# JULY 2020 HIGHLIGHTS

## Criminal Investigations Involving Health Care

### Former Clarksburg, West Virginia, VA Medical Center Nursing Assistant Pleads Guilty to Second-Degree Murder and Assault with Intent to Commit Murder

A former nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, pleaded guilty in the Northern District of West Virginia to seven counts of second-degree murder and one count of assault with intent to commit murder. An investigation by the VA Office of Inspector General (OIG) and the Federal Bureau of Investigation (FBI), which received assistance from the West Virginia State Police and the Greater Harrison County Drug and Violent Crimes Task Force, revealed that the defendant administered insulin to several patients under her care with the intent to cause their deaths. In her role as a nursing assistant, the defendant was not qualified or authorized to administer any medication to patients, including insulin. As a result of her actions, several patients died of hypoglycemia.

### Veteran Sentenced in Connection with Shooting at West Palm Beach VA Medical Center in Florida

A veteran was sentenced in the Southern District of Florida to 25 years of mental health treatment at a suitable medical facility and three years' supervised release. A VA OIG and FBI investigation revealed that the defendant inflicted non-life-threatening injuries on three VA emergency room employees by firing a handgun inside the West Palm Beach VA Medical Center. If it is determined during his commitment that the defendant no longer needs treatment, he will reappear in federal court where he will be sentenced to a prison term of between 12.5 years and 25 years.

### Former Washington DC VA Medical Center Registered Nurse Charged with False Statements

A former Washington DC VA Medical Center registered nurse was charged in the District of Columbia with false statements. A VA OIG and VA Police Service investigation resulted in charges alleging that a veteran who was an inpatient at the medical center died during a shift in which the defendant was assigned to his care. It is alleged that although the defendant signed round logs (documentation) indicating she had checked on the patient hourly, video footage showed that no one entered the deceased veteran's room for several hours. It is further alleged that during an interview, the defendant made additional false statements to agents when she stated the patient was checked hourly to include pain level evaluations.

### Former Contract Physician at the Watertown, New York, VA Outpatient Clinic Pleads Guilty to Forcible Touching

A former VA outpatient clinic contract physician based in Watertown, New York, pleaded guilty in the Superior Court of Jefferson County, New York, to forcible touching. A VA OIG and New York State

Police investigation revealed that the defendant sexually abused multiple active-duty service members while conducting disability evaluation physical examinations as part of their military service separation process.

### Telemarketing Company Owner Pleads Guilty to Conspiracy to Commit Healthcare Fraud

The owner of a telemarketing company pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. A VA OIG, Internal Revenue Service Criminal Investigation (IRS CI), Department of Health and Human Services (HHS) OIG, and FBI investigation resulted in charges alleging the defendant's company targeted the Medicare-aged population to generate orders for durable medical equipment (DME) and cancer genetic (CGx) testing. It is further alleged that the doctors' orders were approved under the guise of telemedicine; however, no actual telemedicine consults occurred, and orders for DME and CGx were approved regardless of medical necessity. The signed doctors' orders for DME and CGx were sold by the defendant to conspirators who then submitted claims to government healthcare programs, including VA's Civilian Health and Medical Program (CHAMPVA). The defendant's company was paid more than $3.4 million from the illegal sale of doctors' orders. The total loss to VA is approximately $800,000.

### Durable Medical Equipment Companies' Owner Pleads Guilty to Conspiracy to Commit Healthcare Fraud

The owner of numerous DME companies pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. A VA OIG, FBI, IRS CI, and HHS OIG investigation resulted in charges alleging the defendant placed the DME companies in the names of straw owners, which allowed for the submission of high volumes of illegal DME claims to government healthcare programs, to include CHAMPVA. The defendant and his coconspirators allegedly purchased thousands of DME doctors' orders for braces from "marketers" who bribed doctors to sign under the guise of telemedicine. In one year, the defendant's companies submitted more than $20 million in illegal DME claims to government healthcare programs. The total loss to VA is approximately $375,000.

### Nonveteran Pleads Guilty in Connection with Fraud Scheme

A nonveteran pleaded guilty in the Eastern District of Pennsylvania to stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, aiding and abetting straw purchases of firearms, and false statements to the Social Security Administration (SSA). A VA OIG and SSA OIG investigation revealed that from approximately April 2010 to September 2019, the defendant defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits. The defendant falsely claimed to be a decorated veteran, specifically, a U.S. Navy SEAL, a prisoner of war, and a Silver Star recipient. After the defendant was arrested, additional investigation with the Bureau of Alcohol, Tobacco, Firearms, and Explosives revealed that the defendant participated in the straw purchase of two firearms. The loss to VA is over $302,000.

