Congressional Testimony

**Assistant Inspector General for Healthcare Inspection Testifies before the House Veterans’ Affairs’ Subcommittee on Oversight and Investigations**

Dr. David Daigh, Assistant Inspector General for Healthcare Inspections, testified before the House Committee on Veterans’ Affairs’ (HVAC) Subcommittee on Oversight and Investigations on September 5, 2018. The hearing focused on reusable medical equipment sterilization issues. Dr. Daigh discussed how important close oversight of nonclinical services is to quality and safe patient care as reported in the Office of Inspector General’s (OIG) March 2018 report, *Critical Deficiencies at the Washington, DC VA Medical Center.*

Criminal Investigations for Health Care

**Business Owner Pled Guilty to Conspiracy to Commit Wire Fraud**

An individual pled guilty to conspiracy to commit wire fraud related to her co-ownership of a company providing services to the Houston, Texas, VA Medical Center (VAMC) Prosthetics Department. Her co-conspirator, a VA Prosthetics Representative, was previously charged with conspiracy, wire fraud, and theft of government property and is awaiting trial. An OIG investigation resulted in charges that allege from January 2011 through December 2014, the defendants conspired to bill VA for false and fraudulent claims for services and then split the proceeds. The overall loss to VA is approximately $499,000.

**Two Individuals Arrested for Distribution of Narcotics at San Diego, California, VA Medical Center**

A San Diego, California, VAMC employee and a contractor were arrested for the distribution of narcotics at the facility. A VA OIG, Drug Enforcement Administration, and VA Police Service investigation resulted in charges that allege the defendants, working separately, sold methamphetamines and cocaine on and off the facility’s grounds to VAMC employees.

**Former Gainesville, Florida, VA Medical Center Nurse Manager Sentenced for Drug Diversion**

A former Gainesville, Florida, VAMC nurse manager was sentenced to 12 months’ probation. An OIG investigation revealed that the defendant diverted oxycodone and hydromorphone for personal use and consumed the controlled substances up to four times per shift while on duty at the facility. The defendant admitted to diverting the controlled substances and subsequently resigned.

**Veteran Arrested for Making Threats at Wilmington, Delaware, VA Medical Center**

A veteran was arrested on charges of threatening to assault a VA employee. An OIG investigation resulted in charges alleging the defendant gained access to the executive area of the Wilmington,
Delaware, VAMC while in possession of an axe and two knives. Upon subsequent medical evaluation at the VAMC, the defendant became violent and threatened VA personnel.

Criminal Investigations for Benefits

**Veteran Sentenced for Wire Fraud**
A veteran who previously pled guilty to wire fraud was sentenced to 36 months’ imprisonment, 24 months’ probation, and 200 hours of community service and was ordered to pay restitution of $362,933 to VA. An OIG investigation revealed that the defendant received a special monthly pension for the loss of use of both of his legs. During this investigation, the defendant was audibly and visually recorded in a wheelchair telling a VA examiner that he had not been able to walk in 10 years. The investigation revealed the defendant, a street gang member, showed no signs of disability and had numerous arrests in Chicago during the time frame in which he claimed to be unable to walk. Video surveillance evidence was obtained showing the defendant walking with no apparent difficulty.

**Commercial Airline Pilots Indicted for False Statements**
Two commercial airline pilots were indicted for making material false statements on their federal airman applications to the Federal Aviation Administration (FAA). Proactive investigations by VA OIG and the Department of Transportation OIG resulted in charges that allege the defendants provided conflicting information by failing to report to the FAA certain significant medical conditions that were previously reported to VA medical examiners in support of their service-connected disability claims. The potential loss to VA is $154,000 for one pilot and $118,000 for the other pilot.

