NOVEMBER 2021 HIGHLIGHTS

Congressional Testimony

Inspector General Testifies on Military Sexual Trauma before US House Veterans' Affairs Subcommittees

Inspector General Michael Missal testified before the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health on November 17, 2021, about the OIG's work regarding benefits and health care for individuals who have experienced military sexual trauma (MST). His testimony focused on the findings from two OIG reports published in August 2021 that address Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) actions related to MST benefits and healthcare services. In the first report, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, the OIG noted that VBA had not effectively implemented the recommendations from an OIG August 2018 report on MST claims. Based on a sample of claims processed after VBA acted on the prior OIG recommendations, the review team estimated about 57 percent of denied claims were incorrectly processed. That rate reflects a decided lack of improvement from the 49 percent error rate noted in the August 2018 report. VBA did not adequately manage the MST-related claims process or provide sufficient oversight. In the second report, *Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations*, the OIG found that MST coordinators at VA medical facilities were often unable to fulfill their roles and responsibilities due to insufficient protected administrative time, competing role demands, limited support staff, and inadequate funding and outreach materials. Inspector General Missal stressed that VA must improve its processes and practices that provide compensation and healthcare services to those who have experienced MST to ensure that those seeking care are not retraumatized and their needs are met. Mr. Missal's written statement is available on the OIG website.

Counselor to the Inspector General Testifies on Pending Legislation before the Senate Veterans' Affairs Committee

Chris Wilber, Counselor to the Inspector General, testified before the Senate Veterans' Affairs Committee on November 17, 2021, at a hearing to consider pending legislation, including S.2687, the Strengthening Oversight for Veterans Act of 2021, and S.2431, the Department of Veterans Affairs Office of Inspector General Training Act of 2021. Mr. Wilber testified in support of both bills. The first bill would give the VA OIG testimonial subpoena authority, which would enable it to compel testimony from former federal employees, former employees of current federal contractors, employees of former federal contractors, and others who do not have an employment or contractual relationship with VA at the time of an audit, review, inspection, or administrative investigation. He discussed the safeguards associated with ensuring this authority is properly used. Mr. Wilber also detailed examples of when the OIG could not interview individuals who left VA just as the OIG was examining a matter, or other witnesses whose testimony was important to conducting thorough oversight of VA personnel, programs,

and operations. The second bill would mandate that VA employees receive one-time training on when and how to report suspected wrongdoing to the OIG and how and when to engage with its staff. It would also enable the OIG to send all-employee emails to VA staff, such as for crime or fraud alerts. He noted that passage of this legislation would empower VA employees to help the OIG identify and address wrongdoing. Enhanced cooperation and reporting outlined in the training can also lead to improvements to VA's operations, cost-saving efforts, patients safety and quality care, and timely benefits and services to eligible veterans. His written statement is available on the OIG website.

Deputy Assistant Inspector General for Audits and Evaluations Testifies on VA's Medical Supply Chain before US House Veterans' Affairs Subcommittees

Leigh Ann Searight, Deputy Assistant Inspector General for Audits and Evaluations, testified before the House Veterans' Affairs' Subcommittee on Oversight and Investigation and the Subcommittee on Technology Modernization about VA's efforts to modernize its supply chain. She focused on the recent OIG report, *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays* and referenced past OIG work related to supply chain deficiencies that can affect getting supplies for patient care when and where they are needed. She responded to questions regarding the ability of the Defense Medical Logistics Standard Support (DMLSS) system to handle VA's requirements across the enterprise for supplies and provide real-time information on supply levels. She noted that VA did not follow its own acquisition framework requirements to ensure the DMLSS system meets the high-priority requirements of medical facilities and that the Veterans Affairs Logistics Redesign (VALOR) program office, which was tasked with managing the deployment of the DMLSS system, lacked a supportive structure and coordination with stakeholders. She concluded that VA still faces considerable challenges to modernize its systems. Ms. Searight's written statement is also available on the OIG website.

Healthcare Investigations

Former Pharmacy Technician at the East Orange VA Medical Center Pleaded Guilty to Theft

An investigation by the VA OIG, Federal Bureau of Investigation (FBI), and VA Police Service revealed that a former pharmacy technician at the East Orange VA Medical Center in New Jersey stole prescription human immunodeficiency virus (HIV) medication from the facility for several years. The former employee then sold the HIV medication for cash. The defendant pleaded guilty in the District of New Jersey to theft of government property. The loss to VA is approximately $10 million.

