CONGRESSIONAL TESTIMONY

Assistant Inspector General’s Testimony Highlights Opportunities to Enhance VA’S Suicide Prevention Efforts

John D. Daigh, Jr., M.D., CPA testified before the U.S. Senate’s Committee on Veterans’ Affairs at a hearing on preventing veteran suicide. Dr. Daigh noted three possible strategies that may lessen the risk that a veteran will attempt or commit suicide. First, he discussed expanding suicide prevention efforts to those veterans who do not receive care through the Veterans Health Administration (VHA). Second, he suggested enhancing prediction models beyond identifying who is at risk to also determine an actionable timeframe for when a veteran may be at highest risk to attempt suicide. Finally, he indicated that efforts could be increased to improve communication between care providers and family members of at-risk veterans. With regard to the third strategy, Dr. Daigh explained that the Office of Inspector General (OIG) has reported on the deaths of many veterans with diverse mental health issues that often revealed significant communication gaps between care providers and the veteran’s family due to privacy and confidentiality laws. By devoting more effort to improving communication through the use of advance directives or other mechanisms, VA could determine if better information flow can reduce veterans’ risk of suicide.

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Former VA Vendor Pleads Guilty to Blackmail

A joint VA OIG and Federal Deposit Insurance Corporation OIG investigation revealed that from April 2014 to April 2015 the defendant received purchase card payments of $125,549 for unnecessary maintenance work. During this time, the defendant kicked back an estimated $39,000 to a former St. Louis, MO, VA supervisor and an estimated $20,800 to his step-father, who at the time was also a VA employee. This investigation is ongoing and there is an anticipated loss to VA of $451,853.

Former Leavenworth, Kansas, VA Medical Center Physician Assistant Convicted of Aggravated Criminal Sodomy, Aggravated Sexual Battery, and Sexual Battery

An OIG and Leavenworth County Sheriff’s Office investigation resulted in charges that the defendant committed sexual assaults during physical examinations. The defendant served as a primary care provider for the Operation Enduring Freedom/Operation Iraqi Freedom Section that included 750 to 1,000 patients. During the investigation, the defendant confessed to over-prescribing narcotic medication as well as exceeding standard examination practices by administering unnecessary and excessive genital examinations to multiple male patients.

Veteran Sentenced for Sexual Abuse of an Incapable Victim

A veteran was sentenced to 100 months’ incarceration, lifetime probation, and was ordered to participate in a sex offender and drug treatment program after pleading guilty
to the sexual abuse of an incapable victim. An OIG investigation revealed that while the defendant and victim were both inpatients at the Lexington, KY, VA Medical Center (VAMC), the defendant sexually assaulted the female victim. The defendant waited until the victim received “sleeping medications” and then went into her room and sexually assaulted the victim on several occasions.

**Minneapolis, Minnesota, VAMC Medical Instrument Technician Charged with Indecent Exposure**

An OIG investigation resulted in charges alleging the defendant exposed himself to two different female coworkers on multiple occasions.

**Veteran Sentenced for VA Travel Benefit Fraud**

A veteran was sentenced to 12 months’ incarceration, 3 years’ supervised release, and was ordered to pay $142,474 to VA in restitution after pleading guilty to theft of Government funds. An OIG and VA Police Service investigation determined that the defendant made more than 700 false claims to the San Francisco, CA, VAMC in order to receive more beneficiary travel pay. The defendant claimed to drive more than 500 miles a day to the medical center, 4 to 5 days per week for several years. In actuality, the defendant was living in a mobile recreational vehicle trailer much closer to the facility.

**Veterans Benefits Administration Investigations**

**Veteran and Family Members Indicted for Fraud**

A veteran and his wife, along with his mother and father, were indicted for healthcare fraud, wire fraud, false statements, and principals. An OIG investigation resulted in charges that allege the veteran owned and operated various companies while claiming to be unemployed due to his service-connected disabilities. The veteran is also alleged to have been gainfully employed while in receipt of VA Individual Unemployability compensation benefits and to have obtained multiple Government set-aside contracts, most with VA, while being 100 percent service-connected for post-traumatic stress disorder (PTSD). The veteran’s wife, mother, and father submitted fraudulent claims to VA on the veteran’s behalf and were instrumental in the alleged fraud scheme. The veteran was also certified as a private pilot and as an aircraft mechanic dating back to 2013 and obtained both certifications only days after claiming to VA multiple alleged disabilities, including PTSD. The veteran failed to report those disabilities to the Federal Aviation Administration (FAA) and was subsequently indicted for falsification of FAA records. The loss to VA is approximately $175,000.

