MAY 2021 HIGHLIGHTS

Congressional Testimony

Counselor to Inspector General Testified before the Subcommittee on Oversight and Investigations, US House of Representatives Committee on Veterans' Affairs

Christopher Wilber, counselor to the inspector general, testified before the Subcommittee on Oversight and Investigations, US House of Representatives Committee on Veterans' Affairs on May 19, 2021. The hearing focused on VA's progress toward improving its Office of Accountability and Whistleblower Protection since issuance of the Office of Inspector General's (OIG) 2019 report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, and ensuring whistleblowers at the department are protected and engaged. Mr. Wilber discussed how OIG staff interact with whistleblowers and complainants as well as provided an update on VA's efforts to close out the report's 22 recommendations. In response to questions, Mr. Wilber discussed the importance of OIG independence and independent legal counsel and explained that the OIG's impression is that the Office of Accountability and Whistleblower Protection has improved its work under recent VA leaders.

Director of Information Technology and Security Audits Testifies before the Subcommittee on Technology Modernization, US House of Representatives Committee on Veterans' Affairs

Mike Bowman, director of information technology and security audits for the OIG's Office of Audits and Evaluations, testified before the Subcommittee on Technology Modernization, US House of Representatives Committee on Veterans' Affairs on May 20, 2021. He discussed VA's ongoing cybersecurity challenges and the results of the OIG's April 2021 report, *Federal Information Security Modernization Act Audit for Fiscal Year 2020*. He shared the OIG's findings and repetitive recommendations made in recent Federal Information Security Modernization Act audits and how that underscores VA's inability to make major improvements and impactful change in their security program.

Investigations Involving Health Care

Former Anchorage VA Medical Center Employee Sentenced and Business Owner Pleads Guilty in Connection with Bribery Scheme

A former contracting officer representative at the Anchorage VA Medical Center was sentenced to one year and one day of imprisonment and restitution of $347,000. The former owner of a service-disabled veteran-owned small business also pleaded guilty to bribery of a public official. An investigation by the VA OIG, FBI, Small Business Administration OIG, and General Services Administration OIG revealed the former business owner paid nearly $30,000 in bribery payments to the former contracting officer representative in exchange for preferential treatment. As a result, the business obtained more than $5

million in set-aside snow removal and housekeeping contracts at the medical center. Both court proceedings occurred in the District of Alaska.

Former Employee of the Fayetteville VA Medical Center Sentenced in Connection with Bribery Scheme

A former specially adapted housing agent at the Fayetteville VA Medical Center was sentenced to two years' incarceration, three years' supervised probation, and restitution of $21,520. A VA OIG investigation revealed that the former VA employee received over $20,000 in bribes from a business partner in exchange for directing more than $1 million in grants intended for the modifications of veterans' homes to his partner's company. The defendant was sentenced in the Eastern District of North Carolina.

Defendant Sentenced in Connection with Compounding Pharmacy Scheme

A defendant was sentenced in the Southern District of Florida to over 11 years' incarceration, three years' supervised release, restitution of $11.8 million, and forfeiture of approximately $7.6 million. An investigation by the VA OIG, Defense Criminal Investigative Service, Food and Drug Administration Office of Criminal Investigations, and FBI revealed the defendant paid recruiters to convince beneficiaries of the Department of Defense's Tricare healthcare program and the Civilian Health and Medical Program of the Department of Veterans Affairs to fill prescriptions for unnecessary, expensive, and supposedly tailor-made compounded medications. The defendant then paid doctors to approve preprinted prescriptions for large amounts of these medications. It is alleged that the doctors did not see the beneficiaries or consider their medical needs before approving the prescriptions. The defendant allegedly steered the beneficiaries to fill their prescriptions at a codefendant's compounding pharmacy, which then billed the Department of Defense and VA for the expensive drug formulations. The loss to VA is $757,044.

Two Defendants Sentenced in Connection with Theft Scheme

A former case manager for a nonprofit organization dedicated to combatting homelessness was sentenced to one year and one day of incarceration, three years' supervised release, and restitution of $112,202. A property agent was sentenced to 21 months' incarceration, three years' supervised release, and restitution of $105,698. An investigation by the VA OIG and Department of Housing and Urban Development (HUD) OIG revealed that the defendants schemed to steal VA Support Services for Veterans Families (SSVF) and HUD-VA Supportive Housing (HUD-VASH) funds. From October 2014 through November 2015, the defendants received housing vouchers from the SSVF and HUD-VASH programs in support of housing homeless veterans. Instead of using these funds to make the appropriate rental payments on behalf of the veterans, the defendants kept the funds for themselves. As a result, 25 veterans were evicted from their residences. Both defendants were sentenced in the Northern District of Georgia.