Former Purchasing Agent at the Jesse Brown VA Medical Center and Medical Supply Company President Indicted for Wire Fraud

A VA OIG investigation resulted in charges alleging that between 2017 and 2020, a former purchasing agent at the Jesse Brown VA Medical Center in Chicago, Illinois, conspired to purchase medical supplies from a vendor in exchange for kickbacks of at least $220,000. The vendor received

approximately $2.8 million in VA purchase card orders from the former employee, of which approximately $1.38 million are alleged to have been fraudulent. The former employee and the president of the medical supply company were indicted in the Northern District of Illinois on charges of wire fraud.

Another Former Purchasing Agent at the Jesse Brown VA Medical Center and Medical Supply Company President Indicted for Roles in Bribery Scheme

According to a VA OIG investigation, a second former purchasing agent at the Jesse Brown VA Medical Center conspired to purchase medical supplies from a vendor in exchange for kickbacks. The vendor received approximately $330,000 in VA purchase card orders; the former employee received at least $39,850 in kickbacks. Both the former employee and the president of the medical supply company were indicted in the Northern District of Illinois on charges of bribery and conspiracy to commit bribery.

Twenty People Indicted on Charges Related to Healthcare Fraud Conspiracy

A multiagency investigation resulted in charges alleging that 20 defendants—including the two founders of a physical therapy practice and 18 of its employees—conspired to commit fraud through various means. From January 2007 to October 2021, the defendants allegedly used unlicensed technicians to provide physical therapy treatment and billed the treatment as if it were performed by a licensed physical therapist or physical therapy assistant, and regularly billed for treatment time in excess of the actual treatment time spent with patients. The defendants were indicted in the Western District of Pennsylvania on charges of conspiracy to commit wire fraud and healthcare fraud. The total amount of loss to the government is approximately $22 million. Of this amount, the total loss to VA is approximately $500,000. The VA OIG, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), Office of Personnel Management OIG, Pennsylvania Office of Attorney General, and the FBI conducted this investigation.

Three Defendants Pleaded Guilty in Connection with Healthcare Fraud

Three defendants were charged with participating in a scheme involving telemarketers, telemedicine doctors, and the sale of durable medical equipment (DME). Telemarketers allegedly solicited braces to prospective patients and then used telemedicine doctors to generate prescriptions, even though they had no relationship with the patients. The telemarketers, in turn, sold the completed orders to the DME companies. Many of the target companies identified in the scheme submitted claims for payment to VA's Civilian Health and Medical Program. The three defendants pleaded guilty in the District of New Jersey to conspiracy to commit healthcare fraud, with two also being indicted on various charges related to healthcare fraud. The loss to VA is approximately $330,000. To date, investigative efforts by the VA OIG, DCIS, FBI, and HHS OIG have led to 17 arrests and 13 convictions.

Former Chief of Pharmacy at the Erie VA Medical Center Pleaded Guilty to Diverting Painkillers

A VA OIG investigation revealed that from 2017 to 2020, the former chief of pharmacy at the Erie VA Medical Center diverted at least 300 hydrocodone and oxycodone tablets for his personal use by removing the tablets from prescription bottles that were waiting to be mailed to veterans. The defendant pleaded guilty in the Western District of Pennsylvania to acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge.

Former Physician at the Chula Vista VA Clinic Charged with Invasion of Privacy

A VA OIG and VA Police Service investigation resulted in charges alleging that a former physician at the Chula Vista VA Clinic secretly planted a concealed video recorder in the facility to record numerous staff members as they used the restroom. The defendant was arraigned in San Diego County Superior Court after being charged with invasion of privacy.

Former Medical Support Assistant at the Memphis VA Medical Center Sentenced for Assaulting Federal Officers

A former medical support assistant at the VA medical center in Memphis, Tennessee, assaulted two VA police officers as they carried out their official police duties. The defendant was initially observed assaulting a third individual in the facility's parking lot. As a VA police officer attempted to detain the defendant, she resisted arrest and struck him several times. After being escorted to the VA Police Service's holding area, the defendant punched another VA police officer in the face, leaving visible marks and scratches. The VA OIG and VA Police Service investigated the matter, and the defendant was sentenced in the Western District of Tennessee to 10 months' imprisonment and one year of supervised release.

