NOVEMBER 2022 HIGHLIGHTS

Featured Publication

Semiannual Report to Congress for April 1–September 30, 2022

The *Semiannual Report to Congress* summarizes the results of VA OIG oversight, provides statistical information, and lists all reports issued from April 1 to September 30, 2022. During this reporting period, VA OIG audits, investigations, inspections, and other reviews identified more than $1.4 billion in monetary impact, bringing the fiscal year's total to nearly $4.6 billion in monetary impact with a return on investment of $24 for every dollar spent. The OIG published 309 products for the full year, with 166 products released during this reporting period alone. The OIG hotline received and triaged nearly 18,400 contacts in the past six months—more than 36,000 for the year—to help identify wrongdoing and address concerns with VA activities. Also during the past six months, special agents opened 178 investigations and closed 213, with efforts leading to 135 arrests. Collectively, the OIG's work also resulted in nearly 600 administrative sanctions and corrective actions during the six-month reporting period.

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Two Defendants Indicted for Conspiring to Distribute Fentanyl at the Bedford, Massachusetts, VA Medical Center

A multiagency investigation resulted in charges alleging that two defendants conspired to target veterans seeking treatment for substance use disorder at the Edith Nourse Rogers Memorial Veterans' Hospital. The defendants were arrested after being indicted in the District of Massachusetts for drug distribution and conspiracy to distribute more than 40 grams of fentanyl. The investigation was conducted by the VA OIG, FBI, Drug Enforcement Administration, and VA Police Service.

Two Former Dallas VA Medical Center Employees Pleaded Guilty to Theft of Government Funds

Two VA medical center employees in Dallas, Texas, participated in a scheme to embezzle $2.9 million from VA. The defendants used government-issued General Services Administration (GSA) purchase cards to make phony purchases through two fictitious shell companies. To conceal the scheme, they created fake invoices and used existing items in the facility's inventory to conceal that the fictitious

companies never delivered any materials. Both defendants pleaded guilty in the Northern District of Texas to theft of government funds. The VA OIG, GSA OIG, and FBI conducted the investigation.

Former Purchasing Agent at the VA Medical Center in Chicago, Illinois, Pleaded Guilty to Role in Bribery Scheme

Between 2018 and 2020, a purchasing agent at the Jesse Brown VA Medical Center conspired to purchase medical supplies from a vendor in exchange for kickbacks. The vendor received approximately $330,000 in VA purchase card orders, and the employee received more than $39,000 in kickbacks. The former purchasing agent pleaded guilty in the Northern District of Illinois to bribery of a public official. The VA OIG investigated the case.

Benefits Investigations

Veteran Sentenced for Stealing Disability Benefits from VA and the Social Security Administration

According to the results of an investigation by the VA OIG and Social Security Administration (SSA) OIG, a veteran stole more than $420,000 from VA and SSA by falsely claiming he was unable to work due to a disability while simultaneously owning and operating an insurance company. The veteran was sentenced in the District of Massachusetts to one year of incarceration, one year of supervised release, and restitution of approximately $99,000 to VA after previously being found guilty at trial of theft of government funds and false statements. The veteran previously paid more than $281,000 as reimbursement to SSA.

Veteran and Spouse Indicted in Connection with Compensation Benefits Fraud Scheme

A VA OIG investigation resulted in charges alleging that a veteran and his spouse made multiple false statements to VA to receive extra monthly compensation benefits, which included aid and attendance, special monthly compensation, and caregiver support program compensation. The loss to VA is more than $586,000. The veteran and his spouse were indicted in the Eastern District of Washington on charges of theft of public money and healthcare fraud.

Former VA-Appointed Fiduciary Indicted for Stealing Benefits from Veteran

Another VA OIG investigation found that a then VA-appointed fiduciary allegedly stole about $143,000 intended for the veteran she was appointed to represent. The defendant allegedly used the veteran's large VA compensation benefits retroactive payment to fund a trip to Las Vegas and purchase household items and vehicles for herself and her daughter, and also gave away some of the funds to personal acquaintances. She was arrested after being indicted in the District of Kansas on charges of misappropriation by a fiduciary.