Investigations Involving Benefits

Owner of a Dog-Handling School Sentenced in Connection with Education Benefits Fraud Scheme

The owner of a canine training school was sentenced in the Western District of Texas to over nine years' imprisonment, three years' supervised release, and restitution of approximately $1.5 million. An investigation by the VA OIG, Internal Revenue Service Criminal Investigation, and FBI revealed the defendant fraudulently obtained VA approval through the submission of multiple materially false statements regarding the school's certifications and on-staff instructors. Similarly, the defendant submitted falsified certification materials to receive licensure to operate in the state of Texas. The loss to VA is over $1.5 million.

Owner of a Barber School Pleads Guilty in Connection with Education Benefits Fraud Scheme

The former owner of a barber school pleaded guilty in the Southern District of Mississippi to wire fraud. A VA OIG investigation revealed the defendant submitted false course enrollments to VA on behalf of veterans who were eligible for Chapter 33, Post 9/11 GI Bill benefits. The total loss to VA is approximately $410,000.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Public Funds

The daughter of a deceased VA beneficiary was sentenced in the Eastern District of Virginia to two years' probation and restitution of approximately $188,000. A VA OIG investigation revealed the defendant stole monthly VA dependency and indemnity compensation benefits intended for her mother, who died in March 2009.

Veteran and Spouse Plead Guilty to Theft of Government Property

A veteran and his spouse pleaded guilty in the District of Kansas to theft of government property. An investigation by the VA OIG and Social Security Administration OIG revealed that the veteran, with assistance from his wife, fraudulently led VA and the Social Security Administration to believe that he was completely blind, which qualified him for special monthly compensation and other VA benefits. The investigation determined that the veteran was able to drive, operate machinery, and perform other normal daily activities without the assistance of another person or low-vision aids. The total loss to the government is $243,483. Of this amount, the total loss to VA is $131,973.

Former Veterans Benefits Administration Database Manager Sentenced for Attempting to Sell the Personal Information of Veterans and VA Employees

A former Veterans Benefits Administration (VBA) database manager was sentenced in the Eastern District of Arkansas to 46 months' imprisonment and two years' supervised release. A VA OIG and US Secret Service investigation revealed that the defendant attempted to sell the personal data of veterans,

their dependents, and VA employees for $100,000 to a confidential source working with law enforcement.

Audits and Reviews

The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings

In 2020, VBA processed about 1.2 million disability compensation claims and paid more than $90.8 billion in total benefits to about five million veterans. To ensure claims decisions are accurate and consistent so veterans receive the benefits they deserve, VBA established a multifaceted quality assurance program. The OIG reviewed the program and identified a systemic weakness in oversight and accountability by the Office of Field Operations, one of two offices involved. While VBA's quality assurance program routinely identified claims-processing deficiencies and communicated results to stakeholders, the Office of Field Operations did not ensure regional office employees adequately addressed identified deficiencies. Until VBA leaders ensure improvements are made, veterans may not get the benefits they deserve. The OIG recommended the acting under secretary for benefits develop and implement a written plan to strengthen oversight of the quality assurance program and monitor the plan to ensure identified deficiencies are adequately addressed.

Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program

VA is spending billions of dollars to replace its aging electronic health record system to capture more comprehensive medical histories for millions of veterans. The new system requires medical facility physical infrastructure upgrades, including electrical and cabling. This report details OIG findings that the Veterans Health Administration's (VHA) cost estimates for these upgrades did not fully meet VA standards for being comprehensive, well-documented, accurate, and credible. The OIG projected that VHA's June and November 2019 estimates were potentially underestimated by as much as $1 billion and $2.6 billion, respectively. The Office of Electronic Health Record Modernization also did not include physical infrastructure cost estimates in statutorily mandated reports to Congress, stating it was not within the office's responsibility to report. VA concurred with the OIG's five recommendations and agreed that the costs associated with these upgrades will be transparently disclosed to Congress.

Compensation and Pension Proceeds Were Generally Handled Accurately but Some Were Delayed

The OIG audited VBA's handling of proceeds to determine whether they were completed accurately and timely. A proceed is an actionable item in the veteran's or beneficiary's record that is created when benefits payments are returned to VA instead of being paid for reasons such as a change of bank account number, a change of address, or a veteran's death. On December 18, 2019, VBA had more than 7,500 open proceeds totaling about $13 million. The OIG determined that VBA generally handled proceeds accurately but sometimes took more than 90 days to close some proceeds. When a proceed remains open

for an extended period, the veteran or beneficiary may undergo financial hardship. Proceeds open more than 90 days totaled an estimated $2.1 million. The OIG recommended VBA set a standard time for closing proceeds and develop oversight and monitoring procedures to ensure proceeds are closed promptly.

