



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

JULY 2022 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Case Testified before the Senate Veterans' Affairs Committee on VA's Electronic Health Records Modernization Program

Deputy Inspector General David Case [testified](#) before the Senate Veterans' Affairs Committee on July 20, 2022. The hearing focused on VA's challenges with deploying the new electronic health record (EHR), a recently released life cycle cost estimate for the program, and the OIG's recent reports discussing an "unknown queue" of unfulfilled medical orders and other risks to patient safety at the medical facility and clinic initial operating sites. Mr. Case answered questions about the system's unknown queue of thousands of medical orders that the system did not deliver to their intended location and other concerns the OIG has about VA's implementation and transparency. A recording of the hearing is available on the [committee website](#).

Deputy Inspector General and Principal Deputy Assistant Inspector General Testify before the House Veterans' Affairs Subcommittee on Technology Modernization about the Electronic Health Records Modernization Program

A week later, Deputy Inspector General David Case was joined by Principal Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak to [testify](#) before the House Veterans' Affairs Subcommittee on Technology Modernization. The hearing focused on VA's deployment timeline for the new EHR, the program's costs, and the OIG's recent reports detailing problems that include the unknown queue and other risks to patient safety, as well as the barriers users face to providing prompt access to high-quality care. They answered questions about patient harm resulting from the unknown queue and voiced concerns about identified problems and their mitigation. Of note, they discussed the lack of transparency when the then Change Management leaders from VA's Office of Electronic Health Record Modernization (a predecessor program office for the new EHR) submitted inaccurate information to the OIG during a review of the user training for the new EHR and its evaluation of trainees' proficiency. A recording of the hearing is available on the [committee website](#).

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Former Chief of Cardiology at the VA Palo Alto Health Care System Sentenced for Felony Abusive Sexual Contact

A VA OIG and VA Police Service investigation found that the former chief of cardiology at the VA Palo Alto Health Care System repeatedly subjected a subordinate doctor to unwanted sexual contact while on VA premises. The former chief was sentenced in the Northern District of California to eight months of incarceration, one year of supervised release, and ordered to pay \$15,000 after previously pleading guilty to abusive sexual contact.

Defendant Charged in Connection with Compounding Pharmacy Scheme

The former owner of a home health company allegedly conspired to fraudulently bill federal and private healthcare insurance programs for compounded medication in exchange for more than \$70,000 in kickbacks. The loss to VA is over \$2.8 million. The defendant was indicted in the Southern District of Texas for conspiracy to pay and receive kickbacks. The investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), Department of Health and Human Services (HHS) OIG, US Postal Service OIG, Department of Labor (DOL) OIG, Texas Health and Human Services, and FBI.

Fifteen Doctors Agreed to Pay over \$2.8 Million to Resolve False Claims Act Allegations

A multiagency investigation resulted in charges alleging that numerous doctors received thousands of dollars in illegal payments from management service organizations (MSOs), which provide nonclinical administrative services to medical practices, in exchange for ordering laboratory tests. The laboratories allegedly funded the scheme by paying volume-based commissions to recruiters who used the MSOs to pay the doctors for their laboratory referrals. The payments were disguised as investment returns but were based on, and offered in exchange for, the doctors' referrals. In connection with this investigation, 15 doctors entered into settlement agreements with the US Attorney's Office for the Eastern District of Texas to resolve False Claims Act allegations involving these illegal kickbacks that were in violation of the Anti-Kickback Statute and the Stark Law. Pursuant to this civil settlement, the doctors will pay more than \$2.8 million. Twenty-one defendants were also indicted in connection with this investigation, which was conducted by the VA OIG, FBI, HHS OIG, and DCIS.

Physician Pleaded Guilty in Connection with Healthcare Fraud Scheme

According to another multiagency investigation, a physician allegedly entered into an improper agreement with a diagnostic imaging company under which he was paid bribes and kickbacks to order unnecessary transcranial doppler tests. In exchange for billing government and private insurance companies as much as \$3.25 million in unnecessary tests based on fraudulent diagnoses, the defendant received about \$148,000 in kickbacks. He pleaded guilty in the District of Massachusetts to conspiracy to commit healthcare fraud and conspiracy to violate the Anti-Kickback Statute. The potential loss to VA is at least \$650,000. The VA OIG, IRS Criminal Investigation, US Postal Inspection Service, DOL Employee Benefits Security Administration, HHS OIG, and FBI conducted this investigation.

