Department of Veterans Affairs

Office of Inspector General

Semiannual Report to Congress

Issue 74 | April 1–September 30, 2015

Message from the Deputy Inspector General

I am pleased to submit this issue of the Semiannual Report to Congress. Pursuant to the Inspector General Act of 1978, as amended, this report presents the results of our accomplishments during the reporting period April 1, 2015–September 30, 2015. Highlighted below are some of the key findings and conclusions that were the result of our work during this reporting period.

The Office of Inspector General (OIG) issued 216 reports and 11 memoranda on VA programs and operations. OIG investigations, inspections, audits, evaluations, and other reviews identified over $1 billion in monetary benefits, for a return on investment of $18 for every dollar expended on OIG oversight. OIG investigators closed 523 investigations and made 209 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work and Hotline activity oversight also resulted in 660 administrative sanctions and corrective actions.

The Office of Investigations has remained vigilant at deterring fraud and bribery among corrupt VA employees. Three individuals including a VA supervisor and two contractors were sentenced to imprisonment for fraud and bribery. A former, East Orange, NJ, VA Medical Center (VAMC) supervisor was sentenced to 46 months' incarceration and 1-year probation for wire fraud and engaging in a monetary transaction in criminally derived property, accepting over $1.2 million in kickback payments. In addition, a VA construction contractor at the same VAMC was sentenced to 37 months' incarceration and 12 months' probation for bribery and conspiracy to defraud the United States, paying approximately $671,000 in bribes to the VA supervisor in order to fraudulently obtain $6 million in VA construction contracts. The contractor and the VA supervisor conspired to set up three companies that were used to obtain VA contracts including a fraudulently claimed Service-Disabled Veteran-Owned Small Business (SDVOSB) company. As part of the same investigation, another contractor was sentenced to 2 years' probation, 6 months' home confinement, and ordered to pay a $2,000 fine for bribing the same VA supervisor to secure favorable treatment on VA contracts. A debarment decision now prevents the contractor from doing business with the Government.

At the request of Congress in the Joint Explanatory Statement to accompany the fiscal year (FY) 2015 omnibus appropriations bill, the Office of Healthcare Inspections (OHI) reviewed the operations and effectiveness of VA substance abuse inpatient rehabilitation programs. The following areas were assessed: (1) the current number of inpatient rehabilitation programs, (2) the annual number of veterans who participate and their average length of treatment, (3) the average length of time for VA treatment compared to non-VA residential treatment, (4) the rate of recidivism for both types of programs, (5) the process used to refer patients to VA treatment, (6) the degree of supervision of patients in VA programs and how often drug tests are performed, and (7) how well mental health and substance abuse treatment are integrated for veterans with comorbidities. As a result of the review, OHI issued 10 recommendations to improve operations in Mental Health Services.

The Office of Audits and Evaluations (OAE) continued to review veteran access to care issues following OIG's August 2014 report that identified serious access problems at the Phoenix VA Health Care System and nationally. OAE evaluated how effectively VA processes veterans' applications for health care and then, once enrolled, whether VA's Patient-Centered Community Care (PC3) initiative enhanced VA's access to medical care.

OAE found Veterans Health Administration's (VHA) Chief Business Office has not effectively managed its business processes to ensure the consistent creation and maintenance of essential data to effectively manage a backlog of pending health care applications. We reported serious enrollment data limitations at VHA's Health Eligibility Center (HEC), including an estimated 477,000 pending records that did not have application dates. Without improvement in its data reliability, VA cannot reliably determine how many records are associated with actual applications for enrollment. OAE also identified pending records of over 307,000 individuals reported as deceased by the Social Security Administration, information security deficiencies, and a lack of controls to ensure proper entry of the HEC's workload into the enrollment system. As a result of this review, OAE issued 13 recommendations to improve the processing of veterans' applications for health care.

OAE reviewed various aspects of the VA's PC3 initiative, where two major contracts were valued at almost $9.5 billion. VA's estimated cost savings, alleged delays and inappropriate referrals, provider network adequacy, clinical accreditation standards, and health record coordination were assessed. OAE first reported they could not attest to the reliability and accuracy of VA information regarding the methodology and calculation of the PC3 cost savings estimate presented in VA's FY 2014 budget submission. The analysis of available PC3 data determined that inadequate price analysis, high-up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate. OAE reported in their second review that VHA's use of PC3 contracted care caused patient care delays. OAE projected that PC3 contractors returned almost 43,500 of 106,000 authorizations (41 percent) due to limited network providers and blind scheduling of patients' appointments.

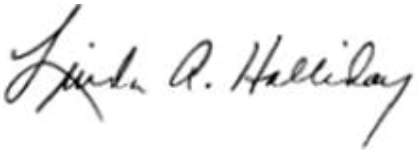
In their subsequent report, OAE determined the PC3 provider networks was insufficient and contributed to limited use among the VAMCs. This report was followed with OAE reporting that a PC3 contractor referred 15 of 58 oncology patients to network practices that did not meet clinical accreditation standards established by the PC3 contract. OAE's fifth PC3 review found that PC3 contractors did not meet the clinical documentation requirements for an estimated 68 percent of episodes of care from January 1, 2014, through September 30, 2014. This caused VHA to make approximately $870,400 in improper payments since payments should not have been made prior to receiving complete clinical documentation. The PC3 initiative, in concept a viable solution to increase access and curb VA's health care costs, was not given the level of scrutiny by VA senior management to ensure contractor performance rose to the expectations of VA or met the needs of veterans.

The accomplishments discussed throughout this report would not have been possible without the unwavering dedication and sustained commitment of our employees to identify opportunities for improvement within VA and accomplish OIG's mission of ensuring our Nation's veterans and their families receive the best care, benefits, and services possible from VA. As a testament to the outstanding results accomplished daily by our employees, OIG work products led to 17 Congressional Hearings during the fiscal year, we were recently honored with 3 awards for project excellence by our peers in the OIG community, and we were recently named by the Brookings Center for Effective Management as the second most productive of OIG organizations in the Federal government based on the last 5 years' return on investment.

The past 18 months have been an unprecedented time within VA and OIG. The VA continues to experience considerable challenges in providing timely care and services to veterans, and OIG reports and work products have identified significant opportunities for improvement. The scope of our responsibility within VA is vast,

and our work requires a commitment to seek out accurate and verifiable information. We need to ask the hard questions, receive criticism professionally, adopt best practices, and often take unpopular stances. Our work consistently protects some of our most vunerable veterans and their families and these efforts consistently improve the effectiveness of the Department's programs and operations. Regardless of the challenges we face, we must always act with integrity and responsibility. Given the increase in interest and requests for OIG reviews and reports by media outlets, Congressional members, and oversight committees, I would like to take this opportunity to publicly acknowledge our OIG staff. Their Herculean efforts during the year have been nothing short of astounding and I am thankful for their unwavering dedication to OIG, veterans, and their families.

In closing, I am appreciative of the continued strong support of our mission demonstrated by the House and Senate Veterans' Affairs Committees and Appropriations Committees, the VA Secretary and Deputy Secretary, and individual Members of Congress who have shown long-standing dedication to improving the lives of all American veterans. Further, I am thankful to our staff for their unwavering dedication to reaffirm our commitments to helping VA be more efficient and effective.



LINDA A. HALLIDAY
Deputy Inspector General

Statistical Highlights

Monetary Impact (in Millions)	6-Month	FY
Better Use of Funds	$635.5	$1,456.2
Fines, Penalties, Restitutions, and Civil Judgments	$16.1	$33.0
Fugitive Felon Program	$106.6	$203.8
Savings and Cost Avoidance	$206.6	$295.9
Questioned Costs	$18.8	$154.1
Dollar Recoveries	$16.4	$24.2
Total Dollar Impact	$1,000.1	$2,167.2
Cost of OIG Operations[1]	$55.1	$109.9
Return on Investment[2]	**18:1**	**20:1**

Investigative Activities	6-Month	FY
Arrests[3]	209	397
Fugitive Felon Arrests	25	47
Fugitive Felon Arrests made by Other Agencies with OIG Assistance	10	17
Indictments	161	324
Criminal Complaints	62	109
Convictions	152	320
Pretrial Diversions and Deferred Prosecutions	31	74
Administrative Investigations Opened	9	23
Administrative Investigations Closed	4	9
Administrative Sanctions and Corrective Actions	361	643
Cases Opened[4]	439	1,001
Cases Closed[5]	523	1,034

Hotline Activities	6-Month	FY
Contacts[6]	19,903	38,098
Cases Opened	670	1,764
Cases Closed[7]	536	1,080
Administrative Sanctions and Corrective Actions[8]	299	622
Substantiation Percentage Rate[9]	37.5	39

Reports and Memoranda	6-Month	FY
Reports Issued		
Audits and Evaluations	27	42
Benefits Inspections	14	22
Joint Reviews	2	3
National Healthcare Reviews	7	11
Hotline Healthcare Inspections	38	62
Combined Assessment Program Reviews	29	60
Community Based Outpatient Clinic Reviews[10]	31	51
Administrative Investigations	3	5
Preaward Contract Reviews	44	91
Postaward Contract Reviews	17	37
Claim Reviews	1	3
Contract Review Special Reports	3	3
Subtotal	**216**	**390**
Memoranda		
Administrative Investigation Advisories	0	0
Administrative Investigation Closures	1	4
Audit Closures	10	14
Healthcare Closures[11]	0	2
Subtotal		
Total Reports and Memoranda	**11**	**20**

Healthcare Inspections Activities	6-Month	FY
Clinical Consultations	**7**	**15**

1. The 6-month operating cost for the Office of Healthcare Inspections ($10.5 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.
2. This figure is calculated by dividing Total Dollar Impact by Cost of OIG Operations.
3. Does not include Fugitive Felon arrests by OIG or other agencies.
4 & 5. Includes administrative investigations opened/closed.
6. FY total reflects an update to the number of contacts reported in the previous Semiannual Report. This update stems from OIG standardizing the definition of a contact.
7, 8, & 9. Includes cases which opened in previous fiscal years.
10. Encompassing 167 facilities for the 6-month period.
11. During this reporting period, OIG published 115 Healthcare administrative closure memorandums that had been issued prior to FY 2015. These are listed in Appendix A. For FY 2015, a total of 138 previously issued Healthcare administrative closure memorandums were published, along with 2 newly issued Healthcare administrative closure memorandums.

Glossary

AIG	Assistant Inspector General
AITC	Austin Information Technology Center
ARRA	American Recovery and Reinvestment Act
CAP	Combined Assessment Program
CAVHCS	Central Alabama VA Health Care System
CAVHS	Central Arkansas Veterans Health Care System
CBO	Chief Business Office
CBOC	Community Based Outpatient Clinic
CID	Criminal Investigation Division
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CIO	Chief Information Officer
CLC	community living center
CPR	cardiopulmonary resuscitation
CSP	compounded sterile product
CT	cardiothoracic
CY	calendar year
DCHV	Domiciliary Care for Homeless Veterans
DCIS	Defense Criminal Investigative Service
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DIG	Deputy Inspector General
DME	durable medical equipment
DOE	Department of Energy
DOL	Department of Labor
DRE	digital rectal examination
EHR	electronic health record
ED	emergency department
EOC	environment of care
ES	enrollment system
FAR	Federal Acquisition Regulation
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFMIA	*Federal Financial Management Improvement Act of 1996*
FISMA	*Federal Information Security Management Act of 2002*
FIT	fecal immunochemical test
FSS	Federal Supply Schedule
FTE	full-time equivalents
FWS	Federal Wage Service
FY	fiscal year
GPD	Grant and Per Diem
GPO	U.S. Government Printing Office
GSA	General Services Administration
HCS	Health Care System
HEC	Health Eligibility Center
HIV	Human Immunodeficiency Virus
HVHCS	Hudson Valley Health Care System
IA	interim agreement
ICU	intensive care unit
IG	Inspector General
IPC	intake processing center
IPERA	*Improper Payments Elimination and Recovery Act of 2010*
IR	interventional radiology
IRS	Internal Revenue Service
ISO	Information Security Officer
IT	Information Technology
IU	individual unemployability
IV	intravenous
MH	mental health
MRI	magnetic resonance imaging
MS&C	medical support and compliance
MSDS	Medical Supply Distribution Section
NAC	National Acquisition Center
NCA	National Cemetery Administration
NVC	Non-VA care
NVCC	Non-VA Care Coordination
OAE	Office of Audits and Evaluations
OALC	Office of Acquisition, Logistics, and Construction
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OHR	Office of Human Resources
OIG	Office of Inspector General
OIT	Office of Information and Technology
OMB	Office of Management and Budget
OP JV	Operation Jersey Vice
OP RWB	Operation Red, White, and Blue

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OPC	outpatient clinic
P.L.	Public Law
PAHCS	Palo Alto Health Care System
PAR	Performance and Accountability Report
PC	primary care
PC3	Patient-Centered Community Care
PCP	primary care provider
PCS	Permanent Change of Station
PHI	protected health information
PII	personally identifiable information
PMAS	Project Management Accountability System
PMC	Pension Management Center
PMG	private medical group
POE	personally-owned equipment
PSA	prostate-specific antigen
PTSD	post-traumatic stress disorder
QAR	Qualitative Assessment Review
QM	quality management
RMO	Records Management Officer
RVU	relative value unit
SBA	Small Business Administration
SCI/D	Spinal Cord Injury and Disorders
SDVOSB	Service-Disabled Veteran-Owned Small Business
SES	Senior Executive Service
SMC	special monthly compensation
SOARD	Service-Oriented Architecture Research and Development
SOM	School of Medicine
SSA	Social Security Administration
SUD	substance use disorders
TBI	Traumatic Brain Injury
TRC	teleradiology reading center
TriWest	TriWest Healthcare Alliance Corporation
UCC	Urgent Care Clinic
UCLA	University of California, Los Angeles
UPP	University of Pittsburgh Physicians, Inc.
UPS	United Parcel Service
USB	Under Secretary for Benefits
USH	Under Secretary for Health
USPS	United States Postal Service
UTSW	University of Texas—Southwestern Medical Center
VACIHCS	VA Central Iowa Health Care System
VAMC	VA Medical Center
VANTHCS	VA North Texas Health Care System
VAPHS	VA Pittsburgh Health Care System
VARO	VA Regional Office
VASNHS	VA Southern Nevada Health Care System
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSC	Veterans Service Center
VSO	Veteran Services Officer
WRAP	Workload Reporting and Productivity

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Reporting Requirements

The table below identifies the sections of this report that address each of the reporting requirements prescribed by the *Inspector General Act of 1978*, as amended.

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

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Reporting Requirements	Section(s)
§ 5 (a) (10) a summary of each audit report issued before the commencement of the reporting period for which no management decision has been made by the end of the reporting period	Appendix A
§ 5 (a) (11) a description and explanation of the reasons for any significant revised management decision made during the reporting period	Appendix A
§ 5 (a) (12) information concerning any significant management decision with which the Inspector General is in disagreement	Appendix A
§ 5 (a) (13) the information described under section 05(b) of the *Federal Financial Management Improvement Act of 1996*	Office of Audits and Evaluations
§ 5 (a) (14) an appendix containing the results of any peer review conducted by another OIG during the reporting period or a statement identifying the date of the last peer review conducted by another OIG	Other Significant OIG Activities
§ 5 (a) (15) a list of any outstanding recommendations from any peer review conducted by another OIG that have not been fully implemented	Other Significant OIG Activities
§ 5 (a) (16) a list of any peer reviews conducted by the VA OIG of another OIG during the reporting period and a list of any recommendations made from any previous peer review that remain outstanding or have not been fully implemented	Other Significant OIG Activities

VA and OIG Mission, Organization, and Resources

Department of Veterans Affairs

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2015, VA is operating under a $163.5 billion budget, with over 354,000 employees serving an estimated 22 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

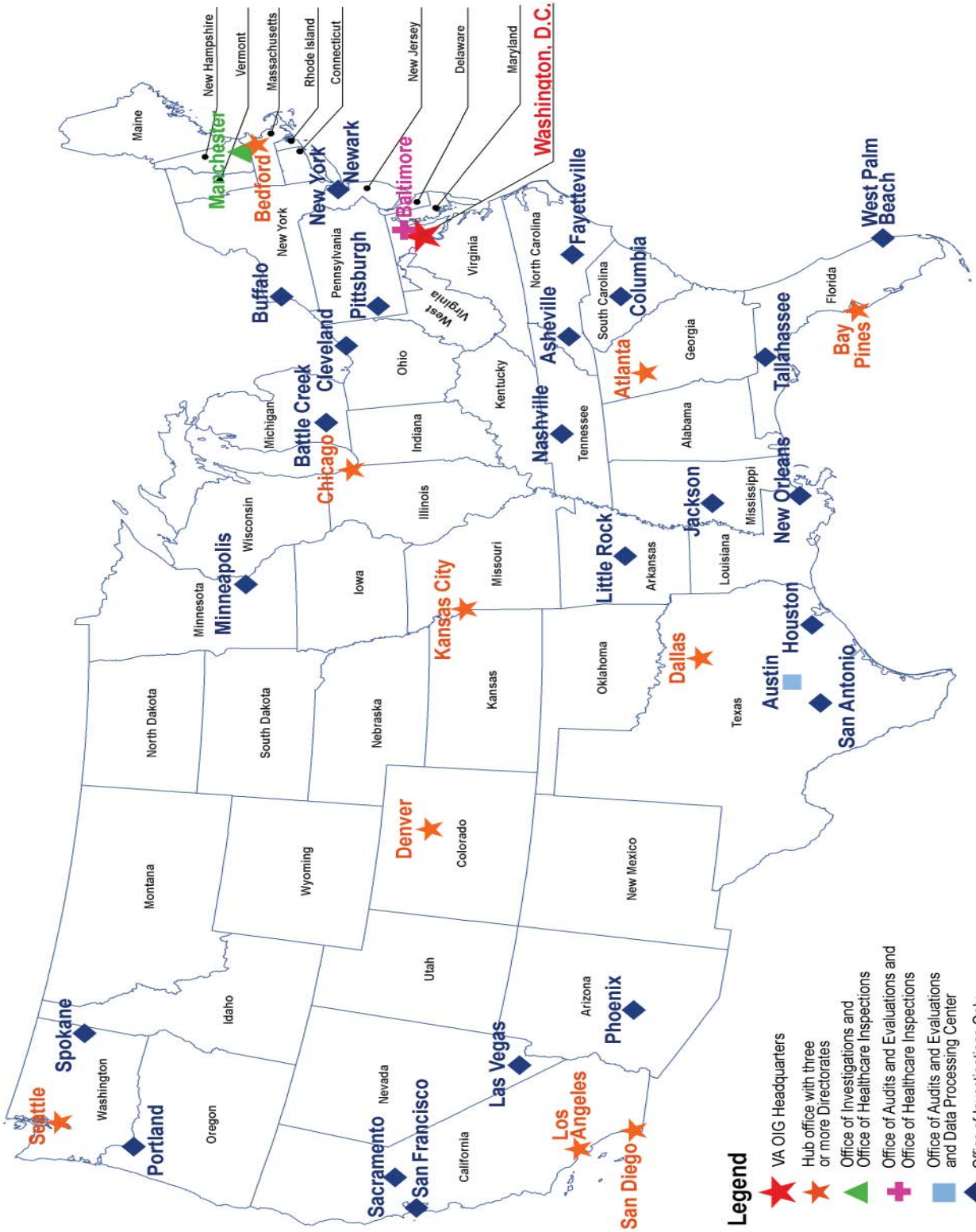
VA has three administrations that serve veterans: the Veterans Health Administration (VHA) provides health care, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration (NCA) provides interment and memorial benefits. For more information,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

VA Office of Inspector General

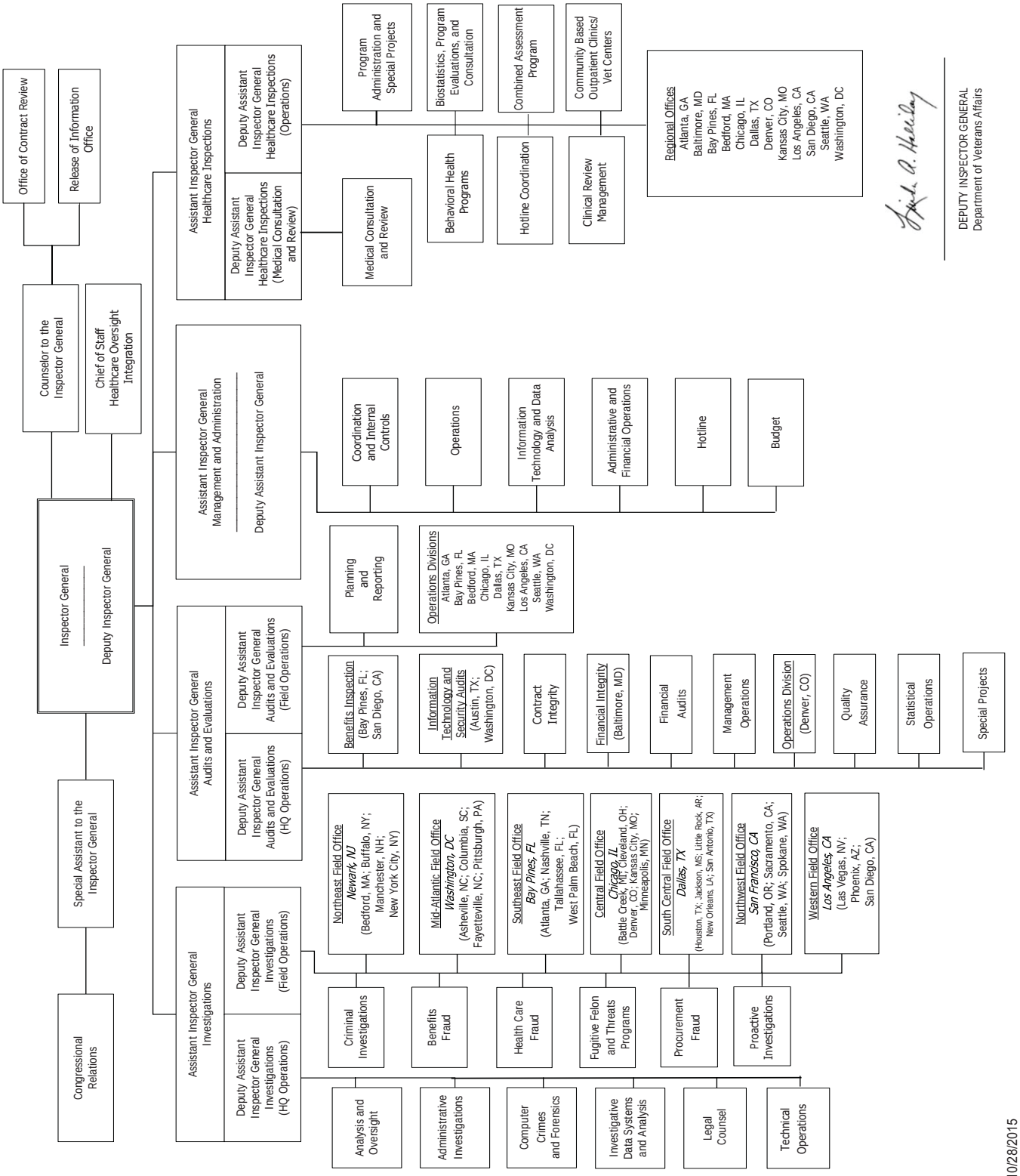
The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General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

OIG, with 662 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2015 funding for OIG operations provides $126.7 million from ongoing appropriations. The Office of Contract Review, with 31 employees, received $4.1 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule (FSS), construction, and health care provider contracts. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country. OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG internet home page at www.va.gov/oig.

OIG Field Offices Map



OIG Organizational Chart



Office of Healthcare Inspections

For many years, VHA has been a national leader in the quality of care provided to patients when compared with the major U.S. health care providers. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety and safeguards against the occurrence of adverse events. The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses medical outcomes. During this reporting period, OIG published 7 national healthcare reviews; 38 Hotline healthcare inspections; 29 Combined Assessment Program (CAP) reviews; and 31 Community Based Outpatient Clinic (CBOC) reviews, covering 167 facilities, to evaluate the quality of veteran care. All reports issued this reporting period are listed in Appendix A.

Combined Assessment Program Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to veterans. CAP reviews provide cyclical oversight of VHA health care facilities. Their purpose is to review selected clinical and administrative operations and to conduct crime awareness briefings. OIG also administers an employee survey prior to each CAP visit, which provides employees the opportunity to confidentially share safety and quality concerns. During this reporting period, OIG issued 29 CAP reports. Topics reviewed in a facility CAP may vary based on the facility's mission and generally run for 12 months. The topics covered this reporting period include: Quality Management (QM), Environment of Care (EOC), Medication Management, Coordination of Care, Magnetic Resonance Imaging (MRI) Safety, Acute Ischemic Stroke Care, Surgical Complexity, and Emergency Airway Management. When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use. During this reporting period, OIG issued three CAP summary reports, which are highlighted in the National Healthcare Reviews section.

Community Based Outpatient Clinic Reviews

The purpose of these cyclical reviews is to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The CBOC inspection process consists of three primary activities: CBOC information gathering and review, medical record reviews for determining compliance with VHA requirements, and onsite inspections. During this reporting period, OIG performed reviews covering 167 CBOCs reporting to 31 parent facilities and 16 Veterans Integrated Service Networks (VISNs). Site visits were made and physical inspections were performed at 31 of these CBOCs. These reviews are captured in 31 reports. The topics covered this reporting period include: EOC, Alcohol Use Disorder, Human Immunodeficiency Virus (HIV) screening, Outpatient Documentation, and Outpatient Lab Results Management. During this reporting period, OIG issued one CBOC summary report, which is highlighted in the National Healthcare Reviews section.

National Healthcare Reviews

OIG Makes Ten Recommendations To Increase Effectiveness of VA Substance Abuse Inpatient Rehabilitation Programs

In the Joint Explanatory Statement to accompany the FY 2015 omnibus appropriations bill, Congress requested OIG review the operations and effectiveness of VA substance abuse inpatient rehabilitation programs and report:

(1) The current number of inpatient rehabilitation programs.
(2) The annual number of veterans who participate and their average length of treatment.
(3) The average length of time for VA treatment compared to non-VA residential treatment.
(4) The rate of recidivism for both types of programs.
(5) The process used to refer patients to VA treatment.
(6) The degree of supervision of patients in VA programs and how often drug tests are performed.
(7) How well mental health (MH) and substance abuse treatment are integrated for veterans with comorbidities.

The review resulted in 10 recommendations to standardize data collection for use in program oversight and benchmarking, strengthen procedures to reduce the risk for contraband and ensure patient safety, consider expanded treatment options, and strengthen post-discharge follow-up.

CAP Summary Report on Evaluation of QM in VHA Facilities FY 2014

OIG completed an evaluation of VHA medical facilities' QM programs. OIG conducted this review at 57 VHA medical facilities during CAP reviews performed across the country from October 1, 2013, through September 30, 2014. Facility senior managers reported that they supported their QM programs and actively participated through being involved in committees, mentoring teams, and reviewing meeting minutes and reports. OIG identified opportunities for improvement in the areas of peer review, teledermatology, utilization management, review of resuscitation events, blood usage review, and surgical oversight and made seven recommendations.

Medical Officer, Nurse, Psychologist, Physician Assistant, and Physical Therapist Are VHA's Top Five Critical Need Occupations

OIG conducted its second of several determinations of VHA occupations with the largest staffing shortages, as required by Section 301 of the *Veterans Access, Choice, and Accountability Act of 2014*. OIG interpreted "largest staffing shortage" to encompass broader deliberation than simply the number needed to replace or backfill vacant positions for an occupation and refer to occupations that met broader criteria as critical need occupations. OIG performed a rule-based analysis of VHA data to identify critical need occupations, analyzed data on gains and losses for these occupations, and assessed VHA's progress with implementing staffing models. OIG determined that the top five critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, and Physical Therapist. The identification of these occupations remains unchanged from OIG's initial determination reported in January 2015. OIG's analysis of staffing gains and losses shows that for these critical need occupations, a significant percentage of total gains was offset by losses. OIG determined that the number of regrettable losses (that is, resignations and transfers to other government agencies) for many critical need occupations was high. This analysis likely does not capture the effect of the 2014 *Veterans Access, Choice, and Accountability Act*, as that law was implemented on August 7, 2014, and OIG's analysis only includes data up until September 30, 2014. However, OIG's analysis does provide an understanding of the historical pattern of staffing changes at VHA leading up to the enactment of that law. Further, OIG found that VHA's staffing model is in development and consists of different models covering distinct areas of VHA staffing needs. VHA is

working on extending the Specialty Productivity Access Report and Quadrant staffing tool to more occupations. OIG made two recommendations.

OIG Recommends VA Define Specific Criteria for Solo Physicians' Professional Practice Evaluations in VHA Facilities

OIG conducted a review to assess whether VHA facilities with a solo physician in four selected specialties (gastroenterology, pathology, nuclear medicine, and radiation oncology) used specialty-specific information for professional practice evaluation and had a physician with comparable privileges generate and/or review the professional practice information. Eighteen facilities validated that they had a solo physician in 1 or more of the 4 specialties during FY 2014 for a total of 21 physicians. This review covered all affected facilities. OIG found good compliance with facilities completing general Focused and Ongoing Professional Practice Evaluation forms. However, each facility is able to select the criteria or monitors they use for professional practice evaluations, and a majority of the information was generic. OIG made two recommendations.

CAP Summary Report on Evaluation of Medication Oversight and Education in VHA Facilities

The purpose of the evaluation was to determine whether clinicians provided appropriate clinical oversight of, and medication education to, patients discharged with orders for one of three selected fluoroquinolone antibiotics. OIG conducted this evaluation at 50 VHA medical facilities during CAP reviews performed across the country from October 1, 2013, through September 30, 2014. Although OIG noted high compliance with VHA policy and Joint Commission standards in many areas, including assessment and identification of potential learning barriers at admission, provision of written instructions and medication lists to patients at discharge, and documentation of patient or caregiver medication education, OIG identified opportunities for improvement and made two recommendations.

CBOC Summary Report for Evaluation of Medication Oversight and Education at CBOCs

The purpose of this systematic review of VHA's CBOCs and other outpatient clinics was to evaluate compliance with selected VHA requirements regarding clinical oversight and education for patients prescribed oral fluoroquinolone antibiotics in the outpatient setting. The objective was to determine the extent of counseling provided to patients who were prescribed an oral fluoroquinolone antibiotic. This included the care elements of medication reconciliation, patient education, and assessment of the patient's understanding as performed by clinical staff. We conducted this focused review at 57 VA medical centers (VAMCs) through the evaluation of the electronic health records of 2,098 patients who were first prescribed a fluoroquinolone antibiotic during July 1, 2012, through June 30, 2013. OIG recommended that clinicians: (1) perform and document medication reconciliation at each outpatient episode of care when a new medication is prescribed, (2) consistently provide and document patient education for new outpatient medications, and (3) consistently assess and document outpatients' understanding of medication education.

CAP Summary Report on Evaluation of Selected Requirements in VHA Community Living Centers

The purpose of the evaluation was to determine whether facilities complied with selected restorative nursing and dining requirements to assist community living center (CLC) residents in maintaining their optimal level of functioning, independence, and dignity. OIG conducted this review at 47 VHA medical facilities during CAP reviews performed across the country from October 1, 2013, through September 30, 2014. Although OIG noted high compliance in many areas, including provision of assistive eating devices to residents during meals, dining atmosphere, and honoring residents' preferences, OIG identified opportunities for VHA facilities to improve and made seven recommendations.

Hotline Healthcare Inspections

OIG Issues Report on Unexpected Death of Patient During Treatment with Multiple Medications at Tomah, Wisconsin

OIG conducted an inspection at the request of Senator Tammy Baldwin and Senator Ron Johnson to assess the merit of an allegation made by a father after his son died unexpectedly during the course of treatment for MH problems at the Tomah VAMC, Tomah, WI. The father alleged that his son (patient) died from an overdose of medications administered at the facility. The medical examiner concluded that the patient's cause of death was mixed drug toxicity. OIG enlisted the services of a non-VA forensic toxicologist to serve as a consultant and subject matter expert. The consultant agreed with the medical examiner's conclusion. OIG determined the patient died in the facility and that he was prescribed medications with potential for respiratory depression. Among the medications the patient received, the additive respiratory depressant effects of buprenorphine and its metabolite norbuprenorphine, along with diazepam and its metabolites, were the plausible mechanism of action for a fatal outcome. These drugs were prescribed by the treating psychiatrists at the facility. However, the consultant forensic toxicologist noted the following, "the possibility that the decedent received additional drug (Suboxone® [buprenorphine/naloxone]) in some form or fashion, cannot be excluded." OIG found deficiencies in the informed consent process and cardiopulmonary resuscitation (CPR) efforts. OIG did not find evidence of written informed consent for buprenorphine treatment. Both psychiatrists involved in the ordering of buprenorphine acknowledged they did not discuss the risks inherent in off-label use of the drug with the patient. CPR deficiencies included role confusion as well as delays in initiating CPR, calling for medical emergency assistance, and applying defibrillator pads to determine cardiac rhythm for possible intervention. Further, certain medications used in emergency situations to reverse effects of possible drug overdose were not available on the unit. OIG made four recommendations.

Tomah VA Staff Acted Appropriately for Patient Experiencing Acute Stroke at Rural Hospital Not Equipped To Treat Problem of This Magnitude

OIG conducted an inspection at the request of Senator Tammy Baldwin and Senator Ron Johnson to assess allegations of poor care and delayed care of a patient at the Tomah VAMC Urgent Care Clinic (UCC) in Tomah, WI. OIG did not substantiate the general allegations of poor care and delayed care; that the patient waited 3 hours before being seen; that other patients arrived, were treated, and released before the case patient; that a physician was unaware of acute ischemic stroke symptoms and treatment; or, that the Tomah VAMC computerized tomography machine was broken. OIG substantiated the allegation that the physician did not affirmatively diagnose the first neurologic event the patient experienced as a transient ischemic attack or acute ischemic stroke; however, the physician properly considered broad diagnostic possibilities for the syncopal episode, which occurred while the patient was in the Tomah VAMC UCC waiting room awaiting a MH evaluation. OIG did not substantiate that the physician failed to treat the patient's second neurologic event, an acute ischemic stroke, with sufficient urgency. OIG determined that transferring the patient to Gundersen Health System by ground ambulance was the appropriate action after a stroke was definitively diagnosed. OIG found that the Tomah VAMC did not own or operate an air ambulance and that one was not available to transfer the patient. OIG concluded that, overall, the UCC staff acted appropriately in the face of a patient experiencing a sudden and unexpected acute ischemic stroke while waiting for a MH evaluation in a rural hospital that was not equipped to treat a health problem of this magnitude. OIG identified opportunities for improvement, none of which impacted this patient's care, and made three recommendations to the Interim Under Secretary for Health (USH) and six recommendations to the Tomah VAMC Director.

