



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

SEPTEMBER 2021 HIGHLIGHTS

Investigations Involving Health Care

Former Community-Based Outpatient Clinic Nurse Practitioner Pleads Guilty to Sodomy and Sexual Abuse

A former VA nurse practitioner pleaded guilty in the Circuit Court of St. Louis County, Missouri, to felony sodomy and misdemeanor sexual abuse. A VA Office of Inspector General (OIG) and VA Police Service investigation revealed that the defendant sexually assaulted two female veteran patients at the community-based outpatient clinic in Florissant, Missouri, in 2019.

Former Employee of Northport VA Medical Center in New York Indicted for Aggravated Sexual Abuse, Sexual Abuse, and False Statements

A former employee of the Northport VA Medical Center was arrested after being indicted in the Eastern District of New York for aggravated sexual abuse, sexual abuse, and false statements. An investigation by the VA OIG, FBI, and VA Police Service resulted in charges alleging that the defendant forcibly committed a sexual act against a coworker while on duty and later made false statements to VA OIG agents when interviewed regarding the act. The defendant, who was a probationary employee, was also terminated from his VA employment as a result of these allegations.

Defendant Indicted in Connection with Healthcare Fraud Scheme

A defendant was indicted in the Northern District of Texas for conspiracy to commit healthcare fraud. An investigation resulted in charges alleging that the defendant's role as a marketer was instrumental in a fraud scheme in which the Department of Defense's TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) were billed approximately \$4 million for unnecessary laboratory testing. Of this amount, approximately \$655,000 was billed to CHAMPVA. This investigation was conducted by the VA OIG, Department of Health and Human Services (HHS) OIG, Department of Labor (DOL) OIG, Defense Criminal Investigative Service (DCIS), Office of Personnel Management OIG, and FBI.

Defendant Pleads Guilty in Connection with Multimillion-Dollar COVID-19 Scam

A defendant pleaded guilty in the Western District of New York to wire fraud in connection with a COVID-19 scam. An investigation by the VA OIG and Homeland Security Investigations revealed the defendant made fraudulent misrepresentations in an attempt to secure orders from VA for face masks and other personal protective equipment that would have totaled over \$806 million. The defendant promised that he could obtain millions of genuine 3M masks from domestic factories knowing that fulfilling the orders would not be possible. The defendant attempted to obtain an upfront payment from VA of over \$3 million. The defendant also obtained approximately \$7.4 million from state governments and private entities by making similar false representations regarding his ability to obtain personal protective equipment.

Nonveteran Sentenced in Connection with Fraud Scheme

A nonveteran was sentenced in the Eastern District of Pennsylvania to 40 months' imprisonment, 36 months' supervised release, and restitution of \$302,121 after previously pleading guilty to charges of 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 US Navy SEAL, a prisoner of war, and a Silver Star recipient. After the defendant was arrested, additional investigation by the Bureau of Alcohol, Tobacco, Firearms and Explosives revealed that the defendant participated in the straw purchase of two firearms. A straw purchase is an illegal firearm purchase where someone buys a firearm on behalf of another person who is unable to pass the required federal background check or does not want his or her name associated with the transaction. The loss to VA is approximately \$302,000.

Two Spinal Device Company Executives Indicted in Connection with Healthcare Fraud Scheme

The founder/chief executive officer and the chief financial officer of a spinal device company were arrested after being indicted in the District of Massachusetts on charges that include violating the anti-kickback statute, conspiracy to violate the anti-kickback statute, and conspiracy to commit money laundering. The VA OIG, US Postal Inspection Service (USPIS), FBI, and HHS OIG conducted this investigation, which resulted in charges alleging the defendants paid millions of dollars in kickbacks to surgeons in exchange for use of the company's surgical products. Six surgeons, including a physician at the VA Medical Center in the Bronx, New York, and a non-VA surgeon who was paid through VA's Choice program, previously entered into civil settlements with the US Attorney's Office in which they acknowledged receiving kickbacks from the company. The VA physician's settlement totaled \$330,668, of which \$103,785 is allocated to VA.

