Department of Veterans Affairs
Office of Inspector General
March 2017 Highlights

CONGRESSIONAL TESTIMONY

Inspector General Delivers Testimony on Importance, Value of OIG Oversight

The Honorable Michael J. Missal testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States House of Representatives, on the oversight the Office of Inspector General (OIG) provides to VA programs and operations. Mr. Missal highlighted the more significant aspects of the OIG's mission, vision, and values and discussed a number of recent or planned operational enhancements initiated since becoming Inspector General (IG) that are intended to better focus OIG efforts on high-risk areas throughout VA in a more proactive and timelier manner. Additionally, he discussed the OIG's fiscal year (FY) 2017 operating budget, our FY 2018 request, and the anticipated effects of the Federal hiring freeze on the OIG's operation. Lastly, he highlighted a number of recent OIG reports demonstrating VA's susceptibility to fraud, waste, abuse, and mismanagement in its programs and operations. Given the historical average of a return on investment of $30 for every $1 expended on OIG oversight, Mr. Missal emphasized the need for the OIG to be positioned to conduct effective oversight. [Click here to access testimony.]

IG Testifies on Historical Challenges Facing VA Community Care, Warns That Adequate Controls Must be in Place to Mitigate Significant Risks

The Honorable Michael J. Missal testified before the Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work concerning VA's Choice Program and the future of VA's Community Care Program. He explained that the OIG's audits, reviews, and inspections have highlighted VA's history of challenges in administering its purchased care programs. Specifically, OIG's work has demonstrated that veterans' access to care, proper expenditure of funds, timely payment of providers, and continuity of care are at risk to the extent that VA lacks adequate processes to manage funds and oversee program execution. Mr. Missal emphasized that while purchasing health care services from community providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. He also indicated that the OIG plans to conduct significant oversight of VA's Community Care programs over the next 3 years. [Click here to access testimony.]

IG Testimony Highlights OIG Work Parallel to Government Accountability Office Concerns on VA Health Care

The Honorable Michael J. Missal testified before the Committee on Veterans' Affairs, United States Senate, on how the OIG's oversight of VA programs and operations corresponds with the U.S. Government Accountability Office's (GAO) decision to place VA Health Care on its biennial High Risk List beginning in 2015 and again in 2017. Mr. Missal highlighted a number of OIG reports with findings related to the five broad areas of concern noted by GAO in placing VA Health Care on its High Risk List:

ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff, and unclear resource needs and allocation priorities. Mr. Missal noted that GAO and the OIG communicate regularly to promote coordination, avoid duplication of effort, and maximize oversight of VA. He also reaffirmed the OIG's commitment to continuing to produce impactful reports that provide VA, Congress, and the public with information about our recommendations to improve the delivery of services and benefits to veterans and the judicious expenditure of taxpayer money. Mr. Missal was accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections. [Click here to access testimony.]

Audit Officials Testify on Identified Deficiencies in Administration of Select VA Human Capital Programs

Mr. Nicholas Dahl, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on National Security, Committee on Oversight and Government Reform, United States House of Representatives, on VA's human capital management risks. Specifically, Mr. Dahl discussed the results of OIG's reviews of Recruitment, Relocation, and Retention (3R) incentive programs and the Drug-Free Workplace program. Both OIG reports identified needs to strengthen controls over the respective programs in order to ensure (1) the strategic and prudent use of taxpayer dollars to recruit and retain highly qualified employees in hard-to-fill positions, and (2) the effective use of pre-employment, random, and reasonable suspicion drug testing to maintain a workplace that is free from illegal drug use. Mr. Dahl also noted that the OIG substantiated allegations that there were delays in processing background investigations and mandatory drug testing for new hires in certain positions at the Atlanta VA Medical Center (VAMC) in Decatur, Georgia. He discussed the recommendations made by the OIG to improve the identified conditions in each report. Mr. Dahl was accompanied by Irene Barnett, Ph.D., Director, Bedford Office of Audits and Evaluations. [Click here to access testimony.]

OIG REPORTS

Evaluation of the Veterans Health Administration Veterans Crisis Line

OIG conducted a healthcare inspection of the Veterans Crisis Line (VCL) with four primary objectives: (1) to evaluate an allegation that VCL staff did not respond adequately to a veteran's urgent needs; (2) to perform a detailed review of VCL's governance structure, operations, and quality assurance functions; (3) to evaluate whether Veterans Health Administration (VHA) completed planned actions in response to OIG's recommendations from a previously published OIG report; and (4) to address complaints received from the U.S. Office of Special Counsel (OSC). OIG determined that VCL staff did not respond adequately to a veteran's urgent needs. OIG found deficiencies in the VCL's processes for managing incoming telephone calls and in governance and oversight of VCL operations. OIG found substantial disagreement about key decisions in operations of the VCL between the VHA Suicide Prevention Office and VHA Member Services. OIG also found that VHA contracting staff and leaders lacked an understanding of the backup center contract terms and did not verify quality control aspects of contractor performance, resulting in deficient oversight. OIG

found some backup call centers used a queuing process that may lead callers to perceive they were on hold, and that VCL leadership had not established expectations or targets for queued call times, or thresholds for taking action on queue times. OIG discovered deficiencies in the VCL Quality Management (QM) program. OIG found several challenges in VCL QM staff's ability to collect, analyze, and effectively review relevant QM data. VCL policies were not consistent with existing VHA policies for veteran safety or risk management and did not incorporate techniques for evaluating available data to improve quality, safety, or value for veterans. OIG found that the VCL had not completed actions to fully implement the seven recommendations from the prior report. OIG substantiated the OSC complainant's allegations that Social Service Assistants (SSA) were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that a newly trained SSA contacted a caller in crisis by telephone to solicit the veteran's location; and an SSA did not document when closing out a veteran's case. [Click here to access report.]

