MAY 2022 HIGHLIGHTS

Featured Publication

Semiannual Report to Congress for October 1, 2021–March 31, 2022

The *Semiannual Report to Congress* summarizes the results of VA OIG oversight, provides statistical information on the OIG's monetary impact and return on investment, and lists all reports issued for the first six months of fiscal year 2022. During that time, the OIG identified nearly $4.1 billion in monetary impact, for a return on investment of $41 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. During this period, the OIG hotline received and triaged 17,646 contacts, while special agents opened 173 investigations and closed 224, with efforts leading to 104 arrests. The OIG's collective work during this reporting period led to 143 reports issued on VA programs and operations, 397 recommendations to VA, as well as 557 administrative sanctions and corrective actions involving VA personnel. Listen to Inspector General Missal discuss the *Semiannual Report to Congress* on the Veteran Oversight Now podcast.

Congressional Testimony

Inspector General Testifies before the Senate Veterans' Affairs Committee on the Quality of VA's Health Care

Inspector General Michael J. Missal testified before the Senate Veterans' Affairs Committee on May 11, 2022. His testimony focused on the challenges that VA faces in providing quality care to patients, particularly during the COVID-19 pandemic and the implementation of the new electronic health record (EHR) system. Emphasizing the importance of patient safety, he stated that inconsistent or ineffective leadership cultivates a complacent and disengaged medical facility culture, making Veterans Health Administration's (VHA) goal of "zero patient harm" improbable without a cultural transformation. Mr. Missal's testimony also focused on the unprecedented challenges VHA faces regarding the hiring of skilled healthcare workers in the aftermath of the pandemic, emphasizing the need for staffing models to support hiring decisions as well as decisions related to enhancing community care networks to meet the demands of the veteran population. Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, also attended the hearing. Both Mr. Missal and Dr. Kroviak responded to questions about OIG reports and findings related to facility leadership. Mr. Missal's written statement is available on the OIG website.

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits,

construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Former East Orange VA Medical Center Employee Sentenced for Theft of Medication

A multiagency investigation revealed that a former pharmacy technician at the East Orange VA Medical Center conspired with a man from New Jersey to steal prescription human immunodeficiency virus (HIV) medication from the facility for several years. The former pharmacy technician ordered large quantities of HIV prescription medication, which she stole and then sold to her coconspirator, who in turn resold the medication for a profit. The former pharmacy technician was sentenced in the District of New Jersey to 57 months of incarceration, three years of supervised release, and restitution of over $8.2 million. The investigation was conducted by the VA OIG, FBI, and VA Police Service.

Six Defendants Charged in Connection with Workers' Compensation Benefits Fraud Scheme Involving Compounded Medications

Six defendants were charged with conspiring to fraudulently bill compounded medications to the Department of Labor's (DOL) Office of Workers' Compensation Programs. A pharmacy owner, doctor, and three other defendants were indicted in the Southern District of Texas on charges of conspiracy to pay healthcare kickbacks, healthcare fraud, and money laundering. A sixth defendant, who is the owner of a physical therapy clinic and pharmacy, was also charged via criminal information. The total loss to the government is approximately $50 million, including about $6 million to VA. The VA OIG, DOL OIG, Defense Criminal Investigative Service (DCIS), US Postal Service OIG, and FBI conducted the investigation.

Pharmaceutical Company Agreed to Pay $815,000 to Resolve Fraud Allegations

A VA OIG investigation determined a pharmaceutical company sold potentially defective and sophisticated counterfeit 3M N95 respirators to at least five VHA facilities. The company entered into a civil agreement in the Southern District of Georgia under which it agreed to pay $815,000 to VA to resolve these allegations.

Two Defendants Sentenced in Connection with Healthcare Fraud Scheme

Another multiagency investigation resulted in charges alleging that multiple defendants participated in a healthcare fraud scheme involving telemarketers, telemedicine doctors, and the sale of durable medical equipment (DME). The telemarketers allegedly solicited prospective patients to request orthotics and used telemedicine doctors to generate prescriptions. The telemedicine doctors did not have a relationship with the patients, and the telemarketers then sold the completed prescription orders to the DME companies. The companies would then cold call unsuspecting "patients" and coerce them into accepting the medically unnecessary DME. Many of the target companies identified in the scheme billed VA's Civilian Health and Medical Program (CHAMPVA). The loss to VA is approximately $330,000. One defendant was sentenced in the District of New Jersey to 120 months of incarceration, three years of

probation, restitution of over $33.7 million, and forfeiture of over $9.4 million. Another defendant was sentenced in the District of New Jersey to 22 months of incarceration, three years of supervised release, and restitution of over $6.9 million. The VA OIG, Department of Health and Human Services (HHS) OIG, FBI, and DCIS conducted the investigation.

