



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## SEPTEMBER 2023 HIGHLIGHTS

### Congressional Testimonies

#### **OIG Director of Claims and Fiduciary Inspection Division Testifies on the Veterans Benefits Administration's Fiduciary Program**

Lisa Van Haeren, director of the Claims and Fiduciary Inspection Division within the OIG's Office of Audits and Evaluations, testified on September 28 before the House Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs. Her testimony related to the Veterans Benefits Administration's Fiduciary Program, which is tasked with protecting VA beneficiaries who are unable to manage their benefits as a result of injury, disease, the infirmities of advanced age, or being younger than 18 years old. VA appoints fiduciaries to receive direct payments on behalf of beneficiaries and disburse those funds for beneficiaries' care, support, welfare, and other needs. Ms. Van Haeren's testimony focused on findings and recommendations from three OIG reports that illustrate weaknesses in the Pension & Fiduciary Services' program management and internal oversight processes. The reports identified delays in determinations of whether a fiduciary is warranted, veterans' reimbursements when their benefits have been misused, and the distribution of deceased veterans' fiduciary-controlled funds to their heirs or back to VA. The delays often created unnecessary risks to veterans' welfare and exposed beneficiaries and their families to potential hardships when VA's assistance was critical. The hearing can be viewed in its entirety on the [committee website](#).

### 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

##### **Business Executive Sentenced in Connection with COVID-19 Fraud Scheme**

A high-level executive for a pharmaceutical secondary wholesaler conspired with others to buy and then hoard designated "scarce" materials—including personal protective equipment—at the height of the COVID-19 pandemic. The coconspirators used deceitful means to sell the equipment to VA and other hospital systems at excessive prices. The company was paid over \$1.8 million for the personal protective equipment, to include over \$334,000 by VA. The executive was sentenced in the Southern District of Mississippi to 30 months in prison, 36 months of supervised release, restitution of over \$281,000, and a fine of \$30,000. The VA OIG, FBI, and Food and Drug Administration's Office of Criminal Investigations completed the investigation.

### **Two Former VA Medical Center Employees Indicted for Bribery Scheme**

Two former employees at the James H. Quillen VA Medical Center were indicted in the Eastern District of Tennessee for allegedly receiving cash bribes in exchange for processing exorbitant payments for orthopedic surgeries. The investigation further alleges that the two former employees formed a close relationship with two other individuals who created and used two shell companies to submit invoices to VA for the surgeries, which the former VA employees paid using a purchase card. The billings, compared to historical billings for similar medical procedures, were approximately seven to 10 times higher. According to the allegations, the two individuals routinely provided the former VA employees with envelopes of cash during the scheme that came to a total of about \$100,000. The loss to VA is approximately \$3.7 million. The investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, and General Services Administration OIG.

## **Benefits Investigations**

### **Veteran Indicted for False Statements about His Claimed Disability**

A VA OIG investigation led to the indictment of a veteran who allegedly lied to VA about being able to use both his feet, which resulted in his receipt of VA compensation and vehicle adaptation benefits to which he was not entitled for almost two decades. The veteran was indicted in the District of New Hampshire for making false statements. The loss to VA is approximately \$662,000.

### **Veteran Indicted for Fabricating Military Service to Receive VA Compensation Benefits**

From January 2010 to March 2023, a veteran allegedly received VA compensation benefits that were awarded based on false accounts of his military service, specifically pertaining to injuries sustained from a roadside bomb in Iraq. It is further alleged that the defendant submitted an application for a Purple Heart award to the US Marine Corps through his local congressman, in which he falsely stated that he had suffered injuries, including traumatic brain injury, during his deployment. The loss to VA is approximately \$344,000. The veteran was arrested after being indicted in the District of Massachusetts on charges of theft of government funds and false statements. The VA OIG and Defense Criminal Investigative Service investigated the case.

