 19-00010-237*	VHA	—
Recommendation 4: The chief of staff ensures that clinical managers clearly define focused professional practice evaluation criteria in advance with providers and monitors clinical managers' compliance. Recommendation 5: The chief of staff confirms that clinical managers include service/section-specific criteria in ongoing professional practice evaluations and monitors compliance. Recommendation 6: The chief of staff makes certain that service chiefs' determination to recommend continuation of privileges be based in part on results of ongoing professional practice activities and monitors service chiefs' compliance.		
Comprehensive Healthcare Inspection Summary Report Fiscal Year 201 *Issued 10/10/2019 | Report Number 19-07040-243*	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 1: The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensure that clinical managers consistently implement improvement actions recommended from peer review activities and monitor clinical managers' compliance.		
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.		
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.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives *Issued 10/17/2019 | Report Number 19-06125-218*	OIT	—
Recommendation 3: The assistant secretary for information and technology implements improved oversight procedures, including specific facility-level procedures, to ensure that sensitive personal information is not being stored on shared network drives.		
Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas *Issued 10/23/2019 | Report Number 19-00035-247*	VHA	—
Recommendation 1: The chief of staff ensures that clinical managers define the focused professional practice evaluation process in advance and monitors clinical managers' compliance. Recommendation 11: The chief of staff confirms that the Women Veterans Health Committee includes required core members and monitors committee's compliance.		
Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017 *Issued 10/24/2019 | Report Number 18-04968-249*	OGC OAWP	—
Recommendation 4: The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process. Recommendation 6: The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all. Recommendation 11: The Assistant Secretary for Accountability and Whistleblower Protection makes certain that in any disciplinary action recommended by the Office of Accountability and Whistleblower Protection, all relevant evidence is provided to the VA Secretary (or the disciplinary officials designated to act on the Secretary's behalf).		
FY 2019 Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2019 | Report Number 19-07247-251*	OM	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut *Issued 11/20/2019 | Report Number 18-04675-23*	VHA	—
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.		
Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut *Issued 11/20/2019 | Report Number 19-00075-14*	VHA	—
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 Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 11/21/2019 | Report Number 19-00013-15*	VHA	—
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.		
Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire *Issued 11/25/2019 | Report Number 19-00040-10*	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
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.		
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.		
Recommendation 11: The chief of staff ensures providers document indication for use for newly prescribed medications in patients' electronic health records and monitors providers' compliance.		
Recommendation 12: The chief of staff ensures that clinicians provide and document patient/caregiver education and understanding of education provided about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.		
Recommendation 13: The chief of staff ensures providers reconcile medication information and resolve discrepancies and monitors the providers' compliance.		
Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland *Issued 11/26/2019 | Report Number 19-05916-24*	VHA	—
Recommendation 2: The VA Maryland Health Care System Director establishes a process to monitor the identification, documentation, and communication of patients' Do Not Attempt Resuscitation status.		
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.		
Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California *Issued 12/2/2019 | Report Number 18-04671-25*	VHA	—
Recommendation 15: The facility director confirms that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.		
Recommendation 17: The chief of staff ensures providers document indication for use for newly prescribed medications in patients' electronic health records and monitors providers' compliance.		
Recommendation 18: The chief of staff ensures that clinicians provide and document patient/caregiver education and understanding of education provided about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 23: The chief of staff certifies that clinicians provide and document patient and/or caregiver education about newly prescribed medications and monitors clinicians' compliance.		
Recommendation 24: The chief of staff makes certain clinicians review and reconcile medications and monitors clinicians' compliance.		
Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System, South Dakota *Issued 12/03/2019 | Report Number 19-00019-26*	VHA	—
Recommendation 6: The chief of staff makes certain that clinicians provide and document patient and/or caregivers education about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.		
Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, Arizona *Issued 12/5/2019 | Report Number 19-00014-33*	VHA	—
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.		
Recommendation 15: The chief of staff ensures clinicians reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health records and monitors clinicians' compliance.		
Insufficient Oversight of VA's Undelivered Orders *Issued 12/16/2019 | Report Number 17-04859-196*	VHA	$132,600,000
Recommendation 5: The Veterans Health Administration chief financial officer and the Veterans Health Administration executive director for procurement should ensure compliance with policy, which requires that obligations be supported by sufficient documentary evidence that substantiates the validity and proper authorization of obligations and that the evidence be retained and readily available upon request.		
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers *Issued 12/17/2019 | Report Number 17-03718-240*	VHA	$84,000,000
Recommendation 1: The executive in charge, office of under secretary for health, and the principal executive director, office of acquisition, logistics, and construction, require the Healthcare Commodities Program Office and Strategic Acquisition Center to develop a formal process to validate correct order fulfillment reporting by the prime vendors, ensure the correct algorithms are used, and help prevent missed opportunities to identify and mitigate issues.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: 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 contracting officer's representatives to ensure performance metric reporting is reviewed for accuracy. The chief of staff ensures clinicians reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health records and monitors clinicians' compliance.		
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 Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio *Issued 12/18/2019 | Report Number 19-00051-40*	VHA	—
Recommendation 9: 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.		
Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 1/8/2020 | Report Number 19-00053-57*	VHA	—
Recommendation 1: The chief of staff ensures that service chiefs initiate and complete focused professional practice evaluations and monitors service chiefs' compliance.		