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in Veterans Integrated Service Network 6

OIG evaluated whether Veterans Integrated Service Network (VISN) 6 provided new veterans timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. VISN 6 did not consistently have timely access to health care for new patients at its VA medical facilities and through Choice. Wait times were significantly higher than the wait time data that VHA's electronic scheduling system showed. This occurred because VISN 6 and medical facility management did not ensure staff consistently implemented VHA's scheduling requirements. Inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice. With respect to those veterans in VISN 6 who received their care through Choice, OIG estimated that 82 percent of the appointments during the relevant time period had wait times longer than 30 days. This occurred primarily because medical facilities did not ensure they had sufficient staffing resources to provide timely access to Choice care. VISN 6 also did not consistently manage the timeliness of specialty care consults. OIG concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Access to health care has been a recurring issue in VHA. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in 2016. OIG made 10 recommendations regarding monitoring controls over scheduling requirements, wait time data, Choice, and consult management. The then Under Secretary for Health (USH) concurred with four recommendations and concurred in principle with six recommendations. VHA's planned corrective actions are acceptable and OIG will monitor VHA's progress until all proposed actions are completed.
[Click here to access report.]

Audit of VHA's Patient Advocacy Program

The Patient Advocacy Program is intended to identify systemic problems in VA health care with veterans experiencing unsatisfactory service. This audit was conducted to

determine whether VHA responded to FY 2015 patient complaints timely and appropriately. VHA did not adequately capture FY 2015 patient complaint information and identify complaint trends. OIG reviewed responses made as recently as May 2016 to FY 2015 complaints. OIG projected more than one-third of approximately 135,000 of VHA's serious patient complaints in the Patient Advocate Tracking System (PATS) lacked key information and were closed erroneously. Serious complaints included issues such as delays in accessing care or services, problems with clinical care, and pain management. In addition, OIG estimated about 11,000 patient complaints at five of the eight sites visited were not recorded in PATS, and VA medical facilities and VISNs in OIG's fieldwork performed limited or no formal complaint trending. VHA missed opportunities to achieve its intended program goals because the Patient Advocacy Program had material weaknesses in internal control areas, such as policies, quality control, information technology, and human capital. As a result, lapses in collecting, monitoring, and trending patient complaints reduced the potential effectiveness of the Patient Advocacy Program and affected VA's progress in becoming more veteran-centric, including identifying systemic issues for improving the quality of veterans' health care. PATS did not have important security controls in place. Approximately 4,000 of about 7,900 users had inappropriate access to PATS due to VHA's untimely review of user privileges and access rights. PATS also lacked audit logs for significant user actions. These conditions occurred and persisted, in part, because the Office of Information and Technology did not adequately assess PATS security and operational risks. As a result, PATS data were vulnerable to unauthorized access and alteration, and records were not available to monitor modifications to sensitive patient information. OIG recommended the USH implement operational controls to ensure the effectiveness of the program and reliability of its patient complaint data. OIG also recommended the Under Secretary and the Assistant Secretary for Information and Technology address PATS security and authorization issues. The USH and Acting Assistant Secretary for Information and Technology concurred with OIG's recommendations. OIG considers their corrective action plans acceptable and will follow up on their implementation. [Click here to access report.]

Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana

OIG conducted a healthcare inspection at the request of Senators Jon Tester and Steve Daines to assess whether patients experienced delays in obtaining consults, and the impact of any consult delays on patient outcomes, at the VA Montana Healthcare System (system), Fort Harrison, MT. OIG also evaluated the adequacy of internal feedback mechanisms related to consults. For consults ordered in FY 2015, OIG found apparent delays for 11,073 of 26,293 patients (42 percent) with at least one in-house consult; 11,863 of 21,221 patients (56 percent) with at least one non-VA care (NVC) consult; and 2,683 of 4,427 patients (61 percent) with at least one Choice consult. Among the VA facilities reviewed for comparison, the system had the lowest or among the lowest percentage of patients with delayed in-house and Choice consults and the highest percentage of patients with delayed NVC consults. OIG found that delays among consults ordered in FY 2015 may have harmed four patients. In July 2015, system leadership initiated a focused effort to identify and resolve factors contributing to

consult delays. Despite this effort, OIG found evidence of persistent issues with completing consults timely in FY 2016. System leadership initiated ongoing reviews to determine if patient harm occurred due to delays in care. OIG found the system had several mechanisms in place for staff to communicate concerns about consult delays to system leadership. Despite available mechanisms, staff expressed concerns about communication with system leadership. OIG recommended the System Director ensure the care of the potentially harmed patients be reviewed by an external source, confer with the Office of Chief Counsel as necessary regarding the potentially harmed patients and take action as appropriate, and continue efforts to improve consult timeliness.
[Click here to access report.]

Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska

OIG conducted a healthcare inspection at the request of Senator Lisa Murkowski to follow up on recommendations made in a previous report, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska*, (Report No. 14-04077-405, July 7, 2015). OIG evaluated selected aspects of the progress the Alaska VA Healthcare System (system) made in implementing the action plans and reviewed access to care data for patients at all system community based outpatient clinics (CBOCs). OIG found that a permanent provider had been in place at the Mat-Su VA CBOC since September 2014 and system leaders had developed a recruitment and retention plan. Improvements were made to contingency plans for ensuring continuity and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events. Training requirements regarding care coordination were implemented in all CBOCs and primary care settings. OIG determined overall access to care throughout the system met VHA performance measure targets based on data maintained by VHA and provider recommendations for new and established primary care patients. The system made improvements to the peer review process and completed planned actions for the patient cases identified in the 2015 report. OIG found that managers continued to monitor provider evaluations and implement enhancements needed for committee reporting. System leaders continued to implement actions to improve culture and morale throughout the system. Based on actions already implemented, recommendations 3 and 6 from the 2015 report are considered closed. The remaining seven recommendations will remain open for continued monitoring of actions by OIG Follow-Up Staff. OIG made no new recommendations. OIG Update: OIG received updated information in May 2016 and determined the planned actions have been completed for the remaining seven recommendations and consider all nine original recommendations closed.
[Click here to access report.]