Healthcare Inspections

Deficiencies in Leaders' Responses to Lapses in Reusable Medical Equipment Reprocessing at the Chillicothe VA Medical Center in Ohio

This inspection reviewed allegations regarding a Sterile Processing Services employee's failure to follow endoscope reprocessing procedures, potentially placing patients at risk. The OIG determined the facility director did not develop and implement an adequate plan to monitor the employee's compliance with Sterile Processing Services reprocessing procedures. Because multiple patients were potentially affected, facility and Veterans Integrated Service Network leaders notified the VHA Clinical Episode Review Team. The team concluded the risk to patients was minimal and a large-scale disclosure was not warranted; however, the determination may have been based on an inaccurate understanding of reprocessing equipment capabilities. The OIG made two recommendations—one to the facility director regarding oversight of the employee's performance and one to the under secretary for health regarding the Clinical Episode Review Team's review of OIG-provided information to determine if it altered the determination of patient risk or the need for a large-scale disclosure.

Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio

The OIG reviewed aspects of care provided to a patient who was struck and killed by a vehicle near facility grounds following elopement from the community living center. The OIG determined that the patient's admission to the center was inappropriate, interventions were inadequate to mitigate the patient's risk for elopement, staff were inadequately trained, and patient safety reports were not completed as required. On the day of the patient's death, staff failed to detect that the patient, who was involuntarily civilly committed to the center, was missing for nearly three hours. Once noted as missing, facility staff failed to follow policy to locate the patient. The OIG also expressed concern that the center may not have been used as intended. The OIG made 12 recommendations to the Veterans Integrated Service Network and facility directors regarding reviews of the patient's care, the use of the community living center, and staff training.

Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

The OIG conducted a healthcare inspection to review patients with profound hypoglycemic (low blood sugar) events at the facility after an OIG criminal investigation was completed. On July 14, 2020, Reta Mays, a former nursing assistant, pleaded guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder. The OIG found that the facility had serious clinical and

administrative failures that contributed to Ms. Mays's criminal actions not being identified and stopped earlier. Healthcare inspectors assessed several areas:

- Ms. Mays's hiring and performance
- Medication management and security
- Clinical evaluations of hypoglycemic events
- Reporting and responding to the events
- Quality programs
- Leaders' responses and corrective actions

The OIG made 15 recommendations related to background investigations, rescue medications, mortality data analyses, patient reviews, inventory accountability, clinical communication and documentation practices, patient safety event training, oversight and reporting, and a culture of safety.

Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma

This inspection evaluated whether ophthalmology residents received appropriate supervision and the quality of care by an attending ophthalmologist. The OIG substantiated that the subject ophthalmologist failed to provide adequate resident supervision and entered inaccurate documentation related to supervision for a single patient case. The ophthalmology residents were unable to reach the subject ophthalmologist during an eye injection procedure when the patient experienced a complication. A note in the patient's electronic health record documented supervision by the subject ophthalmologist but was incorrect because the subject ophthalmologist did not directly participate in and was not present during the care of the patient. Facility leaders performed reviews that identified documented evidence of resident supervision and determined that the subject ophthalmologist documented proper patient care. The OIG made three recommendations related to documentation of resident supervision and the hand-off process for covering attending ophthalmologists.

Drug Interactions Related to a Patient Death, Marion VA Medical Center in Illinois

The OIG conducted a healthcare inspection to evaluate an allegation that a patient died due to complications from high cholesterol. The OIG substantiated that high cholesterol contributed to the patient's death, but the primary cause of death was accidental acute multi-drug intoxication. The psychiatrist and staff failed to document providing the patient with education during a telephone encounter regarding potential side effects or adverse drug-drug interactions from medication changes. The psychiatrist prescribed long-term benzodiazepine use for a posttraumatic stress disorder diagnosis and failed to address both positive and negative drug screens with the patient. The facility failed to launch the Psychotropic Drug Safety Initiative Phase Four Plan. The primary care provider did not comply with facility policy by failing to enter a return-to-clinic order following an appointment. Primary care and behavioral health staff did not comply with facility policy to contact the patient after a missed appointment. The OIG made five recommendations.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

(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

Recently published CHIP reports include:

Aleda E. Lutz VA Medical Center in Saginaw, Michigan

Cincinnati VA Medical Center in Ohio

Chillicothe VA Medical Center in Ohio

Additional Publications

Semiannual Report to Congress, Issue 85, October 1, 2020–March 31, 2021

The Semiannual Report to Congress summarizes the results of VA OIG oversight, provides statistical information, and lists all reports issued from October 1, 2020, to March 31, 2021. During this reporting period, VA OIG audits, evaluations, investigations, inspections, and other reviews identified more than $1.9 billion in monetary impact for a return on investment of $21 for every dollar spent on oversight. During this reporting period, the VA OIG issued 124 reports and publications on VA programs and operations, made 389 recommendations, and conducted investigations that led to 109 arrests.

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To listen to the podcast on the May 2021 highlights, go to www.va.gov/oig/podcasts.