PODCAST TRANSCRIPT
JULY 2020 HIGHLIGHTS

This is Hanna Lin, a Health Systems Specialist with the VA Office of Inspector General (OIG) in Washington, DC. Here are the July highlights.

The Office of Investigations was busy in the month of July. Significant actions included the guilty plea of a nursing assistant to seven counts second-degree murder and one count of assault with intent to commit murder; the sentencing of a veteran to 25 years of mental health treatment; a nonveteran's guilty plea to stolen valor, healthcare fraud, mail fraud, and other charges; and a civil settlement agreement for violations of the False Claims Act.

A former nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, pleaded guilty to seven counts of second-degree murder and one count of assault with intent to commit murder. An investigation by the VA OIG and FBI, with assistance from the West Virginia State Police and the Greater Harrison County Drug and Violent Crimes Task Force, revealed that the defendant administered insulin to several patients under her care with the intent to cause their deaths. In her role as a nursing assistant, the defendant was not qualified or authorized to administer any medication to patients, including insulin.

In another case, a veteran was sentenced in the Southern District of Florida to 25 years of mental health treatment at a suitable medical facility and three years' supervised release. A VA OIG and FBI investigation revealed that the defendant inflicted non-life-threatening injuries on three VA emergency room employees by firing a handgun inside the West Palm Beach VA Medical Center.

In the Eastern District of Pennsylvania, a nonveteran pleaded guilty to stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, aiding and abetting straw purchases of firearms, and false statements to the Social Security Administration. A VA OIG and SSA OIG investigation revealed that from approximately April 2010 to September 2019, the defendant defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits. The defendant falsely claimed to be a decorated veteran, specifically, a Navy SEAL, a prisoner of war, and a Silver Star recipient. After the defendant was arrested, an additional investigation with the Bureau of Alcohol, Tobacco, Firearms, and Explosives revealed that the defendant participated in the straw purchase of two firearms. The loss to VA is over $302,000.

Finally, a for-profit holding company that directly or indirectly owned the assets or stock of inpatient and residential psychiatric and behavioral health facilities entered into a civil settlement agreement with the U.S. Attorney's Office for the Eastern District of Pennsylvania to resolve allegations that the company violated the False Claims Act. A VA OIG, Defense Criminal Investigative Service, Office of Personnel Management OIG, and Health and Human Services OIG investigation resolved allegations that the company knowingly submitted false claims related to unallowable costs for payment. As part of

the settlement, the company agreed to pay $117 million, which included $88.1 million to the federal government and $28.9 million to the Medicaid-participating states. From this settlement, VA will receive over $5.1 million.

In the month of July, the Office of Audits and Evaluations published four reports. In one report, *The Veterans Health Administration Did Not Get Secretary's Approval Before Using Canines for Medical Research*, five members of Congress requested that the OIG review the Veterans Health Administration's (VHA) canine research approval process. Congress recently mandated that the VA Secretary directly approve the use of appropriated funds for canine research. VHA conducted eight studies without the Secretary's direct approval, resulting in the unauthorized use of approximately $400,000 in appropriated funds. There also was no formal procedure to obtain and document the Secretary's approval. Unclear communication, inadequate recordkeeping, and inaccurate recording and verification of approval decisions contributed to VHA's noncompliance. Providing unsupported and potentially inaccurate information could undermine public trust in VA and detract attention from its important mission of supporting a wide range of authorized research on veterans' health. The OIG recommended the under secretary for health establish an approval process for canine research, ensure approval is documented, prevent appropriated funds from being spent without approval, and report to Congress on recent funds spent without the Secretary's approval.

The Office of Healthcare Inspections published 11 reports. In one report, *OIG Inspection of VHA's COVID-19 Screening and Pandemic Readiness*, the OIG evaluated processes specific to preparing facilities to meet unknown demands. This report discusses VHA's response to the pandemic and the evolving challenges faced by VHA in caring for veterans. The OIG engaged leaders from 70 selected facilities in discussions about patient-care services provided from March 11 through June 15, 2020. Topics included the management of urgent and emergent care, adequacy of equipment and supplies, testing capabilities, community living center admissions and discharges, and the engagement of community healthcare partners. Facility leaders described a multitude of actions taken. With the uncertainty of timing and magnitude of possible recurrent outbreaks, it was hoped this review, which presented strategies that various facilities put into place, would promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.

In a separate report, *Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care*, the OIG reviewed the accessibility of dermatology, orthopedics, and urology specialty care for patients in 17 CBOCs classified as highly rural from March 1, 2018 (or from the date the CBOC became highly rural), through February 28, 2019. The OIG identified that sites mostly used referrals to their parent facility and community care specialty providers. Sites rarely used telehealth, inter-facility consults, and eConsults. The OIG made four recommendations to the under secretary for health to assess specialty care needs, ensure VHA Site Tracking System validation, ensure the maintenance of accurate information on VA websites, and assess whether highly rural CBOCs located in non-VA health care centers fully utilized resources in the collocated facilities. After VHA implemented

its coronavirus disease 2019 Response Plan, four of the 17 highly rural CBOCs closed and 13 listed pre-pandemic operations on their websites.

Finally, The Office of Healthcare Inspections completed Comprehensive Healthcare Inspection Program or (CHIP) reviews of seven different VA healthcare facilities. CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The Office of Special Reviews published three investigative reports. In one report, *Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration*, it was substantiated that Peter Shelby, while serving as VA's Assistant Secretary for Human Resources and Administration, improperly steered a $5 million contract for the benefit of individuals with whom he had a personal relationship. The OIG determined that the contract resulted entirely in waste. The contract was awarded on a sole-source basis in accordance with Mr. Shelby's direction, over the objections of his subordinate staff and VA's contracting officials. VA used only 232 of 17,000 leadership development training licenses purchased, and VA received no value whatsoever for contracted talent assessment services. Mr. Shelby resigned from federal service in July 2018 after learning that he had been recommended for possible removal for reasons unrelated to this contract. The OIG made eight recommendations for identified areas for process improvements and for VA to consider any administrative action as warranted. VA concurred with all eight recommendations.

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