APRIL 2024 HIGHLIGHTS

Congressional Testimony

Deputy Assistant Inspector General for Healthcare Inspections Testifies on Ensuring Equity for Women Veterans

Dr. Jennifer Baptiste, Deputy Assistant Inspector General for Healthcare Inspections, testified before the Senate Veterans' Affairs Committee on April 10. She focused on the challenges VA faces in its efforts to increase and enhance its services for women veterans, including addressing the OIG-identified healthcare program deficiencies in supporting the needs of this growing population. Her testimony emphasized the importance of VA improving both access to gender-specific care within their facilities and the coordination of care that women veterans receive in the community, as some services—such as maternity care—are not generally provided by VA. In response to questions, Dr. Baptiste noted that the Veterans Benefits Administration (VBA) should increase the accuracy and timeliness of processing claims for military sexual trauma benefits, and discussed how recommendations that the OIG issues for one VA medical facility should be used as a road map for other facilities to follow as well. The written statement can be found on the OIG website, and the hearing can be viewed 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

Three Defendants Sentenced to Prison and $6.9 Million Forfeiture for Roles in Fraudulent Nursing Diploma Scheme

A multiagency investigation known as "Operation Nightingale" revealed that a network of nursing schools sold more than 7,600 fraudulent nursing diplomas and transcripts to individuals seeking nursing degrees. This scheme enabled thousands of these individuals to take board certification tests to become registered or licensed practical nurses, with many of them passing the test and eventually finding employment with various unwitting healthcare providers throughout the country. This includes more than 260 current and former VA employees. Three defendants were sentenced in the Southern District of Florida to a combined total of 147 months in prison and were ordered to forfeit over $6.9 million after being found guilty following a three-

week trial. These three defendants and an additional 11 codefendants were previously charged for their involvement in this scheme. The VA OIG, Department of Health and Human Services (HHS) OIG, and FBI investigated this case.

Former VA Nurse Sentenced for Sexual Contact with Mentally Disabled Veteran

A VA OIG and VA Police Service investigation found that a registered nurse at the VA Palo Alto Health Care System engaged in inappropriate sexual contact at the facility with a mentally incapacitated veteran who was receiving inpatient treatment. After pleading guilty to abuse of a dependent person, the nurse was sentenced in Santa Clara County Superior Court to one year of probation and ordered to complete a one-year sex offender treatment program, not renew her nursing license, and not have contact with the victim.

Benefits Investigations

Veteran Pleaded Guilty in Connection with Multiple Fraud Schemes

A multiagency investigation revealed that a veteran submitted false documents to VA to obtain a VA-backed loan for a property valued at $2.1 million. The veteran also used his position as an Army financial counselor to target gold star families to invest their survivor benefits in investment accounts that were managed by his private employer. The defendant pleaded guilty in the District of New Jersey to charges of wire fraud, securities fraud, making false statements in a loan application, committing acts furthering a personal financial interest, and making false statements to a federal agency. The investigation was completed by the VA OIG, Homeland Security Investigations, Defense Criminal Investigative Service, and FBI.

Veteran Sentenced for Misleading VA and the Social Security Administration about His Ability to Walk

A veteran fraudulently claimed to have lost the use of both his feet to obtain VA compensation and Social Security Disability Insurance benefits. The total loss to the government is approximately $594,000, which includes a $434,000 loss to VA. The veteran was sentenced in the Western District of Texas to three years of probation and $242,000 in restitution after pleading guilty to making false statements related to a healthcare matter. The VA OIG and Social Security Administration OIG conducted this joint investigation.

Default Civil Judgment Returned against Barber School and Owner for Education Benefits Fraud Scheme

A VA OIG investigation led to the return of a default civil judgment in the Southern District of Mississippi against a barber school and the school's owner for defrauding VA's Post-9/11 GI Bill education assistance program. The investigation revealed that from 2017 to 2019, the school enrolled VA students in yearlong barber courses at a cost of $22,400 while similarly

situated nonveteran students were only charged approximately $2,400. The loss to VA is about $235,734. The judgment entitled the United States to $916,392, which equates to treble damages for the fraudulent receipt of benefits, in addition to 15 statutory penalties. Treble damages are awarded in an amount that is three times the amount for which the wrongdoer is found liable.

