JANUARY 2023 HIGHLIGHTS

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

Former Miami VA Medical Center Employee Was Sentenced in Connection with Bribery Scheme

The former assistant chief of logistics at the Miami VA Medical Center, who was responsible for supervising the ordering of goods and services at the facility, and other VA employees placed orders for supplies in exchange for cash bribes and kickbacks from corrupt vendors. The prices of supplies were often grossly inflated, and some orders were only partially filled or not fulfilled at all. After leaving VA, the former assistant chief immediately began working for one of the vendors and paid kickbacks and bribes to VA employees at multiple VA medical centers in exchange for the placement of orders. The vendors charged in this case were responsible for over $37.6 million in purchase card orders and contracts. The defendant was sentenced in the Eastern District of Pennsylvania to three years of probation and restitution of approximately $134,000 after previously pleading guilty to conspiracy to bribe a public official.

Defendant Pleaded Guilty to Fraudulent Receipt of VA Funds

A multiagency investigation revealed that a defendant fraudulently received VA funds intended to reimburse a not-for-profit integrated healthcare system for community care provided to veterans. The defendant also fraudulently received funds from a public school system, a deposited counterfeit cashier's check, and loans from the Small Business Administration (SBA), and then split the funds with coconspirators. The loss to VA is approximately $750,000. The defendant pleaded guilty in the Southern District of Florida to wire fraud. This investigation was conducted by the VA OIG, Homeland Security Investigations (HSI), Federal Deposit Insurance Corporation OIG, US Secret Service, and Aventura Police Department.

Former VA Employee Pleaded Guilty to Theft of Diabetic Test Strips

A former employee at the Battle Creek VA Medical Center in Michigan used her government position to make numerous unauthorized purchases of diabetic test strips. The former employee then sold those items to individuals who were not affiliated with VA. She admitted to stealing over 7,500 boxes of diabetic test strips, which were valued at more than $400,000. The former employee and one of the

buyers pleaded guilty in the Western District of Michigan to theft of medical products. The case was investigated by the VA OIG and Food and Drug Administration Office of Criminal Investigations, with assistance from the US Postal Inspection Service (USPIS).

Veteran Sentenced for Altering Military Documents to Obtain VA Benefits

In 2011, a veteran registered for VA healthcare benefits by presenting altered military service records that falsely reflected that he served in Vietnam. He later used the same fraudulent documentation to obtain VA compensation benefits. The veteran also used altered documentation that claimed a different date of birth to obtain Social Security and Medicare benefits to which he was not entitled and to obtain a passport. The veteran was sentenced in the District of Alaska to six months of probation and restitution of approximately $528,000 after previously pleading guilty to healthcare benefits fraud, false statements relating to healthcare benefits, Social Security benefits fraud, false statements, and passport fraud. The total loss to the government is more than $530,000. Of this amount, the loss to VA is $330,000. The VA OIG joined with the Social Security Administration OIG, Department of State Diplomatic Security Service, and Department of Health and Human Services (HHS) OIG to conduct the investigation.

Fraudulent Nursing Diploma Scheme Led to Federal Charges against 25 Defendants

A multiagency investigation resulted in charges alleging that a network of schools provided fraudulent nursing diplomas and transcripts in a pay-to-play scheme that enabled thousands of individuals to take board certification tests to become registered nurses or licensed. Some of these individuals were subsequently hired as practical nurses employed by VA and various other healthcare providers throughout the country. Twenty-five of the recruiters who were allegedly involved in the scheme were charged in the Southern District of Florida with multiple offenses, including wire fraud. This investigation was conducted by the VA OIG, FBI, HHS OIG, HSI, USPIS, and Florida Attorney General's Medicaid Fraud Control Unit.

Benefits Investigations

Defendant Sentenced for Fraudulently Obtaining VA Benefits in Deceased Mother's Name

A VA OIG investigation determined that from 1973 through 2021, the daughter of a deceased VA beneficiary signed her late mother's name on the back of her VA checks and forged her name on documents submitted to VA. The daughter also forged her mother's signature on a form that directed VA to deposit the benefits into a bank account that she controlled. When filing for bankruptcy, she also falsely claimed that she had no income when at that time she was fraudulently receiving monthly VA benefits intended for her mother. The defendant was sentenced in the Southern District of Ohio to five years of probation with the first year on home detention and ordered to pay restitution of almost $462,000 after previously pleading guilty to theft of government funds.

Veteran Pleaded Guilty to Defrauding VA and Threatening a Federal Agent

Another VA OIG investigation revealed that a veteran defrauded VA by making false representations that he suffered from posttraumatic stress disorder due to his active-duty service. Based on these false statements, VA increased the veteran's disability rating and provided additional monthly disability benefit payments to him. The loss to VA is close to $119,000. In addition, the defendant also sent a text message to a VA OIG agent in which he threatened physical violence against the agent and any other agent involved in investigating him. He pleaded guilty in the District of New Jersey to theft of government funds and interstate transmission of a threat to injure.

