PODCAST TRANSCRIPT
MAY 2021 HIGHLIGHTS:

IG Michael Missal discusses the healthcare inspection related to the multiple homicides at VA medical center in Clarksburg, West Virginia and the recently published Semiannual Report to Congress covering OIG's activities from October 1, 2020, through March 31, 2021

Adam Roy

This is Adam Roy with the Office of Communications and Public Affairs in the VA Office of Inspector General in Washington, DC. Joining me today is Inspector General Michael Missal to discuss the healthcare inspection report related to Reta Mays, a former VA nursing assistant, who was sentenced to seven consecutive life sentences for the murder of veterans at the VA medical center in Clarksburg, West Virginia. We will also discuss the OIG's recently published 85th Semiannual Report to Congress, which summarizes the OIG's accomplishments from October 1, 2020, through March 31, 2021.

The recent sentencing of Reta Mays was the culmination of a highly complex investigation that began back in June of 2018. What occurred at the Louis A. Johnson VA Medical Center in Clarksburg is tragic and heartbreaking. What's particularly shocking is that these deaths were at the hands of a nursing assistant who was entrusted with providing compassionate and supportive care to veterans. As soon as the details of this investigation became public, questions on leader accountability, patient safety, and hiring and security practices were raised. The VA OIG set out to answer these questions and attempt to understand the conditions in place at the medical center that may have contributed to these patients' deaths.

IG Missal, after being informed by leaders at the medical center and the Veterans Health Administration of potential criminal behavior, how did the OIG approach the process of working both a criminal investigation and healthcare inspection at the same time?

Michael Missal

Adam, we were notified by VA on June 27, 2018, that there were suspicious deaths at the medical center as a result of unexplained hypoglycemia, which is sharp drop in blood sugar levels. Our criminal agents were on site at the medical center the next day to begin the investigation. Our Office of Healthcare Inspections also immediately commenced a parallel healthcare inspection. The focus of the criminal investigation was to identify whether criminal conduct occurred and if it did, who was involved. The focus of the healthcare inspection was to determine how this could happen, looking at the policies and practices at the facility. To ensure the integrity of the criminal investigation, we paused the healthcare inspection until the criminal case was over. Mays pled guilty in July of 2020 and was sentenced on May 11, 2021. We released the results of our healthcare inspection on that same day.

Adam Roy

What specifically did the inspection assess?

Michael Missal

The inspection team looked at a number of issues related to the criminal case, including the hiring of Mays and her performance while employed at the medical center, how the facility conducted medication management and security, the clinical evaluations of the unexplained hypoglycemic or low blood sugar events, the quality assurance and patient safety programs, and VA leaders' responses and corrective actions. Additionally, during the course of the inspection, we also noted areas of concern regarding hospice and palliative care practices and nursing policies and practices.

Adam Roy

The inspection team reviewed a lot of patient records and supporting documents. Can you help our listeners understand the sheer scope and size of this inspection?

Michael Missal

Absolutely. Our physicians also reviewed the electronic health records of more than 200 patients who received medical care at the facility in support of the OIG's criminal investigation. These included the electronic health records of over 100 patients who died on ward 3A dating back to mid-2015 when Mays began employment at the medical center. The inspection team also conducted 75 interviews and reviewed thousands of documents, including relevant policies and procedures.

Adam Roy

Let's discuss some of the topics the inspection team reviewed. What concerns were found related to the hiring of Mays?

Michael Missal

When someone is hired in the federal government, a background investigation is conducted. During Mays' background investigation, the investigator identified issues that needed further review. Unfortunately, no one at the facility followed up as required. Had they done so, they would have discovered that she was the subject of several excessive use of force allegations at a prior employer, the West Virginia Department of Corrections. This may have disqualified her for a position involving interactions with patients.

Adam Roy

Was medicine properly secured at the facility?

Michael Missal

No, it was not. The OIG found that medication was not secure on the ward where she worked. As a nursing assistant, Mays should not have had access to the medication room without authorization. Further, some medication carts were unlocked and unattended. Sadly, these lapses in security created opportunities for Mays to regularly obtain insulin she would later use on patients, causing hypoglycemic events that caused death for seven veterans.

