OCTOBER 2021 HIGHLIGHTS

Congressional Testimony

Deputy AIG for Healthcare Inspections Testifies on Patient Safety before House Veterans Affairs' Subcommittee on Health

Dr. Julie Kroviak, the deputy assistant inspector general for Healthcare Inspections, testified on October 27, 2021, before the House Veterans Affairs' Subcommittee on Health. Her testimony focused on patient safety and the quality of care at VHA medical facilities—highlighting several OIG healthcare inspections and criminal investigations. She emphasized the need for creating an environment that encourages staff reporting of concerns, immediate review and corrective action on patient safety issues, consistent accountability, information-sharing on lessons learned, and strong experienced leaders who constantly communicate key values to achieve transformation. In response to questions, Dr. Kroviak discussed the need to standardize governance structures at the Veterans Integrated Services Network (VISN) level and the need for collaboration between VA medical facilities and Vet Centers, drawing on findings from recent Vet Center Inspection Program reports. Dr. Kroviak noted that although the vast majority of VHA staff are dedicated to providing high-quality care, patient safety must be a continuous activity that fuels every interaction with those receiving care.

Healthcare Investigations

Former Surgical Service Supervisor at VA Medical Center in Cleveland Sentenced for Theft and Kickback Scheme

An investigation by the VA OIG and FBI revealed that a former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. To justify the purchase of surgical implant devices from the vendor, the supervisor falsified patient records to make it appear as if patients had needed the implants, but in fact they did not correlate to any actual surgical or medical procedures. In a separate scheme, he fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to buy goods from a company that he controlled. He was sentenced in the Northern District of Ohio to 37 months' imprisonment and ordered to pay more than $1.2 million in restitution to VA. The medical supplies vendor also pleaded guilty to wire fraud, conspiracy to commit wire fraud, and "honest services" (depriving others of the right to honest services) wire fraud.

Registered Nurse at VA Medical Center in Detroit Indicted in COVID-19 Vaccination Card Fraud Scheme

A registered nurse at the John D. Dingell VA Medical Center in Detroit allegedly stole from the facility authentic COVID-19 vaccination record cards and noted the vaccine lot numbers necessary to make the

cards appear legitimate. The nurse then allegedly resold the cards for $150 to $200 each to individuals within the Detroit area. She was indicted in the Eastern District of Michigan on charges of theft of government property and theft or embezzlement related to a healthcare program. The investigation was conducted by the VA OIG, Department of Health and Human Services OIG, and VA Police Service.

Nonveteran Drug Trafficker Sentenced in Connection with Distribution Scheme

A nonveteran was sentenced for being part of a drug-trafficking organization that distributed cocaine, heroin, and controlled pharmaceuticals throughout Connecticut, including to veterans at the VA medical center in West Haven. He was sentenced in the District of Connecticut to 70 months' incarceration and 48 months' supervised release. The VA OIG, Drug Enforcement Administration, West Haven Police Department, and FBI conducted the investigation.

Veteran Sentenced in Connection with Travel Fraud Scheme

A VA OIG investigation found that from November 2016 to August 2019 a veteran submitted nearly 500 travel reimbursement claims to VA, which resulted in his receipt of over $95,000. For most of these claims, the veteran reported that he travelled about 450 miles round trip an average of three to four times per week for chiropractic and physical therapy appointments. In reality, the defendant stayed at a residence less than 15 miles from his chiropractic and physical therapy appointments. He was sentenced in the District of Kansas to 24 months' probation and ordered to pay $50,000 in restitution to VA after previously pleading guilty to making false statements.

Veteran Sentenced for Leaving Harassing Voicemails for VA Medical Center Staff

A VA OIG and VA Police Service investigation revealed that a veteran, who was previously convicted for making threats against the VA medical centers in Albany and Canandaigua, also left threatening and harassing voicemail messages for multiple employees at the Albany Stratton VA Medical Center in New York. The veteran was sentenced in the Northern District of New York to 24 months' imprisonment and one year of supervised release after previously pleading guilty to aggravated harassment.

Veteran Charged with Making Threats

According to an investigation by the VA OIG and VA Police Service, a veteran left a threatening voicemail message at the VA outpatient clinic in Mansfield, Ohio, after his prescription for a controlled substance medication was discontinued by his medical provider. The veteran allegedly threatened to kill the medical provider and her entire family. He was arrested after being charged in the Northern District of Ohio with making threats against a federal employee.

