AUGUST 2019 HIGHLIGHTS

Criminal Investigations Involving Health Care

Former Fayetteville, Arkansas, VA Medical Center Chief of Pathology Indicted for Involuntary Manslaughter

A former Chief of Pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was indicted in the Western District of Arkansas on 31 counts including involuntary manslaughter, wire fraud, mail fraud, and making false statements pertaining to healthcare matters. A VA OIG investigation resulted in charges alleging that the defendant misdiagnosed thousands of VA patients while under the influence of a substance that provides the effects of alcohol but is not tested for during conventional drug and alcohol testing. The indictment also alleged that the defendant circumvented contractually-obligated drug and alcohol testing.

Individual Pled Guilty to Paying an Illegal Gratuity to a Public Official

An investigation by the VA OIG, the Federal Bureau of Investigation (FBI), and the Internal Revenue Service Criminal Investigation revealed that from December 2017 through June 2018, an individual provided 18 payments to a Veterans Health Administration (VHA) Office of Community Care employee totaling more than $1 million. The payments were made in exchange for the VA employee referring the caregivers of seven Spina Bifida beneficiaries to use the defendant's home health agency, which in turn billed VA for more than $3 million in ineligible home health services. The defendant pled guilty in the District of Colorado to paying an illegal gratuity to a public official and charges against the VA employee are still pending.

Former Bedford, Massachusetts, VA Medical Center Nursing Assistant Pled Guilty to Making False Statements

A VA OIG and FBI investigation found that a former VA medical center nursing assistant in Bedford, Massachusetts, 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 her assigned hourly checks throughout the night. When confronted with evidence indicating the checks were not conducted, the defendant admitted to lying to the agents and falsifying the hourly checks record.

Veteran Sentenced for Possession of Child Pornography

A VA OIG investigation revealed that a veteran collected images of child pornography on two separate computers issued by a Cleveland, Ohio, VA medical center. The defendant was sentenced in the Southern District of West Virginia to 18 months' imprisonment and five years' supervised release. Upon release from prison, the defendant will be required to register as a sex offender.

Veteran Sentenced for Making Threat Against the Mount Vernon, Missouri, VA Community-Based Outpatient Clinic

A veteran was sentenced in the Western District of Missouri to 12 months' imprisonment and three years' supervised release following a VA OIG and FBI investigation that revealed the defendant made at least one threat by telephone to "blow up" the Mount Vernon, Missouri, VA Community Based Outpatient Clinic, resulting in the evacuation and closure of the clinic.

Criminal Investigations Involving Benefits

Trucking School Owner Pled Guilty to Wire Fraud

A joint VA OIG, FBI, and Department of Justice OIG investigation revealed that a trucking school owner, school employees, and veteran students conspired to, or had knowledge of, a scheme to fraudulently enroll veterans at the trucking school from 2011 to 2015. Subsequently, the trucking school owner pled guilty in the Central District of California to wire fraud. The loss to VA is approximately $4.2 million.

Veteran Indicted for Theft of Government Funds

A VA OIG investigation resulted in charges alleging that a veteran provided false statements to VA regarding his lack of use of an arm and a leg, which resulted in increased VA compensation benefits of nearly $8,000 per month. The defendant was arrested following an indictment in the Western District of North Carolina for theft of government funds. The loss to VA is approximately $1.3 million.

Veteran and Spouse Charged in Alleged Fraud Scheme

A veteran and his wife were charged with allegations they sold non-FDA-approved cancer medication while in receipt of VA Individual Unemployability benefits and Social Security Administration (SSA) disability benefits. In addition, the veteran and his wife applied for and received a small business loan and assistance from the Federal Emergency Management Agency after Hurricane Maria. The defendants were arrested after being indicted in the District of Puerto Rico for theft of government funds, false statements, and healthcare fraud. The total loss to the government is over $730,000 and, of this amount, the loss to VA is just over $140,000. The investigation was conducted by the VA OIG, SSA OIG, Food and Drug Administration (FDA) Office of Criminal Investigations, Small Business Administration (SBA) OIG, Department of Health and Human Services OIG, and Department of Homeland Security OIG.

