JULY 2021 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Testifies before Congressional Committees on VA's Electronic Health Record Modernization Program

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

Deputy Assistant Inspector General for Audits and Evaluations Testifies Before the House Veterans' Affairs Subcommittee on Oversight and Investigations

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

Investigations Involving Health Care

Former Pharmacy Technician at the East Orange VA Medical Center Indicted in Connection with Theft Scheme

A former pharmacy technician at the East Orange VA Medical Center in New Jersey was indicted on charges of conspiracy to steal pre-retail medical products belonging to the United States, theft of

government property, and theft of government medical products. An investigation by the VA OIG, the FBI, and VA Police Service resulted in charges alleging the defendant stole prescription human immunodeficiency virus (HIV) medication from the facility for several years. The loss to VA is approximately $10 million. The defendant was indicted in the District of New Jersey.

Two Former Compounding Pharmacy Employees Resentenced in Connection with 2012 Fungal Meningitis Outbreak

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

Former VA Ann Arbor Healthcare System Certified Nurse Anesthetist Pleads Guilty in Connection with Drug Diversion Scheme

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

Former VA Puget Sound Healthcare System Pharmacist Sentenced for Making Threats Against VA Employees

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

Veteran Pleads Guilty to Aggravated Harassment

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

Veteran Arrested for Making Threats Against VA Employees

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

Investigations Involving Benefits

Two Defendants Sentenced in Connection with Fiduciary Fraud Scheme

The owner of a former VA-appointed professional fiduciary was sentenced to 47 years' imprisonment and three years' supervised release and the owner's spouse was sentenced to 15 years' imprisonment and three years' supervised release after both previously pleaded guilty in connection with a fiduciary fraud scheme. Both defendants will be required to pay the entire amount of stolen funds as restitution to the victims. An investigation by the VA OIG, Social Security Administration (SSA) OIG, Internal Revenue Service Criminal Investigation, and the FBI revealed that from November 2006 to July 2017, the defendants engaged in a sophisticated financial scheme with two other individuals to defraud victims of their VA and SSA beneficiary funds. The defendants used funds that were unlawfully transferred from their clients' accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately $3.3 million. Both defendants were sentenced in the District of New Mexico.

Defendant Pleads Guilty in Connection with Life Insurance Fraud Scheme

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

Veteran Pleads Guilty to Theft of Government Funds

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

Defendant Pleads Guilty to Theft of Government Funds

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

Defendant Pleads Guilty to Theft of Government Funds

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

Audits and Reviews

VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules

The OIG examined whether responsible personnel at VHA medical facilities managed time and attendance for part-time physicians on adjustable work schedules. These physicians sign agreements estimating the number of hours they will work that must be reconciled with actual and allowed work hours. The OIG found VHA medical facilities did not ensure correct payments were made because key management controls were missing, or not working, and policies and procedures were not followed. Consequently, the OIG estimated VHA medical facilities had about $8.3 million in questioned costs in 2019, and an additional $8.3 million in 2020. Facilities also may have violated the Antideficiency Act by not correcting underpayments or by having physicians working above the annual 1,820-hour cap because their actual hours and work agreements were not reconciled. VA concurred with the nine recommendations to strengthen management controls, including determining whether Antideficiency Act violations occurred.

Alleged Unauthorized Control over a VA Beneficiary's Funds

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

Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program

The OIG audited VA's Electronic Health Record Modernization program to determine whether information technology (IT) infrastructure upgrade cost estimates met VA standards and Government Accountability Office guidance. The OIG also examined whether reports to Congress included all IT infrastructure upgrade costs needed to support the program. The audit revealed weaknesses in how cost estimates were developed and reported. Specifically, the $4.3 billion in infrastructure estimates reported to Congress were unreliable and lacked complete documentation. Also, VA did not report to Congress other critical program-related upgrade costs of about $2.5 billion, thus significantly underreporting total costs. The OIG made six recommendations for improving the reliability and reporting of cost estimates, including ensuring all costs are disclosed in estimates provided to Congress as required.

Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations

The OIG examined whether VA medical centers have adequate controls for, and provide sufficient oversight of, payments to affiliated nonprofit corporations. VA reimburses affiliates for all or part of the salaries and associated costs for research, education, and training. The OIG previously evaluated complaints involving affiliates with five VA medical centers. For this audit, the team also added medical centers in Albuquerque, New Mexico, and Palo Alto, California. The OIG estimated that the Albuquerque and Palo Alto medical centers made about $17.9 million in improper payments to affiliated nonprofit corporations. Procedures for approving invoices did not require verifying that the services were provided. The team also noted an absence of required periodic reviews by VA supervisors of approved invoices. Furthermore, VA's Nonprofit Program Office did not note these issues in its triennial reviews. The OIG made three recommendations.