OIG Recommends VHA Review How It Compensates Non-VA Facilities for Lung Transplantation To Ensure Proper Reimbursement

OIG conducted an inspection at the request of Senator Charles E. Grassley and the VA Secretary to assess the merit of allegations that the Iowa City VA Health Care System (HCS) (facility), Iowa City, IA, provided poor quality of care; failed to comply with the *Veterans Access, Choice, and Accountability Act of 2014*; and refused to pay for a patient's lung transplant outside of the VA. OIG did not substantiate the allegation that the patient received poor care during a summer 2014 admission to the facility, and while it could not be confirmed whether or not family members were told the patient had pneumonia, OIG determined that the patient and family members understood that the patient had received antibiotics for "an infection." In addition, OIG did not substantiate the allegation that the patient received inadequate treatment for her worsening respiratory condition between summer and fall of 2014. Rather, clinicians aggressively pursued testing during this time to determine whether the patient could receive a lung transplant. OIG did substantiate that while she was an inpatient in fall 2014, physicians did not properly address the patient's multiple episodes of oxygen desaturation and that the patient sustained an acute kidney injury. However, OIG did not conclude the kidney injury resulted from poor quality of care or that it disqualified her from receiving a lung transplant. Finally, OIG did not substantiate the allegation that the facility failed to appropriately address concerns regarding the patient's care when brought to the attention of the patient advocate and Chief of Staff; failed to comply with the *Veterans Access, Choice, and Accountability Act*; or refused to pay for a lung transplant at a non-VA hospital. OIG made two recommendations. The USH and the VISN and Facility Directors provided an acceptable action plan.

OIG Substantiates Provider Workload and Staffing Negatively Impacted Access and Quality of Care at Wasilla, Alaska, CBOC

OIG conducted an inspection at the request of Senator Lisa Murkowski to assess the merit of allegations regarding: (1) provider availability, workload, access, quality of care, and security at the Mat-Su VA CBOC, Wasilla, AK, and (2) scheduling practices at the Alaska VA HCS, Anchorage, AK. OIG substantiated the allegation that provider workload and staffing negatively impacted access to care at the Mat-Su VA CBOC for the patients reviewed. OIG further substantiated that the Mat-Su VA CBOC lacked a permanent provider from May to October 2014. OIG substantiated that decreased and delayed access resulted in quality of care issues. Patient care was compromised by a lack of communication, care coordination, and follow-up, in addition to outright delays in the provision of care. OIG did not substantiate the allegation that since its opening, the Mat-Su VA CBOC has been plagued by security issues. OIG substantiated the allegation that the facility did not comply with VHA scheduling directives in 2008. However, OIG did not find evidence of current scheduling irregularities. OIG substantiated the allegation that adequate urology services were not available to patients following the departure of the system's only urologist in 2008. In addition, OIG found organizational structure and processes lacking, particularly in areas under the domain of clinical leadership. Insufficient processes in peer review, provider evaluation, and committee activity and reporting, as well as issues of culture and employee morale, have the potential to compromise patient safety. OIG made nine recommendations. The VISN and Facility Directors concurred with the recommendations and provided acceptable action plans.

Incorrect Code Status on Patient's Wristband Led to Delay in Life Saving Intervention at VA Northern California HCS, Mather, California

At the request of Congressman Ami Bera, M.D., OIG conducted an evaluation to assess the circumstances of a patient's death and actions taken by staff subsequently at the VA Northern California HCS (the facility), Mather, CA. OIG found that facility staff did not follow through on the patient's request upon admission to discuss advance directives. OIG found no evidence of advance care planning discussion during the patient's hospital stay. OIG substantiated that the patient's wristband had the incorrect code status of Do Not Resuscitate/Do Not Intubate printed on it and that staff did not verify the wristband code status during the patient's

9-day hospital stay. OIG found that the wristband had clinical warnings not pertinent to the patient's current condition. OIG also found that nurses were using a duplicate copy of the wristband as a "workaround" when administering medications. OIG substantiated that the incorrect code status on the patient's wristband led to a delay in life-saving intervention. OIG did not substantiate the allegations that medical-surgical unit staff were afraid to speak up because of the culture of bullying and retaliation on the unit. However, OIG concluded that an evaluation of the unit is warranted based on the unit's All Employee Survey scores related to supervisory behaviors. OIG also concluded that facility leaders need to implement a plan for proactive employee support in response to traumatic events. OIG did not substantiate the allegation that a physician berated staff participating in the code. The facility had already started to implement corrective actions to ensure that staff verify and document patients' code status. The facility performed an institutional disclosure of adverse events to the patient's family and conducted a comprehensive review of the care provided for this patient in accordance with VHA policy. OIG made five recommendations.

OIG Finds Inadequate Psychiatrist Staffing, Improper Scheduling at Central Alabama VA HCS, Montgomery, Alabama

OIG conducted a review at the Central Alabama VA HCS (CAVHCS), Montgomery, AL. In relation to one or more of the CBOCs, OIG substantiated inadequate psychiatrist staffing, waiting lists to see providers, improper scheduling of patients on the Recall Reminder list, excessive wait times for ambulance transport for MH patients requiring non-emergent hospitalization, inadequate primary care (PC)-MH integration, and non-compliance with MH staffing and medication trial requirements. OIG confirmed some PC providers could not enter a MH consult but found this to be an acceptable practice. OIG did not substantiate that multiple MH patients committed suicide due to care delays, leaders refused to provide inpatient detoxification (detox) services, patients did not receive medical treatment for substance use disorders (SUD) and were discharged from the emergency department (ED) with only anti-anxiety medication, patients had to pay for private-sector detox, 24-hour ED observation for detox was insufficient, or the substance abuse treatment program had an inefficient admission process. OIG did not substantiate that the Disturbed Behavior Committee refused to issue a behavioral patient record flag, but it did take an excessive amount of time to do so. OIG did not substantiate that providers routinely prescribed benzodiazepines to high-risk patients, but sometimes they did not document their rationales. Some medication combinations could have placed patients at risk. OIG found that MH treatment coordinators were not assigned consistently. OIG could not substantiate that CBOC providers were unable to be reached after hours, that MH peer reviews were not conducted, or that there were not "enough" acute MH beds. CAVHCS leaders were aware of many issues but often did not implement timely corrective actions. OIG made 17 recommendations to improve operations.

Inspection Substantiates Delays and Lack of Follow-Up in Non-VA Care Program at Montgomery, Alabama, VA Facility

OIG reviewed allegations of deficient consult management, contractor, and administrative practices at the CAVHCS, Montgomery, AL. OIG substantiated delays securing Non-VA Care Coordination (NVCC) services, lack of follow-up, delays in getting NVCC care authorized, staff not verifying eligibility for NVCC care, some NVCC consults being cancelled, and some CBOC nurses scheduling patients directly with community providers. OIG also substantiated insufficient NVCC staffing and repeated leadership changes. OIG could not substantiate that 8,000 consults were reassigned to NVCC, that intra-facility consults went unanswered for months, that patients were not notified when appointments were scheduled, that there were delays in oncology care, or that a patient's colorectal cancer metastasized due to delays in oncology care. OIG did not substantiate that the Dothan CBOC primary care contractor improperly billed for physician-led primary care appointments or that contract providers did not notify patients of critical fecal occult blood test results. OIG substantiated that a contracted private medical group (PMG) completed inadequate initial history and physical exams, that

those reports were not always available in the patients' VA medical records, and some patients with care needs identified by PMG were at risk due to poor or non-existent documentation. OIG substantiated that CAVHCS had multiple vacancies in important clinical areas; that the Podiatry Service did not follow appointment scheduling guidelines; and that Administrative Boards of Investigation were not consistently chartered, completed, or followed through in response to serious events. OIG substantiated that CAVHCS leaders were aware of many of the issues identified in the report and determined that a fractured organizational culture contributed to the development and perpetuation of these issues. OIG was unable to fully evaluate eight additional allegations due to insufficient information and/or details. OIG made seven recommendations.

Follow-up Review Shows VISN and Facility Leadership Took Effective Corrective Actions to Reopen Intensive Care Unit in Fort Wayne, Indiana

OIG conducted an oversight review to follow up on recommendations OIG made in the published report, *Healthcare Inspections-Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana* (Report No. 13-00670-262, Issued on August 28, 2014). The purpose of the review was to evaluate the progress VA Northern Indiana HCS's Fort Wayne campus (facility) had made in implementing the action plan outlined in response to the 2014 report. On October 22, 2014, the facility reopened the Intensive Care Unit (ICU). During OIG's onsite visit in April 2015, OIG found that the facility continued to support 16 medical beds with telemetry capability and 4 ICU beds. OIG determined that VISN 11 and facility leadership had completed actions to reopen the ICU and taken actions to actively recruit and hire staff to fill leadership and qualified clinical positions. OIG also determined that nursing leadership assessed the utilization of the nursing staff to systematically plan assignments. In summary, OIG found the VISN and facility leadership exercised oversight and implementation of corrective actions to resolve the conditions identified in the 2014 report. The facility is now admitting patients to the acute medical unit and the ICU. OIG made no further recommendations.

Review Finds Failure To Diagnose and Treat Patient's Lung Cancer Timely at Martinsburg, West Virginia, VAMC

OIG conducted an inspection to determine the validity of allegations regarding physician leaders' mismanagement and abuse of power at the Martinsburg VAMC, Martinsburg, WV. OIG did not substantiate the allegations that physician leaders overlooked the medical neglect of a patient, denied transfer of critically ill patients, disregarded specialists' opinions, and gave a nurse authority to delay procedures without informing responsible specialists. However, during the course of OIG's review and separate from the original allegation, OIG found that the facility failed to provide timely diagnosis and treatment of a patient's lung cancer. In addition, the facility did not pursue all required administrative procedures in this case. OIG recommended that the Facility Director ensure that the facility: (1) comply with VHA and facility test results notification requirements, (2) strengthen the root cause analysis process, (3) evaluate the care of the subject patient with Regional Counsel for possible disclosure(s) to the surviving family member(s) of the patient, and (4) strengthen and monitor the peer review process. The VISN and Facility Directors concurred with OIG's recommendations and provided acceptable action plans.

Atlanta VAMC Attempted To Provide MH Treatment to Troubled Veteran, Review Confirms Health Information Disclosed

At the request of the Chairman and Ranking Member, Senate Committee on Veterans' Affairs, and the Chairman and Ranking Member, House Committee on Veterans' Affairs, OIG conducted a review of a patient's care at the Atlanta VAMC, Decatur, GA, prior to the patient's death and evaluated an improper disclosure of protected health information outside VA. OIG determined that facility staff provided, or attempted to provide,

appropriate MH treatment and psychosocial support services. Although the veteran verbalized suicidal ideation, she was reluctant to engage in psychotherapy. The veteran missed two MH appointments, but when contacted, exercised her right and declined further MH services. OIG identified appointment scheduling and follow-up deficiencies, a 23-day delay in placing a high-risk for suicide flag, and inconsistent compliance with some high-risk protocol requirements. However, OIG does not believe that these deficiencies had a direct impact on the outcome, as the veteran died more than 2 months after she was referred for placement on the high-risk protocol, more than a month after the missed MH appointments, and 1 week after a face-to-face contact with a clinician. OIG confirmed that information in the veteran's electronic health record (EHR) was improperly disclosed. The record was designated as "non-sensitive" at the time of the disclosure, and VHA currently lacks the ability to audit access to non-sensitive records. OIG recommended that the Interim USH evaluate options to identify individuals who access non-sensitive patient EHRs. OIG also recommended that the Facility Director ensure that staff comply with guidelines for appointment scheduling, notification, and follow-up; make patient contacts in accordance with treatment plans; and adhere to suicide prevention program requirements. The Interim USH and the VISN and Facility Directors concurred with the recommendations and provided acceptable action plans.

Healthcare Inspection Notes Deficiencies in Arterial Study Timeliness, Pain Assessments at Chicago, Illinois, VA Facility

OIG conducted an inspection to assess the merit of allegations made by a confidential complainant relating to quality of care concerns in a diagnostic evaluation at the Jesse Brown VAMC, Chicago, IL. OIG substantiated a delay in scheduling and completing the lower extremity arterial study. OIG could not substantiate the allegation that the patient's requirement for limb amputation would have been different had he received the vascular laboratory lower extremity arterial study sooner. Although not an allegation, OIG identified an additional quality of care issue with this patient's care. During three providers' visits, the patient did not receive complete pain assessments. OIG recommended that the Facility Director: (1) evaluate the scheduling process for vascular consultations and diagnostic tests, and take action if factors potentially impacting quality of care are identified; (2) evaluate the practice of vascular laboratory technicians interpreting the urgency of providers' consult requests and whether providers are notified when consult requests are not scheduled within the providers' timeframe, and take action if needed; (3) ensure that managers develop a policy defining who is responsible for provider and patient notification of consults ordered through the ED or UCC that are not completed timely according to VHA policy; (4) ensure that providers perform comprehensive pain assessments according to VHA policy and monitor compliance; (5) ensure that managers conduct an internal evaluation of the case discussed in this report; and (6) consult with Regional Counsel regarding possible institutional disclosure.

OIG Makes Nine Recommendations To Improve Access to Care and Completeness of Medical Records at VA Maryland HCS

OIG conducted a review in response to concerns raised by Senator Barbara Mikulski regarding lapses in access and quality of care issues at the VA Maryland HCS. The purpose of this review was to determine the extent to which those concerns had merit. OIG substantiated delayed access for a patient at the Perry Point campus and identified some contributing factors, including insufficient primary care provider staffing. OIG substantiated that the system experienced challenges in providing timely access to orthopedic surgical services but had developed an action plan to address these issues prior to our visit. OIG did not substantiate concerns that a second patient experienced delays in service delivery or cancer diagnosis at the UCC at Perry Point. OIG also did not substantiate allegations related to a third patient's diabetes and diabetic neuropathy pain; however, OIG found that community health care information was not included in the patient's EHR because of provider documentation lapses and, possibly, a backlog of documents waiting to be scanned.

OIG further found that the system's policy for tube-feeding nutrition did not comply with all requirements. OIG made nine recommendations.

Delays at Memphis, Tennessee, VA ED Deemed Unavoidable Given Patient Population, Progress Noted Since Last Review

OIG conducted an inspection in response to complaints about the timeliness and quality of care in the ED and PC of the Memphis VAMC, Memphis, TN, which is part of VISN 9. OIG did not substantiate the allegation that Memphis ED personnel were inattentive and failed to provide timely care. The patient was triaged appropriately on arrival. The 4-hour delay the patient experienced before leaving without being seen by an ED provider was unfortunate yet unavoidable due to the patient population in the ED at the time of the patient's visit. OIG did not substantiate the allegation that Primary Care provider (PCP) assistants were inattentive to the patient's requests for medical help via phone and VA's electronic secure messaging system. PC clinic staff responded to the patient's requests, and the patient received the services he requested. While OIG found occasional delays in responding to the patient's requests, overall, delays were not typical. OIG substantiated the allegation that VA refused to pay for private facility care; however, this decision was based on Federal regulations. OIG substantiated the allegation that the facility faxed incorrect records to the ED of a private hospital. This was attributed to human error by a staff member at the facility, and as a result, the facility changed its process for providing medical information to other hospitals. OIG found that the new process was being followed at the time of our visit; therefore, OIG made no recommendation. OIG did not substantiate the allegation that the facility ignored recommendations or postponed implementation of actions recommended by the OIG in previous reports. OIG made no recommendations.

Allegation That Greater Los Angeles HCS Deleted MRI Exam Requests Unfounded, But Delays May Have Put Some Veterans at Risk for Complications

OIG conducted an inspection in response to congressional requests to assess the merit of allegations regarding the deletion of MRI exam requests (orders) and the destruction of medical files at the VA Greater Los Angeles HCS, Los Angeles, CA. OIG did not substantiate that MRI orders were deleted or mass purged or that records were destroyed. OIG found that orders cannot be deleted or destroyed from the computer system. Each order OIG reviewed was canceled individually. OIG did not substantiate the allegation that patients suffered adverse or clinically significant consequences from canceled dated MRI orders in late 2008. OIG reviewed 1,474 MRI orders and found sufficient evidence to support that cancelations did not impact patient care outcomes. However, OIG identified quality of care concerns where a delay or inability to schedule MRIs placed patients at risk for more complicated and prolonged management. Incidentally, OIG identified 170 MRI studies ordered in 2008 that were still pending. OIG determined the facility had not consistently implemented its process to cancel orders older than 1 year. Additionally, radiology clerical staff did not consistently annotate accurate reasons for canceled orders and appointments. OIG also found that the facility should strengthen its view alert notification process to ensure ordering providers were notified of canceled orders. OIG recommended that the Facility Director ensure that the Radiology Department managers confirm that ordered exams are scheduled and completed within the VHA required timeframe, periodically review pending lists of MRI exams to ensure timely scheduling, and implement a consistent procedure for canceling MRI orders. OIG also recommended that responsible providers are notified of canceled MRI orders and that radiology clerical staff accurately annotate reasons for canceling MRI orders and appointments in the EHR.

Improvements Needed in Patient Care, Dental and Neurosurgical Services, and Maternity Information at Muskogee, Oklahoma, VAMC

At the request of Senator James Inhofe, OIG conducted an evaluation of several allegations concerning quality of care and access to care at the Jack C. Montgomery VAMC, Muskogee, OK. OIG substantiated some of the

allegations regarding quality of care. OIG substantiated a patient did not receive appropriate treatment for his back pain because of a delay in the diagnosis of a malignancy, which may have been the source of pain. OIG did not substantiate a failure to provide a patient operative care associated with bleeding gastrointestinal polyps, a failure in VA agreeing to pay for a patient's open heart surgery resulting in a delay, or a provider's failure to address leg swelling or a nose bleed affected the rupture of a patient's "brain aneurysm." OIG did not substantiate the VA advised a patient to wait until he tore the remaining two healthy discs in his back and then call 911 to make it a medical emergency. OIG did not substantiate a delay in scheduling a computed tomography scan and a colonoscopy. OIG substantiated the access to care allegations. OIG substantiated a patient experienced poor access to dental services and that the patient was not notified by mail of his scheduled appointment. OIG also substantiated that another patient experienced poor access to neurosurgical services. OIG conducted a broad review of the facility's NVCC maternity care processes in response to allegations concerning delayed and denied consult requests. While OIG did not substantiate the allegations, OIG found that information pregnant patients receive in a facility document, as well as the non-VA maternity care providers' authorization document, are potentially ambiguous in wording when applied to select cases. In addition, OIG found concerns with Dental Services, parking access and safety, and provider documentation of telephone communications. OIG made eight recommendations.

OIG Recommends VA Consider Expanding Recovery Coordination Activities for Post-Traumatic Stress Disorder Patients in Des Moines, Iowa, VAMC Review

OIG conducted an inspection at the request of Senator Joni Ernst to review allegations regarding poor MH care resulting in a patient's death at the VA Central Iowa Health Care System (VACIHCS), Des Moines, IA. OIG did not substantiate the allegation that the patient had been denied long-term MH services at the time of a winter 2015 ED visit. OIG found no documentation that the patient had requested these services or that his clinical condition would have warranted admission at that time. OIG did not substantiate that the patient received poor quality of care through the ED but concluded that VACIHCS did not comply with VHA policy regarding case management services. OIG reviewed MH programs at VACIHCS from the perspective of how they interfaced to provide care for this patient. The facility appeared to be substantially in compliance with its policy regarding time frames for consult completion. The patient did not experience a delay in obtaining MH, as he had not requested these services in the 2 years prior to his winter 2015 ED visit. OIG determined that the patient was not contacted by the local recovery coordinator because his name did not appear on the list of seriously mentally ill patients. For purposes of recovery coordinator activities, seriously mentally ill patients are considered to be those patients with a diagnosis of schizophrenia, bipolar disorder, or psychoses. This patient had anxiety, depression, and post-traumatic stress disorder (PTSD) but had never been diagnosed with schizophrenia, bipolar disorder, or a psychoses that would have triggered contact from the local recovery coordinator. OIG made two recommendations. The Interim USH and the Acting VISN and Acting Facility Directors concurred with the recommendations and provided an acceptable action plan.

Review Finds Many Inappropriate Referral and Scheduling Practices at Togus, Maine, VAMC MH Service

OIG conducted an inspection at the request of former Ranking Member of the House Committee on Veterans' Affairs, Michael Michaud, regarding allegations of mismanagement of MH consults and other access to care concerns at the VA Maine HCS (facility). OIG substantiated allegations that staff were directed to discontinue using the consult package for MH services referrals in certain circumstances and language in the consult package directed providers not to request MH consults if the patient was not willing to be seen within 14 days. OIG also found that referral processes within the MH services made it difficult to track whether patients' requests for services were met. OIG did not substantiate the allegation that staff were directed to restrict who could submit MH consults. Although OIG did not substantiate the allegation that staff were directed to close

consults before services were rendered, OIG found that this practice occurred. OIG did not substantiate the allegation that facility leadership directed staff to utilize workshops to meet VHA's benchmark for timely MH assessments and follow-up. OIG found that there were concerns about the clinical appropriateness of certain group workshops, patients' attendance in workshops did not "count" towards meeting VHA performance measures, and some of the MH Chief's correspondence with staff emphasized meeting performance measures. OIG did not substantiate the allegation that, in order to meet VHA's benchmark for same day access, staff were directed to use drop-in clinics instead of scheduling appointments or that staff were directed to omit certain information from clinical notes to limit the number of veterans seeking MH services. OIG did not substantiate the allegation that licensed independent providers were directed to see patients for medication management. OIG substantiated the allegation that some of the alleged practices have persisted despite other reviews. OIG made eight recommendations.

Physician Possessed Proper Credentials but Not Granted Privileges To Interpret Medical Studies at Columbia, South Carolina, VAMC

OIG conducted an inspection to assess the merit of allegations received from Senator Bernie Sanders, then-Chairman of the Senate Veterans' Affairs Committee, regarding provider credentialing and privileging concerns at the William Jennings Bryan Dorn VAMC (facility), Columbia, SC. OIG substantiated that a cardiologist was interpreting non-invasive vascular studies without being granted privileges to do so by the facility; however, the cardiologist had the required education and training and was subsequently granted the required privileges. OIG substantiated that the standards of the American College of Radiology and Intersocietal Accreditation Commission were not used for the interpretation and reporting of non-invasive vascular imaging studies. However, VHA does not require adherence to these standards, and the facility was compliant with VA National Radiology Program Standard Operating Procedures. OIG did not substantiate that a CBOC ultrasound technician did not have the required training and competencies to perform non-invasive vascular studies. OIG recommended that the Facility Director ensure that provider privileges reflect current practice. The VISN and Facility Directors concurred with the recommendation and provided an acceptable action plan.

VA Facility Not in Compliance with VHA Outpatient Scheduling Guidelines

OIG conducted a review at the request of former Representative Jack Kingston to assess allegations regarding MH and treatment deficiencies at the Brunswick CBOC, Brunswick, GA. OIG substantiated that a patient was unable to contact or schedule an appointment with his psychiatrist over several weeks in late summer 2014 when the provider was on leave. It did not appear that the psychiatrist informed the My HealtheVet coordinator or designated a surrogate to respond to secure messages in her absence. OIG found that the process of scheduling follow-up appointments did not comply with VHA outpatient scheduling guidelines. OIG did not substantiate that the patient did not have a treatment plan for his PTSD, although OIG did find long periods when the patient did not see his psychiatrist or social worker therapist. While OIG confirmed that the patient was not prescribed anti-anxiety medications by a VA provider for more than a year, OIG did not substantiate the CBOC providers withheld this medication as the complainant implied. OIG substantiated that the CBOC did not offer group therapy for patients with PTSD at the time of the complaint and OIG substantiated that the patient was not receiving or participating in psychotherapy at the time of the complaint. OIG made five recommendations.

VHA Consolidated Mail Outpatient Pharmacies Mail Medications to Nearly One in Five Deceased Patients After Date of Death

OIG conducted an inspection to review allegations regarding the quality and coordination of care of a patient at the Kansas City VAMC, Kansas City, MO, and the Kirksville VA Clinic, a Harry S. Truman Memorial Veterans'

Hospital, Columbia, MO, clinic. OIG substantiated that the patient experienced multiple hip dislocations after replacement surgery. The recurrent hip dislocations resolved after revision surgery. OIG did not substantiate that the Kansas City VAMC delayed payment for ambulance transportation. OIG substantiated that the patient's evaluation for potential aortic aneurysm repair was delayed, but did not substantiate that the aortic aneurysm probably resulted in his death or that VA providers inappropriately postponed surgical repair. OIG substantiated that the patient did not receive appropriate evaluation for recurrent falls and weakness. In addition, his PCP did not follow usual practice in prescribing medications associated with increased fall risk. OIG could not substantiate that the patient was involved in a motor vehicle accident at the VA. OIG found reports of a fall but no reports of a motor vehicle accident for the specified date. OIG substantiated that prescriptions were mailed to the patient after his death. OIG reviewed pharmacy data files to determine whether medications were being dispensed after patients' deaths across VHA. OIG found that 17.2 percent of patients, or 29,173 patients, who died between July 1, 2013, and June 30, 2014, were dispensed at least one prescription after death on the average of 33 days after death; 96 percent of the dispensed medications were for non-controlled substances. OIG could not substantiate the allegation that the patient was denied care three times at the Kirksville CBOC. OIG made five recommendations. The Interim USH and VISN and Facility Directors concurred with the recommendations and provided acceptable action plans.

Review Finds Excessive Waste When Pharmacy Staff Prepares Compounded Sterile Products at San Antonio, Texas, VA Facility

OIG conducted an inspection to assess the merit of allegations made by a complainant regarding the intravenous compounded sterile product (CSP) medication error rate, improper aseptic technique while mixing CSPs, and excessive CSP wastage at the South Texas Veterans HCS (system), San Antonio, TX. A CSP is a pharmaceutical preparation that has been made or modified using manufacturer labeled instructions in a controlled sterile environment. OIG did not substantiate the allegation that the system's pharmacy compounding error rate was high. OIG also did not substantiate that pharmacy personnel did not observe aseptic technique while compounding sterile products. However, OIG did substantiate excessive waste of CSPs. Because the stability of most CSPs increases with refrigerated storage, OIG recommended that the System Director ensure that processes be developed to improve storage conditions of CSPs on patient units in an effort to reduce unnecessary waste.

OIG Finds Reprocessing Equipment Is Properly Maintained at Huntington, West Virginia, VAMC

OIG conducted an inspection in response to complaints concerning responsibility for, and proper maintenance of, the MEDIVATORS Advantage Plus Endoscope Reprocessing System® at the Huntington VAMC (facility), Huntington, WV. OIG did not substantiate the allegation that staff responsible for cleaning gastrointestinal endoscopes failed to perform required maintenance on reprocessing equipment by not replacing filters. OIG did not find documentation to support that the reprocessing equipment became clogged and potentially created a patient safety risk. OIG did not substantiate the allegation that replacing filters on the reprocessing equipment is the responsibility of Sterile Processing Service staff rather than Biomedical Engineering staff. Facility policy states that reprocessing equipment filters will be changed by Biomedical Engineering staff. OIG made no recommendations. The VISN and Facility Directors concurred with our findings.

Most Allegations Refuted in OIG Review of the Jacksonville Outpatient Clinic, Jacksonville, Florida

OIG conducted an inspection in response to an anonymous complaint to Mike Coffman, Chairman of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives Committee on Veterans' Affairs, regarding multiple allegations about the staff and management of the Jacksonville Outpatient Clinic (OPC) in Jacksonville, FL. This review determined whether the allegations had merit. OIG substantiated that

VA maintenance and engineering employees at the Lake City facility provide repair and installation services for VA equipment at the OPC, but this was reasonable. OIG substantiated that female veterans were not able to obtain mammography imaging services until June 2014, which was the planned opening date for the mammography suite. OIG also substantiated that the waiting area carpets were heavily stained. OIG did not substantiate allegations that veterans were turned away without being seen, 19 PC providers treated only 145 veterans in a week, the specialty clinic manager did not enforce tours of duty or break times, complaints about managers bullying staff members were not addressed, Surgical Services staff did nothing while waiting for the operating room air system to be fixed, or that dietary staff saw only 20 veterans in a week and made an onsite community garden. Further, OIG did not substantiate allegations that non-VA mammography requests were denied, Wi-Fi access was not available, the clinic was dirty and housekeeping staff were not trained, security staff did not follow up on an event, or the administrative area access was blocked and staff members were advised to stay out of that area altogether. OIG made one recommendation. The VISN and Facility Directors concurred with the recommendation and provided an acceptable action plan.

OIG Review Finds Backlog of Undelivered Prosthetic Devices and Staffing Issues at Palo Alto, California, HCS Dental Service

OIG conducted an inspection in response to a request from Congresswoman Jackie Speier to evaluate the merit of allegations regarding Dental Service scheduling as well as administrative issues at the VA Palo Alto HCS, Palo Alto, CA. A complainant identified five patients with alleged scheduling issues. OIG substantiated that two of the five patients' appointments were canceled and rescheduled to later dates. OIG did not find evidence of long-term impacts on their clinical outcomes. OIG noted a 5-month delay in scheduling appointment dates for the two patients. OIG substantiated that the staffing ratio for dental assistants to dentists was slightly below VHA recommendations. OIG substantiated that dentists and residents assumed dental assistant duties after dental assistants ended their tours of duty, including the cleaning of instruments and disinfection of environmental surfaces. OIG was informed that in order to assist patients still being seen after dental assistants ended their tours of duty, all dentists and residents were given access to the Omnicells to obtain any necessary supplies. OIG substantiated that the dental clinic had a long backlog of undelivered prosthetic devices. The system instituted corrective actions, but due to incomplete documentation, OIG was not able to fully assess progress in reducing "backlogs" of undelivered prostheses. OIG substantiated that Dental Service had broken and/or insufficient equipment. OIG determined that additional equipment and a radiograph software program have been purchased. OIG concluded that the Dental Service presented numerous concerns and challenges and that it would be beneficial for the VISN to review the Service after all corrective actions have been implemented. OIG made four recommendations.

Colorectal Cancer Screening Issues Unsubstantiated at Palo Alto, California, HCS

OIG's OHI conducted an inspection at the request of Congresswoman Jackie Speier in response to complaints about the colorectal cancer screening process and other administrative issues at the VA Palo Alto HCS (system), Palo Alto, CA. This inspection determined the merit of the allegations. The complainant alleged that the use of fecal immunochemical test (FIT) was substandard care for colorectal cancer screening, that the nearby community medical groups did not use it, and that FIT was a poor substitute for colonoscopy. OIG found the system implemented FIT for screening and that the use of FIT was consistent with current literature and VA and community recommendations. The complainant alleged that an erroneous letter implying that FIT and colonoscopy were equal tests was sent to patients with the purported author's signature block but without the individual's permission. OIG substantiated this allegation. Patients no longer receive this letter as of January 2014. The complainant alleged that the FIT machine sensitivity was low and can be manipulated. OIG did not substantiate this allegation, as the value was pre-set by the manufacturer. The complainant alleged that patients were not given a choice of FIT or colonoscopy for colorectal cancer screening. OIG did not substantiate

this allegation, as PC providers discussed the risks and benefits of both modalities with patients during clinic encounters before ordering tests. OIG recommended that the System Director implement procedures to prevent the unauthorized use of individuals' signature blocks on form letters.

OIG Review Identifies Need for Improved Triage, Telephone Appointment Scheduling at Casa Grande, Arizona, CBOC

OIG conducted an inspection in response to allegations received by Congresswoman Ann Kirkpatrick's office concerning quality of care issues at the CBOC, Casa Grande, AZ. The CBOC is part of the Southern Arizona HCS, Tucson, AZ. OIG did not substantiate that 28 of 38 staff had resigned or transferred. OIG could not substantiate that a patient was placed "on hold" and was never able to reach a scheduler. OIG found that the call response time and call abandonment rate did not meet VHA goals. OIG could not substantiate that a patient suffered a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment. OIG did not substantiate the allegation that the patient was told she would have to wait 6 weeks for a post-hospitalization appointment in 2012. However, there were delays in assessment of the patient's condition prior to two community hospital admissions and a delay in follow-up for the patient after one of the hospitalizations. OIG did not substantiate that a patient committed suicide because he was denied a MH appointment. The patient had a scheduled appointment with a Tucson MH provider prior to his death. According to his EHR, the patient canceled the appointment. OIG did not substantiate that patients were being "double booked" for appointments for the same provider or that a scheduler is "overriding the schedule" and overbooking evaluation appointments. OIG recommended that the HCS Director ensure that same day access appointments and post hospitalization follow-up appointments at the CBOC are triaged appropriately and timely and that processes are strengthened to improve telephone appointment scheduling practices. The Acting VISN Director and System Director concurred with the findings and recommendations and provided acceptable improvement plans.

OIG Review Finds Improved Communication Needed with Families and Caregivers at VA Black Hills HCS, Fort Meade, South Dakota

OIG conducted a review in response to allegations received by former Senator Tim Johnson concerning communication with family and the quality of care for a patient at the VA Black Hills HCS (system), Fort Meade, SD. The complainant alleged that a patient was inappropriately discharged from the system in fall 2013. Additionally, in spring 2014, after the patient was recovering from surgery, system staff failed to contact the patient's wife when he was transferred from the system's ED to a non-VA community hospital, the non-VA community hospital found an abscess under a drain tube, and system staff failed to take the patient's complaints of a smell from the drain tube seriously. OIG found that system staff documented appropriate family notification when the patient was transferred from the system's CLC to the ED. However, OIG did not find documentation that the patient's family was notified as required when he was subsequently transferred from the ED to a non-VA community hospital. While OIG substantiated that the patient was discharged from the system and readmitted to a community hospital with multiple medical problems the following day in fall 2013, OIG did not find that the patient's discharge from the system was inappropriate. OIG did not substantiate quality of care concerns related to the presence of an abscess and the failure of system staff to take patient complaints of a smell from the drain tube seriously in spring 2013. OIG made one recommendation. The VISN and Facility Directors concurred with the recommendation and provided an acceptable action plan.

Improvements Needed in Monitoring Patients During Transportation and in Handoff Communication at West Palm Beach, Florida, VAMC

OIG conducted an inspection in response to allegations about the lack of timeliness of care and management action at the West Palm Beach VAMC, West Palm Beach, FL. OIG substantiated the allegation that the patient was not on the schedule for an interventional radiology (IR) procedure; however, the patient was brought to the

IR area for insertion of a peripherally inserted central catheter line (a non-IR procedure). OIG substantiated that the patient was transported from the ED to the IR area without being appropriately monitored and was not placed on a monitor immediately on arrival to the IR area. In addition, OIG found that required communication between nursing staff in the ED and the IR nurse did not take place prior to the patient being transported from the ED to the IR area. OIG also found that the facility policy for handoff communication did not describe how handoff communication was to be documented. OIG did not substantiate that CPR was not begun promptly when a "code" was called. A review of the patient's EHR found that when the patient was recognized to be in distress, resuscitation efforts took place quickly. OIG did not substantiate the allegation that management was notified of CPR timeliness concerns but failed to take proper action. OIG recommended that the Facility Director ensure that unstable patients be appropriately monitored during transport from one location to another. OIG also recommended that the Facility Director ensure that ED and IR nursing staff receive education in handoff communication requirements and that the facility policy for handoff communications be reviewed for inclusion of documentation of handoff communication. The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable improvement plans.