**Nonveteran Pled Guilty to Theft of Government Property**
A nonveteran pled guilty to stealing VA Dependency and Indemnity Compensation benefits, which were intended for the widow of a veteran. An OIG investigation revealed that although the widow of the veteran died in June 2004, VA continued to directly deposit monthly benefits into her bank account until February 2015. The defendant admitted during an interview with OIG agents that after the widow’s death, he used her benefits to fund renovations on a now defunct restaurant that he owned. Bank records confirmed the defendant’s statements and revealed that he also used the money for vacations, luxury vehicle repairs, and other personal expenses. The total loss to VA is $145,000.

**Two Individuals Pled Guilty in Compensation Benefits and Caregiver Support Scheme**
A nonveteran and his veteran brother, a former Miami, Florida, VA Healthcare System (VA HCS) police officer and Department of Health and Human Services (HHS) OIG special agent, pled guilty to conspiracy and theft of government funds. An OIG investigation revealed that while he was employed as a special agent with HHS OIG, the veteran made false statements and provided forged medical records to the Veterans Benefits Administration (VBA) and Miami, Florida, VA HCS. As a result, the veteran obtained increased VA disability benefits. The nonveteran also received VA Caregiver Support stipends because he was named as his brother’s caregiver. The loss to VA is $116,500.
Criminal Investigations for Other Matters

Two Former Government Contractors Agree to Forfeit Approximately $2.1 Million for Roles in Procurement Fraud Scheme

Two former government contractors agreed to forfeit $2.1 million following a civil complaint that found a nonservice-disabled veteran (non-SDV) illegally managed and controlled a service-disabled veteran-owned small business (SDVOSB) construction company based in Kansas City, Missouri. The non-SDV was previously sentenced for his role in this 'Rent-A-Vet' scheme to fraudulently obtain more than $13.8 million in federal contracts, including $13.7 million in VA contracts, for work in nine states. An OIG-led investigation with assistance from the General Services Administration OIG revealed that this defendant used a veteran's SDV status to create a “pass-through” company for the purpose of obtaining 20 set-aside SDVOSB and veteran-owned small businesses (VOSBs) contracts. The work was then subcontracted to the defendant's non-SDVOSB company, which he owned. Sentencing is still pending for the veteran.

Parking Services Company Owner Sentenced for Wire Fraud and Conspiracy to Commit Wire Fraud and Major Fraud Against the United States

The owner of a parking services company was sentenced to 70 months’ imprisonment, three years’ supervised release, and ordered to pay restitution of over $12.5 million to the VA. An investigation by the VA OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service Criminal Investigation (IRS-CI) revealed that the defendant bribed a VA contracting officer with over $286,000 in cash in order to defraud VA of over $13 million between 2003 and 2017. The defendant had entered into a sharing agreement with VA that required the defendant to pay 60 percent of the collected gross parking revenue to VA. The defendant instead paid bribes to the contracting officer in order to continue the conspiracy even after the contracting officer retired from VA in 2014. The defendant also underreported income and overreported improvements to VA, which allowed him to keep over $13 million that was owed to VA.

Owner of a Massage and Digital Media School Pled Guilty to Bribery

The owner of a massage and digital media school approved for VA benefits under the Vocational Rehabilitation and Employment (VR&E) program pled guilty to bribery. An OIG and FBI investigation revealed that a VR&E counselor approached the defendant to propose that she open a school that would be approved by VA under the VR&E program. The VR&E counselor then steered veterans to the defendant’s school and two other educational institutions approved to receive benefits under the program. The defendant obtained VR&E benefits by providing 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. The investigation revealed that enrolled veterans rarely, if ever, received instruction from school employees. In addition, the defendant made kickback payments to the VR&E counselor. The loss to VA is over $3 million.
Former Non-Profit Organization Executive Pled Guilty to Felony Scheme
A former non-profit organization executive pled guilty to misprision of felony. A VA OIG, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Department of Labor OIG, IRS-CI, FBI, HHS OIG, and Medicaid Fraud Control Unit of the Missouri Attorney General’s Office investigation revealed the defendant unjustly enriched himself and others through a non-profit organization, which was contracted by VA to provide substance abuse counseling and housing for veterans. The defendant admitted that he knew executives conspired to embezzle, steal, and misapply millions of dollars in charity funds but did not inform the charity’s board of directors or report it to the appropriate authorities. The defendant aided the conspirators in the preparation and submission of federal grant applications, which falsely certified the charity’s compliance with restrictions on lobbying. The defendant acknowledged that he embezzled, stole, and misapplied funds totaling $4.3 million. From 2010 to 2016, the non-profit organization had revenues of approximately $837 million, to include over $1.7 million contributed by VA.