Former Phoenix VA Healthcare System Employee Sentenced for Theft of Government Property

A VA OIG investigation uncovered that a former Phoenix VA Healthcare System employee stole property, mostly consisting of home furnishings, that Walmart had donated to the healthcare system for veterans experiencing homelessness or poverty to use. The former employee used a truck belonging to VA's Voluntary Services to pick up donated items from a Walmart distribution center. On numerous occasions, he placed the items in his personal storage lockers instead of taking the donations to the healthcare system's facilities in Phoenix. He was sentenced in the District of Arizona to 60 months of supervised probation and $95,000 in restitution to VA after previously pleading guilty to theft of government property.

Former Coatesville VA Medical Center Employee Sentenced for Threatening Former Coworkers

VA OIG investigators found that a former employee of the Coatesville VA Medical Center in Pennsylvania sent sexually explicit, harassing, and threatening interstate communications and packages to former coworkers. The former employee also targeted the family members of his former coworkers with similarly vulgar communications. He was sentenced in the Eastern District of Pennsylvania to 41 months of incarceration and three years of supervised release.

Veteran Sentenced for Assaulting a Federal Employee

An investigation by the VA OIG and VA Police Service found a veteran made multiple threats to staff during visits to the emergency room of the Syracuse VA Medical Center in New York. During one incident, the veteran was restrained by VA Police Service officers after lunging at and threatening to kill an employee. After pleading guilty to assaulting a federal employee, the veteran was sentenced in the Northern District of New York to time served (six weeks) and two years of probation. He was also mandated to participate in a VA inpatient psychiatric program.

Incarcerated Veteran Indicted for Threatening VA Employees

A multiagency investigation resulted in charges alleging that an incarcerated veteran sent a communication to VA in which he threatened VA employees and the employees of a nonprofit organization. The veteran was allegedly angered after receiving a notification from VA that his monetary benefits would be reduced during his incarceration per VA policy. He was indicted in the District of Massachusetts for the interstate transmission of a threatening communication. The VA OIG, Federal Bureau of Prisons, and FBI conducted the investigation.

Benefits Investigations

Veteran Claiming Blindness for Disability Benefits Sentenced

A VA OIG proactive investigation uncovered that a veteran who maintained a valid Missouri driver's license was rated as 100 percent service-connected disabled for bilateral blindness since 2000. During the investigation, the veteran was observed driving routinely and mowing his lawn. He was sentenced in the Eastern District of Missouri to five years of supervised release and restitution of more than $671,000 after previously pleading guilty to theft of government property.

Veteran Pleaded Guilty after Lying about Impairment

Following a hotline complaint, a VA OIG investigation brought to light that a veteran exaggerated his mental and physical impairments to fraudulently increase his VA compensation benefits. The veteran lied on a mental health test by reporting to VA that he had been in combat, qualifying him for posttraumatic stress disorder benefits. Investigators confirmed that the veteran was a competitive bodybuilder who faked physical ailments to VA examiners, including using a cane at the VA medical center and telling examiners he could not lift more than 10 to 20 pounds. He pleaded guilty in the Southern District of Florida to theft of government funds. The loss to VA is over $245,000.

Former VA-Appointed Fiduciary Pleaded Guilty for Stealing Benefits from Veterans

VA OIG investigators determined that a former VA-appointed fiduciary stole over $300,000 that was intended for use by 10 different veterans that he was appointed to represent. He pleaded guilty in the District of South Carolina to theft of government funds.

Another Former VA Fiduciary Indicted for Fraud

In collaboration with the South Carolina Attorney General's Office, the VA OIG conducted an investigation that resulted in charges alleging that a former VA-appointed fiduciary stole over $65,000 from a veteran she was appointed to represent. The former fiduciary was indicted in the County of Lexington (South Carolina) Court of General Sessions on charges of breach of trust with fraudulent intent and exploitation of a vulnerable adult.

