PODCAST TRANSCRIPT
FEBRUARY 2021 HIGHLIGHTS

Hello listeners. This is Adam Roy with the Department of Veterans Affairs Office of Inspector General and you're listening to highlights for February 2021. Despite ongoing challenges related to the pandemic, the OIG strives forward with oversight of VA's programs and services. We're publishing reports, auditing financial systems, inspecting healthcare facilities, holding organizations that defraud the VA accountable, and investigating those individuals who harm our veterans and their loved ones.

I'll start with updates on several investigations of importance.

The owners of a compounding pharmacy, two physicians, and two third-party marketers were charged through a civil complaint in the District of Nevada with violations of the False Claims Act. An investigation conducted by the VA OIG, FBI, Defense Criminal Investigative Service, and Air Force Office of Special Investigations resulted in charges alleging the defendants submitted false claims for compounded prescriptions to the Department of Defense's healthcare program TRICARE and VA's Civilian Health and Medical Program. It is alleged that the owners of the compounding pharmacy paid substantial kickbacks to third-party marketers in exchange for the referral of prescriptions for compounded drugs. The compounded prescriptions were fraudulently dispensed by doctors who were geographically located in different states than the patients, and for whom no doctor-patient relationship existed. The overall loss to the government is approximately $5.6 million, Of this amount, the loss to VA is approximately $1.9 million.

A former supply supervisor at the Jesse Brown VA Medical Center in Chicago, Illinois, and a medical supply company president were indicted for wire fraud. A VA OIG investigation resulted in charges alleging that the former employee received monetary kickbacks in exchange for initiating VA orders from the medical supply company for medical products, many of which were never delivered to VA. The former employee was also indicted on additional counts of wire fraud, attempted witness tampering, and obstruction. The defendants are accused of defrauding VA of approximately $1.7 million.

A business owner who established numerous durable medical equipment companies pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud and filing a false tax return. A VA OIG, IRS Criminal Investigation, Department of Health and Human Services OIG, and FBI investigation resulted in charges alleging the defendant placed the companies in the names of straw owners, which led to the submission of over $400 million in fraudulent durable medical equipment claims to Medicare and VA's Civilian Health and Medical Program. The defendant and her coconspirators allegedly purchased thousands of doctors' orders for braces from marketers who bribed doctors to sign under the guise of telemedicine. The defendant admitted to using the fraud proceeds to purchase numerous personal items.

A former hospice unit nurse at the VA Bedford Healthcare System in Massachusetts was sentenced to 40 months' incarceration and three years' supervised release after previously pleading guilty to tampering with a consumer product and obtaining a controlled substance by deception. A VA OIG investigation revealed the defendant used tap water to dilute liquid morphine and administered the diluted substance to hospice patients. The defendant then ingested the diluted amount of the remaining drug. To conceal her drug diversion, the defendant falsified medical records by reporting that the patients had received more pain medication than they did.

Now to published reports. The OIG published nine reports in February. All reports are available at www.va.gov/oig. Visit the website and download the full report or read the short summaries. Also, check out our signup page and subscribe to have our reports sent to your inbox automatically.

The OIG published, *Insufficient Oversight for Issuing Prosthetic Supplies and Devices*, assessing VHA's oversight of prosthetic supplies and devices issued to veterans. VA's Prosthetic and Sensory Aids Service costs have increased from over $2.9 billion in fiscal year 2016 to nearly $3.5 billion in fiscal year 2019. The OIG found oversight weaknesses that contributed to Prosthetic and Sensory Aids Service staff copying consults improperly. Consequently, VHA improperly issued an estimated $15.8 million in prosthetic supplies in 2017. Only six percent of transactions for supplies related to deceased veterans were improper and there was no evidence of fraud. VHA concurred with the OIG's four recommendations.

In the report, *VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits*, the OIG reviewed VA's spina bifida program to assess concerns that eligible individuals may not be receiving all their benefits. Children born with spina bifida may receive VA benefits if a biological parent is a veteran presumed to have been exposed to herbicides during the Vietnam War. The OIG found VBA staff generally decided spina bifida benefits claims accurately. However, VBA and VHA program offices did not adequately communicate or share data, contributing to improper payments, payments made after deaths, and delays in health care enrollments. VA also did not consistently reach out to eligible individuals or accurately provide benefits information. The OIG made four recommendations.