Defendant Pleaded Guilty in Connection with Pandemic Supplies Hoarding Scheme

The head buyer for a wholesale pharmaceutical company pleaded guilty in the Southern District of Mississippi to conspiracy to defraud the United States. The buyer was one of multiple defendants who allegedly conspired to buy and then hoard designated scarce materials at the height of the COVID-19 pandemic. The wholesale pharmaceutical company made \$1.8 million in sales of the designated “scarce” materials at prices upwards of 300 percent over costs to hospital systems, including VA. The loss to VA is more than \$334,000. The investigation was conducted by the VA OIG, Food and Drug Administration Office of Criminal Investigations, and FBI.

Defendant Sentenced for Criminal HIPAA Violations

A VA OIG investigation revealed that a former employee of the Des Moines VA Medical Center obtained and disclosed a veteran’s behavioral health records to a coconspirator without authorization. Then, the coconspirator disclosed the records to another party. The coconspirator was sentenced in the Southern District of Iowa to 27 months of imprisonment, three years of supervised release, and restitution of \$2,000 after previously pleading guilty to conspiracy to wrongfully obtain and disclose individually identifiable health information and wrongfully obtaining individually identifiable health information. The former VA employee previously pleaded guilty in connection with this investigation and is awaiting sentencing.

Veteran Sentenced for Assaulting a Federal Officer

A veteran assaulted a VA OIG agent who was assisting local police in performing an emergency medical detention based on the veteran being a threat to himself and others. The VA OIG was investigating alleged threats made by the veteran. The veteran had pleaded guilty and was sentenced in the District of Kansas to time served (over five months) and 12 months of probation, and was ordered to participate in mental health, behavioral health, and substance abuse treatment.

Benefits Investigations

Veteran Sentenced in Connection with Compensation Benefits Fraud Scheme

An investigation by the VA OIG revealed that a veteran fraudulently received VA compensation benefits for blindness. The defendant was rated as having “light perception only” and a visual acuity of 5/200 for approximately 30 years following his discharge from the Army. This investigation revealed that the defendant maintained a driver’s license in multiple states while claiming blindness. During a 15-year period, the defendant and his wife purchased more than 30 automobiles that he routinely drove, including on long-distance trips, for errands, and to VA medical appointments. The defendant was sentenced in the Western District of North Carolina to 10 months of imprisonment, to include five months of home confinement, 36 months of supervised release, and restitution of more than \$930,000 after previously pleading guilty to theft of government funds.

Veteran Guilty at Trial for Fraudulently Claiming Unemployability and Disability Benefits

A veteran was found to have received VA individual unemployability benefits and Social Security Administration (SSA) disability benefits while self-employed as a construction worker and business operator. He also obtained additional SSA benefits for his daughter based on his false claims. The veteran was found guilty by a federal jury in the Eastern District of Arkansas on charges of conspiracy to defraud the United States, theft of government funds, and bankruptcy fraud. The total loss to the government is approximately \$396,000, of which the loss to VA was about \$132,000. The VA OIG and SSA OIG conducted this investigation.

Investigations Involving Other Matters

Former VA Deputy Chief Learning Officer Indicted for Wire Fraud

A hotline complaint led to a multiagency investigation that resulted in charges alleging that a former VA deputy chief learning officer used his influence to help secure consulting subcontracts for a business owned by a former military colleague. In turn, the colleague allegedly made monthly \$4,000 payments, totaling \$176,000, to a company owned by the defendant's spouse for virtually nonexistent services. The defendant was arrested after being indicted in the Middle District of Florida for wire fraud. This investigation was conducted by the VA OIG, General Services Administration OIG, DCIS, and FBI.

VA Employee Pleaded Guilty to Sexual Exploitation of a Child and Possession of Child Pornography

An accounting technician at the Orlando VA Medical Center used his VA-issued computer to solicit and receive sexual content from a 13-year-old victim. The defendant pleaded guilty in the Middle District of Florida to sexual exploitation of a child and possession of child pornography. The investigation was conducted by the VA OIG, FBI, and the Orange County Sheriff's Office.