**Veteran Arrested for Theft of Government Funds**

An OIG investigation resulted in charges that allege the defendant fraudulently received compensation benefits for loss of the use of both his feet. The defendant claimed to VA and OIG agents that he could not walk or even stand for more than a few seconds without falling. The defendant was observed and recorded walking, driving, climbing ladders, mowing his lawn, and engaging in other physical activities. The loss to VA is approximately $157,000.
Veteran Sentenced for Conspiracy to Defraud the United States
A veteran was sentenced to 36 months' probation and was ordered to pay VA restitution of $70,123 after pleading guilty to conspiracy to defraud the United States. An OIG investigation revealed that from June 2009 to January 2017, the veteran collected $65,509 in VA “special monthly pension” benefits by falsely claiming that he was blind. Also, the veteran's wife was sentenced to 12 months' probation after pleading guilty to misprision of a felony. She assisted the veteran in appearing to be blind by guiding him throughout his VA appointments. The veteran also improperly received prosthetic devices valued at $4,614. The investigation revealed that the veteran was able to maintain a driver’s license, drive, and perform other daily activities without assistance. [Department of Justice News Release]

Daughters of Deceased VA Beneficiaries Sentenced for Theft
The daughter of a deceased VA beneficiary was sentenced to 3 years' probation and was ordered to pay VA restitution of $179,466 after pleading guilty to theft of Government funds. A VA OIG and Treasury OIG investigation revealed that the defendant stole Dependency and Indemnity Compensation benefits that were direct-deposited after her mother’s death in July 1999. The defendant admitted to forging VA documents and using the VA funds for personal expenses.
In a separate case, the daughter of another deceased VA beneficiary was sentenced to 4 months' incarceration, 4 months' home confinement, and 5 years' probation, and was ordered to pay VA restitution of $147,557 after pleading guilty to theft of Government funds. An OIG and Federal Bureau of Investigation joint effort revealed that the defendant stole, endorsed, and negotiated VA benefit checks issued after her mother’s death in August 1997. The defendant used the funds for personal expenses.

Other Investigations
Veteran Charged with Wire Fraud Conspiracy
An OIG and Internal Revenue Service Criminal Investigation Division (IRS CID) investigation resulted in charges that allege the defendant and the owners of a welding school provided false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. Allegedly, the enrolled veterans rarely, if ever, received instruction from employees at the school. The defendant, who enrolled in three courses at the school, admitted that he did not receive any instruction during his period of enrollment and instead visited the school only to sign-in to create the appearance that he was attending the required number of hours. Also, the school owners are alleged to have hired the defendant to recruit additional veteran students. The defendant stated that he recruited approximately 20 veterans to enroll at the school and informed those veterans that they would not have to attend classes, but could still receive their housing allowance. To date, VA has paid more than $1.4 million to the school in tuition and more than $1.1 million to veteran enrollees in housing allowances, books, and supply stipends.
Chiropractor Sentenced for Theft of Government Funds

A chiropractor was sentenced to 2 months’ home detention and 5 years’ probation and was ordered to pay VA their share of $39,155 in restitution, along with two other defendants, after pleading guilty to theft of Government funds. An OIG investigation revealed that a VA contractor subcontracted with a clinic to provide VA disability examinations for local veterans. The examinations were performed in violation of the primary contract with VA, which required that the examinations be conducted by a licensed and credentialed provider who had a clear and unrestricted license and was not excluded from participating in Federal health care programs. The investigation revealed that a total of 209 subcontractor examinations were submitted for 53 veterans by an unlicensed person using another doctor’s name and license without permission.

