PODCAST TRANSCRIPT
DECEMBER 2020 HIGHLIGHTS

Hello, this is Adam Roy with the Office of Inspector General in Washington, DC. You're listening to the OIG's highlights for December 2020. I'll be covering updates to ongoing investigations and summarizing several reports published in December. All reports are available online at www.va.gov/oig.

Let's start with the December 10th report, *Senior VA Officials' Response to a Veteran's Sexual Assault Allegations*. In response to a congressional request, the OIG investigated VA's response to a veteran's complaint that she was sexually assaulted at the Washington DC VA Medical Center, including whether the VA Secretary or other senior officials investigated or sought to undermine the veteran's credibility. The OIG lacked conclusive evidence to reconcile conflicting testimony regarding whether Secretary Wilkie investigated or asked others to investigate the veteran. Six senior officials testified, however, that the Secretary stated the veteran had made, or may have made, prior similar complaints—which some understood meant prior complaints were unfounded. Officials questioning the veteran's credibility affected responses, including VA police conducting a background check first on the veteran and public affairs staff's engaging media to scrutinize the veteran. Despite the inspector general confirming VA could take action, leaders failed to follow up on available information regarding the individual the veteran accused or to address inhospitable conditions at the facility. View the full report on our website.

In investigation news, here are several updates.

A terminated employee of the West Palm Beach VA Medical Center in Florida was sentenced to 27 months' incarceration, 24 months' probation, and ordered restitution of $1.4 million. A VA OIG investigation, which was based on a hotline complaint, resulted in charges that this defendant and 17 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach, Florida; Miami, Florida; and Philadelphia, Pennsylvania. To date, 15 individuals have pleaded guilty in connection with this investigation.

Elsewhere in Florida, a former transportation assistant at the VA's Outpatient Clinic in The Villages was sentenced to 18 months' incarceration and forfeiture of approximately $380,000. A VA OIG investigation revealed that the former transportation assistant, who had the authority to award transportation assignments to vendors, conspired with his daughter and ex-wife to create and control two companies to which he steered VA transportation assignments.

Over in Arkansas, a physician was sentenced to three years' probation, a fine of $180,000, and restitution of approximately $33,000. An investigation by the VA OIG, FBI, Defense Criminal Investigative Service, and Department of Health and Human Services OIG revealed that the defendant

used telemedicine to fraudulently prescribe compounded medication that resulted in over $5 million paid by government healthcare insurance programs, to include VA's Civilian Health and Medical Program. The loss to VA is over $300,000.

In Nevada, the owner of a home healthcare company was sentenced to 41 months' incarceration, three years' supervised release, restitution of approximately $1.7 million and forfeiture of approximately $1.7 million. A VA OIG and FBI investigation revealed that, while claiming to offer home healthcare and fiduciary services to veterans and surviving spouses, the defendant submitted fraudulent applications for pension, survivor's pension, and aid and attendance benefits to VA on behalf of elderly veterans and surviving spouses.

In North Carolina, a veteran was indicted on charges of theft of government funds, false statements, and false claims. A VA OIG investigation resulted in charges alleging that the veteran fraudulently received VA compensation benefits for blindness. The defendant was rated as having "light perception only" and a visual acuity of 5/200 for approximately 30 years upon his discharge from the Army. It is alleged that the defendant maintained a driver's license in multiple states while claiming blindness. It is further alleged that during a 15-year period, the defendant and his wife purchased approximately 33 automobiles that he routinely drove, including on long-distance trips, to perform errands, and to VA medical appointments. The loss to VA is approximately $978,000.

And more fraud in Texas, where the owner of a construction company pleaded guilty to conspiracy to defraud the United States. A VA OIG, General Services Administration OIG, Army Criminal Investigation Command, Small Business Administration OIG, and DCIS investigation resulted in this charge that alleged the defendant and two other individuals conspired to defraud VA by obtaining a service-disabled veteran-owned small business set-aside construction contract valued at more than $20 million.

Now back to published reports.