Review Finds No Delays in Treatment for Patients with Legionnaire's Disease at Pittsburgh, Pennsylvania, VA HCS

OIG conducted an inspection in response to complaints about delayed reporting of positive Legionella test results in 2012, potentially delaying treatment and causing death for patients at the VA Pittsburgh HCS, Pittsburgh, PA. The complainant also alleged that water samples for Legionella monitoring were collected improperly by excessively flushing the water line prior to collection in order to obtain false negative results. OIG substantiated that reporting of positive Legionella test results was occasionally delayed but found no evidence of delays in treatment for patients with Legionnaires' disease, either for those who died or for those who survived. OIG did not substantiate that water samples collected for environmental cultures of Legionella were collected improperly. OIG made no recommendations.

Better Communication with Community Providers Needed at Veterans HCS of the Ozarks

OIG assessed the merit of allegations regarding the quality of care provided to a patient at the Gene Taylor CBOC, Mount Vernon, MO. OIG substantiated that CBOC staff did not appropriately evaluate the patient's gastroesophageal reflux disease symptoms but concluded that it is unlikely that this influenced his outcome. A non-VA specialist diagnosed the patient with esophageal cancer within 3 months of his first complaints of increased heartburn. VHA policy requires VA providers to manage conditions for which they prescribe medications, even if the patient is also seeing a non-VA provider for that condition (dual care). The patient's EHR did not list which medical records the VA provider had available when increasing the patient's medication. OIG cannot determine whether the CBOC provider's summarized notes accurately reflected the patient's non-VA care or whether the CBOC provider needed to take additional action. OIG did not substantiate that CBOC providers inappropriately denied a request for Nexium. VHA's drug formulary lists preferred medications based on competitive pricing, safety, and efficacy. VHA requires facilities to have a process for reviewing non-formulary medication requests which may be approved if certain criteria are satisfied. In this case, the CBOC provider offered to prescribe Nexium if the patient tried other medications first, as required under VHA policy. The patient was in the process of trying other medications when he was diagnosed with cancer; he then requested that further medication management be done by his non-VA physicians. OIG made one recommendation to the Interim USH and one recommendation to the Veterans HCS of the Ozarks Director. The Interim USH and VISN and Facility Directors agreed with the findings and recommendations and provided acceptable improvement plans.

OIG Review Finds Delayed Surgery, Opportunities for Improvement in NVCC at Eastern Colorado HCS, Denver, Colorado

OIG assessed the merit of an allegation made by a complainant that a consult delay may have resulted in a patient's death at the VA Eastern Colorado HCS (facility), Denver, CO. OIG substantiated a delay in surgery; however, OIG could not substantiate that it contributed to the patient's death. According to the patient's death certificate, the patient died of natural causes, specifically, hypertension and cardiovascular disease. Without an autopsy, OIG cannot determine if the patient died of a ruptured aortic abdominal or common iliac artery aneurysm. The patient's surgery was delayed due to the unavailability of the facility's endovascular surgeon and the subsequent referral for non-VA medical care. Prior to a site visit, NVCC managers had identified the possible delay in processing the patient's NVCC consult and instituted corrective actions. However, OIG found that there was still confusion between the requesting provider and the NVCC staff in the interpretation of the "urgency" field in the consult request and what it meant to "process" the consult. OIG made one recommendation.

OIG Recommends Changes to Admission Process for Short-Stay Rehabilitation Unit at Tuscaloosa VAMC, Tuscaloosa, Alabama

OIG conducted an inspection in response to an anonymous complaint concerning the Short-Stay Rehabilitation Unit (Valor Center) at the Tuscaloosa VAMC, Tuscaloosa, AL. OIG did not substantiate that the facility did not have a screening process for prospective Valor Center patients or that patients were inappropriately admitted to the Valor Center. However, OIG determined that the Valor Center prospective patient screening practices at the time of the site review were not in compliance with the facility's CLC and the Valor Center admission policies. Also, while not an allegation, OIG determined that pre-admission consults with the facility physiatrist were not documented in patients' EHR. OIG did not substantiate that staff who point out potential wrongdoing were intimidated, transferred, harassed, or terminated. OIG substantiated that the Associate Chief of Staff for Geriatrics and Extended Care Services was the decision maker for admissions to the Valor Center and that performance-based pay was connected to the Valor Center's average daily bed census. However, OIG determined that neither was against VHA policy, and the performance pay incentive did not influence the Associate Chief of Staff's Valor Center admission decisions. OIG substantiated poor handoff communication for newly admitted patients. OIG made three recommendations. The VISN and Facility Directors concurred with the recommendations and provided an acceptable action plan.

Review Finds Surgical Resident Progress Notes Not Cosigned Timely at the Omaha, Nebraska, HCS

OIG assessed the merit of allegations regarding lack of supervision for vascular surgery residents resulting in poor patient care at the VA Nebraska-Western Iowa HCS, Omaha, NE. OIG did not substantiate the allegation that vascular residents were not supervised by attending surgeons. OIG found that vascular resident supervision documentation met VHA requirements and the Accreditation Council for Graduate Medical Education (accrediting body for resident supervision programs) guidelines. The six cases identified by the complainant did not demonstrate adverse events or near misses attributable to a lack of resident supervision. During the review, OIG found that attending surgeons did not cosign vascular surgical resident notes timely. VHA policy requires that facilities define and document the timeframe for cosigning resident notes. While local policy defines a 7-day timeframe for attending surgeons' co-signature of outpatient resident progress notes, OIG did not find a documented timeframe requirement for co-signature of inpatient resident progress notes. OIG did not find that delays in attending surgeons' co-signatures on resident notes resulted in poor patient care. OIG made two recommendations. The VISN and System Directors concurred with the findings and recommendations and provided acceptable action plans.

Sheridan, Wyoming HCS Lacked Process To Identify Patient's Aspiration Risk, Respiratory Distress Not Adequately Addressed

OIG reviewed quality of care allegations at the Sheridan VA HCS, Sheridan, WY. OIG could not substantiate the allegation that the facility did not adhere to clinical care recommendations previously identified by the facility for the management of a patient's dysphagia (difficulty swallowing). Documentation indicated staff knowledge of the patient's risk for aspiration; however, EHR's do not provide conclusive evidence of steps taken to manage the patient's dysphagia. OIG found that the facility lacked a mechanism that would assist staff in quickly detecting previously identified dysphagia and aspiration risk. OIG found that the patient's respiratory distress was not adequately addressed after admission in the hours immediately prior to the patient's death. OIG did not substantiate that the patient received a suprapubic catheter to ease the patient's care for previous caregivers, that the facility failed to adequately address the patient's care needs as an outpatient causing him to become more acutely ill before being admitted, or that the facility refused to provide physical therapy for the patient. OIG was also unable to substantiate that the facility refused to receive the patient via ambulance on multiple occasions. OIG found opportunities to align actual practice in the area of provider privileging with local facility and VHA policy. OIG recommended that the Facility Director: (1) ensure that staff comply with VHA and facility policies and practices related to the management of dysphagia, including assessment, and documentation of the patient's response to the provided care recommendations and aspiration risk precautions; (2) implement applicable recommendations from previous event-related reviews, if any; and, (3) review local credentialing and privileging processes to ensure compliance with VHA Handbook 1100.19. The VISN and Facility Directors concurred with the findings and recommendations.

Allegations of Chronic Cleanliness Issues at the Hunter Holmes McGuire VAMC, Richmond, Virginia, Not Substantiated

OIG conducted an inspection in response to complaints about EOC and the possible presence of mold in the Spinal Cord Injury and Disorders (SCI/D) units at the Hunter Holmes McGuire VAMC, Richmond, VA. The complainant alleged that chronic cleanliness issues were associated with patient reports of chronic respiratory problems and lost time from work for SCI/D staff, facility managers did not act to rule out the presence of black mold, and indoor air potentially contained high levels of mold in the SCI/D units. Senior leadership concealed this information. OIG did not substantiate the allegations. OIG found that the facility monitored cleanliness and cleaning processes and did not identify chronic cleanliness issues in the SCI/D units. OIG did not confirm effects on respiratory conditions of SCI/D patients or lost time for staff related to cleanliness issues in EOC. The facility sampled indoor air quality in March 2014 and acted on the mold level from one sample although no limits or standards for mold levels were established. The facility communicated air sampling results and actions taken to VISN leaders and external partners. OIG made no recommendations.

Review Does Not Substantiate Substandard Prostate Cancer Screening at VA Eastern Colorado HCS

At the request of Congressman Mike Coffman, OIG's OHI conducted an inspection to determine the quality of care provided to a patient who alleged that substandard prostate cancer screening delayed his diagnosis of prostate cancer at the VA Eastern Colorado HCS, Denver, CO. OIG did not substantiate that the patient received substandard prostate cancer screening. OIG found that guidelines for prostate cancer screening vary. During the time the patient was followed by VHA providers, prostate-specific antigen (PSA) testing without a digital (finger) rectal examination (DRE) for prostate cancer screening of an asymptomatic patient from 2010 to present was consistent with VHA guidance, U.S. Preventive Services Task Force, and 2013 American Urological Association guidelines, but differed from the 2009 American Urological Association Best Practice Statement. Test results in September 2011 showed that the patient had an elevated PSA level. A DRE performed in March 2012 revealed the patient had an enlarged prostate. Further testing later in March 2012 showed the PSA

level was within normal range. The patient had a urology visit in April, a prostate biopsy in May, and a referral to radiation oncology in June 2012. The patient was reportedly cancer free at the time of this review. OIG made no recommendations.

Inadequate Care, Inappropriate Cancellation of Consults at Kansas City, Missouri, VAMC

OIG conducted an inspection at the request of Representative Kevin Yoder in response to concerns about the extent to which a patient received timely and adequate care for PTSD and other health care needs at the Kansas City VAMC, Kansas City, MO. OIG did not substantiate the allegation that the patient was told he would have to wait 30 days for inpatient treatment for PTSD. OIG found that the patient had multiple health issues and had been screened for admission to another program and assigned an admission date to the other program 35 days after being screened. However, the patient died a few days after acceptance into the program. OIG substantiated that aspects of the patient's care were inadequate. In particular, OIG found that some requests for outpatient consultations were inappropriately cancelled or discontinued, the patient's abnormal findings and/or care needs were not fully assessed, and appropriate consults were not made when the patient was treated in the ED. Whether addressing these issues previously would have resulted in a different outcome for the patient is unknown. However, addressing these issues now will help facilitate a more patient-centered environment, especially for those veterans with complex medical and MH issues. Incidental to the review, OIG noted that because the VAMC did not have a signed release of information, staffs were unable to discuss the patient's care with a family member. OIG made one recommendation to the Interim USH and three recommendations to the Facility Director. The Interim USH and the VISN and Facility Directors concurred with OIG findings and recommendations.

Alleged Suicides and Inappropriate Changes to MH Treatment Program at Coatesville, Pennsylvania, VAMC

OIG conducted an inspection to assess the merit of allegations that two suicides may have occurred following the early termination of case management services, and two suicides may have occurred with the closure of a sub-acute psychiatric inpatient ward at the Coatesville VAMC in Coatesville, PA. OIG also assessed allegations that the VAMC did not follow VHA guidelines in closing or modifying other MH care programs. OIG did not substantiate that any patient suicides occurred due to early termination of case management or the closure of a sub-acute psychiatric inpatient ward. OIG found that the VAMC complied with VHA policy when it closed the beds on the ward. OIG did not substantiate that the changes were made without regard to patient safety. OIG did not substantiate that the consolidation of two Domiciliary Care for Homeless Veterans (DCHV) units violated VHA policy. OIG substantiated the allegation that admission criteria to the DCHV program were restrictive; however, the issue was identified during a VHA site visit and corrected. OIG substantiated that the VAMC's decision to close the Community Transition and Wellness Center violated VHA policy. OIG found that the VAMC did not transition the Community Transition and Wellness Center program to a Psychosocial Rehabilitation and Recovery Center as required by VHA policy. OIG recommended that the Facility Director coordinate with VHA leadership regarding the establishment of a Psychosocial Rehabilitation and Recovery Center.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) provides independent evaluations of VA's activities to ensure the integrity of its programs and operations. Staff perform audits, evaluations, reviews, and inspections of VA programs, functions, and facilities. This work addresses the areas of program results, economy and efficiency, finance, fraud detection, and compliance. OIG reports on current performance challenges and accountability to help foster good program management and financial stewardship, ensuring effective Government operations. Staff are involved in evaluating diverse areas such as the access and delivery of medical care, veterans' eligibility for benefits and benefits administration, resource utilization, financial and contract management, forensic auditing, fraud prevention, and information security. During the reporting period, OAE published 27 audits and evaluations of VA programs and operations, conducted 14 benefits inspections of VA Regional Office (VARO) operations, participated in one joint administrative investigation, and administratively closed 10 reviews.

Veterans Health Administration Audits and Evaluations

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

OIG Substantiates Whistleblower's Claims of Extensive, Persistent Problems in Veterans Health Care Enrollment Records, Atlanta, Georgia

At the request of the House Committee on Veterans' Affairs, OIG conducted a review of VHA's Health Eligibility Center (HEC) to evaluate the merit of allegations of mismanagement pertaining to a backlog of pending health care applications, veterans who died while their applications were pending, purged or deleted veteran health records, and unprocessed applications. OIG substantiated the existence of about 867,000 pending records that had not reached a final determination as of September 30, 2015. OIG also substantiated that pending records included entries for over 307,000 individuals reported as deceased by the Social Security Administration (SSA). However, due to limitations in the HEC's Enrollment System (ES) data, OIG could not reliably determine how many pending records existed as a result of applications for health care. This occurred because the enrollment program did not effectively define, collect, and manage enrollment data. In addition, VHA lacked adequate procedures to identify date of death information and implement necessary updates to the individual's status. OIG also substantiated that employees incorrectly marked unprocessed applications as completed and possibly deleted 10,000 or more transactions from the HEC's Workload Reporting and Productivity (WRAP) tool over the past 5 years. WRAP was vulnerable because the HEC did not ensure that adequate business processes and security controls were in place, manage WRAP user permissions, and maintain audit trails to identify reviews and approvals of any deleted transactions. In addition, the Office of Information and Technology (OIT) did not provide proper oversight for the development, security, and data backup retention for WRAP. OIT also did not collect and retain WRAP audit logs in accordance with VA policy. Finally, OIG substantiated that the HEC identified over 11,000 unprocessed health care applications and about 28,000 other transactions in January 2013. This backlog developed because the HEC did not adequately monitor and manage its workload and lacked controls to ensure entry of WRAP workload into ES. OIG provided recommendations to the USH to address ES data integrity issues, enrollment program policy limitations, and the access and security of the WRAP tool. OIG also provided recommendations to the Assistant Secretary of OIT to implement adequate security controls for the WRAP tool, and ensure the collection and retention of WRAP audit logs and system backups. OIG further recommended that the USH and Assistant Secretary of OIT confer with the Office of Human Resources (OHR) and the Office of General Counsel (OGC) to fully evaluate the implications of the

findings of the report, determine if administrative action should be taken against any VHA or OIT senior officials involved, and ensure that appropriate action is taken. The USH and Assistant Secretary of OIT concurred with OIG findings and recommendations.

Patient-Centered Community Care Contracts Cost VA $14.9 Million More Than if VA Used Non-VA Care Program To Purchase Same Health Care Services

In April 2014, OIG received a request from the U.S. House of Representatives Committee on Appropriations to review VA's FY 2014 Patient-Centered Community Care (PC3) costs and the $13 million cost savings estimate presented in VA's budget submission. OIG could not attest to the reliability and accuracy of VA information regarding the methodology and calculation of the PC3 cost savings estimate. OIG's analysis of available PC3 data determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate. OIG found that in FY 2014 PC3 cost about $14.9 million more than if VA had used the NVC program to purchase the same health care services. VA assumed that the PC3 contractors would develop adequate provider networks, VA medical facilities would achieve desired 25 to 50 percent contract utilization rates, and accrued PC3 cost savings for health care services would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent PC3 utilization rate in FY 2014. OIG recommended the Interim USH revise VA's PC3 cost analyses and address VA's low PC3 utilization rates. Additionally, OIG recommended the Executive Director, Office of Acquisition, Logistics, and Construction (OALC), ensure all required contract documents are maintained in the PC3 contract files.

Pervasive Dissatisfaction Found with PC3 Contracts, Vendors Returned 41 Percent of Authorizations for Patient Care to VA

OIG examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. OIG found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities OIG reviewed to stop using the PC3 program as intended. OIG projected PC3 contractors returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling. Blind scheduling occurred when PC3 contractors scheduled appointments without discussing the tentative appointment with the veteran. OIG determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submit timely authorizations and PC3 contractors schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. This was the second of a series of reports addressing PC3 service delivery issues. OIG is conducting additional reviews to evaluate the adequacy of the PC3 contract, provider networks, and the completeness of the medical documentation for PC3 payments. OIG will report these results separately. OIG recommended the Interim USH ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements.

Audit Finds VA's Contracted Care Networks Lack Medical Providers in Geographic Locations Where Veterans Need Them

OIG assessed the adequacy of PC3 provider networks developed under VHA contracts valued at approximately $9.4 billion. OIG found inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA spent $3.8 million of its $2.8 billion FY 2014 NVC budget (0.14 percent) on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its NVC expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks

that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because PC3 networks lacked needed specialty care providers, returned authorizations had to be re-authorized through NVC and increased veterans' wait times for care, and NVC provided veterans more timely care than PC3. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3, the CBO lacked an effective implementation strategy for the roll-out of PC3, and neither VHA nor the PC3 contractors maintained adequate data to measure and monitor network adequacy. OIG recommended the USH strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex healthcare initiatives.

VA's Contracted Care Network Did Not Provide VA Clinical Documentation Timely, VA Made $870K in Improper Payments

OIG estimates PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during our period of review from January 1, 2014, through September 30, 2014. OIG estimates that 48 percent of the clinical documentation was provided to VA late and 20 percent was incomplete. VHA made approximately $870,400 of improper payments when payments should not have been made prior to receiving complete clinical documentation. VHA did not apply contract penalties to Health Net Federal Services, LLC when it did not meet performance requirements related to the timely return of clinical documentation. VHA applied a penalty of only $753. The maximum allowable penalty was $15,909. If VA exercises the remaining 3 option years of the PC3 contract without adequately addressing the identified issues, VA could make about $5.5 million in improper payments and missed assessed penalties. OIG also found that PC3 patients experienced delays in VHA referring and following up on their care with TriWest Healthcare Alliance Corporation (TriWest), as well as TriWest not timely notifying VHA of three malignancy diagnoses resulting from colonoscopies. These issues occurred because VHA relied on contractor-reported data, lacked an adequate program for monitoring contractor performance, and a process to verify whether the contractor meets contract performance standards. As a result, VHA lacked assurance that PC3 is providing patients adequate continuity of care. OIG recommended VHA implement a mechanism to verify PC3 contractors' performance without relying on contractors' self-reported data, VHA ensure PC3 contractors properly annotate and report critical findings in a timely manner, and that VHA imposes financial or other remedies when contractors fail to meet requirements.

VA Contracted Care Network Referred Oncology Patients to Providers Who Did Not Meet Clinical Accreditation Standards, North Las Vegas, Nevada

OIG performed this review to determine the merits of allegations made to the OIG in November 2014. The complainant alleged that a VA Southern Nevada Healthcare System (VASNHS) employee limited the choice of providers for patients needing NVC for radiation oncology treatments and directed patients to one NVC provider because of a friendship with a physician associated with the provider's business. It was further alleged the VASNHS Chief of Staff directed staff not to refer patients to the NVC provider and the NVC provider had a previous contract that VA canceled due to poor performance. OIG did not substantiate the allegations. However, while reviewing these allegations OIG found TriWest, a PC3 contractor, referred 15 of 58 oncology patients to network practices that did not meet clinical accreditation standards established under the terms of the PC3 contract. OIG recommended the USH ensure that TriWest refers radiation oncology patients only to practices/facilities properly accredited under the terms of the contract, determine whether the PC3 contract needs to be amended, and to ensure patients receive radiation oncology treatments that meet VHA's standards of care.

OIG Finds VHA Could Better Use 25 Percent of Psychiatrists' Clinic Time To Improve Veterans' Access to MH

OIG conducted this audit to evaluate VHA's efforts to improve veterans' access to outpatient psychiatrists. OIG determined that VHA has not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. From FY 2012 through FY 2014, VHA increased outpatient psychiatrist full-time equivalents (FTEs) by almost 15 percent. During that time, the number of veterans' outpatient encounters with psychiatrists increased by roughly 10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased roughly 9 percent. OIG found that VHA did not have an effective method for establishing psychiatrist staffing needs. Throughout recent hiring initiatives, VHA did not stress a specific need for psychiatrists; instead, facilities determined their own staffing needs. This resulted in 94 of 140 health care facilities that needed additional psychiatrist FTEs to meet demand as of December 2014. In addition, OIG found that VHA did not ensure facilities used consistent and effective clinic management practices. Because of this, OIG determined that VHA facilities could have better used approximately 25 percent of psychiatrist FTE clinical time to see veterans in FY 2014, which equated to nearly $113.5 million in psychiatrists' pay. Over the next 5 years, this would equate to over $567 million if VHA does not strengthen clinic management now. OIG recommended the USH ensure facilities incorporate the Office of MH Operations staffing model to determine the appropriate number of psychiatrists needed, and attain appropriate staffing levels or identify alternative options. OIG also recommended the USH develop clinic management business rules, reassess the appropriateness of VHA's productivity target for psychiatrists, and develop a mechanism to monitor the variance in which psychiatrists code encounters. The USH concurred with OIG's findings and recommendations and plans to complete all corrective actions by September 2016.

St. Louis, Missouri, HCS MH Leadership Provided Insufficient Oversight for Consult Processing, Better Guidance Needed

OIG determined the merits of allegations received during May and June 2014. OIG substantiated the allegation that the St. Louis, MO, VA HCS inappropriately changed the status of consults to "Complete" prior to the provider actually completing the appointment with the patient. Starting in October 2013 and continuing through June 2014, a HCS employee inappropriately changed the status of 12 of 20 sampled consults (60 percent) to "Complete" before the provider completed the appointment. OIG found that St. Louis VA HCS MH Clinic leadership did not provide sufficient oversight for processing consults and the St. Louis VA HCS did not have well-defined guidance to ensure staff took appropriate actions when processing consults. In addition, OIG substantiated the allegation that St. Louis VA HCS psychiatrists received performance pay based on productivity data. OIG reviewed the FY 2013 performance pay assessments completed by the Associate Chief of Staff for MH for eight full-time outpatient psychiatrists and found they each received an average of $13,710 in total performance pay. Seven of the eight psychiatrists met or exceeded the productivity goal. As a result, each received an average of $2,920 for meeting the productivity goal. OIG determined that the one psychiatrist who did not meet the productivity goal received no performance pay for productivity, but he did receive 80 percent of the performance pay—a total of $11,896—because he met the other goals of his performance pay assessment. OIG recommended the Acting Director of the St. Louis VA HCS ensure staff receive appropriate training and guidance on consult management and perform a follow up analysis of completed consults to ensure they are not completed inappropriately. The Acting Director of the St. Louis VA HCS concurred with the OIG's report. The Acting Director's corrective actions were acceptable and OIG considers the recommendations closed.

Oklahoma City VAMC Inappropriately Discontinued Ophthalmology and Teleretinal Imaging Consults

OIG substantiated an anonymous allegation that Oklahoma City VAMC ophthalmology staff, teleretinal imaging staff, and referring providers acted inappropriately on discontinued consults. VAMC ophthalmology staff discontinued about 31 percent more consults than the national average in FY 2014 and about 42 percent more in FY 2015 (as of March 10, 2015). Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days. In addition, ophthalmology staff and referring providers did not take the necessary steps to refer the patients to NVC staff to obtain their medical care outside of the VA. Referring providers did not ensure that discontinued teleretinal imaging consults received the appropriate ophthalmology clinic follow-up. As a result of OIG's inquiries about inappropriate consult actions, Oklahoma City VAMC leadership initiated a follow-up review of ophthalmology consults discontinued from January 1, 2014, through March 3, 2015, and identified issues with 439 of 1,937 discontinued consults (about 23 percent). Ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well-defined guidance to ensure staff took appropriate actions when processing consults. OIG recommended the Interim Director of the Oklahoma City VAMC take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on initiating and processing consults.

OIG Recommends Strengthening Teleradiology Oversight at Central Arkansas Veterans HCS, Little Rock, Arkansas

OIG reviewed the Central Arkansas Veterans Healthcare System (CAVHS) Teleradiology Reading Center (TRC) to determine the merits of an allegation that radiologists stopped reading exams for CAVHS patients when they had reached their minimum Relative Value Unit (RVU) level and then performed fee-basis interpretations for other VA facilities during their tours of duty under a TRC agreement. OIG did not substantiate the allegation that CAVHS radiologists inappropriately performed fee-basis interpretations for other VISN 16 medical facilities during their scheduled duty hours. OIG's review of 7,657 interpretations between January 1, 2014, and June 30, 2014, determined that CAVHS radiologists conducted their TRC interpretations during non-duty hours. OIG did not find that radiologists stopped performing radiology interpretations for CAVHS patients when they had reached their minimum production level. However, OIG found VISN 16 could improve their controls to add more reliability to their determinations that radiologists performed TRC interpretations during non-duty hours. Of 7,657 interpretations, OIG identified 384 interpretations that appeared radiologists started or accessed during duty hours. OIG used data not accessed by VISN staff and identified the actual time radiologists dictated their interpretation. OIG determined radiologists made all 384 interpretations during non-duty hours. OIG also found that CAVHS radiologists' timecards did not accurately show their official weekend tour of duty and VISN 16 had not reviewed the TRC agreement in the past 5 years. OIG recommended the Interim VISN 16 Director review the time interpretations started and ended to ensure radiologists perform TRC interpretations during their non-duty hours, establish policy on an official tour of duty for weekend duty, and require annual certification of the TRC agreement.

Palo Alto, California, HCS Allowed Technology Firm's Staff Access to VA Patient Information Without Required Background Investigations

In October 2014, the House Commitee on Veterans' Affairs provided OIG a complainant's allegation that the VA Palo Alto Health Care System (PAHCS) Chief of Informatics entered into an illegal agreement with Kyron, a health technology company, to allow data sharing of sensitive VA patient information. This allegation involved veterans' personally identifiable information (PII), protected health information (PHI), and other sensitive information being vulnerable to increased risks of compromised confidentiality. Allegedly, sensitive VA patient information was transmitted outside of VA's firewall. The complainant also alleged Kyron

personnel received access to VA patient information through VA systems and networks without appropriate background investigations. OIG did not substantiate the allegations that the Chief of Informatics formed an illegal agreement with Kyron or that sensitive patient information was transmitted outside of VA's firewall. However, OIG substantiated the allegation that Kyron personnel received access to VA patient information without appropriate background investigations. OIG determined the Chief of Informatics, who was also the local program manager for the pilot program, failed to ensure Kyron personnel met the appropriate background investigation requirements before granting access to VA patient information. The Chief of Informatics also failed to ensure Kyron personnel completed VA's security and privacy awareness training. Further, the Information Security Officers (ISOs) failed to execute their required responsibilities by not providing PAHCS management and staff guidance on information security matters. More specifically, the ISOs did not coordinate, advise, and participate in the development and maintenance of system security documentation and system risk analysis prior to Kyron placing its software on a VA server. As a result, Kyron did not have formal authorization to operate its software on a VA server. OIG concluded the lack of coordination between the Chief of Informatics and ISOs in executing the Kyron agreement potentially jeopardized the confidentiality of veteran's PII, PHI, and other sensitive information. The Chief of Informatics admitted to proceeding with the pilot before obtaining documented support from the local ISOs. After the OIG informed PAHCS officials of the initial results in November 2014, they discontinued Kyron's personnel access to VA de-identified patient information until Kyron's personnel received VA completed background investigations, appropriate security, and privacy training.

Unclear Eligibility Requirements Has Resulted in Inequitable Access to VHA's Homeless Providers Grant and Per Diem Program

OIG conducted this audit to determine if VHA's Grant and Per Diem (GPD) program case management oversight ensures services to eligible veterans are provided in accordance with grant agreements. OIG found VHA's oversight of homeless providers' case management helped to ensure services were provided in accordance with grant agreements for those veterans in the program. However, eligibility requirements need to be clarified so all homeless veterans have equal access to case management services. OIG found 15 of 130 VA medical facilities (12 percent) within 6 different VISNs required veterans to be eligible for VA health care to participate in the GPD program. GPD policy only requires an individual to have served in the active military, naval, or air service, and been discharged or released under conditions other than dishonorable. The VHA Handbook and U.S. Code provide minimum active duty requirements to be eligible for VA health care benefits. VHA has been silent on addressing this additional eligibility requirement in its current policy. VHA has not aggressively pursued an OGC formal opinion and confusion at all program levels regarding eligibility requirements has resulted in inequitable access to case management services. In addition, OIG observed medication security issues at 5 of 22 providers (23 percent) OIG visited within 5 of the 6 medical facilities in our sample. This occurred because VHA and program providers did not ensure controls were sufficient to properly secure medications. As a result, veterans' health and rehabilitation are potentially at risk.

Review Finds VHA Misused $2.6 Million of Medical Support and Compliance Appropriations for Information Technology Project

OIG conducted this review to evaluate the merits of allegations that VHA mismanaged the Service-Oriented Architecture Research and Development (SOARD) pilot project. OIG substantiated an allegation that VHA misused Medical Support and Compliance (MS&C) appropriations to pay for SOARD instead of using congressionally-mandated information technology (IT) systems appropriations. This occurred because the former Assistant Deputy Under Secretary for Health for Administrative Operations inappropriately authorized $2.6 million of MS&C appropriations for SOARD. In addition, the former USH inappropriately approved an additional $48.8 million of MS&C appropriations to deploy Maximo, the underlying software for SOARD. OIT denied VHA's request for additional IT systems appropriations for SOARD, thus ending nationwide deployment

of Maximo before VHA could obligate the $48.8 million. Additionally, although OIT used Project Management Accountability System (PMAS) to manage SOARD, OIT lacked controls to prevent VHA's improper use of MS&C appropriations before using PMAS. OIG did not substantiate two other allegations. OIG recommended the Interim USH establish an oversight mechanism, remedy all MS&C appropriations used to pay for SOARD, and determine if VA should take administrative action against VHA senior officials involved in SOARD funding decisions. OIG also recommended the Executive in Charge of OIT obtain Chief Financial Officer certifications that VA is using proper appropriations to fund IT projects.

$43.1 Million in VHA Funds Went Unmanaged for 3 Years While Parked at the U.S. Government Printing Office

OIG received a Hotline allegation that VA had "parked" approximately $43 million in annual appropriations at the U.S. Government Printing Office (GPO) and that the funds remained unexpended with little activity since the transfer of funds in 2011. "Parking" refers to the transfer of funds to a revolving fund through an intra-agency agreement in an attempt to keep the funds available for new work after the period of availability for the funds expires. OIG initiated this review to determine if VA officials appropriately managed these funds. OIG substantiated that VA parked $43 million dollars at GPO for an excessively long period. VA had no contract or agreement with GPO on the specific need for these funds. OIG found that approximately $35.2 million of approximately $43.1 million remained unused at GPO as of July 2014 in a deposit account for enrollment communications. OIG identified approximately $5.6 million had been paid to the VA Supply Fund as service fees, despite there being no services rendered. In addition, VA only expended approximately $2.3 million over the 34-month period from October 2011 through July 2014, which was not used consistently with the intended need. OIG determined VHA CBO officials, in conjunction with VA Supply Fund officials, accepted almost $43.1 million of FY 2011 funds from within VHA without a bona fide need. CBO transferred approximately $43.1 million in FY 2011 appropriations to the Supply Fund to print and distribute tailored handbooks, but the funds were deposited in an unrelated account designated for enrollment communications at GPO. As such, CBO officials were able to use the funds in the GPO account at their discretion with no designated purpose. Supply Fund management acknowledged that they should not have accepted the funds without a bona fide need or charged fees on funds transferred through these accounts. OIG found that Supply Fund staff did not provide adequate fiscal oversight of the transferred funds. Supply Fund staff did not regularly review open obligations as required by VA policy or reconcile VA's financial accounting records with source documents related to the transferred funds. Thus, this funding went essentially unmanaged for 3 FYs. Then, in April 2014, Supply Fund management inappropriately changed the funds' obligation end dates without ensuring that the obligations were still valid. Further, OIG found a lack of transparency in VA's financial accounting records with respect to the change of obligation end dates. OIG concluded a breakdown of VA fiscal controls and a lack of oversight led to the parking of funds for an excessively long period and the failure to detect and properly use and manage these funds. VA financial and Supply Fund policies contain provisions on the management, use, and oversight of appropriated funds. However, the policies were not followed and there was a lack of supervisory review to ensure the policies were implemented properly. OIG recommended VA consult with its OGC to remedy the inappropriate expenditure of approximately $2.3 million of expired funds, take action to deobligate any outstanding balances as deemed appropriate, and evaluate the need for Supply Fund to refund the service fees valued at $5.6 million. OIG also recommended VA implement corrective actions to ensure fiscal controls are enforced to avoid future misuse of appropriated funds. OIG recommended VA review fiscal controls in the Financial Management System to ensure data integrity and an audit trail that reflects the occurrence and source of any accounting record changes. Finally, OIG recommended VA confer with OHR and the OGC to determine the appropriate administrative action to take, if any, against management for directing the misuse of approximately $43.1 million of FY 2011 appropriated funds. The Principal Executive Director for OALC agreed with our findings and recommendations and provided plans to implement acceptable corrective

actions. The Deputy Assistant Secretary for Finance also concurred and will put processes in place to track the history of new obligations. The Deputy Under Secretary for Health for Operations and Management concurred and will confer with OGC to determine the appropriate administrative action to take.

Incorrect Wage Rates at Hudson Valley HCS Results in Nearly $600K in Overpayments to 104 Employees in Calendar Year 2014, Montrose, New York

OIG evaluated the merits of an allegation that wage rates paid to Federal Wage Service (FWS) employees working at the Castle Point campus within the Hudson Valley Health Care System (HVHCS) were inappropriate. OIG substantiated the allegation that wage rates paid to FWS employees in the Engineering and Environmental Management Services at the Castle Point campus were incorrect. OIG found all 256 FWS employees in the Engineering and Environmental Management Services were assigned Montrose as their official duty station, regardless of whether they regularly performed their duties at Montrose or Castle Point. OIG determined that 104 of the 256 HVHCS FWS employees in the Engineering and Environmental Management Services performed their regular duties at the Castle Point campus during calendar year (CY) 2014. These 104 employees incorrectly received the higher Montrose wage rate instead of the correct wage rate for Castle Point. OIG found management officials in the Engineering and Environmental Management Services did not follow VA policy on determining employees' official duty stations. In addition, OIG found Human Resources oversight on ensuring the accuracy of official duty stations for employees was insufficient. OIG estimated HVHCS's use of inappropriate wage rates for the Castle Point FWS employees in the Engineering and Environmental Management Services resulted in overpayments of about $592,550 in CY 2014. If HVHCS does not correct the official duty station for the 104 employees, this could result in additional overpayments of about $3 million over the next 5 years. OIG recommended the Interim Director of VISN 3 ensure HVHCS management takes immediate steps to correct inappropriate wage rates paid to FWS employees and improve controls over the designation of official duty stations. OIG also recommended the Interim Director take steps to determine whether administrative actions are appropriate to hold HVHCS officials accountable.