Adam Roy

The report identifies the facility staff's failures to complete patient safety event reports related to the hypoglycemic deaths or the unusually high use of D50, medication used to treat hypoglycemia or insulin shock. It also describes how nursing staff failed to report concerns surrounding the deaths of patients to quality, safety, and value staff, who have oversight responsibilities for monitoring and identifying trends related to patient safety. What do these examples say about the medical center's culture during that time?

Michael Missal

In every hospital, whether it is a VA facility or one in the private sector, patients are exposed to known risks that are often inherent to that environment. Ultimately, quality health care is dependent on leaders who promote a culture of safety that reduces or eliminates those risks whenever possible. When that doesn't occur, weaknesses in a facility's culture of safety can have devastating consequences. In this case, we found that the facility had serious, pervasive, and deep-rooted clinical and administrative failures that contributed to Mays's criminal actions not being identified and stopped earlier. The failures occurred in virtually all the critical functions and areas required to promote patient safety and prevent avoidable adverse events. The facility did not consistently promote a culture that prioritized patient safety and, consequently, a combination of clinical and administrative failures created the conditions that allowed Mays to commit these criminal acts and for them to go undetected for so long.

Adam Roy

What happens next?

Michael Missal

Adam, the healthcare inspection report included 15 recommendations that were related to the issues that we identified in our inspection. VA concurred with each of these recommendations and provided

acceptable action plans to implement them. The OIG will follow up with VA regularly until each of the recommendations is closed out.

Adam Roy

Changing topics, let's discuss the recent Semiannual Report to Congress. All Federal OIG offices are required to submit semiannual reports to Congress twice a year. Known as the SAR, this report informs on all oversight work completed and also provides critical information that can influence the funding and direction of programs and services provided by the Department of Veterans Affairs. IG Missal, what story does the semiannual report tell about the OIG's recent oversight activities?

Michael Missal

Adam, it tells a lot about the accomplishments of our office, but it is really a story of dedication and perseverance. Although we are now in the second year of the COVID-19 pandemic, we continue to provide effective oversight of VA programs and make meaningful recommendations that will improve programs and operations for our nation's veterans. Our office was flexible and creative in finding ways to conduct audits, evaluations, inspections, reviews and investigations and publish reports despite ongoing pandemic-related challenges. During this reporting period, our work identified more than $1.9 billion in monetary impact, for a return on investment of $21 for every dollar spent on oversight. We issued 124 reports and publications, made 389 recommendations, and conducted investigations that led to 109 arrests.

Adam Roy

How has COVID-19 impacted the OIG's work this reporting period?

Michael Missal

The OIG made COVID-19-related projects a priority. For example, during this reporting period, we looked at how the pandemic created backlogs in healthcare and disability benefit appointments and delays in delivery of some services. We reviewed VHA's emergency department and urgent care operations during the pandemic and the steps VHA took to expand virtual care through telehealth options like videoconferencing. Our recommendations should help VA mitigate the aftermath of the pandemic and provide a better path forward for VA to achieve its broader objectives.

Adam Roy

Our SAR highlights several COVID-19-related investigations. How is the pandemic keeping our investigators busy?

Michael Missal

Our investigators have been particularly responsive to allegations of medical supply procurement fraud. For example, a businessman pleaded guilty to a fraud scheme where he falsely claimed that he possessed large quantities of personal protective equipment, like N95 masks. In another example, the owner of a wholesale pharmaceutical company defrauded healthcare providers, including VA, of more than $1.8 million by acquiring and hoarding personal protective equipment and then selling it at inflated prices. Both of these examples demonstrate the tremendous value this office provides in protecting VA during an extremely challenging time in the delivery of health care.

Adam Roy

Inspector General Missal, thank you for your time today.