Addressing the COVID-19 pandemic, the OIG reviewed measures taken by VHA's Homeless Program Office, medical facilities, and community service providers to mitigate COVID-19 risks in transitional housing programs for veterans experiencing homelessness. The report, titled *Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing*, was published on December 18. The review team found that transitional housing service providers at the 14 assessed facilities successfully implemented four of six specific Centers for Disease Control and Prevention measures but could have strengthened implementation of two others. They involved communicating precautions to high-risk veterans and social distancing. VHA and service provider staff said the Homeless Program Office allowed them the flexibility to isolate vulnerable veterans, facilitate telehealth exams, and

coordinate the provision of medical care in the community. Some service providers and VA medical facilities also developed their own best practices for reducing risks. The OIG made four recommendations to the under secretary for health regarding additional measures to strengthen the implementation of CDC guidelines at the service providers' facilities.

The OIG published *Management and Oversight of the Electronic Wait List for Healthcare Services* substantiating allegations that VHA data on VA's website regarding the electronic wait list for patient appointments was inconsistent with internal data sources. The audit team confirmed the website data did not include entries older than two years or administrative entries, such as patients requesting care at a different facility. Because VHA addressed these issues, the OIG did not make related recommendations. The team did find that patients were not removed from the wait list when appropriate, indicating that VHA employees did not review entries daily and supervisors did not validate the list weekly. This lack of oversight increases the risk that patients will not receive care in a timely manner or at their preferred facility and could lead to the appearance that veterans waited longer than they did for care. Although VHA improved management of its wait list, the OIG provided three recommendations.

The OIG also published a report titled *Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement*. We examined whether claim processors followed VA regulations and procedures when determining service connection for posttraumatic stress disorder claims that were not related to military sexual trauma. The review team found that claims processors inaccurately processed about 18,300 of 118,000 PTSD claims completed in fiscal year 2019. Most errors occurred because claims processors did not verify or ask veterans to provide the disorder's cause, known as an in-service stressor. The OIG recommended that the VBA determine the actions needed to ensure staff understand requirements for gathering evidence and verifying stressors for PTSD claims and whether the adjudication procedures manual needs to be reorganized and amended to help staff process PTSD claims more accurately.

In healthcare, the OIG conducted a review of VHA's response to anticipated demand of emergency department and urgent care center services during the COVID-19 pandemic. The team deployed a survey and interviewed 63 emergency department and urgent care center directors. Identified issues included a small number of negative pressure rooms and small waiting rooms making it difficult to isolate patients. Twenty-three directors reported a loss of staff due to providers testing positive, transfers, or retirements. Testing was generally available. Some directors reported a lack of or need to ration certain items of personal protective equipment. Lessons learned included rethinking how emergency or urgent care can be delivered in a pandemic and continuing to provide care to non-COVID-19 patients while attending to the special care needs of patients with COVID-19.

The OIG completed a healthcare inspection in the critical care unit at the Charlie Norwood VA Medical Center in Augusta, Georgia. This healthcare inspection assessed allegations that deficiencies in care coordination between facility staff and remote telemedicine intensive care unit staff resulted in deaths, injuries, or poor outcomes for patients in the critical care unit after general surgery residents were withdrawn. While the OIG was unable to determine the withdrawal resulted in poor patient outcomes, the OIG found a misunderstanding of the tele-ICU program and lack of engagement between facility and tele-ICU staff contributed to challenging and impaired communication processes, including the reporting of patient safety events. The OIG made six recommendations to the facility director related to communication and coordination, on-call processes, medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, and orientation and competency training. Two recommendations made to the VISN 10 Tele-ICU medical director related to patient safety reporting training and coordination of patient care reviews.

Finally, the OIG published Comprehensive Healthcare Inspection Program—or CHIP—reports on two facilities in December. Facilities inspected were the William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina and the Charlie Norwood VA Medical Center in Augusta, Georgia.

Thank you for listening to the VA OIG's monthly highlights for December 2020.

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