Alleged Quality of Care Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

At the request of the then-Congresswoman Lois Capps, OIG conducted a healthcare inspection to assess quality of care concerns in the management of a patient at the VA Greater Los Angeles Healthcare System (system), Los Angeles, CA, and from a home

health agency contracted by the system. OIG did not substantiate that the patient received poor care while an inpatient at the system. OIG determined that the patient received appropriate care in response to his medical needs. Throughout his almost 3-week stay, the patient had 12 consultations from various clinical services and 2 gastrointestinal procedures. OIG could not substantiate that the patient had maggots in his underwear the day after he left the system because it could not be proven if or when the presence of maggots occurred. OIG found no documentation regarding maggots prior to the patient leaving the system or by the Emergency Department staff who examined the patient at a local community hospital a few hours after the patient left the system and again the following day. OIG could not substantiate that the home health agency provided poor care to the patient once he was in his own home because the office that provided services had since closed, the staff who cared for him were no longer employed by the agency, and no agency treatment records could be located. OIG identified inconsistent compliance with the nursing documentation requirements in the electronic health record of the patient's pressure ulcers regarding wound location, drainage information, improvement, and wound characteristics, as required. OIG also found inconsistent documentation of collaboration and participation by providers/physicians related to the patient's pressure ulcer. OIG recommended that nursing staff comply with pressure ulcer documentation requirements and that physician providers routinely document participation in the interdisciplinary plan for patients with pressure ulcers. [Click here to access report.]

Audit of VHA's Alleged Improper Payments to Providers After Veterans' Reported Deaths

In September 2015, OIG received an allegation that VHA paid NVC providers for services that could not have been rendered to about 4,200 deceased veterans listed in Social Security Administration's Death Master File. To investigate the allegation, OIG reviewed payment records documenting outpatient and inpatient claims worth about $15.5 million to determine whether, and to what extent, improper payments were made from FYs 2011–2015. OIG substantiated the allegation and found VHA improperly paid for 12 of the 25 billed NVC outpatient services reviewed, totaling about $810 in improper payments. These improper payments occurred because NVC authorization clerks failed to update the end dates on veterans' NVC authorizations to reflect their dates of death, as required by VHA policy. However, OIG did not substantiate that VHA made improper payments for inpatient services because the services had been rendered before the veterans' dates of death. For the 60 billed NVC inpatient services reviewed, OIG determined the veterans' dates of death in the Death Master File were incorrect and/or the payment records did not reflect the last dates the veterans received care. Although OIG did not find a systemic issue, we estimated VHA annually makes about $101,000 in improper payments to NVC providers for deceased veterans. VHA could improperly pay NVC providers about $505,000 for outpatient services over the next 5 years unless it ensures NVC authorizations for deceased veterans are updated in accordance with VHA policy. OIG recommended that the USH recover the improper payments identified and ensure VA medical facilities update NVC authorizations for deceased veterans as required by VHA policy. The USH concurred with OIG's report and provided an acceptable action plan. [Click here to access report.]

Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VAMC, Augusta, Georgia
OIG conducted an inspection to evaluate allegations involving improper completion of consults, false documentation, inappropriate scheduling practices, and Non-VA Care Coordination (NVCC) document scanning errors at the Charlie Norwood VAMC, Augusta, GA. OIG did not substantiate that senior managers instructed clerks to delete consults for all clinics. OIG substantiated a physician was completing consults prior to seeing patients and a supervisor instructed some employees to improperly complete NVCC consults and document "Services provided or patient refused services." OIG also substantiated that a clinic scheduler manipulated patients' desired appointment dates in an effort to correct scheduling errors and that managers directed a clerk not to schedule new patients if they could not be scheduled within 14 days [of desired date]. OIG found the facility identified 3,776 "errors" that prevented uploading of NVCC documentation because a software option had not been enabled. OIG learned that the employees who had been instructed to improperly close consults had completed an additional 1,212 NVCC consults. In support of an OIG criminal investigation, we reviewed all 2,726 consults. The false documentation aspect of this review was under criminal investigation for more than 18 months, and OIG delayed publication of this report pending completion of the investigation. OIG recommended the Interim USH ensure that VA facilities certify the use of appropriate DocManager™ software settings, the VISN Director review the circumstances surrounding improperly completed consults and managers' failures to promptly and fully evaluate the improperly completed urology consults, and confer with appropriate VA offices to determine the need for administrative action, if any. OIG also recommended that the Facility Director clinically evaluate the improperly completed urology consults, monitor the status of the improperly completed NVCC consults, and ensure that all clinic schedulers are trained on correct scheduling practices. [Click here to access report.]