### **Son of a Deceased VA Beneficiary Pleaded Guilty to Theft of Government Funds**

A VA OIG and Social Security Administration OIG investigation revealed that the son of a deceased VA beneficiary spent approximately \$163,000 in VA and Social Security benefits that were deposited into a joint bank account he shared with the decedent. Of this amount, the total paid by VA is over \$125,000. The defendant pleaded guilty in the District of Nevada to theft of government funds.

### **Defendant Sentenced for Stealing 10 Years' Worth of VA Survivor's Benefits**

According to an investigation by the VA OIG, after a VA beneficiary passed away in 2009, the new tenant in the decedent's apartment unlawfully cashed the decedent's VA Dependency and Indemnity

Compensation benefits checks from 2010 to 2020. The defendant was sentenced in the Eastern District of New York to two years of supervised release and restitution of nearly \$140,000 to VA after pleading guilty to theft of government funds.

## Investigations Involving Other Matters

### **Four Defendants Indicted for Service-Disabled Veteran-Owned Small Business Fraud**

A VA OIG investigation resulted in charges alleging four defendants agreed to submit a proposal for a service-disabled veteran-owned small business (SDVOSB) set-aside contract to construct a Cancer Infusion Therapy Center at the C.W. Bill Young VA Medical Center in Bay Pines, Florida. The defendants were subsequently awarded the contract, which was valued at \$8.9 million. The defendants allegedly failed to disclose to VA contracting officials that the SDVOSB prime contractors were a pass-through for a large, nonveteran-owned construction company that managed nearly all the work for the contract and received most of the payments. The partially constructed cancer center was later razed after an independent engineering assessment concluded that the building was structurally deficient. The potential loss to VA is approximately \$4.8 million. The defendants were arrested after being indicted in the Middle District of Florida for wire fraud, conspiracy to commit wire fraud, and major fraud against the government.

### **Physician and Two Pharmacists Indicted for Workers' Compensation Fraud Scheme**

Two pharmacists and a physician allegedly conspired with others to submit false and fraudulent claims to the Department of Labor's Office of Workers' Compensation Program (OWCP) for drugs reimbursed at high prices that were often medically unnecessary and induced by kickbacks and bribes. The investigation alleges that the two pharmacists paid illegal kickbacks and bribes, often through shell entities or in cash, directly to physicians, a clinic owner, a medical assistant, and other marketers. In total, the two pharmacies owned by one of the pharmacists submitted approximately \$170 million in fraudulent OWCP claims, including approximately \$1.5 million worth of claims for VA employees participating in the workers' compensation program (OWCP seeks reimbursement from VA for these claims through "charge backs"). The defendants were indicted in the Southern District of Texas on various charges related to this scheme. This investigation was conducted by the VA OIG, US Postal Service OIG, Department of Labor OIG, and FBI.

### **Two Defendants Pleaded Guilty in Connection with Another Workers' Compensation Fraud Scheme**

From 2011 until 2017, the former owner of a medical supply and billing company and the company's chief executive officer conspired to defraud healthcare benefit programs, including OWCP and private workers' compensation programs, by submitting claims for topical medications supplied by the company. The medications were prescribed and dispensed by healthcare providers who were paid kickbacks based on amounts collected through this scheme. Two of the healthcare providers did not

have the legal authority to disburse medications in their state. The former owner and chief executive officer pleaded guilty in the Western District of Arkansas to conspiracy to commit wire fraud and illegal remunerations. Another defendant was previously sentenced to 48 months in prison. Two other defendants have also pleaded guilty and are awaiting sentencing. The total loss to OWCP is over \$3.9 million. Of this amount, the loss to VA is more than \$487,000.