### Sister of Individual Receiving VA Benefits for Spina Bifida Diagnosis Sentenced for Healthcare Fraud

The sister of a deceased woman who received VA benefits for her spina bifida diagnosis was sentenced in the Southern District of West Virginia to 42 months' incarceration, three years' supervised release, and restitution of approximately $289,000 after previously pleading guilty to healthcare fraud. VA provides monetary allowances, vocational training and rehabilitation, and VA-financed health care benefits to certain Korea and Vietnam veterans' birth children who have been diagnosed with spina bifida. A VA OIG, FBI, and HHS OIG investigation revealed that for 18 months the defendant fraudulently billed VA's Spina Bifida Health Care Benefits Program by charging eight hours of home health care, seven days per week, at $736 per day. The defendant spent only a few hours per week with her sister and maintained full-time employment during a portion of the period in which she billed VA for her sister's home health care. The judge imposed a sentencing enhancement for obstruction after finding that the defendant staged an elaborate hoax to fake her own death to avoid federal sentencing. The scheme involved a false report of her fall from a national park overlook, which led to an extensive search effort. The defendant was subsequently found hiding in a closet in her home.

### Former VA Police Officer in Bay Pines, Florida, Sentenced for Criminal Civil Rights Violation and Making False Entries in a Report

A former VA police officer at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, was sentenced in the Middle District of Florida to 24 months' imprisonment and three years' supervised release. The defendant previously pleaded guilty to depriving an individual of his Fourth Amendment right to a reasonable search and seizure under color of law and knowingly making false entries in a report with the intent to obstruct an investigation within the jurisdiction of a federal agency. A VA OIG and FBI investigation revealed the defendant used excessive force during an unlawful arrest and falsified a police report and two arrest affidavits following the incident.

### Former Shreveport, Louisiana, VA Medical Center Pharmacist Sentenced for Drug Diversion

A former pharmacist at the Overton Brooks VA Medical Center in Shreveport, Louisiana, was sentenced in the Western District of Louisiana to 12 months and one day imprisonment and one year of supervised release. The defendant was previously found guilty at trial of acquiring controlled substances by fraud. A VA OIG investigation resulted in charges alleging the defendant diverted opioid pills from outpatient prescriptions that were being prepared to be mailed out to veterans. When performing final verifications, the defendant allegedly diverted some pills before sealing the packages and placing them in the outgoing mail.

### Muskogee, Oklahoma, VA Community Based Outpatient Clinic Physician Indicted for Mail Theft and Diversion of a Controlled Substance

A general physician employed at the Ernest Childers VA Outpatient Clinic in Muskogee, Oklahoma, was arrested after being indicted in the Northern District of Oklahoma for mail theft and diversion of a

controlled substance. A VA OIG investigation resulted in charges alleging the defendant diverted previously mailed out narcotics that were returned to the facility's mail room as undeliverable, but before they were returned to the pharmacy for disposal.

# Criminal Investigations Involving Benefits

### Veteran and Wife Indicted in Connection with Fraud Scheme

A veteran and his wife were indicted in the Western District of Michigan for conspiracy to defraud the government, theft, false statements, and fraudulent claims. A VA OIG investigation resulted in charges alleging the defendants falsely reported to VA that the veteran was unable to walk or use his arms. It is further alleged that when applying for a VA Caregiver Support Program grant, the wife stated that she cared full-time for the veteran when in fact she often left the home while the veteran worked on the family ranch without assistance. The loss to VA is over $264,000.

# Criminal Investigations Involving Other Matters

### Company Agrees to Pay $117 Million to Resolve False Claims Act Allegations

A for-profit holding company that directly or indirectly owned the assets or stock of inpatient and residential psychiatric and behavioral health facilities entered into a civil settlement agreement with the U.S. Attorney's Office for the Eastern District of Pennsylvania to resolve allegations that the company violated the False Claims Act. A VA OIG, Defense Criminal Investigative Service (DCIS), Office of Personnel Management OIG, and HHS OIG investigation resolved allegations that the company knowingly submitted false claims related to unallowable costs for payment. As part of the settlement, the company agreed to pay $117 million, which included $88.1 million to the federal government and $28.9 million to the Medicaid-participating states. From this settlement, VA will receive over $5.1 million.