The OIG published, *Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*, after receiving allegations that VHA medical facilities lacked enough PPE to keep pace with the escalating needs to protect personnel and patients as COVID-19 spread. In response, a review team assessed how VHA reported and monitored its PPE supply levels during the pandemic. Based on interviews with 22 people involved in logistics operations for 42 facilities, none reported running out of PPE items. The OIG found VHA took swift steps to work around known limitations in its inventory management system, to use near real-time data to shift and order supplies, and to help ensure facilities did not exhaust PPE supplies. VHA could, however, improve the accuracy and consistency of information collected about PPE supplies to guide decisions. The OIG recommended providing

guidance for reporting usable expired items and effectively verifying PPE information. VHA was also urged to report any data limitations until corrections can be made.

In the report, *Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement*, the OIG determined that VHA lacked effective procedures for purchasing, inventorying, and tracking biologic implants. The audit team's visits to four medical facilities revealed purchasing agents did not always record implants properly or use the appropriate funds. The facilities also had an inaccurate and incomplete inventory of biologic implants and did not review the inventory on hand. For example, the audit team could not locate 714 biologic implants in facility inventories, valued at almost $1.1 million. Finally, facilities failed to track at least 45 percent of implants reportedly used from October 2017 through March 2019. VHA concurred with the OIG's 11 recommendations.

The inspection of misconduct by a gynecological provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi addressed allegations regarding inappropriate conduct toward women veterans by the provider; a nurse chaperone's failure to provide patient support; and three additional concerns related to patient complaint processes, leaders' response to the provider's misconduct, and reporting. The provider's conduct was unprofessional and insensitive, and the nurse chaperone did not provide support to the patients. VHA has not incorporated trauma-informed care and sensitive examination policies into training and practice, and VHA policies did not outline the role and training of chaperones. The OIG made six recommendations.

In another inspection, conducted at the request of Representative Carol Miller of West Virginia, the OIG assessed allegations that a patient received untimely and poor quality of care in the emergency department and oncology service at the Beckley VA Medical Center. The OIG did not substantiate that the patient received untimely or poor quality of care in the facility's emergency department. On two occasions, there was no documentation that a primary care provider communicated test results with the patient. The OIG found deficits in an oncologist's use of scheduling orders and adherence to the Primary Care and Oncology Service Agreement wait times. The OIG was unable to determine whether compliance with the Return to Clinic policy would have altered the patient's course. The OIG made two recommendations.

The OIG conducted a healthcare inspection titled, *VHA's Response following Cardiac Catheterization Lab Closure at the Samuel S. Stratton VA Medical Center in Albany, New York*, after it did not receive a response from VISN 2 staff following an inquiry to assess an allegation that the cardiac catherization lab was closed due to concerns of risk to patients. A facility fact-finding review identified concerns with communication and team dynamics and suspended lab procedures. VISN and facility leaders arranged for a National Cardiology Program Office review, which made recommendations addressing the cardiologists' clinical judgement and technical skills. Also, facility leaders convened an administrative investigation board and initiated management reviews. VISN and facility leaders decided that the lab should remain closed indefinitely. The OIG made three recommendations.

Pursuant to a congressional request, the OIG conducted an inspection at the Washington DC VA Medical Center to review patients who did not receive mammography exam results. After the discovery of unsent exam result letters, the facility completed reviews and four patients with breast cancer were identified. Though the four patients did not receive letters, they received timely notification from the ordering provider and follow-up. Ordering providers did not consistently document patient notification of abnormal exam results. The OIG made seven recommendations.

Finally, the OIG published one Comprehensive Healthcare Inspection Program report on the Dayton VA Medical Center in Ohio. The report focused on a variety of topics, to include COVID-19 pandemic readiness and response.

Thank you for listening to the VA OIG's monthly highlights for February 2021. Visit our website and listen to our companion podcasts on specific OIG reports and stay tuned for next month's highlights.

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