Criminal Investigations Involving Other Matters

Construction Company and Owner Agree to Civil Settlement

A VA OIG investigation revealed that a large construction company controlled a service-disabled veteran-owned small business (SDVOSB) joint venture that fraudulently obtained $11.9 million in set-

aside contracts awarded by VA and the Army Corps of Engineers for VA projects. The construction company and its nonveteran owner entered into a civil settlement with the U.S. Attorney's Office for the Southern District of California under which the company agreed to pay nearly $3.3 million dollars to settle a False Claims Act complaint. The company and the owner were also separately sentenced in the Southern District of California. The owner was sentenced to 18 months' imprisonment and the company was sentenced to pay over $330,000 in forfeiture.

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

A former SDVOSB construction company officer was accused of allegedly creating the company to act as a pass through for a non-SDVOSB company so that it could qualify for, and bid on, set-aside contracts. The former officer entered into a civil settlement with the U.S. Attorney's Office for the District of New Jersey under which the individual agreed to pay $2.4 million to the government to resolve the allegations. This settlement is the result of a VA OIG and SBA OIG investigation involving numerous construction contracts at VA facilities in New Jersey and New York. The total value of these VA contracts is approximately $58 million.

Former Temple, Texas, VA Medical Center Maintenance and Operations Supervisor Sentenced in Theft Scheme

A VA OIG investigation revealed that the former VA Maintenance and Operations supervisor, his wife, and a third-party vendor used the wife's company to steal funds from VA. The former supervisor and his wife provided the third-party vendor with fraudulent invoices from her company for services that were not actually provided to the vendor. The vendor paid the former supervisor, and then fabricated his own set of invoices used to bill VA for goods and services that were never provided. The amount of these invoices equaled the amount the vendor paid to the former supervisor plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The defendant was sentenced in the Western District of Texas to 12 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $715,000. The loss to VA is approximately $1.1 million.

Medical Supply Company Agrees to Civil Settlement

An investigation by the VA OIG, Defense Criminal Investigative Service, and Army Criminal Investigation Command substantiated that between December 2011 and March 2015, a medical supply company violated the False Claims Act by selling products not in compliance with the Trade Agreements Act to the Department of Defense and VA. The company was manufacturing products in China and Malaysia that were then sold to U.S. government agencies in violation of the Act. As a result, the supply company entered into a civil settlement in the Eastern District of Pennsylvania under which it agreed to pay $3.3 million to resolve the allegations. VA will receive more than $300,000 as part of the settlement.

Audits and Reviews

Non-VA Emergency Care Claims Inappropriately Denied and Rejected

In response to a congressional request, the OIG conducted this audit to determine whether processors of non-VA emergency care claims inappropriately denied or rejected them, and, if so, whether the cause was pressure to meet production standards. The OIG reviewed sampled claims for non-VA emergency care and found 31 percent of denied or rejected emergency care claims—with an estimated billed amount of $716 million—were inappropriately processed from April 1 through September 30, 2017, potentially creating undue financial risk to an estimated 60,800 veterans. The OIG also found some of those denied and rejected claims should have been approved. The OIG concluded there was a significant risk that some errors resulted from pressure to meet production targets, insufficient quality assurance of claims processing accuracy, and incentives associated with meeting production targets.

Health Information Management Medical Documentation Backlog

The OIG conducted this audit to determine if VHA medical facilities accurately and promptly scan and enter medical documents into patients' records. The OIG found that limited monitoring and oversight of scanning activities created backlogs that put the continuity of patient care at risk. The audit team calculated that VHA medical facilities had a cumulative backlog of approximately 5.15 miles of stacked paper compiled of at least 597,000 individual electronic files dating back to October 2016. This occurred in part because staff did not promptly scan documents and enter them into the electronic medical records and did not always perform appropriate reviews to ensure the quality and legibility of scanned documents. The OIG also found staffing shortages contributed to the backlogs.

VA's Implementation of the Veterans Information Systems and Technology Architecture Scheduling Enhancement Project Near Completion

This audit examined whether the Office of Information and Technology and VHA effectively managed the implementation of VA's Veterans Information Systems and Technology Architecture (VistA) Scheduling Enhancement (VSE) project. VSE was intended to be an interim solution to VA's outdated medical appointment scheduling system. The OIG found the VSE management team did not ensure scheduling enhancements were adequately developed and met users' needs. VA has since decided to use a standalone scheduling component within the electronic health records system being developed by the Cerner Corporation as a permanent solution. According to a December 2018 report to Congress, the first standalone scheduling component is planned for deployment in 2020.