Employee of Biloxi VA Medical Center in Mississippi Pleads Guilty in Connection with Theft Scheme

A Biloxi VA Medical Center employee pleaded guilty in the Southern District of Mississippi to theft of government property. A VA OIG, FBI, and USPIS investigation revealed the defendant stole N95 masks, electronics, and medical devices from the facility. The defendant then resold the items at second-hand retailers during the COVID-19 pandemic and received approximately \$73,600 through these resales.

Registered Nurse at Detroit, Michigan, VA Medical Center Charged in COVID-19 Vaccination Card Fraud Scheme

A registered nurse at the John D. Dingell VA Medical Center in Detroit was charged in the Eastern District of Michigan with theft of government property and theft or embezzlement related to a healthcare program. An investigation by the VA OIG, HHS OIG, and VA Police Service resulted in charges

alleging that the defendant stole from the facility authentic COVID-19 vaccination record cards and the vaccine lot numbers necessary to make the cards appear legitimate. The defendant then allegedly resold the cards for \$150 to \$200 each to individuals within the metro Detroit area.

Investigation Involving Benefits

For-Profit Trade School Owner Sentenced in Connection with Education Benefits Fraud Scheme

The owner of a heating, ventilation, and air conditioning trade school was sentenced in the Northern District of Texas to 235 months' incarceration, three years' supervised release, and restitution of approximately \$65.2 million. A federal jury previously found the defendant guilty of seven counts of wire fraud and four counts of money laundering. An investigation resulted in charges alleging the defendant fraudulently obtained state and VA approval for his for-profit school. The defendant then allegedly used the fraudulently obtained approval status to entice veterans to attend the school, which resulted in the fraudulent collection of VA education benefits. The loss to VA is approximately \$71 million. The investigation was conducted by VA OIG, FBI, and USPIS.

Investigations Involving Other Matters

Nonveteran Construction Company Owner Pleads Guilty in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

A nonveteran owner of a construction company pleaded guilty in the Western District of Missouri to conspiracy to commit wire and major program fraud and filing a false tax return. A multiagency investigation revealed that between 2009 and 2018, the defendant and his coconspirators controlled and operated a service-disabled veteran-owned small business (SDVOSB). The defendant furthered the conspiracy by submitting false invoicing, false past performance questionnaires, and false references on behalf of the construction company. The company was awarded approximately \$335 million in set-aside contracts, of which approximately \$118 million was awarded by VA. When the company was growing too large to compete for small business contracts, the defendant and his coconspirators used the minority status of another coconspirator to set up a second SDVOSB. The second business was awarded an additional \$11 million in set-aside contracts. All defendants have pleaded guilty and are awaiting sentencing. The investigation was conducted by the VA OIG, Army Criminal Investigation Division, Department of Agriculture OIG, General Services Administration OIG, IRS Criminal Investigation, Air Force Office of Special Investigations, Naval Criminal Investigative Service, Defense Contract Audit Agency–Operations Investigative Support, US Secret Service, Small Business Administration OIG, DCIS, DOL OIG, and DOL Employee Benefits Security Administration.

Defendant Sentenced for Fraud Schemes Targeting Veterans

A veteran was sentenced in the Eastern District of Virginia to 114 months' imprisonment and restitution of \$431,004 after previously pleading guilty to wire fraud and aggravated identity theft. A VA OIG and

FBI investigation revealed that from 2016 through 2020, the defendant operated an entity that purported to provide caregiving, contracting, and rental assistance services. Instead, the defendant victimized at least 29 individuals, predominately targeting elderly and vulnerable veterans. The defendant defrauded one elderly veteran of over \$262,000 by embezzling their retirement savings and diverting their VA benefits payments and the proceeds of a loan that she fraudulently obtained using the veteran's name. The defendant caused several veterans to apply for VA grants designated for home improvement, but she failed to perform all the promised work and used a portion of these payments for her own benefit. The defendant also engaged in a rental fraud scheme in which she purported to assist veterans and others with housing, while diverting rental and security deposit payments for her own benefit.