VISN 19 Contracting Office Small Business Liaison and Two Accomplices Indicted in Bribery Scheme
A small business liaison working in the Veterans Integrated Service Network 19 Contracting Office in Denver, Colorado, and two associates were indicted and arrested on charges that included conspiracy to commit bribery, receipt of a bribe, payment of a bribe, attempted extortion, and criminal conflict of interest. A VA OIG, FBI, and Small Business Administration OIG investigation found the VA employee, whose job was to find VOSBs to compete for VA contracts, had a side business providing paid training and consulting services to eligible VOSBs but did not report the relationships on his annual ethics/financial disclosure forms. The VA employee also conspired with two associates to solicit bribes from eligible VOSBs, which the associates received and then provided a kick-back to the employee. An undercover FBI agent paid $10,000 to the conspirators to manipulate the VA contract bidding process, of which $2,500 was kicked back to the VA employee.

Administrative Investigation
Alleged Misuse of Government-Owned Vehicles within the Long Island and Calverton National Cemeteries in New York
The OIG investigated an allegation that the Executive Director of the Florida National Cemetery improperly stored his personal vehicle in a garage on Long Island National Cemetery property after he transferred to Florida and asked subordinates to drive him in government vehicles to and from his residence on the Long Island National Cemetery property to the airport. The Executive Director of the Calverton National Cemetery also allegedly asked subordinates to drive him in government vehicles to and from his residence and the airport. Additionally, two employees allegedly misused VA resources by taking two government vehicles from New York to training in Virginia and one extended his travel to
sightsee with his spouse. The OIG did not substantiate any of these allegations, so no recommendations were issued.

Audits and Reviews

**Timeliness of Final Competency Determinations**

The OIG reviewed VA’s Fiduciary Program to determine whether VBA finalized proposed incompetency determinations in a timely manner. The OIG found delays in final competency determinations completed from March 1 through August 31, 2017. Delays can result in incompetent beneficiaries receiving ongoing benefits payments without the protection of a VA-appointed fiduciary. The OIG estimated 13,600 unprotected beneficiaries received $62.4 million in ongoing benefits. Delays can also result in beneficiaries waiting longer for withheld retroactive benefits. The OIG estimated 12,400 beneficiaries had approximately $77.5 million in retroactive benefits payments withheld. The OIG made six recommendations related to entering cases into the Beneficiary Fiduciary Field System, reminding VBA staff to notify Fiduciary Hubs when waivers are received, ensuring Fiduciary Hubs have access to documents in the Legacy Content Manager, prioritizing cases, meeting VBA’s timeliness standards, and distributing cases according to policy.

**VA’s Management of Land Use Under the West Los Angeles Leasing Act of 2016**

The OIG conducted this audit to determine if VA is complying with the *West Los Angeles Leasing Act of 2016*, P.L. 114-226. The OIG assessed whether leases and other land use agreements complied with the Act, adhered with other federal laws, were veteran-focused, and managed effectively. The OIG reviewed 40 land use agreements and determined that 11 did not comply with the Act, other applicable laws, or the draft master plan, which was developed to assist VA in revitalizing the West LA campus to become veteran-focused. Fourteen non-VA entities were also operating with an expired or no documented agreement. The OIG found veteran input on land use was insufficient, policies governing “out leases” and revocable licenses lacked clarity, and capital asset inventory records were incomplete. The OIG recommended VA implement a plan that puts the West Los Angeles campus in compliance. VA should also obtain input from the veteran community advisory board on campus land use, update land use policies, and ensure the capital asset inventory reflects all agreements.

**Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina**

The OIG conducted this audit to determine whether community care providers associated with the Fayetteville, North Carolina, VAMC stopped accepting Non-VA Care and Veterans Choice Program authorizations. In July 2017, the OIG received an allegation that two orthopedic providers stopped accepting VA patients because claim payments were not timely. The OIG substantiated that at least 15 community providers stopped accepting VA patients from January 2015 through July 2017, primarily because claims were not paid in a timely manner and there was difficulty resolving unpaid claims. Having fewer community providers available affected the ability to schedule patients for dermatology,
neurosurgery, orthopedic, and urology services in the community. Also, VA paid about $156,000 in interest on delayed payments. If additional providers stop accepting VA patients, there is a risk of increased wait times and travel. The OIG made six recommendations to improve oversight of claims processing timeliness and monitoring of community provider participation.

Leasing Procedures Used to Acquire VA’s Wilmington Health Care Center

The OIG reviewed the Wilmington Health Care Center in North Carolina in response to a request from Congressman Walter B. Jones, who asked the OIG to determine whether selecting the Wilmington airport site for the Center was in the best interest of taxpayers and if VA officials used appropriate procedures during the selection and award process. The OIG determined that the selection of the Wilmington airport site was not in the taxpayers’ best interest. VA will pay $2.3 million more than fair market rent over the 20-year lease. This occurred because Construction and Facilities Management (CFM) leadership lacked oversight. CFM has since implemented policies and procedures negating the need for most recommendations. The OIG did recommend that the CFM establish a formal policy for transferring contract files. Because CFM was unable to provide information on all offers, the OIG could not determine whether CFM used appropriate selection and award procedures.

Review of Accuracy of Reported Pending Disability Claims Backlog Statistics

The OIG reviewed VBA’s statistics related to pending disability claims to determine if it accurately reported its backlog of rating claims pending for more than 125 days. Although VBA reported it had reduced its claims backlog from a peak of 611,000 in March 2013 to 70,537 at the end of May 2018, the OIG found that VBA’s reported backlog included only about 79 percent of all claims that were awaiting rating decisions for more than 125 days. The OIG found that what the backlog represented was not always clearly defined because VA reported four differently-worded definitions for the backlog. Also, VBA’s prioritization of its backlog sometimes delayed processing other claims. Finally, inaccurate claims impaired VBA’s ability to manage its workload. The OIG recommended that VBA reconsider which claims are reported in the disability claims backlog and provide a clear definition. Also, the OIG recommended VBA implement a plan to provide consistent oversight and training of claims assistants.

VA Policy for Administering Traumatic Brain Injury Examinations

The OIG conducted this review at the request of the HVAC Subcommittee on Disability Assistance and Memorial Affairs. The Subcommittee asked the OIG to respond to questions related to VA policies that specify the qualifications of medical professionals who conduct traumatic brain injury (TBI) medical examinations. In 2008, VA revised the criteria used to evaluate TBI. However, VA failed to implement procedures then to ensure veterans received adequate initial TBI medical examinations. Subsequent VBA and Veterans Health Administration (VHA) policies regarding initial TBI medical examinations were not consistent. Between September 2007 and July 2015, VBA updated its policy relating to TBI medical examinations five times while VHA changed its policies four times. The OIG recommended that VBA coordinate with VHA to determine whether any qualified veterans were excluded from equitable relief and whether there are other veterans entitled to consideration for equitable relief.
Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts

The OIG audited VHA’s Office of Community Care (OCC) to determine the accuracy of bulk payments made to third party administrators (TPAs) under contracts that include care provided through the Veterans Choice Program. The Choice Program allows veterans to obtain care within their community and is administered under contracts with two TPAs, Health Net Federal Services and TriWest Healthcare Alliance Corporation. The TPAs perform a variety of administrative services, including paying claims from healthcare providers. In 2016, the OCC implemented a method to process healthcare claim payments to TPAs on an aggregated basis, referred to as bulk payments. This process did not have effective internal controls in place to detect improper claims. The OIG found $66.1 million in duplicate payments and $35.3 million in three other payment error types, for a total of $101.4 million in estimated overpayments to the TPAs. The OIG recommended that VHA continue to support processes to prevent duplicate payments, ensure that controls are in place to prevent duplicate payments to TPAs, and work with the Office of General Counsel to determine a process for reimbursement of overpayments by TPAs.

National Healthcare Review

Review of Pain Management Services in Veterans Health Administration Facilities

A number of members of Congress asked the OIG to assess pain management practices, including opioid prescribing and the treatment of substance abuse at VHA medical facilities. Of the more than 5.7 million VA patients (non-hospice/palliative care) with at least one clinical encounter in FY 2015, the OIG found that 16.7 percent were dispensed opioids. Of these, 93.9 percent had diagnoses of pain or mental health issues and 56.7 percent had both. Higher-risk groups included veterans on opioid doses greater than 200 morphine equivalents per day or both opioids and benzodiazepines. The OIG made 10 recommendations to the VHA Executive in Charge related to state prescription drug monitoring programs, the number of patients on chronic opioid therapy on a primary care provider’s panel, pain management specialists, pain assessment tools, complementary and integrative health services, urine drug testing, concurrent use of benzodiazepines and opioids, and medication reconciliation.

Healthcare Inspections

Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware

The OIG evaluated allegations regarding the care of two patients in the Hemodialysis Unit at the Wilmington, Delaware, VAMC. Although the OIG was unable to substantiate that care received in the dialysis unit contributed to the first patient’s death, the OIG identified quality of care issues related to ordering and monitoring blood glucose levels and administration of non-scheduled medications. Seventeen hours after the dialysis treatment, the patient was found deceased in his/her car in the facility parking lot. The VA police actions were found to be inconsistent with requirements that may have
facilitated detecting the patient in a visible, illegally parked vehicle. The OIG substantiated that staff initiated cardiopulmonary resuscitation on a second patient. The patient recovered, but the OIG identified concerns related to the emergency response. The VA concurred with OIG’s 14 recommendations related to policy and processes, verbal medication orders, code blue documentation and reporting, and police policy.

**Quality of Care Concerns Regarding a Patient Who had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan**

A healthcare inspection was conducted to assess the care of a patient who underwent cardiac surgery at the VA Ann Arbor HCS. The OIG was unable to substantiate that the patient received inappropriate care during surgery that ultimately led to his/her death because there was a lack of evidence as to how or when a cardiopulmonary bypass catheter, inserted to divert blood flow from the heart, became misplaced. The OIG did not substantiate that the patient was abandoned by the anesthesiologist during surgery. The OIG determined the facility did not complete all required quality management processes and did not evaluate the success of the modifications that the surgeon and anesthesiologist made in their practices after the patient’s surgery. The OIG made two recommendations related to the facility’s compliance with quality management requirements and a review of modifications made by the anesthesiologist and surgeon in their cardiac surgery practices.

**Review of Mental Health Care Provided Prior to a Veteran’s Death by Suicide, Minneapolis VA Health Care System, Minnesota**

In response to a request from Representative Tim Walz the OIG reviewed the care of a patient who died from a self-inflicted gunshot wound less than 24 hours after discharge from the inpatient mental health unit of the Minneapolis VA HCS. The OIG determined the inpatient treatment team failed to collaborate with outpatient providers, facilitate outpatient medication management, and educate the patient about limiting firearms access. The Suicide Prevention Coordinator did not collaborate with the treatment team, determine the need for a Patient Record Flag prior to discharge, or provide required training. The Coordinator also did not complete Behavioral Health Autopsies within required time frames. Among additional deficits, the HCS did not comply with policy for conducting a root cause analysis. Although the OIG did not determine that identified deficits caused the patient’s suicide, it made seven recommendations related to improving care coordination, documentation, training, and administrative processes.

