PODCAST TRANSCRIPT
MARCH 2021 HIGHLIGHTS

Adam Roy

This is Adam Roy with the Department of Veterans Affairs Office of Inspector General and you're listening to highlights for March 2021. I'll share investigation updates and briefly summarize recently published reports. But first, joining me today, is Inspector General Michael Missal to discuss his recent testimony before the House Veterans Affairs Committee's Subcommittee on Oversight and Investigations on the VA's medical and surgical supply chain during the pandemic and related modernization efforts.

Mr. Missal, the pandemic continues to impact so many of VA's programs and operations, to include further stressing aspects of VA's supply chain operations, like procurement and inventory management. In your testimony, you described VA's numerous and well-documented challenges related to supply chain oversight and the development of new IT systems. Can you briefly talk about these challenges and how the pandemic has further aggravated supply chain issues?

Michael Missal

Adam, I'm happy to do so. VA healthcare facilities have long experienced barriers to real-time tracking of inventory, purchasing, distribution, storage, and other supply management functions. This has led to operational breakdowns and the need for workarounds that sometimes lack compliance with VA policies and procedures. Prior to the pandemic, our reports identified IT, contracting, and staffing problems contributing to some VA medical centers not consistently having supplies when and where they were needed them for patient care. The COVID-19 pandemic has exacerbated supply chain issues while placing unprecedented demands on healthcare delivery worldwide.

Adam Roy

What's impeding VA from developing the IT systems it needs to support VA's supply chain challenges?

Michael Missal

It has been another long-standing issue we have seen. Since 2000, the OIG has identified IT planning and implementation as a major management challenge given VA's history of failed projects after significant IT investments. OIG audits in recent years have highlighted that IT systems' development problems have persisted largely because of inadequate planning, fragmented governance, unrealistic timelines, and insufficient monitoring and controls. This has made IT projects, including those

associated with supply chain management, susceptible to cost overruns, schedule slippages, performance problems, and in some cases, complete project failures.

Adam Roy

Can you share examples of previous OIG reports that identified these issues?

Michael Missal

Sure. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the Washington DC VA Medical Center, one of VA's biggest and most complex facilities, had equipment and supply issues that could be putting patients at risk for harm. The OIG's final report identified many deficiencies across several areas related to patient care, financial oversight, and leadership failures. In particular, the report detailed problems with ensuring supplies and equipment reached patient care areas when needed, in part due to the facility's failure to use the VA-required Generic Inventory Package system. Veterans' surgical procedures were delayed or canceled due to the unavailability of needed supplies. As a result, in some case, clinicians went to an adjacent hospital to borrow supplies while the patient was under anesthesia. We made 40 recommendations in our report on this matter, over a dozen of which related to ensuring the availability of necessary supplies, instruments, and equipment.

As a result of the inventory management issues identified at the DC VA Medical Center, an OIG team conducted a national audit looking at the oversight of the VA medical centers' migration of data from an earlier inventory system to the Generic Inventory Package system. The audit team found medical centers encountered challenges as part of the migration to the new inventory management system and that significant discrepancies existed between actual inventory and the data for tracking expendable medical supplies. Given our work in this area and complaints we continue to receive, we have concerns about the VA-wide inventory and logistics systems.

Adam Roy

You further testified about VA's supply chain management during the pandemic. How has the VA responded to its rapidly changing need for supplies like personal protective equipment?

Michael Missal

Early on, supply availability was influenced in part by frequently changing CDC policies related to the use and conservation of personal protective equipment or PPE, such as N95 masks. In interviews with health care facility leadership, they told us about situations where they experienced shortages of PPE or concerns that they might not have significant supplies.

In July 2020, the OIG published a report that included interviews of VHA leaders and staff to capture a snapshot of the adequacy of equipment and supplies in their facilities during the highly dynamic first wave of the pandemic. In particular, 67 of the 70 facility leaders reported having sufficient supplies of PPE.

This was a big improvement from an early OIG report, issued March 26, 2020, on facility pandemic readiness and visitor screening reviews, really at the beginning of the pandemic. That report highlighted that 33 of 54 facility leaders interviewed stated that they did not have adequate supplies or equipment, or both, including some specific items of PPE such as gowns and N95 masks.

The improvements in the early months of the pandemic were the result, in part, of VHA leaders and staff taking quick actions to develop supply management processes and tools. VHA developed tracking dashboards and critical processes that they needed to layer on top of their flawed inventory management system and other systems to provide the real-time information they needed.

Adam Roy

Thank you for your time today, Mr. Missal. I encourage our listeners to visit our website and read the IG's complete statement available under the media section. There you will also find another recent testimony by our Deputy Assistant Inspector General for Audits and Evaluations, Mr. Brent Arronte. He testified before the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs on March 23, regarding the increase in VA's disability exam inventory caused by the pandemic. Because VA canceled in-person disability exams as a protective measure, a backlog of exams mounted quickly. In addition, some claims were improperly denied due to canceled appointments during the pandemic. His testimony discussed these and other issues drawn from the OIG's November 2020 report *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*. The OIG's findings focused on VBA's failure to create a documented plan to reduce the exam inventory to pre-pandemic levels.

I'll now share several investigation updates.

