AUGUST 2021 HIGHLIGHTS

Investigations Involving Health Care

Defendant Pleads Guilty in Connection with Theft Scheme

A defendant pleaded guilty in the District of New Jersey to conspiracy to steal government property. An investigation by the VA Office of Inspector General (OIG), FBI, and VA Police Service resulted in charges alleging the defendant conspired with a former pharmacy technician at the East Orange VA Medical Center in New Jersey to steal prescription human immunodeficiency virus medication from the facility for several years. The total loss to VA is approximately $8.2 million.

Two Defendants Indicted in Kidnapping of Elderly Woman with Dementia

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

Former Kerrville VA Medical Center Pharmacy Technician and Two Accomplices Indicted in Connection with Drug Diversion Scheme

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

Veteran Pleads Guilty to Making Threats

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

Veteran Arrested for Making Threats

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

Investigations Involving Benefits

Veteran Sentenced in Connection with Compensation Benefits Fraud Scheme

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

Veteran Indicted in Connection with Compensation Benefits Fraud Scheme

A veteran was arrested after being indicted in the Southern District of Florida for theft of government funds and false statements. A VA OIG investigation, which was initiated based upon a hotline complaint, resulted in charges alleging the defendant lied about his physical disabilities and manufactured combat stories to VA examiners to obtain a 100 percent permanent and total VA disability rating. It is alleged that, though he was a competitive bodybuilder, the defendant attended examinations using a cane and faked difficulty walking and moving his extremities. The total loss to VA is $245,286.

Defendant Sentenced in Connection with Theft Scheme

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

Audits and Reviews

Fiscal Year 2020 Risk Assessment of VA's Charge Card Program

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

end spending surges, but also because they accounted for 1.4 percent and 0.3 percent, respectively, of VA's FY 2020 spending on charge card transactions.

Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA

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

Improvements Still Needed in Processing Military Sexual Trauma Claims

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

Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program

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

opportunities to improve VHA medical facilities' management of the program. The OIG recommended documenting quarterly monitoring of services veterans receive, improving the provider billing and payment process, and ensuring veterans do not receive the same services through the VDC and Family Caregiver programs. VHA also should establish procedures to identify staffing needs and track demand for services.

Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020

The OIG determined whether VA complied with the requirements of the Payment Integrity Information Act of 2019 (PIIA) for FY 2020. VA did not comply with PIIA because it did not satisfy two of six requirements: to meet reduction targets for two programs, Pension and Purchased Long-Term Services and Supports, assessed to be at risk for improper payments and to report an improper payment rate of less than 10 percent for five VA programs and activities that had improper payment estimates in the materials accompanying the annual financial statement. VA satisfied the other four requirements. The OIG recommended the under secretary for benefits ensure the Pension Program meets its reduction target. The OIG also recommended the acting deputy under secretary for health ensure the Purchased Long-Term Services and Supports Program meets its reduction target and reduce improper payments for five VA programs to below 10 percent.

National Healthcare Reviews

Review of Veterans Health Administration Staffing Models

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

Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations

The OIG conducted a survey and interviews to evaluate select activities and challenges of MST coordinators and Veterans Integrated Service Network points of contact. The OIG also reviewed the

culture of safety for patients requesting MST-related care. Based on analysis of survey results and interview information, the OIG found that insufficient protected administrative time, role demands, insufficient support staff, and inadequate funding and outreach materials challenged MST coordinators' ability to fulfill their role's responsibilities. The OIG made one recommendation to the under secretary for health to evaluate the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of MST coordinators' responsibilities, and take action as warranted.

Healthcare Inspections

Deficiencies in Coordination of Care for Patients with Treatment-Resistant Depression at the VA San Diego Healthcare System in California

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

Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina

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

Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas

This inspection assessed the COVID-19 screening and treatment of a patient with serious mental illness. Facility staff did not complete the patient's COVID-19 temperature screening and failed to medically manage the symptomatic patient. The patient disappeared, was found non-responsive off-site four days later, taken to the facility, and died the following day. Mental health staff failed to address surrogacy documentation discrepancies and educate the family on COVID-19 screening and the visitor policy. Facility staff did not comply with the missing patient policy, report an adverse event, or ensure a timely review of the patient's care. Facility leaders did not timely or accurately disclose to the patient's family the medical mismanagement that led to the patient's adverse clinical outcome. The OIG made nine recommendations related to COVID-19 screening, visitor policy, mental health care coordination, surrogacy, missing and at-risk patients, adverse events, issue briefs, root cause analyses, and institutional disclosures.

Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

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

Deficiencies in the Management of a Patient's Reported Intimate Partner Violence, Ralph H. Johnson VA Medical Center, Charleston, South Carolina

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

Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin

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

Financial Inspection

Financial Efficiency Review of the Miami VA Healthcare System

The OIG assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Miami VA Healthcare System in Florida. The review focused on four areas: (1) use of the Medical/Surgical Prime Vendor-Next Generation program, a collection of contracts that streamlines purchasing for certain medical supplies; (2) use of purchase cards, such as requirements for documenting transactions; (3) the number of administrative staff compared to similar facilities and the accurate recording of labor costs; and (4) efficiency in pharmacy operations, such as inventory management and the healthcare system's efforts to reduce costs. The OIG made 12 recommendations for improving cost efficiency to the healthcare system director.

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
(9) High-risk processes

Recently published CHIP reports include:

VA Eastern Colorado Health Care System in Aurora

Montana VA Health Care System in Fort Harrison

VA Western Colorado Health Care System in Grand Junction

Sheridan VA Medical Center in Wyoming

Veterans Integrated Service Network 20: VA Northwest Health Network in Vancouver, Washington

Mann-Grandstaff VA Medical Center in Spokane, Washington

Roseburg VA Health Care System in Oregon

Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2020

VA Salt Lake City Health Care System in Utah

Additional Publications

Medical Facilities Forfeited Drug Return Credits through Inadequate Monitoring of Vendor Invoices

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

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