



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT JANUARY 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 January 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. Let's get started.

We open with two criminal investigations that resulted in serious jailtime. Robert Levy, a former chief of pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was sentenced to 20 years in prison for involuntary manslaughter and mail fraud. In another case, Jonathan Yates, a former doctor specializing in osteopathic manipulation therapy at the Beckley VA Medical Center in West Virginia was sentenced to 25 years' incarceration for civil rights offense.

In the case of Levy, the OIG identified that he had misdiagnosed thousands of VA patients over a period of several years. His negligence caused significant harm, even death, to the patients under his care. The former doctor suffered from substance abuse. He had been reprimanded and stripped of his license several years ago for being under the influence of alcohol while at work. He would go on and complete a treatment program and return to his job. However, when he returned, he used his position to purchase a potent substance that causes a lengthy intoxication period, but no hangover, and is undetectable using routine drug and alcohol testing methods. He purchased this substance, known as 2-methyl-2-butanol, through online marketplaces and used it regularly. This sentence sends a message that those who abuse their positions of trust in caring for veterans will be held accountable.

The same applies to former doctor Jonathan Yates, who used the privileges assigned to medical practitioners and the inherent trust patients give them to sexually abuse three patients seeking treatment for chronic pain. He was sentenced to 25 years and his sentence holds him accountable for his actions. These veterans suffered horrific abuse by a doctor entrusted with their care.

In both cases, the OIG's thoughts are with all those harmed and we remain vigilant in our efforts to keep all VA patients safe.

Next up. Updates to ongoing investigations.

A contractor responsible for administering two programs that enabled veterans to obtain medical care from private sector providers in their communities entered into a settlement agreement with the Department of Justice and the U.S. Attorney's Office for the District of Arizona to resolve allegations that it retained overpayments received from VA. The contractor will pay \$179.7 million to the government. Of this amount, VA will receive approximately \$158 million.

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The owner of a wholesale pharmaceutical company was indicted in Mississippi on charges of conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials. A VA OIG, U.S. Immigration and Customs Enforcement's Homeland Security Investigations, and FBI investigation resulted in charges alleging that the defendant participated in a scheme to defraud healthcare providers, to include VA, of more than \$1.8 million by acquiring and hoarding personal protective equipment. The defendant allegedly sold N95 masks to VA for as much as \$25 per mask, despite acquiring such masks at much lower prices.

A terminated employee at the VA Puget Sound Healthcare System in Seattle, Washington, was sentenced to three months' incarceration, nine months' home confinement with electronic monitoring, and three years' supervised release after pleading guilty to theft of government property. A VA OIG investigation revealed that the defendant stole several pieces of medical equipment, to include ventilators and bronchoscopes, and then sold the stolen items online.

A former case manager for the VA Supportive Services for Veteran Families grant program and a property manager pleaded guilty in Georgia to conspiracy to steal government funds. A VA OIG and Department of Housing and Urban Development OIG investigation revealed that the defendants executed a scheme to steal funds. From October 2014 through November 2015, the defendants received housing vouchers in support of housing homeless veterans. Instead of using these funds to make the appropriate rental payments on behalf of the veterans, the defendants kept the funds for themselves. As a result, 25 veterans were evicted from their residences.

A former bank manager in Las Vegas, Nevada, was sentenced to 30 months' imprisonment, three years' supervised release, and ordered to pay restitution of over \$1 million, of which VA will receive approximately \$750,000. A VA OIG and Social Security Administration OIG investigation revealed that the defendant used his position as a bank manager to access VA and social security benefit payments that were made to two deceased beneficiaries. The defendant then used the funds for personal expenses.

A government contractor that provides electricity solutions for buildings and data centers entered into a nonprosecution and civil agreement with the Department of Justice and the U.S. Attorney's Office for the District of Vermont. As part of the agreement, the contractor will pay \$1.7 million in criminal forfeiture and admitted that its conduct constituted wire fraud. The contractor also agreed to pay \$9.3 million to resolve False Claims Act and Anti-Kickback Statute liability for a former employee's scheme, which involved inflating estimates and assessing improper costs in proposals and overcharging federal agencies, including VA. This investigation was conducted by the VA OIG, Naval Criminal Investigative Service, Department of Agriculture OIG, Coast Guard Investigative Service, General Services Administration OIG, and the FBI.