Investigations Involving Other Matters

Federal Contractor Pleaded Guilty to Bribery Charge

VA OIG investigators revealed that a federal contractor offered bribes to a VA contracting officer in

return for steering contracts for personal protective equipment (PPE) to his company. The federal contractor pleaded guilty in the Northern District of New York to bribery of a public official.

Veteran Pleaded Guilty to Making Threats against VA Doctors

A multiagency investigation found that a veteran called the White House VA Hotline and threatened to injure and kill doctors at the Fargo VA Medical Center in North Dakota. The veteran pleaded guilty in the District of North Dakota to communicating interstate threats. The VA OIG, VA Police Service, and US Marshals conducted the investigation.

Veteran Indicted for Threatening the Chief of Police at the Clarksburg, West Virginia, VA Medical Center

A VA OIG and VA Police Service investigation resulted in charges alleging that on three separate occasions, a veteran threatened to kill the chief of police at the Louis A. Johnson VA Medical Center in Clarksburg. The veteran was indicted in the Northern District of West Virginia on charges of influencing a federal officer by threat.

Former VA Employee Charged with Threatening a Public Official

According to a multiagency investigation, a former employee at the VA regional office in Providence, Rhode Island, allegedly sent a series of text messages to current and former personnel of the Veterans Benefits Administration containing threats directed at the facility's executive director and other individuals. The former employee was arrested after being charged in the District of Rhode Island with retaliating against a federal official by threatening. The investigation was conducted by the VA OIG, Federal Protective Service, and Barnstable (Massachusetts) Police Department.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following report this month.

Healthcare Access and Administration

The Veterans Health Administration Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics

The OIG reviewed Veterans Health Administration (VHA) monitoring of its staff's follow-up for healthcare appointments canceled during the pandemic and identified opportunities to improve oversight. VHA showed evidence of having followed up in approximately 87 percent of these appointments over seven months in 2021, which surpassed its goal of 80 percent. However, when the OIG evaluated data by type of care, more than one-third of some key categories such as mammography

and women's preventive care fell below 80 percent, with every facility having at least one type below 80 percent. When assessed by month, data showed seven of 138 facilities reviewed dropped below 80 percent in overall follow-up rate for two consecutive months. VHA officials also had not reevaluated the specific staff activities used to determine if a canceled appointment had been followed up. VHA concurred with the OIG's two recommendations to (1) better monitor follow-up rates and assist facilities that fell below established metrics and (2) reassess the activities determinative of follow-up activity.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Featured Report

Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearms

The OIG conducted a review of VHA's lethal means safety (LMS) training, firearms access and safe storage discussions, and clinicians' perspectives on lethal means interventions. The review team examined the electronic health records of 480 patients with firearm-related suicide behavior events. Among patients with nonfatal firearm suicide behavior events, VHA staff failed to document required safe storage discussions in approximately 30 percent of comprehensive suicide risk evaluations and 21 percent of safety plans. Six of the 18 Veterans Integrated Service Networks (VISNs) fell below an average of 90 percent compliance with required LMS training. Clinicians who reported completing the training also reported documenting firearms access and safe storage information in suicide risk assessments and safety plans at a higher rate than those who did not complete the training. VHA concurred with the OIG's seven recommendations to the under secretary for health related to training compliance and oversight; one-time LMS training; comprehensive suicide risk evaluation and safety plan completion; and evaluation of staff barriers to conducting and documenting the suicide risk identification strategy, firearms access, and safe storage discussions.