Veteran Arrested for Assault with a Deadly Weapon

A veteran assaulted two VA police officers at the San Diego VA Medical Center after medical staff attempted to treat him. During the altercation with police, the defendant allegedly gained control of an officer's service-issued firearm and attempted to shoot another officer but missed. The round went through the patient room wall and into a neighboring patient's room that was occupied. This investigation was conducted by the VA OIG and VA Police Service.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following reports this month.

Featured Burn Pit Exposure Reports

Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure

Veterans Benefits Administration (VBA) staff processed more than 21,100 claims from June 2007 through September 2021 with issues related to the burn pits used by the US military in Iraq, Afghanistan, and Djibouti. The OIG examined whether VBA staff followed regulations and procedures when processing those claims. Based on statistical samples, the OIG generally found burn pit-related claims that were granted were done so correctly, but that denials were premature.

The OIG made seven recommendations to VBA to improve the processing of burn pit-related claims, including correcting four errors for improperly granted conditions, and reviewing and correcting prematurely denied claims. VBA should also update its adjudication procedures manual to provide separate and specific guidance for handling burn pit exposure claims and modify its medical examination request application to add burn pit fact sheet language. Finally, VBA should update training materials and ensure they are consistent with guidance.

Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement

The OIG reviewed the management of the Veterans Health Administration's (VHA) airborne hazards and open burn pit registry exam program and found the 140-item questionnaire was not clear and oriented for veterans to easily use. Veterans did not always realize from the questionnaire and related information that they were responsible for scheduling their own exams. Improvements in the registry exam process would help ensure more eligible and interested veterans receive them, which became increasingly important since August 2021 when VA established a presumptive "service connection" for respiratory conditions due to exposure to particulate matter, such as asthma, sinusitis, and rhinitis.

The OIG recommendations included revising the questionnaire to be more veteran-centric, identifying whether veterans with unscheduled exams are still interested in one, and implementing processes and metrics to ensure exams are completed. In addition, VHA should develop guidance to ensure responsible parties review and discuss performance data and enhance registry information systems.

Procurement

Contract Closeout Compliance Needs Improvement at Regional Procurement Offices Central and West

In fiscal year (FY) 2020, the VA OIG published a report on contract closeout compliance at the regional procurement office (RPO) East. Because of problems identified there, the OIG examined whether RPO Central and RPO West contracting officers adequately performed and documented contract closeout requirements. When contracting officers do not follow the necessary steps to close out contracts, they increase future financial and legal risk to the government. The OIG reviewed a random sample of

contracts and found contracting officers at the two RPOs did not adequately perform required closeout duties. Reasons included unclear policies and systems, ineffective oversight of the process, and heavy workload. The OIG recommended the executive directors for RPO Central and RPO West establish consistent quality assurance reviews, balance contracting officer workload, update guidance on simplified acquisition procedures, consider additional strategies to ensure contract closeout compliance, and verify that the contract files for the 81 sampled contracts have complete closeout documentation.

Inadequate Acceptance of Supplies and Services at Regional Procurement Office West Resulted in \$12.8 Million in Questioned Costs

The OIG reviewed whether RPO West contracting officials administered contracts and accepted supplies and services in accordance with federal and VA regulations. The OIG found they did not always maintain documentation to demonstrate proper acceptance of supplies and services. Several factors contributed to noncompliance, including officials not understanding their responsibilities, heavy workload, ineffective oversight, and prioritization of awarding contracts. This noncompliance resulted in \$12.8 million in questioned cost. Until VHA improves oversight of contracting officials and ensures their compliance with federal regulations, it lacks assurance that veterans are receiving critical supplies and services. The OIG made eight recommendations to RPO West's executive director to strengthen contract administration, including establishing controls to ensure electronic files are created for all contracts requiring a representative, completing delegation memorandums when required, and representatives uploading required acceptance documentation. The executive director should also assess existing contracts for compliance and correct as needed.

Benefits Delivery and Administration

Safeguarding PII Collected in VBA Education Compliance Surveys

This review revealed that survey records for VA educational programs submitted remotely during the pandemic lacked sufficient protection for students' personally identifiable information. This management advisory memorandum conveyed information to help VBA determine the need for corrective actions. The OIG issues management advisory memorandums when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. On March 16, 2020, VBA required in-person surveys to be conducted remotely and documents submitted electronically as COVID-19 precautions. About 4,570 surveys were conducted during the prior two years, with record requests for an estimated nearly 37,800 students. The OIG reviewed documents for 30 of those surveys and found 26 contained personally identifiable information of 323 students, including full names, dates of birth, social security numbers, and addresses. Lack of standard procedures and oversight resulted in personally identifiable information not being consistently safeguarded as required. The OIG did not assess whether information had been inappropriately disclosed. VBA agreed to review and evaluate the OIG findings and take needed corrective action.