Recommendation 15: The chief of staff ensures that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland *Issued 1/9/2020 | Report Number 19-00016-61*	VHA	—
Recommendation 1: The facility director ensures that peer reviews are completed within 120 calendar days or that a written extension is requested and approved by the facility director and monitors peer review coordinator's compliance.		
Recommendation 9: The chief of staff ensures the service chiefs document the focused professional practice evaluation results in the provider's profile and monitors compliance.		
Recommendation 11: The chief of staff ensures that service chiefs include reviews of relevant data in professional practice evaluations when determining continuation of provider's privileges and monitors service chiefs' compliance.		
Recommendation 12: The chief of staff ensures the service chiefs include service-specific criteria in professional practice evaluations and monitors compliance.		
Recommendation 13: The associate director ensures that areas used by patients are clean and safe and monitors compliance.		
Recommendation 14: The associate director confirms that damaged furniture and wheelchairs are repaired or removed from service and monitors compliance.		
Recommendation 15: The facility director makes certain that the basement tunnel at Perry Point VA is free from water hazards and monitors compliance.		
Recommendation 16: The associate director certifies that panic alarms are installed and tested as required and monitors compliance.		
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts *Issued 1/13/2020 | Report Number 19-00038-63*	VHA	—
Recommendation 17: The chief of staff certifies that clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and evaluate understanding when education is provided, and monitors clinicians' compliance.		
Recommendation 19: The facility director confirms that the Women Veterans Health Committee meets at least quarterly, includes required core members, and reports to the appropriate executive committee and monitors the committee's compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts *Issued 1/13/2020 | Report Number 19-00043-66*	VHA	—
Recommendation 1: The facility director makes certain that required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.		
Recommendation 3: The facility director ensures that the patient safety manager submits each root cause analysis to the National Center for Patient Safety within the required time frame and monitors compliance.		
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 8: The associate director ensures that floors and ceilings tiles are repaired, cleaned, and maintained and window screens are replaced and monitors compliance.		
Recommendation 12: The facility director ensures an emergency operations plan is developed and reviewed annually.		
Recommendation 14: The chief of staff makes certain that clinicians justify and document the reason for initiating the medication and monitors clinicians' compliance.		
Recommendation 15: The chief of staff ensures that clinicians provide and document patient and/or caregiver education and evaluate understanding of education provided about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.		
Recommendation 16: The chief of staff ensures clinicians review and reconcile medication information and maintain and communicate accurate patient medication information in patients' electronic health record and monitors clinicians' 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.		
Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes *Issued 1/14/2020 | Report Number 19-00021-41*	VHA	$261,300,000
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.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 3: Coordinate with the appropriate offices and services, including the Office of Procurement, Acquisitions, and Logistics, Prosthetic and Sensory Aids Service, sleep medicine, and the Veterans Health Administration National Infectious Diseases Service, to (a) assess the viability, potential patient care, and financial impact of an alternative to purchasing sleep apnea devices; (b) make and provide clear guidance on any changes to current Veterans Health Administration processes, including device returns, cleaning, and reissuance; and (c) designate an office with authority to ensure medical facilities implement any processes and recommendations from the assessment.		
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas *Issued 1/15/2020 | Report Number 19-06863-69*	VHA	—
Recommendation 4: The chief medical officer confirms that facility service chiefs clearly define focused professional practice evaluation criteria in advance with licensed independent practitioners and monitors facility service chiefs' compliance.		
Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities *Issued 1/16/2021 | Report Number 18-05121-36*	VHA	—
Recommendation 5: Develop and implement specific facility plans to address the backlog of open consults and the growing number of new consults.		
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System *Issued 1/23/2020 | Report Number 19-06378-73*	VHA	—
Recommendation 8: The VA North Texas Health Care System Director ensures implementation of an effective tracking mechanism to ensure VA providers receive results for women veterans referred to care in the community and monitors for compliance with Veterans Health Administration policy.		
Recommendation 9: The VA North Texas Health Care System Director verifies review of the electronic health records of women veterans referred to Care in the Community whose medical records have not been obtained and takes action if indicated.		
Recommendation 15: The VA North Texas Health Care System Director ensures staff conduct high-risk patient goals of care conversations for life-sustaining treatment plans as required and monitors for compliance with Veterans Health Administration policy.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 16: The VA North Texas Health Care System Director takes steps to ensure provider documentation of high-risk patient goals of care and life-sustaining treatment plan in the required electronic health record template and monitors for compliance with Veterans Health Administration policy.		
Recommendation 17: The VA North Texas Health Care System Director verifies capture and reporting of all codes to the resuscitation subcommittee and monitors for compliance with Veterans Health Administration policy.		
Recommendation 18: The VA North Texas Health Care System Director ensures that the Critical Care Committee minutes reflect corrective action plans and follow-through to remediate concerns identified by the resuscitation subcommittee and monitors for compliance.		
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts *Issued 1/29/2020 | Report Number 19-06866-68*	VHA	—
Recommendation 4: The chief medical officer ensures that facility clinical managers define criteria in advance for licensed independent practitioners' focused professional practice evaluations and monitors clinical managers' compliance.		
Little Rock VARO Employee Inaccurately Established and Decided Claims *Issued 1/30/2020 | Report Number 19-06757-70*	VBA	$311,000
Recommendation 1: Review rating decisions made by the rating veterans service representative since being released on single-signature status, and correct any decisions found to be made in error.		
Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments *Issued 2/11/2020 | Report Number 18-05738-56*	VBA	$56,800,000
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.		
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.		
Review of Veterans Health Administration Community Living Centers and Corresponding Star Ratings *Issued 2/12/2020 | Report Number 18-05113-81*	VHA	—

