



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

NOVEMBER 2019 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies about the OIG's Review of VA's Office of Accountability and Whistleblower Protection

Inspector General Michael Missal [testified](#) at a hearing before the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on November 14, 2019. The hearing focused on the recent Office of Inspector General (OIG) report *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*. Mr. Missal discussed the six findings in the report, which also included 22 recommendations, and how leadership failures distracted the Office of Accountability and Whistleblower Protection from its core mission and diminished the confidence of whistleblowers and other potential complainants in the operations of the office.

Deputy Assistant Inspector General for Audits and Evaluations Testifies before the House Veterans' Affairs' Subcommittee on Technology Modernization

Mr. Nick Dahl, Deputy Assistant Inspector General for Audits and Evaluations, [testified](#) about VA's cybersecurity challenges and cyber risk management at a November 14, 2019, hearing held by the House Committee on Veterans' Affairs' Subcommittee on Technology Modernization. Mr. Dahl's testimony focused on the challenges to protecting the confidentiality, integrity, and availability of VA systems and data. He was accompanied by Mr. Michael Bowman, Director of the Information Technology and Security Audit Division.

Criminal Investigations Involving Health Care

Nonveteran Indicted in Connection with Fraud Scheme

A nonveteran was arrested in the Eastern District of Pennsylvania after being indicted for stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, and false statements to the Social Security Administration (SSA). A VA OIG and SSA OIG investigation resulted in charges alleging that the defendant defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits from approximately April 2010 to September 2019. The defendant is also alleged to have falsely claimed to be a decorated veteran, specifically, a U.S. Navy SEAL, prisoner of war, and Silver Star award recipient. The loss to VA is approximately \$302,121.

Veteran Indicted in Connection with Shooting at West Palm Beach, Florida, VA Medical Center

A veteran was indicted in the Southern District of Florida for assault on a federal employee with a deadly weapon, possession of a firearm by a convicted felon, possession of a firearm in a federal facility with intent to commit a crime, and discharge of a firearm in furtherance of a crime of violence. An investigation by the VA OIG and the Federal Bureau of Investigation (FBI) resulted in charges alleging

that on February 27, 2019, the defendant inflicted non-life-threatening injuries on three VA employees by firing a handgun inside the West Palm Beach VA Medical Center. The defendant was previously arrested by criminal complaint and his indictment was held pending psychological evaluations.

Defendant Pled Guilty to Drug Distribution at a Massachusetts VA Residential Facility

An individual was arrested by the VA OIG and Drug Enforcement Administration agents after a joint investigation indicated the subject may have been the source of drugs that caused the fatal overdose of a veteran living at a VA residential facility in Massachusetts. The defendant pled guilty in the District of Massachusetts to the distribution of fentanyl, the distribution of 40 grams or more of fentanyl, and possession with intent to distribute 28 grams or more of crack cocaine.

Criminal Investigations Involving Benefits

Technical Training School Owner and Wife Pled Guilty in Connection with Fraud Scheme

A VA OIG and FBI investigation revealed the owner of a technical training school submitted fraudulent documents to VA for several years. The owner and his wife admitted to falsifying student enrollment documents and employer verification information dating back to 2015, which caused VA to pay over \$29 million in tuition, books, fees, and monthly student housing allowances. As a result of the investigation, both the owner and his wife pled guilty in the Southern District of California to wire fraud and making false statements.

Seven Individuals Indicted for Identity Theft Scheme

Seven nonveterans were indicted in the Southern District of Florida for conspiracy to commit bank fraud, conspiracy to commit wire fraud, and aggravated identity theft. Five of the defendants were subsequently arrested and two remain at large. A VA OIG, Homeland Security Investigations, and U.S. Postal Inspection Service investigation discovered defendants in Jamaica were allegedly redirecting the monthly benefit payments of veterans and Social Security recipients to alternate bank accounts. The stolen funds were then loaded onto prepaid cards and mailed to codefendants in the Miami area. Once in Miami, a portion of the funds were removed and the remainder was sent back to Jamaica. Additionally, these defendants allegedly participated in telemarketing scams that targeted elderly U.S. citizens. To date, 17 nonveterans have been indicted, 14 arrested, and nine sentenced to a combined 451 months' incarceration, 288 months of supervised release, 36 months' probation, and approximately \$2.5 million in restitution. The total loss to VA is more than \$7 million.

Veteran Indicted for Compensation Benefits Fraud

A VA OIG proactive investigation resulted in charges alleging that a veteran grossly exaggerated the severity of his service-connected conditions in order to receive more than \$8,000 per month in VA compensation benefits. Members of the U.S. Marshals Service Fugitive Task Force assisted the VA OIG investigation in serving four seizure warrants for a vehicle, a motorized scooter, and approximately

\$170,000 of funds from two of the veteran's bank accounts. The defendant was arrested after being indicted in the Middle District of North Carolina for healthcare fraud and theft. The loss to VA is approximately \$1.2 million.

