



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

JULY 2019 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies on Whistleblower Issues before the House Veterans' Affairs Subcommittee

Inspector General Missal [testified](#) at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations. The hearing focused on the experiences of whistleblowers in the Department of Veterans Affairs (VA). This hearing was a continuation of a June 25th hearing before the subcommittee. Mr. Missal discussed the OIG's process for handling complaints as well as how the OIG interacts with VA's Office of Accountability and Whistleblower Protection and the U.S. Office of Special Counsel. Mr. Missal reaffirmed the OIG's commitment to treat all complainants with respect, dignity, and confidentiality to the greatest extent possible.

Criminal Investigations Involving Health Care

Two Defendants Arrested for Drug Distribution

A former San Diego, California, VA Medical Center inpatient and his girlfriend were arrested in the Superior Court of California on charges of distribution of a controlled substance. A VA OIG and Drug Enforcement Administration (DEA) investigation resulted in charges alleging that the defendants provided counterfeit fentanyl pills to an inpatient who was subsequently found deceased in his VA domiciliary room.

Three Defendants Arrested for Drug Distribution

Three nonveteran defendants were arrested after being charged in the District of Connecticut with drug distribution. A VA OIG, Federal Bureau of Investigation (FBI), DEA, and local police investigation resulted in charges alleging the defendants are part of a drug trafficking organization responsible for the large-scale distribution of cocaine, heroin, and controlled pharmaceuticals throughout Connecticut, including to veterans at the West Haven, Connecticut, VA Medical Center.

Former Bedford, Massachusetts, VA Medical Center Nursing Assistant Charged with Making False Statements

A VA OIG and FBI investigation resulted in charges alleging that a former Bedford, Massachusetts, VA Medical Center Nursing Assistant made false statements to VA OIG agents when questioned regarding the unattended death of a VA inpatient. When interviewed on two occasions, the defendant told agents that she had conducted assigned hourly checks throughout the night. When confronted with evidence to the contrary, the defendant admitted to lying to the agents and falsifying the hourly checks record to reflect that the checks were conducted.

Former Bath, New York, VA Medical Center Inpatient Charged with Possession of Fentanyl

A veteran was arrested and charged by criminal complaint in the Western District of New York with possession of fentanyl. A VA OIG, VA Police Service, and DEA investigation resulted in charges alleging that while a resident at the Bath, New York, VA Medical Center, the defendant returned to the facility after a weekend trip home in possession of numerous items of contraband, including approximately 20 storage bags of a substance later determined to be fentanyl. Four knives, an unspent round of ammunition, three used hypodermic needles, and a bag of unused needles were also recovered.

Veteran Sentenced for Making Threats against VA Employees and a Congresswoman

A veteran was sentenced in San Mateo Superior Court to 92 months' imprisonment following an investigation that determined the defendant threatened to kill at least five employees at the VA Medical Centers in Palo Alto and San Francisco, California. The defendant also threatened to harm U.S. Congresswoman Jackie Speier, members of her congressional staff, and African Americans at the VA. During one month, the defendant called various VA facilities in the Northern California area more than 600 times and placed many other threatening calls to Congresswoman Speier's office and the San Francisco District Attorney's Office. The investigation was conducted by the VA OIG, VA Police Service, FBI, and San Mateo Police Department.

Criminal Investigations Involving Benefits

Veteran Charged with Theft of Public Money

A veteran was indicted in the District of Kansas for theft of public money. A VA OIG and Social Security Administration (SSA) OIG investigation resulted in charges alleging that the defendant misrepresented symptoms of conversion disorder and choreiform gait disorder to obtain a 100 percent service-connected disability rating, VA Aid and Attendance benefits, and VA Survivors' and Dependents' Educational Assistance. The total estimated loss to the government is over \$567,000. Of this amount, the loss to VA is approximately \$422,600.

Veteran Sentenced for Compensation Benefits Fraud

A veteran was sentenced in the Northern District of California to 37 months' imprisonment following an investigation that revealed the defendant repeatedly submitted false claims and information to VA and other federal agencies. Some of the false claims related to the defendant's military service. Consequently, the defendant was awarded a VA disability rating of 100 percent and medically retired from the Federal Bureau of Prisons at the age of 35. The veteran was ordered to pay approximately \$632,400 in restitution to the government. Of this amount, VA will receive approximately \$249,500. The VA OIG, Department of Justice OIG, Department of Labor OIG, Office of Personnel Management OIG, and SSA OIG conducted the investigation.