Staff Purchased Excess Medical Supplies and Did Not Identify Inventory Discrepancies at the East Orange, New Jersey, VAMC

OIG evaluated the merits of allegations that Logistics Service at the East Orange VAMC purchased excess medical supplies resulting in mismanagement of Government resources and that a Logistics Service employee was misusing official time by leaving early every Friday. OIG substantiated the allegation that Medical Supply Distribution Section (MSDS) staff at the East Orange VAMC purchased medical supplies that were beyond normal stock levels. VHA policy defines a normal stock level as the maximum amount of an item that should be maintained in stock. During an inspection of primary storage areas at the medical center, OIG identified about 2,900 excess medical supply items valued at approximately $48,100. OIG reviewed inventory reports to determine whether additional excess medical supplies existed. However, OIG determined that the inventory reports were inaccurate, and as a result, OIG could not determine the extent of excess medical supplies at the East Orange VAMC. These inventory issues occurred because Logistics Service and MSDS management did not effectively monitor the staffs' management of the facility's medical supply inventories. Additionally, when they did identify inventory discrepancies, logistics staff did not determine why discrepancies were occurring. Without such action, the East Orange VAMC cannot implement corrective actions to account for its physical inventories or increase the accuracy of the information in their inventory system. OIG did not substantiate the time and attendance allegation. OIG recommended the Interim Director of VISN 3 ensure the VA New Jersey HCS take steps to improve medical supply inventory controls to minimize purchases of excess medical supplies.

Veterans Benefits Administration Audits and Evaluations

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

Audit of VA's Fiduciary Program Shows Growing Backlog of Field Exams To Assess Competency of Vulnerable Veterans

The Fiduciary Program was established to protect veterans and other beneficiaries who, due to injury, disease, or age, are unable to manage their VA benefits. Field examinations are a critical tool for VBA to assess the competency and welfare of these beneficiaries. OIG conducted this audit to assess whether the Fiduciary Program scheduled and completed field examinations within timeliness standards. OIG concluded VBA did not meet timeliness standards for about 45,500 (42 percent) of approximately 109,000 pending and completed field examinations during CY 2013. OIG followed-up by examining reported program performance for the first 9 months of CY 2014 and identified approximately 21,900 field examinations not completed and exceeding VBA timeliness standards, representing an approximately 15 percent increase. This occurred because Field Examiner staffing did not keep pace with the growth in the beneficiary population, and VBA did not staff the hubs (VA consolidated individual VARO fiduciary activities into six regional Fiduciary Hubs) according to their staffing plan. During CY 2013, the beneficiary population under the supervision of the Fiduciary Program grew 10 percent, while the number of Field Examiners assigned grew 2 percent. VBA's staffing plan set a target of 1 Field Examiner for every 325 beneficiaries. However, as of September 30, 2014, VBA employed 1 Field Examiner for every 386 beneficiaries supervised under the Fiduciary Program. Untimely field examinations placed approximately $360.7 million in benefit payments and about $487.6 million in estate values at increased risk. In addition, VBA did not schedule required field examinations for a projected 1,800 beneficiaries in CY 2013. Lapses in scheduling occurred because of inadequate management oversight. As a result, beneficiaries' well-being and approximately $36.1 million in benefit payments were placed at increased risk.

Unprocessed Documents for Nine Veterans' Claims Found in Shred Bins Awaiting Destruction at Los Angeles VARO

OIG substantiated that VARO Los Angeles staff were not following VBA policy on management of veterans' and other Governmental paper records. OIG found nine pieces of claims-related mail that VARO staff failed to properly process. Eight of the documents had the potential to affect veterans' benefits, while one had no effect on a veteran's benefits. Although OIG could not substantiate that the VARO inappropriately shredded some claims-related documents, OIG found sufficient evidence to conclude the VARO staff likely would have inappropriately shredded the nine documents OIG found. OIG's review determined that the Los Angeles VARO's implementation of VBA's established processes for the disposition of paper records were not adequate. OIG found that the Los Angeles VARO Records Management Officer (RMO) position was vacant from August 2014 until OIG's inspection in February 2015. This was because the VARO's Assistant Director had determined that it was not necessary to fill the RMO position when the incumbent was promoted. Not filling the RMO position eliminated the final certification in the VARO's authorized shredding process, which VBA established to prevent improper shredding of claims-related documents. If not for OIG's review, it is likely that the VARO staff would have inappropriately destroyed these nine claims-related documents OIG found. OIG recommended the VARO Director implement a plan and provide training to ensure all VARO staff comply with VBA's policy for handling, processing, and protection of claims-related documents and other Government records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect veterans' benefits. In order to determine whether this is an isolated problem or a systemic issue, OIG initiated surprise inspections at 10 selected VAROs across the nation. These 10 sites are Atlanta, GA;

Baltimore, MD; Chicago, IL; Houston, TX; New Orleans, LA; Oakland, CA; Philadelphia, PA; Reno, NV; San Juan, PR; and St. Petersburg, FL. OIG expects to publish a final report and offer additional recommendations for improvement once the results of the 10 VARO inspections are complete. OIG will request the Under Secretary for Benefit's (USB) comments and publish the Los Angeles VARO Director's action plan when OIG publishes the summary results of the surprise inspections.

Review of $1.3 Billion System Reveals Inadequate Cost Control, Unplanned Requirements Changes, and Inefficient Contracting

In February 2013, OIG reported VA could not provide reasonable assurance the Veterans Benefits Management System (VBMS) would meet its goals of increasing claims processing accuracy to 98 percent and eliminating the disability claims backlog by 2015. OIG conducted this follow-up review to determine how effectively VA is managing cost, performance, and schedule of VBMS development to meet its claims processing accuracy and backlog elimination goals. VA remained partially effective in managing VBMS development to help meet claims processing accuracy and backlog elimination goals. However, since September 2009, total estimated VBMS costs increased significantly from about $579.2 million to approximately $1.3 billion in January 2015. The increases were due to inadequate cost control, unplanned changes in system and business requirements, and inefficient contracting practices. As a result, VA could not ensure an effective return on its investment and total actual VBMS system development costs remained unknown. Amid evolving requirements, VBMS did not fully provide the capability to process claims from initial application to benefits delivery. Users lacked training needed to leverage the enhanced functionality provided. System response-time issues resulted from rapid software enhancements while system disruptions were due to inadequate service continuity practices. Until these issues are addressed, VA will continue to lack assurance of meeting its claims processing accuracy and backlog elimination goals by the end of 2015. OIG recommended the Executive in Charge of OIT, in conjunction with the USB, define and stabilize system and business requirements, address system performance problems, deploy required functionality to process claims end-to-end, and institute metrics needed to identify and ensure progress toward meeting stated goals.

VBA Not Taking Timely Action To Protect Veterans' Funds From Misuse by Those Entrusted To Manage Their Finances

OIG conducted this audit to determine whether VBA protects the VA-derived income and estates of beneficiaries who are unable to manage their financial affairs when misuse of beneficiary funds is alleged. VBA did not timely process 147 of 304 (48 percent) required actions associated with 122 beneficiaries or according to policy in response to allegations or indications of misuse of beneficiary funds during CY 2013. VBA also did not replace two fiduciaries who misused beneficiary funds. Specifically, VBA did not timely complete 117 of 265 (44 percent) required actions to determine if misuse of funds occurred in response to allegations and indications of beneficiary fund misuse; complete 30 of 39 (77 percent) required actions after VBA concluded misuse of funds occurred, such as reissuing (restoring) misused funds, performing effective collection actions, and completing internal negligence determinations; or replace two fiduciaries who misused beneficiary funds and allowed both to continue to manage the combined estates of 48 other beneficiaries. Fiduciary Hub management generally attributed untimely misuse actions to increases in Fiduciary Hub workload. Required actions after VBA concluded misuse of funds occurred were not completed due to a lack of policies and VBA staff not being clear about some policies. Also, VBA did not monitor or perform quality reviews of all misuse activities, which contributed to untimely and uncompleted misuse actions. If VBA does not timely complete misuse actions, beneficiary funds are at increased risk of misuse. OIG projects that during CY 2013, VBA did not timely complete required misuse actions to ensure the protection of 758 beneficiaries' VA-derived estates valued at about $45.2 million. VBA also did not restore approximately $2.1 million of misused beneficiary funds. Additionally, unless VBA improves the timeliness of actions in response to allegations and indications

of misuse, OIG projects VBA may not adequately protect annual benefit payments to beneficiaries valued at approximately $16 million or $80 million during CYs 2014 through 2018.

OIG Recommends Better Controls on Date Stamping Equipment and Refresher Training at Boston, Massachusetts, VARO

OIG substantiated that a Veteran Services Officer (VSO), accredited and employed by the Veterans of Foreign Wars (VFW), Department of Massachusetts, manipulated or attempted to manipulate dates of claims at the Boston VARO. OIG also found evidence indicating the VSO may have engaged in a similar manipulation scheme at the VARO in Togus, Maine. The VSO secretly date stamped multiple blank documents, providing the opportunity to cut, attach, and photocopy these dates onto claims documents for other claimants. Manipulation of dates of claims appeared to be a routine practice dating back to at least July 2013. OIG found approximately 25 benefits claims in the VSO's workspace that had not been submitted to the VARO for processing; with some of the claims dated back to October 2013. OIG could not identify claims where the VSO may have altered the actual dates of claim because there is no audit trail that tracks claims submitted by individual VSOs. Untimely processing by the VSO impedes the VARO's ability to initiate required development actions and results in veterans waiting longer for their claim to be processed. The VSO was able to manipulate dates of claims to cover up the untimely submission of claims because VARO management did not ensure only authorized staff accessed and used its date stamping equipment. Additionally, VARO management did not ensure the keys needed to unlock and operate date stamping machines were securely stored. Rather, keys were stored in unlocked desk drawers near the date stamping machines. Further, manipulation of dates of claims compromised the data integrity of claims processing timeliness and introduced delays in processing benefits claims. OIG recommended the USB implement plans to ensure only authorized staff at the Boston VARO use date stamping equipment and that they receive refresher training on securing date stamping equipment.

OIG Confirms Second Instance of Data Manipulation by a Houston, Texas, VARO Employee

On December 13, 2014, OIG received an allegation from VBA senior leadership in VA Central Office that a Houston VARO employee inappropriately removed veteran benefit claims controls from their electronic record. VBA uses electronic system controls to identify types of claims and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. Similarly, OIG received, and confirmed, an allegation of data manipulation at the Houston VARO several months earlier by another employee. However, the periods of each employee's alleged data manipulations did not overlap. OIG substantiated the most recent allegation that the employee inappropriately cancelled and cleared controls in the electronic record used to track and identify benefits claims without taking proper actions to complete the claims. VBA's internal review team determined the employee incorrectly cancelled and cleared system controls in 81 (89 percent) of 91 claims pending in FY 2013. The VBA team's review was limited to FY 2013, as a specific inventory goal was in place that year and the employee's number of cases cancelled in FY 2014 was determined to be significantly lower. OIG sampled 32 of the 81 (40 percent) cases and determined the internal review team accurately identified cases that were not completed properly. The employee conceded the actions were inappropriate and stated the actions were the result of attempts to improve the appearance of the pending claim inventory for the employee's team. Furthermore, the employee stated he had no knowledge of any other employees manipulating data. These inappropriate actions misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may never have received decisions on their claims if the VARO's internal review team had not discovered the improper actions by the employee. However, as VBA completed over 1.1 million claims in FY 2013 and the Houston VARO completed over 38,200 in FY 2013, the 81 cases determined to be incorrectly cancelled and cleared by the employee does not materially impair VBA's data integrity associated with its reported pending

workload of claims nationwide. Therefore, OIG recommended the Houston VARO Director take immediate action to correct, as appropriate, all actions the employee took to cancel and clear controls so that veterans claims are accurate moving forward. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee. Finally, OIG recommended the Director submit the remaining and previously unavailable claims the employee cancelled in FY 2013 to OIG for review.

OIG Finds Seattle, Washington, VARO Mismanaged Unprocessed Mail, Unnecessarily Proposed To Discontinue Unemployability Benefits

On March 6, 2015, OIG received allegations that Seattle, WA, VARO staffs were storing more than 1,000 pieces of unprocessed mail, primarily Employment Questionnaires, which were needed to continue individual unemployability (IU) benefits, for several months. The complainant alleged the mismanagement of Employment Questionnaires resulted in the transmission of hundreds of unnecessary notifications proposing to discontinue IU benefits. The complainant also alleged VARO management delayed taking any action to process the unprocessed mail. OIG substantiated VARO staff mismanaged unprocessed mail relating to IU benefits and unnecessarily proposed to discontinue IU benefits for 27 (20 percent) of the 132 employment questionnaires OIG reviewed. OIG did not substantiate the allegation that VARO management delayed taking corrective actions to address unprocessed mail—rather, the Director instructed staff to take immediate action to process the mail once he learned of the situation. Recommendations for improvement included convening administrative investigation boards to determine why VARO management was unaware that unprocessed mail had been stored within the Intake Processing Center (IPC) and why IPC staff did not seek assistance for processing employment questionnaires. OIG also recommended refresher training for staff with oversight and functional responsibility for mail processing. Further, OIG recommended that the USB ensure audit trails coexist with corrective action plans in all instances of mismanagement or data manipulation. VBA's Pacific District Director concurred in principle with OIG's first two recommendations but proposed an alternative to administrative investigation boards. OIG will monitor planned actions and follow up on their implementation.

OIG Finds Mismanagement and Distrust Impede Philadelphia, Pennsylvania, VARO Operational Effectiveness

In late May 2014, OIG began receiving a number of allegations through the OIG Hotline of mismanagement at the Philadelphia, PA, VARO. Many of these allegations included indicators that staff had a serious mistrust of VARO management. On June 19, 2014, OIG benefits inspectors, auditors, and criminal and administrative investigators began a comprehensive review of conditions at the Philadelphia VARO. Overall, OIG staff conducted over 100 interviews with VARO management and staff to assess the merits of multiple allegations of wrongdoing. OIG substantiated serious issues involving mismanagement and distrust of VARO management impeding the effectiveness of its operations and services to veterans. Overall, OIG made 35 recommendations for improvement at the Philadelphia VARO, encompassing mismanagement of VA resources resulting in compromised data integrity; lack of financial stewardship; and lack of confidence in management's ability to effectively manage workload, to include mail management and in protecting documents containing PII. There is an immediate need to improve the operation and management of this VARO and take actions to ensure a more effective work environment. Further, the extent to which management oversight has been determined to be ineffective and/or lacking requires VBA oversight and action. It is imperative to ensure VBA leadership and the VARO Director implement plans to ensure the unprocessed workload OIG identified is processed and to provide appropriate oversight that is critical to minimizing the potential future financial risk of making inaccurate benefit payments. This includes maintaining oversight needed to ensure all future workload is processed timely and ensuring the accurate and timely delivery of benefits and services.

Veterans Benefits Administration Benefits Inspections

The Benefits Inspection Program is part of OIG's efforts to ensure our Nation's veterans receive timely and accurate benefits and services. These independent inspections provide recurring oversight of VAROs, focusing on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the Benefits Inspection Program are to evaluate how well VAROs are accomplishing their mission of providing veterans with convenient access to high-quality benefits services and report systemic trends in VARO operations. Benefits Inspections also determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses. These inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders. The Benefits Inspection Divisions issued 14 reports during this reporting period, which are listed in Appendix A.

Overall, 18 percent of benefit claims OIG reviewed requiring a rating decision were processed in error. These errors involved claims related to temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, and special monthly compensation (SMC) and ancillary benefits. Further, VAROs did not timely process benefit reductions, causing improper payments to veterans.

Key findings included:

- Temporary 100 Percent Disability Evaluations: 26 percent of these claims were processed in error. OIG identified processing errors resulting in 995 improper payments to 51 veterans totaling approximately $1,891,000.
- TBI claims: 7 percent of these claims were processed in error. OIG identified processing errors resulting in 86 improper payments to 6 veterans totaling approximately $42,600.
- SMC and Ancillary Benefits: 22 percent of these claims were processed in error. OIG identified processing errors resulting in 1,016 improper payments to 42 veterans totaling approximately $737,000.
- Benefit Reductions: 33 percent of benefits reductions were delayed or incorrectly processed. OIG identified processing errors resulting in 856 improper payments to 126 veterans totaling approximately $895,000.

Other Audits and Evaluations

OIG performs audits of administrative support functions and financial management operations, focusing on adequacy of VA management systems in providing managers information needed to efficiently and effectively manage and safeguard VA assets and resources. OIG oversight work satisfies 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.

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

VA Did Not Comply With Two of Six Improper Payments Elimination and Recovery Act Requirements, Five Programs Did Not Meet Improper Payment Reduction Targets

OIG conducted the FY 2014 review to determine whether VA complied with the requirements of the *Improper Payments Elimination and Recovery Act* (IPERA), P.L. 111-204. VA reported improper payment estimates totaling approximately $1.6 billion in its FY 2014 Performance and Accountability Report (PAR) compared with $1.1 billion in its FY 2013 PAR. The increase was due primarily to higher estimated improper payments for the Compensation and Pension programs under VBA. VA did not comply with two of six IPERA requirements for FY 2014. VBA reported four programs that did not meet its reduction targets. VHA also reported a missed target for one program. Further, VBA did not meet the requirement to publish an improper payment estimate for one program because the estimate was not considered reliable. Additionally, VA's risk assessments should incorporate a stronger consideration of contracting risk. VBA and VHA should make improvements in their sample evaluation procedures. VBA's Compensation program crossed an Office of Management and Budget (OMB) threshold for potential designation as a high-priority program due to OIG's review identifying additional improper payments within the sample transactions. Thus, OIG increased the projection of the potential improper payment in VBA's Compensation program.

VA May Have Overpaid $3 Million Plus for Kentucky Land Purchase Then Misrepresented Information to Congress on Increase in Market Value

OIG reviewed VA's appraisal process in support of land purchased in Louisville, KY. OIG determined VA's OALC conducted two appraisals of the property in December 2010 and in February 2012. The first appraisal valued the property at $9,850,000. The second appraisal valued the property at $12,905,000. However, OALC did not obtain a required review appraisal, conducted by an independent third party, necessary for determining the appropriateness of the two appraisals prior to purchasing the land for $12,905,000. Instead, VA obtained the review appraisal at a cost of $2,477 nearly two years after the property was purchased. Spending $2,447 for the review appraisal was a waste of the taxpayers' money since the sale was complete and no further action could be taken based on the review appraisal. As a result, VA may have overpaid more than $3 million for this property. Furthermore, OALC misrepresented information provided to the House Committee on Veterans' Affairs regarding the 31 percent increase in market value. OALC reported the analysis of highest and best use of the property was revised from residential to mixed-use development. This was contrary to OIG's findings, as both appraisals state that the highest and best use of the property would be for mixed-use development.

Chief Financial Officers Act of 1990 Compliance

OIG contracted with an independent public accounting firm to audit VA's consolidated financial statements for FY 2014, in accordance with the *Chief Financial Officers Act of 1990*, P.L. 101-576. VA received an unqualified opinion, meaning that its financial statements were materially accurate. VA restated its FY 2013 financial statements for Cumulative Results of Operation and Unexpended Appropriations, although this had no effect on Total Net Position. As a result, the contractor replaced its FY 2013 auditor's report with its FY 2014 report on the restated financial statements. With respect to internal control, the contractor identified one material weakness, "IT Security Controls," which was a repeated condition. They also identified two significant deficiencies, "Financial Reporting" and "Accrued Operating Expenses." Additionally, the contractor reported that VA did not substantially comply with Federal financial management systems requirements and cited instances of noncompliance with Title 38 U.S. Code § 5315 and Title 31 U.S. Code § 3715, pertaining to the charging of interest and recovery of administrative costs. The contractor noted that VA was investigating two possible violations of the *Antideficiency Act*, P.L. 97–258, and is in the process of reporting two others. Three of these instances involved the combination of minor construction projects above the $10 million ceiling, beyond which

congressional approval for use of funds is required. The contractor also referenced an OIG report issued in FY 2014 citing less than full compliance by VA with IPERA.

Federal Information Security Management Act Compliance

In compliance with FISMA, the FY 2014 assessment determines the extent VA's information security program complied with FISMA requirements and applicable National Institute for Standards and Technology guidelines. OIG contracted with an independent accounting firm to perform this audit. VA has made progress developing policies and procedures but still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, this FISMA audit continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems. Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database, and server platforms VA-wide. Further, VA has not remediated approximately 9,000 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its information security posture. As a result, the FY 2014 consolidated financial statement audit concluded that a material weakness still exists in VA's information security program.

Federal Financial Management Improvement Act of 1996 Compliance

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208 (FFMIA), requires OIG 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 FY 2014 consolidated financial statements reported that VA did not substantially comply with the Federal financial management systems requirements of FFMIA. This condition was due to VA's complex, disjointed, and legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continued 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. These difficulties contributed to the material weakness of "IT Security Controls" and the significant deficiency of "Financial Reporting" noted in the audit report for VA's FY 2014 consolidated financial statements.

Joint Reviews and Settlements

OIG Finds Two VBA Senior Executive Service Members Misused Positions for Personal and Financial Gain, VBA Mismanaged Relocation Program

The Chairman and Ranking Member of the House Committee on Veterans' Affairs and the Chairman and Ranking Member of the Senate Committee on Veterans' Affairs requested the OIG investigate allegations concerning financial benefits and preference given at VA. An anonymous complainant alleged that Ms. Diana Rubens, Philadelphia VARO Director, improperly received $288,206.77 in relocation expenses for transferring from VBA Headquarters to her current position at the VARO and retained her high-level Senior Executive Service (SES) salary, despite the position being two levels lower on VA's SES pay scale. OIG was also asked to conduct a broader review of VA's Permanent Change of Station (PCS) Relocation program. Ms. Rubens was reassigned from her position as Deputy Under Secretary for Field Operations to the position of Director, Philadelphia VARO, effective June 1, 2014. VA paid $274,019.12 related to Ms. Rubens' PCS move. Relocation expenses paid for Ms. Rubens' move were generally allowable under Federal and VA policy; however, the OIG identified issues with the timeliness of VA's approval of Ms. Rubens' participation in the Appraised Value Offer program, as well as a 17-day extension for temporary quarters subsistence expense allowance. In addition, Ms. Rubens was reimbursed $76.50 for alcoholic beverages, which is prohibited, and $47 for meal and tip expenses that were not supported by required receipts. More importantly, OIG concluded that Ms. Rubens inappropriately used her position of authority for personal and financial benefit when she participated personally and substantially in creating the Philadelphia VARO Director vacancy and then volunteering for the vacancy.

During the course of the investigation, OIG identified a second instance of a senior executive's inappropriate use of her position. Ms. Kimberly Graves was reassigned from her position as the Director of VBA's Eastern Area Office to the position of Director, St. Paul VARO, effective October 19, 2014. VA paid $129,467.56 related to Ms. Graves' PCS move. OIG concluded that Ms. Graves also inappropriately used her position of authority for personal and financial benefit when she participated personally and substantially in creating the St. Paul VARO Director vacancy and then volunteering for the vacancy. Both Ms. Rubens' and Ms. Graves' reassignments resulted in a significant decrease in job responsibilities, yet both retained their annual salaries—$181,497 and $173,949, respectively. Based on Federal regulations, OIG determined that VA could not reduce their annual salaries upon reassignment despite the decrease in the scope of their responsibilities. However, a senior executive's annual salary can be reduced if the individual receives a less than fully successful annual summary rating; fails to meet performance requirements for a critical element; or, as a disciplinary or adverse action resulting from conduct related activity. OIG also reviewed records related to 23 VBA reassignments of employees who were either promoted to SES positions or were moved to different SES positions in FYs 2013, 2014, and 2015. Twenty-one of the 23 reassignments included salary increases. OIG determined that VBA management used moves of senior executives as a method to justify annual salary increases and used VA's PCS program to pay moving expenses for these employees. From FY 2010 to 2013, U.S. Office of Personnel Management guidelines precluded all SES employees from receiving annual pay increases. In FY 2012, the VA Secretary determined no VBA executives would receive performance awards based on concerns over the backlog of veterans' disability claims.

OIG identified salary increases that did not consistently reflect changes in the positions' scope of responsibility and that when VBA filled vacant SES positions the selectees often received significant annual salary increases over what their predecessors were paid. For example, one VARO Director received a salary increase of $30,417 or 22 percent more than his predecessor. Annual salary increases associated with these relocations totaled about $321,000, and PCS relocation expenses paid were valued at about $1.3 million. Additionally, VBA paid $140,000

in unjustified relocation incentives. In total, VA spent just over $1.8 million on the reassignments. OIG does not question the need to reassign some staff to manage a national network of VAROs; however, we concluded that VBA misused VA's PCS program for the benefit of its SES workforce. OIG made criminal referrals to the U.S. Attorney's Office, District of Columbia, regarding official actions orchestrated by Ms. Rubens and Ms. Graves. Formal decisions regarding prosecutorial merit are pending. OIG provided 12 recommendations to VA to increase oversight of the Department's PCS program and to determine appropriate administrative actions to take, if any, against senior VBA officials.

Allegations Regarding Quality of Care and Professional Conduct Not Substantiated, Contractual Issues Substantiated at the VA North Texas HCS, Dallas, Texas, Provided by the University of Texas—Southwestern Medical Center

In response to anonymous allegations, OIG conducted a review of cardiothoracic (CT) surgery and perfusion services provided by the University of Texas Southwestern Medical Center (UTSW) at the VA North Texas Health Care System (VANTHCS) in Dallas, TX. The allegations involved quality of care issues with regards to CT surgery, professional conduct of the CT surgeons, and contractual issues for CT surgery and perfusion services. The review was conducted by OIG's Office of Contract Review and OHI. OIG's review did not substantiate any of the allegations of poor quality of care or unprofessional conduct by the UTSW CT surgeons. However, OIG substantiated four issues with regards to UTSW contract for CT surgery and perfusion services. OIG found that VANTHCS has not had a long-term contract with UTSW for CT surgery since September 2010 and there is no evidence that prices paid to UTSW for CT surgery and perfusion services have been determined to be fair and reasonable. Management has concurred with OIG's findings and recommendations.

Office of Investigations

Veterans Health Administration Investigations

The Office of Investigations conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 103 cases; made 97 arrests; obtained over $2.2 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $2 million in savings, efficiencies, and cost avoidance; and recovered nearly $15,000.

During this reporting period, OIG opened 30 investigations relating to the diversion of controlled substances by VA employees, veterans, and private citizens. A total of 46 defendants were charged with various crimes relating to drug diversion. These investigations resulted in over $34,000 in court ordered payment of fines, restitution, penalties, and civil judgments; and nearly $718,000 in savings, efficiencies, cost avoidance, and recoveries.

OIG initiated four investigations related to the fraudulent receipt of health benefits, which resulted in seven arrests for various related crimes. These investigations resulted in nearly $1.9 million in fines, restitution, penalties, and civil judgments; and nearly $37,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OIG also initiates investigations related to beneficiary travel fraud involving VA patients, and any VA employees who conspire with them, who grossly inflate reported mileage to and from VA facilities in order to increase reimbursement for travel expenses. During this reporting period, OIG opened two investigative cases and made six arrests. The investigations resulted in over $92,000 in court ordered payment of fines, restitution, penalties, and civil judgments and $39,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

OIG opened eight investigations regarding criminal activities carried out by VHA employees (excluding crimes related to drug diversion). The types of crimes investigated included Workers' Compensation fraud, theft from veterans, and theft of VA property or funds. As a result of OIG work in this area, 15 defendants were charged with crimes. The investigations resulted in over $125,000 in court ordered payments of fines, restitution, and penalties as well as over $651,000 in savings, efficiencies, cost avoidance, and recoveries.

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

Former East Orange, New Jersey, VAMC Supervisor and Contractors Sentenced for Fraud and Bribery

A former East Orange, NJ, VAMC supervisory engineer was sentenced to 46 months' incarceration and 1 year of probation after pleading guilty to honest services wire fraud, wire fraud, and engaging in a monetary transaction in criminally derived property. Between 2007 and 2012, the VA supervisor accepted more than $1.2 million in kickback payments. In addition, a former East Orange, NJ, VA construction contractor was sentenced to 37 months' incarceration and 12 months' probation after pleading guilty to bribery and conspiracy to defraud the United States. Restitution and forfeitures are to be imposed at a later date for both defendants. An OIG, Federal Bureau of Investigations (FBI), and Internal Revenue Service (IRS) Criminal Investigations Division (CID) investigation revealed that the contractor paid $671,000 in bribes to the VA supervisor in order to fraudulently obtain $6 million in VA construction contracts, to include Service-Disabled Veteran-Owned Small Business (SDVOSB) contracts, and for failing to pay $250,374 in Federal income taxes. The contractor and VA supervisor conspired to set up three companies that were used to obtain VA contracts, one of which was a fraudulently claimed SDVOSB company. As part of the same investigation, the owner of another company

was previously sentenced to 2 years' probation, 6 months' home confinement, and ordered to pay a $2,000 fine after pleading guilty to bribing the same VA supervisor. The company's owner wanted favorable treatment on VA contracts and made a payment of $1,000 towards an agreed upon $5,000 bribe. A debarment decision now prevents the contractor from doing business with the Government.

Joint Investigation by OIG and FBI Results in Conviction of Design Contractor Who Received Inside Information from Former VA Executive

An architect, formerly employed by a VA contractor, was convicted at trial of conspiracy, wire fraud, mail fraud, theft of Government property, and of violating the Hobbs Act. An OIG and FBI investigation revealed that the defendant bribed the former Director of the Cleveland and Dayton VAMCs in order to receive non-public information concerning VA contracts. As a result, the defendant obtained an advantage over other companies in the awarding of approximately $750 million in VA contracts to his former employer. The former VAMC Director improperly obtained the information from the VA Office of Asset and Enterprise Management. The former VAMC Director has already pled guilty to corruption-related charges in a separate case and awaits sentencing.

West Palm Beach, Florida, VAMC Employee Sentenced for "Kickbacks"

A West Palm Beach, FL, VAMC employee, who was the chief of prosthetics, was sentenced to 9 months' incarceration, 6 months' home confinement, 1 year supervised release, and a $15,000 fine. An OIG investigation revealed that the defendant solicited and accepted over $71,000 in kickbacks from a durable medical equipment (DME) vendor to create fraudulent orders, which were never provided to veterans. For over 4 years, the defendant used his position at VA to steer over $2.2 million in DME orders to the vendor. Additionally, the defendant conspired with the vendor to create an orthotic shoe fitting business in which they agreed to split the profits. The loss to VA is approximately $143,019 for the fraudulent DME orders and $671,730 in overcharges.

Grand Jury Returns 50-Count Indictment Against Former Augusta, Georgia, VAMC Chief of Fee Basis Who Falsified Medical Consults

The former Augusta, GA, VAMC chief of fee basis was indicted on 50 counts and subsequently arrested for false statements related to health care matters. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 NVCC consults at the medical center. Specifically, the defendant directed his subordinates to falsely document, "Services provided or patient refused services," in the patients' VA EHR even though employees had not reviewed the records or contacted the patients. OIG's OHI conducted a review of the approximately 2,700 patient records and determined that 500 patients never received care and/or refused services.

Sacramento, California, VAMC Engineer Pleads Guilty to Receipt of a Gratuity by a Public Official

A Sacramento, CA, VAMC engineer pled guilty to receipt of a gratuity by a public official. An OIG and FBI investigation revealed that the engineer, while acting as a Contracting Officer's Representative on several VA construction projects, accepted from a VA contractor two Disneyland vacation packages, a new Ford F-150 pickup truck, and at least $25,000 in cash. After providing the illegal gratuities to the defendant, the VA contractor received favorable treatment from VA. Upon signing the plea agreement, the engineer resigned in lieu of termination.

Former Madison, Wisconsin, VAMC Employee Sentenced for Identity Theft

A former Madison, WI, VAMC employee was sentenced to 18 months' incarceration (stayed) and 5 years' probation after pleading guilty to misappropriating an identity to obtain money and theft. An OIG and local

police investigation revealed that the defendant stole the PII of deceased veterans while employed at the medical center and used the information to open credit card accounts.

Long Beach, California, VAMC Employee Arrested for Criminal Threats

A Long Beach, CA, VAMC employee was arrested for criminal threats. An OIG and VA Police Service investigation revealed that the defendant made threats against a VA employee who had accused him of sexual harassment/battery and also made threats against a witness. The defendant resigned in lieu of termination.

Miami, Florida, VAMC Nurse Arrested for Obstruction and Altering Computer Records

A Miami, FL, VAMC nurse was arrested after being indicted for obstruction and altering VA computer records. An OIG investigation revealed that the defendant manipulated patient data and withheld information from physicians that caused the patient, who was in a Surgical ICU, to be discharged to a less acute care unit, where the patient later died. The defendant altered the patient's record to reflect that their vital signs were stable, when in fact they were not, and failed to provide medications to the patient that were prescribed by the treating physicians. The investigation further revealed that the defendant made additional alterations to the patient's record after his death in order to conceal the patient's true condition and to obstruct an administrative inquiry into the patient's death.

Former Ann Arbor, Michigan, VA Canteen Chief Arrested for Theft of Government Funds

A former Ann Arbor, MI, VA canteen chief was arrested for theft of Government funds. An OIG investigation revealed that the defendant embezzled more than $150,000 in cash from the canteen. The total loss to VA in this case is approximately $478,000.

Northport, New York, VAMC Pharmacist Arrested for Theft of Government Property

A Northport, NY, VAMC pharmacist was arrested for theft of Government property. An OIG and VA Police Service investigation revealed that the defendant diverted a variety of non-controlled substances, to include blood pressure medication, cholesterol medication, and anti-nausea medication from the VAMC. The defendant admitted to the theft of pharmaceuticals from VA for many years, and a subsequent search of his residence resulted in the recovery of more than 30 stock bottles of medicines intended for VA patients.

Former Memphis, Tennessee, VAMC Employee Arrested for Purchase Order Fraud

A former Memphis, TN, VAMC employee and another subject were indicted and subsequently arrested for conspiracy, theft of Government funds, wire fraud, and engaging in monetary transactions of property derived from specified unlawful activity. An OIG and VA Police Service investigation revealed that the defendants conspired to create a fraudulent pharmaceutical supply company that was operated from the non-veteran's FedEx office. From 2008 to 2013, the defendants submitted hundreds of duplicate fraudulent purchase orders to VA, resulting in a loss of approximately $1.1 million.

West Roxbury, Massachusetts, Campus Contractor Pleads Guilty to Wire Fraud

A VA contractor pled guilty to wire fraud after an OIG investigation revealed that from October 2012 to October 2014 the contractor and a VA employee, who was also charged with wire fraud, conspired to order goods and services that were not needed and were never provided to the Boston HCS – West Roxbury, MA, campus. The VA employee, who was responsible for the maintenance and IT support of medical equipment, created the false purchase orders and paid the contractor using his VA-issued credit card. The investigation determined that for at least 82 purchases, the VA paid the contractor and his company a total of $222,242. The employee and contractor then divided the proceeds.