**Alleged Inadequate Mental Health Treatment at the Dayton VA Medical Center, Ohio**

The OIG conducted an inspection regarding the health care of a resident who died approximately 36 hours after admission to the Dayton VAMC’s Mental Health Residential Rehabilitation Treatment Program (MHRRT). The OIG did not substantiate that staff failed to treat the resident or assign a counselor. However, one clinical opioid withdrawal symptom scale was not performed, counseling staff did not meet with the resident on admission, and the resident did not receive a therapeutic activity schedule. The OIG was unable to substantiate that the resident died by a suicidal act because there were
no suicide indicators and the resident’s intentions were unknown. The OIG also found that residents did not receive privileging levels program information at admission and that this program may not have been congruent with MHRRTP goals. The OIG made three recommendations related to clinical opioid withdrawal scales, timely therapeutic activity schedules, and the residents’ privileging levels program.

**Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky**

The OIG assessed concerns that a primary care provider at the Berea, Kentucky, Community Based Outpatient Clinic falsely documented patients’ blood pressure readings. The provider documented repeat readings of 128/78 in 99.5 percent of the 1,370 primary care encounters reviewed. In a subset of high-risk patients, the provider’s inadequate treatment of hypertension placed patients at risk for adverse clinical outcomes, including death. The OIG concluded that the provider’s falsification of blood pressure readings was most likely due to the provider’s attempt to reduce workload (as additional follow-up is required for higher readings). The OIG noted inadequate performance measure data validation processes, improper blood pressure rechecks documentation by a licensed practical nurse, and a likelihood that the provider and nurse knew about each other’s deficient practices but did not take action. Facility leaders took prompt steps to evaluate the provider’s actions and mitigate risk to patients. The OIG made seven recommendations related to administrative actions, patient follow-up, data integrity, policies and procedures, and training.

**Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center, New York**

The OIG substantiated that a patient fell and required hip fracture repair surgery but did not substantiate the fall was caused by deficient fall precautions or that the patient’s death was caused by abuse or neglect. Although the OIG substantiated the patient did not receive all required anticoagulation medication doses, the OIG did not substantiate the missing doses contributed to the patient’s death. The OIG was unable to substantiate that the patient did not receive one-to-one observation because of conflicting evidence. The OIG did not substantiate that a nurse manager received complaints about staff that impacted patient care and failed to take corrective action or that facility leaders covered up the patient’s death. The OIG made three recommendations related to 24-hour observation flow sheets, updated quality management review, and institutional disclosure.

**Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York**

The OIG substantiated Patient A died after choking on food, but could not attribute the cause to nurse staffing. The OIG team also substantiated that staff called the wrong code, delaying Patient A’s transport; that staff did not consistently document hourly rounds; and that a second patient’s wrists were bound by a palm protector strap, although there was no evidence to suggest an intentional act of wrongdoing. The OIG was unable to substantiate whether patients were regularly left unsupervised while eating, or a lack of staff vigilance. The OIG did not substantiate that managers misrepresented the
cause of Patient A’s death, that one community living center (CLC) lacked security, or that CLC nursing managers were often unavailable. The OIG made nine recommendations related to emergency medical response processes and policies, CLC meal staffing and delivery processes, safety rounds, and reviews of Patient A’s care.

Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York

The OIG substantiated that nursing leaders were aware of staffing shortages; administrative registered nurses provided CLC nursing care; facility leaders pressured CLC managers to accept admissions; and at times CLCs were closed to admissions, although residents were not transferred due to staffing deficiencies. The OIG was unable to substantiate that the use of float staff and overtime placed residents at a higher risk for adverse events. The OIG found the facility failed to use alternative staffing. There was also a delay in filling vacant positions and a lack of approval for increased staff. Also, overtime funding exceeded the cost of filling vacant positions. The OIG made three recommendations related to CLC nurse staffing and recruitment, alternative staffing, and overtime management.

Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia

OIG healthcare inspectors reviewed allegations that a non-VA imaging center reported mammogram results as normal for a patient with known breast cancer managed by the Atlanta VA HCS, which delayed the patient’s care. The OIG substantiated that the 2016 mammogram results at issue were reported as “normal” but determined the interpretation was reasonable based on evidence available to the radiologist at the time of the interpretation and did not delay care. In the course of the inspection, the OIG identified multiple process concerns and made seven recommendations to ensure that patients who transitioned from a contract care provider in 2015 to other non-VA providers received care, facility mammography policy and practice are consistent, timely non-VA mammograms are scheduled and undergo consistent clinical review, availability of mammogram results improve, gender-specific care is provided by Women’s Health primary care providers, and the facility provides executive oversight of its Women Veterans Program.

Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York

VA domiciliary facilities provide a bridge between inpatient treatment for mental health issues and community-based day treatment clinics. There is a less restrictive environment for VA patients in a domiciliary as they move from VA inpatient care to the community in addressing their specific mental health needs. This report identified areas for improvement within the Bath residential treatment program as well as for VHA nationally. The report indicates that a veteran’s treatment and movement through the domiciliary treatment plan was interrupted by opiate overdose. That case prompted a review of the Bath residential treatment program’s fentanyl positive drug tests for FY 2017. The OIG found that the average turnaround time for results was 8.3 days and concluded that waiting this long for results
compromised staff’s ability to address substance use concerns in a timely and effective manner. OIG staff also found that the Bath VA’s tracking of positive drug tests was inaccurate. Staff had recorded several test results incorrectly and did not include all confirmed positive test results. The team also identified concerns with the use of color-coded stickers to identify patients at risk for opioid use or at high risk for suicide. The OIG made eight recommendations related to drug screening guidelines, regional drug abuse identification, timely laboratory turnaround times and result notifications, positive test tracking and monitoring, results interpretation training, color-coded sticker practices, and personal protective equipment and training for contraband searches.

Communities are often aware of the fluctuation in the rates of drugs being abused over time within their local area. This report underscores the need for VA facilities to remain aware of the prevalent drugs being abused in their community and then to apply the appropriate drug screens to treat and care for veterans who have substance use disorders.

**Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio**

Senators Jon Tester and Sherrod Brown asked the OIG to review the care of a patient who fell to his death from a second-story window at the Chillicothe VAMC. The OIG determined adequate security measures were not in place as required. The patient received care for medical and mental health issues on a medical unit. A special observer was assigned to maintain sight of the patient at all times. However, the special observer was unable to maintain visual contact when the patient entered a bathroom, locked the door, and climbed out the window. The OIG also assessed the provision of grief counseling. Although the facility offered grief counseling, it did not disclose all significant facts about the death to the family. The OIG made recommendations to secure windows, monitor compliance with relevant policy and training requirements, and confer with Chief Counsel about family notification of the patient’s death.

**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) Long-Term Care;
(8) Women’s Health; and
(9) High-Risk Processes.

In September, CHIP reviews were published for the following sites:

**Oklahoma City VA Health Care System, Oklahoma**

**Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois**

**Veterans Health Care System of the Ozarks, Fayetteville, Arkansas**

**Northport VA Medical Center, New York**

**Roseburg VA Health Care System, Oregon**

**Battle Creek VA Medical Center, Michigan**

**Gulf Coast Veterans Health Care System, Biloxi, Mississippi**

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