Former Fiduciary Pled Guilty to Charge of Misappropriation

A former VA professional fiduciary pled guilty in the Northern District of California to misappropriation by fiduciaries. An OIG investigation revealed that the defendant misappropriated the VA funds of eight severely-disabled beneficiaries to pay for his personal living expenses. The loss to VA is approximately \$84,300.

Criminal Investigations Involving Other Matters

Service-Disabled Veteran-Owned Small Business Agrees to Civil Settlement

An investigation substantiated that a Service-Disabled Veteran-Owned Small Business (SDVOSB) violated the False Claims Act by selling substandard defective products to the United States that were not in compliance with the contractually required national electric code and structural standards. In support of the Veterans Health Administration's (VHA) Continuity of Operations Plan, VA acquired approximately 24 Medical Response Support Units (RSUs) from the SDVOSB for \$1.4 million. VA subsequently awarded an additional \$1.7 million in contractual task orders to the SDVOSB for the maintenance, storage, and transport of the RSUs. During their deployment, VA personnel encountered multiple electrical problems; heating, ventilating, and air conditioning issues; and structural defects which limited the RSUs ability to deploy efficiently and consistently. The investigation was conducted by the VA OIG, Defense Criminal Investigative Service, General Services Administration OIG, and the Army Criminal Investigative Command. As a result of the joint investigation, the SDVOSB entered into a civil settlement with the U.S. Attorney's Office for the Southern District of Georgia in which the company agreed to pay \$2.4 million to settle False Claim Act allegations.

Audits and Reviews

Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement

The OIG audited the Program of Comprehensive Assistance for Family Caregivers to determine whether VHA discharged veterans and their caregivers from the program and subsequently canceled caregiver stipends in a timely manner following a caregiver death or veteran death, incarceration, or hospitalization. The team found VHA acted timely to discharge veterans and caregivers, except in about 6 percent of cases, causing at least \$356,000 in improper and questionable stipends. If controls are not improved, VHA could pay an estimated \$583,000 over five years. The OIG also substantiated that VA improperly paid a caregiver approximately \$71,000 because a caregiver support coordinator did not initiate prompt action to discharge the veteran and cancel the stipend. The OIG recommended establishing regular processes to match enrolled veteran and caregiver records against VA death, incarceration, and hospitalization data; outlining veteran and caregiver responsibilities for death notifications; and clarifying program guidance.

Annual Risk Assessment of VA's Charge Card Program

The OIG conducted an annual risk assessment of VA's charge card program to evaluate the fiscal year 2018 transactions for the three types of charge card business lines—purchase cards (including convenience checks), travel cards, and fleet cards. The OIG determined that the purchase card program remains at medium risk of illegal, improper, or erroneous purchases. Purchase card transaction data mining identified potential misuse of the cards. Also, OIG investigations, audits, and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation and VA policies and procedures. The OIG's assessment also found that VA's Travel Card Program and Fleet Card Program both remain at low risk for illegal, improper, or erroneous purchases, primarily because data mining showed a low percentage of potential duplicate and split purchases.

Management of Major Medical Leases Needs Improvement

The OIG conducted an audit to determine whether VA effectively managed the procurement and awarding of major medical leases under the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). The OIG found that VA major medical leases authorized by VACAA are approximately 22 months behind schedule on average. The OIG recommended VA ensure adequate funds are available for planning activities, reconsider centralizing major medical lease acquisition funding activities, make certain adequate resources are available to deliver leases on schedule, ensure prospectus cost estimates provided to Congress are accurate, establish clear lines of authority for critical lease acquisition decisions, and adhere to appropriate security requirements by performing risk evaluations prior to solicitation. Though VA has taken some steps to improve the major lease acquisition process, several of the recommendations remain unaddressed. Implementing these recommendations should result in faster and more cost-efficient acquisition of major medical leases.