Investigations Involving Other Matters

Former Philadelphia VA Medical Center Employee Pleaded Guilty in Connection with False Travel Reimbursement Claims Scheme

A VA OIG and VA Police Service investigation revealed that a former employee at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania, used his access to VA's Concur travel reimbursement system to approve and certify false payments in the names of other VA employees. From December 2015 through September 2019, the former employee directed approximately $487,000 in bogus travel reimbursement payments to various bank accounts under his control. He pleaded guilty in the Eastern District of Pennsylvania to theft of government funds.

Veteran Construction Company Owner Sentenced for Service-Disabled Veteran-Owned Small Business Fraud Scheme

A multiagency investigation disclosed that between 2009 and 2018, a service-disabled veteran-owned small business that was certified by the Small Business Administration's (SBA) 8(a) business development program was awarded approximately $335 million in set-aside contracts, of which about $118 million was awarded by VA. Although a veteran claimed to control and operate the company, this investigation determined that the business was controlled by three nonveterans. When the company grew too large to compete for small business contracts, the veteran's coconspirators used the minority status of another coconspirator to set up a second company. This second company was awarded an additional $11 million in set-aside contracts. The veteran was sentenced in the Western District of Missouri to 12 months in prison and three years of supervised release. The investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation (IRS CI), Naval Criminal Investigative Service, US Air Force Office of Special Investigations, SBA OIG, US Army Criminal Investigation Division, Department of Agriculture OIG, General Services Administration OIG, Defense Contract Audit Agency—Operations Investigative Support, US Secret Service, DOL OIG, DOL Employee Benefits Security Administration, and DCIS.

Missouri Charity Agreed to Pay Over $8 Million in Connection with Embezzlement and Bribery Scheme

Another multiagency investigation resulted in a nonprofit organization entering into a nonprosecution agreement in the Western District of Missouri under which it agreed to forfeit over $6.9 million to the US Treasury and to pay over $1 million in restitution to the state of Arkansas. This nonprofit organization contracted with VA to provide substance abuse counseling and housing services for veterans. As a condition of this nonprosecution agreement, representatives of the nonprofit organization admitted their former officers and employees conspired to embezzle funds and to bribe several elected state officials. To increase the supply of funds to embezzle, the former officers and employees allegedly caused the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through political outreach that violated both law and public policy. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, including $1.7 million contributed by VA. To date, nine defendants have been indicted and arrested, seven convicted, and two sentenced. The investigation was conducted by the VA OIG, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, HHS OIG, FBI, DOL OIG, IRS CI, and the Medicaid Fraud Control Unit of the Missouri Attorney General's Office.

Veteran Pleaded Guilty to Assaulting a Federal Officer

A veteran assaulted a VA OIG agent who was assisting local police in performing an emergency medical detention based on the veteran being a threat to himself and others. At the time, the VA OIG was investigating alleged threats made by the veteran. The defendant pleaded guilty in the District of Kansas to assault of a federal officer.

Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) provides independent oversight of VA's activities to improve the integrity of its programs and operations. This work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. OAE released the following reports this month.

Publications on Healthcare Access and Administration

Purchases of Smartphones and Tablets for Veterans' Use during the COVID-19 Pandemic

The COVID-19 pandemic accelerated efforts by VHA to expand telehealth. Accordingly, VHA created a new digital divide consult to issue iPhones to veterans experiencing homelessness who were enrolled in the Department of Housing and Urban Development VA Supportive Housing Program. VHA was already loaning iPads through the consult process to other veterans who lacked telehealth-capable devices. The OIG initiated this review to evaluate whether purchases of iPads and iPhones for veterans during the pandemic met mission needs. The OIG found that VHA incurred approximately $2.3 million in wasted data plan costs while the devices remained in storage. The OIG recommended that VHA establish a realistic goal and a process for monitoring days in storage and determine the viability of initiating data plan charges only when a device is issued to the veteran.

VHA Continues to Face Challenges with Billing Private Insurers for Community Care

The OIG's audit was conducted to determine how effectively VHA billed private insurers for community care costs unrelated to military service. The OIG found the billing process was ineffective, estimating that more than half of billable claims over a three-year period were not submitted before filing deadlines expired. As a result, VHA did not collect an estimated $217.5 million that should have been recovered, which could grow to $805.2 million by September 30, 2022, if problems are not corrected. Although officials were broadly aware of those problems, their responses were insufficient to correct them. The OIG recommended VHA develop procedures that prioritize processing to meet insurers' filing deadlines and strengthen its controls to ensure information needed to process bills for reimbursement is complete and accurate. VHA should also assess staff resources and workload to ensure they are sufficiently aligned to process the anticipated volume of claims to be billed.