Benefits Investigations

Three Defendants Guilty of Identity Theft and Other Charges

A multiagency investigation resulted in charges alleging that defendants in Jamaica were redirecting the monthly benefit payments of veterans and Social Security recipients to alternate bank accounts. The stolen funds were then loaded onto prepaid credit cards and mailed to codefendants in the Miami and Atlanta areas. The codefendants removed the funds, kept a portion, and sent the remainder back to Jamaica. These subjects also participated in telemarketing scams that targeted elderly US citizens. Two defendants were convicted at trial in the Southern District of Florida on charges of conspiracy to commit bank fraud, conspiracy to commit wire fraud, and aggravated identity theft. A third defendant pleaded guilty to the same counts. The VA OIG, Homeland Security Investigations, and US Postal Inspection Service conducted the investigation. To date, 18 nonveterans have been indicted, 15 arrested, 15 convicted, and nine sentenced to a combined 451 months' incarceration, 288 months' supervised release, 36 months' probation, and approximately $2.5 million in restitution. The total loss to VA is more than $7 million.

Defendant Sentenced for Theft of Government Funds

A VA OIG and Social Security Administration (SSA) OIG investigation determined that from October 2002 until December 2019, a nonveteran 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 electronically deposited. The total loss to the government is $673,584. Of this amount, the loss to VA is $548,459. The defendant was sentenced in the Eastern District of Pennsylvania to six months' home confinement, three years' probation, and restitution of $673,584 after previously pleading guilty to theft of government funds.

Former VA Fiduciary Sentenced for Misappropriation

A former VA-appointed fiduciary was sentenced in the Western District of Pennsylvania to one day of incarceration, three years' supervised release, restitution of $75,000, and a fine of $4,000 after previously pleading guilty to misappropriation by a fiduciary. A VA OIG investigation found that the defendant embezzled VA funds intended for his veteran brother, including over $130,000 in unauthorized money transfers, over $25,000 in ATM cash withdrawals, and numerous purchases for his own personal use. The purchases included a diamond ring, a pickup truck, and two motorcycles.

Investigation Involving Other Matters

Veteran Pleaded Guilty in Connection with Service-Disabled Veteran-Owned Small Business Scheme

According to an investigation by the VA OIG, Department of Labor OIG, and General Services Administration OIG, a veteran owner of a service-disabled veteran-owned small business (SDVOSB) participated in a "pass-through" scheme in which she falsely claimed to control the business, when in fact other individuals held ownership interest and controlled the company. The defendant also allegedly submitted false information to several government agencies to qualify the business as an SDVOSB. From March 2010 to February 2018, the defendant's company was awarded approximately $4.8 million in set-aside contracts, of which approximately $4.2 million was awarded by VA. The defendant pleaded guilty in the District of Kansas to wire fraud.

Administrative Investigation

Alleged Misconduct by Construction and Facilities Deputy Executive Director Not Substantiated

This administrative investigation examined whether the deputy executive director of VA's Office of Construction and Facilities Management (OCFM), during his tenure as acting executive director, failed to respond appropriately to a 2018 audit by OCFM's Quality Assurance Service. While his failure to respond was not substantiated, the OIG found that he did not broadly communicate how he responded, except to his executive leadership team after an 11-month delay, which led some OCFM staff to believe he ignored the report and failed to adequately follow up on the risk of fraud. The OIG determined that

OCFM lacks a governing policy related to tracking this type of audit and made a corresponding recommendation. The OIG also investigated whether in 2019 the deputy executive director falsely attested to the effectiveness of OCFM's internal controls. Based on interviews and contemporaneous evidence, the OIG did not find that he made false statements, despite his comments at a February 2020 meeting that he had concerns about the quality of OCFM's controls and its assessment process. VA concurred with the OIG's findings and its recommendation.

Audits and Reviews

Audit of VA's Compliance under the DATA Act of 2014

The VA OIG contracted with CliftonLarsonAllen LLP (CLA) to audit VA's compliance under the Digital Accountability and Transparency Act of 2014 (DATA Act). CLA conducted this performance audit with data sampled from the fourth quarter of FY 2020, in accordance with generally accepted government auditing standards. CLA primarily conducted its audit work during FY 2021, and the results of the audit are presented in this report. Overall, CLA made 12 recommendations. The VA OIG did not express an opinion on VA's compliance under the DATA Act.