Investigations Involving Other Matters

Nonveteran Sentenced for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

Five federal agencies conducted an investigation that revealed two nonveterans fraudulently created a service-disabled veteran-owned small business (SDVOSB) in Texas by installing a service-disabled veteran as the ostensible owner of the business, which actually remained under their control. Over 10 years, the SDVOSB was awarded more than $254 million in government contracts. Of this amount, approximately $77 million was awarded by VA, including a $24 million set-aside contract to build a parking garage at the VA Long-Term Spinal Cord Injury Clinic in Dallas, Texas. One of the nonveterans was sentenced in the Western District of Texas to 27 months in prison, 36 months of supervised release, and a fine of $1.75 million after previously being found guilty at trial of conspiracy to defraud the United States and wire fraud. The other nonveteran and the veteran named as the owner previously pleaded guilty in connection with this investigation, which was conducted by the VA OIG, SBA OIG, General Services Administration OIG, Defense Criminal Investigative Service, and Army Criminal Investigation Division.

Former VA Nurse Charged in Connection with Workers' Compensation Fraud Scheme

A VA OIG and Department of Labor (DOL) OIG investigation alleges that from 2015 through 2021, a former nurse at the VA medical center in Chillicothe, Ohio, submitted fraudulent reimbursement claim forms to DOL's Office of Workers' Compensation Program for medication she allegedly used due to an injury that resulted from her VA employment. In support of these false claims, she attached fraudulent homemade receipts pertaining to medication that she had not paid for or received. After reimbursing her for the fraudulent medication claims, DOL then charged back these amounts to VA. The loss to VA is approximately $932,000. The former nurse was charged in the Southern District of Ohio with healthcare fraud related to the fraudulent workers' compensation reimbursement claims.

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 reports on two inspections this month that assess whether VA facilities are meeting federal security requirements.

Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama

This first OIG inspection found deficiencies in three areas: configuration management, security management, and access controls. Deficiencies in configuration management included critical-risk vulnerabilities, uninstalled patches, and unscannable database servers, all of which deprive users of reliable access to information and could risk unauthorized access. The team identified a security management weakness concerning missing action plans to address identified vulnerabilities. Weak access controls, such as missing logs and uninstalled backup power supplies, compromised the security and maintenance of the information system. The assistant secretary for information and technology concurred with six of the OIG's eight recommendations aimed at improving these controls, partially concurred with one recommendation, and nonconcurred with the recommendation to ensure all medical center databases are part of the periodic database scan process. Responsive action plans were submitted for the seven recommendations that received concurrences or partial concurrence. Regarding the nonconcurrence, the evidence provided by VA, which was meant to demonstrate that all databases at the medical center are included in the scanning process, does not include the specific devices missing from the original response to the OIG's request for scan results. Consequently, the OIG was unable to validate the claim that all databases are included in the medical center's scanning process and therefore stands by this recommendation.

Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics

The OIG conducted its second information security inspection at the Southern Oregon Rehabilitation Center and Clinics and also found deficiencies with configuration management, security management, and access controls. Configuration management controls were deficient in vulnerability remediation—the process to identify and fix weaknesses. The security management control deficiency was in system security planning, which is needed for authorizing a system to operate. The access control deficiencies were in network segmentation, physical access, environmental, audit and monitoring, and records management controls. Without these safeguards, breaches are more likely to occur and assets are at risk of accidental or intentional destruction. The assistant secretary for information and technology concurred with all but one of the OIG's nine recommendations aimed at correcting these deficiencies. Regarding the nonconcurrence, the assistant secretary reported that the devices identified by the OIG as lacking required isolation do not meet the definition for devices subject to this requirement. However, these devices were identified by the facility as containing medical systems and therefore, per VA policy, fall under the medical device isolation architecture guidance. The OIG also stands by this recommendation and others in the report.

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.

National Review

Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs

This review assessed elements of the Veterans Health Administration (VHA) Intensive Community Mental Health Recovery (ICMHR) programs, which provide high-intensity, community-based care to veterans with serious mental illness. The review team examined visit frequency for ICMHR-enrolled veterans, as well as VHA healthcare systems' contingency planning for veterans' medication access during emergencies, including long-acting injectable antipsychotic medications. The OIG found ICMHR programs did not meet VHA's visit frequency requirement of two to three visits weekly, on average, for high-intensity services. Additionally, the majority of VHA healthcare systems did not have ICMHR-specific contingency plans for veteran medication access. The OIG made three recommendations to the under secretary for health related to ICMHR visit frequency and the intensity of care provided, the ongoing role of virtual care in the delivery of ICMHR services, and ICMHR-specific contingency planning for veterans' medication access during emergencies.