Administrative Investigation

Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus

This administrative investigation focused on the circumstances of a veteran's death on the Edith Nourse Rogers Memorial Veterans Hospital campus in Bedford, Massachusetts. The veteran, Timothy White, resided at an independent living facility operated by a private company in space leased through VA's enhanced-use lease program. A month after Mr. White was reported missing, another resident found his body in an emergency exit stairwell down the hall from his room. The VA police department's failure to locate Mr. White resulted in part because Veterans Health Administration (VHA) policy requires extensive searches for missing patients but not for missing residents. The then police chief also improperly ceased routine patrols of the building in which Mr. White was found. Inadequate oversight of the lease terms resulted in stairwells not being cleaned. Routine patrols or cleanings would have likely led to Mr. White being found earlier. VA concurred with the OIG's seven recommendations to improve policies and procedures.

Audits and Reviews

Blue Water Navy Outreach Requirements Were Met, but Claims Processing and Procedures Could Improve

Since 1991, Vietnam veterans in a defined area are presumed to have been exposed to harmful herbicides such as Agent Orange. The Blue Water Navy Vietnam Veterans Act of 2019 extended this presumption to veterans who served within 12 nautical miles of Vietnam. This review examined whether Veterans Benefit Administration (VBA) employees notified Navy veterans of their potential eligibility for medical benefits under the act, correctly determined claimants' eligibility for benefits, and made accurate rating decisions on the veterans' claims. Although VBA met its outreach requirements and generally determined veterans' herbicide exposure correctly, VBA had not established procedures for resolving unlikely ship location search results used to help determine eligibility. In addition, approximately 46 percent of VBA's rating decisions were inaccurate from April through June 2020,

resulting in about \$37.2 million in improper payments to veterans. The OIG made three recommendations for corrective action.

Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2019

VA must report annually to Congress on its capacity in five areas: spinal cord injury and disorder, traumatic brain injury, blind rehabilitation, prosthetics and sensory aids, and mental health. The requirement was established to ensure that VA's capacity to serve disabled veterans does not fall below 1996 levels. The OIG is required to report to Congress on the accuracy of VA's report. The OIG found nothing to suggest the capacity report was not fairly stated and accurate in all material respects, with some exceptions noted. As the OIG previously reported, VA cannot compare current mental health capacity with 1996 capacity because of changes in diagnosis and treatment, service provision, and data collection. The OIG believes that by modernizing reporting metrics, Congress would be better positioned to assess VA's capacity to provide care for today's disabled veterans.

Excess Purchase of Surgical Supplies and Improper Purchase Card Transactions at the New Orleans VA Medical Center in Louisiana

The OIG evaluated an August 2019 hotline complaint alleging mismanagement of supplies, equipment, and operating rooms while activating the New Orleans VA Medical Center in Louisiana. The OIG substantiated that the medical center purchased about \$1.85 million in excess surgical supplies. Employees also violated VA policies by not properly accounting for nor advertising the excess supplies to other facilities. Employees violated the Federal Acquisition Regulation (FAR) and VA financial policy when they used purchase cards instead of contracts to obtain supplies. The OIG recommended the Southeast Louisiana Veterans Health Care System director account for undocumented excess supplies, determine if action should be taken on some \$675,000 in missing supplies listed in a report of survey, and ensure identified FAR violations are reported and appropriately ratified. The director should ensure employees obtain guidance when they are uncertain about proper use of government purchase cards.

Summary of Fiscal Year 2020 Preaward Reviews of Healthcare Resource Proposals from Affiliates

The OIG reviewed 31 proposals for sole-source healthcare staffing contracts in FY 2020 and provided information that VA contracting officers could use to help negotiate fair and reasonable prices. These contracts allow VA to fill, at a fixed price, positions for which it is unable to hire staff. The proposals typically come from VA-affiliated schools of medicine or their associated hospitals or physician practice groups. The review teams identified \$81 million in potential cost savings for 29 of the 31 proposals. As of March 2021, VA contracting officers had awarded 25 of the 31 proposals and sustained over \$16 million in cost savings. Reviews of individual proposals were not previously published because they contain clinical staff's sensitive personal data. This report summarizes prior OIG findings and recommendations regarding three key areas: costs underlying proposed hourly rates, prices offered per procedure, and potential conflicts of interest.

Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors

In FY 2019, VA provided veterans with about \$318.8 million in medically prescribed prosthetic and rehabilitative items such as artificial limbs, shoes, shoe inserts, and compression garments. The OIG audited to determine if VHA's oversight ensured medical facilities paid reasonable prices when reimbursing vendors for these items. The OIG found because VHA's oversight of prosthetic spending was ineffective, medical facilities sometimes reimbursed vendors at unreasonable rates. Medical facilities spent about \$10 million more than reasonable rates from October 2019 through March 2020. Furthermore, the OIG found that prosthetic spending data was unreliable—about 36,200 transactions in the national prosthetics patient database from October 2019 through March 2020 contained at least one inaccurate data element, including the price paid. The OIG made four recommendations, including monitoring spending to make sure medical facilities reimburse vendors at reasonable prices.

Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened

VA's contracting officers obligated approximately \$36.9 billion for goods and services required for veteran care and support in FY 2020. A warrant gives federal contracting officers the authority to obligate taxpayer dollars for procuring goods and services. While VA's contracting officer warrant program complies with FAR requirements, it may not fully mitigate the risks associated with contracting officer warrants. VA needs to thoroughly justify warrants, gather data to effectively distribute contracting officers' workload, and institute guidance to help determine when and how to reinstate warrants to individuals with past performance issues. Finally, VA should improve consistency for how warrant boards conduct their activities. The OIG made three recommendations to strengthen VA's warrant program, to include assessing the warrant justification template, determining whether additional procedures to monitor contracting officer workload should be implemented, and identifying updates to policies to increase consistency.

A Summary of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2020

The OIG reviews proposals submitted to VA for Federal Supply Schedule pharmaceutical contracts valued annually at \$5 million or greater. These reviews help VA contract specialists negotiate fair and reasonable prices for the government and taxpayers. Individual reviews are not published because they contain sensitive commercial information. To promote transparency, the OIG issued a report summarizing the reviews of pharmaceutical contract proposals conducted in FY 2020. The 15 proposals had a cumulative 10-year estimated contract value of approximately \$10 billion and included a total of 515 offered drug items. This OIG report detailed how many proposals were accurate, complete, and current, and summarized pricing and prior recommendations for those that were not. It did not include additional recommendations for VA response. Contract specialists have completed negotiations on the

proposals, and the OIG's recommendations collectively resulted in approximately \$42 million in savings for VA.

VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report

The West Los Angeles Leasing Act of 2016 requires land use of the West Los Angeles campus to "principally benefit" veterans and families. The OIG found that VA has made little progress in implementing the draft master plan that would provide housing for 1,200 veterans due to required environmental impact studies, needed infrastructure upgrades, difficulties establishing a principal developer enhanced-use lease, and fundraising challenges. As of July 2021, VA had only 55 of the 480 housing units available, which is 11 percent of the four-year target. Additionally, the OIG identified seven noncompliant land-use agreements. While a 2018 OIG audit identified two of these seven agreements, VA has not yet taken sufficient corrective action. The OIG recommended that VA implement a plan to bring the five new land-use agreements into compliance and ensure its capital asset inventory accurately reflects all land-use agreements lasting six months or longer.

National Healthcare Review

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2021

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 eighth staffing report, the OIG evaluated severe occupational staffing shortages and compared this information to the previous three years. The OIG found 98 percent of facilities identified one or more severe occupational staffing shortages. Every year since 2014, medical officer and nurse occupations were identified as severe shortages. Within the medical officer occupational series, psychiatry was the most frequently identified clinical severe staffing shortage. Medical support assistance was the most frequently identified nonclinical severe staffing shortage. Since FY 2018, the overall number of severe occupational staffing shortages decreased from 3,068 to 2,152. Similarly, the number of occupations reported by at least 20 percent of facilities decreased from 30 to 19. The OIG made no recommendations.

Healthcare Inspections

Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama

The OIG assessed and substantiated allegations that staff at the facility denied a patient's discharge requests and did not ensure access to a patient advocate. Staff also failed to follow informed consent procedures. Staff did not conduct sufficient or timely decision-making capacity evaluation. The patient remained on voluntary admission for nearly two years and 11 months. Staff did not adequately assess

the patient's admission status and did not follow commitment requirements. Staff did not comply with against medical advice requirements. Additionally, staff did not properly identify a surrogate decision-maker and did not address ethical concerns regarding the appropriateness of the patient's surrogate decision-maker. Further, staff did not properly manage a letter from the patient to a public official. The OIG made seven recommendations.