VBA Improperly Created Debts When Reducing Veterans' Disability Levels

The OIG reviewed retroactive reductions in disability levels that affected veterans' compensation benefits. The review team found instances in which VBA employees erroneously created about \$13.4 million in debts without always informing veterans. Some veterans were not given an opportunity to dispute the debts or request waivers and were likely unaware they did not receive all their benefits. Errors generally occurred because VBA's electronic system did not show employees each time a debt was created. VA concurred with the OIG's four recommendations, including correcting identified errors. VBA should also review all compensation awards completed since January 1, 2020, with debts related to reduced disability levels, and take appropriate action. Updating VBA's electronic system could make it easier for employees to see when their actions create a debt for veterans. Finally, VBA should conduct periodic reviews to determine whether recommendations were effectively implemented, or additional measures are needed.

Financial Efficiency

Financial Efficiency Review of the VA Boston Healthcare System in Massachusetts

The OIG assessed the VA Boston Healthcare System's stewardship and oversight of funds and identified potential cost efficiencies. The review team looked at open obligation oversight, purchase card usage, inventory and supply management, and pharmacy operations. The team found 35 percent of open obligations sampled were not reviewed to see if they were still valid and necessary; 28 percent of tested purchase card transactions were intentionally split to stay below the cardholder's single purchase limit rather than purchased through contracts; amounts of stock on hand were insufficient in more than 70 percent of tested cases due to inaccurate inventory system entries; and the pharmacy drug turnover rate was low because pharmacy technicians were unable to properly forecast needed drug inventories. The OIG made eight recommendations to improve the stewardship of VA resources and address issues that could adversely affect patient care.

Financial Efficiency Review of the VA Black Hills Health Care System in South Dakota

This review examined how the VA Black Hills Health Care System in South Dakota was also overseeing and spending funds and potential cost efficiencies in carrying out its functions. The same financial activities and administrative processes were evaluated as the prior report. The review team identified opportunities for improvement in all areas. The OIG made seven recommendations to redress issues that, if not remediated, may eventually interfere with effective financial efficiency practices and the strong stewardship of VA resources.

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a

single OIG directorate or office. The Office of Special Reviews released the following cross-directorate report this month in collaboration with the Office of Healthcare Inspections and with statistical support from the Office of Audits and Evaluations.

Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training

This administrative investigation found two leaders in the then VA Office of Electronic Health Record Modernization's Change Management group did not intentionally seek to mislead OIG healthcare inspectors during a prior review of VA's training for medical facility staff on implementing a new record system. However, the leaders' carelessness resulted in delayed and inaccurate information being submitted to the OIG that impeded oversight efforts. Errors in removing all failing scores and not disclosing that data were removed and were possibly unreliable led to misreporting more favorable pass rates than those initially calculated internally—from 44 to 89 percent. VA concurred with two OIG recommendations to provide guidance to program staff on providing timely, accurate, and complete responses to OIG requests and encouraging direct staff-level communication to resolve questions. VA also agreed to consider whether administrative action should be taken concerning the conduct of the two leaders responsible.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

National Healthcare Review

The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm

The OIG conducted an inspection to assess a safety concern with the new EHR that resulted in patient harm. The OIG reviewed the safety risk and found that the new EHR sent thousands of orders for medical care to an undetectable location, or unknown queue, instead of the requested location. VA end-users were unaware of the unknown queue. VHA staff completed clinical reviews to assess patient harm and found the unknown queue caused 149 patient harm events. In late 2021, VHA staff provided the Deputy Secretary and the Executive Director for VA's EHR modernization effort with information on the unknown queue safety issue and patient harm. Despite actions to minimize orders being routed to the unknown queue, the OIG remains concerned with the effectiveness of Oracle Cerner's plan to mitigate the safety risk posed by the unknown queue.