Review of Alleged Mismanagement of Construction Projects at the VAMC in Clarksburg, West Virginia
OIG substantiated a Hotline allegation of improper management and oversight of minor, nonrecurring maintenance, and clinical specific initiative construction projects at the Louis A. Johnson VAMC in Clarksburg, WV. The complainant alleged eight construction projects were mismanaged, which led to project cost overruns, delays, cancellations, unnecessary change orders, and additional work. Most significant was a parking garage planned for at a cost of approximately $9.7 million that was reduced from approximately 430 new spaces to approximately 25 new spaces before the project was canceled in March 2016. The VAMC also had to reduce other construction projects in scope because of inadequate planning and delayed project completion. The VAMC has completed only three of the eight projects; all three cost significantly more than planned. This occurred because of inaccurate cost estimates, untimely performance of site surveys, and failure to ensure project designs were within funding limitations. In total, OIG identified approximately $2.8 million in unnecessary costs and delays in completing projects needed to serve veterans. Accordingly, OIG recommended the VISN 5 Director ensure the Louis A. Johnson VAMC implements a plan to use or repurpose the heating and air conditioning system identified by this review, train staff on

developing cost estimates and funding requests, and ensure timely performance of site surveys. [Click here to access report.]

Review of Alleged Use of Incorrect Effective Dates at the VA Regional Office in Chicago, Illinois

OIG assessed the merits of a December 2015 OIG Hotline allegation that claims processors at the Chicago VA Regional Office (VARO) assigned incorrect effective dates when processing claims associated with "intent to file" (ITF) submissions. An ITF provides claimants the opportunity to submit minimal information related to their claim for benefits and allows up to one year for the claimant to provide additional information and evidence necessary to complete the claim. If benefits are subsequently established, VA may use the date the VARO received the ITF as the basis for an earlier effective date for benefits payments. OIG substantiated the allegation that Rating Veterans Service Representatives (RVSRs) at the Chicago VARO did not always assign the correct effective dates when they received an ITF. Overall, RVSRs established incorrect effective dates for 15 of the 30 disability claims (50 percent) OIG sampled from a universe of 616 claims. Five of the errors resulted in 15 improper benefits payments totaling approximately $5,700; 10 of the errors had incorrect effective dates but did not affect benefits payments. The majority of effective date errors occurred when the claimant submitted an ITF electronically. In these cases, the Veterans Benefits Administration (VBA) automatically updates the corporate database; however, there is no standardized form within the electronic claims folder, which increases the likelihood the VARO overlooks the ITF. Although a notification letter is generated, it is stored in a separate VBA system. Generally, OIG attributed the errors to a lack of guidance within VBA policy on how to identify ITF filings and insufficient analysis of effective date errors, which led to weaknesses in training. Using incorrect effective dates may result in incorrect benefits payments. However, subsequent to OIG's review, VBA updated its policy to include instructions on identifying ITFs and made additional ITF training available nationwide. OIG recommended the Chicago VARO Director conduct a review and take appropriate actions on the 586 claims associated with ITFs remaining from OIG's universe. In addition, OIG recommended the Director implement a plan to ensure sufficient analysis is completed to identify effective date errors related to ITFs. Furthermore, OIG recommended the VARO Director ensure claims processors receive training on how to identify ITFs. The VARO Director concurred with the recommendations and provided sufficient evidence to close the recommendations. [Click here to access report.]

Opioid Prescribing Practice Concerns, VA Illiana Health Care System, Danville, Illinois

OIG conducted a healthcare inspection to assess an alleged unsafe opioid prescribing practice of a primary care physician (PCP) at VA Illiana Health Care System, Danville, IL. The specific allegation related to the initiation of a fentanyl patch to treat pain in a patient with a complex mental health history who subsequently died of fentanyl toxicity. OIG found the PCP considered the use of non-steroidal anti-inflammatory medications for pain but was concerned about an interaction with one of the patient's other medications. Fentanyl is typically prescribed to alleviate severe pain and not indicated

for the management of acute pain or in opioid naïve patients. This patient had received opioid medications in the past for chronic pain issues and would be considered opioid tolerant. The PCP had safety concerns regarding oral opioid analgesics and prescribed a low dose fentanyl patch in a small supply. The autopsy report showed pieces of fentanyl patches in the patient's gastric contents, indicating that the patient likely ingested one or more patches. The patient also had two patches on his back; one of which he obtained outside the VA as the dose on one of the patches was approximately eight times the dose the VA PCP had ordered. Facility pharmacy staff performed an opioid medications audit and confirmed that each fentanyl patch ordered by the VA PCP had been dispensed to the patient with the prescribed lower dose. OIG did not substantiate that the PCP engaged in unsafe opioid prescribing practices, specifically regarding initiation of a fentanyl patch to treat pain in a patient with a complex mental health history who subsequently died of fentanyl toxicity. The provider followed the 2010 VA/Department of Defense Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain recommendations when initiating the patient's pain management. If used appropriately, the low dose fentanyl patches would not likely have resulted in fentanyl toxicity or death. OIG made no recommendations.
[Click here to access report.]

Independent Review of VA's FY 2016 Performance Summary Report on Drug Control Funds to the Office of National Drug Control Policy
As required by the Office of National Drug Control Policy (ONDCP) Drug Control Accounting Circular, OIG reviewed VA's FY 2016 Performance Summary Report to ONDCP. OIG attested to VA's ability to capture performance information accurately and whether the current system was properly applied to generate the performance data reported in the Performance Summary Report. Based upon OIG's review and the criteria of the Circular, nothing came to OIG's attention that caused us to believe that VA does not have a system to meet its FY 2016 targets for the continuity of care performance measure (Patient Care) and the substance abuse disorder ongoing studies performance measure (Research and Development) in all material respects.
[Click here to access report.]

Independent Review of VA's FY 2016 Detailed Accounting Submission to the ONDCP
OIG is required to review the VA's FY 2016 Detailed Accounting Submission to the ONDCP. The Submission concerns assertions on VA's drug methodology, reprogrammings and transfers, and fund control notices. Based upon OIG's review, nothing came to OIG's attention that caused us to believe that management's assertions included in VA's Submission are not fairly stated in all material respects based on the set criteria. [Click here to access report.]