Former Philadelphia, Pennsylvania, Nursing Assistant Sentenced for Billing Fraud

A former certified nursing assistant at the Philadelphia, PA, VAMC was sentenced to 6 months' home confinement with electronic monitoring, 5 years' supervised release, and ordered to pay VA $45,063 in restitution. An OIG and VA Police Service investigation revealed that from May 2012 to September 2013 the defendant attempted to receive over $125,000 by double billing the medical center for his services.

Asheville, North Carolina, VAMC Employee Sentenced for Purchase Card Fraud

A VA employee was sentenced to 13 months' incarceration, 3 years' supervised release, and ordered to pay $43,816 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant, who was employed as a purchasing agent at the Asheville, NC, VAMC, utilized and allowed others to utilize his VA purchase card to buy personal items. Items were bought online and from local merchants, including a truck for his personal use.

Long Beach, California, VAMC Pharmacy Technician Indicted for Tampering with Consumer Products and Possession of Controlled Substances by Deception

A Long Beach, CA, VAMC pharmacy technician was indicted for tampering with consumer products and possession of controlled substances by deception. An OIG investigation revealed the employee diverted Vicodin, Soma, and morphine. The employee also admitted to diverting a large quantity of fentanyl while compounding intravenous (IV) medications or by withdrawing 10–12 percent of the fluid from fentanyl IV bags. The reduced quantity of fluid in the tainted IV bags was later administered to patients. Additionally, the employee admitted to using diverted narcotics while on duty.

Pittsburgh, Pennsylvania, VAMC Contract Specialist Pleads Guilty to Theft of Government Funds

A Pittsburgh, PA, VAMC contract specialist, who is currently under suspension, pled guilty to theft of Government funds. An OIG and VA Police Service investigation revealed that the employee used a VA-issued Government purchase card to make 29 unauthorized transactions for personal use. The transactions, for merchandise and gift cards, totaled $28,361.

Non-Veteran Pleads Guilty to Health Care Fraud

A non-veteran pled guilty to health care fraud. An OIG investigation revealed that the defendant falsely claimed to have served from 1996 to 2010 in the Army National Guard, to have suffered from PTSD, and to have served in combat during two tours in Afghanistan. In actuality, the defendant never served in the military and was incarcerated during the time period that she claimed to have been in the military. For over 2 years, the defendant received over $20,000 in VA health care benefits in addition to NVC paid by VA. The defendant also fraudulently received more than 10,000 milligrams of oxycodone from VA. Soon after the defendant admitted to the fraudulent activity, she fled to New Mexico where she was apprehended by the U.S. Marshals Service and extradited to New Hampshire. The defendant is being held pending further judicial action.

Non-Veteran Sentenced for Health Care Fraud

A non-veteran was sentenced to 3 years' probation and ordered to pay $48,169 in restitution after pleading guilty to making a false claim for benefits. An OIG and Defense Criminal Investigative Service (DCIS) investigation revealed that the defendant fraudulently received $48,169 in medical care from the Miami, FL, VAMC that he was not entitled to receive. The defendant also fraudulently applied for VA disability and compensation benefits numerous times, although no benefits were actually paid.

Non-Veteran Arrested for Theft of Health Care Benefits

A non-veteran was arrested for theft in connection with health care, theft of Government property, fraudulent demand against the United States, and fraudulently holding oneself out to be a recipient of military decorations or medals. An OIG investigation revealed that the defendant falsely represented himself as both a United States Marine Corps and California Army National Guard veteran in order to obtain VA health care benefits. The loss to VA is $13,623.

Former Greenville, North Carolina, VA Health Care Center Physician Indicted for Fraudulently Obtaining a Controlled Substance

A former Greenville, NC, VA Health Care Center physician was indicted for obtaining a controlled substance by fraud or forgery. An OIG, Drug Enforcement Agency (DEA), local police, and North Carolina State Medical Board investigation revealed that the former VA physician had an inappropriate relationship with a veteran while employed by VA, and after leaving VA employment the physician continued to prescribe controlled medications to the veteran using VA prescription pads. Both the physician and the veteran received controlled substances from the prescriptions that were filled at outside pharmacies. The physician surrendered her medical license and DEA number as a result of this investigation.

Two Former Muskogee, Oklahoma, VAMC Employees and Two Other Subjects Plead Guilty to Drug Conspiracy

Two former Muskogee, OK, VAMC employees and two other subjects pled guilty to drug conspiracy. An OIG and DEA investigation revealed that a former VAMC employee stole VA prescription pads from the medical center and used those pads to illegally obtain prescription pills. The former employee organized a loose affiliation of friends and associates to obtain and distribute these narcotics throughout southeast Oklahoma.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 18 months' incarceration after pleading guilty to possession with intent to distribute a Class A and Class B substance (heroin and amphetamine). An OIG, DEA, and VA Police Service investigation revealed that the defendant, while residing at the Bedford, MA, VAMC, sold prescription and illicit drugs to veterans who were receiving treatment for substance abuse. During the time the defendant was selling drugs at the VAMC, he was on pretrial release after being charged with armed bank robbery. The investigation was initiated based on a history of illicit drugs being used at the VAMC, recent drug overdoses, and the concerns of medical staff that the sale and use of drugs was interfering with substance abuse treatment.

Non-Veteran Arrested for Criminal Possession of a Controlled Substance

A non-veteran was arrested for criminal possession of a controlled substance. An OIG, VA Police Service, and Ontario County Sheriff's Office investigation revealed that the defendant intended to sell drugs to a veteran who was going through addiction counseling at the Canandaigua, NY, VAMC.

Former White River Junction, Vermont, VAMC Canteen Chief Charged with False Pretenses and Embezzlement

A former White River Junction, VT, VAMC canteen chief was charged with false pretenses and embezzlement. An OIG investigation revealed that from June 2013 to August 2013 the defendant stole approximately $1,200 from the facility's various funds and canteen safe. The defendant resigned from her position while under investigation.

Veteran's Wife Sentenced for Attempted Murder

A veteran's wife was sentenced to 15 years' incarceration for attempted murder. An OIG, VA Police Service, and local law enforcement investigation revealed that the veteran had been treated numerous times at the Mountain Home, TN, VAMC for unexplained life threatening illnesses, with indications of elevated levels of barium carbonate (used in rat poison). During the initial investigation into the possible poisoning, the defendant lured her husband behind their home, shot him in the back, and left him for dead. The victim survived and a subsequent search of the defendant's residence resulted in the discovery of evidence that indicated that the defendant had in fact been poisoning her husband.

Veteran Indicted for Child Pornography

A veteran was indicted on multiple charges of illegal use of a minor in nudity-oriented material or performance. An OIG investigation revealed that the defendant, while a resident at the Cleveland, OH, VAMC domiciliary, used a computer located in the domiciliary computer lab to view child pornography. A search warrant executed on the defendant's personal computer tablet showed the defendant also used that device to view child pornography.

Northampton, Massachusetts, VAMC Nursing Assistant Charged with Assaulting Disabled Veteran

A Northampton, MA, VAMC nursing assistant was charged with assaulting an elderly disabled veteran. An OIG and VA Police Service investigation revealed that the defendant forcefully took the veteran to the ground during a psychiatric intervention causing injury. The defendant continued to verbally and physically assault the veteran after the patient had been taken to his room.

University of California, Los Angeles, Anesthesiologist Sentenced for Drug Diversion

A University of California, Los Angeles (UCLA), anesthesiologist was sentenced to 2 years' probation, a $10,000 fine, and ordered to undergo drug testing after pleading guilty to theft of Government property and possession of a controlled substance. In addition, the California Medical Board adopted a stipulated civil settlement and disciplinary order between the anesthesiologist and the California Attorney General's Office involving gross negligence, incompetence, use of dangerous drugs, and unprofessional conduct. The civil agreement required the anesthesiologist to be placed on probation for 5 years, which included random drug testing, ethics training, psychiatric evaluation, psychotherapy, professional monitoring, and other requirements. An OIG investigation revealed that during a rotation at the West Los Angeles, CA, VAMC, and while providing anesthesia care to a veteran in surgery, the anesthesiologist collapsed in the operating room due to ingestion of three tablets of clonazepam and self-injection of ketamine, midazolam, and fentanyl. The defendant was found on the floor with a tourniquet around his wrist and empty vials of the controlled substances near him. The investigation determined that the defendant diverted the drugs from the VAMC. During sentencing, the anesthesiologist admitted placing the patient's life in danger.

Lyons, New Jersey, VAMC Drug Distribution Investigations Result in Multiple Convictions

A 2-year VA OIG, FBI, and VA Police Service investigation, named *Operation Red, White, and Blue Magic* (OP RWB), was concluded. OP RWB resulted in seven defendants with extensive criminal histories being prosecuted on Federal drug distribution charges. The investigation was initiated following the death of a veteran at the Lyons, NJ, VAMC from a drug overdose. Five out of the seven defendants were VA employees and all seven subjects pled guilty. Along with receiving probation and monetary penalties, six of the seven defendants were sentenced to incarceration. Due to the success of OP RWB, Operation Jersey Vice (OP JV) was initiated. This investigation continued the pursuit of individuals selling illegal drugs on VA property. The case resulted in

the successful prosecution of four defendants. OP RWB and OP JV led to four additional independent and successful investigations, including illegal drug activity and loan sharking.

Veterans and Other Subjects Arrested for Drug Distribution at the Philadelphia, Pennsylvania, VAMC

As part of "Operation Sentinel," 10 veterans were arrested for the distribution of heroin, oxycodone, Percocet, and methadone at the Philadelphia, PA, VAMC. Also, two additional subjects are being sought on outstanding arrest warrants; four other subjects will be issued U.S. District Court Violation Notices. A VA OIG, PA State Police, and VA Police Service investigation determined that the defendants were selling heroin and their VA-prescription medication to other veterans receiving treatment at the medical center. The investigation was initiated after a veteran seeking to overcome his drug addiction was pressured by the defendants to purchase narcotics at the VAMC and to sell them his VA prescription medication.

Non-Veteran Arrested for Drug Distribution Through the Bronx, New York, VAMC

A non-veteran was arrested after being indicted for his involvement in the distribution of cocaine through the Bronx, NY, VAMC. An OIG, U.S. Postal Inspection Service, DEA, and VA Police Service investigation resulted in the identification of the subject's fingerprints on the interior packaging of five parcels mailed from San Juan, PR, to the VAMC. Each parcel contained 1–2 kilograms of cocaine.

Two VA Employees and Others Arrested for Drug Distribution at the Long Beach, California, VAMC

Operation Diverted Dreams, which is a multi-agency drug investigation, has resulted in the arrest of 24 defendants, including two VA employees, who were charged with selling heroin, methamphetamine, marijuana, crack cocaine, oxycodone, Percocet, fentanyl, and tramadol at the Long Beach, CA, VAMC. A handgun and a fully automatic SKS rifle were also sold to undercover officers during the investigation.

Two West Haven, Connecticut, VAMC Employees Arrested for Selling Narcotics and Endangering the Welfare of a Child

Two West Haven, CT, VAMC Food and Nutrition Service employees were arrested for selling narcotics and endangering the welfare of a child. An OIG and Statewide narcotics task force investigation determined that the defendants sold heroin during an undercover operation at the medical center. One of the employees had her 3-year-old child with her when she delivered the heroin to the other employee to sell.

Veterans Sentenced for "Doctor Shopping"

A total of 22 cases were adjudicated against veterans who were indicted for obtaining prescription medication by fraud, deceit, or subterfuge, and theft of Government property. Twenty of the veterans entered the Pretrial Diversion Program, one veteran was sentenced to 1 year of probation, and the remaining veteran received a time served sentence. The sentences were the result of an OIG investigation that revealed that the veterans were simultaneously obtaining controlled medication from the Greenville, SC, CBOC and outside sources.

Former U.S. Postal Service Employee and Spouse Indicted for Theft of VA Drugs

A former U.S. Postal Service (USPS) employee and his spouse were indicted and arrested for conspiracy to possess stolen U.S. mail, theft of VA mail packages, and conspiracy to possess hydrocodone to distribute. An OIG and U.S. Postal Inspection Service investigation determined that the defendants diverted approximately 552 VA drug packages from the USPS Hub in Memphis, TN. The packages were destined for the Jackson, MS, area but were redirected to Alabama by the defendant for distribution and resale. The loss to VA is $22,342.

Veterans Arrested for Theft of VA Property

Two former veteran inpatients at the Coatesville, PA, VAMC were charged with theft by unlawful taking or disposition, receiving stolen property, and criminal conspiracy. An OIG, VA Police Service, and local law enforcement investigation determined that from April 2012 to February 2013 the defendants stole approximately 890 pounds of various metallic plumbing supplies from the medical center and sold them to scrap yards in two different cities. The loss to VA is approximately $34,000.

Six Veterans Plead Guilty to VA Travel Benefit Fraud, West Palm Beach, Florida, VAMC

Six veterans pled guilty to false statements, and one veteran was convicted at trial of false statements and theft of Government funds. The aggregate sentences amounted to 4 months' incarceration, 252 months' probation, and $74,889 in restitution. An OIG investigation revealed that the defendants submitted fraudulent travel vouchers using incorrect and/or fictitious addresses, indicating that they were traveling much farther distances to and from the West Palm Beach, FL, VAMC in order to receive greater travel benefit reimbursements. The total loss to VA is $116,870.

Veteran Pleads Guilty to VA Travel Benefit Fraud, Montrose, New York, VAMC

A veteran pled guilty to grand larceny relating to beneficiary travel fraud. A VA OIG, New York State Medicaid OIG, and New York District Attorney's Office investigation revealed that on 513 occasions the defendant claimed and received Medicaid-paid transportation to and from the Montrose, NY, VAMC while also being reimbursed for travel by VA. The loss to VA is $19,733.

Veteran Indicted for VA Travel Benefit Fraud

A veteran was indicted for theft after an OIG investigation revealed that for over 9 months he filed 115 false travel vouchers. The defendant claimed to have repeatedly travelled 224 miles roundtrip to attend his medical appointments; however, he was living less than 4 miles from the Spokane, WA, VAMC. The loss to VA is $10,877.

Veterans Benefits Administration Investigations

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

OIG's IT and Data Analysis Division, in coordination with the Office of Investigations, conducts an ongoing proactive Death Match project to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. During this reporting period, OIG opened 217 investigations, which resulted in 33 arrests and $5.9 million in recoveries. Since the inception of the Death Match project in 2000, OIG has identified 18,535 possible cases with over 3,962 investigative cases opened. Investigations have resulted in the actual recovery of $88.4 million, with an additional $32.1 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $188.6 million. To date, there have been 734 arrests on these cases with additional cases awaiting judicial action.

In the area of monetary benefits, OIG opened 286 cases; made 89 arrests; obtained over $5.1 million in court ordered payment of fines, restitution, penalties, and civil judgments; achieved over $15.6 million in savings, efficiencies, and cost avoidance; and recovered more than $6.6 million. One hundred and fifty-five of these investigations involved the fraudulent receipt of VA monetary benefits including deceased payee, fiduciary fraud, identity theft, and beneficiaries fraudulently receiving these benefits. Various criminal charges were filed against 84 defendants for these types of investigations. OIG obtained $5.1 million in court ordered payment of fines, restitution, and penalties and achieved an additional $22.2 million in savings, efficiencies, cost avoidance, and recoveries.

Husband and Wife Convicted of Embezzling VA Education and Charitable Funds

A husband and wife were convicted at trial of embezzling VA education and charitable funds that were intended to provide job training, benefits, and equipment for injured Marines returning from Iraq and Afghanistan. An OIG and IRS CID investigation revealed that from 2007 to 2009 the defendants were directors of a tax-exempt foundation that trained injured veterans for careers in the film industry. The defendants conspired to defraud VA by submitting false claims in order to receive funds for training and equipment that were never provided. Also, although the defendants claimed to have donated over $200,000 to start the foundation, they took over $400,000 from the foundation's accounts. The defendants routinely commingled the finances of the foundation with their personal finances, thereby obstructing the ability of the IRS to monitor the foundation's tax-exempt status and to determine the defendants' personal income tax liability. The loss to VA is $213,176.

Former VA Fiduciaries Indicted for Misappropriation by a Fiduciary

A former VA appointed fiduciary, who was also an administrator of a nursing home, was indicted for misappropriation by a fiduciary. An OIG investigation determined that the defendant embezzled more than $313,000 from a veteran's benefit payments. A second former VA fiduciary was indicted for theft of Government funds. An OIG investigation determined that the defendant stole $69,686 in VA funds intended for a veteran and used the money for personal expenses.

Former VA Fiduciary Arrested for Wire Fraud and Theft of Government Funds

A former VA fiduciary was indicted and arrested for wire fraud and theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole $259,563 of VA and SSA benefits from a disabled veteran. During the time the fiduciary embezzled the funds, he knew that the veteran lived in a state veteran's home. Gold and silver coins purchased with the stolen funds were recovered during a search of the defendant's residence.

VA Fiduciary Arrested for Criminal Mistreatment and Theft

A VA fiduciary assigned to over 80 veterans was indicted and arrested for criminal mistreatment and theft. A VA OIG, SSA OIG, and Oregon Department of Justice's Medicaid Fraud Control Unit investigation revealed that the defendant overcharged her clients, deposited checks intended for veteran clients into personal and business accounts, and failed to provide final estates to surviving heirs of deceased clients. The total loss to the beneficiaries is approximately $211,000.

VA Fiduciary Sentenced for Misappropriation by a Fiduciary

A VA fiduciary was sentenced to 366 days' incarceration, 3 years' supervised release, and was ordered to pay restitution of $159,961 after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed that the defendant stole funds and personal property from his VA and non-Federal clients for whom he served as a state-appointed conservator.

VA Fiduciary Pleads Guilty to Misappropriation by a Fiduciary

A VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation revealed that for over 5 years the defendant embezzled $141,734 from 22 veterans by setting up a sham health care company and opening a bank account in its name in order to receive funds from veterans, taking excessive cash withdrawals on veterans' accounts, transferring VA funds from one veteran's account to other veterans' accounts in a Ponzi-style scheme, and taking excessive fiduciary fees from veterans.

VA Fiduciary Sentenced for Theft

A VA court-appointed fiduciary was sentenced to 15 months' incarceration, 12 months' supervised release, and was ordered to pay restitution of $321,512 after pleading guilty to theft of Government property, Social Security representative fraud, and criminal forfeiture related to allegations of theft. A $320,000 Forfeiture Money Judgment was also issued, and an order of Disbarment was filed. A VA OIG and SSA OIG investigation revealed that the defendant failed to provide fiduciary accountings to VA and misused over $89,636 in VA funds issued to an incompetent veteran.

Fiduciary Indicted for Theft

The brother of a veteran who is unable to manage his financial affairs was indicted for theft of Government funds. An OIG investigation revealed that the defendant, while acting as his brother's fiduciary, embezzled VA benefits for his own use. The loss to the veteran is $26,405.

Former VA Fiduciary Sentenced for Theft by Conversion

A former VA fiduciary was sentenced to 10 years' probation and ordered to pay VA restitution of $15,747 after pleading guilty to theft by conversion. An OIG investigation revealed that the defendant, appointed as a VA fiduciary to manage a veteran's financial affairs, diverted VA funds for his own use.

VA Beneficiary's Granddaughter Sentenced for the Financial Exploitation of a Vulnerable Adult

A VA beneficiary's granddaughter was sentenced to 1 to 2 years' incarceration (suspended), 2 years' probation, 40 hours' community service, and ordered to pay restitution of $41,567 after pleading guilty to the financial exploitation of a vulnerable adult. An OIG and state Attorney General's Office investigation revealed that the defendant stole over $40,000 of her grandmother's funds, to include $23,830 of VA benefits. The victim, who received VA widow's benefits, suffered from dementia and resided in a nursing home. The victim died during the investigation.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for theft of Government funds. An OIG and SSA OIG investigation revealed that the defendant had been in receipt of VA compensation benefits and SSA benefits since 1997, claiming loss of use of both hands and feet due to Multiple Sclerosis. While allegedly suffering from his level of reported disability, the defendant lived an active lifestyle to include participating in a 2008 "Marine Corps Mud Run," playing adult league baseball from 2006 through 2012, working as both a personal fitness trainer and a weight trainer for a high school football team, and assisting with football games. Additionally, surveillance showed the defendant using a wheelchair during VA appointments and then ambulating without aids at area restaurants and bars. The loss to VA is $1,545,890, and the loss to SSA is $133,107.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted and arrested for wire fraud after an OIG and FBI investigation revealed he misrepresented the extent and severity of his disabilities in order to obtain VA benefits, including funds for the installation of a swimming pool and purchase of an automobile. From 1995 to 2015 the veteran falsely represented to VA that he had significant loss of vision, requiring the use of aids for the blind or visually impaired. The defendant was observed driving a vehicle at the VAMC and in the community, as well as performing other daily activities that required better vision than claimed. The loss to VA is approximately $800,000.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for false statements and theft of Government funds. An OIG investigation, initiated following a proactive review by OIG's Data Analysis Division, revealed that in 1998 the defendant provided a medical exam from a non-VA ophthalmologist that stated his visual acuity was "hand motion" only, his vision would not get better, and could not be corrected by surgery. VA awarded the defendant a 100 percent disability rating in 1998 for blindness. The investigation further revealed that the defendant had a valid driver's license, rode a motorcycle, and worked for 6 years (2006-2012) as a mail clerk at a private business. A VA ophthalmologist examined the defendant and determined he is not and could never have been blind. The loss to VA is approximately $468,000.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 12 months' home confinement, 36 months' probation (to run concurrently with the home confinement), and ordered to pay restitution of $456,649 after being convicted at trial of wire fraud and theft of Government funds. An OIG investigation revealed that the defendant was awarded a 100 percent VA disability with an individual unemployability enhancement after falsely claiming that his diabetes was caused by his exposure to Agent Orange while serving in Vietnam. The investigation determined that the defendant was never in Vietnam.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 84 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $811,592. A VA OIG and SSA OIG investigation revealed that since 1999 the defendant received IU benefits while working as a pastor, mortgage broker, car salesman, and golf professional. The defendant worked under other individuals' identities in order to conceal his work history from VA and SSA. The loss to VA is $365,000.

Veteran Pleads Guilty to Theft of VA Compensation Benefits

A veteran pled guilty to theft of Government funds after an OIG investigation revealed that he claimed false stressors in order to fraudulently collect VA compensation benefits for 13 years. The defendant claimed that he participated in a "dead body detail" during Operation Desert Storm; that he was involved in an incident where a fellow soldier's Humvee was fired upon causing the vehicle to lose control and crash, killing the soldier; and that he was involved in firefights with Iraqi combatants. The defendant was able to successfully obtain multiple diagnoses of PTSD dating back to the 1990's by referencing these false stressors and requesting a Central Office review with emphasis on entitlement for PTSD. The investigation revealed that from July 1991 to January 1992 the defendant served as a U.S. Army administrative clerk in Saudi Arabia and Kuwait and did not serve in a combat role or engage in combat during his tour of duty overseas. The defendant was never issued a weapon overseas. Additionally, the defendant was not involved in any Humvee accident or "dead body detail." The loss to VA is $150,164. The defendant was previously convicted in 1996 as the result of an OIG investigation involving the VA Home Loan Program.

Veteran Pleads Guilty To Making False Statements to VA

A veteran pled guilty to making false statements after an OIG investigation revealed that since 1999 he claimed that he was 100 percent disabled for blindness. However, the defendant was observed driving his registered vehicle (including to his Compensation and Pension exam) and navigating in public without assistance or use of a cane after he claimed to VA that he could do neither. The loss to VA is $344,700.

Veteran Sentenced for Making False Statements

A veteran was sentenced to 10 months' incarceration and 3 years' probation after pleading guilty to making false statements. An OIG investigation revealed that the defendant submitted more than 90 fraudulent forms for 21 different veterans without their consent and then planned to keep for himself any benefits issued by VA. The defendant forged each veteran's signature and falsely stated that each veteran suffered from various medical conditions.

Veterans Sentenced for "Stolen Valor"

A veteran was sentenced to 6 months' incarceration, 2 years' supervised release, and ordered to pay VA $174,656 in restitution after pleading guilty to theft of public money. An OIG investigation revealed that the defendant fraudulently received VA compensation benefits based on an altered DD 214 that he falsified in 1970 by claiming multiple combat awards, including two Purple Hearts and a Silver Star. Approximately 30 years later, the defendant submitted a fraudulent application to VA seeking compensation for PTSD and shell fragment wounds. The defendant claimed to have participated in hand-to-hand combat and sustained bayonet wounds, a gunshot wound, and shrapnel wounds. The defendant claimed on VA forms and in discussions with VA physicians that he had survived these battle wounds and that he had killed numerous enemy combatants. Through a review of records, witness interviews, and the defendant's own admissions, the investigation determined that the defendant did not receive any combat awards and did not suffer any combat injuries while in Vietnam. Also, the investigation determined that his scars were actually caused by minor cosmetic surgery. A second veteran was sentenced to 2 years' probation and ordered to pay $101,367 in restitution after pleading guilty to falsely altering a certificate of discharge from the U.S. Navy. An OIG investigation revealed that the veteran altered his DD 214 to indicate he received a Purple Heart as well as a Vietnam Gallantry Cross in order to qualify for benefits. A copy of the veteran's service record did not list any of the awards claimed and indicates the veteran never deployed to Vietnam.

Veteran Arrested for Theft of Government Funds

A veteran was arrested for theft of Government funds. A VA OIG and Department of Transportation OIG investigation revealed that the defendant applied for and received IU benefits while he was employed full-time by the Federal Aviation Administration. The loss to VA is over $97,000.

Veteran Indicted for Theft and Fraud

A veteran was indicted for theft of Government funds and Social Security fraud. A VA OIG and SSA OIG investigation revealed that the veteran received $199,311 in VA individual unemployabilty benefits and Social Security disability insurance benefits while working as an IT specialist for a collectibles company. The veteran did not report his employment to VA or SSA. The loss to VA is $86,197, and the loss to SSA is $113,114.

Veteran Pleads Guilty to Theft of VA Benefits

A veteran pled guilty to theft after an OIG investigation revealed that he received VA benefits under two different claim numbers. The court ordered that the defendant pay VA restitution of $67,665 as part of the plea agreement.

An OIG investigation revealed that VA funds for both claims were direct deposited into two separate accounts at different banks and that the funds were subsequently withdrawn from the accounts.

Veteran Sentenced for VA Compensation Theft

A veteran was sentenced to 2 years' probation, an $8,000 fine, and was ordered to pay VA restitution of $53,852 after pleading guilty to theft of public money. An OIG investigation revealed that the defendant, who was declared unemployable by VA as of September 2011, was employed prior to that timeframe and continued to work into 2015 for various employers, earning substantial income despite claiming to VA on three occasions that he was not employed. The defendant admitted to providing VA with false and incomplete information regarding his employment so he could receive the additional IU benefits.

Widow of Deceased VA Beneficiary Indicted for Theft

The widow of a deceased VA beneficiary was indicted for theft of Government funds and false statements. An OIG investigation revealed that the defendant failed to notify VA of her 1995 remarriage and continued to receive VA Dependency and Indemnity Compensation (DIC) benefits until July 2013. The defendant admitted to using the funds for her and her family's personal expenses. The loss to VA is approximately $126,000.

Widow Pleads Guilty to Theft of Government Funds

The widow of a deceased veteran and mother of two minor VA beneficiaries (children of the veteran) pled guilty to theft of Government funds. An OIG investigation revealed that the defendant concealed her employment income and her children's Social Security income in order to continue to fraudulently receive VA benefits. The loss to VA is $41,170.

Veteran and Wife Indicted for VA Pension Fraud

A veteran and his wife were indicted for conspiracy to commit theft of Government funds and theft of Government funds. An OIG investigation revealed that for 8 years the defendants submitted numerous false VA Pension Eligibility Verification reports that concealed the earned income of his wife. This income would have disqualified the veteran from receiving pension benefits. The loss to VA is $197,784.

Former Spouse of a Veteran Sentenced for Theft of Government Funds and False Statements

The former spouse of a veteran was sentenced to 3 years' probation and ordered to pay VA $55,894 in restitution after pleading guilty to theft of Government funds and false statements. An OIG investigation revealed that the defendant, who was receiving VA widow's pension benefits, failed to report her remarriage and provided false statements in an effort to continue to fraudulently receive the benefits.

Non-Veteran Pleads Guilty to VA Education Benefits Fraud

A non-veteran pled guilty to conspiracy to defraud the United States, theft of Government funds, and mail fraud. An OIG investigation revealed that the defendant fraudulently received Chapter 33 education benefits and also assisted veterans with submitting fraudulent applications for educational benefits they were not entitled to receive. The loss to VA is approximately $108,000.

Non-Veteran and Two Veterans Plead Guilty To Conspiring To Defraud VA of Education Benefits

A non-veteran and two veterans pled guilty to conspiring to defraud VA. The non-veteran operated a barber school and created false documents to indicate veterans were attending class and taking tests. The veterans would contact VA each month and falsely claim to be attending the barber school in order to receive VA

education benefits. The non-veteran ensured he received a portion of the monthly education benefit by contacting VA and reporting veterans for non-attendance if they failed to pay him. Additional charges are expected involving 13 additional veterans who also received VA education benefits to attend the school. The loss to VA is approximately $139,000.

Veteran Sentenced for VA Education Fraud

A veteran was sentenced to 366 days' incarceration, 3 years' supervised release, ordered to pay VA restitution of $75,955, and a forfeiture of $70,000. An OIG investigation revealed that the defendant falsely claimed to be attending school at a community college. The defendant made these fraudulent claims in order to obtain Post-9/11 GI Bill benefits and carried out his scheme by falsely claiming to VA that the certifications were prepared and submitted by the school, when in fact they were sent by the defendant.

Veteran Pleads Guilty to Theft of Government Funds

A veteran pled guilty to theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA and SSA benefits since approximately 1987. The defendant filed fraudulent VA and SSA documents purporting that his 103-year-old mother was still alive. Evidence indicates that the beneficiary is deceased. Her remains have not yet been located. The loss to VA is approximately $304,000.

Daughters of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased DIC beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her mother's death in January 1998. The loss to VA is approximately $194,000.

In a separate case, the daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG and FBI investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in December 2009. The defendant voluntarily surrendered an automated teller machine card in her deceased mother's name, which she admitted using to access the account. The defendant resigned from the Columbus Police Department during the investigation. The loss to VA is $89,646.

Niece of Deceased VA Beneficiary Indicted for Theft of Government Funds

The niece of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her aunt's death in July 2007. The loss to VA is $107,452.

Wife of Deceased Veteran Pleads Guilty to Theft of Government Funds

The wife of a deceased veteran pled guilty to theft of Government funds. A VA OIG, USPS, and SSA OIG investigation revealed that the defendant remarried twice after the veteran's death, but provided documents to the Government indicating that she never remarried. The investigation also revealed that the two subsequent marriages were to two service members, in two different states, at the same time. The loss to VA is $83,848, and the loss to SSA is $48,260.

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

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the daughter stole $90,006 in VA benefits that were direct deposited after her mother's death in February 2008. The defendant admitted to not notifying VA of her mother's death in order to continue to fraudulently receive the VA funds.

In a separate case, the daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA and subsequently stole VA benefits that were direct deposited after her mother's death in July 2005. The loss to VA is $133,924.

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

The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA DIC benefits that were direct deposited after his mother's death in September 2005. The defendant admitted to using the funds for personal expenses. The loss to VA is $147,723.

Son-in-Law of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The son-in-law of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the beneficiary's death in September 2006. The loss to VA is $114,000.

Daughters of Deceased VA Beneficiaries Sentenced for Theft of VA Benefits

The daughter of a deceased VA widow beneficiary was sentenced to 2 years' incarceration, 5 years' probation, and ordered to pay VA $271,403 in restitution. A VA OIG and SSA OIG investigation revealed that the defendant stole VA benefits that were direct deposited to a joint account after her mother's death in March 1993.
In a separate case, a daughter of a deceased VA beneficiary was sentenced to 33 months' incarceration, 2 years' probation, and ordered to pay $143,403 in restitution to VA and SSA. A VA OIG and SSA OIG investigation revealed that this defendant stole VA and SSA benefits that were direct deposited to her mother's account after her death in December 2008. This defendant used the stolen funds for her personal expenses.

In a separate case, the daughter of a deceased VA beneficiary was sentenced to 5 years' probation, ordered to pay VA restitution of $78,939, and to participate in a substance abuse and MH program after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant received, forged, and negotiated VA benefit checks and also stole direct deposits after her mother's death in October 2009. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA to make it appear her mother was still alive in order to continue to receive the VA benefits.

Daughters of Deceased VA Beneficiaries Arrested for Theft

The daughter of a deceased VA beneficiary was arrested for theft and other charges. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated VA and SSA benefit checks issued after her mother's death in June 2005. The loss to VA is approximately $110,000, and the loss to SSA is approximately $63,000.

In a separate case, a daughter of a deceased VA widow beneficiary was arrested after being indicted for theft of Government funds. An OIG investigation revealed that this defendant stole VA DIC benefits that were direct deposited after her mother's death in April 2007. This defendant was interviewed and confessed to the theft. Contrary to instructions, she subsequently withdrew additional funds from the account before they could be reclaimed. The loss to VA is $103,191.

In a third case, the daughter of a deceased VA beneficiary was indicted and arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after her mother's death in January 2009. The loss to VA is $87,016.

Other Investigations

OIG investigates a wide array of criminal offenses in addition to those listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices, OIG opened 15 cases and made 23 arrests. These investigations resulted in $7.4 million in court ordered payment of fines, restitution, penalties, and civil judgments; and nearly $203,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Medical Device Company Former Chief Executive Officer and Vice President of Sales Indicted on Multiple Charges

The former chief executive officer and vice president of sales of Acclarent, Inc., a medical device company, were indicted for conspiracy, securities fraud, wire fraud, and violations of the Food, Drug, and Cosmetic Act. An OIG, FBI, DCIS, and Food and Drug Administration (FDA) investigation revealed that the two defendants engaged in a scheme to fraudulently drive up Acclarent, Inc., revenues and stock valuation by illegally marketing a medical device known as the Relieva Stratus Microflow Spacer ("Stratus") for uses not approved by FDA. Despite the fact that the company had told the FDA that the Stratus was a medical device intended to maintain an opening to the patient's sinus, the defendants launched the product intending it to be used as a steroid delivery device. VA purchased products from Acclarent, Inc., including the Stratus.

OIG Investigation Results in Civil Settlement Agreement

An OIG investigation revealed that two co-owners of a California based SDVOSB fraudulently secured approximately $30 million in VA set-aside contracts from NCA. The veteran who was listed as the owner of the SDVOSB admitted that he was not in control of the company. Further investigation revealed that the non-veteran co-owner ran the business, which was similar to his former company that had previously been awarded several NCA contracts prior to 2007 (the year NCA contracts became designated as SDVOSB set-asides). The SDVOSB owners signed a Civil Settlement Agreement and agreed to pay VA $1 million.