Healthcare Inspections

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2022

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. This is the ninth iteration of the staffing report, and the fifth evaluating facility-level data. The information evaluated for this report was compared to the previous four years. The OIG found that every VHA facility identified at least one severe occupational staffing shortage. Every year since 2014, the medical officer and nurse occupations were identified as severe occupational shortages. Practical nurse was the most frequently reported clinical severe occupational staffing shortage, and custodial worker was the most frequently identified nonclinical severe staffing shortage. In FY 2022, facilities reported 22 percent more severe occupational staffing shortages as compared to FY 2021. Additionally, FY 2022 was the first time that facilities identified more than 90 occupations as severe shortages.

Improvements in Sterile Processing Service and Leadership Oversight at the Edward Hines, Jr. VA Hospital in Hines, Illinois

The OIG initiated an inspection regarding allegations of deficient practices within the Sterile Processing Service (SPS) and associated leadership failures. The OIG did not substantiate allegations of inappropriate reprocessing of reusable medical equipment, or that SPS standard operating procedures were chaotic and incomplete. Facility action plans from April 2021 had been implemented to address prior SPS deficiencies, and the facility had sustained process improvement actions. The OIG did not substantiate that SPS leaders failed to provide adequate oversight, quality control, education, and training to SPS staff or that SPS leaders and education and training staff lacked appropriate knowledge to provide staff training. Facility leaders worked with Veterans Integrated Service Network (VISN) subject matter experts to ensure continuity of SPS leadership when vacancies existed. Both the VISN and facility leaders maintained adequate oversight—identifying and taking actions in response to concerns and providing support for quality improvement efforts within SPS.

Review of Veterans Health Administration's Response to a Medication Recall

This inspection assessed VHA's process in responding to a medication recall. The recall included two medications incorrectly packaged together in the same bottle by the distributor. The VHA medication recall process generally met requirements. However, the OIG identified potential vulnerabilities related to monitoring and reporting adverse drug events and variations in the software used to record medication lot numbers. The VHA National Center for Patient Safety monitored communications and responded according to VHA policy requirements and VHA Pharmacy Benefits Management distributed medication recall safety information to ensure patient notification. The OIG could not, though, determine if VHA monitored all adverse drug events from recalled medications.

Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia

The OIG examined the oversight that VA conducted of a healthcare provider who engaged in sexual misconduct targeting patients, and who practiced acupuncture without credentials or privileges. The inspection team also reviewed leaders' awareness and responses to these allegations. Identified deficiencies include the inadequate supervision of the provider and that former facility leaders did not act on their initial awareness of the provider's sexual misconduct towards patients, refusal to use chaperones, and performance of acupuncture without credentials and privileges. The VISN initiated an administrative investigation to determine if complaints were addressed; however, not all complaints were reviewed. Reviews also were not conducted to identify if the provider performed acupuncture on patients. The VISN subsequently commenced a review of the provider's patients to identify those who received acupuncture and initiated clinical and quality management corrective actions. The OIG made five recommendations related to incomplete administrative investigation board actions, oversight, quality management actions, training, and reporting providers to state licensing boards.

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. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection.

The OIG published the following CHIP reports this month for these facilities and systems:

Martinsburg VA Medical Center in West Virginia

Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland

Featured Hotline Cases

The OIG's Hotline Complaint Center accepts complaints from VA employees and the general public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following is a case opened in July by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Delayed Scheduling for Routine Clinic Appointments Resulted in a Backlog at the Community Based Outpatient Clinic in Princeton, West Virginia

A complainant alleged patients of the VA clinic in Princeton, West Virginia, experienced delay in care due to a backlog of order for return to clinic (RTC) appointments. The Princeton VA clinic's parent

facility, the Beckley VA Medical Center, conducted an independent review of the allegations and identified all patients seen at the clinic between January 1, 2020, and December 31, 2021. The review found that some patients experienced a wait time greater than 60 days from the patient-indicated date (the date the patient communicates to VA they would like to be seen). In response to the findings, the Princeton VA clinic implemented several corrective actions to address issues that led to the backlog for scheduling follow-up appointments. These included directing resources from the Beckley VA Medical Center to help the clinic reduce its backlog; facility leadership developing a daily checklist for medical support assistants (MSAs) to certify requirements were met; establishing a new local standard operating procedure for how MSAs process orders and other documents; and eliminating unnecessary processes of providers.