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 1: The Under Secretary for Health supplements the use of Community Living Center Compare with adjustment measures to better address the Community Living Center to Centers for Medicare and Medicaid Services comparison challenges for veterans, their families, and the public.		
Recommendation 2: The Under Secretary for Health continues to develop specific measures that employ a more rigorous risk adjustment to better measure staffing and quality performance with respect to the Community Living Center population.		
Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio *Issued 2/20/2020 | Report Number 18-01275-89*	VHA	—
Recommendation 7: The Dayton VA Medical Center Director verifies policies and procedures are in place for monitoring of critically ill patients to track deterioration and need for intervention in the Emergency Department and during transport, and monitor compliance.		
Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri *Issued 3/24/2020 | Report Number 19-07682-103*	VHA	—
Recommendation 5: The VA St. Louis Health Care System Director ensures alignment of content for the regadenoson stress test protocols and education provided to staff and healthcare trainees.		
Federal Information Security Modernization Act Audit for Fiscal Year 2019 *Issued 3/31/2020 | Report Number 19-06935-96*	OIT	—
Recommendation 1: We recommended the Assistant Secretary for Information and Technology consistently implement an improved continuous monitoring program in accordance with the NIST Risk Management Framework. Specifically, implement an independent security control assessment process to evaluate the effectiveness of security controls prior to granting authorization decisions. (This is a modified repeat recommendation from prior years.)		
Recommendation 2: We recommended the Assistant Secretary for Information and Technology implement improved mechanisms to ensure system stewards and information system security officers follow procedures for establishing, tracking, and updating Plans of Action and Milestones for all known risks and weaknesses including those identified during security control assessments. (This is a modified repeat recommendation from prior years.)		
Recommendation 3: We recommended the Assistant Secretary for Information and Technology implement controls to ensure that system stewards and responsible officials obtain appropriate documentation prior to closing Plans of Action and Milestones. (This is a modified repeat recommendation from prior years.)		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: We recommended the Assistant Secretary for Information and Technology develop mechanisms to ensure system security plans reflect current operational environments, include an accurate status of the implementation of system security controls, and all applicable security controls are properly evaluated. (This is a repeat recommendation from prior years.)		
Recommendation 5: We recommended the Assistant Secretary for Information and Technology implement improved processes for reviewing and updating key security documents such as security plans and interconnection agreements on an annual basis and ensure the information accurately reflects the current environment. (This is a modified repeat recommendation from prior years.)		
Recommendation 6: We recommended the Assistant Secretary for Information and Technology implement improved processes to ensure compliance with VA password policy and security standards on domain controls, operating systems, databases, applications, and network devices. (This is a repeat recommendation from prior years.)		
Recommendation 7: We recommended the Assistant Secretary for Information and Technology implement periodic reviews to minimize access by system users with incompatible roles, permissions in excess of required functional responsibilities, and unauthorized accounts. (This is a repeat recommendation from prior years.)		
Recommendation 8: We recommended the Assistant Secretary for Information and Technology enable system audit logs on all critical systems and platforms and conduct centralized reviews of security violations across the enterprise. (This is a repeat recommendation from prior years)		
Recommendation 9: We recommended the Assistant Secretary for Information and Technology fully implement two-factor authentication to the extent feasible for all user accounts throughout the agency. (This is a repeat recommendation from prior years.)		
Recommendation 10: We recommended the Assistant Secretary for Information and Technology implement more effective automated mechanisms to continuously identify and remediate security deficiencies on VA's network infrastructure, database platforms, and web application servers. (This is a repeat recommendation from prior years.)		
Recommendation 11: We recommended the Assistant Secretary for Information and Technology implement a more effective patch and vulnerability management program to address security deficiencies identified during our assessments of VA's web applications, database platforms, network infrastructure, and workstations. (This is a repeat recommendation from prior years.)		
Recommendation 12: We recommended the Assistant Secretary for Information and Technology maintain a complete and accurate security baseline configuration for all platforms and ensure all baselines are appropriately implemented for compliance with established VA security standards. (This is a repeat recommendation from prior years.)		