I encourage our listeners to visit our website and review the Semiannual Report to Congress. There you will also find recent testimony from Christopher Wilber, counselor to the inspector general, who testified before the Subcommittee on Oversight and Investigations, US House of Representatives Committee on Veterans' Affairs on May 19. The hearing focused on VA's progress toward improving its Office of Accountability and Whistleblower Protection since issuance of the OIG's 2019 report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*. Mr. Wilber discussed how OIG staff interact with whistleblowers and complainants as well as provided an update on VA's efforts to close out the report's 22 recommendations. The next day, May 20, Mike Bowman, director of information technology and security audits for the OIG's Office of Audits and Evaluations, testified before the Subcommittee on Technology Modernization and discussed VA's ongoing cybersecurity challenges and the results of the OIG's April 2021 report, *Federal Information Security Modernization Act Audit for Fiscal Year 2020*. He shared the OIG's findings and repetitive recommendations made in recent Federal Information Security Modernization Act audits and how that underscores VA's inability to make major improvements and impactful change in their security program.

Now to investigations. Here's a quick rundown on those who thought they could scheme and steal and what happens when the VA OIG catches up to them.

An investigation revealed a former business owner paid nearly $30,000 in bribery payments to a former contracting officer representative at the Anchorage VA Medical Center in Alaska in exchange for preferential treatment. As a result, the business obtained more than $5 million in set-aside snow removal and housekeeping contracts. The former employee was sentenced to one year and one day of imprisonment and restitution of $347,000. The former owner pleaded guilty to bribery of a public official.

Over in North Carolina, a former specially adapted housing agent at the Fayetteville VA Medical Center was sentenced to two years' incarceration, three years' supervised probation, and restitution of $21,000. A VA OIG investigation revealed that the former VA employee received about $20,000 in bribes from a business partner in exchange for directing more than $1 million in grants intended for the modifications of veterans' homes to his partner's company.

An investigation by the VA OIG and Department of Housing and Urban Development OIG revealed that two defendants schemed to steal funds intended for housing homeless veterans. Instead of using these funds to make the appropriate rental payments on behalf of the veterans, the former case manager for a nonprofit and a property agent kept the funds for themselves. As a result, 25 veterans were evicted from their residences. The former case manager was sentenced to one year and one day of incarceration, three years' supervised release, and restitution of over $100,000. The property agent was sentenced to 21 months' incarceration, three years' supervised release, and restitution of over $100,000. Both defendants were sentenced in the Northern District of Georgia.

The owner of a canine training school was sentenced in the Western District of Texas to over nine years' imprisonment, three years' supervised release, and restitution of approximately $1.5 million. The investigation revealed the defendant fraudulently obtained VA approval through the submission of multiple materially false statements regarding the school's certifications and on-staff instructors. Similarly, the defendant submitted falsified certification materials to receive licensure to operate in the state of Texas. The loss to VA is over $1.5 million.

The former owner of a barber school pleaded guilty in the Southern District of Mississippi to wire fraud. A VA OIG investigation revealed the defendant submitted false course enrollments to VA on behalf of veterans who were eligible for Post 9/11 GI Bill benefits. The total loss to VA is approximately $410,000.

A veteran and his spouse pleaded guilty in the District of Kansas to theft of government property. An investigation by the VA OIG and Social Security Administration OIG revealed that the veteran, with assistance from his wife, fraudulently led VA and the Social Security Administration to believe that he was completely blind, which qualified him for special monthly compensation and other VA benefits. The investigation determined that the veteran was able to drive, operate machinery, and perform other normal daily activities without the assistance of another person or low-vision aids. The total loss to the government is approximately $240,000.

And lastly, a former VA database manager was sentenced in the Eastern District of Arkansas to 46 months' imprisonment and two years' supervised release. A VA OIG and US Secret Service investigation revealed that the defendant attempted to sell the personal data of veterans, their dependents, and VA employees for $100,000 to a confidential source working with law enforcement.

Now to published reports. In May, the VA OIG published 12 reports, including the Semiannual Report to Congress. I'll highlight a few of them now.