VBA Overpaid Veterans Due to Delays in Reducing Compensation Benefits

VBA's Office of Field Operations is tasked with providing disability compensation benefits effectively and efficiently. Sometimes evidence causes VBA to consider decreasing or discontinuing them, called

proposals to reduce benefits. Benefits remain unchanged while veterans challenge proposed actions. Lengthy delays in distributing or working proposals can cause excessive payments that cannot be recouped by VA. The OIG found about 88 percent of claims reviewed involved delays. While the OIG shares VBA's goal to prioritize claims that grant veterans' benefits above proposed reductions, the latter cannot be allowed to stagnate.

Adaptive Sports Grants Management Needs Improvement

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

VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds

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

Contracted Residence Programs Need Stronger Monitoring to Ensure Veterans Experiencing Homelessness Receive Services

The OIG assessed whether VHA effectively monitored participants in the Contracted Residential Services program, which provides temporary housing and services to veterans experiencing homelessness. The audit team also examined how VHA administered program contracts to ensure veterans received needed services, contractors met the contract terms and conditions, and funds were used appropriately. The team found that medical facility staff did not consistently prepare case management documentation for veterans and monitor their progress in the program. Contracting officers

also did not always properly delegate responsibilities to staff who functioned as contracting officer's representatives. Other issues identified included invoices that lacked required supporting documentation. Based on its review of a statistical sample of 14 contracts, the audit team estimated that 107 of 119 contracts had monitoring and administration deficiencies, and that VHA made about $35.3 million in improper payments. The OIG made five recommendations for corrective action.

Healthcare Inspections

Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia

This inspection assessed a provider's documentation deficiencies and accumulated view alerts that may have resulted in patients' adverse clinical outcomes and reviewed facility leaders' actions. The OIG did not identify adverse clinical outcomes related to the provider's delinquent electronic health record (EHR) documentation and was unable to determine if patients experienced adverse clinical outcomes from the provider's 4,000 accumulated view alerts, because alerts were addressed and no longer viewable. Facility leaders implemented actions to address and monitor the provider's documentation deficiencies and found no accumulated view alert-related adverse clinical outcomes. However, leaders need to develop and implement strategies to manage view alerts and assess retrospective reviews related to accumulated view alerts. The facility also did not monitor EHRs for patients' episodes of care without associated progress notes or define providers' required view alerts' response time. The OIG made three recommendations related to providers' view alert time frames and monitoring EHRs and view alerts.

Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington

The OIG conducted an inspection to assess training for VA's transition to a new EHR system at the Mann-Grandstaff VA Medical Center in Spokane, Washington. The OIG identified multiple, broad deficiencies related to training content and delivery, VA Office of Electronic Health Record Modernization's attempt to evaluate training, contractor performance of work on training, and EHR modernization governance concerns. The OIG observed that center employees demonstrated a commitment to the EHR transition while prioritizing patient care during a global pandemic. The OIG made 11 recommendations related to training content and delivery, evaluating contractor performance, evaluating training, reviewing the governance of the EHR modernization effort, tracking EHR patient complaints, and assessment of employee morale.

Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque

This inspection evaluated allegations that Community Care (CC) consults were completed without scanning and attaching available clinical results to patients' EHR; consult completion triggered view alerts that consult results were available for review when they were not; and Veterans Integrated Service

Network 22 and facility leaders were aware of this practice and did not take action. The OIG substantiated that CC nurses completed consults without scanning and attaching clinical documentation to patients' EHRs. CC nurses lacked a comprehensive orientation and training program to provide the required knowledge and skills to correctly perform their duties. The chief of CC did not verify adherence to consult-related VHA requirements or conduct regular reviews to identify areas for improvements. The OIG made five recommendations related to the CC consult completion process, nursing competencies and training, committee oversight and monitoring, facility leaders' oversight, and CC organizational structure and leaders' expertise.

Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas

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

Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee

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

Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Healthcare System in Utah

The OIG conducted an inspection to assess allegations of lack of care coordination, a delay in care, refusal to hire a pharmacist, relocation delays, and bussing patients to the facility for care. The OIG substantiated the nurse delayed care by not returning the patient's call or discussing the patient's request and being off anticoagulant medications with the covering provider. The facility conducted an internal review that was incomplete and included inaccurate information and leaders were unable to determine if an institutional disclosure was warranted. The OIG substantiated the Orem community-based outpatient clinic relocation was delayed; however, the facility implemented a contingency plan to address the delay. The OIG did not substantiate a lack of care coordination, that the chief of pharmacy refused to hire a pharmacist and it affected the patient's ability to obtain medication, and that patients were bussed to the main facility for care. The OIG made three recommendations.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus: (1) leadership and organizational risks; (2) quality, safety, and value; (3) credentialing and privileging; (4) environment of care; (5) medication management; (6) mental health care; (7) geriatric care; (8) women's health; and (9) high-risk processes. Recently published CHIP reports include:

Veterans Integrated Service Network 10: VA Healthcare System Serving Ohio, Indiana and Michigan in Cincinnati

Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19

Boise VA Medical Center in Idaho

VA Portland Health Care System in Oregon

VA Puget Sound Health Care System in Seattle, Washington

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To listen to the podcast on the July 2021 highlights, go to www.va.gov/oig/podcasts.