Jamaican Nationals Arrested for Wire Fraud and Conspiracy to Commit Wire Fraud

To date, eight subjects have been arrested and seven have been sentenced to a combined 336 months’ incarceration, 216 months’ of supervised release, and 36 months’ probation. The seven who were sentenced have also been ordered to pay $2,164,783 in restitution. Two additional subjects have been indicted and are currently fugitives. An investigation conducted by VA OIG, Homeland Security Investigations, U.S. Postal Inspection Service, and Social Security Administration OIG in the Miami, FL, area resulted in the discovery of some of the defendants in Jamaica redirecting the monthly benefit payments of veterans and Social Security recipients. Subsequently, pre-paid credit cards containing the benefit payments were mailed to the other defendants in the Miami, FL, area where the funds were removed, a portion kept, and the remainder sent back to Jamaica. This Florida-based investigation began as a proactive, nationwide effort to combat the growing problem of veterans’ benefits redirections. It is estimated that approximately $7 million in VA benefits have been redirected nationwide since 2015.

Veteran Indicted for Access with Intent to View Child Pornography

An OIG investigation resulted in charges that allege the defendant, while residing as an inpatient at the Hampton, VA, VAMC domiciliary, used a computer belonging to his roommate to access and download child pornography.

Non-Veterans Arrested for Identity Theft Charges

Two Tampa, FL, non-veterans were arrested for theft of Government property, access device fraud, aggravated identity theft, and conspiracy. An OIG, IRS CID, and Tampa Police Department investigation revealed that the defendants illegally obtained numerous VAMC records, used at least 20 veterans’ personally identifiable information from the records, then filed fraudulent tax returns, and opened lines of credit in the victims’ names. The defendants obtained approximately $561,000 from the fraud.

Assaults and Threats Made Against VA Employees

Former St. Louis, Missouri, VAMC Employee Arrested for Interstate Violation of a Protection Order

An OIG investigation resulted in charges that allege the defendant made threats to another VA employee via text message stating that she was going to kill people at the
St. Louis, MO, VAMC. The recipient of the threat subsequently obtained a protection order against the defendant. The investigation revealed that the defendant also later traveled interstate to engage in conduct that was against the protection order.

**Veteran Arrested for Assault of a Stockton, California, VA Community Based Outpatient Clinic Employee**

An OIG investigation resulted in charges that allege the defendant, after being asked to leave the Stockton clinic where he exhibited disruptive behavior, returned with a bicycle chain and lock wrapped around his hand and shoved a clinic employee against a door.

**RECENTLY RELEASED OIG REPORTS**

*Overview of VA Suicide Prevention Efforts and Data Collection* – OIG, at the request of Senator Bill Nelson, conducted a healthcare review to address questions regarding VA suicide prevention efforts and suicide data collection.

*Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System, Tucson, Arizona* – OIG, at the request of Senator John McCain, Senator Jeff Flake, Congresswoman Martha McSally, former Congresswoman Ann Kirkpatrick, and Congressman Raúl M. Grijalva, conducted a healthcare inspection to assess allegations regarding patients’ delayed access to primary care and contaminated reusable medical equipment at the Southern Arizona VA Health Care System (HCS).

*Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VAMC, Tomah, Wisconsin* – OIG, at the request of Senators Tammy Baldwin, Chuck Grassley, and Ron Johnson, and Representatives Ron Kind and Timothy Walz, assessed improper dental infection control practices and administrative action taken by VHA at the Tomah VAMC.

*Alleged Provision of Care, Nursing Supervision, and Scheduling Issues at Community Based Outpatient Clinics at the Amarillo VA HCS, Amarillo, Texas* – OIG, at the request of Congressman Mac Thornberry, conducted a healthcare inspection to assess allegations at the Amarillo VA HCS, Amarillo, TX, concerning provision of care at the Childress, TX, and Clovis, NM, Community Based Outpatient Clinics (CBOC); nursing supervision at the Childress, TX, CBOC; and scheduling issues at the Lubbock, TX, CBOC.

*Inconsistent Transfer Procedures for Urgent Care Clinic Patients with Stroke Symptoms, Manchester VAMC, Manchester, New Hampshire* – OIG, pursuant to a request from Congresswoman Ann McLane Kuster, evaluated stroke care at the Manchester VAMC.

*Review of Alleged Use of Wrong VA Funds To Purchase Information Technology Equipment* – OIG assessed an allegation referred by the former Chairman of the U.S. House of Representatives Committee on Veterans’ Affairs that Veterans Integrated Service Network 23 may have misused medical funding when procuring information technology (IT) equipment and that purchase orders and contracts appeared to bundle IT hardware and software together with medical equipment while being classified exclusively as medical equipment.
Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans HCS, Temple, TX – OIG reviewed an allegation regarding untimely consults at the Central Texas Veterans HCS.