A medical device manufacturer's former chief executive officer and former vice president of sales were sentenced in Massachusetts for their roles in the marketing and distribution of a device for use outside of

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Food and Drug Administration approval. The former chief executive officer was sentenced to pay a criminal fine of \$1 million, and the former vice president of sales was sentenced to pay a criminal fine of \$500,000. The company previously entered into a global settlement with the government under which it agreed to pay a fine of \$18 million. Of this amount, VA's portion of the settlement was \$372,382. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, Food and Drug Administration Office of Criminal Investigations, and the FBI.

The OIG published six reports in January. 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 receive every report in your inbox the day it publishes.

The OIG published an audit titled, VA Needs to Comply Fully with the Geospatial Data Act of 2018, to determine whether VA complied with the requirements of the "Covered Agency Responsibilities" section of the Geospatial Data Act of 2018. VA did not meet three of the 13 responsibilities. The OIG recommended that VA establish mandatory policies and responsibilities to promote the integration of geospatial data and establish a process that ensures geospatial data and activities are included on VA record schedules that have been approved by the National Archives and Records Administration.

In another report titled, Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk, the OIG assessed the merits of an August 2019 hotline allegation that a deceased veteran's VA funds had been misused while he was living at a California nursing home. As part of this assessment, which is the subject of another report, the OIG discovered VBA had not finalized the veteran's incompetency proposal, which had been initiated three years before his death. This delay conflicts with VBA guidance that the decision be made, and a fiduciary appointed, within 141 days. The OIG expanded its review and found VBA had not finalized incompetency proposals for 221 beneficiaries from 2016 through 2019; statistical analysis of 55 of these showed nearly all had incomplete decisions—that is, had stalled. The OIG shared the 221 records with VBA so that it could determine whether further action is needed to ensure incompetency proposals are finalized.

Also, the OIG reviewed a patient's mental health care prior to death by suicide. The OIG substantiated that the patient died by suicide within three days of discharge, and inpatient staff had initiated medication and provided discharge instructions that included suicide prevention materials. Inpatient staff did not include Vet Center staff in discharge planning and failed to complete the comprehensive suicide risk evaluation. Visit our website for the full report titled, Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri.

The OIG conducted a healthcare inspection at the VA Central Iowa Health Care System in Des Moines in response to a referral regarding a urologist who practiced, was privileged, and ordered controlled substances without a Drug Enforcement Administration registration. The urologist practiced and was privileged without DEA credentials because facility leaders did not timely implement a directive

requiring prescribers who order controlled substances to possess an individual DEA registration. Upon recognizing the urologist's noncompliance, facility leaders acted, and the urologist obtained the required DEA registration. The failure of the urologist to timely obtain a DEA registration was not related to clinical competency. Visit our website to review the OIG's five recommendations.

In another healthcare inspection, the OIG evaluated allegations against a thoracic surgeon at C.W. Bill Young VA Medical Center in Bay Pines, Florida, regarding surgical complications including patient deaths, operative note misrepresentations, and the facility's inappropriate reporting of the surgeon's complication rate. A non-VA consultant identified quality of care concerns in 16 of 24 patient cases reviewed. Facility external management reviews found concerns with five patient cases, and in February 2019 the surgeon was reassigned to a nonclinical care setting. A VHA panel of cardiothoracic surgeons reviewed 22 of the 24 cases as well as additional cases. In December 2019, the panel determined that the surgeon delivered surgical care within quality expectations and the surgeon resumed patient care.

And lastly, the OIG found that a patient experienced a medication delay in late 2019 due to a stock shortage at the Manila Outpatient Clinic in Pasay City, Philippines prior to and during the COVID-19 pandemic. The OIG was unable to substantiate if a second patient experienced medication refill delays because the OIG could not determine when the refills were requested. Clinic leaders identified an increased pharmacy processing time in October 2019, and the chief of pharmacy services initiated an action plan that decreased the processing time. In March 2020, the President of the Philippines declared a COVID-19 emergency and implemented a quarantine that imposed travel limitations. As a result, four patients experienced medication delivery delays in March and April 2020. The OIG found that pharmacists could not dispense insulin to a patient as the clinic had no stock of the perishable medication after April 2020. The OIG determined none of these delays resulted in adverse clinical outcomes. The OIG made two recommendations related to pharmacy stock shortages and processing delays.

Thank you for listening to the VA OIG's monthly highlights for January 2021. Check out other podcasts on specific OIG reports online and stay tuned for next month's highlights.

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