Recommendation 13: We recommended the Assistant Secretary for Information and Technology implement improved network access controls that restrict medical devices from systems hosted on the general network. (This is a modified repeat recommendation from prior years.)		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 14: We recommended the Assistant Secretary for Information and Technology consolidate the security responsibilities for networks not managed by the Office of Information and Technology, under a common control for each site and ensure vulnerabilities are remediated in a timely manner. (This is a repeat recommendation from prior years.)		
Recommendation 15: We recommended the Assistant Secretary for Information and Technology implement improved processes to ensure that all devices and platforms are evaluated using credentialed vulnerability assessments. (This is a repeat recommendation from prior years.)		
Recommendation 16: We recommended the Assistant Secretary for Information and Technology implement improved procedures to enforce standardized system development and change control processes that integrates information security throughout the life cycle of each system. (This is a repeat recommendation from prior years.)		
Recommendation 17: We recommended the Assistant Secretary for Information and Technology review system boundaries, recovery priorities, system components, and system interdependencies and implement appropriate mechanisms to ensure that established system recovery objectives are met. (This is a modified repeat recommendation from prior years.)		
Recommendation 18: We recommended the Assistant Secretary for Information and Technology implement more effective agency-wide incident response procedures to ensure timely notification, reporting, updating, and resolution of computer security incidents in accordance with VA standards. (This is a repeat recommendation from prior years.)		
Recommendation 19: We recommended the Assistant Secretary for Information and Technology ensure that VA's Cybersecurity Operations Center has full access to all security incident data to facilitate an agency-wide awareness of information security events. (This is a repeat recommendation from prior years.)		
Recommendation 20: We recommended the Assistant Secretary for Information and Technology implement improved safeguards to identify and prevent unauthorized vulnerability scans on VA networks. (This is a repeat recommendation from prior years.)		
Recommendation 21: We recommended the Assistant Secretary for Information and Technology implement improved measures to ensure that security control deficiencies are tracked individually instead of consolidating security deficiencies under one control. (This is a modified repeat recommendation from prior years.)		
Recommendation 22: We recommended the Assistant Secretary for Information and Technology fully develop a comprehensive list of approved and unapproved software and implement continuous monitoring processes to prevent the use of prohibited software on agency devices. (This is a repeat recommendation from prior years.)		
Recommendation 23: We recommended the Assistant Secretary for Information and Technology develop a comprehensive inventory process to identify connected hardware, software, and firmware used to support VA programs and operations. (This is a repeat recommendation from prior years.)		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 24: We recommended the Assistant Secretary for Information and Technology implement improved procedures for monitoring contractor-managed systems and services and ensure information security controls adequately protect VA sensitive systems and data. (This is a modified repeat recommendation from prior years.)		
Recommendation 25: We recommended the Executive in Charge for Information and Technology ensure appropriate levels of background investigations be completed for all personnel in a timely manner, implement processes to monitor and ensure timely reinvestigations on all applicable employees and contractors, and monitor the status of the requested investigations.		
Total		**$1,662,711,000**

APPENDIX C: REPORTING REQUIREMENTS

TABLE C.1. REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

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

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

APPENDIX C: REPORTING REQUIREMENTS

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

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

APPENDIX C: REPORTING REQUIREMENTS

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

APPENDIX C: REPORTING REQUIREMENTS

DEFINITIONS

As defined in the IG Act:

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

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

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

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

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

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

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

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

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

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

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

(F) any other savings which are specifically identified;

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

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

Final action means—

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

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

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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