Nonveteran Charged with Stolen Valor and Benefits Fraud

Another VA OIG investigation resulted in charges alleging that a nonveteran obtained VA compensation benefits by fraudulently claiming to be a decorated US Marine Corps veteran who had been a prisoner of war during deployment to Iraq in 2005. The defendant also allegedly claimed to suffer from posttraumatic stress disorder and other injuries caused by an improvised explosive device attack while serving in Iraq. The nonveteran allegedly forged and falsified documents in support of his VA benefits application, to include a fraudulent DD Form 214 and Purple Heart certificate. The loss to VA is over $146,000. The defendant was arrested after being indicted in the District of Minnesota on charges of wire fraud, false military discharge certificate, fraudulent use of military medals, and theft of government funds.

Investigations Involving Other Matters

Former Procurement Supervisor Sentenced for Role in Kickback Scheme

A procurement supervisor at the Jesse Brown VA Medical Center in Chicago received kickbacks totaling approximately $36,250 from the president of a medical supply company in exchange for initiating and approving orders for medical products that were never delivered to VA. The total loss to VA is approximately $1.7 million. The defendant was sentenced in the Northern District of Illinois to 84 months in prison, three years of supervised release, and restitution of more than $1.7 million. He was also ordered to repay $2,600 in salary that he received during the investigation. The VA OIG conducted this investigation.

Former Adult Day Care Center Board Member Pleaded Guilty to Embezzlement

A multiagency investigation revealed a former board member for an adult day care center added attendance days and services that were not provided to bills sent for payment to VA and other agencies. When management at the adult day care center uncovered the situation, the defendant was immediately relieved of her duties and the alleged fraud was reported to law enforcement. The total loss is approximately $477,000. Of this amount, the loss to VA is over $362,000. The defendant pleaded guilty in the Seventh Judicial Circuit Court for the County of Pennington (South Dakota) to grand theft by embezzlement. The VA OIG, South Dakota Department of Human Services, Rapid City Police Department, and HHS OIG conducted the investigation.

Thirteen VA Employees Indicted on Charges Related to COVID-19 Fraud Scheme

According to another multiagency investigation, in 2020 and 2021, 13 Cleveland VA Medical Center employees allegedly received $434,181 in Pandemic Unemployment Assistance benefits by falsifying their applications and failing to disclose their employment and wages earned at VA. Funded by the CARES Act, the unemployment benefits were distributed by the Department of Labor to the Ohio Department of Job and Family Services, which then paid the medical center employees. The defendants were indicted in Cuyahoga County (Ohio) Court on charges of theft and tampering with government records. The VA OIG, Department of Labor OIG, and US Postal Inspection Service 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 report.

Community Care

Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance

The Veterans Community Care Program allows the Veterans Health Administration (VHA) to purchase care for veterans through Community Care Network contracts. The Office of Integrated Veteran Care (IVC) oversees execution of these contracts with third-party administrators (TPAs) that manage community care providers in assigned regions of the network. The OIG found that IVC did not hold TPAs accountable for specific contract requirements, which limited the number of community providers available at the eight facilities the audit team visited. Specifically, IVC did not oversee that TPAs ensured facilities had enough community providers to administer care within the timeliness and drive-time standards required. IVC also did not conduct analyses of facilities' network adequacy needs, confirm TPAs maintained provider networks accepting VA patients, or position itself to defend facilities' needs for additional providers. The under secretary for health concurred with the OIG's eight recommendations regarding oversight of future TPAs.

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 in April.