### **Defendant Indicted for COVID-19 Paycheck Protection Fraud Scheme**

A VA OIG and US Secret Service investigation resulted in charges alleging that an individual fraudulently obtained loans through the Paycheck Protection Program and Economic Injury Disaster Loan program for a nonoperational business that did not have any employees. The loss to the government is over \$387,000. The defendant was indicted in the Eastern District of Louisiana on charges of theft of government funds and false statements. This investigation was conducted under the auspices of the Pandemic Response Accountability Committee.<sup>1</sup>

### **Former VA Police Officer Indicted on Federal Civil Rights and Assault Charges**

According to a multiagency investigation, a former VA Police Service officer at the West Los Angeles VA Medical Center allegedly used a department-issued baton to illegally strike a man about 45 times during an arrest at the facility in January 2022. The former officer was indicted in the Central District of California on charges of deprivation of rights under color of law resulting in bodily injury and assault with a dangerous weapon with the intent to do bodily harm. This investigation was conducted by the VA OIG, VA Office of Security and Law Enforcement, and FBI.

### **Veteran Allegedly Threatened VA and VA OIG Employees and the White House**

A veteran was indicted for threatening to kill a VA social worker at the community-based outpatient clinic in Lynchburg, Virginia. The veteran also allegedly made threats directed against a VA OIG employee, other VA personnel, the White House, and the District of Columbia Office of the Inspector General. The veteran was indicted in the Western District of Virginia for threatening a federal employee. The VA OIG conducted the investigation.

## **Office of Audits and Evaluations**

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve 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 released the following reports.

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<sup>1</sup> As one of the 21 different offices of inspector general that serve as members of the Pandemic Response Accountability Committee, the VA OIG provides assistance to the government's efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA's programs and operations.

## Benefits

### **Improvements Needed for VBA's Claims Automation Project**

This review examined whether an automation project by the Veterans Benefits Administration (VBA) supported accurate decisions on veterans' disability benefits claims while improving processing timeliness and reducing manual effort. The project automates evidence-gathering tasks including extracting blood pressure readings and hypertension-related medication data from VA treatment records. These are compiled into a summary sheet uploaded to the veteran's electronic claims folder. The OIG found that summary sheets did not contain comprehensive blood pressure information that would assist processors in accurately deciding claims, which resulted in increased manual effort. Moreover, guidance on using the summary sheets differed from guidance provided to nonproject claims processors, quality assurance was insufficient, and timeliness metrics did not factor in the high priority given hypertension claims, making it difficult to assess improvement in claims decisions. The OIG made four recommendations to achieve project goals.

### **Staff Did Not Limit the Use of Schools and Training Programs That Were Only Approved for the Veteran Readiness and Employment Program**

The OIG assessed whether VBA's Veteran Readiness and Employment (VR&E) service properly approved and monitored participants' use of Chapter 31-only training programs, which assist veterans who have service-connected disabilities that limit employment opportunities. By law, these programs may only be used when approved GI Bill programs cannot meet a veteran's unique needs. VR&E was found to have misinterpreted a 2016 law requiring individual waivers from the service's executive director each time a Chapter 31-only program was selected. Consequently, VR&E did not issue waivers or have oversight controls to limit these programs to veterans with the requisite needs. Further, VR&E did not complete required compliance surveys for the programs. The OIG questioned about \$13 million that lacked requisite documentation to send veterans to these programs instead of approved GI Bill programs. VA concurred with the report's five recommendations—two of which have been closed based on VA-submitted documentation.

### **VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2023**

The Transparency Act requires VA to report to Congress its plans to spend COVID-19 relief funding, including funding related to the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and charges the OIG with overseeing the use of that funding. The OIG's fourth semiannual report found VA initially purchased services, supplies, and materials that were not aligned with the FFCRA but took action to correct its obligations and expenditures. Also, expenditure transfers may pose a risk to VA's financial reporting and VA generally did not comply with its financial policies to process and authorize FFCRA expenditure transfers.

However, VA generally complied with the Transparency Act for CARES Act reporting requirements and biweekly reports. The OIG made one recommendation to VA's under secretary for health to ensure that Veterans Health Administration (VHA) fiscal staff are trained on the VA financial policy requirements for journal vouchers (including expenditure transfers).