### Cancer Treatment Center Agrees to Pay $2.3 Million to Resolve Civil Claims Pertaining to Physician-Administered Drugs

A non-VA cancer treatment center entered into a civil settlement in the Middle District of Florida under which the entity agreed to return over $2.3 million in overpayments to VA. Although most veterans enrolled in the VA healthcare system receive care in VA-operated medical facilities, VA may also contract with non-VA facilities to provide services that are not readily available from a VA medical facility. The Code of Federal Regulations allows for VA to reimburse non-VA care providers for certain physician-administered drugs in accordance with Medicare pricing schedules. This VA OIG investigation resolved allegations that the cancer treatment center submitted claims to VA that were related to physician-administered drugs but calculated over the applicable Medicare rates. This investigation was based upon a hotline complaint and the findings of a subsequent audit conducted by VA OIG's Office of Audit and Evaluations.

### Pharmaceutical Manufacturer Agrees to Pay $678 Million to Resolve False Claims Act and Anti-Kickback Statute Allegations

A pharmaceutical manufacturer entered into a civil agreement with the Southern District of New York and the Department of Justice Civil Division's Commercial Litigation Branch, agreeing to pay $678 million to resolve allegations that it violated the False Claims Act and the Anti-Kickback Statute. Of this amount, VA will receive over $1.3 million. A VA OIG, DCIS, FBI, and HHS OIG investigation resolved allegations that between 2002 and 2011, the company operated a nationwide sham speaker program that was established to induce physicians to increase the number of prescriptions they wrote for the company's cardiovascular and diabetes drugs. This kickback scheme included payments to physicians for speaking fees, recreational outings, lavish meals, and expensive alcohol. As a result, federal healthcare programs to include VA paid hundreds of millions of dollars in reimbursements for these tainted prescriptions.

### Cemetery Co-Owner Sentenced for Conspiracy to Commit Mail Fraud

A co-owner of a cemetery was sentenced in the Middle District of Pennsylvania to 13 months' imprisonment (to run concurrently with a previously imposed state sentence), two years' supervised release, and restitution of approximately $495,000 after previously pleading guilty to conspiracy to commit mail fraud. A VA OIG, Northern York County Regional Police Department, and FBI investigation revealed the defendant and a codefendant defrauded at least 223 customers out of approximately $495,000. Instead of applying customers' monies to prepaid cemetery services and products, the defendants embezzled the money for their own personal gain. VA's National Cemetery Administration provided grave markers for veterans buried at the cemetery, many of which were never found, and the burial sites of several veterans could not be confirmed. The codefendant is currently awaiting sentencing.

## Audits and Reviews

### The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research

Five members of Congress requested that the OIG review the VHA's canine research approval process. Congress recently mandated that the VA Secretary directly approve the use of appropriated funds for canine research. VHA conducted eight studies without the Secretary's direct approval, resulting in the unauthorized use of approximately $400,000 in appropriated funds. There also was no formal procedure to obtain and document the Secretary's approval. Unclear communication, inadequate recordkeeping, and inaccurate recording and verification of approval decisions contributed to VHA's noncompliance. Providing unsupported and potentially inaccurate information could undermine public trust in VA and detract attention from its important mission of supporting a wide range of authorized research on veterans' health. The OIG recommended the under secretary for health establish an approval process for

canine research, ensure approval is documented, prevent appropriated funds from being spent without approval, and report to Congress on recent funds spent without the Secretary's approval.

### Potential Payment Errors Made by Veteran Readiness and Employment Service

The OIG issued a management advisory memorandum to the Veterans Benefits Administration (VBA) to request VBA examine potential overpayments by the Vocational Rehabilitation and Employment Program. The payments to schools covered veterans' tuition. The OIG analyzed data on 1.8 million tuition payments and determined that the program potentially made 360 errors in payments from January 1, 2014, through December 30, 2019, totaling more than $554,000 in overpayments. The overpayments ranged from $18 to $237,762 and averaged $1,542. The errors appeared to have resulted from program staff transposing numbers or adding one or more digits to the invoice amounts. In alerting VBA, the OIG did not determine if the program corrected or recovered the overpayments. Given the small percentage of errors, the OIG did not initiate an audit or investigation. Instead, the OIG has provided the potential errors to VBA to examine and take any actions, including recovering overpayments, as appropriate.