Clinical Assessment Program Reviews
In March 2017, OIG published 10 Clinical Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous

CAP findings, or the rotation of CAP review topics over time. The reviews covered the following thirteen activities:

(1) Quality, Safety, and Value;
(2) Environment of Care;
(3) Medication Management: Anticoagulation Therapy;
(4) Coordination of Care: Inter-Facility Transfers;
(5) Moderate Sedation;
(6) Community Nursing Home Oversight;
(7) Management of Disruptive/Violent Behavior;
(8) Follow-Up on Medication;
(9) Mental Health Residential Rehabilitation Treatment Program;
(10) Post-Traumatic Stress Disorder Care;
(11) Diagnostic Care: Point-of-Care Testing;
(12) Quality Management;
(13) Nurse Staffing.

Southern Arizona VA Health Care System, Tucson, Arizona
Boise VAMC, Boise, Idaho
Louis Stokes Cleveland VAMC, Cleveland, Ohio
VA Portland Health Care System, Portland, Oregon
Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
Canandaigua VAMC, Canandaigua, New York
VA Caribbean Healthcare System, San Juan, Puerto Rico
VA Salt Lake City Health Care System, Salt Lake City, Utah
CAP Evaluation Summary–Evaluation of Inpatient Flow in VHA Facilities
Evaluation of the Quality, Safety, and Value Program in VHA Facilities

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

West Los Angeles, California, VAMC Employee Charged With Assault
A West Los Angeles, CA, VAMC employee was charged with assaulting another employee with a deadly weapon. An OIG investigation revealed that two employees got into an argument and one employee allegedly used his VA-issued utility knife to stab the other employee. The incident was witnessed by another VA employee. The victim received an 8-inch laceration on his torso and another stab wound, resulting in 13 stitches. The defendant subsequently admitted to stabbing the victim.

Seattle, Washington, VAMC Employee Arrested for Possession of a Firearm
A Seattle, WA, VAMC employee was arrested for possession of a firearm by a felon. An OIG, Federal Bureau of Investigation (FBI), Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), and VA Police Service investigation was initiated after an anonymous tip alleged that the employee was stealing chemicals from the medical center in an effort to develop concentrated hydrogen peroxide for unknown reasons.

The defendant had also been involved in several workplace altercations in the past year. The investigation further revealed that the employee, a convicted felon, possessed weapons and also sold narcotics. A search of the defendant's vehicle parked at the medical center resulted in the seizure of a loaded pistol and methamphetamine. The defendant is being held pending further judicial action.

Northport, New York, VAMC Union President Pleads Guilty to Petit Larceny
A Northport, NY, VAMC employee and former American Federation of Government Employees president pled guilty to petit larceny. In furtherance of this plea deal, the defendant agreed to make full restitution. The defendant also agreed to serve a 60-day jail sentence or to perform 280 hours' community service in lieu of jail, followed by 3 years' probation. An OIG, Department of Labor (DOL) Office of Labor Management Standards, and Attorney General's Office investigation revealed that the defendant embezzled approximately $45,000 from the union's bank account and used the funds for personal expenditures.

Non-Veteran Pleads Guilty to Theft of Government Funds
A non-veteran pled guilty to theft of Government funds. An OIG investigation revealed that the defendant, who never served in the military, was able to obtain medical benefits as well as VA grant benefits by submitting falsified documents to VA claiming he served in the Marine Corps. The loss to VA is $130,121.

Former Richmond, Virginia, VAMC Nurse Sentenced for Drug Diversion
A former Richmond, VA, VAMC registered nurse was sentenced to 4 months' home detention and 3 years' probation after pleading guilty to obtaining controlled substances by misrepresentation, fraud, or deception. During an OIG and VA Police Service investigation, the defendant confessed to diverting for personal use approximately 20 to 30 oxycodone 5mg tablets and 8 to 10 fentanyl patches (varying in strength from 25 to 100 micrograms) from two Omnicell medication dispensers. The defendant also confessed to occasionally shorting patients that were under her care by giving them a limited dose of their prescribed pain medication in order to satisfy her addiction. The defendant resigned her position as a result of this investigation.

Long Beach, California, VAMC Employee Sentenced for Selling Heroin
A VA employee was sentenced to 3 years' incarceration for selling heroin to an undercover officer at the Long Beach, CA, VAMC on multiple occasions. An OIG, VA Police Service, Los Angeles High Intensity Drug Trafficking Areas, Los Angeles Sheriff's Department, Drug Enforcement Administration, and ATF investigation revealed that 24 subjects, including veterans and two VA employees, sold heroin, methamphetamine, marijuana, crack cocaine, oxycodone, Percocet, Tylenol with Codeine, morphine, hydrocodone, fentanyl, and Tramadol at the medical center. A handgun and a fully automatic SKS rifle were also sold to undercover officers.

Ann Arbor, Michigan, VAMC Patient Arrested for the Distribution of an Illegal Substance that Resulted in the Death of Another Veteran

An Ann Arbor, MI, VAMC patient was indicted and arrested for the distribution of an illegal substance that resulted in the death of another veteran. An OIG and FBI investigation resulted in the defendant being charged with introducing a mixture of heroin and fentanyl into the medical center and providing a portion to the victim that resulted in his death.

Veteran Indicted on Multiple Drug Charges

A veteran was indicted on multiple felony drug charges. An OIG investigation revealed that the defendant obtained opioids from VA and his non-VA medical provider from 2014 to 2016, which resulted in the defendant receiving approximately 1,260 tablets by deception. The defendant admitted to distributing the extra controlled substances he obtained to other individuals.

