SEPTEMBER 2020 HIGHLIGHTS

Criminal Investigations Involving Health Care

Former Beckley, West Virginia, VA Medical Center Doctor Pleads Guilty to Civil Rights Offense

A former Beckley, West Virginia, VA Medical Center doctor specializing in Osteopathic Manipulation Therapy pleaded guilty in the Southern District of West Virginia to the deprivation of rights under the color of law (civil rights). A VA Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), and VA Police Service investigation revealed that the defendant sexually abused three patients who sought chronic pain treatment during examinations at the facility.

Former Contract Physician at the Watertown, New York, VA Outpatient Clinic Sentenced for Forcible Touching

A former VA outpatient clinic contract physician based in Watertown, New York, was sentenced in the Superior Court of Jefferson County, New York, to six years' probation with sex offender conditions and ordered to turn over his medical license after previously pleading guilty 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.

Philadelphia, Pennsylvania, VA Medical Center Chief of Environmental Management Service Indicted in Connection with Bribery Scheme

The Chief of Environmental Management Service at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania, was indicted in the Eastern District of Pennsylvania for bribery. A suspended employee of the West Palm Beach VA Medical Center in Florida also pleaded guilty to conspiracy to commit healthcare fraud. A VA OIG investigation resulted in charges alleging that these defendants and 15 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the two medical centers. The charges allege that VA employees placed supply orders in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts.

Telemarketing Company Owner Sentenced for Conspiracy to Commit Healthcare Fraud

The owner of a telemarketing company was sentenced in the Middle District of Florida to four years' imprisonment, three years' supervised release, and restitution of $3.42 million after previously pleading guilty to conspiracy to commit healthcare fraud. Of this amount, VA will receive $1.71 million. An investigation by the VA OIG, Internal Revenue Service Criminal Investigation (IRS-CI), Department of Health and Human Services (HHS) OIG, and FBI resulted in charges alleging the defendant's company

targeted the Medicare-aged population to generate orders for durable medical equipment and cancer genetic 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 durable medical equipment and cancer genetic testing were approved regardless of medical necessity. The signed doctors' orders for durable medical equipment and cancer genetic testing were sold by the defendant to conspirators who submitted claims to government healthcare programs, including VA's Civilian Health and Medical Program (CHAMPVA).

Defendant Sentenced for Defrauding VA's Civilian Health and Medical Program

A deceased veteran's widow was sentenced in the Southern District of Texas to one year and one day of imprisonment, three years' probation, and restitution of $642,078 to VA after previously pleading guilty to false statements relating to healthcare matters. A VA OIG investigation revealed that over a period of five years, the defendant fabricated fictitious pharmacy receipts and submitted them to CHAMPVA for reimbursement.

Florida Doctor Pleads Guilty in Connection with Healthcare Fraud Scheme

A doctor pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. An investigation by the VA OIG, IRS-CI, HHS OIG, and FBI resulted in charges alleging the defendant and his coconspirators established a conglomerate of DME companies. The companies were placed 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 companies submitted more than $20 million in illegal DME claims to government healthcare programs. The loss to VA is approximately $375,000.

Former Transportation Assistant at The Villages, Florida, VA Outpatient Clinic Pleads Guilty in Connection with Fraud Scheme

A former transportation assistant at VA's outpatient clinic in The Villages, Florida, pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud and wire fraud, and solicitation and receipt of a healthcare kickback. A VA OIG investigation revealed that the defendant, who had the authority to award transportation assignments to vendors, created and controlled two companies to whom he steered VA transportation assignments. As a result, VA paid $305,673 to these companies. The defendant also solicited and received approximately $76,789 in kickbacks from two other transportation vendors. The defendant's ex-wife and daughter, who were involved in the fraud scheme, previously pleaded guilty to making false statements and conspiracy to commit healthcare fraud and wire fraud.