Son of Disabled Veteran Indicted for Theft of Government Funds

The son of a disabled veteran was indicted for theft of Government funds after having been previously indicted for the same charge and aggravated identity theft. The most recent indictment is related to a $111,000 VA contract paid after the defendant's previous indictment and more than $34,000 paid after his arrest. A VA OIG, Army Criminal Investigation Command, DCIS, General Services Administration (GSA) OIG, SSA OIG, and Small Business Administration (SBA) OIG investigation revealed that the defendant, using two separate businesses, obtained 15 SDVOSB contracts by using his father's identity and military record without his father's knowledge or consent (the father was not involved in any way with either business). The defendant fraudulently certified both businesses as SDVOSBs through VA's Center for Veterans Enterprise and GSA's Central Contractor Registration/Online Representations and Certifications Application. As a result, the son was awarded 5 VA contracts and 10 U.S. Army and Air Force contracts. The 15 contracts totaled $2.7 million with the value of the VA contracts at $1 million.

Three Subjects Arrested for Service-Disabled Veteran-Owned Small Business Fraud

Three subjects were indicted and arrested for major fraud against the Government and wire fraud. A VA OIG and SBA OIG investigation revealed that the defendants used a "pass-through" scheme to create a SDVOSB in order to qualify for and obtain VA SDVOSB set-aside construction contracts at the San Juan, PR, VAMC. The defendants created the fraud scheme by using a service-disabled sibling, who was a full-time USPS employee, with no construction experience or equipment to establish a construction business. The defendants created

the SDVOSB after learning that construction contracts would only be awarded to SDVOSBs as a result of a Government stimulus package supporting SDVOSBs. The VA contracts included American Recovery and Reinvestment Act (ARRA) funds and were worth approximately $8.4 million.

Four Subjects Arrested for Fraud Against the Government

Four subjects were indicted and arrested for major fraud against the Government, wire fraud, tampering with a witness, and other charges. A multi-agency investigation revealed that the defendants were owners of and/or officers in multiple companies, all classified and operated as small businesses. At one time, all of the companies operated under the SBA 8(a) program or the VA SDVOSB program. The investigation further revealed that from February 2003 to October 2014 the defendants conspired with each other and other persons to defraud the United States and its agencies of over $140 million in contract payments from 8(a) and SDVOSB contracts by fraudulently claiming that the companies were owned by disadvantaged persons and a service- disabled veteran. The VA portion of the contracts included ARRA funds and were worth approximately $7.9 million.

Subject Arrested for Conspiracy To Commit Wire Fraud

A subject was arrested for conspiracy to commit wire fraud. A multi-agency investigation revealed that the defendant, a previously convicted felon, obtained Government contracts under fraudulent pretenses and utilized the U.S. Government to commit fraud. The defendant would obtain a Government contract and apply for and obtain credit from a third party vendor by using shell companies. The defendant then had the third party vendors fulfill the Government contracts. However, the defendant's company did not pay the third party vendors after receiving payment from the Government. The losses claimed by the multiple vendors totaled over $900,000.

Contract Employee Pleads Guilty to Mail Fraud

A former employee of a VA Home Based Primary Care contractor pled guilty to mail fraud. An OIG and U.S. Secret Service investigation revealed that the employee stole approximately $75,000 from an 87-year-old blind veteran beneficiary for whom she was entrusted to care and pay bills. The defendant wrote checks to herself and forged the veteran's signature with his signature stamp. The defendant purchased a motorcycle and a sports utility vehicle with the stolen funds, both of which were seized during the investigation. The defendant also admitted to gambling a significant portion of the money away.

Former District Manager of Pharmaceutical Company Pleads Guilty to Conspiracy to Commit Health Care Fraud

The former district manager of a pharmaceutical company pled guilty to conspiracy to commit health care fraud. This plea was the result of a larger multi-agency investigation into allegations of kickbacks, off-label marketing, and the submission of false claims in the form of prior authorizations.

Ohio Home Health Care Employees Indicted for Health Care Fraud

Five employees of a northeast Ohio home health care provider, including the owners, were indicted for their roles in a health care fraud conspiracy. A Northern Ohio Health Care Fraud Task Force revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information on annual provider agreements submitted to the Cleveland, OH, VAMC. Asset forfeiture action is pending against property owned by the defendants. The overall loss to the Government is approximately $7 million. Of this amount, the loss to VA is over $300,000.

VA Contractor Arrested for Providing Gratuity to VA Contracting Officer

A VA contractor was arrested after being indicted for providing a gratuity to a VA contracting officer. The contractor had moved to the Philippines and was arrested after returning to the U.S. An OIG and FBI investigation revealed that after receiving VA contracts the defendant paid for birthday trips to Las Vegas for the contracting officer's birthdays in 2008, 2009, and 2010. The gratuities included payment of airline tickets and hotel accommodations for the VA employee and her friends.

University Official Sentenced for Possession of Unauthorized Access Devices and Aggravated Identity Theft

A university official was sentenced to 34 months' incarceration and 1 year of supervised release after pleading guilty to possession of unauthorized access devices and aggravated identity theft. An OIG, FBI, and IRS Task Force investigation revealed that the defendant stole veterans' and military service members' identities that he obtained while overseeing VA education benefits at Kaplan University. During the investigation, law enforcement purchased or seized approximately 378 identities of veterans that either attended or applied to Kaplan University.

Husband and Wife Sentenced for Fraud and Identity Theft

A husband and wife were sentenced to 324 months' and 138 months' incarceration, respectively and were ordered to jointly pay $1,820,759 in restitution. The husband pled guilty to conspiracy to commit mail and wire fraud, wire fraud, aggravated identity theft, and felon in possession of firearms and ammunition. The wife pled guilty to wire fraud and aggravated identity theft. An OIG, IRS CID, and local police investigation revealed that the defendants used veterans' PII from stolen Tampa, FL, VAMC medical records and private hospital records to file approximately $5 million in fraudulent tax returns. Additionally, the husband, a previously convicted felon, was found in possession of multiple firearms during the execution of a search warrant at his residence.

Contract Employee Sentenced for Identity Theft

A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents was sentenced to 81 months' incarceration and ordered to pay the IRS $1.16 million in restitution and VA $1,981 in restitution after pleading guilty to access device fraud and aggravated identity theft. An OIG, IRS CID, Florida Department of Law Enforcement, Florida Highway Patrol, and local police investigation revealed that the defendant stole medical records containing veterans' PII that were supposed to be destroyed. The defendant then sold the records to multiple defendants who subsequently used the PII to file $1.4 million in fraudulent tax returns.

Non-Veteran Pleads Guilty to Identity Theft Charges

A non-veteran pled guilty to multiple identity theft related charges. An OIG and IRS CID investigation revealed that the defendant conspired to steal the personal identifying information of veterans and used the information to submit $3.5 million in fraudulent tax returns.

Former USPS Employee and Daughter Arrested for Conspiracy and Falsification of Records

A former USPS employee and his daughter were indicted and arrested for conspiracy for receiving kickbacks and falsification of records. A multi-agency investigation determined that the former employee, affiliated with a business that assisted Federal employees in filing for workers compensation benefits, received more than $250,000 for referring employees to a health care company suspected of defrauding VA and other Federal agencies by keeping employees on workers compensation longer than necessary and billing for services not provided. The former employee also laundered a portion of the payments through his daughter's bank account.

After learning of the investigation, the employee and his daughter falsified documentation by transferring the business to her. The loss to the Government is over $1 million.

Non-Veteran Convicted of Bank Fraud and Aggravated Identity Theft

A non-veteran was convicted at trial of bank fraud and aggravated identity theft. An OIG investigation revealed that the defendant used the identity of his father, a veteran, in an attempt to obtain a VA mortgage loan for a home valued at approximately $490,000. The defendant falsely claimed to the bank that he served in the military for 30 years and earned a Purple Heart.

Non-Veteran Sentenced for Identity Theft

A non-veteran was sentenced to 5 years' incarceration (suspended), 5 years' probation (to include random drug and alcohol screens), and ordered to pay VA restitution of $19,341 after pleading guilty to theft of identity, theft of services over $10,000, and theft by deception over $500. An OIG and state police investigation revealed that the defendant used his veteran brother's identity to obtain controlled substances, health care, and beneficiary travel payments from the Louisville, KY, VAMC.

Four Subjects Charged with Fraud Relating to Workers' Compensation Program

Four subjects were charged with health care fraud, conspiracy, and money laundering relating to their ownership and operation of multiple workers' compensation clinics. A VA OIG, USPS OIG, Department of Labor (DOL) OIG, Department of Homeland Security OIG, and IRS CID investigation revealed that since January 2011 the defendants conspired to unlawfully bill multiple Federal agencies for false and fraudulent claims and for services not rendered. The investigation also revealed that in July 2013, shortly after executing a Federal search warrant on the subject business, two of the defendants laundered $700,000 in order to conceal the money's location from law enforcement. The overall loss to the Government is approximately $5.6 million.

Former Rhode Island State Cemetery Employee Pleads Guilty to Theft of Government Property

A former Rhode Island State cemetery employee pled guilty to theft of Government property. An OIG and Rhode Island State Police investigation revealed that for several years the defendant removed worn or broken grave markers from the cemetery and brought them to his residence. A search of the defendant's property revealed that approximately 150 VA-provided grave markers were being used as flooring for a shed and two make-shift garages. Additional grave markers and a box of American flags, allegedly stolen from the State veterans' cemetery, were also discovered on the defendant's property.

Four Subjects Arrested for Theft of U.S. Treasury Checks

Four subjects, including two USPS mail sorters, were arrested for conspiracy, theft of mail, theft of Government funds, forgery, bank fraud, and aggravated identity theft for their roles in a conspiracy to steal U.S. Treasury checks from the mail and then to either sell the checks or deposit them in fraudulently opened bank accounts. A VA OIG, USPS OIG, U.S. Treasury OIG, and local police investigation resulted in the seizure of approximately 960 Treasury checks, to include some VA benefit checks, valued at $1.6 million and the seizure of more than $165,000 in proceeds gained as a result of the sale of the stolen checks. The investigation is ongoing as other suspects have been identified.

Former United Parcel Service Employee Sentenced for Theft of VA Drugs

A former United Parcel Service (UPS) employee was sentenced to 3 years' supervised probation, ordered to attend a substance abuse treatment program, and ordered to pay VA restitution of $1,390 after pleading guilty to theft of Government property. An OIG investigation revealed that between March 2011 and June 2012 the

defendant stole VA controlled substances, specifically oxycodone, morphine, hydromorphone, and methadone, from 17 UPS packages.

Assaults and Threats Made Against VA Employees

During this reporting period, OIG initiated 27 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 12 defendants. Investigations resulted in nearly $300,000 in savings, efficiencies, cost avoidance, and dollar recoveries. OIG investigative work resulted in the following:

- A veteran was sentenced to 9 months' home confinement and 1 year of probation after pleading guilty to assault on a Federal employee. An OIG investigation revealed that the defendant assaulted a VA police officer at the Miami, FL, VAMC during a traffic stop. After the police officer stopped the vehicle, the defendant attacked and repeatedly punched the officer, inflicting multiple injuries to the officer's face.
- A Hot Springs, SD, VAMC food service worker was indicted for assault of a Federal employee. The defendant made multiple threats to VA staff, threatened to kill a VA Police officer, and threatened to blow up bridges and kill civilians. While at the medical center, the defendant grabbed a female nurse and forced her hands on his genitals. The defendant later exposed himself to the same nurse and stated he would "kill girls that won't go out with me."
- The son of a Memphis, TN, VAMC physician was sentenced to 5 years' incarceration after pleading guilty to aggravated assault. An OIG, FBI, and local police investigation revealed that the defendant traveled from Virginia and stabbed his father at the medical center.
- The husband of a Portland, OR, VAMC employee pled guilty to assault. An OIG and VA Police Service investigation revealed that the defendant hit and strangled his wife in the medical center parking lot.
- A veteran was arrested for forcible touching after having been previously arrested for aggravated harassment. Both arrests involved the defendant's harassing behavior of a VA employee at the Buffalo, NY, Community Day Program Center.
- A veteran pled guilty to assaulting an East Orange, NJ, VAMC employee. An OIG investigation revealed that the defendant attacked a social worker by striking her with a cane and fracturing her elbow. The defendant was ordered by the court to be held pending sentencing.
- A non-veteran was arrested for aggravated harassment by communicating a threat to VA staff. An OIG, VA Police Service, and local police investigation revealed that the defendant made telephonic threats to a New York, NY, VAMC employee. The defendant was angry with the medical center for not providing him health care. The defendant stated "he would come to the medical center and do harm like a past incident that happened in Texas where a VA doctor was shot."
- A veteran was convicted at trial of stalking and harassment. In addition, the judge enacted a temporary order of protection until sentencing. An OIG, VA Police Service, and local district attorney's investigation revealed that the defendant consistently sent letters and left telephone messages for a Bronx, NY, VAMC social worker who was formerly assigned to the defendant. The defendant had previously been warned several times by both VA Police and OIG agents not to have any contact with the victim.
- A veteran was indicted for transmitting a threat in interstate commerce and making threats to a Federal official. An OIG and VA Police Service investigation revealed that the defendant threatened to kill a Palo

Alto, CA, VA nurse who he believed interfered with his "life/medical situation." The defendant used the My HealtheVet website to transmit the threats, which included a statement about using his .357 firearm to blow the nurse's brains out. On the same day that the threat was transmitted to the nurse, the local police went to the veteran's home, seized a .22 caliber Hi-Point semiautomatic pistol, and transported him to a local hospital for psychological evaluation. The next day, the defendant threatened to strike the nurse in the head with an aluminum baseball bat if the nurse "crosses the line and affects his lifestyle."

- A veteran was sentenced to 5 months' incarceration and 1 year of supervised release after pleading guilty to possession of a firearm on Federal property. An OIG investigation was initiated after the defendant's daughter notified the local police that the defendant took a firearm from his daughter's home and was on his way to the West Palm Beach, FL, VAMC. The defendant was subsequently stopped in the parking lot of the medical center with the weapon in his possession. The investigation also revealed that the defendant previously made numerous threats against VA employees at multiple VAMCs and had a non-expiring order of protection against him.
- A veteran was sentenced to 3 years' supervised probation and ordered to attend counseling for MH, substance abuse, and anger management after pleading guilty to assault on Government officials. The defendant was incarcerated for several months prior to his sentencing due to the severity of the threat. An OIG, VA Police Service, FBI, and local law enforcement investigation revealed that the defendant threatened to shoot and kill doctors and nurses at the Fayetteville, NC, VAMC and staff at Fort Bragg, NC.
- A veteran was sentenced to 274 days' incarceration, 5 years' probation, and $600 in fines and restitution after pleading guilty to criminal threats, resisting an executive officer, and MH firearms prohibition. An OIG and VA Police Service investigation revealed that the defendant arrived at the Long Beach, CA, VAMC and threatened to kill himself, his girlfriend, and three Long Beach, CA, VA police officers. The defendant also assaulted two of the officers while attempting to leave the medical center. During the investigation, a handgun and two rifles were recovered. The defendant was not legally permitted to possess these weapons.
- A veteran was indicted for making threats to a Federal official. An OIG and VA Police Service investigation revealed that the veteran was seeking a certain procedure in a non-VA facility located in Florida, although the veteran was a resident of Vermont. VA did not find the veteran eligible for such a procedure, even within the VA system. After the veteran learned that the VAMC denied the consult for the non-VA care, the veteran threatened the Chief of Staff and his family. Specific conditions of the veteran's release included home detention with a location monitoring bracelet and no contact with VA staff or property except through the VA Police Service and the emergency room.

Fugitive Felons Arrested with OIG Assistance

OIG continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. To date, 61.9 million felony warrants have been received from the National Crime Information Center and participating states resulting in 74,739 investigative leads being referred to law enforcement agencies. Over 2,507 fugitives have been apprehended as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, OIG has identified $1.19 billion in estimated overpayments with an estimated cost avoidance of $1.45 billion. During this reporting period, OIG opened 26 and closed 30 fugitive felon investigations, identifying $48.5 million in estimated overpayments. OIG investigative work resulted in the arrest of 25 fugitive felons, including 5 VA employees. VA employees were apprehended on charges related to burglary, cocaine possession, probation violations, and hit and run. Based on the information provided to OIG, at least 10 additional arrests were made by other law enforcement agencies.

- A Hampton, VA, VAMC employee was arrested at the medical center by local police with the assistance of OIG and VA Police Service. The fugitive was wanted for burglary.
- A Miami, FL, VAMC employee was arrested at the medical center by local police with the assistance of OIG and VA Police Service. The fugitive was wanted for leaving the scene of an accident involving an injury to the victim.
- A veteran participating in the Compensated Work Therapy program at the West Palm Beach, FL, VAMC was arrested by local police with the assistance of OIG and VA Police Service. The veteran was wanted for failing to register as a sex offender.
- A veteran was arrested at his residence by members of a U.S. Marshals Fugitive Task Force with the assistance of OIG. The veteran was wanted for the molestation of a child.
- A veteran was arrested at the Bedford, MA, VAMC by local police with the assistance of OIG and VA Police Service. The veteran was wanted for felony assault and battery.
- A veteran was arrested at the West Palm Beach, FL, VAMC by the U.S. Marshals Service with the assistance of OIG and VA Police Service. The fugitive was wanted in Arizona for failure to appear on weapons and drug charges.

Administrative Investigations

OIG's Administrative Investigations Division independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to the Congress and the Department. During this reporting period, OIG opened nine and closed four administrative investigations. The Division investigated nine allegations, seven of which were substantiated. This work resulted in the issuance of 3 reports containing 17 recommendations for administrative or corrective action. These reports are listed in Appendix A.

The Administrative Investigations Division issues advisory memoranda when an allegation has been substantiated and OIG suggests VA take some action based on the investigation, but where the violation does not rise to the level of a formal recommendation. The Division also prepares administrative closures for allegations that are not substantiated and not otherwise included in a report or advisory memorandum. During this reporting period, the Administrative Investigations Division did not issue any advisory memorandums but issued one administrative closure.

OIG Criticizes Office of Information and Technology Officials' Response to Improper Access of VA Network by Contractors While Working in China and India

Seven years after the 2006 data breach, VA information security employees still reacted with indifference, little sense of urgency, or responsibility concerning a possible cyber threat incident. Austin Information Technology Center (AITC) OIT employees failed to follow VA information security policy and contract security requirements when they approved VA contractor employees to work remotely and access VA's network from China and India. One accessed it from China using personally-owned equipment (POE) that he took to and left in China, and the other accessed it from India using POE that he took with him to India and then brought back to the United States. After the Acting Chief Information Officer (CIO) learned of this improper remote access, he gave verbal instructions for it to cease; however, VA information security employees at all levels failed to quickly respond to stop the practice and to determine if there was a compromise to any VA data as a result

of VA's network being accessed internationally. Further, OIG found that a VA employee, as well as other VA contractor employees, improperly connected to VA's network from foreign locations.

OIG Finds Philadelphia VARO Official Misused Position for Private Gain of Subordinate and Spouse, Invited Staff to Home for Psychic Readings

The Assistant Director, Philadelphia VARO, while as the Acting Director, misused her position for the private gain of a subordinate and his spouse, misused her title to endorse the private enterprise, and invited subordinates to her home to take part in psychic readings. OIG also found that she had a less-than-arm's-length relationship with subordinates whom she characterized as friends. As a senior leader, she is held to a higher standard and should set the tone for her subordinates to follow, and establishing personal relationships with a select group of employees within her chain of authority gives the appearance of preference for those few employees. Although OIG found no actual preference, just the appearance of preference diminishes her position and authority as a senior leader. Further, OIG found that the Manager of the Pension Management Center (PMC), failed to report his spouse's income on his 2013 and 2014 Confidential Financial Disclosure Reports, Office of Government Ethics Form 450, which he certified as true, complete, and correct. OIG made a criminal referral of the false statements to the U.S. Department of Justice, but they declined to criminally prosecute in favor of administrative actions. The PMC Manager also failed to claim that same financial gain on his and his spouse's income tax returns. OIG referred the failure to report income to the IRS and the Pennsylvania State Department of Revenue.

OIG Investigators Substantiate Improper Usage of Private Social Networking Website with Vulnerable Security Features

Some VA employees improperly used Yammer.com, a web-based collaboration technology, which was not approved or monitored as required by VA policy. Further, the website had vulnerable security features, there were recurring website malfunctions, and users engaged in a misuse of time and resources. Although one VA Technical Reference Model approved, with constraints, the installation of Yammer's Notifier, a Windows desktop application, use of the Yammer social network was not VA-approved for employee use. Further, it was not only promoted by a number of VA employees, but it was used and showcased in June 2013 by the former VA Executive in Charge of OIT and CIO, for an open chat forum, as well as in a June 2014 CIO message reminding employees to comply with VA Directive 6515 when using Yammer, giving the false impression that VA approved the use of Yammer.com. The Yammer website did not have an administrator or system set in place to ensure removal of former VA or contractor employees. Additionally, the relatively simple process to post to Yammer made VA vulnerable to current and former users purposely or accidentally uploading PII, PHI, or VA sensitive information. Yammer users violated VA policy when they downloaded and shared files, videos, and images, risking malware or viruses spreading quickly from the site. Further, Yammer regularly spammed and excessively emailed users, as well as VA employees who had no interest in joining the site, and users were unable to remove the Online Now instant messaging feature, resulting in every user violating VA policy simply by logging onto the site. There were numerous user posts that were non-VA related, unprofessional, or had disparaging content that reflected a broad misuse of time and resources. Moreover, the continuous data streams, instant messaging, video, audio, large files and attachments, and other uploaded non-VA content to the site may cause congestion, delay, or disruption of service and degrade the performance of VA's network.

Office of Management and Administration

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

Coordination and Internal Controls Division

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

Operations Division

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

Information Technology and Data Analysis Division

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

Data Analysis staff provide automated data processing technical support of OIG and other Federal and governmental agencies requiring information from VA files. Data Analysis Division products facilitate the identification of fraud-related activities and support OIG comprehensive initiatives that result in solutions beneficial to VA. The following summary provides an example of the type of Data Analysis Division projects initiated this semiannual period.

Proactive Review Leads to Veteran Indictment for Making False Statements and Theft of Government Funds

A proactive review by the Information Technology and Data Analysis Division uncovered a veteran who was receiving disability compensation for total blindness (i.e., anatomical loss of both eyes) while simultaneously holding a valid Florida driver's license. The division promptly notified OIG's Office of Investigations who conducted an investigation detailed on page 59. The estimated loss to the VA is $468,000.

Administrative and Financial Operations Division

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

Budget Division

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

Hotline Division

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

During this reporting period, the Hotline received 19,903 contacts, 670 of which became Hotline cases. An additional 179 of the contacts became Hotline non-case referrals. The Hotline makes non-case referrals to the appropriate VA organization if the allegation does not rise to the level of a case but appears to warrant VA action. The Hotline also closed 536 cases, substantiating allegations 37.5 percent of the time. External Hotline cases resulted in 299 administrative sanctions and corrective actions and $1.56 million in monetary benefits. In addition, the Hotline responded to more than 916 requests for record reviews from VA staff offices during the reporting period. The case summaries that follow were initiated as a direct result of Hotline contacts.

Malfunctioning Equipment at Batavia Community Living Center Oak Lodge, Buffalo, New York

A veteran reported that it took 50 minutes for staff to respond to his call light requesting assistance. At the time, the veteran was recovering from a stroke and in need of assistance with activities of daily living. A review by the facility determined that there is vulnerability in the call-bell system. The problem can allow for an individual unit to become unplugged but not indicate a problem at the nurse's station if it became unplugged after the call bell was activated. As a result of their investigation, the facility informed the manufacturer of the issue and requested a system upgrade to alleviate the problem. In the interim, new procedures were implemented and additional staff training was provided to ensure disconnected call bells are identified in a timely manner.

DIC Fraud

The PMC conducted a review of a widow's benefits to determine if she was receiving DIC payments even though she was remarried. After obtaining applicable legal documents the PMC concluded she had remarried. As a result, they sent the individual a due process letter proposing to terminate her DIC benefits effective to the

date of her remarriage in 2007. In addition to terminating her benefits, the PMC initiated an overpayment for $114,603.

Benefits Fraud by Incarcerated Veteran

The Regional Office in Little Rock, AR conducted a Social Security Prison Match and confirmed that an incarcerated veteran was still receiving full compensation benefits as well as benefits for a spouse and dependent child. As a result of the check, the veteran's benefits were reduced to 10 percent and an overpayment of $74,969.06 was established against the veteran's account.

Compensation Benefits Fraud

The Seattle, WA, VARO conducted a review to determine if a veteran from Lakewood, CA, was improperly receiving dependent VA benefits for a woman who was not his wife. The veteran failed to respond to a letter of due process notifying him of the proposed reduction in benefits and therefore the Regional Office terminated the veteran's dependent benefits back to 2009 and initiated an overpayment of $9,177.49.

Healthcare Fraud by Using Fraudulent DD 214

The Temple, TX, VAMC conducted a review to determine if a veteran assigned to their facility had been receiving care, to include an extensive hospital stay, even though the individual was not entitled to VA medical benefits. It was determined that the veteran was using several names, all with the same social security number, and that the veteran had multiple, fraudulent DD 214 with those names. The DD 214 all indicated an Honorable discharge when in fact this was not true. As a result of the review, the facility took several corrective actions. They notified the veteran that he was not eligible for care and initiated collection action for care provided since 2011. Additionally, they cancelled all pending appointments and updated records to show that the veteran was ineligible for care.

Office of Contract Review

The Office of Contract Review operates under a reimbursable agreement with VA's OALC to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OIG provides advisory services to OALC contracting activities. OIG completed 65 reviews in this reporting period. The tables that follow provide an overview of OIG performance during this reporting period.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Forty-four preaward reviews identified more than $176 million in potential cost savings during this reporting period. In addition to FSS and Architect/Engineering Services proposals, preaward reviews during this reporting period included 20 health care provider proposals, accounting for approximately $41 million of the identified potential savings.

Period	Preaward Reports Issued	Potential Cost Savings
October 1, 2014 – March 31, 2015	47	$73,679,191
April 1 – September 30, 2015	44	$176,860,852
Fiscal Year	91	$250,540,043

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the *Veterans Health Care Act of 1992*, P.L. 102-585, for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over $9.7 million, including approximately $6 million related to *Veterans Health Care Act* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 17 postaward reviews performed, 11 involved voluntary disclosures. In four reviews, OIG identified additional funds due. VA recovered 100 percent of recommended recoveries for postaward contract reviews.

Period	Postaward Reports Issued	Dollar Recoveries
October 1, 2014 – March 31, 2015	20	$1,971,852
April 1 – September 30, 2015	17	$9,684,676
Fiscal Year	37	$11,656,528

Claim Reviews

OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, OIG reviewed one claim and determined that approximately $10 million of claimed costs were unsupported and should be disallowed.

Office of Contract Review

Period	Claim Reports Issued	Potential Cost Savings
October 1, 2014 – March 31, 2015	2	$249,306
April 1 – September 30, 2015	1	$10,090,327
Fiscal Year	3	$10,339,633

Special Reports

Period	Special Reports Issued	Dollar Recoveries
October 1, 2014 – March 31, 2015	0	$0
April 1 – September 30, 2015	3	$44,082
Fiscal Year	3	$44,082

OIG, VHA Disagree on Finding of Improper Sole-Source Contracts To Fund Educational Costs

OIG conducted a review of contracts awarded sole-source to affiliated Schools of Medicine (SOM) for education costs pursuant to VHA Handbook 1400.10. The review determined that the contracts do not meet the requirements of the Federal Acquisition Regulation (FAR) and that the authority cited by VHA Handbook 1400.10, 38 U.S.C. § 8153, does not authorize the funding of physician resident training costs of VA's affiliated SOMs. The review also concluded that the provisions in VA Handbook 1400.10 were inconsistent with the provisions in VA Handbook 1400.05, which establishes policy for payment relating to resident training programs that are authorized under 38 U.S.C. Section 7604(c). VHA, based on advice from OGC, did not concur with the findings.

VA Pittsburgh HCS Cannot Be Sure Hours Invoiced for Physician Contracts Were Received Due to Inadequate Monitoring

OIG reviewed three separate physician contracts awarded by VA Pittsburgh Healthcare System (VAPHS) to University of Pittsburgh Physicians, Inc. (UPP). OIG found that VAPHS did not have an adequate system or process to monitor contract performance and cannot be sure that VAPHS received all the hours invoiced by UPP. Because of the inadequate review of invoices, OIG found that VA was being billed twice the hours and FTE level than the contract requirements for one of the contracts. OIG also found that VA was reimbursing UPP 100 percent of the call-back hours for a dual-appointed physician even though his call-back hours should have been pro-rated based on his dual employment status. OIG also found that VAPHS awarded administrative and overhead expenses on all three contracts without appropriate supporting documentation as required in VA Directive 1663. OIG recommended that VAPHS implement a process to adequately administer the performance for all its physician contracts, consult with Regional Counsel concerning the billed call-back hours for the dual appointed physician, and ensure future sole-source physician contracts that contain administrative and overhead costs are compliant with VA Directive 1663. Management concurred with OIG's findings and recommendations.

Review of a Covered Drug Manufacturer's Interim Agreement Under Letter Contract With VA's National Acquisition Center

OIG conducted a review of an Interim Agreement (IA) under a letter contract with the VA National Acquisition Center (NAC). Under FAR Section 16.603, a letter contract serves to provide more time for the negotiation and award of a formal contract and should be in place no longer than 180 days. The NAC has awarded IAs and letter contracts with pharmaceutical manufacturers for purposes of compliance with Section 603 of the *Veterans Health Care Act of 1992*, P.L. 102-585. The review determined that the IA had been in place nearly seven years and lacked a schedule for definitizing a formal contract, in violation of FAR requirements. The review also determined that Federal Ceiling Prices mandated by the P.L. cannot be calculated correctly under an IA. The NAC has awarded 165 IAs in the last 10 years, and 153 of them exceeded the prescribed timeframes for definitizing a formal contract. OALC concurred with OIG's findings and recommended corrective actions.

Other Significant OIG Activities

Congressional Testimony

Deputy Inspector General Testifies on OIG's Interactions with Potential Whistleblowers and Hotline Complaint Process

Linda A. Halliday, Deputy Inspector General (DIG), testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, on "Whistleblower Claims at the U.S. Department of Veterans Affairs." She discussed how the OIG interacts with individuals who report allegations concerning VA programs and operations to the OIG Hotline. Ms. Halliday emphasized that these individuals are the lifeline of OIG organizations, and that OIG is committed to protecting their identities, understanding their concerns, objectively seeking the truth, and ensuring VA pursues accountability and corrective action for wrongdoing. She reaffirmed OIG's commitment to review and evaluate ways in which OIG can enhance its interactions with individuals who report allegations, and she described recent initiatives to strengthen OIG's internal whistleblower training and Whistleblower Protection Ombudsman programs. She was accompanied by Dr. John D. Daigh, Jr., Assistant Inspector General (AIG) for Healthcare Inspections, and Ms. Maureen T. Regan, Counselor to the IG.

DIG Explains Steps OIG Takes To Protect and Educate Whistleblowers to Senate Panel

Linda A. Halliday, DIG, testified before the Committee on Homeland Security and Governmental Affairs, United States Senate, at a hearing titled, "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers." Ms. Halliday discussed the fundamental importance of whistleblowers to the OIG mission and how the OIG works to protect and encourage Federal employees to come forward with allegations of waste, fraud, abuse, and mismanagement. She elaborated on the OIG's efforts to educate employees about whistleblower protections, to encourage employees to report suspected wrongdoing, and to protect the identities of those who do. Ms. Halliday also emphasized that while the OIG strongly encourages any employee with information of wrongdoing to report it to the OIG, it is imperative that employees ensure they are doing so in a manner that does not compromise sensitive veteran information. She was accompanied by Mr. Quentin G. Aucoin, AIG for Investigations.

AIG Testifies Before House Committee on Veterans' Affairs on Mismanagement and Data Manipulation at the Philadelphia and Oakland VAROs

Linda A. Halliday, who at the time of the testimony was the AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the results of OIG recently published reports that substantiated allegations of mismanagement and data manipulation at the Philadelphia, Pennsylvania, VARO and allegations of claims mismanagement at the Oakland, California, VARO. Ms. Halliday told the Committee that OIG identified serious issues at the Philadelphia VARO involving mismanagement and that OIG made 35 recommendations for improvement encompassing operational activities relating to data integrity, public contact, financial stewardship, mail mismanagement, and other areas of concern. Ms. Halliday also stated that Oakland VARO staff had not processed a significant number of informal requests for benefits found in October 2012 that dated back as far as July 2002 and improperly stored formal claims. Furthermore, management's poor recordkeeping practices precluded OIG from confirming that VARO staff processed all of the informal claims or if the initial list contained 13,184 informal claims. Ms. Halliday was accompanied by Ms. Nora Stokes, Director, OIG Bay Pines Benefits Inspection Division and Mr. Brent Arronte, then-Director, OIG San Diego Benefits Inspection Division.

OIG's Top Physician Tells Senate Veterans' Affairs Committee VHA Must Make Quality Health Care Its Most Important Mission

Dr. John D. Daigh, Jr., AIG for Healthcare Inspections, accompanied by Mr. Gary K. Abe, Deputy AIG for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States Senate, to discuss OIG's health care reviews and audits of programs and performance of VHA. Dr. Daigh testified that VHA is at risk of not performing its chief mission to deliver high quality health care as the result of several intersecting factors: 1) VHA has several missions, and too often management decisions compromise the most important mission of providing veterans with quality health care; 2) leadership has too often compromised national VHA standards to meet short term goals; 3) the VISN do not consistently support local VAMCs to encourage success and proactively address areas of risk; 4) resource management data gaps make the cost-effective delivery of a national benefit challenging, and 5) VHA's internal processes are inefficient and make the conduct of routine business unnecessarily burdensome. Dr. Daigh reported that the issues confronting VHA are issues that OIG has long reported as serious and in need of attention at the VA Central Office, VISN, and facility levels, and that OIG will continue to do so until that lasting change has occurred.

AIG Tells House Committee on Veterans' Affairs Subcommittee That VA's Purchase Card Program Is at Risk for Waste, Fraud, and Abuse

Linda A. Halliday, who at the time of the testimony was the AIG for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, concerning OIG's work related to VA's Purchase Card Program. Ms. Halliday told the Committee that the number of VA's purchase card transactions is voluminous, the value represents significant financial expenditures, and that overall OIG considers VA's Purchase Card Program at medium risk for waste, fraud, and abuse. She stated that OIG's fiscal year 2015 risk assessment of VA's Purchase Card Program identified seven areas of high-risk practices that OIG will continue to target for oversight. She also discussed recent OIG reports that identified significant control weaknesses that did not prevent transactions involving unauthorized commitments, improper payments, split purchases, and purchases that lacked appropriate supporting documentation, and noted that VA must significantly strengthen internal controls to prevent further misuse of taxpayer dollars intended to serve veterans and their families. Ms. Halliday was accompanied by Mr. Quentin G. Aucoin, then-Deputy AIG for Investigations (Field Operations), Mr. Kent Wrathall, Director, Atlanta Office of Audits and Evaluations, and Mr. Murray Leigh, Director, Financial Integrity Division, Office of Audits and Evaluations.