### **Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions**

Office of Audits and Evaluations staff conducted this review to determine whether VBA processes Gulf War illness disability claims in accordance with VA regulatory requirements. Gulf War illness refers to a group of unexplained or ill-defined chronic symptoms found in veterans deployed to the Persian Gulf during Operations Desert Storm and Desert Shield. The OIG found that VBA's Gulf War illness claims process did not ensure all requirements were met before claims processors decided disability compensation claims. As a result, VBA prematurely decided an estimated 3,200 of the 13,800 Gulf War illness claims (23 percent) completed from October 1, 2021, through March 31, 2022, leading to at least \$5.1 million in improper overpayments. Five recommendations were made to update instructions, definitions, and diagnostic criteria provided to examiners and to clarify for claims processors that all regulatory requirements must be met to award benefits.

## **Healthcare Access and Administration**

### **VHA Faces Challenges Implementing the Appeals Modernization Act**

VA implemented the Appeals Modernization Act (AMA) in 2019 to offer veterans faster resolution of disagreements with VA benefits decisions. Although it largely focuses on VBA benefits decisions, it also applies to decisions made by VHA, such as clothing allowances related to prosthetics use and reimbursement of non-VA emergency care. Previous OIG reports found difficulties with the appeals modernization rollout. Additional concerns prompted this review to determine whether VHA processed and tracked appeals of benefits decisions in accordance with the AMA's requirements and two VHA interim policy notices. The OIG found VHA program offices did not give claimants the information needed to initiate higher-level reviews and supplemental claims regarding benefits decisions. In addition, VHA did not accurately track reviews because it did not implement effective systems, sufficient policies, or adequate training. The report includes 14 recommendations to improve information given to claimants, centralize intake, and better track and standardize retention of decision reviews.

### **Inconsistent Guidance and Limited Oversight Contributed to Inaccurate Community Care Wait-Time Eligibility Calculations at the C.W. Bill Young VA Medical Center in Bay Pines, Florida**

From 2020 to 2022, some schedulers at the VA medical center in Bay Pines, Florida, determined community care eligibility with a locally developed calculator for wait times that undercounted patients'



wait time by about 12 days, limiting veterans' healthcare choices. This review examined what contributed to the Bay Pines calculator's inaccuracy and the facility's inability to discover it, as well as the steps taken to ensure all medical facilities correctly determine wait-time eligibility. The OIG found that the Bay Pines calculator used the wrong date—the "patient indicated" date, rather than the file entry date, which is required by the MISSION Act—to assess wait-time eligibility. In addition, the guidance for schedulers was confusing and oversight efforts were not designed to assess the accuracy of eligibility determinations. The under secretary for health concurred with the OIG's four recommendations to ensure schedulers consistently use the correct dates to determine wait-time eligibility.

### **VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement**

Applicants for VHA positions undergo background investigations as a condition of their employment to help ensure their suitability to care for veterans and be entrusted with sensitive information and resources. This audit is a follow-up to a 2018 OIG report that identified deficiencies and governance concerns with the VHA personnel suitability program. This follow-up audit found VHA staff did not initiate or adjudicate all background investigations within required time periods and did not maintain documentation to validate the completion of favorable adjudications. These deficiencies allowed some personnel in direct patient care to be employed without vetting for long periods, although identified cases were eventually favorably completed. VA concurred with seven OIG recommendations to address the lack of program monitoring, insufficient staffing, the lack of a single system for tracking investigations with adequate data, and the need for more robust oversight.

### **Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans**

The MISSION Act of 2018 requires VA to ensure that non-VA providers (community care providers) who prescribe opioids to veterans receive and certify reviewing VA's Opioid Safety Initiative (OSI) guidelines that require providers to query state prescription drug monitoring program (PDMP) databases that track controlled substance prescriptions. The Office of Audits and Evaluations team assessed whether VA ensured non-VA providers received and certified reviewing the guidelines, whether non-VA providers in an OIG sample conducted required PDMP queries, and whether a sample of veterans' medical records included opioid prescriptions. VA's Office of Integrated Veteran Care was found to have inadequate oversight to ensure non-VA providers received the OSI guidelines and certified their review. The office also did not monitor VA's third-party administrators to ensure non-VA providers completed PDMP queries. Non-VA provider opioid prescription information was generally documented in the OIG sample's medical records but was recorded in different sections, making it more difficult for providers to access this information. Three recommendations were made to improve compliance with the MISSION Act.