Texas Doctor Pleads Guilty to Obstruction of a Healthcare Investigation

A doctor pleaded guilty in the Eastern District of Arkansas to obstruction of a healthcare investigation. An investigation by the VA OIG, Defense Criminal Investigative Service, HHS OIG, and

FBI revealed that the defendant used telemedicine to fraudulently prescribe compounding medication, which resulted in over $5 million paid by government healthcare insurance programs, to include CHAMPVA. The investigation further revealed that the defendant did not speak to many of the patients for whom she wrote prescriptions. The defendant also misled agents during an interview that was conducted in connection with this investigation. The loss to VA is $305,430.

Defendant Sentenced for Assaulting VA Police Officers at the Buffalo, New York, VA Medical Center

A nonveteran was sentenced in the Western District of New York to six months' imprisonment, one year of supervised release, and 200 hours of community service. A VA OIG and VA Police Service investigation revealed that the defendant drove to the Buffalo, New York, VA Medical Center to confront his girlfriend about a domestic incident while she was working at the facility and a verbal altercation ensued. When VA Police Service officers attempted to intervene, the defendant fought with the officers and head-butted one in the face. Two other officers involved in the incident suffered minor injuries.

Criminal Investigations Involving Benefits

Veteran Pleads Guilty in Connection with Life Insurance Fraud Scheme

A veteran pleaded guilty in the Southern District of California to wire fraud. An investigation by the VA OIG, Naval Criminal Investigative Service, and FBI resulted in charges alleging that this defendant and at least 16 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 of the scheme allegedly recruited a Navy medical doctor and a Navy nurse to create false medical records and sign the claims. VA supervises the administration of the TSGLI program. The loss to the TSGLI program is approximately $2 million.

Former Bank Manager Pleads Guilty to Theft of Government Funds

A former bank manager pleaded guilty in the District of Nevada to theft of government funds. An investigation by the VA OIG and Social Security Administration (SSA) OIG revealed that the defendant used his position as a bank manager to fraudulently obtain VA and SSA benefit payments that were made to two deceased beneficiaries. The defendant used the funds for personal expenses. The total loss is $1,194,672. Of the amount, the loss to VA is $757,985.

Veteran Pleads Guilty to Theft of Government Funds

A veteran pleaded guilty in the Middle District of Florida to theft of government funds. A VA OIG and SSA OIG investigation revealed that the defendant made false representations regarding his physical limitations in connection with his application for VA disability compensation benefits. Based upon these false representations, VA found that the defendant was entitled to monthly compensation benefits and

other related benefits. The investigation further revealed that the defendant also fraudulently received Social Security Disability Insurance benefits. The total loss to the government is $730,561. Of this amount, the loss to VA is $549,426.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The daughter of a deceased VA beneficiary was sentenced in the Northern District of California to 36 months' probation and restitution of $286,612 after pleading guilty to theft of government funds. A VA OIG investigation revealed that the defendant stole monthly VA Dependency and Indemnity Compensation payments intended for her mother, who died in September 2002.

Daughter-in-Law of Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter-in-law of a deceased VA beneficiary was arrested after being indicted in the District of Arizona for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant stole monthly VA Dependency and Indemnity Compensation payments intended for her mother-in-law, who died in August 2003. The loss to VA is over $232,000.

Criminal Investigations Involving Other Matters

Medical Office Administrator Sentenced for Role in Workers' Compensation Fraud Scheme

A medical office administrator was sentenced in the Northern District of Texas to 18 months' incarceration, two years' supervised release, and restitution of $437,940 to the federal government. VA's portion of the restitution is still being determined. An investigation by the VA OIG, Department of Labor (DOL) OIG, U.S. Postal Service OIG, Department of Justice OIG, and Army Criminal Investigation Command Major Procurement Fraud Unit resulted in charges alleging the defendant submitted false claims to DOL's Office of Workers' Compensation Program (OWCP) on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, assigned inaccurate billing codes to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The investigation revealed that this defendant and a coconspirator perpetuated the fraud for a period of approximately six years. The loss to VA is approximately $2.9 million.