A VA OIG and Drug Enforcement Administration investigation revealed that a defendant sold fentanyl to the friend of a veteran. The friend later provided the fentanyl to the veteran, who fatally overdosed at a VA residential facility in Lowell, Massachusetts. This defendant was sentenced to 10 years' incarceration and eight years' supervised release.

A former pharmacy technician at the VA Medical Center in East Orange, New Jersey, was arrested after being charged with theft of government medical products. A VA OIG, FBI, and VA Police Service investigation resulted in charges alleging the defendant stole prescription HIV medication from the facility for several years. The loss to VA is approximately $8.2 million.

A former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center in Ohio pleaded guilty to theft of government property, "honest services" wire fraud, wire fraud, and false statements relating to healthcare matters. A VA OIG and FBI investigation resulted in charges alleging the defendant received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor.

A nonveteran was sentenced in the Western District of Washington to three years' probation after previously pleading guilty to theft of public funds. A VA OIG investigation revealed that the defendant stole VA funds from the bank account of a deceased VA beneficiary by conducting 173 ATM withdrawals during an eight-year period.

A Virginia-based construction company entered into a settlement agreement to resolve allegations that the company violated the False Claims Act. A VA OIG and Department of Labor OIG investigation resolved allegations that the company submitted falsified payroll records pertaining to two construction projects at the VA Medical Center in Coatesville, Pennsylvania. Pursuant to the settlement, the company will pay approximately $550,000. Of this amount, VA will receive approximately $180,000.

Now to published reports. The OIG published 14 reports in March. 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. I'll highlight several reports now.

The OIG conducted an audit to assess VA's oversight of the Medical/Surgical Prime Vendor-Next Generation Program, under which prime vendors maintain inventories of medical and surgical supplies and restock medical facilities when needed. The OIG found VA controls were insufficient to ensure medical facility staff accurately reviewed, verified, or certified distribution fee invoices for the program. The OIG made 10 recommendations related to improving oversight of verification and certification of distribution fee invoices and ensuring the accuracy of on-site representative fees.

In another audit, the OIG determined whether contractor employees accurately processed claims for non-VA care. VA contracted Signature Performance to help process claims for such care, but the contract did not require contractor employees to follow VA's claims-processing guidance. The OIG found 13 percent of the contractor's claims decisions did not align with Office of Community Care guidance, increasing the risk that veterans are unnecessarily billed. OIG recommendations to the under secretary included providing additional training and guidance, enhancing quality surveillance, and ensuring contract requirements specify that contractor employees must follow guidance.

In the report, *Handling Administrative Errors at the Chicago VA Regional Benefits Office in Illinois*, the OIG reviewed a March 2019 allegation that employees at the VA regional benefits office were not following VBA procedures for correcting administrative errors. The OIG substantiated the allegation based on procedures in place at the time each error was corrected. The OIG recommended the director of the Chicago VA regional office ensure the errors identified by the review team are corrected, monitor

the effectiveness of actions taken to improve the accuracy of corrections, and determine whether additional measures are needed.

The OIG also reviewed how effectively VBA managers fulfilled the plan VA was required to submit to Congress for a skills certification program for claims processors, which includes a required test to ensure they have the skills, knowledge, and abilities for accurately carrying out their tasks. The OIG found VBA did not meet the plan requirements during fiscal years 2016 through 2019. The OIG's recommendations included creating written guidelines, a tracking mechanism, updates to Congress on the positions subject to testing, plans to train and retrain staff who failed tests, and notifying Congress of plans to take personnel actions against individuals who fail consecutive tests after remediation, as required by law.

In a management advisory memorandum, the OIG identified potential risks associated with VHA's efforts to quickly add new staff to meet increased demand for healthcare services caused by the pandemic. To achieve VHA's goal of bringing all new employees on duty within three days of making a tentative offer, VHA has been modifying or deferring tasks such as fingerprinting, background investigations, and drug testing. Because the associated risks, if realized, could damage the trust veterans have in VA keeping their information secure and ensuring care providers are suitably qualified, this memorandum raised issues for VHA to consider in determining whether vulnerabilities and related processes warrant further review.

The OIG assessed concerns regarding mental health care provided to a patient who died by suicide at the Phoenix VA Health Care System. The report included seven recommendations related to the patient's care, suicide risk assessment, documentation, timely community care authorization, missed appointment procedures, community care scheduling, and prompt behavioral health autopsies.

The OIG also conducted a review to assess VHA's virtual primary care response to the COVID-19 pandemic between February 7 and June 16, 2020. Virtual care options during the pandemic included video conferencing through the VA Video Connect and third-party applications as well as telephone appointments. The OIG made two recommendations related to access, equipment, and training. Visit our website for a companion podcast on this report, featuring team members who led the review.

Finally, the OIG published two Comprehensive Healthcare Inspection Program reports. These inspections are performed approximately every three years for each facility. In the first report, VISN 7, the VA Southeast Network in Duluth, Georgia, was inspected. In the second, the OIG inspected the facilities' pandemic readiness and response in VISN 10, encompassing Ohio, Indiana, and Michigan, and VISN 20, VA's Northwest Network.

Thank you for listening to the VA OIG's monthly highlights for March 2021.

OIG podcasts are produced by the Office of Communications. Find other OIG podcasts at va.gov/oig. Report fraud, waste, abuse, or possible criminal activity to OIG online or call the OIG hotline at 1-800-488-8244.