## Information Technology

### **Inspection of Information Security at the VA Beckley Healthcare System in West Virginia**

The inspection of the VA Beckley Healthcare System identified multiple security deficiencies with configuration management, security management, and access controls. Among the findings were incomplete and inaccurate information on vulnerabilities needing remediation, the healthcare system's special purpose IT system lacking an authorization to operate, sensitive network segments not being separately controlled, some systems lacking a functional uninterrupted power supply, the medical center's computer room and 19 communication closets not adequately protecting data lines and IT equipment, and unencrypted hard drives not being sanitized before they were shipped out for destruction. The OIG made 10 recommendations to address these deficiencies.

### **Inspection of Information Security at the VA El Paso Healthcare System in Texas**

At this healthcare system, the OIG identified two deficiencies in configuration management controls, none in security management controls, and six in access controls. The configuration management deficiencies were specifically in the areas of vulnerability management controls—as the healthcare system's controls did not identify all network weaknesses, such as unsupported versions of applications—and flaw remediation controls, which did not ensure comprehensive patch management. Further, some vulnerabilities were not remediated within established time frames. The OIG also identified and recommended eight corrective actions to address multiple access control deficiencies: inventories of keys used by employees to gain access to buildings and rooms were not completed; reviews of physical access logs were not done quarterly as required; temperature and humidity controls were lacking in communications rooms; surveillance cameras were inoperable; water detection controls were not working; and the emergency power shutoff was not tested annually.

### **Inspection of Information Security at the VA Dublin Healthcare System in Georgia**

A third information security inspection took place at the VA Dublin Healthcare System in Georgia, where the OIG also found deficiencies with configuration management, security management, and access controls. Weaknesses in configuration management included unidentified critical-risk vulnerabilities, which could risk unauthorized access to, or the alteration or destruction of, critical systems. The three identified security management control deficiencies were lack of authorization to operate, inappropriate security categorizations, and lack of remediation of unapproved software. The healthcare system also had deficiencies in physical access security, emergency power, and monitoring of physical and environmental controls. Four recommendations were directed to the assistant secretary for information and technology and chief information officer and three recommendations to the Carl Vinson VA Medical Center director to improve controls at the facility.



### **VA Should Strengthen Enterprise Cloud Security and Privacy Controls**

This audit focused on whether VA is effectively assessing and monitoring security and privacy controls for the Veterans Affairs Enterprise Cloud (VAEC), which hosts more than 200 systems used by employees, veterans, and contractors. In September 2020, the National Institute of Standards and Technology updated its guidance to improve security and privacy controls. Although VA made some progress, its cloud systems were not fully compliant as of June 2023. The audit team found deficiencies in securing personally identifiable information and supply chain management for all 13 VAEC systems reviewed. Further, the majority of VAEC-hosted systems did not have proof of continuous monitoring. The team also concluded that VA lacks a consistent process to identify, document, and submit cloud service recoupment claims when vendors are responsible for outages that exceed contract requirements, thereby missing opportunities to recoup service credits. VA concurred with the OIG's five recommendations involving updating its security and privacy guidance, monitoring VA Enterprise Cloud systems, and improving processes for submitting recoupment claims.

### **Financial Efficiency**

#### **A Summary of Preaward Reviews and Examinations of VA Federal Supply Schedule (FSS) Pharmaceutical Proposals Issued in Fiscal Year 2022**

The OIG reviews pharmaceutical proposals submitted to the VA National Acquisition Center for FSS contracts valued annually at \$5 million or more. This report summarizes 14 OIG preaward contract reviews of pharmaceutical proposals conducted in fiscal year 2022. These proposals had a cumulative 10-year estimated contract value of \$11.2 billion and included 808 offered drug items. The OIG concluded that commercial disclosures were accurate, complete, and current for four proposals. The remaining 10 proposals could not be reliably used for negotiations by VA until deficiencies were corrected. The OIG recommended lower prices than offered for 10 proposals, resulting in total sustained cost savings of approximately \$6.5 million over the life of the contracts. For 29 of 78 items in the OIG's sample, the team determined proposed tracking customers were not suitable and recommended appropriate options. This report details the prior recommendations to VA but does not propose any additional corrective actions.

