



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT JANUARY 2020 HIGHLIGHTS

Jan 2020:

This is Christina Horton, a Systems Administrator with the VA Office of Inspector General in Hines. Here are the January highlights.

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a January 29, 2020, hearing before the House Committee on Veterans' Affairs on "Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach." Dr. Kroviak's testimony was drawn from nearly two dozen VA Office of Inspector General (OIG) reports, such as [*Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2018*](#), [*Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*](#), and [*Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida*](#), and two reports discussing veteran deaths by suicide at the Minneapolis VA Medical Center. In these reports, the OIG found inadequate coordination of care to be an underlying theme in many of the suicides. During questioning, Dr. Kroviak reiterated OIG findings that the root causes for poorly implemented Veterans Health Administration (VHA) policies include staffing shortages, inadequate training, and leadership failures.

A recent OIG criminal investigation resulted in the sentencing of eight former pharmaceutical company executives, including the founder and majority owner, chief executive officer, and vice president of sales, in the District of Massachusetts for their roles in a Racketeer Influenced and Corrupt Organizations (RICO) Act conspiracy. Each defendant received a custodial sentence with incarceration time ranging from 12 to 66 months. The investigation revealed the pharmaceutical company's executives led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of a reimbursement center, the defendants also conspired to mislead and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorizations from insurers. VA's Civilian Health and Medical Program (CHAMPVA) paid the company approximately \$3.3 million for this drug. This case was investigated by the VA OIG, Department of Labor (DOL) OIG, U.S. Postal Service OIG, Health and Human Services (HHS) OIG, U.S. Postal Inspection Service, Food and Drug Administration Office of Criminal Investigations, Drug Enforcement Administration, Office of Personnel Management OIG, FBI, and Defense Criminal Investigation Service.

The OIG published 22 oversight reports in January including 13 Comprehensive Healthcare Inspection Program reports. In the report [*Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes*](#), the OIG determined if VHA efficiently manages positive airway pressure

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devices and supplies for veterans diagnosed with sleep apnea. The number of veterans who receive devices and supplies increased dramatically in five years, increasing VA's financial risk. VHA did not efficiently manage devices and associated supplies—almost half of the 250,000 veterans issued a device from October 2016 through May 2018 used it less than half the time. VHA could save up to \$39.9 million annually with alternative processes such as loaning devices rather than purchasing them. A loan program could save up to an additional \$12.4 million annually by not purchasing device supplies for veterans who do not use their devices. The OIG made three recommendations to the under secretary for health regarding management of sleep apnea devices including looking at staffing levels, ways to better monitor device use, and alternatives to purchasing devices.

In another report, [*Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System*](#), the OIG evaluated concerns related to deficiencies in the Women Veterans Health Program, quality management in patient safety and resuscitation attempts, and leaders' responses to recommendations from oversight bodies at the facility. The facility had an insufficient number of women's health primary care providers available to provide gender specific comprehensive primary care for women veterans. Resources needed to support comprehensive women veterans' healthcare were insufficient. Community Care results were not consistently tracked. The facility's quality management performance measurement and evaluation processes did not ensure awareness of quality of care concerns to inform facility leaders' of required institutional disclosures and adverse event decision-making. The resuscitation committee did not capture and review all resuscitation attempts, nor take corrective actions to identify the causes surrounding these events. The OIG made 18 recommendations related to staffing, appointment times, current and future resources, community care, and quality management processes.

Other reports include [*Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims, Improvements Are Needed in the Community Care Consult Process at Veterans Integrated Service Network 8 Facilities*](#), and a [*Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington*](#).

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