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

A veteran pleaded guilty in the Southern District of Florida to making a false statement. An investigation by the VA OIG and Treasury Inspector General for Tax Administration revealed that the defendant's company held service-disabled veteran-owned small business set-aside courier contracts with VA and the Internal Revenue Service while he was incarcerated in a state prison. The defendant continued to certify that he was in control of the day-to-day operation of the company despite not being able to make phone calls to his drivers, correspond with VA contracting officials, or sign contracting

documents. The defendant also received VA Individual Unemployability benefits and continually certified to VA that he had not been employed despite owning his own business and holding multiple government contracts. The total loss to VA is approximately $1.2 million.

Administrative Investigation

Misuse of Funds, Improper Disposal of Equipment, and Destruction of Records

The OIG received allegations of misconduct in the operations of the Veterans Health Administration's (VHA) Consolidated Patient Account Center (CPAC) field offices, which function within the Office of Community Care, and substantiated that (1) CPAC management improperly used government funds to purchase food for CPAC employees in fiscal years 2015 and 2016, (2) one CPAC violated VA policy for disposing of excess equipment when computer monitors were given to a local school without following established procedures, and (3) some CPAC field offices violated VA policy requiring that destruction of temporary paper records be performed pursuant to a written contract. The OIG made two recommendations with which VA concurred and took prompt corrective action. The OIG considers these recommendations closed. Allegations relating to improper travel, the misuse of funds for the purchase of planners and a wheelchair, and the improper use of purchase cards for armored car services were not substantiated.

Audits and Reviews

Appointment Management During the COVID-19 Pandemic

VHA protected patients and employees from COVID-19 by canceling face-to-face appointments that were not urgent and converting some to virtual appointments. The OIG assessed the status of these canceled appointments and VHA's strategies for managing them. The OIG found that about five million appointments (68 percent) canceled from March 15 through May 1, 2020, had evidence of follow-up or other tracking, but about 2.3 million appointments (32 percent) did not. The review team also determined that medical facilities did not consistently follow VHA's guidance on annotating canceled appointments, and on leaving consults open so that medical providers could reschedule them. In addition, the team noted that canceling appointments in batches could mask the instances where patients were not contacted for rescheduling. The OIG made three recommendations to VHA on rescheduling strategy and oversight, monitoring progress on cancellation follow-up, and taking appropriate follow-up action on canceled or discontinued consults.

Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources

The purpose of this OIG audit was to review whether VHA established adequate financial management practices at the VA Southeast Network (VISN 7) and the VA Great Lakes Health Care System (VISN 12) to promote the efficient use of financial resources. The audit team found that VHA's financial management practices did not include financial controls, such as performance indicators, to readily

assess whether its regional networks and medical centers were using their funds cost effectively. The OIG made three recommendations to VHA that included establishing key performance indicators that align with medical center operations and can be used to assess the efficient use of operating funds, specifying the office responsible for establishing financial controls at networks and medical centers, and requiring establishment and publication of organizational charts identifying the appropriate financial management reporting lines of authority and developing familiarization training on those lines of authority at the appropriate levels.

The Veterans Benefits Administration Inadequately Supported Permanent and Total Disability Decisions

The Veterans Benefits Administration (VBA) manages VA's disability compensation program. The OIG examined whether VBA staff cited adequate medical evidence to support decisions involving veterans' permanent and total (P&T) disability status. The OIG found that 61 percent of the decisions sampled did not cite adequate medical evidence, and about 15,100 veterans received P&T status without this evidence. As a result, VA may have improperly paid an estimated $38 million in dental, medical, and education benefits for P&T veterans and dependents between October 1, 2017, and December 31, 2019, and may pay more than $84 million for these benefits over the next five years. The OIG recommended VBA update P&T status procedures for consistency with relevant statute, revise procedures to ensure staff supports P&T status decisions by citing evidence, revise the title and language used in the decisions for clarity, and provide training to staff on updated procedures.

Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care

The OIG determined that VHA did not consistently use data from its National Surgery Office to improve operating room efficiency. Problems persisted for at least two years at less efficient facilities because regional and facility leaders did not monitor them and follow up on the root causes. At more efficient VHA facilities, surgical workgroups focused on operating room efficiency in addition to surgical outcomes. The audit team estimated that, under non-pandemic conditions, greater regional and facility oversight of surgical support elements would reduce surgical cancellations by 8,600 over five years, save approximately $30 million, and improve services for about 7,200 patients. Surgical support elements include clinical service staff, sterile processing and logistics services, and environmental and resource management. VHA concurred with the OIG's six recommendations in areas such as oversight, assessment and sharing of efficiency data, and clarifying performance measures.

Date of Receipt of Claims and Mail Processing During the COVID-19 National State of Emergency

The OIG reviewed VBA's processing of mail and benefit claims during the COVID-19 pandemic. The review team found VBA staff continued to process mail received at VA facilities but did not properly apply new guidance related to date of receipt for an estimated 98 percent of about 3,200 claims established from April 7 through April 20, 2020. The date of receipt may be used to determine when

veterans become entitled to benefit payments. Veterans could be underpaid if a date of receipt is incorrect. VBA concurred with the OIG's recommendations to (1) ensure VBA staff understand date of receipt guidance for claims received during the pandemic and implement those actions; (2) make certain that claims received and completed from March 1, 2020, had the correct date of entitlement; and (3) evaluate existing guidance for recording the date of receipt for claims without a postmark.

Financial Controls Related to VA-Affiliated Nonprofit Corporations: Idaho Veterans Research and Education Foundation

The OIG investigated whether the former executive director of the Idaho Veterans Research and Education Foundation, a VA-affiliated nonprofit, improperly raised her pay and misused the nonprofit's credit card. It also assessed controls and oversight regarding the nonprofit's expenditures and VA payments. Findings confirm the former director did receive an unapproved salary increase and used the credit card for personal purchases. She pleaded guilty to federal program theft, paid about $44,300 in restitution, and was sentenced to five years' probation. The current executive director also received a questionable salary increase. Finally, VA improperly paid about $50,600 to the nonprofit due in part to insufficient oversight. Recommendations to the medical center director included determining whether administrative action should be taken against the current executive director, ensuring the nonprofit requires two or more officials oversee salary changes and better controls credit card use, and establishing procedures for proper invoice review and oversight.

The Veterans Health Administration's Governance of Robotic Surgical System Investments Needs Improvement

This audit examined whether VHA adequately governs its purchase and use of robotic surgical systems, which cost between $1.5 million and $2.2 million each. The findings included that VHA did not consistently support its acquisition of robotic surgical systems as required. Between June 2013 and September 2018, 13 of 45 systems had incomplete information to support a justification, and 10 systems had no documented evidence of VHA approval. This occurred because VHA did not adequately manage the internal process for submitting and reviewing applications to acquire the systems. VHA also lacked comprehensive data on robotic surgeries because medical facility staff recorded procedures inconsistently. Its National Surgery Office reported about 2,300 fewer procedures than the robotic systems manufacturer had tracked. The OIG made five recommendations, to which VHA concurred, to improve the governance of robotic surgical systems.

Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide

The OIG examined whether VBA managed the Quality Review and Consistency Program to improve uniformity in its disability claims processing. The program identifies and studies error trends found in quality reviews to develop consistency studies for claims processors. The OIG determined that VBA missed opportunities to drive nationwide consistency in how claims are processed. For example, the Compensation Service could have shared more accessible information about staff comprehension and

performance with regional offices to drive improvements. The Office of Field Operations did not ensure all claims processors participated in required studies or use study results to ensure improvements were made. The OIG recommended the Compensation Service ensure detailed consistency study reports go to the Office of Field Operations and all regional office managers. The Office of Field Operations should also develop a process to monitor regional offices to increase employee participation in consistency studies and require regional managers to review study results to correct identified performance issues.