#### **Manufacturers Failed to Make Some Drugs Available to Government Agencies at a Discount as Required**

The Veterans Health Care Act of 1992 mandates that manufacturers discount drugs they sell to VA, the Department of Defense (DoD), the Public Health Service, and the Coast Guard. The OIG conducts individual audits of manufacturers that have self-disclosed potential noncompliance. This review, however, was conducted to proactively determine the number of covered drugs that manufacturers did not make available as required and the possible reasons. The OIG found manufacturers did not make 22.8 percent of drugs covered by the law available at a discount. This resulted in an estimated

\$28.1 million in overcharges to VA and the DoD. Recommendations included better communicating to manufacturers about exemptions and familiarizing them with the law.

## Management Advisory Memoranda

The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

### **The Electronic Health Record Modernization Program Could Strengthen Its Process for Reviewing Task Order Progress Reports**

The OIG issued this management advisory memorandum to VA following an allegation that Cerner, the contractor responsible for developing and implementing VA's new electronic health records system, billed VA for progress reports containing only minimal information. Because the allegation referenced contractor deliverables from October 2019 through March 2020 and that Cerner was behind in billing VA in January 2020, the OIG reviewed the progress reports associated only with that timeframe for the first task order under the governing contract to assess the merits of the allegation. The OIG did not substantiate the allegation but did note VA lacked contractor timeline requirements for correcting insufficient progress reports. The delays observed for contractors' corrections to progress reports could limit VA's ability to promptly and accurately monitor contractors' progress on particular tasks. This memorandum conveys the information necessary for the Electronic Health Record Modernization Integration Office to determine if remedial actions are warranted.

### **Opportunities Exist to Improve the Accuracy of Veterans' Emergency Housing Assistance and Permanent Housing Placement Data**

VHA's Supportive Services for Veteran Families program helps veterans and their families who are experiencing, or at imminent risk for, homelessness. The Office of Audits and Evaluations team assessed the program's oversight of grantees' use of emergency housing assistance to place veterans in permanent housing and the program's efforts to do so in a timely manner. The OIG found that due to software limitations and data entry errors, program data did not always accurately reflect the dates veterans started receiving emergency housing assistance or when they moved into permanent housing. Without accurate data related to how long veterans stay in emergency housing, VHA lacks the information to follow up with grantees in a timely manner, assist grantees, and ensure compliance with the 60-day limit on emergency housing assistance for veterans. The OIG encouraged VHA leaders to consider strengthening the data-validation process.

### **Inconsistent Disability Benefits Questionnaires May Lead to Inaccurate Mental Competency Determinations**

While assessing an anonymous allegation of wrongdoing involving two fiduciaries, the OIG discovered inconsistencies in the disability benefits questionnaires the VBA uses to elicit medical professionals' assessments of veterans' mental competency. Two of the four questionnaires included the regulatory definition of mental incompetency, but none of them posed the question for assessing mental competency in a way that matches the regulatory definition wording. A disability medical examiner's response to the mental competency question can influence a decision on that veteran's ability to manage their own financial affairs, including benefit payments. Language discrepancies on the questionnaire can lead medical examiners to provide inaccurate assessments and disparate outcomes for veterans. This memorandum is meant to convey the information necessary for VBA to determine if additional actions are warranted beyond those noted in VA's response.