Veteran Sentenced for Compensation Benefits Fraud

A veteran was sentenced in the Southern District of Illinois to 36 months' probation after pleading guilty to false statements. A VA OIG investigation revealed the defendant falsely told VA that he had served as a sniper in the Special Forces and had been shot, stabbed, and "blown up" in order to receive compensation benefits to which he was not entitled. When confronted, the defendant admitted to lying to VA about his service record and claimed injuries. In addition to the criminal conviction, VA is currently withholding the veteran's benefits to recover the amount he fraudulently received, about \$210,125.

Individual Indicted for Compensation Benefits Fraud and Healthcare Fraud Scheme

A VA OIG investigation resulted in charges alleging that from approximately February 1992 to November 2016, a nonveteran used the identity of a deceased veteran to fraudulently obtain VA compensation and healthcare benefits. The defendant was indicted in the Central District of California for healthcare fraud and theft of government funds, and the loss to VA is over \$111,500.

Niece of Deceased VA Beneficiary Pled Guilty to Theft of Government Funds

A VA OIG investigation revealed that the niece of a deceased VA beneficiary continued to receive monthly Dependency and Indemnity Compensation benefits intended for her aunt, who died in July 2008. The defendant pled guilty in the Northern District of Illinois to theft of government funds. The loss to VA is approximately \$110,025.

Criminal Investigations Involving Other Matters

Business Owner Convicted for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

A joint investigation by the VA OIG, Navy Criminal Investigative Service (NCIS), NASA OIG, Defense Criminal Investigative Service, and Small Business Administration OIG resulted in charges alleging that individuals conspired to obtain set-aside contracts by falsely certifying eligibility and passing work through to the principal defendant's company, which did not qualify as a service-disabled veteran-owned small business (SDVOSB). The scheme involved falsifying records and moving employees among companies to give those entities the appearance of self-performance. The defendants allegedly obtained at least \$15 million in government contracts fraudulently through this scheme, including approximately \$4.4 million in SDVOSB set-aside contracts awarded by VA. The principal defendant was found guilty of conspiracy, major fraud against the government, and wire fraud following a week-long jury trial in the Northern District of Ohio. Six other defendants, including a service-disabled veteran, pled guilty prior to trial.

Three Veterans Indicted for Life Insurance Fraud Scheme

An investigation resulted in charges alleging that three veterans, and at least nine others, submitted numerous Traumatic Servicemembers Group Life Insurance (TSGLI) claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living to generate payouts of \$25,000 to \$100,000 per claim. The leader allegedly recruited a Naval command medical doctor and a Navy nurse to create false medical records and sign the claims. VA supervises the administration of the TSGLI program, and the investigation was conducted by the VA OIG, NCIS, and the FBI. The three veterans were indicted in the Southern District of California for conspiracy to commit wire fraud, wire fraud, and making a false claim. The loss to the TSGLI program is approximately \$2 million.

Audits and Reviews

FY 2019 Audit of VA's Compliance under the DATA Act of 2014

The OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's compliance with the Digital Accountability and Transparency Act of 2014 for the first quarter of fiscal year 2019. CLA reported VA's financial management and related systems have limited functionality to fully meet the reporting standards and requirements, and that data management and reporting processes need improvement to ensure compliance. As a result, CLA determined VA did not fully meet the required reporting standards and attributes of completeness, timeliness, quality, and accuracy. The 16 recommendations from CLA aim to improve compliance, including that VA continue system modernization efforts and improve internal controls over aspects of the data submission process. VA concurred with all recommendations and provided planned corrective actions. CLA is responsible for the report, including its conclusions and recommendations, and the OIG does not express an opinion on VA's compliance.

Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters

The Veterans Benefits Administration's (VBA) Records Management Center disclosed third-party information in Privacy Act requests. The VA OIG reviewed 30 Privacy Act responses and found 18 responses included 1,027 third-party names and social security numbers. The act requires VBA to let individuals copy their claims files, but many records include information about third parties, such as social security numbers of other service members and medical professionals. The third-party information the OIG identified had been redacted until a May 2016 policy change. With VA's legal support, VBA changed this policy because the redaction requirement was a major contributor to the massive requests backlog and interfered with veterans' online access to their records. However, these disclosures raised legal concerns, and responses under the May 2016 policy put millions of people at risk of identity theft. The VA OIG asked the Under Secretary for Benefits to immediately suspend the

release policy. After initially rejecting the request, VA issued a policy in September to require the redaction or removal of third-party information.

