



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT SEPTEMBER 2020 HIGHLIGHTS

This is Hanna Lin, a health systems specialist with the VA Office of Inspector General (OIG) in Washington, DC. Here are the September highlights.

We kick things off with the VA OIG Office of Investigations which was extremely busy in the month of September. The first case we'll highlight involves a former Beckley, West Virginia, VA Medical Center doctor specializing in Osteopathic Manipulation Therapy who pleaded guilty in the Southern District of West Virginia to the deprivation of rights under the color of law (civil rights). A VA OIG, FBI, and VA Police Service investigation revealed that the defendant sexually abused three patients who sought chronic pain treatment during examinations at the facility.

In another case, a former bank manager pleaded guilty in the District of Nevada to theft of government funds. An investigation by the VA OIG and Social Security Administration OIG revealed that the defendant used his position as a bank manager to fraudulently obtain VA and Social Security Administration benefit payments that were made to two deceased beneficiaries. The defendant used the funds for personal expenses. The loss is \$1,194,672. Of the amount, the loss to VA is \$757,985.

Our third highlighted case of September takes place in the state of Texas, where a medical office administrator was sentenced in the Northern District of Texas to 18 months' incarceration, two years' supervised release, and restitution of \$437,940 to the federal government. VA's portion of the restitution is still being determined. An investigation by the VA OIG, Department of Labor OIG, U.S. Postal Service OIG, Department of Justice OIG, and Army Criminal Investigation Command Major Procurement Fraud Unit resulted in charges alleging the defendant submitted false claims to Department of Labor's Office of Workers' Compensation Program on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, assigned inaccurate billing codes to increase the practice's Office of Workers' Compensation Program reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The investigation revealed that this defendant and a coconspirator perpetuated the fraud for a period of approximately six years. The loss to VA is approximately \$2.9 million.

Wrapping up our Office of Investigations highlights this month, the daughter of a deceased VA beneficiary was sentenced in the Northern District of California to 36 months' probation and restitution of \$286,612 after pleading guilty to theft of government funds. A VA OIG investigation revealed that the defendant stole monthly VA Dependency and Indemnity Compensation payments intended for her mother, who died in September 2002.

In the month of September, the Office of Audits and Evaluations published 10 reports. In the first report, the purpose of the audit was to review whether the Veteran's Health Administration, or VHA,

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established adequate financial management practices at the VA Southeast Network, or VISN 7, and the VA Great Lakes Health Care System or VISN 12, to promote the efficient use of financial resources. The audit team found that VHA's financial management practices did not include financial controls, such as performance indicators, to readily assess whether its regional networks and medical centers were using their funds cost effectively. The OIG made three recommendations to VHA that included establishing key performance indicators that align with medical center operations and can be used to assess the efficient use of operating funds, specifying the office responsible for establishing financial controls at networks and medical centers, and requiring establishment and publication of organizational charts identifying the appropriate financial management reporting lines of authority and developing familiarization training on those lines of authority at the appropriate levels.

In another report, the OIG determined that VHA did not consistently use data from its National Surgery Office to improve operating room efficiency. Problems persisted for at least two years at less efficient facilities because regional and facility leaders did not monitor them and follow up on the root causes. At more efficient VHA facilities, surgical workgroups focused on operating room efficiency in addition to surgical outcomes. The audit team estimated that, under non-pandemic conditions, greater regional and facility oversight of surgical support elements would reduce surgical cancellations by 8,600 over five years, save approximately \$30 million, and improve services for about 7,200 patients. Surgical support elements include clinical service staff, sterile processing and logistics services, and environmental and resource management. VHA concurred with the OIG's six recommendations in areas such as oversight, assessment and sharing of efficiency data, and clarifying performance measures.

Finally, we finish with an audit report in which the OIG investigated whether the former executive director of the Idaho Veterans Research and Education Foundation, a VA-affiliated nonprofit, improperly raised her pay and misused the nonprofit's credit card. It also assessed controls and oversight regarding the nonprofit's expenditures and VA payments. Findings confirm the former director did receive an unapproved salary increase and used the credit card for personal purchases. She pleaded guilty to federal program theft, paid about \$44,300 in restitution, and was sentenced to five years' probation. The current executive director also received a questionable salary increase. Finally, VA improperly paid about \$50,600 to the nonprofit due in part to insufficient oversight. Recommendations to the medical center director included determining whether administrative action should be taken against the current executive director, ensuring the nonprofit requires two or more officials oversee salary changes and better controls credit card use, and establishing procedures for proper invoice review and oversight.

The Office of Healthcare Inspections published seven reports this month. The first healthcare inspection evaluated whether a patient received the care needed at the Memphis, Tennessee, VA medical center. The patient died by suicide the day following a visit to the emergency department. The OIG substantiated that the patient presented to the emergency department seeking treatment for insomnia and psychiatric medication refills. After an evaluation and negative suicide screening, the patient was

discharged with instructions to go to the outpatient mental health clinic immediately for medication management. The OIG found no documentation that the patient registered or received treatment in the clinic. The patient received mental health care through the community. The OIG found deficiencies in care coordination with facility community care staff, community care providers, and the third-party administrator. Authorizations for community care treatment were not timely, resulting in the patient's inability to receive several medication refills. The OIG made 16 recommendations to the facility director.

In another inspection, the OIG evaluated facility leaders' response to a report that a urologist had physical impairments. Leaders failed to adequately oversee the urologist's performance by not formally evaluating reported impairments. Management reviews were conducted, but the processes were flawed. Privileging process failures delayed removing the urologist's privilege to perform open procedures and failed to inform the urologist of active privileges. Facility leaders were noncompliant with VHA directives regarding reporting physicians to the National Practitioner Data Bank and state licensing boards. Frequent personnel changes in leadership positions affected oversight, privileging, and reporting processes. Poor communication regarding the urologist, a lack of knowledge of position responsibilities, and inexperienced support staff contributed to noncompliance. The OIG previously identified deficiencies in focused professional practice evaluations and National Practitioner Data Bank reporting; therefore, recommendations were not made regarding these issues. The OIG made six recommendations to VISN 7 and facility directors.

Finally, we wrap up with a healthcare inspection titled, *Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans*. Here, the OIG conducted a healthcare inspection to evaluate concerns that failure to follow pharmacy and nursing policies and procedures may have contributed to the death of a patient. The OIG determined that pharmacy staff failed to comply with the policy's intent by sending an unaffixed IV norepinephrine label to the intensive care unit. Subsequently, an intensive care unit nurse failed to follow policy when they placed the incorrect IV norepinephrine label on the IV fentanyl without first verifying the patient and medication information. Intensive care unit nursing staff also failed to follow the infusion rate orders, assess the medication effectiveness, and did not completely document their actions and findings. Additional concerns the OIG identified included unsecured IV controlled substances and the facility's failure to conduct a thorough review of the medication error. The OIG made eight recommendations.

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