### The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies

The OIG examined whether the VBA's Systematic Technical Accuracy Review (STAR) program provided accurate quality reviews of decisions on veterans' claims for disability benefits, used procedures to ensure corrective actions were timely and accurate, and provided feedback to managers and staff to improve the claims decision-making process. The review team found the quality review process needs improvement. Approximately 55 percent of claims had deficiencies. These included benefit entitlement errors that could affect veterans' disability compensation payments and procedural deficiencies such as requesting an unnecessary medical examination. Other noted problems involved the process for correcting errors, as well as feedback from STAR reviews that did not improve decision-making on benefits claims. Recommendations focused on the quality review checklist, processes for second reviews and error corrections, training requirements for STAR analysts, and STAR feedback for regional offices.

### Deficiencies in the Quality Review Team Program

Quality review team (QRT) program specialists in the VBA oversee employees who process disability compensation claims. The OIG examined whether QRT specialists conducted accurate quality reviews, managers decided requests for reconsideration appropriately, and employees initiated timely action to correct claims processing errors. The OIG estimated that QRT specialists missed claims-processing errors in 35 percent of quality reviews. Managers also inappropriately overturned errors identified by QRT specialists in about 50 percent of quality reviews for which employees requested reconsideration. In addition, peer reviews were inadequate to identify errors missed during initial reviews, and performance reviews of QRT specialists did not ensure competency for identifying errors. Recommendations to the under secretary for benefits included revising the processes for peer reviews,

QRT specialist performance reviews, and error reconsideration. Another recommendation focused on improving oversight of the error correction process.

# Healthcare Inspections

### Deficiencies in Evaluation, Documentation, and Care Coordination for a Bariatric Surgery Patient at the VA Pittsburgh Healthcare System in Pennsylvania

This inspection assessed allegations of inadequate preoperative evaluations and the management of postoperative care for a patient approved for bariatric surgery at the VA Pittsburgh Healthcare System. The OIG did not substantiate that the patient was inappropriately or inadequately evaluated and approved for bariatric surgery. The lack of three preoperative tests did not affect surgical outcome. The OIG substantiated that the Managing Overweight and/or Obesity for Veterans Everywhere coordinator overstated the patient's mental health treatment and did not correct the documentation error after discovering it. The OIG noted that the lack of formal communication could have contributed to the incomplete preoperative evaluation. The patient was sufficiently monitored following surgery but completed suicide despite consistent postoperative care. The OIG made six recommendations regarding development and review of policy and procedure for bariatric surgery evaluations, communication, and staff education on documentation requirements.

### Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

A healthcare inspection was conducted to evaluate an anesthesia provider's practice. Unsafe practices were not identified after review of nine identified patient electronic health records. Initial hiring process deficiencies were noted related to the provider's reporting, and the facility's verification, of previous employment. The provider did not accurately document a prior discharge, and the facility credentialing and privileging staff did not complete required timely verifications. Additionally, the provider's personnel file was missing proficiency reports. Facility staff did not consistently follow VHA policy to report patient safety events and quality of care concerns, affecting facility leaders' ability to respond and take appropriate action. One recommendation, made to the under secretary for health, addressed physician applicants' listing of contracting companies. Other recommendations made to the facility related to credentialing and privileging checks, annual proficiency reports, reporting to the Professional Standards Board, and training related to patient safety reporting.

### Inadequate Care by a Clinical Pharmacy Specialist and a Primary Care Provider at the Tennessee Valley Healthcare System in Nashville

This healthcare inspection evaluated an allegation that a clinical pharmacy specialist (CPS) failed to act on a patient's abnormal test results, resulting in the patient going undiagnosed and untreated for pancreatic cancer for three months. Findings included that a primary care provider failed to acknowledge or assess the patient's unintentional weight loss during an annual physical; the CPS failed to act on a patient's abnormal test results, including communicating the results to the patient; and

VHA's current electronic health record lacks a process to ensure that test results are communicated and acted upon by ordering providers. Facility policies and practices supported CPSs collaborating with primary care providers when patients' conditions changed; however, an opportunity for collaboration was missed in this instance. The OIG made two recommendations related to reviewing the patient's episode of care and ensuring staff are aware of and follow the VHA directive regarding communication of test results.

### Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care

The OIG reviewed the accessibility of dermatology, orthopedics, and urology specialty care for patients in 17 CBOCs classified as highly rural from March 1, 2018 (or from the date the CBOC became highly rural), through February 28, 2019. The OIG identified that sites mostly used referrals to their parent facility and community care specialty providers. Sites rarely used telehealth, inter-facility consults, and eConsults. The OIG made four recommendations to the under secretary for health to assess specialty care needs, ensure VHA Site Tracking System validation, ensure the maintenance of accurate information on VA websites, and assess whether highly rural CBOCs located in non-VA health care centers fully utilized resources in the colocated facilities. After VHA implemented its coronavirus disease 2019 Response Plan, 4 of the 17 highly rural CBOCs closed and 13 listed pre-pandemic operations on their websites.