Healthcare Inspections

Follow-Up Review of the Veterans Crisis Line in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas

The OIG conducted a healthcare inspection to assess sustained performance of actions on previous OIG recommendations for the Veterans Crisis Line (VCL). OIG staff followed up on areas of concern identified in two previous OIG VCL reports, published in 2016 and 2017, and found that the VCL sustained actions related to governance structure and oversight, operations, and quality management. For example, the VCL was realigned under the Office of Mental Health and Suicide Prevention, hired a permanent director, and remained under a directive that formalized operations. Further, operations processes were improved, the utilization of backup centers decreased, and backup center oversight also improved. VCL addressed previously identified staffing and training deficiencies and sustained actions related to quality management leadership training, policy, and process concerns. However, during the current review, OIG staff found that the VCL needed to analyze and address issues affecting rescue

efforts and made one new recommendation related to improving the location determination of veteran callers who need rescue.

Episodes of Non-adherence to Privacy and Security Policies at the Tibor Rubin VA Medical Center in Long Beach, California

The OIG conducted an inspection to evaluate possible patient information privacy and security breaches. After a VA computer update, a medical diagnostic device no longer interfaced with VA patients' electronic health records. A facility provider implemented workarounds by using a personal laptop, email and electronic internet storage that was contrary to VA and VHA privacy and security policies. Although the facility mitigated some privacy concerns, the team identified additional issues with staff text messages, unencrypted email, and unapproved device usage. Neither VA or facility policy addressed these issues. Consequently, the inspection team concluded that patients' sensitive personal information was at risk for disclosure to outside sources. Additionally, facility staff used prohibited logbooks to track patient information and test equipment. The OIG made six recommendations related to communication and education, disclosure of protected patient information, VA policy review, and use of logbooks.

Factors Contributing to the Death of a Ventilator-Dependent Patient at the VA San Diego Healthcare System in California

The OIG evaluated factors that may have contributed to the death of a ventilator-dependent patient on the spinal cord injury (SCI) unit at the San Diego Healthcare System and followed up on the facility's response. The OIG determined that the facility did not implement risk mitigation strategies for use of the in-line Passy-Muir® Valve (PMV) on ventilated patients. Specifically, the facility did not have policies outlining the use of the PMV, monitoring and documenting ventilator and alarm settings while using the PMV, or for use of anti-disconnect devices. Staff failed to report ventilator tubing disconnections, and SCI leadership did not follow standard operating procedure for clinical alarm management. The OIG made five recommendations related to policy and training for use of the PMV on the SCI unit and the anti-disconnect device, potential issuance of a National Patient Safety Advisory, training that addresses the reporting of patient safety issues, and reviewing clinical alarms according to facility policies.

Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center

The OIG conducted a healthcare inspection to evaluate concerns related to a VA medical center patient's response to oxycodone (event) and assess management actions taken after the event. Providers ordered oxycodone consistent with manufacturers recommendations; however, the patient experienced symptoms of overdose. After administration of naloxone, the patient's symptoms immediately improved, indicating the patient had a response to the oxycodone. Facility managers did not consider the event for internal quality review or for outside reporting. A clinical disclosure, though warranted, was not documented and the Facility Director did not ensure compliance with the peer review policy. In addition, the Surgical Work Group did not meet monthly and meeting minutes lacked discussion of

required data. The OIG made six recommendations related to resident supervision, reporting adverse drug events, clinical disclosures, peer reviews, and the Surgical Work Group.

Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System in Albuquerque

A healthcare inspection determined that patients' access to outpatient mental health appointments was limited and appointment delays occurred. Contributing factors included underutilization of non-VA and telemental health care, staffing shortages, staff hiring delays, hiring practices, disproportionate care provider productivity, and deficient training and supervision of scheduling staff. The OIG found issues with the facility's no-show policy and staff follow-up with no-show patients. The facility had an incomplete administrative investigative board review/action plan, and some consults were marked complete without documentation that patients were evaluated and/or seen as requested. The OIG made 12 recommendations related to electronic wait lists, outpatient mental health appointments, non-VA and telemental health care, appointment scheduling delays, staff shortages, hiring practices, policy compliance, administrative investigation board review processes, and the consult completion process.

Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System in Florida

The OIG conducted a healthcare inspection to address an alleged inadequate response to a Code Orange and patient safety concerns for a missing patient at the facility. The OIG substantiated the patient went missing from the facility in spring 2018. A staff physician determined the patient's at-risk status and facility staff activated a Code Orange. However, staff misidentified the patient which delayed the search for two hours. The patient was located and returned to the facility five days later. The facility's incident report did not address the misidentified patient, and the fact-finding did not include all staff involved in the event. Staff received training on missing and wandering patients and Code Orange visual aids. Following the event, unit leaders held a staff meeting and daily huddles. The facility also introduced time-out huddles before calling a Code Orange to ensure the correct identity of the patient, and VA police began conducting annual drills. The OIG made three recommendations to address deficiencies.

Alleged Interference and Failure to Comply with the Pain Management Directive and Opioid Safety Initiative at the VA Northern Indiana Health Care System in Fort Wayne

The OIG determined that the Chief of Staff interfered with primary care providers' prescribing practices at the VA Northern Indiana Health Care System. The OIG found that the system did not follow all requirements in VHA's Pain Management directive, had met six of the nine goals in VHA's Opioid Safety Initiative, and not all system providers used the required opioid risk assessment tools for patients on long-term opioid therapy. The OIG made one recommendation to the Veterans Integrated Service Network 10 Director related to the ethics of a system leader interfering with the opioid prescribing practices of primary care providers. The OIG also made 11 recommendations to the System Director related to the Pain Management Committee, pain assessments, annual evaluation of compliance with the Pain Management Strategy, tertiary pain rehabilitation programs, stepped care education and training,

the pain management team, opioid risk assessment tools, veteran requests to change providers, prescription drug monitoring program reports, and opioid and benzodiazepine tapering protocols.

Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center in Augusta, Georgia

A healthcare inspection was conducted to assess allegations of multiple quality of care and leaders' failures at the Charlie Norwood VA Medical Center. Many of the allegations were largely unfounded; however, the OIG identified several concerns including clinical staff members who did not feel supported by the leadership team. Poor nursing morale was attributed to inadequate nurse staffing levels and accountability. Communication and understanding of certain facility policies was inadequate. Deficits were identified related to nurse competency assessments and the facility's response to a 2018 sentinel event. The OIG-identified security lapses, unavailability of some laboratory services, and unclear patient transfer policies potentially placed emergency department patients at risk. Also, communication related to a connecting bridge between the facility and an adjacent healthcare institution was a confusing and contentious problem for staff. The OIG made 27 recommendations involving communication, hiring processes, nurse staffing and competencies, policy development and communication, provider privileges, and emergency department security.

Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility

The OIG conducted an inspection at a Veterans Integrated Service Network 4 medical facility to assess the discharge of a patient from an inpatient mental health unit and the subsequent transfer to a federal detention center where the patient died eight days in a manner the associate medical examiner identified as natural. The OIG substantiated that facility staff failed to engage in proper treatment and discharge planning processes. Specifically, concerns identified by the inspection team included the facility staff's discharge planning, compliance with voluntary and involuntary admission policies, use of available guidance regarding the patient's legal and psychiatric status, and patient record flag management. The OIG made 10 recommendations to the VISN and Facility Directors regarding inclusion of family in mental health treatment and discharge planning, assessment of decision-making capacity and voluntary admission status, documentation of a patient's surrogate, complete diagnostic summaries to receiving providers, assignment of a mental health treatment coordinator, release of information processes, voluntary and involuntary admission processes, and access to consultative resources.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews 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 reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

- (1) Leadership and Organizational Risks;

- (2) Quality, Safety, and Value;
- (3) Credentialing and Privileging;
- (4) Environment of Care;
- (5) Medication Management;
- (6) Mental Health Care;
- (7) Geriatric Care;
- (8) Women's Health; and
- (9) High-Risk Processes.

Cheyenne VA Medical Center, Cheyenne, Wyoming

Amarillo VA Health Care System, Amarillo, Texas

James H. Quillen VA Medical Center, Mountain Home, Tennessee

To listen to the podcast on the OIG's July 2019 activity highlights, go to www.va.gov/oig/podcasts.