Veteran Sentenced for Obtaining a Controlled Substance by Fraud or Forgery

A veteran was sentenced to 3 to 13 months' incarceration, 18 months' supervised probation, and was ordered to pay $2,907 in fines/cost after pleading guilty to obtaining a controlled substance by fraud or forgery. An OIG and local police investigation revealed that the veteran went to multiple VAMCs, military installations, and private pharmacies in three states presenting forged prescriptions for controlled narcotics. The veteran then sold or used the fraudulently obtained narcotics. After being charged, the veteran absconded and was a fugitive for over a year.

Veteran Sentenced for Travel Benefit Fraud

A veteran was sentenced to time served (30 days), 3 years' supervised probation, and was ordered to pay VA $10,225 in restitution after pleading guilty to presenting a false, fictitious, or fraudulent claim to a Department of the United States. An OIG investigation revealed that for nearly 2 years the defendant claimed an address 128 miles from the Asheville, NC, VAMC. In actuality, the defendant was living in HUD-VA Supportive Housing only 14 miles from the facility. This defendant was part of a larger investigation involving multiple beneficiary travel fraud suspects that led to the arrest of 13 veterans and restitution of more than $100,000 being ordered paid back to the facility.

Veterans Benefits Administration Investigations

Former VA Field Examiner Arrested for Mail Fraud

A former VA field examiner was indicted and arrested for mail fraud. An OIG investigation resulted in allegations that the defendant drafted a Last Will and Testament for an incompetent veteran and listed himself as the sole beneficiary of the veteran's financial assets, valued at approximately $680,000. The defendant then used the U.S. Postal Service (USPS) to place the fraudulent document on file with the veteran's fiduciary, Regions Bank. The defendant resigned from VA employment in lieu of termination.

VA-Appointed Fiduciary Indicted for Theft of Government Funds
A VA-appointed fiduciary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with misusing a veteran's VA benefits. The defendant allegedly used the veteran's funds for personal use after making general withdrawals, writing checks to cash, and making automated teller machine (ATM) withdrawals. The loss to the veteran is $24,937.

Defendant Pleads Guilty to Theft of Government Funds
A defendant pled guilty to theft of Government funds. An OIG investigation determined that a former VBA employee fraudulently used the identities of multiple veterans to prepare special monetary payments that were directly deposited by VA into multiple bank accounts held either by the VBA employee or the defendant. As a result of this scheme, this defendant fraudulently received VA funds of approximately $45,900. The loss to VA as a result of the former VBA employee's actions was approximately $66,996.

Veteran Pleads Guilty to Wire Fraud and Spouse Pleads Guilty to Misprision of a Felony
A veteran pled guilty to wire fraud and his spouse pled guilty to misprision of a felony. A VA OIG, USPS OIG, DOL OIG, and VA Police Service investigation revealed that the veteran, who was rated 100 percent disabled and receiving special monthly compensation for loss of use of both feet and major depressive disorder, was able to ambulate and carry out daily tasks with a clear ability to use both of his feet. Additionally, the veteran was receiving Federal Workers' Compensation benefits from a fraudulent injury he claimed to have suffered through his previous employment with the USPS. The veteran's spouse was charged in relation to her assistance in furthering the fraud by pushing her husband in his wheelchair to his VA appointments and benefitting financially from the proceeds. The loss to VA is $922,137.

Veteran's Widow Sentenced for Making False Statements
A widow receiving Dependency and Indemnity Compensation (DIC) benefits was sentenced to 18 months' incarceration, 3 years' supervised release, and was ordered to pay $254,272 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant failed to disclose her remarriage to VA and subsequently made material false statements concerning her marital status in order to continue to receive VA benefits.

Veteran Pleads Guilty to Theft of Government Funds and Social Security Fraud
A veteran pled guilty to theft of Government funds and Social Security Administration (SSA) fraud. A VA OIG and SSA OIG investigation revealed that the defendant served in the military and received VA pension benefits under one Social Security number, but earned income under a separate Social Security number. The defendant's earned income, if reported, would have made him ineligible for a VA pension benefit. The loss to VA is $205,534.

Veteran Indicted for VA Compensation Fraud
A veteran was indicted for theft of Government funds. The defendant is alleged to have altered his DD-214 in order to fraudulently receive VA compensation benefits. The loss to VA is $142,284.

Veteran and Wife Arrested for Conspiracy and Theft of Government Funds
A veteran and his wife were indicted and arrested for conspiracy and theft of Government funds. An OIG investigation resulted in charges that alleged the veteran provided false information to VA regarding his vision loss. The veteran had been granted Special Monthly Pension based on the need for Aid and Attendance for blindness. The investigation revealed that the veteran has a valid driver's license, drives himself, and performs normal daily activities without the assistance of another person or low vision aids. The loss to VA is $63,352.

Grandson of Deceased Veteran Sentenced for Theft of Government Funds
The grandson of a deceased veteran was sentenced to 15 months' incarceration, 3 years' supervised released, and was ordered to pay VA $304,415 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the veteran's death in July 2007.

Stepson of Deceased Beneficiary Charged with Concealing Veteran's Death and Stealing Government Benefits
The stepson of a deceased VA beneficiary was arrested for fraud schemes, theft, taking the identity of another, money laundering, and concealment of a dead body. A VA OIG, SSA OIG, and local law enforcement investigation resulted in the defendant being charged with burying his stepfather in the backyard in order to conceal his death and steal his VA and SSA benefits. As a result of this deception, VA and SSA benefits continued to be direct deposited to the beneficiary's account after his death in December 2011. The loss to the Government is $300,000, to include a loss to VA of $175,000.