National Reviews

Featured Report

Veterans Health Administration's Failure to Properly Identify and Exclude Ineligible Providers from the VA Community Care Program

The OIG reviewed the process by which VHA identifies healthcare providers who had been removed from VA employment due to violations of policy "relating to the delivery of safe and appropriate care" and excludes them from the VA Community Care Program, as required by the MISSION Act. The OIG found that VHA's process failed to identify all healthcare providers removed from VA employment and also did not accurately identify personnel actions that indicated healthcare providers were removed from VA for violating policies relating to the delivery of safe and appropriate care. The process cannot discern the reason a provider was removed. These process failures resulted in ineligible healthcare providers being included in, as well as eligible providers being excluded from, the community care program. VHA concurred with the OIG's two recommendations to improve the criteria and processes used to identify ineligible healthcare providers and the reason for their removal from VA employment.

Deficiencies in Attention Deficit Hyperactivity Disorder Diagnostic Assessment, Evaluation of Stimulant Medication Risks, and Policy Guidance

This report evaluated VHA's attention deficit hyperactivity disorder (ADHD) diagnostic assessment practices, stimulant medication prescribing practices, training, and policies. The OIG found that prescribers insufficiently documented support for ADHD diagnoses corresponding to new stimulant prescriptions, as well as inadequately assessed the risks and contraindications of these prescriptions. Prescribers met the goals of prescription drug monitoring program queries (75 percent of new and 95 percent of active controlled substance prescriptions); however, the OIG found deficiencies in prescribers' reported ADHD diagnostic and stimulant-prescribing training and knowledge.[1] In an OIG survey, 13 percent of mental health and 65 percent of

[1] Since 2016, VHA requires prescribers to query state prescription drug monitoring programs, which are state-level databases that allow prescribers to review a patient's prescription history to inform clinical practice and protect patients at risk for misuse of controlled substances. The information obtained by querying prescription drug

primary care survey respondents reported being somewhat or not knowledgeable about prescribing stimulants as treatment for ADHD. VHA also has no established ADHD-related policies. The OIG made five recommendations to the under secretary for health related to diagnostic assessment, assessment of risks and contraindications, prescription drug monitoring program goals, the referral process for complex mental health conditions, and ADHD policy and clinical practice guidance.

Opportunities Exist to Better Integrate Health-Related Social Needs and Social Determinants of Health into Discharge Assessment and Planning

In this review, the OIG assessed the incorporation of social determinants of health (SDOH) and health-related social needs (HRSN) into discharge assessments, planning, policies, and templates, as well as VHA's efforts to identify and address SDOH/HRSN with health disparity tools and community resources.[2] The review found no VHA policies or procedures that incorporated SDOH/HRSN into discharge assessment and planning within inpatient units. Although the review team identified three national reference documents that addressed SDOH/HRSN, these were not considered formal guidance and were largely unknown to medical center leaders. VHA launched the Assessing Circumstances and Offering Resources for Needs initiative in 2018, a screening tool that expands VHA's capability to collect data, incorporates SDOH/HRSN questions, and captures results within electronic health records; however, only two medical centers used the tool within inpatient medical units. The OIG made five recommendations to the under secretary for health, including developing a national policy to incorporate SDOH/HRSN into discharge assessment and planning, evaluating barriers to assessing SDOH/HRSN, and establishing community resource partnerships to address SDOH.

Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care

The Making Advances in Mammography and Medical Options for Veterans Act of 2022 requires the OIG to report on mammography services and breast cancer care provided to veterans. In accordance with this requirement, the OIG conducted an evaluation of mammography services delivered through the outpatient settings of randomly selected VA medical facilities and community providers. The OIG also assessed the performance of VA's Women's Oncology System of Excellence and patients' accessibility to a comprehensive care team, for those diagnosed with breast cancer, as required by the legislation. Because veterans receive

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monitoring programs enables VHA providers to identify patients who are receiving controlled substances from multiple sources and can be helpful in preventing diversion of controlled substances and substance use disorders.

