



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT FEBRUARY 2019 HIGHLIGHTS

FEBRUARY 2019

Kristie van Gaalen:

This is Kristie van Gaalen, a nurse consultant with the VA Office of Inspector General in Bay Pines, Florida. I am excited to have been recently hired to work in the Inspector General's Office and to provide you with our February highlights.

Inspector General Michael Missal met with lawmakers on Capitol Hill, including Representative Debbie Wasserman Schultz, who is the chairwoman of the House Appropriations Subcommittee, and Representative Mark Takano, who is the chairman of the House Committee on Veterans' Affairs. Both meetings provided an opportunity to hear about their respective committees' priorities for the new Congress and to provide updates on OIG developments. The meetings resulted in productive conversations that touched on multiple aspects of the OIG's oversight work.

The OIG published two oversight reports in February. In the report *Medication Management, Dispensing, and Administration Deficiencies at the VA Maryland Health Care System in Perry Point, Maryland*, the OIG reviewed the care of a patient who died in the hospice unit after receiving a potential overdose of pain medication. The OIG found that facility processes and medication management issues contributed to increased patient risk when dispensing pain medication solution in a bulk bottle for multiple patients. The OIG made eight recommendations related to evaluating and addressing the inaccuracies and risks involved with using bulk bottles of oxycodone solution, the quality review of the patient's death, nurse hiring practices, and that competencies for high-alert medications are met.

In the second report *Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center in Florida*, the OIG assessed allegations that a patient died while experiencing a delay in obtaining approval for surgery outside VA. The OIG substantiated that there were delays in the processing the patient's approval and identified other patients with non-VA cardiothoracic surgery consults during the period of January 1, 2017, through October 31, 2017. The delays were related to an increase in the number of consults and limited staff available to process them. The OIG did not identify adverse clinical outcomes associated with the delays, including for the patient who had died. The OIG made six recommendations. These included the need to address a practitioner's evaluation of the patient six months prior to death, to implement a tool to track the non-VA consult process, and to improve additional processes to comply with VA policies.

Among its many criminal investigative activities, a joint OIG and FBI investigation resulted in the conviction and sentencing of a former VA employee and three other individuals for their roles in a

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PODCAST TRANSCRIPT

scheme to defraud the VA of education benefits. The VA employee received cash bribes to steer \$2 million in education payments intended for disabled veterans to three for-profit schools. The schools sent VA false information about the education benefits being provided to veterans. In turn, the former VA employee knowingly used this false information to facilitate payments to the schools. The former VA employee was sentenced to 132 months in prison and the other three individuals involved in the scheme were sentenced to 70, 20, and 30 months in prison. All four individuals were also sentenced to pay restitution that totaled \$1.85 million.

The OIG's podcasts are produced by OIG staff. To hear other podcasts, learn more about the OIG and its oversight reports, or to report wrongdoing, visit the website at www.va.gov/oig.