Care in the Community Report

Care in the Community Healthcare Inspection of VA Heartland Network (VISN 15)

The OIG Care in the Community healthcare inspection program examines clinical and administrative processes associated with VA providing access to quality outpatient healthcare to veterans. This report provides a focused evaluation of VISN 15 and its oversight of the quality of care delivered in community-based outpatient clinics and through its community care referrals to non-VA providers. The

OIG's review covered four focus areas: care coordination (with a focus on congestive heart failure management); primary care and mental health (targeting diagnostic evaluations following positive screenings for depression or alcohol misuse); quality of care (including home dialysis care); and women's health (specifically on mammography care and communication of results). The three OIG recommendations were (1) ensuring an end-stage renal disease provider sees patients in the home dialysis program at least monthly, as evidenced by a progress note in the medical record by the responsible independent renal practitioner; (2) performing initial and annual home visits for patients in the VISN 15 home dialysis program; and (3) monitoring the quality of non-VA home dialysis clinical contract services.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports 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 inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection. The OIG published one CHIP report this month on the *Mountain Home VA Healthcare System in Tennessee*.

Other Reports

Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic

The Pandemic Response Accountability Committee's Health Care Subgroup developed this report to share insights about the expansion—and the emerging risks—of telehealth in selected programs across six agencies during the first year of the COVID-19 pandemic. The programs included VHA, Medicare, TRICARE, Federal Employees Health Benefits Program, Office of Workers' Compensation Programs, and Department of Justice prisoner healthcare services. The expansion of telehealth services clearly helped millions of individuals access health care during the crisis, but also introduced several integrity risks associated with billing, including high-volume billing, duplicate claims, and inappropriate charges for the most expensive telehealth services. The study found that program integrity can be strengthened by implementing ongoing monitoring of telehealth services, developing controls to prevent inappropriate payments, educating providers and individuals about telehealth, collecting additional data to support oversight, and collecting and reviewing data about the impact of telehealth on quality of care. The PRAC's Health Care Subgroup consists of the inspectors general from the Departments of Veterans Affairs, Justice, Defense, Labor, Health and Human Services, and the Office of Personnel Management.

Summary of Internal Investigations regarding Misconduct by a Former VA OIG Special Agent in Charge

VA OIG attorney-advisors conducted two related internal investigations following allegations that a then

special agent in charge (SAC) engaged in inappropriate conduct or sexual harassment of OIG personnel that his superiors ignored and that contributed to a hostile work environment. OIG disciplinary officials determined the SAC engaged in "conduct unbecoming" and should be removed from federal service. The SAC retired during the 30-day advance notice period that is required before completing a removal action. The evidence did not support a charge of sexual harassment, failure to act by senior leaders, or a hostile work environment. To enhance future reporting and a safe workplace, the OIG implemented and updated directives on romantic relationships involving coworkers and sexual misconduct in addition to other responsive actions. The OIG publishes summaries of internal investigations of alleged senior personnel misconduct to promote transparency and accountability. Summary information released is consistent with applicable privacy laws and regulations.

Featured Hotline Case

The OIG's hotline staff accept complaints from VA employees, the veteran community, and the public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

A Patient Attempted Suicide by Medication Overdose at the VA Medical Center in Washington, DC

OIG hotline staff received a complaint alleging that a veteran attempted suicide in the emergency department (ED) of the Washington DC VA Medical Center after presenting with suicidal ideation. After the allegation was referred to the facility for review, it was revealed the one-to-one sitter responsible for providing constant observation of the suicidal patient did not follow appropriate procedures, instead leaving the patient alone with their belongings in an ED triage room. Additionally, because no beds were immediately available in the main ED, the patient was not asked to wear a hospital gown nor have their belongings secured away from their person. This resulted in the patient taking an overdose of their prescribed amitriptyline. Following the suicide attempt, the veteran was transferred to the medical intensive care unit for stabilization and observation. The following corrective actions were implemented:

- A new process requiring ED leaders, or their designee, be notified when a one-to-one observation is instituted in the ED
- Improved environmental safety checklists and sitter documentation tools aligning with the Office of Nursing Services' recommended best practices
- Annual training for caring and managing patients deemed at high risk for suicide, including face-to-face education with simulations
- Vocera devices (secure integrated wireless voice communications) issued to ED sitters to help meet requirements for communicating hand-offs