Review of Alleged Continued Misuse of VA Funds To Develop the Health Care Claims Processing System – OIG evaluated two confidential OIG Hotline complaints alleging that the Chief Business Office (CBO) continued to spend approximately $11 million of medical support and compliance appropriations on Health Care Claims Processing System development from August through September 2014, despite being told by OIG during an April 2014 meeting between the OIG, CBO, and Financial Services Center that they should have used the IT Systems appropriation.

Quality of Care and Other Concerns, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois – OIG conducted a healthcare inspection to assess allegations made by confidential complainants regarding quality of care and other concerns at the Captain James A. Lovell Federal Health Care Center.

Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto HCS, Palo Alto, California – OIG conducted a healthcare inspection to assess allegations of delays in patients receiving transcatheter aortic valve replacement procedures due to VHA policy requirements at the VA Palo Alto HCS.

OIG Determination of VHA Occupational Staffing Shortages FY 2017 – OIG conducted its fourth determination of VHA occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014.

Review of Alleged Payment Issues at Kerrville VA Hospital Kerrville, Texas – OIG received a complaint from a veteran alleging that the Peterson Regional Medical Center (PRMC) in Kerrville, TX, canceled his sleep study appointment because VA owed PRMC more than $2 million and that PRMC was no longer accepting VA referrals for non-VA Care as a result.

Audit of Purchase Card Use To Procure Prosthetics – OIG reviewed allegations that VHA inappropriately used Government purchase cards to procure commonly used prosthetics, instead of establishing contracts to leverage VHA’s purchasing power, and failed to ensure fair and reasonable prices.

Administrative Summary – Review of PTSD Consult Management, Battle Creek VAMC, Battle Creek, Michigan – OIG conducted a healthcare inspection to assess allegations made regarding the management of outpatient PTSD consults by the PTSD Clinical Team at the Battle Creek VAMC.

Review of Alleged Adverse Effect on Patient Care Due to Removal of a Computer-Assisted Survey Instrument – OIG reviewed an allegation received in September 2015 that the Office of Information and Technology removed the Prescription Opioid Documentation and Surveillance application from a VA server at the Northern California HCS Pain Management Clinic.
Benefits Inspection Program
In September 2017, OIG published seven Benefits Inspection Program reports containing OIG findings for the VA Regional Offices (VAROs) listed below. The purpose of the Benefits Inspection Program was to ensure the nation’s veterans receive timely and accurate benefits and services. OIG conducted onsite inspections at randomly-selected VAROs to assess their effectiveness. In FY 2017, OIG looked at the following four mission operations for each of the listed VAROs:
(1) Disability Claims Processing
(2) Management Controls
(3) Data Integrity
(4) Public Contact

VAROs
Anchorage, Alaska
Denver, Colorado
Wilmington, Delaware
Detroit, Michigan
St. Louis, Missouri
Winston-Salem, North Carolina
San Juan, Puerto Rico

Clinical Assessment Program Reviews
In September 2017, OIG published three Clinical Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected healthcare 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 ten 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) Diagnostic Care: Point-of-Care Testing;
(9) Mental Health Residential Treatment Program; and
(10) Nurse Staffing.

VA Eastern Colorado Health Care System, Denver, Colorado
Wilmington VAMC, Wilmington, Delaware
ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations concerning high-ranking senior officials and other high-profile matters of interest to Congress and VA. While these reviews and investigations may result in the release 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 leaders of the investigative results.

To view and download these administrative investigation advisories, click on the links below:

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<th>Advisory Number</th>
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<tr>
<td>17-03095-368</td>
<td>Alleged Improper Physician Performance Pay, Veterans Health Administration, Ralph H. Johnson VA Medical Center, Charleston, South Carolina</td>
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AUDIT WORK PRODUCTS

OIG performs audits, evaluations, and reviews to determine the validity of allegations regarding mismanagement, wastefulness, and inefficiency of VA programs and functions. However, when OIG cannot substantiate an allegation or appropriate actions are taken by VA officials during the course of an ongoing project, OIG may issue an audit work product in place of a report.

You may view and download these audit work products by clicking on the links below:
https://www.va.gov/oig/publications/audit-work-products.asp

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<td>17-00000-379</td>
<td>Inspector General Memorandum Concerning Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act</td>
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MICHAEL J. MISSAL
Inspector General