[2] The VA Office of Health Equity defines SDOH as "the social, economic, and physical conditions in the environments where people live, work, and play." HRSN are individual social and economic needs such as housing stability, access to food, employment, personal safety, transportation, and affordable utilities.

mammography services and breast cancer care through VA and community providers, the OIG deployed teams from both its Comprehensive Healthcare Inspection Program (CHIP) and Care in the Community Program to gather data for this inspection. The OIG issued three recommendations for improvement to ensure that

- facility leaders and staff are aware of the services offered to veterans diagnosed with breast cancer through the Women's Oncology System of Excellence;
- the under secretary for health and National Oncology Program staff offer a range of services for patients diagnosed with breast cancer, including rehabilitative services, through the Women's Oncology System of Excellence; and
- staff enter data into the local cancer registry database in a timely manner.

Healthcare Inspections

Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California

This inspection assessed the high usage of community care services for primary care, the impact of that use, and healthcare system leaders' oversight of VA outpatient clinics. The OIG found that a new company responsible for managing the healthcare system's five non-VHA-operated clinics experienced challenges staffing the clinics, which increased the number of patients assigned to the panels of patient aligned care team providers. As a result, healthcare system leaders paused enrollment of new patients at all five non-VHA-operated clinics. While there were delays in processing and scheduling community care consults (referrals) after the increase in primary care in the community, the OIG did not identify patients who experienced poor outcomes. A lack of oversight of non-VHA-operated clinics, as well as frequent changes of leadership at the healthcare system and the new company, highlighted a vulnerability in the overall management of primary care services. The OIG made three recommendations regarding primary care staffing and panel sizes, timeliness of community care consult processing, and clinic oversight.

Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico

An inspection was initiated to assess allegations and concerns about reprocessing of reusable medical devices and VISN oversight. The OIG substantiated that patients underwent gastroenterology procedures with reusable medical devices that did not have high-level disinfection documentation. While no adverse clinical outcomes were found, Sterile Processing Service leaders did not inform the Gastroenterology Service when documentation was missing, which impeded clinical staff from ensuring risks to patient safety were immediately addressed.

Deficiencies in Sterile Processing Service quality assurance processes persisted into March 2023, despite facility leaders' awareness of related findings from a May 2022 VISN audit. The OIG determined that failures in VISN oversight resulted in delayed implementation of corrective actions, which did not occur for over a year from the original audit findings. The OIG made seven recommendations regarding VISN oversight, facility high-level disinfection documentation, and clear communication about Sterile Processing Service staff roles and responsibilities.

Comprehensive Healthcare Inspections

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. April's CHIP reports centered on the following facilities:

- VA Central Iowa Health Care System in Des Moines
- Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan
- VA Maine Healthcare System in Augusta
- VA Northern Indiana Health Care System in Marion
- Syracuse VA Medical Center in New York
- VA Salt Lake City Health Care System in Utah
- Bay Pines VA Healthcare System in Florida
- VA Bedford Healthcare System in Massachusetts
- Martinsburg VA Medical Center in West Virginia
- Tuscaloosa VA Medical Center in Alabama
- Boise VA Medical Center in Idaho
- Jesse Brown VA Medical Center in Chicago, Illinois
- G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi
- Edward Hines, Jr. VA Hospital in Hines, Illinois
- Louis A. Johnson VA Medical Center in Clarksburg, West Virginia
- VA Nebraska-Western Iowa Health Care System in Omaha
- VA Illiana Health Care System in Danville, Illinois
- Central Virginia VA Health Care System in Richmond
- Kansas City VA Medical Center in Missouri
- VA Eastern Kansas Health Care System in Topeka
- VA Finger Lakes Healthcare System in Bath, New York

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families. 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. April's VCIP reports focused on the following districts and vet centers:

- Southeast District 2 Zone 1: Vet Centers in Augusta, Marietta, and Savannah in Georgia; Johnson City, Tennessee; Charleston, South Carolina; and Bay County, Florida
- Southeast District 2 Zone 2: Vet Centers in Ft. Lauderdale, Ft. Myers, Gainesville, Lakeland, and Naples in Florida; and San Juan in Puerto Rico
- Southeast District 2 Vet Center Operations

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To listen to the podcast on the April highlights, go to the monthly highlights page on the VA OIG website.