Chief of Staff for Healthcare Oversight Integration Testifies on Challenges Alaska Veterans Face Getting Timely Care

Dr. Andrea C. Buck, OIG Chief of Staff for Healthcare Oversight Integration, testified at a field hearing in Eagle River, AK, before the Committee on Veterans' Affairs, United States Senate, on "Exploring the Veterans Choice Program's Problems in Alaska." She highlighted the challenges some veterans have faced in receiving timely access to care in Alaska. Although VHA reported that as of May 2014 the Alaska VA HCS provided overall good access to care, Dr. Buck discussed that an OIG healthcare inspection conducted in August 2014 revealed that there were significant access to care problems at the Mat-Su clinic in Wasilla, AK. She emphasized that meeting the health care needs of Alaska veterans must remain one of VA's highest health care priorities and discussed several additional OIG oversight projects planned or underway that focus on the Alaska VA HCS and/or issues related to veterans' access to health care. Dr. Buck was accompanied by Ms. Sami O'Neill, Director of the Seattle, WA, OHI.

OIG Testifies Conditions Persist That Put Beneficiaries and Their VA-Derived Estates at Unnecessary Risk

Mr. Gary K. Abe, Deputy AIG for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, concerning OIG's work related to VA's Fiduciary Program. He told the Committee that despite major changes to structure, oversight, and operation of the Fiduciary Program since OIG's 2010 audit, significant challenges remain. Mr. Abe discussed recent audit work in the Fiduciary Program including a report issued on June 1, 2015, *Audit of the Fiduciary Program's Management of Field Examinations,* where OIG reported that VBA faces a large and growing backlog of field examinations, which are critical tools for VBA to assess the competency and welfare of these beneficiaries. His testimony also included past and recent investigations that have uncovered unscrupulous fiduciaries who have misappropriated from tens of thousands to millions of dollars from the accounts of unsuspecting VA beneficiaries under the supervision of the Fiduciary Program. This type of theft can only be stopped by aggressive and consistent oversight by the Fiduciary Program. Mr. Abe was accompanied by Mr. Quentin G. Aucoin, AIG for Investigations, and Mr. Tim Crowe, Director, Bay Pines Office of Audits and Evaluations.

False Claims Act Settlements

For this reporting period, VA received payments totaling $1,335,732 from settlement agreements in complaints filed under the *qui tam* provisions of the *False Claims Act*. This amount represents VA's single damages in these cases; the total collected by the Department of Justice on behalf of VA exceeded $2.5 million. The amount represents settlements in two cases, one of which was based on violations of the *Trade Agreements Act*. The remaining settlement was based on violations of regulations relating to off-label marketing.

Peer and Qualitative Assessment Reviews

The *Restoring American Financial Stability Act of 2010,* P.L. 111-203, requires VA OIG to report the results of any peer review conducted of VA OIG's audit operation by another OIG during the reporting period or to identify the date of the last peer review conducted by another OIG, in addition to any outstanding recommendations that have not been fully implemented. There were no peer reviews done on VA OIG during this reporting period. On March 21, 2013, DOL OIG completed their quality control peer review of VA OIG's system of quality control, and provided a peer review rating of 'pass.' There was one finding not considered of sufficient significance to affect the opinion expressed in their report. The next peer review is scheduled for November 2015 and will be conducted by the U.S. Agency for International Development OIG.

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

Additionally, VA OIG reports that no Council of the Inspectors General on Integrity and Efficiency (CIGIE) Qualitative Assessment Review (QAR) was conducted by another OIG during this reporting period. The last CIGIE QAR conducted on VA OIG's investigative operations was completed by the Environmental Protection Agency OIG in March 2013. The final report was issued on August 23, 2013, and contained no recommendations. VA OIG conducted a CIGIE QAR of the Department of Energy (DOE) OIG's Investigative Operations in April 2014 and issued the final report in July 2014. The report indicated the system of internal safeguards and management procedures for the investigative function of DOE OIG, in effect for the year ending

2013, is in compliance with the quality standards established by CIGIE and the applicable Attorney General Guidelines. These safeguards and procedures provide reasonable assurance of conforming with professional standards in the conduct of its investigations.

Government Contractor Audit Findings

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each IG appointed under the *Inspector General Act of 1978* to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued five reports meeting this requirement. Four of the reports are related to a multi-billion dollar PC3 contract. The remaining report addresses a VA land purchase.

Review of FY 2014 PC3 Program Costs

OIG's analysis determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate in FY 2014. VA paid approximately $18.9 million in FY 2014 to the PC3 contractors: $15.1 million (80 percent) for implementation and administrative fees and $3.8 million (20 percent) for health care services. These same health care services would have cost about $4.0 million if they had been purchased under the NVC program. This occurred because VA did not conduct adequate price analyses to support its cost savings estimate.

Hotline Review of Delays in PC3 Provided Care

PC3 contracted care issues caused delays in care. PC3 was not achieving its intended purpose to provide veterans timely access to care. Pervasive dissatisfaction under the PC3 contracts caused all nine of the facilities reviewed to limit or stop using the PC3 program as intended. From January 1 through September 30, 2014, the national utilization rate was about 9 percent. This is significant since VHA was relying on high-usage rates to achieve estimated cost. It took VHA an average of 19 days to submit the authorization to the PC3 contractors. VHA has no timeliness criteria for submitting authorizations to the contractors. OIG projected PC3 contractors returned—or should have returned—almost 43,500 of 106,000 authorizations because of limited network providers and "blind scheduling," that is, PC3 contractors scheduling appointments without discussing the tentative appointment with the veteran.

Review of Selected PC3 Care Provider Networks

Inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA spent 0.14 percent, or $3.8 million of its $2.8 billion FY 2014 NVC budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its NVC expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate due to delayed delivery of care. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the CBO planning and implementation of PC3; the CBO lacked an effective implementation strategy for the roll-out of PC3; and neither VHA nor the PC3 contractors maintained adequate data to measure and monitor network adequacy.

Review of PC3 Care Health Record Coordination

Funds put to better use total $257,652 and questioned costs total $5.5 million. OIG estimates PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during our period of review from January 1, 2014, through September 30, 2014. OIG estimated that 48 percent of the clinical documentation was provided to VA late and 20 percent was incomplete. VHA made about $870,400 of improper payments when payments should not have been made prior to receiving complete clinical documentation. VHA did not apply contract penalties to Health Net Federal Services, LLC, when it did not meet performance requirements related to the timely return of clinical documentation. VHA applied a penalty of only $753. The maximum allowable penalty was $15,909. If VA exercises the remaining three option years of the PC3 contract without adequately addressing the identified issues, VA could make about $5.5 million in improper payments and missed assessed penalties. OIG also found that PC3 patients experienced delays in VHA referring and following up on their care with TriWest, as well as TriWest not timely notifying VHA of three malignancy diagnoses resulting from colonoscopies. These issues occurred because VHA relied on contractor-reported data, lacked an adequate program for monitoring contractor performance, and lacked a process to verify whether the contractor meets contract performance standards. As a result, VHA lacked assurance that PC3 is providing patients adequate continuity of care.

Review of Louisville Land Purchase Appraisal

OIG determined that OALC conducted two appraisals of property in Louisville, KY, in December 2010 and in February 2012. The first appraisal valued the property at $9,850,000. The second appraisal valued the property at $12,905,000. However, OALC did not obtain a required review appraisal for determining the appropriateness of the two appraisals prior to purchasing the land for $12,905,000. VA did obtain a review appraisal in April 2014, nearly 2 years after the property was purchased and at a cost of $2,447. Spending $2,447 for the review appraisal was a waste of the taxpayers' money because the timing of the review appraisal was useless in determining whether VA paid just compensation for the property. OALC did not obtain a review appraisal prior to purchasing the property because VA policies were not clear as to when to obtain a review appraisal. As a result, VA lacks assurance the purchase price paid was reasonable, and VA may have overpaid more than $3 million for this property. Furthermore, OALC misrepresented information provided to the House Veterans' Affairs Committee regarding the 31 percent increase in the property's market value over a 14-month period from December 2010 to February 2012. OALC stated the analysis of highest and best use of the property was revised from residential to mixed-use development. This was contrary to OIG's findings, as both appraisals state that the highest and best use of the property would be for mixed-use development. With effective oversight, OALC leadership could have avoided the possible overpayment and put this money to better use. Funds put to better use total $3,057,447.

IG Act Reporting Requirements Not Elsewhere Reported

Reviews of Legislative, Regulatory, and Administrative Proposals

OIG is required to review existing and proposed legislation and regulations and to make recommendations concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, OIG reviewed 180 proposals and made 21 comments.

Refusals To Provide Information or Assistance

The *Inspector General Act of 1978*, as amended, authorizes OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes OIG to request information or assistance from any Federal, State, or local government agency or unit as necessary in order to carry out the

duties and responsibilities prescribed to OIG in the Act. OIG is required to provide a summary of instances when such information or assistance is refused. OIG reports no such instances occurring during this reporting period.

Employee Recognition

OIG Employees Currently Serving on or Returning From Active Military Duty

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

- John Moore, a Hotline Analyst at OIG Headquarters, was activated by the U.S. Army National Guard in March 2013.
- Kenneth Sardegna, an Auditor at OIG Headquarters, was activated by the U.S. Army in June 2007.
- Charles Cook, a Health Systems Specialist in Bay Pines, FL, OHI, was activated by the U.S. Army in March 2014.
- Ricardo Wallace-Jimenez, a Criminal Investigator in Spokane, WA, Office of Investigations, was activated by the U.S. Army National Guard in June 2015 and returned from active military duty in September 2015.
- Brian Celetka, a Supervisory Criminal Investigator in Nashville, TN, Office of Investigations, was activated by the Air National Guard in July 2015 and returned from active military duty in September 2015.

Appendix A: Reports Issued During Reporting Period

Table 1: List of Reports Issued by Type				
Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
4/15/2015 15-01332-121	Review of Alleged Data Manipulation at VA Regional Office Boston, Massachusetts			
4/15/2015 14-03651-203	Review of Alleged Data Manipulation and Mismanagement at the VA Regional Office Philadelphia, Pennsylvania			$2,230,647
4/28/2015 14-02916-336	Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings			
4/30/2015 14-04493-198	Review of Alleged Mismanagement of Radiologists Interpretations at Central Arkansas Veterans Healthcare System			
5/14/2015 14-03380-356	Fiscal Year 2014 Review of VA's Compliance With the *Improper Payments Elimination and Recovery Act*			
5/19/2015 14-01820-355	*Federal Information Security Management Act* Audit for Fiscal Year 2014			
6/1/2015 14-01883-371	Audit of Fiduciary Program's Management of Field Examinations			
6/15/2015 15-02354-220	Review of Second Instance of Employee Manipulation at the Houston VA Regional Office			
6/17/2015 14-00730-206	Review of Alleged Improper Advances of VHA Appropriated Funds to the U.S. Government Printing Office	$35,200,000	$35,200,000	$7,900,000
6/29/2015 15-01927-375	Review of Alleged Mismanagement of Medical Supplies at the VA Medical Center, East Orange, New Jersey	$48,100	$48,100	
6/29/2015 14-01991-387	Audit of Homeless Providers Grant and Per Diem Case Management Oversight			
7/1/2015 14-04116-408	Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
8/5/2015 14-00545-343	Review of Alleged Mismanagement of VHA's Service-Oriented Architecture Research and Development Pilot Project			$2,600,000
8/17/2015 15-04652-448	Interim Report - Review of Alleged Shredding of Claims-Related Evidence at the VA Regional Office Los Angeles, California			
8/25/2015 13-03917-487	Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists	$567,000,000	$567,000,000	
8/27/2015 13-03922-453	Audit of Fiduciary Program Controls Addressing Beneficiary Fund Misuse			
8/31/2015 15-02397-494	Review of Alleged Mishandling of Ophthalmology Consults at the Oklahoma City, Oklahoma, VA Medical Center			
9/2/2015 14-01792-510	Review of Alleged Mismanagement at the Health Eligibility Center			
9/14/2015 13-00690-455	Follow-up Review of the Veterans Benefits Management System	$27,000,000	$27,000,000	
9/17/2015 14-02666-456	Review of Land Purchase for the Replacement Hospital in Louisville, Kentucky	$3,057,447	$3,057,447	
9/28/2015 14-04945-413	Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System			
9/29/2015 15-00718-507	Review of Patient-Centered Community Care (PC3) Provider Network Adequacy			
9/29/2015 14-03434-530	Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System			
9/30/2015 15-00574-501	Review of Patient-Centered Community Care (PC3) Health Record Coordination	$257,652	$257,652	$5,510,945
9/30/2015 15-02745-522	Review of VBA's Alleged Mismanagement of Unemployability Benefits at VA Regional Office Seattle, Washington			

Office of Audits and Evaluations | Audits, Evaluations, and Reviews				
Issue Date and Report Number	Title	Dollar Value of Funds		Questioned Costs
		Recommended for Better Use by OIG	Agreed to by Management	
9/30/2015 15-01590-523	Review of Alleged Inappropriate Referrals at VHA's Southern Nevada Healthcare System to a Non-VA Medical Provider			
9/30/2015 15-02053-537	Review of Alleged Improper Pay at Hudson Valley Health Care System	$2,962,765	$2,962,765	$ 592,553
		$635,525,964	$635,525,964	$18,834,145

Office of Audits and Evaluations | Benefits Inspections		
Issue Date	Number	Facility
5/19/2015	14-04876-204	VA Regional Office Indianapolis, Indiana
5/20/2015	14-04878-205	VA Regional Office Pittsburgh, Pennsylvania
7/28/2015	15-01193-433	VA Regional Office Louisville, Kentucky
7/30/2015	14-04983-412	VA Regional Office Cleveland, Ohio
8/25/2015	15-00001-436	VA Regional Office St. Petersburg, Florida
8/26/2015	15-00452-411	VA Regional Office Winston-Salem, North Carolina
8/26/2015	15-01290-435	VA Regional Office Wichita, Kansas
9/8/2015	15-02614-434	VA Regional Office Lincoln, Nebraska
9/9/2015	15-00399-410	VA Regional Office San Diego, California
9/9/2015	15-02706-485	VA Regional Office Fort Harrison, Montana
9/15/2015	15-01860-502	VA Regional Office Sioux Falls, South Dakota
9/17/2015	15-01381-437	VA Regional Office Phoenix, Arizona
9/17/2015	15-01996-503	VA Regional Office Honolulu, Hawaii
9/30/2015	15-01110-493	VA Regional Office Los Angeles, California

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
4/9/2015	15-00069-199	VA Puget Sound Health Care System, Seattle, Washington
4/9/2015	15-00073-200	Dayton VA Medical Center, Dayton, Ohio
4/16/2015	15-00030-202	Martinsburg VA Medical Center, Martinsburg, West Virginia
4/22/2015	15-00074-207	Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
4/30/2015	15-00032-226	VA Palo Alto Health Care System, Palo Alto, California
5/15/2015	15-00076-350	VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
5/18/2015	15-00075-351	VA St. Louis Health Care System, St. Louis, Missouri
5/21/2015	15-00077-352	William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

Office of Healthcare Inspections | Combined Assessment Program Reviews		
Issue Date	Number	Facility
6/2/2015	15-00078-364	VA Boston Healthcare System, Boston, Massachusetts
6/2/2015	15-00079-358	VA Sierra Nevada Health Care System, Reno, Nevada
6/4/2015	14-04220-363	Phoenix VA Health Care System, Phoenix, Arizona
6/25/2015	15-00601-376	North Florida/South Georgia Veterans Health System, Gainesville, Florida
7/2/2015	15-00594-389	Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
7/10/2015	15-00595-417	Chillicothe VA Medical Center, Chillicothe, Ohio
7/14/2015	15-00602-425	Iowa City VA Health Care System, Iowa City, Iowa
7/15/2015	15-00596-429	Central Texas Veterans Health Care System, Temple, Texas
7/22/2015	15-00598-446	Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
7/28/2015	15-00599-438	Mann-Grandstaff VA Medical Center, Spokane, Washington
8/18/2015	15-00597-462	Northport VA Medical Center, Northport, New York
8/18/2015	15-00603-477	G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi
8/24/2015	15-00607-483	San Francisco VA Health Care System, San Francisco, California
8/26/2015	15-00604-488	VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania
8/31/2015	15-00606-495	Battle Creek VA Medical Center, Battle Creek, Michigan
9/14/2015	15-00615-513	Durham VA Medical Center, Durham, North Carolina
9/17/2015	15-00619-515	Robley Rex VA Medical Center, Louisville, Kentucky
9/30/2015	15-00617-539	William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
9/30/2015	15-00616-543	VA New Jersey Health Care System, East Orange, New Jersey
9/30/2015	15-00605-544	VA Maine Healthcare System, Augusta, Maine
9/30/2015	15-00620-548	Manchester VA Medical Center, Manchester, New Hampshire

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	Number	Parent Facility
4/16/2015	15-00121-201	Veterans Health Care System of the Ozarks, Fayetteville, Arkansas
4/23/2015	15-00123-211	VA St. Louis Health Care System, St. Louis, Missouri
4/27/2015	15-00114-212	Ralph H. Johnson VA Medical Center, Charleston, South Carolina
5/5/2015	15-00110-228	VA Palo Alto Health Care System, Palo Alto, California
5/5/2015	15-00129-339	VA Roseburg Healthcare System, Roseburg, Oregon
5/6/2015	15-00124-227	VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
5/14/2015	15-00126-342	VA Boston Healthcare System, Boston, Massachusetts
5/15/2015	15-00112-338	VA Puget Sound Health Care System, Seattle, Washington
5/21/2015	14-04398-340	Beckley VA Medical Center, Beckley, West Virginia
6/4/2015	15-00127-357	VA Sierra Nevada Health Care System, Reno, Nevada
6/4/2015	15-00128-359	Phoenix VA Health Care System, Phoenix, Arizona
6/5/2015	15-00125-367	William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

Office of Healthcare Inspections | Community Based Outpatient Clinic Reviews		
Issue Date	**Number**	**Parent Facility**
6/11/2015	15-00143-372	North Florida/South Georgia Veterans Health System, Gainesville, Florida
6/11/2015	15-00131-373	Chillicothe VA Medical Center, Chillicothe, Ohio
7/13/2015	15-00138-392	Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
7/23/2015	15-00144-426	Iowa City VA Health Care System, Iowa City, Iowa
7/27/2015	15-00132-430	Central Texas Veterans Health Care System, Temple, Texas
7/27/2015	15-00130-432	Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
8/4/2015	15-00139-451	Mann-Grandstaff VA Medical Center, Spokane, Washington
8/7/2015	15-00134-454	Northport VA Medical Center, Northport, New York
8/19/2015	15-00152-481	G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi
8/27/2015	15-00156-490	San Francisco VA Health Care System, San Francisco, California
9/1/2015	15-00158-499	Durham VA Medical Center, Durham, North Carolina
9/1/2015	15-00154-500	VA Maine Healthcare System, Augusta, Maine
9/14/2015	15-00170-517	Robley Rex VA Medical Center, Louisville, Kentucky
9/15/2015	15-00153-508	VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania
9/28/2015	15-00165-529	William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
9/28/2015	15-00166-531	Alaska VA Healthcare System, Anchorage, Alaska
9/30/2015	15-00171-533	Manchester VA Medical Center, Manchester, New Hampshire
9/30/2015	15-00180-538	VA Pacific Islands Health Care System, Honolulu, Hawaii
9/30/2015	15-00176-541	Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

Office of Healthcare Inspections | National Healthcare Reviews		
Issue Date	**Number**	**Title**
4/22/2015	14-00378-208	Combined Assessment Program Summary Report - Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2014
6/3/2015	15-00911-362	Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities
6/16/2015	15-00359-374	Combined Assessment Program Summary Report - Evaluation of Medication Oversight and Education in Veterans Health Administration Facilities
6/18/2015	15-01297-368	Community Based Outpatient Clinics Summary Report - Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/24/2015	15-01721-382	Combined Assessment Program Summary Report - Evaluation of Selected Requirements in Veterans Health Administration Community Living Centers
7/30/2015	15-01579-457	Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
9/1/2015	15-03063-511	OIG Determination of Veterans Health Administration's Occupational Staffing Shortages

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
4/14/2015	14-03824-155	Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
4/16/2015	15-00347-154	Alleged Lack of Timeliness and Quality of Care Concerns at the Memphis VA Medical Center, Memphis, Tennessee
5/21/2015	13-04212-346	Administrative and Quality Care Concerns, Martinsburg VA Medical Center, Martinsburg, West Virginia
6/10/2015	15-02627-386	Alleged Poor Mental Health Care Resulting in a Patient Death, VA Central Iowa Health Care System, Des Moines, Iowa
6/11/2015	14-02195-381	Alleged Magnetic Resonance Imaging Order Deletion and Record Destruction, VA Greater Los Angeles Healthcare System, Los Angeles, California
6/15/2015	15-00425-380	Medication Management Concerns, South Texas Veterans Health Care System, San Antonio, Texas
6/16/2015	14-04573-378	Quality of Care and Access to Care Concerns Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma
6/17/2015	14-05158-377	Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine
6/18/2015	15-02456-396	Care of an Urgent Care Clinic Patient, Tomah VA Medical Center, Tomah, Wisconsin
6/23/2015	15-02276-391	Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia
6/24/2015	14-05078-393	Credentialing and Privileging Concerns, Wm. Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
6/25/2015	14-02634-397	Alleged Improper Maintenance of Reprocessing Equipment, Huntington VA Medical Center, Huntington, West Virginia
6/25/2015	14-04547-401	Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities
6/30/2015	15-01116-390	Alleged Mental Health Access and Treatment Deficiencies, Brunswick Community Outpatient Clinic, Brunswick, Georgia
7/2/2015	15-00191-406	Alleged Lapse in Timeliness of Care, West Palm Beach VA Medical Center, West Palm Beach, Florida
7/6/2015	14-04547-398	Alleged Quality of Care Concerns, Gene Taylor Community Based Outpatient Clinic, Mount Vernon, Missouri
7/6/2015	14-03688-399	Testing for Legionella, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania
7/7/2015	14-04049-379	Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado
7/7/2015	14-04260-395	Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, Arizona

Office of Healthcare Inspections | Hotline Healthcare Inspections		
Issue Date	**Number**	**Report Title**
7/7/2015	14-04077-405	Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska
7/7/2015	15-01445-400	Alleged Short-Stay Rehabilitation Unit Concerns, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
7/8/2015	14-04491-394	Communication and Quality of Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota
7/8/2015	14-04401-416	Staff and Management Concerns at the Jacksonville Outpatient Clinic, Jacksonville, Florida
7/9/2015	14-04037-404	Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
7/9/2015	14-04754-407	Alleged Colorectal Cancer Screening and Administrative Issues, VA Palo Alto Health Care System, Palo Alto, California
7/9/2015	15-01968-424	Alleged Poor Quality of Care and Refusal to Pay for Lung Transplantation, Iowa City VA Health Care System, Iowa City, Iowa
7/9/2015	14-04755-428	Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto Health Care System, Palo Alto, California
7/14/2015	14-00903-422	Quality of Care Issues, Sheridan VA Healthcare System, Sheridan, Wyoming
7/28/2015	15-00533-440	Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, California
7/29/2015	14-04530-414	Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015	14-04530-452	Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/30/2015	15-02842-450	Alleged Mold and Environment of Care Concerns in the Spinal Cord Injury and Disorders Units, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
8/6/2015	15-02131-471	Unexpected Death of a Patient During Treatment with Multiple Medications, Tomah VA Medical Center, Tomah, Wisconsin
9/2/2015	14-03531-402	Alleged Delayed Mental Health Treatment and Other Care Issues, Kansas City VA Medical Center, Kansas City, Missouri
9/3/2015	14-03833-385	Alleged Substandard Prostate Cancer Screening, VA Eastern Colorado Health Care System, Denver, Colorado
9/29/2015	14-02952-498	Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois
9/29/2015	13-00670-540	Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Health Care System, Fort Wayne, Indiana
9/30/2015	13-04038-521	Alleged Suicides and Inappropriate Changes to Mental Health Treatment Program, Coatesville VA Medical Center, Coatesville, Pennsylvania

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/21/2015	05-03285-225	Alleged Practice Inconsistencies, West Palm Beach VA Medical Center, West Palm Beach, Florida
4/21/2015	06-01512-224	Alleged Misdiagnosis, VA San Diego Healthcare System, San Diego, California
4/21/2015	06-01671-222	Quality of Care Issues, Bay Pines VA Medical Center, Bay Pines, Florida
4/21/2015	06-03056-221	Administrative Investigative Board, Atlanta VA Medical Center, Atlanta, Georgia
4/21/2015	09-01858-233	Alleged Quality of Care Issues at the Rhode Island State Veterans Home, Providence, Rhode Island
4/21/2015	09-03665-232	Alleged Cardiology and Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona
4/21/2015	10-00126-230	Lack of Cardiology and Vascular Services, Manchester VA Medical Center, Manchester, New Hampshire
4/21/2015	10-00689-231	Physician Privileging Issues, Marion VA Medical Center, Marion, Illinois
4/21/2015	10-02487-235	Alleged Patient Confidentiality, CBOC Staffing and Clinic Workload Issues, Ashtabula Community Based Outpatient Clinic, Ashtabula, Ohio
4/21/2015	10-03888-240	Alleged Mold Issues Impacting Employee and Patient Safety at the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
4/21/2015	11-00057-238	Time and Attendance Issues, John D. Dingell VA Medical Center, Detroit, Michigan
4/21/2015	11-00374-239	Alleged Emergency Department Safety Issues, Durham VA Medical Center, Durham, North Carolina
4/21/2015	11-00446-234	Review of Tucson VA Medical Center, Anthem CBOC, and Phoenix VA Medical Center, Arizona
4/21/2015	11-01025-242	Review of Alleged Quality of Care Issues, Manhattan Campus of the VA New York Harbor Health Care System, New York, New York
4/21/2015	11-01057-241	Patient Neglect in the Community Living Center, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
4/21/2015	11-01082-237	Alleged Quality of Care Concerns, Anesthesia Section, Dayton VA Medical Center, Dayton, Ohio
4/21/2015	11-01499-236	Alleged Delay in Diagnosis and Treatment of Cervical Cancer, VA North Texas Health Care System, Dallas, Texas
4/21/2015	12-01687-213	Alleged Research Irregularities, VA Western New York Health Care System, Buffalo, New York
4/21/2015	12-02154-214	Alleged Mismanagement of Resources, VA Montana Health Care System, Fort Harrison, Montana
4/21/2015	12-02884-218	Quality of Care Issues, Spokane VA Medical Center, Spokane, Washington

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/21/2015	12-03988-215	Teleretinal Imaging Program Review, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas
4/21/2015	13-00173-216	Home Oxygen Issues, Iowa City VA Health Care System, Iowa City, Iowa
4/21/2015	13-01208-217	Alleged Safety Issues in Mobile Health Clinics, Northport VA Medical Center, Northport, New York
4/22/2015	06-01538-257	Alleged Quality of Care Concerns, Southern Arizona VA Health Care System, Tucson, Arizona
4/22/2015	06-03398-259	Alleged Insufficient Staffing, Employee Health, and Patient Safety Issues, Marion VA Medical Center, Marion, Indiana
4/22/2015	06-03705-256	Alleged Physician Credentialing Violation and Inadequate Physician Supervision, VA Connecticut Healthcare System, West Haven, Connecticut
4/22/2015	07-00645-243	Staffing Issues in Anesthesiology, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
4/22/2015	07-01041-255	Suspicious Death, VA Connecticut Healthcare System, West Haven, Connecticut
4/22/2015	07-01995-258	Alleged Inappropriate Treatment, VA Puget Sound Health Care System, Seattle, Washington
4/22/2015	08-01704-246	Alleged Unsanitary Environment, San Bernardino Vet Center, San Bernardino, California
4/22/2015	08-01865-244	Quality of Care at the Michael E. DeBakey VA Medical Center, Houston, Texas
4/22/2015	08-02841-245	Allegations of Abuse of Controlled Substances Prescriptive Authority, James A. Haley VA Medical Center, Tampa, Florida
4/22/2015	09-00313-273	Allegation of a Physician Overmedicating Mental Health Patients, Malcolm Randall VAMC, NF/SGVHA (Valdosta CBOC)
4/22/2015	09-02826-271	Legionnaire's Disease-Related Testing, VA Pittsburgh Health Care System, Pittsburgh, Pennsylvania
4/22/2015	10-00348-270	Delay of Inter-Facility Transfer, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin
4/22/2015	10-00369-261	Alleged Failure to Diagnose Renal Cancer, Charles George VA Medical Center, Asheville, North Carolina
4/22/2015	10-01107-272	Alleged Conflict of Interest, Marion VA Medical Center, Marion, Illinois
4/22/2015	10-01388-275	Waiting Times for Mental Health Clinic Appointments, Atlanta VA Medical Center, Atlanta, Georgia
4/22/2015	10-02443-264	Review of Oral Cancer Diagnosis, Birmingham VA Medical Center, Birmingham, Alabama

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/22/2015	10-02852-260	Misuse of Intergovernmental Personnel Act Appointments to Pay Administrative Salaries at the East Bay Institute for Research and Education, Martinez, California
4/22/2015	10-03221-265	Out-of-Operating Room Airway Management, Central Arkansas VA Health Care System, North Little Rock, Arkansas
4/22/2015	10-03276-267	Review of Selected Surgical Services, Phoenix VA Health Care System, Phoenix, Arizon
4/22/2015	10-03463-263	Improper Handling of Laboratory Specimens at the VA Gulf Coast Health Care System, Biloxi, Mississippi
4/22/2015	11-00037-268	Delay of Diabetes Mellitus Diagnosis, VA Maryland Health Care System, Perry Point, Maryland
4/22/2015	11-00235-269	Alleged Quality of Care Issues, Robley Rex VA Medical Center, Louisville, Kentucky
4/22/2015	11-00530-262	Alleged Quality of Care Issues, Bay Pines VA Healthcare System, Bay Pines, Florida
4/22/2015	11-01519-251	Alleged Quality of Care Issues, VA Black Hills Health Care System, Fort Meade, South Dakota
4/22/2015	11-01978-247	Alleged Medical/Surgical Unit Staffing Deficiencies, Charles George Veterans Affairs Medical Center, Asheville, North Carolina
4/22/2015	11-03136-266	Alleged Dental Service Issues at Wilmington VA Medical Center, Wilmington, Delaware
4/22/2015	11-04406-252	Alleged Quality of Care Issues, VA Montana Health Care System, Fort Harrison, Montana
4/22/2015	12-00027-250	Quality of Care Issues at the Knoxville VA Outpatient Clinic, Knoxville, Tennessee
4/22/2015	12-00768-249	Adverse Outcomes after Minor Surgical Procedures, Central Alabama Veterans Health Care System, Montgomery and Tuskegee, Alabama
4/22/2015	12-01236-254	Quality of Care and Credentialing Issues, VA North Texas Health Care System, Dallas, Texas
4/22/2015	12-03253-253	Pharmacy Wait Time and Supply Availability, VA North Texas Health Care System, Dallas, Texas
4/22/2015	14-03184-248	Cardiology Patient Care Delays, New Mexico VA Health Care System, Albuquerque, New Mexico
4/23/2015	05-02815-223	Insufficient Staffing and Mismanagement Issues, Jesse Brown VA Medical Center, Chicago, Illinois
4/23/2015	06-00690-280	Delay in Neurosurgery Care, Bronx VA Medical Center, Bronx, New York
4/23/2015	06-01214-310	Patient Treatment Issues, Bay Pines VA Medical Center, Bay Pines, Florida

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/23/2015	07-01494-281	Patient Safety Issues, Hampton VA Medical Center, Hampton, Virginia
4/23/2015	07-01893-282	Alleged Quality of Care Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia
4/23/2015	08-00411-279	Alleged Credentialing and Privileging Irregularities and Background Issues at the VA Illiana Health Care System, Danville, Illinois
4/23/2015	08-00725-283	Non-Profit Research Corporation and Physician Time and Attendance Issues, Atlanta VA Medical Center, Atlanta, Georgia
4/23/2015	08-01325-312	Hiring Practices and Surgical Service Issues, VA Illiana Health Care System, Danville, Illinois
4/23/2015	08-02868-276	Quality of Care and Discharge Planning Issues, Martinsburg VA Medical Center, Martinsburg, West Virginia
4/23/2015	09-00717-277	Alleged Research Program Improprieties, VA Central Iowa Health Care System, Des Moines, Iowa
4/23/2015	09-01813-278	Alleged Quality of Care Issues, New Jersey Healthcare System, Lyons Campus, East Orange, New Jersey
4/23/2015	09-02066-274	Alleged Patient Care and Contracting Issues at the Loch Raven Community Living Center, VA Maryland Health Care System, Baltimore, Maryland
4/23/2015	11-03033-284	Alleged Fraudulent Computerized CPRS Documentation, Saginaw VA Medical Center, Saginaw, Michigan
4/23/2015	12-00206-290	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
4/23/2015	12-00206-291	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
4/23/2015	12-00336-293	Alleged Quality of Care Issues, St. Cloud VA Health Care System, St. Cloud, Minnesota
4/23/2015	12-02180-289	Allegedly Working While Intoxicated, Manchester VA Medical Center, Manchester, New Hampshire
4/23/2015	12-02378-294	Review of Alleged Quality of Care and Responsiveness Issues, Bay Pines VA Healthcare System, Bay Pines, Florida
4/23/2015	12-02438-311	Misrepresentation of an Unlicensed Researcher as a Physician, Michael E. DeBakey VA Medical Center, Houston, Texas
4/23/2015	12-02655-286	Alleged Quality of Care Concerns, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
4/23/2015	12-03247-298	Research Follow-Up and BSL-3 Issues, Office of Research Oversight, Washington, DC
4/23/2015	12-03354-285	Alleged Poor Clinical Practice by an Otolaryngologist, Southeast Louisiana Veterans Health Care System, New Orleans, Louisana

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/23/2015	12-04429-296	Review of Alleged Patient Abuse and Staff Issues, Tennessee Valley Healthcare System Alvin C. York Campus, Murfreesboro, Tennessee
4/23/2015	12-04535-305	Alleged Violation of Ethical Standards, Tallahassee Outpatient Clinic, Tallahassee, Florida
4/23/2015	12-04621-309	Alleged Patient Safety Issues, The Villages Outpatient Clinic, The Villages, Florida
4/23/2015	13-00448-297	Alleged Quality of Care Issues, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
4/23/2015	13-00756-302	Review of Alleged Quality of Care Issues, Rochester Community Based Outpatient Clinic, Rochester, Minnesota
4/23/2015	13-00902-301	Review of Delay in Treatment for Prostate Cancer, Phoenix VA Health Care System, Phoenix, Arizona
4/23/2015	13-00945-303	Scope of Practice, Patient Abuse, and Medication Management in the Surgical Intensive Care Unit, VA Salt Lake City Health Care System, Salt Lake City, Utah
4/23/2015	13-01247-308	Alleged Quality of Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
4/23/2015	13-01685-304	Review of Care of a Dying Patient, South Texas Veterans Health Care System, San Antonio, Texas
4/23/2015	13-01693-306	Review of Seattle Dermatology Quality of Care, VA Puget Sound Health Care System, Seattle, Washington
4/23/2015	13-01759-300	Review of Alleged Surgeon Competency and Quality of Care Concerns, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
4/23/2015	13-03001-295	Review of Mental Health Services Issues, El Paso VA Health Care System, El Paso, Texas
4/23/2015	13-03137-307	Review of Failure to Recognize and Respond to a Patient in Crisis, South Texas Veterans Health Care System, San Antonio, Texas
4/23/2015	13-03473-299	Community Living Center Patient Neglect/Abuse, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
4/24/2015	05-01370-332	Delay in Evaluation and Treatment of Pulmonary Metastasis from Malignant Melanoma, VA Illiana Health Care System, Danville, IL, Richard L. Roudebush VAMC, Indianapolis, Indiana, and Iowa City VA Health Care System, Iowa City, Iowa
4/24/2015	05-03445-324	Alleged Hiring Misconduct, Central Texas Veterans Health Care System, Temple, Texas
4/24/2015	06-01144-315	Alleged Compromised Quality of Care and Alleged Poor/Falsified Documentation, Lebanon VA Medical Center, Lebanon, Pennsylvania
4/24/2015	06-01390-322	Alleged Implanted Defective Stent-Graft Devices, Pittsburgh VA Medical Center, Pittsburgh, Pennsylvania