### Safety Concerns When Providing Care in the Community at the VA Southern Nevada Healthcare System in North Las Vegas

Following a referral from the U.S. Office of Special Counsel, the OIG evaluated allegations that facility leaders responded inadequately after a patient attacked and later threatened a social worker. The OIG substantiated managers failed to timely respond after the social worker reported an assault during a home visit and did not address the social worker's health needs after the assault. The social worker was not informed by a supervisor of a subsequent threat until two weeks after facility leaders became aware of the threat. Additional issues included disruptive behavior flag placement, VA police participation deficiencies in Disruptive Behavior Committees, and staffing in the facility Housing and Urban Development Veterans Affairs Supporting Housing (HUD-VASH) program. The OIG made six recommendations related to off-campus patient disruptive behavior incidents, work-related emotional or mental health injury, timely notification of threats, patient record flags, Disruptive Behavior Committee, and HUD-VASH staffing and training.

### Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness

On March 26, 2020, the OIG published *OIG Inspection of VHA's COVID-19 Screening and Pandemic Readiness*. That report evaluated processes specific to preparing facilities to meet unknown demands. This report discusses VHA's response to the pandemic and the evolving challenges faced by VHA in caring for veterans. The OIG engaged leaders from 70 selected facilities in discussions about patient-

care services provided from March 11 through June 15, 2020. Topics included the management of urgent and emergent care, adequacy of equipment and supplies, testing capabilities, community living center admissions and discharges, and the engagement of community healthcare partners. Facility leaders described a multitude of actions taken. With the uncertainty of timing and magnitude of possible recurrent outbreaks, it was hoped this review, which presented strategies that various facilities put into place, would promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.

### Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia

The OIG conducted an inspection and substantiated that three patients experienced delays in non-VA community care consult (NVCC) scheduling. However, the delays did not result in increased risk of or adverse clinical outcomes for the three patients. The OIG performed an expanded review of 221 consults and found delays. Two of the 221 patients had an increased risk of an adverse clinical outcome; however, both patients received care, and neither experienced an adverse clinical outcome. The other patients reviewed did not have increased risks of or adverse clinical outcomes related to consult delays. The facility also had a backlog of open NVCC consults with contributory factors that included deficiencies in consult processing, scheduling, and timeliness; scheduling audits; and consult procedures. The OIG made six recommendations to the facility director related to NVCC consult management, hiring, and training of staff; patient case reviews; and NVCC policy.

### Alleged Deficiencies within the Cardiac Telemetry Monitoring Service at the Nashville VA Medical Center in Tennessee

This inspection evaluated alleged deficiencies related to cardiac telemetry monitoring services including policies, staffing, and communication. The OIG did not substantiate outdated telemetry policies, staffing shortages, inadequate training, or inappropriate treatment of patients with "do not resuscitate" orders. Isolated communication issues between telemetry technicians and telemetry patient nurses related to the location and movement of telemetry patients in the hospital were identified. However, an electronic patient tracking system was available in an emergency. In 2018, facility leaders identified other communication issues. The OIG reviewed facility leaders' actions and noted overall improvement. The rapid response team policy and staff practice regarding the initiation of a rapid response team call did not always align, which is important to mitigate system vulnerabilities. The OIG made one recommendation to the Tennessee Valley Healthcare System director to ensure consistency between the system's policy and actual practice for initiating a rapid response team call.

### Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center

This inspection assessed patient care provided at the Washington DC VA Medical Center and an allegation that a physician made a statement to the effect of "[the patient] can go shoot [themself]. I do not care." The patient died by suicide six days after discharge from the emergency department without required suicide prevention planning. Lack of collaboration, hand-off deficiencies, and insufficient

record review led to providers' failure to enact the recommended treatment plan. The OIG substantiated that a physician made the alleged statement. Staff did not receive required abuse and neglect education, and facility leaders did not conduct a formal fact-finding or administrative investigation. The suicide prevention coordinator failed to complete the suicide behavior report and the emergency department did not meet safety and security requirements. The OIG made one recommendation to the Veterans Integrated Service Network director and 10 recommendations to the facility director.

### Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

The OIG initiated an inspection to evaluate facility leaders' oversight and response to misdiagnoses by a pathologist. The Pathology and Laboratory Medicine chief (chief) performed quality reviews, identified a misdiagnosis, and conducted comprehensive reviews that identified additional misdiagnoses. Facility leaders suspended, and then terminated, the pathologist. The pathologist appealed to the VHA Disciplinary Appeals Board and was subsequently reinstated. The chief reviewed the misdiagnoses, completed supplemental reports, and notified providers. The OIG found no documentation that providers informed three patients of their misdiagnoses. One patient experienced an adverse clinical outcome with no documented disclosures. Staff and leaders did not report the misdiagnoses as adverse events. Quarterly retrospective reviews of all pathology reports exceeded requirements, but the chief did not consistently review 10 percent of each pathologist's cases. Leaders did not follow mandated privileging processes and were unaware of state licensing board reporting requirements. The OIG made 10 recommendations.

### Focused Performance Review of Select Metrics at the Ioannis A. Lougaris VA Medical Center in Reno, Nevada

The OIG conducted a review to identify and evaluate declining performance as reflected in the facility's Strategic Analytics for Improvement and Learning data. The OIG focused on the facility's performance in six quality domains—Access, Performance Measures, Mental Health, Emergency Department Throughput, Patient Experience, and Employee Satisfaction, as well as leaders' awareness of and response to the negative trending. The OIG did not find evidence of large-scale system or process deficits such as a dysfunctional organizational or communication structure. In relation to the six quality domains, the OIG found staffing and pay issues, as well as inefficient processes, that may have contributed to some of the selected performance measure declines. One recommendation was made to the facility director to ensure that mechanisms to report and follow up on performance deficits were well defined and disseminated to staff, and that monitors were in place to confirm functionality.

## 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) Care Coordination
(8) Women's Health
(9) High-Risk Processes

### Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan

### Tomah VA Medical Center in Wisconsin

### John J. Pershing VA Medical Center in Poplar Bluff, Missouri

### Harry S. Truman Memorial Veteran's Hospital in Columbia, Missouri

### Marion VA Medical Center in Illinois

### Kansas City VA Medical Center in Missouri

### VA Illiana Health Care System in Danville, Illinois

## Special Reviews

### Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration

The Office of Special Reviews (OSR) substantiated that Peter Shelby, while serving as VA's Assistant Secretary for Human Resources and Administration, improperly steered a $5 million contract for the benefit of individuals with whom he had a personal relationship. The OIG determined that the contract resulted entirely in waste. The contract was awarded on a sole-source basis in accordance with Mr. Shelby's direction, over the objections of his subordinate staff and VA's contracting officials. VA used only 232 of 17,000 leadership development training licenses purchased, and VA received no value whatsoever for contracted talent assessment services. Mr. Shelby resigned from federal service in July 2018 after learning that he had been recommended for possible removal for reasons unrelated to this contract. The OIG made eight recommendations for identified areas for process improvements and for VA to consider any administrative action as warranted. VA concurred with all eight recommendations.

### Alleged Misuse of Official Time and Possible Ethics Violation by an Information Technology Employee

The OSR investigated but could not substantiate allegations that an employee in VA's Office of Information and Technology misused his government email by sending personal emails during work hours and took advantage of his telework arrangement to handle personal matters during his duty hours. However, the OIG did determine that the employee engaged in conduct that appeared contrary to ethical rules prohibiting the use of public office for private gain by referring staff who were planning conferences for his group to his wife, a sales manager for a hotel chain, and otherwise involving himself in the arrangements made with the hotel chain for those conferences. The OIG made one recommendation relating to a supervisory review of the employee's conduct and consideration of appropriate administrative action, if any. VA concurred with this recommendation.

### Allegations of Nepotism at the Miami VA Healthcare System in Florida

In response to allegations made to the OIG hotline, the OIG investigated whether chief nurses within the Miami VA Health Care System violated the federal antinepotism statute by arranging to have their spouses hired for positions for which the spouses were not qualified. This allegation could not be substantiated. However, the OIG did substantiate an allegation that a specific chief nurse violated the federal antinepotism statue by recommending the chief nurse's spouse for a position at the healthcare system. The chief nurse is a public official and was prohibited from advocating for the employment by the VA of the chief nurse's spouse. The chief nurse advocated for the spouse's employment in an email contrary to the antinepotism statute. The spouse withdrew his/her application without providing an explanation and was not hired by VA. The OIG made one recommendation relating to possible administrative action against the chief nurse.

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To listen to the podcast on the OIG's July 2020 activity highlights, go to www.va.gov/oig/podcasts.