Audit of VA's Financial Statements for FY 2021 and 2020

The OIG also contracted with CLA to audit VA's financial statements, which is an annual requirement. CLA provided an unmodified opinion on VA's financial statements for FY 2021 and FY 2020. It identified three material weaknesses: (1) controls over significant accounting estimates, (2) financial systems and reporting, and (3) IT security controls. CLA made recommendations for addressing each of these weaknesses. CLA also identified two significant deficiencies: 1) obligations, undelivered orders, and accrued expenses, and 2) entity-level controls. CLA is responsible for this audit report and the conclusions expressed in it.

New Patient Scheduling System Needs Improvement as VA Expands Its Implementation

In this review, the OIG assessed whether VHA and the then Office of Electronic Health Record Modernization (OEHRM) effectively implemented the patient-scheduling component of VA's new electronic health record system at two sites in Columbus, Ohio, and Spokane, Washington, in 2020. While the new scheduling system has the potential to transform VHA scheduling, it was implemented without full resolution of identified limitations, leading to reduced effectiveness and increased risk of patient care delays. With limited guidance and inadequate training on how to respond to issues, schedulers developed work-arounds. The help tickets that schedulers submitted to try to address issues were ineffectively managed. VA planned to implement the new scheduling system at all 11 Veterans Integrated Services Network (VISN) 20 facilities by December 2021. VISN 20 includes Alaska, Washington, Oregon, Idaho, and one county each in California and Montana. However, in March 2021, OEHRM paused future deployment to conduct a strategic review of the electronic health record program. VA concurred with the OIG's recommendations to help resolve identified issues with the new scheduling system that could affect additional sites.

DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays

The OIG reviewed VA's oversight and coordination of the DMLSS supply management system pilot implementation to identify challenges to future medical facility deployments. The OIG found the system did not meet more than 40 percent of the high-priority essential business requirements identified by pilot site staff. Consequently, staff had to develop work-arounds to maintain day-to-day operations. The program office tasked with overseeing the effort had a slow and unsteady start. The office was created in early 2019 to manage the DMLSS system deployment but did not receive funding until January 2020. Additionally, it did not effectively coordinate with key stakeholders early enough to minimize operational issues, which should be addressed before further deployments. VA concurred with OIG recommendations and reported progress in aligning the DMLSS deployment process with governing policy, better identifying unmet requirements and postdeployment challenges, and obtaining adequate staffing and stable leadership.

National Healthcare Review

Deficiencies in Select Community Care Consult (Stat) Processes during the COVID-19 Pandemic

The OIG conducted a national review of stat community care consults (urgent consults that must be completed within 24 hours) generated at the outset of the COVID-19 pandemic to evaluate consult processes. The evaluation included electronic health record reviews of 2,236 stat community care consults in an active, scheduled, or completed status from March 20 to June 30, 2020. An electronic survey was also completed by 138 of the 139 VA medical facilities that processed these consults. The OIG made six recommendations to the under secretary for health related to community care resources, facility practices, and VHA requirements that specifically focused on stat community care consults. The OIG did not identify any negative patient care outcomes.

Healthcare Inspections

Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20 (in Oregon)

In this healthcare inspection, the OIG assessed an allegation of inadequate care coordination at the Southern Oregon Rehabilitation Center and Clinics in White City (collectively referred to as the facility) and Roseburg VA Health Care System (Roseburg) in Oregon. The OIG did not substantiate that a resident was inappropriately admitted to the facility's Mental Health Residential Rehabilitation Treatment Program but found the resident's discharge was not coordinated. The resident, whose transport to Roseburg did not comply with policy, was determined by its staff to not meet Roseburg admission criteria and was discharged to the community. An OIG record review of five residents found that four met admission criteria. The team was unable to determine if the fifth resident met criteria. The

OIG also determined that three residents fell in the shower area, with one suffering an injury. Five recommendations were made to the facility director related to discharges, the discharge template, transport of residents, medical evaluations, and a review of shower area falls.

Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network

The OIG reviewed select aspects of operations and performance at two VHA facilities in the same VISN, with one historically rating as lower performing and the other as higher performing. The OIG found that both facilities approached and addressed many patient safety and quality-of-care issues similarly. However, after an in-depth review of data, policies, governance structures, and leadership interviews, the OIG found several factors directly shaped each facility's ability to focus, prioritize, and accomplish progressively higher performance. Two broad factors were (1) leadership and (2) the integration of an effective quality, safety, and value program with high-reliability organization principles. The OIG also determined that facility culture and human resource–related considerations affected operations and performance. Although the OIG did not make formal recommendations, the report identified opportunities and provided eight suggestions for VISNs to consider for providing meaningful and timely assistance to both struggling and better-performing facilities.

Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico

This report focuses on the evaluation of a patient's care, facility leaders' responses to quality and timeliness of care, and teleradiology process limitations. Teleradiology is the transmission of diagnostic images to a location beyond the immediate area, where the images were taken to be shared with other radiologists and physicians. A resident ordered an abdomen and pelvis CT scan, but did not follow-up on the result in which the radiologist noted a possible spiculated lung nodule and recommended a follow-up chest CT scan in 90 days. Because both the resident and the supervising provider failed to address the result, the follow-up scan took 175 days for completion. The results indicated resolution of the previously noted lung nodule but also revealed worsening of opacities in the lung, representing a possible infection or cancer. Further imaging was recommended. The follow-up imaging scan showed a lesion in the right lung, but a biopsy was not done. The patient was examined and diagnosed with cancer at a non-VA hospital. The OIG concluded that deficiencies in care coordination contributed to delays in diagnosis, and the facility failed to use quality processes to evaluate the patient's care. Also, contract teleradiologists did not compare images with available prior imaging studies. The OIG made six recommendations.

Discharge Planning Deficits for a Veteran at the Malcom Randall VA Medical Center in Gainesville, Florida

This healthcare inspection assessed concerns related to discharge planning and care coordination for a patient who died 17 days after discharge from a 33-day hospital stay. The OIG determined that the facility's interdisciplinary team failed to develop a discharge plan that adequately ensured patient safety

and continuity of care. In addition, the facility did not have a discharge-planning policy that outlined interdisciplinary team membership, communication expectations, or roles in discharge planning. The attending physician, an occupational therapist, and a social worker did not perform necessary functions or collaborate effectively to ensure patient safety at discharge. The report includes five recommendations to the facility director related to roles and responsibilities of interdisciplinary team members, communication of changes in patient care recommendations between providers, and a review of the care rendered to the patient by providers involved in discharge planning.

Management Advisory Memorandum

Successive VA Errors Created a $210,000 Debt for a Veteran with a "Service-Connected Mental Illness"

In April 2021, the OIG discovered VBA had incorrectly created a debt of about $210,000 for a veteran. Staff created the debt during an attempt to correct a disability-rating error. Subsequently, the overpayment should have been considered an administrative error, which veterans are not responsible for paying. The veteran reasonably believed that he was entitled to 100 percent disability evaluation, and the veteran or his representative contacted VBA at least 21 times over a two-year period regarding his evaluation. His many attempts to clarify the record are indicative of the stress veterans feel when there is uncertainty about their compensation or potential debt. When the VBA discovered the overpayment, staff assured the veteran he would not be responsible for repayment; however, employees created the debt anyway. The OIG review team contacted VBA's Compensation Service with a detailed accounting of the case. The next day, Compensation Service attributed the debt to administrative error and approved waiving the debt, which was ultimately eliminated from VA's electronic system. The OIG did not request any further action on this case, but VBA should consider steps to avoid this type of error in the future as it can cause significant financial and emotional stress for beneficiaries.

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
- Medical staff credentialing
- Environment of care

- Mental health (focusing on suicide prevention)
- Care coordination (targeting interfacility transfers)
- Women's health (examining comprehensive care)

Recently published CHIP reports include the following:

Orlando VA Healthcare System in Florida

Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8

Veterans Integrated Service Network 1: VA New England Healthcare System in Bedford, Massachusetts

Additional Publications

Semiannual Report to Congress, #86, April 1–September 30, 2021

The *Semiannual Report to Congress* summarizes the results of OIG oversight, provides statistical information, and lists all reports issued from April 1 through September 30, 2021. During this reporting period, the OIG identified over $2.9 billion in monetary impact for a return on investment of $29 for every dollar spent on oversight. This does not include the inestimable value of the healthcare oversight work completed to advance patient safety and quality care. To listen to Inspector General Missal discuss the *Semiannual Report to Congress*, visit the Veteran Oversight Now podcast.

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