PODCAST TRANSCRIPT
MARCH 2020 HIGHLIGHTS

March 2020:

This is Quintin Durden, a Deputy Director with the VA Office of Inspector General in Washington, D.C. Here are the March highlights.

Mr. David Case, Deputy Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Technology Modernization Subcommittee March 5, 2020, on "Getting It Right: Challenges with the Go-Live of Electronic Health Record Modernization." Mr. Case's testimony was drawn from two not-yet-published VA Office of Inspector General (OIG) reports, *Review of Access to Care and Capabilities During the Transition to VA's New EHR* and *Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System*. He explained that the OIG's work found VA had not met its own readiness guidelines for deploying the new Electronic Health Record (EHR) to the Mann-Grandstaff VA Medical Center in Spokane, Washington, and that the mitigations for incomplete capabilities—for example, requiring staff to use at least two internal systems and sometimes third-party software to find and manually transfer information, verify patient eligibility, and track approvals, all while providing patient care—posed significant patient safety risks. During the hearing, Mr. Case explained that the VA OIG would continue oversight of the EHR modernization program and monitor VA's new schedule for going live and deploying the system's full capabilities incrementally.

In other testimony, Mr. Christopher Wilber, Counselor to the Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee March 10, 2020, on pending legislation including H.R. 5843, the Strengthening Oversight for Veterans Act of 2020. Mr. Wilber testified in support of the bill, which would give the VA OIG testimonial subpoena authority. He explained how it would strengthen the VA OIG's work, discussed examples of inspections and investigations where the VA OIG could not interview former VA employees, and noted safeguards for witnesses.

As a result of another OIG investigation, a former Veterans Health Administration (VHA) Office of Community Care benefits adviser was found guilty by a federal jury in the District of Colorado of healthcare fraud, conspiracy, payment of illegal kickbacks and gratuities, money laundering, and conflict of interest. An investigation by the VA OIG, FBI, and IRS Criminal Investigation (IRS CI) resulted in charges that, from May 2017 through June 2018, the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives. The unlawful referrals led to payments totaling approximately $19 million from VA to these home health agencies.

As result of another OIG investigation, the former chief of podiatry for the Sacramento, California, VA Medical Center was sentenced in the Eastern District of California to 78 months' imprisonment and 24

months' supervised release and ordered to pay $234,260 in restitution to VA. A former VA prosthetics vendor, who was previously sentenced to 60 months' imprisonment and 36 months' supervised release, was also ordered to pay $479,360 in restitution to VA. An investigation by the VA OIG, Homeland Security Investigations, and VA Police Service resulted in charges that, between March 2008 and February 2015, the former chief and the vendor engaged in a scheme to defraud VA by billing for custom prescription footwear containing carbon graphite plates but instead provided veterans with inferior footwear containing preinstalled components. In addition, the chief, vendor, and a former employee of the vendor who separately pleaded guilty in December 2016 agreed to make materially false statements to VA regarding where their shoes were manufactured while applying for a national VA contract worth over $11 million per year.

The OIG published 8 oversight reports in March. In one report, *VA OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, the VA OIG evaluated COVID-19 screening processes at 237 VA facilities and collected data on pandemic preparations. Screening processes were adequate at 71 percent of visited medical centers, and many community-based outpatient clinics had screening procedures in place. Although VA announced a no visitors policy for community living centers on March 10, 2020, VA OIG staff had access to nine. Almost all medical facilities visited were collecting COVID-19 specimens, but only the VA Palo Alto Health Care System had the capability to process them. Facility leaders reported that the medication inventory may be insufficient, and some expressed concerns with their inventory of COVID-19 testing kits and personal protective equipment. Almost half of facility leaders reported a rise in absenteeism but were able to provide coverage to minimize impact. As of March 19, 2020, 43 percent of facility leaders reported plans to share intensive care beds and personal protective equipment supplies with community providers. Most leaders said they would send patients to another VA medical center or a private, community, university, or Department of Defense hospital if unable to meet patient care needs related to COVID-19.

In the report, *Federal Information Security Modernization Act Audit for Fiscal Year 2019*, the VA OIG contracted with an independent public accounting firm to assess VA's information security program for FY 2019, in accordance with the Federal Information Security Modernization Act (FISMA). The firm, CliftonLarsonAllen LLP, evaluated 49 major applications and general support systems hosted at 24 VA facilities. The firm concluded that VA continues to face significant challenges meeting FISMA requirements and made 25 recommendations. Recommendations included improving both performance monitoring and the deployment of security patches and system upgrades. The firm noted that all recommendations were repeated or modified from previous reports on FISMA compliance. CliftonLarsonAllen LLP will follow up on outstanding recommendations and evaluate VA's corrective actions during its FISMA audit for FY 2020. If delays in addressing recommendations continue, the VA OIG is concerned that a material weakness in informational technology security controls may be reported in the FY 2020 audit of VA's consolidated financial statements.

Finally, in *Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri*, the VA OIG conducted a healthcare inspection to evaluate a research cardiologist's provision of follow-up care, a cardiology fellow's provision of follow-up care and interpretation of electrocardiograms, the oversight of facility research bodies, and stress-test procedure instructions. After a research cardiologist failed to initiate cardiac follow-up care or notify a patient and the patient's primary provider of positive stress-test results, the cardiology fellow managed follow-up care; however, the VA OIG was unable to determine if the fellow had difficulty interpreting electrocardiograms. The facility research oversight bodies did not ensure primary providers' notification of patient enrollments in a research study. Instructions provided to cardiology fellows differed from the protocol used by facility staff. The VA OIG made six recommendations related to stress-test results; a review of enrolled patients' result notifications and follow-up care; disclosure; research oversight; and review of the stress-test laboratory educational material.

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