VHA Did Not Effectively Manage Appeals of Non-VA Care Claims

The VA OIG conducted this audit to determine whether appeals of non-VA care claims decisions were effectively managed and processed and also focused on the readiness of Veterans Health Administration (VHA) to implement the appeals process in the Veterans Appeals Improvement and Modernization Act of 2017. The audit team found significant deficiencies with the management of appeals, including unprocessed and unaccounted-for appeals stored in file cabinets, boxes, and bins. Office of Community Care leaders lacked effective oversight of its appeals function, and the appeals manager's roles and responsibilities had not been clearly defined. Also, VHA did not effectively prepare for the new appeals process and faces significant challenges. The VA OIG made eight recommendations to improve appeals management, including identifying and processing existing appeals, ensuring incoming appeals go to facilities that will process them, providing staff clear policies and procedures, and ensuring appropriate access and use of the appeals system of record.

Healthcare Inspections

Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida

The OIG assessed allegations involving ophthalmology equipment maintenance and repair issues and other concerns at the facility. The OIG did not substantiate allegations related to specific ophthalmology equipment and was unable to determine whether Eye Clinic procedures were canceled due to equipment issues. The OIG did substantiate an increase in community care consults for eye care; however, the increased volume was largely the result of changes in access. The OIG also substantiated that Prosthetic and Sensory Aids Service took four to six weeks to issue a purchase order, resulting in patients waiting six to eight weeks for eyeglasses. The OIG was unable to determine if facility leaders had not responded to complaints for at least 15 years. The OIG made four recommendations related to work order documentation, equipment corrective maintenance timeliness and communication, timeliness of eyeglass purchase order processing, and addressing the backlog of open eyeglass purchase order requests.

Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System, Anchorage, Alaska

The OIG reviewed allegations of deficiencies in quality of care and administrative processes that contributed to two patient deaths by suicide and one patient's self-harm behavior at the Alaska VA Healthcare System's outpatient Social and Behavioral Health Services. The OIG found that facility staff failed to follow missing patient policies and schedule follow-up appointments, and that a patient was evaluated by multiple providers. Also, the OIG found that the Same Day Access Clinic had gaps in triage staff coverage, lacked morning psychiatric coverage, and had providers that were double booked. However, the OIG was unable to determine that these deficits contributed to adverse patient outcomes.

The OIG also found that facility staff closed scheduling orders without contacting patients and completing documentation and that there was a backlog of scheduling orders. Additionally, the OIG found that the facility lacked missed appointment, Mental Health Treatment Coordinator, and behavioral health emergency policies and that facility leaders did not implement Behavioral Health Interdisciplinary Program teams. The OIG identified opportunities for improved culture of safety and made 11 recommendations.

Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut

The OIG conducted an inspection in response to Senator Richard Blumenthal's request to review Surgical and Sterile Processing Services (SPS) concerns within the VA Connecticut Healthcare System (system). The request came after The Joint Commission and the National Program Office for Sterile Processing surveys of the system found SPS deficiencies. Consequently, system leaders immediately reduced SPS reprocessing services and limited surgical procedures. The OIG inspection reviewed SPS standard operating procedures (SOPs), training, competencies, and staffing; surgical cancellations; patient safety; and surgical and post-operative infection rates. The team identified additional concerns regarding leaders' decision-making, the system's infrastructure, and the residency program. The OIG made two recommendations to the Veterans Integrated Service Network (VISN) Director related to oversight and nine recommendations to the System Director related to decision-making, restoration of trust in system leaders, oversight of pending SPS projects, SOPs, competencies and training, staffing, evaluation of surgical supplies, review of the residency programs, and VISN collaboration.

Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland

The OIG evaluated allegations that a patient at the Baltimore VA Medical Center "may have died wrongfully," and that resuscitation was attempted despite a Do Not Attempt Resuscitation (DNAR) order. The patient died due to aspiration pneumonia and cardiopulmonary arrest, but the OIG was unable to determine if the death was wrongful. The OIG substantiated that staff attempted resuscitation on a patient with a DNAR status. There was no DNAR order in the patient's electronic health record when resuscitation was attempted. Residents and physicians did not comply with DNAR documentation requirements and failed to communicate the DNAR status to healthcare team members. Further, facility leaders failed to act on an identified pharmacy safety issue related to the administration of haloperidol in patients with Parkinson's, facility staff did not comply with code blue documentation requirements, measures to identify and rectify challenges with resuscitation processes were insufficient, and leaders failed to hold staff accountable. The OIG made four recommendations.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews 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 reviews 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) Medical Staff Privileging
- (4) Environment of Care
- (5) Medication Management
- (6) Mental Health
- (7) Geriatric Care
- (8) Women's Health
- (9) High-Risk Processes

Fargo VA Health Care System, North Dakota

Carl Vinson VA Medical Center, Dublin, Georgia

James A. Haley Veterans' Hospital, Tampa, Florida

VA Connecticut Healthcare System, West Haven, Connecticut

Charlie Norwood VA Medical Center, Augusta, Georgia

Manchester VA Medical Center, New Hampshire

El Paso VA Health Care System, Texas

Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania

To listen to the podcast on the OIG's November 2019 activity highlights, go to www.va.gov/oig/podcasts.