Care in the Community Inspection

Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)

The OIG Care in the Community healthcare inspection program examines clinical and administrative processes associated with providing quality outpatient healthcare to veterans. This report provides a focused evaluation of Veterans Integrated Service Network (VISN) 7 and its oversight of the quality of care delivered in community-based outpatient clinics and through its community care referrals to non-VA providers. Although it is difficult to measure the value of well-delivered and coordinated care between VA and non-VA providers, the findings in this report may help VISN leaders identify vulnerable areas of community care that, if properly addressed, should improve healthcare quality for veterans. The OIG reviewed care coordination (congestive heart failure management), primary and mental health care (diagnostic evaluations following positive screenings for depression or alcohol misuse), quality of care (home dialysis), and women's health (mammography care and communication of results). The OIG issued two recommendations for improvement in two areas, quality of care and women's health, including monitoring the quality of home dialysis contracted clinical services for

patients receiving non-VA home dialysis services and ensuring that ordering providers communicate normal mammography results to patients within 14 calendar days.

Healthcare Inspections

Featured Report

Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana

This inspection was conducted by the OIG to assess allegations and concerns related to client care and leadership at the South Bend Vet Center in Indiana. The OIG substantiated that facility staff inaccurately assessed three clients' suicide risk levels, including one client who died by suicide. The vet center director (VCD) also guided staff to rate suicide risk levels low to avoid leaders' involvement; failed to provide adequate oversight and instruction to a counseling intern, including on actions needed to mitigate suicide risk; and did not facilitate a time-sensitive transition of care and ensure measures, consistent with a client's high-risk behaviors, hospitalization, and posthospitalization needs, were in place. The OIG also determined (1) a district leader that removed the VCD from clinical care failed to report clinical deficiencies to the state licensing board; (2) vet centers lacked a clear process for state licensing board reporting; and (3) district leaders failed to ensure remediation of repeat deficiencies identified during the facility's quality reviews. VA concurred with the OIG's eight recommendations: three to the chief readjustment counseling officer related to adverse events, intern oversight, and state licensing boards, as well as five recommendations to the Midwest District 3 director related to assessing and mitigating suicide risk, continuity of care, adverse events, and state licensing board reporting.

Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

The OIG assessed allegations at the VA medical center in Indianapolis that an interventional cardiologist was hired despite poor training and references and provided inferior quality of care to patients that resulted in adverse clinical outcomes, and that facility leaders did not respond to staff concerns regarding this provider. The OIG did not substantiate the allegations but found multiple process-related deficiencies related to credentialing, privileging, and performance evaluation. The volume of percutaneous coronary intervention (PCI) procedures performed at the facility, a type of cardiac catheterization procedure used to treat narrowed or blocked arteries, was also found to be insufficient to maintain interventional cardiologists' competence and patient safety. Five recommendations were made to the facility director related to the verification of credentialing and privileging documentation, the mentoring of newly trained interventional cardiologists, focused professional practice evaluation administration and documentation, timely completion of fact-finding investigations, and assessment of PCI procedure volume and compliance with related standard operating procedures.

Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

This inspection focused on allegations related to a psychiatry trainee using a modality called intensive short-term dynamic psychotherapy on a female patient. The OIG did not substantiate the psychiatry trainee's behavior with the patient was inappropriate and was unable to determine that the treatment resulted in a decline in the patient's mental health. However, the supervisor did not provide adequate supervision of the psychiatry resident and mental health department leaders were not responsive to the patient's concerns. During the inspection, the OIG identified an additional concern regarding the improper creation, storage, and disposition of video recordings and consent forms. VA concurred with the six recommendations in the report: one to the under secretary for health to assess the scope of current and former VA psychiatry residents being in possession of patients' personal health information; two to the VISN director related to trainee supervision, documentation, document control, and treatment protocols; and three to the facility director regarding responses to the patient's concerns, records, and use of video recordings.

Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland

An inspection team reviewed an allegation that a patient received poor care in the emergency department at the Baltimore VA Medical Center, which resulted in an amputation at the patient's forearm at a non-VA hospital days later. The OIG substantiated that the patient received poor emergency department care when a physician assistant failed to obtain laboratory studies and document a clinical consultation with an attending physician. The overseeing attending physician failed to identify concerns with the physician assistant's care of the patient. These failures may have contributed to the patient's amputation. They may also have been a factor in the patient's problem list in the electronic health record (EHR) not being maintained and providers' failure to address the patient's second complaint of knee pain. The facility director concurred with the OIG's four recommendations related to staff training, comprehensive clinical assessments, clinical consultation processes, and patient problem lists.

Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada

This healthcare inspection assessed concerns regarding a primary care provider potentially falsifying blood pressure readings at the North Las Vegas VA Medical Center. The OIG determined the provider knowingly documented false blood pressures in patients' medical records during VA Video Connect (VVC) visits and found the provider's explanations—that the VVC template and the lack of VVC training led to his entering false blood pressures—were inaccurate. The OIG concluded that the VVC template does not require providers to document false blood pressure readings when actual readings had not been obtained during the visit, as claimed by the provider. The OIG also confirmed that the provider completed all required VVC training courses prior to completing VVC visits. Despite the falsified blood pressure, the provider expressed the belief that no patients were harmed due to his use of multiple

mitigation strategies, including sending providing blood pressure monitors to all patients and notating in their files that the documented blood pressures were inaccurate. From a sample of EHRs reviewed, the provider's mitigation strategies did not occur for most patients; however, no patient experienced an adverse clinical outcome. Despite retraining, the provider's inability to conduct VVC visits was concerning. Facility leaders failed to initiate state licensing board reporting and did not clinically review and amend EHRs with prior false blood pressures. The OIG issued five recommendations to the facility director to verify the provider's ability to complete and document VVC visits, consider administrative action, initiate state licensing board reporting processes, and ensure the provider's blood pressure entries in EHRs are reviewed and amended.

Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison

In response to an allegation of abuse and quality of care concerns for a patient at the Fort Harrison VA Medical Center and Miles City Community Living Center (CLC), the OIG substantiated that a physical therapist and nursing staff mistreated the patient during physical therapy in the CLC. Moreover, a failure in care coordination between physicians led to an absence of a suggested follow-up plan for a suspected lung mass in the patient's discharge summary. One OIG recommendation was directed to the network director related to facility actions in response to mistreatment allegations, and six were directed to the facility director related to ensuring the rights of CLC patients, reviewing the care provided to the patient by the CLC nursing staff and physician and during the patient's acute care hospitalization, reviewing the screening and admissions process for CLC patients, and complying with the state licensing board reporting policy.

Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System

The OIG substantiated allegations that staff from the VA North Texas Health Care System domiciliary substance use disorder treatment program placed patients on waitlists and failed to offer non-VA community residential care referrals. Also, the VISN 17 chief mental health officer lacked the authority to ensure staff adherence to national mental health residential rehabilitation treatment program policy. The standard operating procedure used for this treatment program was inconsistent with VHA's scheduling requirements, and the system's policy did not include the VHA requirement for staff to assign mental health treatment coordinators to patients awaiting program admission. The OIG made two recommendations to the under secretary for health to improve program oversight and mental health treatment coordinator assignment procedures, and three recommendations to the VA North Texas Healthcare System director related to alternative treatment options when domiciliary substance use disorder admission wait times exceed 30 days, management of community residential care referrals, and scheduling procedures.

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. This month's CHIP report focused on the El Paso VA Health Care System in Texas, and the evaluation addressed leadership and organizational risks; quality, safety, and value; medical staff privileging; environment of care; and mental health with a focus on emergency department and urgent care center suicide prevention initiatives.

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. As with CHIP reports, the OIG selects and evaluates specific areas of focus on a rotating basis for its vet center inspections. See the report overview section of each report for the areas of focus at the time of the inspection. VCIP reports on selected vet centers in Midwest District 3's Zone 3 and Zone 1 were published in January 2023.

Featured Hotline Case

The OIG's hotline staff accepts 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.

Poor Documentation and Inadequate Staff Training of Puget Sound's Community and Primary Care Clinics Caused a Patient's Delay in Care

A complainant reported a patient at the VA Puget Sound Health Care System had been waiting over a year for the facility's community care office to approve a consult (referral) for a follow-up positron emission tomography (PET) scan. The OIG hotline staff requested a response from the Puget Sound facility, which reviewed and substantiated the complaint. A chart review of the patient's treatment record revealed the care provider failed to document the patient's eligibility for care in the community and failed three times before correctly entering the standard episode of care (SEOC) notations using Consult Toolbox—the software that enables staff to track and manage consults. Per VA's Office of Community Care (OCC) field guidebook, documentation of a patient's eligibility for care in the community and the SEOC are required before a consult is approved. The Puget Sound Health Care System provided additional training to the community care provider liaison and community care clinical

reviewers on the proper use of Consult Toolbox to ensure community care eligibility is documented and the appropriate SEOC is selected to minimize delays in care. In addition, OCC is now reviewing how healthcare providers are entering consults and conducting on-the-spot training when warranted.

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To listen to the podcast on the January highlights, go to www.va.gov/oig/podcasts.