Healthcare Inspections

Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida

The OIG conducted this healthcare inspection in response to House Veterans Affairs Committee Chairman Mark Takano's request to review the circumstances of a patient's death by suicide. The OIG team found the patient received reasonable care during admission. However, the facility failed to abate identified safety hazards on the unit. Patient safety cameras on the unit were nonoperational and the 15-minute patient safety rounds policy failed to provide clear guidance and expectations for staff. The facility did not meet VHA requirements for staffing an Interdisciplinary Safety Inspection Team or training staff. The OIG found inadequate oversight by both the VHA Mental Health Environment of Care Checklist (MHEOCC) Work Group and Veterans Integrated Service Network 8. Facility leaders also lacked awareness of patient safety requirements regarding the mental health unit.

Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi

The OIG assessed an allegation that a thoracic surgeon provided poor quality of care to five patients. The surgeon no longer worked in the health care system. The facility had validated quality of care concerns for two of five patients and took appropriate action. Prior to hiring the surgeon, facility leaders were aware of licensure and malpractice issues, including the relinquishing of a state medical license. The OIG found that facility leaders were deficient in granting and continuing the surgeon's clinical privileges and made errors during the surgeon's removal process that prevented reporting to the National Practitioner Data Bank and delayed reporting to state licensing boards.

Pathology Processing Delays at the Memphis VA Medical Center in Tennessee

The OIG evaluated allegations that surgical pathology specimen processing delays in the pathology and laboratory medicine service (P&LMS) resulted in harm and possibly death to multiple patients. The OIG found that none of the reviewed patients with delays experienced adverse clinical outcomes and that turnaround times improved for surgical pathology specimens processed onsite. However, P&LMS quality management program action plans were not fully implemented. Also, approximately 39 percent of P&LMS positions were vacant and pathologist staff shortages contributed to inconsistent surgical pathology quality assurance and prolonged specimen turnaround times. In addition, the OIG found deficiencies in P&LMS staff initial training and annual competency documentation. Facility leaders did not conceal deficiencies but submitted a delayed and incomplete issue brief to Veterans Integrated Service Network leaders.

Alleged Delay in Surgical Care, Lack of Resident Oversight, and Improper Physician Pay at Edward Hines, Jr. VA Hospital in Hines, Illinois

Allegations were made of a delay in surgical care, lack of resident oversight, and improper physician pay. The OIG substantiated a delay of approximately three hours occurred in performing an appendectomy. However, the patient received appropriate preoperative care, and there was no evidence of an adverse outcome related to the delay. The delay was due to another patient requiring surgery more urgently and poor communication. The facility's practice for scheduling surgeries did not address communication among key staff. The OIG did not substantiate the appendectomy was delayed because of inadequate resident oversight. As to physician pay, because of a lack of a verification process to determine if surgeons' timecards matched actual hours worked, it could not be determined if surgeons were unavailable or working at other institutions while being paid by VA.

Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System in California

A healthcare inspection was conducted to determine if staff failed to provide mental health care to a patient who sought care and subsequently died by suicide. The OIG did not substantiate that the system failed to provide mental health care when the patient sought help. The OIG found that the suicide risk assessment of the patient was adequate and complied with requirements. The system also complied with resident supervision policies. However, the OIG team identified (1) deficits in the decision-making process to deactivate the patient's High Risk for Suicide Patient Record Flag and (2) VHA did not clearly delineate flag deactivation requirements. Deficiencies in the medication-reconciliation process were also found.

Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

This healthcare inspection evaluated the care of a patient who died in a behavioral health unit. The OIG team found that the unit's registered nurses (RNs) did not fulfill their position responsibilities or ensure accurate record documentation. Also, unit staff did not initiate appropriate resuscitation efforts after finding the patient unresponsive, but the OIG was unable to determine whether initiating full resuscitation efforts would have been successful if employed at the time the patient was found unresponsive. The OIG also found an RN inappropriately determined the patient's death; there was inconsistent tracking of RN basic life support training; emergency department providers did not document handoff to the admitting behavioral health provider; and an emergency cart was unlocked and contained an expired item. The OIG also found that staff did not document resuscitation measures on required forms and the designated committee did not review the event.

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) Quality, safety, and value;
(2) Medical staff privileging;
(3) Environment of care;
(4) Medication management;
(5) Mental health;
(6) Geriatric care;
(7) Women's health; and
(8) High-risk processes.

There was one CHIP report published in August:

Central California VA Health Care System, Fresno, California

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