Daughter of Deceased VA Beneficiary Arrested for Bank Fraud and Aggravated Identity Theft
The daughter of a deceased VA beneficiary was indicted and subsequently arrested for bank fraud and aggravated identity theft. An OIG investigation resulted in the defendant being charged with using an ATM card to steal VA benefits that were direct deposited after her mother's death in August 2009. When the defendant no longer had access to the ATM card, she wrote personal checks to herself and forged her mother's signature. The loss to VA is $119,389.

Daughter of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The daughter of a deceased VA DIC beneficiary was sentenced to 1 day of incarceration, 12 months' supervised release, and was ordered to pay VA $114,048 in restitution after pleading guilty to theft of Government funds. A VA OIG and Pension Benefit Guarantee Corporation (PBGC) OIG investigation resulted in the defendant

being charged with stealing VA and PBGC benefits that were direct deposited after her mother's death in March 2005. The defendant maintained a post office box in her deceased mother's name and submitted correspondence to VA bearing her deceased mother's forged signature in order to continue to receive benefits.

Daughter-in-Law of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The daughter-in-law of a deceased VA DIC beneficiary was sentenced to 1 year of probation and was ordered to pay VA $109,518 in restitution after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after the beneficiary's death in October 2007. The defendant also forged her deceased mother-in-law's name on a VA marital status questionnaire in 2010 reporting that she had not remarried. In addition, the defendant's husband, who admitted that he also used the VA funds, entered into a pre-trial diversion agreement.

Son of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother's death in June 2009. The defendant stole most of the VA funds by making checks payable to himself. The loss to VA is $108,690.

Friend of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The friend of a deceased VA beneficiary was sentenced to 21 months' incarceration, 24 months' supervised release, and was ordered to pay VA $101,250 in restitution. An OIG investigation revealed that the defendant failed to report the beneficiary's death to VA and stole VA benefits that were direct deposited after her death in February 2008.

Former Daughter-in-Law of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The former daughter-in-law of a deceased VA beneficiary, who was also the Power of Attorney, was sentenced to 3 months' incarceration, 3 years' supervised release, and was ordered to pay $93,588 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds (checks and direct deposits) issued after the beneficiary's death in November 2005. The defendant used the funds for personal expenses. The defendant also defrauded the deceased beneficiary's private pension fund.

Other Investigations

Beauty School Owners Sentenced for VA Education Fraud
The owner of a beauty school was sentenced to 63 months' incarceration, 36 months' supervised release, 150 hours' community service, and was ordered to pay $4,526,653 in restitution after pleading guilty to conspiracy to commit wire fraud and engaging in monetary transactions in property derived from specified unlawful activity. A second owner was sentenced to 60 months' incarceration, 36 months' supervised

release, 400 hours' community service, and was ordered to pay $4,526,653 in restitution after pleading guilty to conspiracy to commit wire fraud. An OIG, Internal Revenue Service (IRS) Criminal Investigation Division (CID), and Naval Criminal Investigation Service investigation revealed that the owners of the school provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to the enrolled veterans whose tuition was paid by VA. In reality, the enrolled veterans rarely, if ever, received instruction from employees at the school. The owners required the enrolled veterans to sign in and out at the school each day in order to create the appearance that they were attending the required number of hours, but permitted the veterans to leave the school during the hours they were ostensibly attending class. As a result, VA paid $4,526,653 to the school in tuition funds and over $10.5 million to veterans to cover housing costs and other educational expenses.

Six Non-Veterans Sentenced for Redirecting Benefit Payments
Six non-veterans were sentenced to a combined 336 months' incarceration, 216 months' of supervised release, and were ordered to pay $2,105,318 in restitution. An additional defendant pled guilty to conspiracy to commit wire fraud. Two additional defendants are still awaiting sentencing and two subjects are fugitives. An OIG, Homeland Security Investigations, and U.S. Postal Inspection Service investigation resulted in the discovery of defendants in Jamaica redirecting the monthly benefit payments of veterans and SSA recipients. Subsequently, pre-paid credit cards containing the benefit payments were mailed to co-defendants in the U.S. (Miami) where the funds were removed, a portion kept, and the remainder sent back to Jamaica. Additionally, the investigation identified that the co-defendants were allegedly involved in lottery scams which target elderly, vulnerable victims. The defendants' guilty pleas and cooperation led to the discovery of several additional co-conspirators in Jamaica. The loss to VA, SSA, and the lottery scam victims is approximately $3 million. This investigation began as a proactive, nationwide effort to combat the growing problem of veterans' benefits redirections.

Veteran and Business Associate Plead Guilty to Misprision of a Felony
A service-connected disabled veteran and a business associate, who owned a separate minority-owned small business, pled guilty to misprision of a felony. In addition, the owner of a small business pled guilty, and also pled guilty on behalf of his company, to conspiracy. A multi-agency investigation revealed that over $350 million in set-aside (veteran-owned, minority-owned, women-owned) construction contracts were fraudulently obtained by the defendants, who conspired in creating companies for the sole purpose of obtaining set-aside Government contracts, all while providing false information to VA and the Small Business Administration in order to qualify for the contracts.

Company Owner Pleads Guilty to Conspiracy to Commit Mail Fraud
The owner of three companies, who contracted with various Government agencies, pled guilty to conspiracy to commit mail fraud. A multi-agency investigation revealed that beginning as early as February 2010 the defendant received numerous contracts from

the Government, to include a VA contract, through FedBid.com. Once the companies secured a contract from the Government, they arranged for victim-vendors to provide the goods to the Government. To induce the victim-vendors to agree to provide the goods and extend credit to the companies, the defendant made fraudulent representations regarding his companies' creditworthiness and association with the Government. As part of the conspiracy, the defendant falsely promised to pay the victim-vendors for the goods. The defendant subsequently failed to pay dozens of victim-vendors over $1 million for goods provided to the various Government agencies.