The OIG published the report, *Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program.* At the time of this audit, VA was about two-and-a-half years into an estimated 10-year modernization effort to replace its aging electronic health record system. The new system is being designed to be interoperable with the one used by the Department of Defense. As a result, healthcare providers will be able to access more comprehensive medical histories for the over nine million veterans enrolled in the VA healthcare program. The Office of Electronic Health Record Modernization manages VA's transition to the new system. VA has reported that the program will cost about $16 billion over the 10 years needed to implement the new system across Veterans Health Administration facilities nationwide. Because of the extensive costs to taxpayers and the importance of the EHRM program to providing veterans with quality care, the VA OIG conducted this audit as part of its oversight of the complex modernization program.

Specifically, the OIG initiated this audit to determine whether VA developed and reported reliable cost estimates for physical infrastructure upgrades necessary to support the new electronic health record system. This report details OIG findings that the Veterans Health Administration's cost estimates for these upgrades did not fully meet VA standards for being comprehensive, well-documented, accurate, and credible. The OIG projected that VHA's June and November 2019 estimates were potentially underestimated by as much as $1 billion and $2.6 billion, respectively. The Office of Electronic Health Record Modernization also did not include physical infrastructure cost estimates in statutorily mandated reports to Congress, stating it was not within the office's responsibility to report. VA concurred with the OIG's five recommendations and agreed that the costs associated with these upgrades will be transparently disclosed to Congress.

In another report, the OIG audited the Veterans Benefits Administration's handling of proceeds to determine whether they were completed accurately and timely. A proceed is an actionable item in the veteran's or beneficiary's record that is created when benefits payments are returned to VA instead of being paid for reasons such as a change of bank account number, a change of address, or a veteran's death. On December 18, 2019, VBA had more than 7,500 open proceeds totaling about $13 million. The OIG determined that the Veterans Benefits Administration generally handled proceeds accurately but sometimes took more than 90 days to close some proceeds. When a proceed remains open for an extended period, the veteran or beneficiary may undergo financial hardship. Proceeds open more than 90 days totaled an estimated $2.1 million. The OIG recommended VBA set a standard time for closing proceeds and develop oversight and monitoring procedures to ensure proceeds are closed promptly.

The VA OIG published two healthcare inspection reports on events at the Chillicothe VA Medical Center in Ohio. The first inspection reviewed allegations regarding a Sterile Processing Services employee's failure to follow endoscope reprocessing procedures, potentially placing patients at risk. The OIG determined the facility director did not develop and implement an adequate plan to monitor the employee's compliance with reprocessing procedures. Because multiple patients were potentially affected, leaders notified the Veterans Health Administration's Clinical Episode Review Team. The

team concluded the risk to patients was minimal and a large-scale disclosure was not warranted; however, the determination may have been based on an inaccurate understanding of reprocessing equipment capabilities. The OIG made two recommendations—one to the facility director regarding oversight of the employee's performance and one to the under secretary for health regarding the Clinical Episode Review Team's review of OIG-provided information to determine if it altered the determination of patient risk or the need for a large-scale disclosure.

In the second inspection at Chillicothe, the OIG reviewed aspects of care provided to a patient who was struck and killed by a vehicle near facility grounds following elopement from the community living center. The OIG determined that the patient's admission to the center was inappropriate, interventions were inadequate to mitigate the patient's risk for elopement, staff were inadequately trained, and patient safety reports were not completed as required. On the day of the patient's death, staff failed to detect that the patient, who was involuntarily civilly committed to the center, was missing for nearly three hours. Once noted as missing, facility staff failed to follow policy to locate the patient. The OIG made 12 recommendations related to reviewing the patient's care, the use of the community living center, and staff training.

Finally, the OIG published three Comprehensive Healthcare Inspection Program or CHIP reports on VA medical centers located in Saginaw, Michigan, and in Cincinnati and Columbus, Ohio. CHIP reports ensure our nation's veterans receive high-quality and timely healthcare and are performed every three years. Inspections focus on variety of issues like mental health, medication management, and safety.

Find summaries of all VA OIG reports online at our website. Thank you for listening to the monthly highlights for May 2021.

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