## **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.

### **Healthcare Inspections**

#### **Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth**

The Office of Healthcare Inspections' team reviewed concerns related to care coordination for patients at the VA Eastern Kansas Health Care System who received care and were dually prescribed opioids and benzodiazepines from Community Care Network (CCN) providers. The OIG found issues related to incomplete and delayed CCN providers' documentation, risk-mitigation strategies, prescriptions dispensed at VHA and non-VA pharmacies, medication reconciliation, and medication profile updates. In addition to identifying two patients who received multiple controlled substance prescriptions from a combination of VHA and CCN providers, the review team identified concerns with the Veterans Integrated Service Network (VISN) director's and system staffs' oversight of the opioid-prescribing practices of CCN providers and reporting unsafe provider practices. The report has 13 recommendations related to ensuring oversight of CCN providers' prescribing practices, documentation of CCN-prescribed medication and risk-mitigation strategies, and training.

### **A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas**

A Veterans Crisis Line (VCL) responder was found to have inadequately assessed suicide risk and alcohol use for a patient who died by suicide within an hour after the patient's text contact with the VCL. The responder failed to effectively develop a safety plan, involve a family member, confirm access to lethal means was reduced, and consider transferring communications from text to telephone. VCL leaders also failed to provide adequate oversight and quality assurance. After being notified of the patient's death, VCL leaders and staff failed to complete a root cause analysis, consider a disclosure to the patient's personal representatives, alert Audie L. Murphy Memorial Veterans Hospital staff of the patient's death, address a family member's complaint about the VCL's services, and discontinue caring letters (brief messages of concern sent to patients following contact with the VCL). VCL personnel also potentially interfered in the OIG inspection. Facility leaders and staff failed to update the patient's electronic health record and complete a behavioral health autopsy as well. The OIG made 14 recommendations.

## **National Reviews**

### **Featured Joint Report**

#### **Review of Personnel Shortages in Federal Health Care Programs during the COVID-19 Pandemic**

The COVID-19 pandemic put an unprecedented strain on the nation's federal healthcare systems. The Pandemic Response Accountability Committee Health Care Subgroup surveyed more than 300 facilities across four federal healthcare programs to determine if the facilities had sufficient medical staff during the pandemic. The VA OIG reviewed staffing at VHA facilities, the Department of Justice OIG reviewed Federal Bureau of Prisons facilities, the DoD OIG reviewed medical treatment facilities, and the Health and Human Services OIG reviewed staffing within Medicare- and Medicaid-certified nursing homes. Collectively, the subgroup confirmed that most facilities had challenges hiring and maintaining the staff they needed. This joint report provides insights into shortages in personnel positions most commonly reported; factors contributing to personnel shortages; impacts on healthcare personnel, patients, and healthcare services provided by the federal programs; and strategies to mitigate staff shortages caused or exacerbated by the pandemic. Specific insights include the following:

- Nurses and medical officers were the most commonly reported positions that experienced shortages during the pandemic.

- A limited labor pool, noncompetitive pay, COVID-19 requirements, and a challenging hiring process were the most commonly reported factors that contributed to personnel shortages.
- A decrease in patient access to care and satisfaction, as well as an increase in healthcare personnel work hours and responsibilities, were the most commonly reported effects from personnel shortages.
- Monetary incentives were the most commonly reported strategy to recruit and retain personnel.

These insights can help policymakers understand the challenges that federal healthcare programs experienced throughout the pandemic and determine the actions necessary to ensure sufficient staffing for ongoing healthcare needs and future pandemic response efforts.

### **Review of Veterans Health Administration Reproductive Health Services**

The OIG conducted a national review of VHA's reproductive health services. VA medical facilities were generally able to provide reproductive health services. The concerns most frequently reported were not unique to reproductive health care and were consistent with recognized broader challenges, including provision of rural health care, community care provider availability and coordination, and VHA staffing shortages. Challenges were more frequently reported regarding implementation of abortion services, newly authorized under VA's interim final rule related to reproductive health services. Despite federal protections, facility leaders described concerns that providing abortion services in states with legal restrictions would place providers at risk for civil or criminal liability or disciplinary action by state licensing boards. Lack of community-based abortion resources and the need for ongoing national guidance and trainings were also identified as challenges for implementation. Facility leaders will need ongoing support as VHA continues to develop guidance.