Facility Leaders' Response to Level 2 and Level 3 Pathology Reading Errors at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

The OIG conducted an inspection to evaluate facility progress in responding to pathology reading errors identified during a look-back review of cases interpreted by a former facility pathologist. The OIG found facility processes for disclosures of pathological errors and electronic health record (EHR) amendment met VHA requirements. However, opportunities for improved tracking of clinical disclosure completion existed. In addition, a process was lacking for clinical providers to communicate subsequent health changes to the clinical review team for reconsideration of institutional disclosure needs. Although amended pathology reports were completed for patients identified with level 3 diagnostic errors, fewer than 5 percent of the amended pathology reports were entered into EHRs of patients identified with level 2 diagnostic errors at the time of the OIG site visit. The OIG made three recommendations related to processes for documentation of clinical disclosures, communication to the clinical review team, and completion of EHR amendments.

Facility Leaders Provided Oversight of a Physician in Fellowship Training at VA Sierra Nevada Health Care System in Reno

The OIG assessed the oversight and performance of a physician in fellowship training at the VA Sierra Nevada Health Care System. The physician, arrested by Canadian authorities for the alleged murder of a patient, participated in a geriatric fellowship at the facility in 2018–19. The OIG reviewed the physician's patient care and found no deficiencies in the quality of care and no statistical significance between the physician's rotations and patient deaths. The physician was onboarded and received supervision and evaluation per VHA requirements. Facility leaders initiated an issue brief and EHR review, although the review was not inclusive of all relevant patient deaths. Upon OIG request, the Veterans Integrated Service Network reviewed an additional seven patients and noted no clinical deficits in care that could have contributed to patient deaths. The OIG made no recommendations.

Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

The OIG evaluated a patient's care at the facility, including referral to the VA Palo Alto posttraumatic stress disorder residential rehabilitation treatment program (RRTP). Staff made efforts to accommodate the patient's preferences, completed safety planning, and conducted military sexual trauma screening. Leaders and staff did not assign a mental health treatment coordinator or establish policy. Staff did not adequately manage the patient's high risk for suicide patient record flag or ensure flag inactivation

approval. VHA policy and suicide behavior reporting guidance was inconsistent and leaders did not follow VHA staff-specific guidance. Staff also did not timely complete a behavioral health autopsy. RRTP staff did not timely screen the patient or accept self-referrals. Inconsistent with VHA policy, RRTP policy included additional service animal admission requirements. The OIG made two recommendations to the under secretary for health, three recommendations to the facility director, and two recommendations to the VA Palo Alto director.

Clinically Appropriate Anemia Care and Timing of a Colonoscopy Procedure for a Patient at the VA Caribbean Healthcare System in San Juan, Puerto Rico

A healthcare inspection was conducted to assess concerns about the diagnosis and treatment of anemia and coordination of a colonoscopy for a patient who subsequently died. The patient had iron-deficiency anemia. The OIG found the primary care provider evaluated and treated the anemia effectively. In 2017, the patient developed a blood clot, requiring anticoagulant treatment. In 2018, the patient developed an abnormal heart rhythm and remained on an anticoagulant. The OIG determined that the anticoagulant treatment was managed appropriately. In 2020, the patient was admitted to the facility on two occasions. During the second hospitalization, the patient was evaluated and treated for rectal bleeding and cardiology staff were consulted for a possible heart attack. At the end of a cardiac catheterization, the patient developed cardiac arrest and could not be resuscitated. The OIG found the timing of the patient's colonoscopy to be clinically appropriate. No recommendations were made.

Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina

The OIG assessed concerns of quality, coordination, and timeliness of care, and the impact of COVID-19 on a patient with unintentional weight loss who was later diagnosed with oral cancer and died at another VA medical center. The OIG substantiated that a primary care provider and dietitians did not provide quality care. The primary care provider did not order a test, and dietitians did not conduct comprehensive nutritional assessments. The OIG substantiated that the patient's nurse and dietitians did not coordinate care with the patient's primary care provider. The nurse did not facilitate a requested face-to-face visit, and dietitians did not communicate the patient's progressively worsening nutritional status. A scheduling error delayed a follow-up dietitian appointment, and a delay occurred in scheduling a non-VA dental appointment. The OIG made six recommendations related to nutritional assessments, care coordination, appointment scheduling, and COVID-19 scheduling practices and impact on patient care.

Failure to Mitigate Risk of and Manage a COVID-19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois

The OIG conducted an inspection to assess allegations that, during a COVID-19 outbreak, community living center (CLC) staff and leaders at the Illiana VA Medical Center in Danville, Illinois, failed to observe infection control practices specific to respiratory personal protective equipment; minimize risk of exposure to COVID-19; perform ongoing COVID-19 testing; and notify residents, families, and staff

of positive test results. The OIG substantiated that the facility failed to observe general infection control practices and minimize the risk of exposure to COVID-19. The OIG did not substantiate a failure to notify residents, families, and staff of COVID-19 test results but did substantiate a lack of a post-baseline testing plan and a failure to test all staff after potential exposure. The OIG found that actions taken by leaders following the CLC outbreak lacked input from frontline staff to identify corrective actions and opportunities for improvement. The OIG made 14 recommendations.

Financial Inspection

Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans

The OIG assessed the Southeast Louisiana Veterans Health Care System's oversight of funds for FY 2019 and identified opportunities for cost efficiency. The review team found that the system fell short of VA's recommended use of a contract program for medical supply purchases and did not always monitor its prime vendor's performance or report performance problems. The system also did not always follow policies and regulations concerning purchase card use, which resulted in possible cost inefficiencies, inadequate oversight of cardholders and transactions, and improper payments of \$140,016. The review team also found that this VA health care system had over 250 more administrative employees than other systems of similar size but has implemented strategies to increase staffing efficiency. Also, the system spent approximately \$9 million more on prescription drugs than similar systems but has begun improving efficiency and cost savings. The OIG made six recommendations to the healthcare system director to address the issues identified in this review.

Management Advisory Memorandum

Inadequate Business Intelligence Reporting Capabilities in the Integrated Financial and Acquisition Management System

The OIG is conducting an audit to determine whether VA's Financial Management Business Transformation Service identified and addressed issues with a new IT system following its initial deployment at the National Cemetery Administration. The new system will be used throughout VA to manage budgetary, financial, and contracting activities. The OIG issued a management advisory memorandum to share observations from the ongoing audit and expects to publish the final report in FY 2022. The audit team found that the National Cemetery Administration was experiencing significant challenges with the system's business intelligence reporting capabilities. The OIG requested that the Office of Management inform the OIG of any actions it takes to address the issues identified.

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 OIG's current areas of focus are (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; and (9) high-risk processes. Recently published CHIP reports include:

Providence VA Medical Center in Rhode Island

Oklahoma City VA Health Care System in Oklahoma

Eastern Oklahoma VA Health Care System in Muskogee

Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts

VA Central Western Massachusetts Healthcare System in Leeds

Manchester VA Medical Center in New Hampshire

White River Junction VA Medical Center in Vermont

Cheyenne VA Medical Center in Wyoming

Veterans Integrated Service Network 19: VA Rocky Mountain Network in Glendale, Colorado

Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020

VA Maine Healthcare System in Augusta

North Florida/South Georgia Veterans Health System in Gainesville, Florida

VA Boston Healthcare System in Massachusetts

West Palm Beach VA Medical Center in Florida

VA Connecticut Healthcare System in West Haven

Miami VA Healthcare System in Florida

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. The following are the OIG's current inspection areas of focus:

- (1) Leadership and organizational risks
- (2) Quality reviews

- (3) COVID-19 response
- (4) Suicide prevention
- (5) Consultation, supervision, and training
- (6) Environment of care

Recently published VCIP reports include:

Southeast District 2 Zone 2 and Selected Vet Centers

Continental District 4 Zone 2 and Selected Vet Centers

Pacific District 5 Zone 1 and Selected Vet Centers

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