Publication on Benefits Delivery and Administration

Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement

The OIG audited Post-9/11 GI Bill student enrollments, including vacation breaks, and found VBA did not always accurately process them. An estimated 2,500 of 10,000 enrollments should have been

adjusted but were not. Insufficient training and guidance meant school certifying officials frequently made mistakes. About 790 of the estimated errors involved officials either not reporting or underreporting vacation breaks. VBA claims examiners often mishandled enrollments even with the correct information. The OIG estimated that claims examiners incorrectly processed vacation breaks that were accurately reported for about 1,700 of the 2,500 enrollments with vacation break errors. Those estimated 2,500 enrollments resulted in about 14,400 days of undercharges to students' entitlement and about $624,000 in underpayments for monthly housing allowances and college funds. The five report recommendations included that VBA should update guidance and training for school certifying officials. In addition, VBA should submit amended enrollments for identified reporting errors for remedial action.

Office of Special Reviews

The Office of Special Reviews (OSR) conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. OSR released the following cross-directorate report this month in collaboration with the Office of Healthcare Inspections and with statistical support from the Office of Audits and Evaluations.

Featured OIG Cross-Directorate Report

Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability

This joint audit led by the Department of Defense (DoD) OIG examined actions taken by DoD and VA to implement the Cerner Millennium patient electronic health record (EHR) system throughout VA. The audit assessed internal controls and compliance with legal requirements, as well as actions by DoD, VA, and their joint Federal Electronic Health Record Modernization (FEHRM) Program Office to help ensure that healthcare providers serving veterans can access a patient's complete medical history—spanning from the start of military service through VA healthcare engagement. The audit focused on whether those actions would achieve interoperability between DoD, VA, and external healthcare providers. The audit found that DoD and VA took some actions to achieve system interoperability, but there are remaining challenges. DoD and VA did not consistently migrate information from legacy systems into Cerner Millennium to create a single, complete patient EHR; develop interfaces from all medical devices to the system; or ensure users were granted access to Cerner Millennium only for information needed for their duties. A contributing factor for these deficiencies was that the FEHRM Program Office did not develop a clear plan to achieve full interoperability or actively manage the program's success. The audit report recommends that DoD and VA review FEHRM's actions and direct the program office to comply with its charter and applicable laws. The FEHRM should also coordinate with DoD and VA on implementing recommendations that include (1) determining the type of healthcare information that constitutes a complete EHR;

(2) implementing a plan for accurately migrating legacy healthcare information; (3) creating medical device interfaces to directly transfer healthcare information to Cerner Millennium; and (4) executing a plan to modify system user roles to ensure their access is restricted to only information needed to perform their duties.

Office of Healthcare Inspections

The Office of Healthcare Inspections (OHI) assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. OHI released the following reports this month.

National Healthcare Review

The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic

The OIG reviewed how VHA addressed the emotional well-being of employees during the COVID-19 pandemic, and performed an overview of programs developed and deployed in response to the pandemic. The review team interviewed VA and VHA leaders and then deployed a survey focused on VHA guidance regarding employees' emotional well-being during the pandemic, available resources, monitoring those resources, and employees' use of them. The National Center for Organization Development created a COVID-19 consultation process for VHA leaders. The Organizational Health Council team also developed a COVID-19 employee support toolkit and other resources. Several program offices independently generated and disseminated pandemic-related employee well-being resources. The OIG's survey identified that awareness of employee emotional well-being supports generally diminished the less senior the position, leaders and employees made little use of resources, and employees perceived leaders' support to be inadequate. The OIG made one recommendation to the under secretary for health to review the processes by which COVID-19 emotional well-being resources were developed and disseminated and take action as needed to increase staff awareness of these available resources.

Healthcare Inspections

Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania

This inspection evaluated a behavioral health certified registered nurse practitioner's (BHNP) assessment and documentation practices and leaders' completion of BHNPs' ongoing professional

practice evaluations (OPPEs) at the VA Pittsburgh Healthcare System in Pennsylvania. The inspection revealed multiple deficiencies in a BHNP's assessment and documentation practices and found adverse clinical outcomes for one of eight patients. The BHNP did not document a comprehensive suicide risk assessment for that patient, as required by The Joint Commission. A nurse manager evaluated BHNPs as "satisfactory" against the OPPE elements regarding their "copy and paste use" and "safety plan completion for high risk for suicide patients" but had not actually evaluated these elements. The OIG made five recommendations regarding the BHNP's assessment and documentation practices, better alignment of policy with leaders' expectations related to patients prescribed antipsychotic medications, Behavioral Health managers' verification of the BHNPs' OPPE reviews, and managers' oversight of those OPPEs.