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/24/2015	06-01587-321	Alleged Quality of Care Issues, Fargo VA Medical Center, Fargo, North Dakota
4/24/2015	06-01764-323	Inadequate Supervision of Patients and Failure to Report Incidents at the Northern Arizona VA Health Care System, Prescott, Arizona
4/24/2015	06-02774-333	Alleged Patient Abuse, VA Maryland Healthcare System, Baltimore, Maryland
4/24/2015	06-02927-314	Compromised Patient Safety and Privacy at the New Mexico VA Health Care System, Albuquerque, New Mexico
4/24/2015	06-03685-331	Hospital Acquired Legionella Infection, Samuel S. Stratton VA Medical Center, Albany, New York
4/24/2015	08-00777-326	Alleged Quality of Care Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina
4/24/2015	08-01333-329	MRI Timeliness Involving VA Boston Healthcare System, Boston, Massachusetts, and Togus VA Medical Center, Augusta, Maine
4/24/2015	08-01399-334	Alleged Denial of Extended Care Services, VA Maryland Health Care System, Baltimore, Maryland
4/24/2015	09-00068-328	Quality of Care Issues, Tennessee Valley Healthcare System, Murfreesboro, Tennessee
4/24/2015	09-00775-330	Alleged Insufficient Staffing Issues at the Alaska VA Healthcare System and Regional Office, Alaska VA Healthcare System, Anchorage, Alaska
4/24/2015	09-02208-327	Quality of Care Concerns, VA Western New York Healthcare System, Buffalo, New York
4/24/2015	09-02508-325	Allegations that Retaliation Led to a Reduction in the Level of Care and that Patient Safety was Jeopardized, James A. Haley Veteran's Hospital, Tampa, Florida
4/24/2015	10-00480-313	Delay in Diagnosis, Lexington VA Medical Center, Lexington, Kentucky
4/24/2015	10-03929-337	Review of Alleged Discharge Planning Issues, Robley Rex VA Medical Center, Louisville, Kentucky
4/24/2015	11-00014-317	Opioid Use Policies at the Miles City and Glendive Community Based Outpatient Clinics, VA Montana Healthcare System, Fort Harrison, Montana
4/24/2015	11-02538-318	Clinical and Administrative Issues in the Residential Treatment Programs, Carl Vinson VA Medical Center, Dublin, Georgia
4/24/2015	11-02865-316	Increased Surgical Mortality and Falsification of Documents, Louis Stokes VA Medical Center, Cleveland, Ohio
4/24/2015	12-00206-320	Alleged Quality of Care Issues, Grand Junction VA Medical Center, Grand Junction, Colorado
4/24/2015	12-02149-319	Alleged Safety Issues in the Surgical Intensive Care Unit, New Mexico VA Healthcare System, Albuquerque, New Mexico

Office of Healthcare Inspections | Hotline Administrative Closures		
Publicly Released Date	**Number**	**Title**
4/24/2015	12-03148-335	Scheduling Practice and Fee Basis Review, Central Texas Veterans Health Care System, Temple, Texas
5/1/2015	13-00244-348	Alleged Violation of Patient Rights, Sheridan VA Health Care System, Sheridan, Wyoming
5/1/2015	14-04496-349	Consult Management Concerns, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas

Joint Reviews		
Issue Date	**Number**	**Report Title**
9/28/2015	15-02997-526	Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA
9/30/2015	14-04598-461	Review of Allegations Regarding Quality of Care, Professional Conduct, and Contractual Issues for Cardiothoracic Surgery and Perfusion Services at the VA North Texas Health Care System Provided by the University of Texas—Southwestern Medical Center

Office of Investigations | Administrative Investigations		
Issue Date	**Number**	**Report Title**
4/13/2015	13-01730-159	Improper Access to the VA Network by VA Contractors from Foreign Countries, Office of Information and Technology, Austin, Texas
5/28/2015	14-04494-347	Misuse of Position and Failure to Disclose and to Satisfy Financial Obligations, Veterans Benefits Administration, VA Regional Office Philadelphia, Pennsylvania
8/17/2015	13-03054-463	Improper Use of Web-based Collaboration Technology, Office of Information and Technology

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
4/13/2015	12-02591-209	Review of Proposal Submitted Under a Solicitation	$390,413
4/13/2015	15-01469-190	Review of Proposal Submitted Under a Solicitation	$4,947,343
4/15/2015	15-01793-219	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$4,790,266
4/22/2015	15-00514-229	Review of Federal Supply Schedule Contract Extension Proposal Submitted Under a Contract	

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
4/23/2015	15-01374-292	Review of Request for Modification Under a Federal Supply Schedule Contract	$1,990,769
4/23/2015	15-02010-288	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
4/27/2015	15-02976-287	Review of Proposal Submitted Under a Solicitation	$278,830
4/29/2015	14-02895-341	Review of Proposal Submitted Under a Contract	$76,518
5/6/2015	15-02316-354	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$8,741,488
5/15/2015	15-03085-360	Review of Proposal Submitted Under a Solicitation	$2,340,203
5/18/2015	15-01393-361	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$6,705,311
5/19/2015	15-02770-365	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
5/19/2015	15-03376-366	Review of Proposal Submitted Under a Solicitation	$738,495
5/27/2015	15-03379-369	Review of Proposal Submitted Under a Solicitation	$1,394,343
6/17/2015	15-02924-403	Review of Request for Modification Under a Federal Supply Schedule Contract	
6/23/2015	15-03758-388	Review of Proposal Submitted Under a Solicitation	$229,043
6/25/2015	15-04072-419	Review of Proposal Submitted Under a Solicitation	$13,533,795
6/25/2015	15-04089-418	Review of Proposal Submitted Under a Solicitation	$1,927,645
6/29/2015	15-02787-423	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$12,751,325
7/1/2015	15-03757-420	Review of Proposal Submitted Under a Solicitation	$555,495
7/2/2015	15-03922-427	Review of Proposal Submitted Under a Solicitation	$272,420
7/8/2015	15-03204-431	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
7/14/2015	15-04071-442	Review of Proposal Submitted Under a Solicitation	$1,984,180
7/14/2015	15-04155-441	Review of Proposal Submitted Under a Solicitation	$1,687,486
7/15/2015	15-03060-444	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$1,797,689
7/21/2015	15-04273-449	Review of Proposal Submitted Under a Solicitation	$423,754
7/23/2015	15-04152-445	Review of Proposal Submitted Under a Solicitation	$858,795
7/29/2015	15-03925-458	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
8/5/2015	15-03749-464	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
8/13/2015	15-04630-484	Review of Proposal Submitted Under a Solicitation	$8,635,941

Office of Contract Review | Preaward Reviews			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
8/13/2015	15-04632-486	Review of Proposal Submitted Under a Solicitation	$355,605
8/14/2015	15-03260-489	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
8/17/2015	15-03885-491	Review of Request for Modification Under a Federal Supply Schedule Contract	
8/17/2015	15-03931-492	Review of Request for Equitable Adjustment Proposal Submitted Under Contract	$435,155
8/24/2015	15-03643-506	Review of Product Addition Proposals Submitted Under a Federal Supply Schedule Contract	$1,464,416
8/24/2015	15-03884-505	Review of Contract Extension Proposal Submitted Under a Federal Supply Schedule Contract	$4,146,260
8/26/2015	15-05001-509	Review of Contract Extension Proposal Under Federal Supply Schedule Contract	
8/31/2015	15-04182-512	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$8,611,510
9/1/2015	15-04384-516	Review of Proposal Submitted Under a Solicitation	$198,335
9/10/2015	15-04991-527	Review of Proposal Submitted Under a Solicitation	
9/14/2015	15-03445-528	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$81,012,909
9/16/2015	15-04856-532	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	
9/17/2015	15-04666-534	Review of Proposal Submitted Under a Solicitation	$297,355
9/28/2015	15-04579-542	Review of Federal Supply Schedule Proposal Submitted Under a Solicitation	$3,287,760
			$176,860,852

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
4/7/2015	15-01151-210	Review of Public Law Compliance for the Covered Drug Under a Federal Supply Schedule Contract	$11,135
5/5/2015	14-04484-344	Review of Voluntary Disclosure and Refund Offers Under a Federal Supply Schedule Contract	$32,043
5/5/2015	15-00688-345	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$127,599
5/11/2015	15-02869-353	Review of a Federal Supply Schedule Contract	
6/8/2015	14-02891-383	Follow-up Review of Novo Nordisk, Inc. Self-Audit under Federal Supply Schedule Contracts	$20,171

Office of Contract Review | Postaward Reviews			
Issue Date	**Number**	**Report Title**	**Dollar Recoveries**
6/8/2015	15-01656-384	Review of Voluntary Disclosure Under a Federal Supply Schedule Contract	$89,171
7/14/2015	15-01589-439	Review of Voluntary Disclosure Submitted Under Federal Supply Schedule Contracts	$10,487
8/18/2015	15-02258-460	Review of Voluntary Disclosure Submitted Under Federal Supply Schedule Contracts	$558,480
8/19/2015	15-03984-496	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$896,113
8/27/2015	15-03929-504	Calculation of Unabsorbed Overhead in Connection with Complaint Submitted Under a Contract	
8/31/2015	14-00009-514	Review of Compliance with Public Law Under a Federal Supply Schedule Contract	$183,296
9/8/2015	15-02881-520	Postaward Review of a Federal Supply Schedule Contract	$1,385,308
9/23/2015	15-04056-536	Review of Voluntary Disclosure Submitted Under Federal Supply Schedule Contracts	$573
9/24/2015	14-03806-547	Review of Voluntary Disclosure and Refund Offer Under a Contract	$630,358
9/28/2015	11-02502-546	Review of Voluntary Disclosure and Refund Offer Under a Federal Supply Schedule Contract	$37,071
9/28/2015	14-00005-545	Review of Compliance with Public Law Under Federal Supply Schedule Contracts	$5,702,869
9/28/2015	14-03777-549	Postaward Review of a Federal Supply Schedule Contract	
			$9,684,676

Office of Contract Review | Claim Review			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
9/4/2015	14-04377-519	Review of Certified Claim	$10,090,327
			$10,090,327

Office of Contract Review | Special Reports			
Issue Date	**Number**	**Report Title**	**Savings and Cost Avoidance**
7/7/2015	14-04259-409	Improper Use of Title 38 Section 8153 Contracts to Fund Educational Costs of the Graduate Medical Education Programs of Affiliated Schools of Medicine	
8/7/2015	13-03592-443	Review of Healthcare Services Contracts at VA Pittsburgh Healthcare System in Pittsburgh, Pennsylvania	$44,082
9/30/2015	14-02899-415	Review of a Covered Drug Manufacturer's Interim Agreement under Letter Contract with VA's National Acquisition Center	
			$44,082

Total Potential Monetary Benefits of Reports Issued				
Report Type	**BUOF**	**Questioned Costs**	**Savings and Cost Avoidance**	**Dollar Recoveries**
Audits, Evaluations, and Reviews	$635,525,964	$18,834,145		
Preaward Reviews			$176,860,852	
Postaward Reviews				$9,684,676
Claim Review			$10,090,327	
Special Reviews				$44,082
	$635,525,964	**$18,834,145**	**$186,951,179**	**$9,728,758**

Table 2: Resolution Status of Reports with Questioned Costs		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0
Issued during reporting period	5	$18,834,145
Total inventory this period	**5**	**$18,834,145**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	5	$18,834,145
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**5**	**$18,834,145**
Total carried over to next period	**0**	**$0**

Table 3: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management		
Resolution Status	**Number**	**Dollar Value**
No management decision made by commencement of reporting period	0	$0

Table 3: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management

Resolution Status	Number	Dollar Value
Issued during reporting period	7	$635,525,964
Total inventory this period	**7**	**$635,525,964**
Management decisions made during the reporting period		
Disallowed costs (agreed to by management)	7	$635,525,964
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**7**	**$635,525,964**
Total carried over to next period	**0**	**$0**

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

Appendix B: Unimplemented Reports and Recommendations

The follow-up reporting and tracking of OIG report recommendations is 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 an OIG's report within 12 months of its issuance/publication. If the agency fails to complete final action within the 12-month period, OIG is required to identify the matter in each Semiannual Report to Congress and Periodic Status Report to Congress until final action on the management decision is completed.

Table 1 identifies the number of open OIG reports and recommendations with results sorted by action office. As of September 30, 2015, there are 256 total open reports and 1,432 total open recommendations. However, 13 reports and 15 recommendations are counted multiple times in Table 1 because they have actions at more than one office. Table 2 identifies the 47 reports and 102 recommendations that, as of September 30, 2015, remain open for more than 1 year. The total monetary benefit attached to these reports is $1,761,862,198.

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

	Reports Open More Than 1 Year	Reports Open Less Than 1 Year	Total Reports Open	Recommendations Open More Than 1 Year	Recommendations Open Less Than 1 Year	Total Recommendations Open
Veterans Health Administration	27	177	204	56	1137	1193
Veterans Benefits Administration	11	26	37	27	119	146
National Cemetery Administration	0	0	0	0	0	0
Office of Public and Intergovernmental Affairs	0	0	0	0	0	0
Office of Acquisitions, Logistics, and Construction	4	3	7	10	10	20
Office of Management (OM)	2	2	4	5	3	8
Office of Information and Technology	4	7	11	5	61	66
Office of Human Resources and Administration	1	1	2	1	5	6
Office of Operations, Security, and Preparedness (OSP)	2	0	2	2	0	2
Office of General Counsel	1	0	1	3	0	3
Chief of Staff (COS)	0	1	1	0	3	3
Total	**52**	**217**	**269**	**109**	**1,338**	**1,447**

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
07/11/06	**06-02238-163**	**Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans**	**OSP**	**None**
Recommendation d: We recommend that the Secretary ensure that all position descriptions are evaluated and have proper sensitivity level designations, that there is consistency nationwide for positions that are similar in nature or have similar access to VA protected information and automated systems, and that all required background checks are completed in a timely manner.				
06/07/10	**08-02969-165**	**Review of Federal Supply Schedule 621 I--Professional and Allied Healthcare Staffing Services**	**OALC**	**None**
Recommendation 1: We recommend that the Deputy Assistant Secretary for OAL [Office of Acquisition and Logistics] direct the NAC [National Acquisition Center] to not award any 621 I contracts unless the Contracting Officer can determine that the prices offered are fair and reasonable. *Recommendation 2: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to eliminate national NTE [not-to-exceed] pricing as a pricing objective, and to establish pricing objectives under 621 I contracts that are consistent with the goals of the FSS Program (MFC [most favored customer] pricing, or the best pricing to commercial customers purchasing under similar terms and conditions as the Government).* *Recommendation 3: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to revise the 621 I Solicitation's CSP [Commercial Sales Practices] format to require disclosure of information relevant to Recommendation 2.* *Recommendation 4: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to use price analysis methodologies that place significant reliance on the 621 I CSP disclosures, once revised.* *Recommendation 5: We recommend that the Deputy Assistant Secretary for OAL direct the NAC to cease using comparisons to existing FSS prices and/or national market surveys as methodologies for establishing price reasonableness.*				
02/18/11	**09-03850-99**	**Audit of the Veterans Service Network**	**OIT**	**$35,000,000**
Recommendation 3: We recommend the Assistant Secretary, Office of Information and Technology, define the level of effort and apply the resources required to complete data migration for all entitlement programs and decommission the Benefits Delivery Network legacy system.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/21/11	09-00981-227	Review of VHA Sole-Source Contracts with Affiliated Institutions	VHA	None
Recommendation 11: We recommend the Under Secretary for Health seek a legislative amendment to 38 U.S.C. § 8153 and § 7409 to authorize VA to enter into personal services contracts when the services are to be provided at a VA facility.				
02/23/12	11-00733-95	Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires	VBA	None
Recommendation 2: We recommend the Under Secretary for Benefits develop front-end controls for the disability benefits questionnaire process to verify the identity and credentials of private physicians who submit completed disability benefits questionnaires, including those entered into the Fast Track Claims Processing System. *Recommendation 4: We recommend the Under Secretary for Benefits develop controls to electronically capture information contained on completed disability benefits questionnaires.* *Recommendation 6: We recommend the Under Secretary for Benefits take steps to improve quality assurance reviews by focusing reviews on disability benefits questionnaires that pose an increased risk of fraud.*				
03/30/12	11-00312-127	Audit of VHA's Prosthetics Supply Inventory Management	VHA	$35,500,000
Recommendation 5: We recommended the Under Secretary for Health revise the Veterans Health Administration's Inventory Management Handbook to require at least one prosthetic supply inventory manager from each VA medical center to attend VA's Acquisition Academy's Supply Chain Management School and become Certified VA Supply Chain Managers.				
05/30/12	10-03166-75	Audit of VA Regional Offices' Appeals Management Processes	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals. *Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.* *Recommendation 3: We recommended the Under Secretary for Benefits implement criteria requiring appeals staff to initiate a review or development for Notices of Disagreement and certified appeals within 60 days of receipt.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 4: We recommended the Under Secretary for Benefits revise current policy to require de novo reviews on all appeals.				
09/28/12	**12-00375-290**	**Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC**	**OM/OGC**	**None**
Recommendation 4: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer convene an independent group to determine the appropriateness and the legal sufficiency of the Brecksville EUL [Enhanced Use Lease] and service agreements contained in the EUL, particularly in light of the indictment of Michael Forlani and the suspension of VetDev [Veterans Development, LLC] and other entities identified in the indictment, and take appropriate action to include long and short term plans, including the renegotiation of the terms and conditions of the agreements for the administration building and the parking garage. *Recommendation 5: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer make a referral to the VA's Procurement Executive for a determination whether any of the service agreements constitute an unauthorized commitment and, if so, take appropriate action to rectify the problem.* *Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer immediately determine what services VOA [Volunteers of America] is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.*				
09/28/12	**12-01012-298**	**Review of Open Market Purchases under VA's Pharmaceutical Prime Vendor Contract Number V797P-1020 Awarded to McKesson Corporation**	**VHA/OALC**	**None**
Recommendation 7: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction determine the feasibility of creating an electronic interface to allow the price files to be updated with the vendor supplied Excel spreadsheets to eliminate the necessity for manually entering prices. *Recommendation 8: We recommend that the Principal Executive Director for Acquisition, Logistics, and Construction seek legislative changes that would require manufacturers/dealers/resellers to offer generics on contracts.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 15: We recommend that the Under Secretary for Health and the Principal Executive Director for Acquisition, Logistics, and Construction conduct a study to determine the impact TAA [Trade Agreements Act] has in restricting access to generic pharmaceuticals and to what extent waivers or regulatory changes are necessary to ensure adequate product availability.				
09/30/12	**12-00165-277**	**Review of Alleged Delays in VA Contractor Background Investigations**	**OIT/OSP**	**None**
Recommendation 2: We recommend the Assistant Secretary for Operations, Security, and Preparedness, in conjunction with the Assistant Secretary for Information Technology, implement a central case management system to automate the background investigation process and effectively monitor VA contractor status and associated contract costs during the background investigation process.				
09/30/12	**12-02525-291**	**Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida**	**OM/OIT**	**$762,198**
Recommendation 25: We recommended the VA Secretary establish budgetary controls to ensure centralized accounting for individual conference expenditures. *Recommendation 26: We recommended the VA Secretary ensure conference budgets are authorized and monitored to ensure appropriate expenditures.* *Recommendation 43: We recommended the VA Secretary establish an effective cost system for credit card purchases that appropriately assigns costs to individual major VA events.*				
12/11/12	**11-00317-37**	**Audit of Vocational Rehabilitation and Employment Program's Self-Employment Services at Eastern and Central Area Offices**	**VBA**	**None**
Recommendation 3: We recommended the Under Secretary for Benefits develop and implement performance measures that evaluate the success of self-employment services.				
03/06/13	**12-02802-111**	**Review of Alleged Transmission of Sensitive VA Data Over Internet Connections**	**OIT**	**None**
Recommendation 1: We recommend the Assistant Secretary for Information and Technology identify VA networks transmitting unprotected sensitive data over unencrypted telecommunication networks and implement technical configuration controls to ensure encryption of such data in accordance with applicable VA and Federal information security requirements.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
03/28/13	**12-02503-151**	**Administrative Investigation, Misuse of Official Time and Resources and Failure to Properly Supervise, Office of Human Resources and Administration, Washington, DC**	**OHRA**	**None**
Recommendation 2: We recommend that the Acting Assistant Secretary for Human Resources and Administration determine the total salary paid to _____ for the 39 days that _____ was AWOL [absent without leave] from VA or worked for _____ while on sick leave and ensure that a bill of collection is issued to _____ for that amount, since _____ cannot receive pay for the period of time that _____ was absent without authorization.				
09/04/13	**12-00181-299**	**Audit of VBA's Pension Payments**	**VBA**	**$502,000,000**
Recommendation 1: We recommend the Under Secretary for Benefits ensure the Pension and Fiduciary Service implements procedures that ensure continued veteran and beneficiary eligibility. *Recommendation 4: We recommend the Under Secretary for Benefits establish a matching program with Medicaid to automatically identify veterans and beneficiaries that require nursing home adjustments.*				
10/22/13	**12-04046-307**	**Review of VA's Management of Health Care Center Leases**	**VHA/OALC**	**None**
Recommendation 1: We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction, in coordination with the Under Secretary for Health, establish adequate guidance for the procurement of large-scale build-to-lease facilities.				
02/06/14	**13-00872-71**	**Healthcare Inspection – Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina**	**VHA**	**None**
Recommendation 5: We recommended that the Facility Director ensure that infection control surveillance data is analyzed and trended, and that Infection Control Sub-Council minutes include required elements and reflect preventive and corrective measures.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
02/12/14	**13-03624-58**	**Healthcare Inspection – Alleged Patient Safety Concerns in the Operating Room, VA Maine Healthcare System, Augusta, Maine**	**VHA**	**None**
Recommendation 3: We recommended that the Facility Director implement the recommendations made during a protected Veterans Health Administration Surgical Program review.				
03/18/14	**14-00223-93**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Colorado Health Care System, Denver, Colorado**	**VHA**	**None**
Recommendation 2: We recommended that all staff document that medication reconciliation was completed at each episode of care when the newly prescribed fluoroquinolone was administered, prescribed, or modified.				
03/31/14	**13-02697-113**	**Review of the Lease Awarded to Westar Development Company, LLC for the Butler, Pennsylvania Health Care Center**	**OALC**	**None**
Recommendation 8: We recommended that the Principal Executive Director, OALC require vendors to submit documentation, such as teaming arrangements, that key team members such as architects, engineers, and GCs [general contractor] are committed and able to do the project				
04/08/14	**13-02053-119**	**Healthcare Inspection – Questionable Cardiac Interventions and Poor Management of Cardiovascular Care Edward Hines, Jr. VA Hospital, Hines, Illinois**	**VHA**	**None**
Recommendation 1: We recommended that the Facility Director ensure that cardiologists performing coronary interventions and surgeons performing cardiac surgery adhere to accepted standards of care.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
04/10/14	**14-00658-121**	**Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that patient care areas are clean and that water leaks and subsequent structural damage are addressed and resolved timely and that compliance be monitored.				
04/28/14	**14-00227-131**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at Birmingham VA Medical Center, Birmingham, Alabama**	**VHA**	**None**
Recommendation 4: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified. *Recommendation 5: We recommended that staff consistently provide written medication information that includes the flouroquinolone.* *Recommendation 6: We recommended that staff consistently provide medication counseling/education that includes the fluoroquinolone.*				
05/14/14	**13-03213-152**	**Audit of VHA's Mobile Medical Units**	**VHA**	**None**
Recommendation 4: We recommended the Under Secretary for Health publish necessary policy and guidance to provide for effective and efficient mobile medical unit operations.				
05/20/14	**13-04243-151**	**Combined Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware**	**VHA**	**None**
Recommendation 19: We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications and that compliance be monitored.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
05/27/14	**14-00686-166**	**Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan**	**VHA**	**None**
Recommendation 10: We recommended that the facility consult with VHA program managers regarding SPS [Sterile Processing Service] humidity control issues and that recommended actions be followed.				
05/28/14	**13-03018-159**	**Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub**	**VBA**	**None**
Recommendation 5: We recommended the Under Secretary for Benefits ensures the Eastern Area Fiduciary Hub implements a plan to expedite completion of their backlog of field examinations to meet performance standards.				
05/28/14	**14-01119-168**	**Healthcare Inspection – Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi**	**VHA**	**None**
Recommendation 1: We recommended that the System Director actively recruits and fills approved physician vacancies within the Extended Care Service.				
06/03/14	**13-02129-177**	**Audit of the Management of Concurrent VA and Military Drill Pay Compensation**	**VBA**	**$623,100,000**
Recommendation 1: We recommended the Under Secretary for Benefits take measures to ensure drill pay offsets identified after fiscal year 2012 are timely processed. *Recommendation 2: We recommended the Under Secretary for Benefits ensure fiscal years 2011 and 2012 drill pay offsets are processed.* *Recommendation 3: We recommended the Under Secretary for Benefits modify existing information technology systems to more effectively monitor, track, and report on drill pay offset activities.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
06/06/14	**14-01686-185**	**Follow-Up Audit of 100 Percent Disability Evaluations**	**VBA**	**$222,600,000**
Recommendation 1: We recommended the Under Secretary for Benefits ensure regional office staff take the appropriate action to review and process the records of all veterans with a temporary 100 percent disability evaluation within 180 days of the veteran's inclusion on the TRAP report or the veteran's scheduled exam.				
06/26/14	**14-00235-195**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilmington VA Medical Center, Wilmington, Delaware**	**VHA**	**None**
Recommendation 8: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				
06/26/14	**14-00914-190**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Kansas Health Care System, Topeka, Kansas**	**VHA**	**None**
Recommendation 1: We recommended that external signage clearly identifies the building as a VA CBOC at the Garnett CBOC. *Recommendation 8: We recommended that the parent facility's Emergency Management Committee evaluate the Chanute, Fort Scott, and Garnett CBOCs' emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.* *Recommendation 9: We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.* *Recommendation 10: We recommended that CBOC/Primary Care Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.*				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
07/07/14	11-00323-169	Follow-Up Audit of VHA's Workers' Compensation Case Management	VHA	$97,500,000
Recommendation 2: We recommended the Acting Under Secretary for Health establish a directive mandating Workers' Compensation Program specialists implement the workers' compensation guidebook to ensure specialists question the validity of claims lacking adequate supporting evidence. *Recommendation 3: We recommended the Acting Under Secretary for Health establish a structure with a clear chain of command to ensure workers' compensation compliance with case management requirements, oversight, and policy enforcement.* *Recommendation 4: We recommended the Acting Under Secretary for Health implement controls to ensure workers' compensation staff who are responsible for case management make job offers to medically able employees (repeat recommendation from the 2004 and 2011 VA Office of Inspector General audit reports).* *Recommendation 5: We recommended the Acting Under Secretary for Health ensure medical center directors assign adequate staff to manage Workers' Compensation Program cases (repeat recommendation from the 2004 and 2011 VA Office of Inspector General audit reports).*				
07/07/14	14-00910-205	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington	VHA	None
Recommendation 3: We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.				
07/08/14	14-00915-206	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Robert J. Dole VA Medical Center, Wichita, Kansas	VHA	None
Recommendation 13: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 14: We recommended that staff consistently provide written medication information that includes the fluoroquinolone. *Recommendation 15: We recommended that staff provide medication counseling/education as required.* *Recommendation 16: We recommended that staff document the evaluation of patient's level of understanding for the medication education.*				
07/11/14	**13-01452-214**	**Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments**	**VBA**	**$205,000,000**
Recommendation 1: We recommended the Under Secretary for Benefits ensure the Post-9/11 G.I. Bill application provides veterans with clear, adequate information on educational benefits and the requirement to relinquish other education benefits before submission. *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.* *Recommendation 7: We recommended the Under Secretary for Benefits reconcile Education Service procedures and Federal regulations and decide whether or not book stipends will be recovered from students who withdraw from courses without mitigating circumstances.* *Recommendation 8: We recommended the Under Secretary for Benefits ensure the Veterans Benefits Administration collects outstanding improper payments identified by this audit as defined by the Improper Payments Elimination and Recovery Act.*				
07/14/14	**13-03699-209**	**Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years**	**VBA**	**$40,400,000**
Recommendation 1: We recommended the Under Secretary for Benefits implement a plan to identify all provisionally-rated claims and ensure the proper controls are entered in the electronic system to track, manage, and complete them. *Recommendation 2: We recommended the Under Secretary for Benefits implement actions to include provisionally-rated claims in the rating inventory and correct the aging of provisional claims in pending workload statistics.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 3: We recommended the Under Secretary for Benefits implement a plan to expedite final decisions on all issues in provisionally-rated claims. *Recommendation 4: We recommended the Under Secretary for Benefits implement actions to complete quality reviews to ensure accuracy of all provisionally-rated claims processed under this Special Initiative.*				
07/14/14	**14-03644-225**	**Review of Alleged Mail Mismanagement at VBA's Baltimore VA Regional Office**	**VBA**	**None**
Recommendation 5: We recommend the Under Secretary for Benefits implement a plan to ensure Baltimore VA Regional Office staff assess the impact that mismanaged mail and claims processing actions had on benefits delivery and provide that information for our review.				
07/22/14	**14-00931-213**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at John D. Dingell VA Medical Center, Detroit, Michigan**	**VHA**	**None**
Recommendation 2: We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.				
08/01/14	**14-02065-230**	**Combined Assessment Program Review of the Washington DC VA Medical Center, Washington, DC**	**VHA**	**None**
Recommendation 15: We recommended that processes be strengthened to ensure that the medication list provided to the patient/caregiver at discharge is reconciled with the dosage and frequency ordered and that compliance be monitored.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
08/26/14	14-02603-267	Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System	VHA	None
Recommendation 1: We recommended the VA Secretary direct the Veterans Health Administration to review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients who suffered adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families. *Recommendation 9: We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care.* *Recommendation 13: We recommended that upon the completion of the investigation the VA Secretary confer with appropriate VA staff and determine whether administrative action should be taken against management officials at the Phoenix VA Health Care System and ensure that action is taken where appropriate.* *Recommendation 19: We recommended the VA Secretary provide veterans needed care in a timely manner and minimize the use of the Electronic Wait Lists.* *Recommendation 21: We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.* *Recommendation 23: We recommended the VA Secretary initiate actions to update the Veterans Health Administration's current electronic scheduling system and ensure milestones and costs are monitored.*				
08/28/14	14-00657-261	Audit of VBA's Efforts to Effectively Obtain Veterans' Service Treatment Records	VBA	None
Recommendation 1: We recommended the Under Secretary for Benefits improve monitoring to ensure Veterans Affairs Regional Office staff establish claims in the Veteran Benefits Administration's data systems within 7 days of receipt.				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 2: We recommended the Under Secretary for Benefits develop a timeliness standard for Veterans Affairs Regional Office staff making initial requests for service treatment records. *Recommendation 4: We recommended the Under Secretary for Benefits complete testing of the National Guard and Reserve pilot program and consider nationwide implementation based on results of the testing.*				
09/02/14	**14-02068-264**	**Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado**	**VHA**	**None**
Recommendation 3: We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed. *Recommendation 7: We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.* *Recommendation 8: We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.* *Recommendation 10: We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.* *Recommendation 11: We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.* *Recommendation 12: We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.* *Recommendation 13: We recommended that processes be strengthened to ensure that the Restorative Care Coordinator documents patient restorative program goals and progress weekly in accordance with facility policy and that compliance be monitored.* *Recommendation 14: We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and documented in patients' electronic health records and that compliance be monitored.*				

Table 2: Unimplemented OIG Reports and Recommendations More Than 1 Year Old				
Issue Date	**Number**	**Title**	**Responsible Organization(s)**	**Monetary Impact of Open Recommendations**
Recommendation 15: We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and placed in patients' electronic health records, that any contraindications are identified and resolution documented prior to the scan, that Level 2 personnel conducting the secondary screenings sign the forms prior to the scan, and that compliance be monitored. *Recommendation 16: We recommended that the facility implement processes to monitor compliance with colorectal cancer timeliness and patient notification requirements.*				
09/04/14	**14-02069-268**	**Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan**	**VHA**	**None**
Recommendation 2: We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored. *Recommendation 17: We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.*				
09/08/14	**14-00938-272**	**Community Based Outpatient Clinic and Primary Care Clinic Reviews at Minneapolis VA Health Care System, Minneapolis, Minnesota**	**VHA**	**None**
Recommendation 7: We recommended that clinical executive/primary care leaders ensure that CBOC/Primary Care Clinic Designated Women's Health Providers maintain proficiency as required for the provision of women's health care.				
09/11/14	**14-02072-283**	**Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon**	**VHA**	**None**
Recommendation 8: We recommended that processes be strengthened to ensure that licensed independent practitioners are notified of critical laboratory test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored.				

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

Issue Date	Number	Title	Responsible Organization(s)	Monetary Impact of Open Recommendations
Recommendation 9: We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the electronic health records and that compliance be monitored. *Recommendation 10: We recommended that processes be strengthened to ensure that safety plans contain documentation of assessment of available lethal means and ways to keep the environment safe and that compliance be monitored.*				
09/23/14	**14-02198-284**	**Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting**	**VHA**	**None**
Recommendation 1: We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record. *Recommendation 2: We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.*				
Total				**$1,761,862,198**

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On the Cover

Thousands of volunteers placed remembrance wreaths on veterans' graves at VA national cemeteries as part of Wreaths Across America. Ceremonies took place on Saturday, December 14, 2013. The Civil Air Patrol organizes the wreath-laying ceremonies with assistance from local citizens and veterans service organizations. All 131 VA national cemeteries receive at least seven wreaths, one for each service branch, one for the Merchant Marines and one for Prisoners of War and those Missing In Action (POW/MIA). This is the eighth year of Wreaths Across America, a nationwide program which distributes holiday wreaths as a tribute to veterans laid to rest at VA national cemeteries and state veterans cemeteries. It is also the 22nd year that the Worcester Wreath Company of Harrington, Maine, will donate wreaths to Arlington National Cemetery. Through this program, company president Morrill Worcester seeks to recognize veterans, active duty military and their families. His goal is to remind the public to remember the veterans, honor their service, and teach children the value of freedom. Photo courtesy of Robert Turtil.

Department of Veterans Affairs

Office of Inspector General

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