### **Review of Veterans Health Administration's Multi-tiered Patient Safety Program**

The Office of Healthcare Inspections team conducted surveys of VISN patient safety officers (PSOs) and medical facility patient safety managers (PSMs), including questions about oversight, culture, staffing, and training. The OIG also conducted interviews with VHA quality and patient safety leaders and PSOs. The OIG identified opportunities to strengthen patient safety programs at VISNs and facilities, such as evaluating communication barriers, establishing facility patient safety program oversight requirements, revising National Center for Patient Safety quarterly reports, developing a PSM staffing configuration, implementing formalized PSO and PSM training, and reviewing factors contributing to their burnout. VHA concurred with the OIG's nine recommendations.

### **Comprehensive Healthcare Inspections**

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that 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 inspections. September's CHIP reports focused on the following facilities:

- [Erie VA Medical Center in Pennsylvania](#)
- [VA Sierra Nevada Health Care System in Reno](#)
- [St. Cloud VA Health Care System in Minnesota](#)
- [Wilkes-Barre VA Medical Center in Pennsylvania](#)
- [Michael E. DeBakey VA Medical Center in Houston, Texas](#)
- [Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania](#)
- [VA Northern California Health Care System in Mather](#)
- [Central Arkansas Veterans Healthcare System in Little Rock](#)
- [Gulf Coast Veterans Health Care System in Biloxi, Mississippi](#)
- [Alexandria VA Health Care System in Pineville, Louisiana](#)

The OIG also analyzes findings across individual CHIP reports and, from these analyses, produces CHIP summary reports that provide national-level evaluations focused on specific areas of care. During this month, the OIG published one CHIP summary report:

### **Evaluation of Medication Management in Veterans Health Administration Facilities**

This report highlights the aggregate results of a focused evaluation of VHA facilities' medication management related to teratogenic medication prescriptions (drugs administered to women, who if pregnant, may cause a change in their fetus or child). The report draws from healthcare inspections performed at 45 VHA medical facilities. The inspection team interviewed key staff and reviewed the electronic health records of 1,352 randomly selected patients with the potential to become pregnant, who received care at the inspected facilities from July 1, 2020, through June 30, 2021, and were prescribed a teratogenic medication. The OIG issued one recommendation for improvement related to providing counseling to patients on the risks and benefits of teratogenic medications.

## **Featured Hotline Case**

The OIG's hotline staff accepts complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross 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.



### **The VA Greater Los Angeles Health Care System Develop Plans for A New Geriatric-Psychiatric Ward after the Review of a Patient's Fall**

The OIG Hotline received an allegation that an elderly patient of the VA Greater Los Angeles Health Care System sustained a ground-level fall during admission to the mental health inpatient unit in May 2022. The allegation was reviewed and substantiated by the medical center. The veteran was found to be at a high risk for a fall at the time of admission. As a result, standard fall precautions were implemented by the receiving mental health unit, to include conducting checks on the patient every 15 minutes. Despite these actions, an unwitnessed fall occurred when the veteran attempted to move to the bathroom without a nurse's assistance and without use of an available wheelchair. The fall resulted in a left hip fracture. A root cause analysis (RCA) investigation revealed that a mental health treatment plan and safety plan were not completed for the veteran within VA-prescribed timelines. The RCA also determined that the inpatient mental health unit faces challenges in meeting the needs of geriatric patients requiring inpatient psychiatric care. This includes accommodating the patient's mental health safety and the need for assistive mobility devices by geriatric patients. As a result of the medical center's responsive review to the OIG referral, eight corrective actions were identified to include chart audits, frequent reminders to patients on how to safely move within the ward, and mental health leaders' decision to create a new psychiatric ward for geriatric patients. The architectural designs are reported to be underway.

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To listen to the podcast on the September 2023 highlights, go to [www.va.gov/oig/podcasts](https://www.va.gov/oig/podcasts).