VA's Noncompliance with Preaward Review Requirements for Sole-Source Proposals for Healthcare Services

VA spends millions of dollars annually on sole-source healthcare resource contracts with affiliated educational institutions. This review examined whether VA complied with the requirement to obtain an OIG preaward review of these contract proposals from affiliates and the potential monetary impact of identified noncompliance. Preaward reviews generally provide VA with pricing recommendations based on the affiliate's actual expenses for providing services and are used by VA contracting officers to negotiate fair and reasonable prices for the government and taxpayers. Of the contracts that met the $500,000-plus threshold during the review period, VA awarded 63 percent without the required OIG preaward review. Contract files and other sources revealed contracting officers awarded and extended interim contracts using methods to circumvent the review requirements. Contracting officers also did not consistently document that the negotiated price was fair and reasonable, as required by regulation and policy. The OIG made three recommendations.

Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System

The OIG examined whether the VA Office of Community Care accurately reimbursed millions of dollars to third-party administrators for payments made to community healthcare providers under the Veterans Choice Program for services to veterans during the audit period. The audit team found the office reimbursed third-party administrators at rates higher than what was typical for similar medical services in a given geographic area. The office could have saved approximately $132.1 million during the period audited if it reimbursed third-party administrators at verifiable usual and customary rates, as required by the contract. Additionally, the office did not fully implement prior OIG recommendations to develop effective payment and internal control processes for the Choice program. As a result, the office made about $73 million in overpayments to third-party administrators for medical services provided under the program. The OIG made eight recommendations in this report to address these issues.

National Healthcare Review

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and nonclinical occupations experiencing staffing shortages within VHA. In this seventh staffing report, the OIG evaluated severe occupational staffing shortages and compared this

information to the previous two years. The OIG surveyed medical center directors and found 95 percent of facilities identified one or more severe occupational staffing shortages. Medical officer and nurse were the most frequently cited shortages. Within the medical officer occupational series, Psychiatry was the most frequently identified clinical severe staffing shortage. Custodial worker was the most frequently identified nonclinical severe staffing shortage. Since fiscal year 2018, the overall number of severe occupational staffing shortages decreased from 3,068 to 2,430 in fiscal year 2020. Similarly, the number of occupations reported by at least 20 percent of facilities decreased from 30 to 17. The OIG made no recommendations.

Healthcare Inspections

Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide at the Memphis VA Medical Center in Tennessee

This healthcare inspection evaluated whether a patient received the care needed at the Memphis VA Medical Center. The patient died by suicide the day following a visit to the emergency department. The OIG substantiated that the patient presented to the emergency department seeking treatment for insomnia and psychiatric medication refills. After an evaluation and negative suicide screening, the patient was discharged with instructions to go to the outpatient mental health clinic immediately for medication management. The OIG found no documentation that the patient registered or received treatment in the clinic. The patient received mental health care through the community. The OIG found deficiencies in care coordination with facility community care staff, community care providers, and the third-party administrator. Authorizations for community care treatment were not timely, resulting in the patient's inability to receive several medication refills. The OIG made 16 recommendations to the facility director.

Mismanagement of Emergency Department Care of a Patient with Acute Coronary Syndrome at the Robert J. Dole VA Medical Center in Wichita, Kansas

The healthcare inspection assessed allegations that coordination and quality of care issues contributed to the delay of an interfacility transfer resulting in a patient death shortly after transfer from the facility to a community hospital. The OIG substantiated that coordination and quality of care issues in the management of a patient who presented to the emergency department with acute coronary syndrome symptoms contributed to the patient's death. The emergency department physician mismanaged the patient's care by failing to initiate a timely interfacility transfer to a hospital capable of providing percutaneous coronary intervention (PCI). The failure to transfer the patient for PCI within 30 minutes of arrival limited the patient's chances for the best possible outcome. The OIG made one recommendation to the VISN related to peer review and nine recommendations to the facility director related to staff training, interfacility transfers, policy updates, committee oversight, and institutional disclosure.

Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

This inspection assessed allegations related to the prior authorization drug request process. The required consult template included limited space and prescribers did not always know about an option to document supplemental information. The relationship between Pharmacy and Therapeutics Committee leaders and the mental health representative was problematic and noncollaborative. The prior authorization drug request process did not delay treatment; however, a mental health prescriber may have contributed to one patient not receiving medications. Facility leaders did not effectively resolve unprofessional communications between Mental Health and Pharmacy Services staff. A pharmacist canceled medication orders without communicating with a patient; however, the requesting prescriber was required to notify the patient. Pharmacists did not cancel medication orders without communicating with the requesting prescriber or deny a large number of requests. The OIG made five recommendations regarding prescriber education, effective treatment plans, review of electronic health records and email, and workplace relationships.

Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia

The OIG evaluated facility leaders' response to a report that a urologist had physical impairments. Leaders failed to adequately oversee the urologist's performance by not formally evaluating reported impairments. Management reviews were conducted, but the processes were flawed. Privileging process failures delayed removing the urologist's privilege to perform open procedures and failed to inform the urologist of active privileges. Facility leaders were noncompliant with VHA directives regarding reporting physicians to the National Practitioner Data Bank and state licensing boards. Frequent personnel changes in leadership positions affected oversight, privileging, and reporting processes. Poor communication regarding the urologist, a lack of knowledge of position responsibilities, and inexperienced support staff contributed to noncompliance. The OIG previously identified deficiencies in focused professional practice evaluations and National Practitioner Data Bank reporting; therefore, recommendations were not made regarding these issues. The OIG made six recommendations to VISN 7 and facility directors.

Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California

This inspection assessed allegations related to staffing shortages, adverse events, environment of care, infection control, a registry agency's provision of staff, and registry staff's inability to document care. Facility leaders failed to address community living center (CLC) staffing shortages yet maintained a high resident census, reduced the number of operating beds without VHA authorization, used inaccurate staffing targets, and relied on inconsistently supplied registry staff. The facility did not further analyze an event with a higher potential for an adverse clinical outcome. Registry staff could not document in electronic health records. Twenty-four-hour Environmental Management Service support was not

consistently available or easily contacted. Staff did not meet hand-hygiene compliance. The CLC had flying insects. Managers followed identified quarantine processes. The OIG made 10 recommendations regarding staffing methodology, operating beds, staff retention and recruitment, adverse events, registry staff electronic health record access, pest control, hand hygiene, and contract performance.

Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans

The OIG conducted a healthcare inspection to evaluate concerns that failure to follow pharmacy and nursing policies and procedures may have contributed to the death of a patient. The OIG determined that pharmacy staff failed to comply with the policy's intent by sending an unaffixed IV norepinephrine label to the intensive care unit. Subsequently, an intensive care unit nurse failed to follow policy when they placed the incorrect IV norepinephrine label on the IV fentanyl without first verifying the patient and medication information. Intensive care unit nursing staff also failed to follow the infusion rate orders, assess the medication effectiveness, and did not completely document their actions and findings. Additional concerns the OIG identified included unsecured IV controlled substances and the facility's failure to conduct a thorough review of the medication error. The OIG made eight recommendations.

Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia

This inspection evaluated allegations related to the care provided to a patient who died at the facility and an allegation of inadequate psychiatric provider coverage. The OIG did not substantiate that the patient died due to overmedication, because the cause of death was pulmonary thromboemboli. Given that the patient was restrained for approximately 71 hours, the staff's failure to effectively address the patient's deep vein thrombosis prophylaxis needs contributed to the patient's death. Facility leaders and staff failed to comply with Georgia State law involuntary commitment process requirements. The lack of mental health provider involvement likely contributed to the patient's death. The Downtown Division lacked adequate psychiatric providers. The OIG concluded that the Disruptive Behavior Committee failed to provide input that may have contributed to a mismanagement of the patient's mental health treatment needs. The OIG made 18 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) Credentialing and Privileging
(4) Environment of Care

(5) Medication Management
(6) Mental Health Care
(7) Geriatric Care
(8) Women's Health
(9) High-Risk Processes

Tuscaloosa VA Medical Center in Alabama

Central Alabama Veterans Health Care System in Montgomery

Birmingham VA Medical Center in Alabama

Veterans Integrated Service Network 12: VA Great Lakes Health Care System in Westchester, Illinois

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