Facility Leaders' Response to Inappropriate Mental Health Provider–Patient Relationships at the VA Illiana Health Care System in Danville, Illinois

This inspection evaluated leaders' response to the knowledge of inappropriate provider–patient relationships. Facility leaders took initial actions to address three inappropriate relationships between mental health providers (Providers A, B, and C) and their respective patients. However, effective facility leader actions to investigate and address the inappropriate relationships of Providers A and B occurred only after an Office of Accountability and Whistleblower Protection complaint. Facility leaders ineffectively addressed Provider C's inappropriate relationship before the involved patient died by overdose. Facility leaders failed to report Provider A to the appropriate professional certification board, failed to report Providers B and C to their state licensing boards in a timely manner, and did not address the circumstances that contributed to the overdose death. The OIG made one recommendation to the Veterans Integrated Service Network (VISN) 12 director related to evaluating processes that affected facility supervisors' identification and actions to address inappropriate relationships. The OIG made two recommendations to the facility director related to timely reporting of providers to state licensing or certification boards, and reviewing the deceased patient's care to determine if there was an adverse event and if so, whether institutional disclosure is warranted.

Inadequate Discharge Coordination for a Vulnerable Patient at the Portland VA Medical Center in Oregon

The OIG evaluated allegations that staff inappropriately discharged a patient with a severe cognitive impairment, "turned away" the patient, and failed to provide the patient's records to Adult Protective Services (APS), a county government office that investigates abuse of adults ages 60 and older. The patient, who had a history of alcohol use and cognitive impairment, presented to the emergency department with gangrene and experiencing homelessness. Approximately one hour after discharge, the patient returned to the emergency department a second time. A social worker provided the patient with a bus ticket "to return to the shelter." The OIG did not substantiate the patient was inappropriately discharged and was unable to determine whether staff discussed the patient's discharge plan with family. The OIG did substantiate that staff did not establish a safe transportation plan after the patient returned

after being discharged. Finally, the OIG also did not substantiate that staff failed to provide the patient's records to APS. The OIG made three recommendations related to consideration of requiring staff to document family contacts, a review of the Emergency Department social worker's care coordination of the patient, and consideration of Privacy Office staff communicating the missing elements when returning a release of information request.

Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio

To evaluate allegations related to quality and management of patient care and the availability of resources, the OIG conducted a healthcare inspection at the Chillicothe VA Medical Center. The team found that a patient was referred by an urgent care provider to the Complementary and Alternative Medicine (CAM) Clinic for pain management of a T12 vertebrae compression fracture. However, the urgent care provider delayed entering the consult for eight days, resulting in a chiropractor and clinical massage therapist's inability to review the consult details before treating the patient and documenting that care. The patient returned eight days later with an acute burst fracture and rib fractures. Due to the lack of documentation and provider recall, the OIG was unable to conclusively determine the relationship of the care provided and the bone fractures. The OIG reviewed nine additional allegations, which were unsupported. The OIG made two recommendations to the facility director related to education of providers, chiropractors, and clinical massage therapists on the use of consults and timely documentation, and conducting an internal review of the CAM program processes related to patient care, reviewing consults, scheduling appointments, checking in patients, and documentation.

Deficiencies in the Care of a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

This inspection evaluated the adequacy of a patient's outpatient care prior to surgery and during preoperative and postoperative care. After surgery, the patient was admitted, suffered alcohol withdrawal and declining health, and died under hospice care. In the months prior to the patient's surgery, primary care staff failed to provide sufficient care coordination and treatment. During the patient's hospital stay, medical-surgical nurses did not consistently assess the patient's alcohol withdrawal symptoms or administer medications according to the facility alcohol withdrawal treatment protocol or according to physician orders. In addition, medical-surgical unit nursing leaders did not have adequate quality controls or training in place to ensure the provision of safe and effective alcohol withdrawal nursing care, and the alcohol withdrawal protocol could be discontinued prior to onset of a patient's withdrawal symptoms. The OIG made one recommendation to the VISN director and nine recommendations to the facility director.

Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center in Gainesville, Florida

The OIG conducted an inspection to review the care of an unresponsive patient transported to the facility by ambulance, and leaders' response following the patient's death at a community hospital. The

inspection team found that facility emergency department nurses failed to provide emergency care to an unresponsive patient who arrived by ambulance. Despite emergency medical services (EMS) personnel having relayed the criticality of the patient's condition and the limited information available about the patient's identity while en route to the facility, emergency department nurses and an administrative officer wasted critical time on determining whether the patient was a veteran (which he was) rather than focusing on patient care. Furthermore, the OIG identified concerns with nurse competencies and determined the actions that leaders previously implemented to address Emergency Medical Treatment and Labor Act-related patient incidents were not effective in preventing additional incidents. The OIG made five recommendations regarding the consideration of administrative actions and state licensing board reporting, prioritization of emergency patient care, and nurse competencies.

Care in the Community Report

Care in the Community Healthcare Inspection of VA Midwest Health Care Network (VISN 23)

The OIG Care in the Community healthcare inspection program examines clinical and administrative processes associated with providing quality care to veterans in outpatient settings. This report provides a focused evaluation of VISN 23 and its oversight of the quality of care delivered in its community-based outpatient clinics and through community care referrals to non-VA providers. The OIG reviewed care coordination (particularly for congestive heart failure management); primary care and mental health (related to diagnostic evaluations following positive screenings for depression or alcohol misuse); quality of care (focusing on home dialysis care); and women's health (specifically mammography care and the communication of results). The OIG issued three recommendations for improvement, including completing initial and annual home visits for patients accepted into the VISN 23 home dialysis program, monitoring the quality of home dialysis contracted clinical services, and receiving timely procedure results from community providers.

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. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection:

The OIG published the following CHIP reports this month:

VA Finger Lakes Healthcare System in Bath, New York

Northport VA Medical Center in New York

VA New Jersey Health Care System in East Orange

Samuel S. Stratton VA Medical Center in Albany, New York

VA NY Harbor Healthcare System in New York

Veterans Integrated Service Network 2: New York/New Jersey VA Health Care Network in Bronx, New York

Featured Hotline Cases

The OIG's Hotline Complaint Center accepts complaints from VA employees and the general public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following are cases opened in May by the Hotline Division that were not included in inspections, audits, investigations, or reviews.

Poor Facilities Management Results in Delayed Emergency Response to a Patient Threatening to Commit Suicide at the Wichita VA Medical Center in Kansas

A VA OIG hotline complaint resulted in changes being made to the Wichita VA Medical Center's network-based duress and emergency notification system. The medical center conducted a review and found that a behavioral health provider's duress alarm failed to alert VA police when the provider hit the button nine times after a patient threatened suicide by gun in the provider's office. Although the provider's duress alarm failed, the provider telephoned VA police and they responded. When they arrived, the patient had already left the premises. A welfare check was conducted, and the patient was found unharmed. The medical center has since begun transitioning to a more reliable emergency notification system that allows users to activate the duress alarm even when not logged into their computers.

Inadequate Patient Supervision Results in a Patient's Elopement from Ralph H. Johnson VA Medical Center's Mental Health Unit in Charleston, South Carolina

The response to a hotline complaint resulted in multiple preventative strategies being implemented at the Ralph H. Johnson VA Medical Center. The medical center substantiated an OIG-conveyed complaint that alleged a patient eloped (left without authorization) from an inpatient mental health unit by entering a utility closet with a self-closing, self-locking door; dropping down a laundry chute; and exiting the building. The elopement was not detected for approximately two hours. Staff worked with community responders and a probate court to return the patient to the inpatient unit where the course of treatment was completed without further incident. The medical center has since implemented multiple preventative strategies to reduce the risk for future incidents of elopement. These strategies include installation of a lock on the laundry chute; modification to the medical center's safety observations

standard operating procedure to specify a patient's identity must be verified and three breaths must be observed during each 15-minute check; installation of a visual alarm on the door to the utility room; requiring patients assigned to the unit to wear scrubs with a unique color; purchasing and installing a patient elopement monitoring system on the unit; and requiring all staff assigned to the unit to complete the annual mental health environment of care training.

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To listen to the podcast on the May 2022 highlights, go to www.va.gov/oig/podcasts.