Thirty-Three Non-Veterans Plead Guilty to Conspiracy to Defraud the Government with Respect to Claims

Thirty-three non-veterans, including three former Battle Creek, MI, VAMC employees, pled guilty to conspiracy to defraud the Government with respect to claims. A multi-agency investigation revealed that from 2008 to 2016 the defendants utilized other individuals' personal identification information, obtained in part from patients and employees of the medical center and inmates of the Michigan Department of Corrections, to file false tax returns totaling over $22 million. For his part, the leader of the conspiracy was sentenced to 10 years' incarceration and was ordered to pay $16 million in restitution. Additionally, this defendant was sentenced to an additional and consecutive 37 months' incarceration related to a weapon recovered during the execution of a search warrant of his residence. The three former VAMC employees are scheduled to be sentenced later this year.

New England Compounding Center Owner Convicted of Multiple Charges

The owner and head pharmacist of the New England Compounding Center (NECC) was convicted at trial of racketeering, racketeering conspiracy, mail fraud, and introduction of misbranded drugs into interstate commerce with the intent to defraud and mislead in connection with a 2012 nationwide fungal meningitis outbreak. An OIG, Federal Drug Administration (FDA) Office of Criminal Investigation, FBI, Defense Criminal Investigative Service, and USPS investigation revealed that the defendant directed and authorized the shipping of contaminated methylprednisolone acetate to NECC customers nationwide. In addition, the defendant authorized the shipping of drugs before test results confirming their sterility were returned, never notified customers of nonsterile results, and shipped compounded drugs with expired ingredients. Furthermore, certain batches of drugs were manufactured, in part, by an unlicensed pharmacy technician at NECC. The defendant also repeatedly took steps to shield NECC's operations from regulatory oversight by the FDA by claiming to be a pharmacy dispensing drugs pursuant to valid, patient-specific prescriptions. The investigation further revealed that VA purchased approximately $1 million worth of various pharmaceutical products from NECC. The Government contended that all products compounded and sold to NECC customers, including VA, were made in an unsafe manner and under unsanitary conditions.

Eight Subjects Arrested for Conspiracy to Commit Health Care Fraud and Conspiracy to Launder Money

Eight subjects were indicted and arrested for conspiracy to commit health care fraud and conspiracy to launder money related to their alleged participation in a massive health care fraud and kickback scheme involving compound pharmacy prescriptions. Approximately $158 million in alleged false and fraudulent claims were submitted through DOL's, Office of Workers' Compensation Program with approximately $82 million of the fraudulent claims being paid by the Government. This amount includes $14 million in alleged fraudulent charges to VA with approximately $7.5 million paid out. The Government has seized over $58 million in bank and stock accounts related to the alleged criminal conduct.

Health Care Executive Charged with Health Care Fraud, Conspiracy, and Money Laundering

A health care executive was charged with health care fraud, conspiracy, and money laundering relating to his ownership and operation of multiple workers' compensation companies that provided durable medical equipment and muscle and range of motion test and reports. A VA OIG, USPS OIG, DOL OIG, Department of Homeland Security (DHS) OIG, and IRS CID investigation revealed that from September 2011 to November 2013 the defendant allegedly conspired to fraudulently charge Federal agencies for health care items and services that were the result of kickback payments and were not medically necessary. The investigation also revealed that the defendant allegedly conspired to unlawfully bill for services not performed as described in each invoice. The loss to the Government is approximately $2 million.

Former Chief Executive Officer Pleads Guilty To Obstructing a Health Care Crime Investigation

The former chief executive officer (CEO) of a medical clinic was sentenced to 3 years' probation and a $4,000 fine after pleading guilty to obstructing a health care crime investigation. A VA OIG, USPS OIG, DOL OIG, and DHS OIG investigation was initiated into allegations that the clinic was defrauding VA and other Federal agencies by billing for services not provided. It was subsequently determined that the clinic's operators were paying kickbacks for the referral of Federal workers' compensation claimants. When interviewed, the CEO made false material statements and failed to disclose that she had played an active role in helping her co-conspirators launder approximately $2.5 million in illicit proceeds by allowing them to purchase real estate in her name.

Assaults and Threats Made Against VA Employees

Veteran Arrested for Making Threat to Lebanon, Pennsylvania, VAMC

A veteran was arrested for communicating a threat which caused the evacuation of a building at the Lebanon, PA, VAMC. An OIG and VA Police Service investigation resulted in an allegation that the defendant used a pre-paid cell phone to communicate a threat to a county dispatcher in PA leading to the disruption of patient services at the medical center for several hours while the building was searched for explosives by law

enforcement officers. The veteran was identified after a review of the pre-paid cell phone's call logs found an outgoing telephone number matching a "next of kin" phone number in the veteran's VA record.

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG's vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.

https://www.va.gov/oig/publications/administrative-investigation-advisories.asp

Administrative Investigation Advisories (March 2017)	
Advisory Number	**Title**
15-01328-166	Administrative Investigation – Alleged Misuse of Official Time, Falsified Documents, Conflict of Interest, and Quality of Care, Birmingham VA Medical Center
17-00730-174	Administrative Investigation – Alleged Misuse of Travel Funds, VA Central Office, Washington, DC
17-01003-189	Administrative Investigation – Alleged Misuse of Travel Funds, VA Eastern Kansas Health Care System - Colmery-O'Neil VA Medical Center, Topeka, KS

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