Benefits Investigations

Director of Trucking School Sentenced in Connection with Education Benefits Fraud Scheme

The director and certifying official of a trucking school was sentenced in connection with a scheme that involved the fraudulent enrollment of veterans at the school from 2011 to 2015. According to the

investigation, which was conducted by the VA OIG, FBI, and Department of Justice OIG, the school's owner, employees, and veteran students either conspired or had knowledge of the scheme. The director was sentenced in the Central District of California to 15 months' imprisonment, three years' supervised release, and restitution of over $4 million. The total loss to VA is approximately $4.1 million.

Investigations Involving Other Matters

Four Defendants Pleaded Guilty in Connection with False Surety Bond Scheme

A VA OIG and Environmental Protection Agency OIG investigation exposed that four individuals provided federal, state, and local government agencies and private construction companies with worthless surety bonds by using nonexistent assets (land, trusts, and gold) to back the bonds. They collected nearly $6 million in fees for the fraudulent bonds from the government and private contractors. Over $1 billion of government and private construction projects were at risk of default due to this scheme, potentially leaving the government and private entities financially responsible for the total amount of the contracts. The contracts included construction projects at VA medical centers and national cemeteries, Department of Defense military bases, and vital public infrastructure such as housing projects, major bridges, and dams. The defendants pleaded guilty in the Southern District of Florida to conspiracy to commit mail and wire fraud.

Construction Company Agreed to Pay $4.75 Million to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that a construction company violated the False Claims Act by creating a service-disabled veteran-owned small business (SDVOSB) as a "pass-through" to obtain set-aside contracts for which it was otherwise ineligible. The company entered into a consent judgment with the US Attorney's Office for the Western District of New York under which the company agreed to pay approximately $4.75 million to resolve the allegations. The total value of the VA contracts awarded to the SDVOSB was approximately $20 million. The VA OIG, Small Business Administration (SBA) OIG, Defense Criminal Investigative Service, and Army Criminal Investigation Command conducted the investigation.

Defendant Sentenced in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

Another multiagency investigation also found that two individuals fraudulently obtained several SDVOSB set-aside construction contracts valued at more than $16 million. Of this amount, the total value of the VA set-aside contracts is approximately $4.3 million. One defendant was sentenced in the District of Utah to 12 months' probation and a fine of $105,100 after previously pleading guilty to major program fraud. The second defendant was previously sentenced to 24 months' probation and a fine of $52,500 after pleading guilty to the same offense. This investigation was conducted by the VA OIG, General Services Administration OIG, Air Force Office of Special Investigations, Army Criminal

Investigation Command, Department of Transportation OIG, Department of Agriculture OIG, SBA OIG, and FBI.

Audits and Reviews

Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance

The OIG examined whether VISN 21 effectively managed its nonrecurring maintenance (NRM) needs by executing medical facilities' long-range action plans. Within VISN 21, deferred maintenance cost estimates had significantly increased in the prior decade from $599.3 million in FY 2012 to $1.4 billion by March 2021. VISN 21 medical facilities executed only 18 percent of their approved NRM projects for FYs 2015–2018, increasing the risk for health service interruptions, environmental problems, accidents, and driving up operating costs. Several factors contributed to these issues: execution of nonurgent, out-of-cycle projects; insufficient engineering staffing; misalignment of long-range action plans with the NRM program's budget; and a lack of program performance metrics. The OIG made seven recommendations to help VA more effectively manage its NRM needs. The recommendations included establishing and enforcing urgent-need criteria, implementing and annually reviewing an engineering staffing model that aligns with NRM needs, ensuring feasible long-range action plans, and establishing NRM performance metrics.

Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments

Social Security payments may increase annually based on changes to the cost of living. When this happens, VA reduces pensions for veterans and other beneficiaries because they are receiving more income from another source. The OIG received two allegations in 2020 that the automated letters sent to beneficiaries failed to provide proper notification before pensions were reduced or discontinued.
The review team found that pensions were not reduced in accordance with VA policies to (1) include specific information in the notification letters (such as the current and proposed pension amounts) and (2) consider evidence that the pension should not be reduced. The team determined that the monetary impact on each beneficiary was limited. However, inadequate processing of pension reductions could result in improper benefit payments, unnecessary debts, and undue stress for beneficiaries. The OIG made three recommendations to the under secretary for benefits to address the issues identified.

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:

- Leadership and organizational risks
- COVID-19 pandemic readiness and response
- Quality, safety, and value
- Registered nurse credentialing
- Medication management (targeting remdesivir use for COVID-19)
- Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
- Care coordination (spotlighting interfacility transfers)
- High-risk processes (examining the management of disruptive and violent behavior)

Recently published CHIP reports include the following:

James A. Haley Veterans' Hospital in Tampa, Florida

Bay Pines VA Healthcare System in Florida

VA Caribbean Healthcare System in San Juan, Puerto Rico

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