PODCAST TRANSCRIPT

September 2021 Highlights

Welcome back to another podcast episode by the Veterans Affairs, Office of Inspector General. This is your host Adam Roy, and I'll be sharing VA OIG's recently published oversight work and other updates. September was another busy month, here in the OIG. Prior to closing out fiscal year 2021, the OIG published 38 reports. Combined with the August results, that's 62 published reports over the past 60 days. Despite ongoing pandemic-related challenges, OIG auditors and inspectors remain committed, continuing to conduct oversight and make recommendations that improve VA programs and lives of our veterans and their families.

Be on the lookout for our next Semiannual Report to Congress, which covers the reporting period of April 1 through September 30. In that report, we will publish performance metrics on the last six months and throughout all of fiscal year 2021. The 86th Semiannual Report to Congress will be available at our website, www.va.gov/oig, later in November.

The VA OIG's Office of Investigations had many updates to ongoing investigations in September. I'll highlight a few cases now. For the full list, check out September's published highlights on our website.

A former employee of the Northport VA Medical Center was arrested after being indicted in the Eastern District of New York for aggravated sexual abuse, sexual abuse, and false statements. An investigation by the VA OIG, FBI, and VA Police Service resulted in charges alleging that the defendant forcibly committed a sexual act against a coworker while on duty and later made false statements when interviewed by VA OIG agents. The defendant, who was a probationary employee, was also terminated from his VA employment as a result of these allegations.

Also, in New York, a defendant pleaded guilty to wire fraud in connection with a COVID-19 scam. An investigation by the VA OIG and Homeland Security Investigations revealed the defendant made fraudulent misrepresentations in an attempt to secure orders from VA for 125 million face masks and other personal protective equipment totaling over $806 million. The defendant promised to obtain millions of masks from domestic factories while knowing that fulfilling the orders would not be possible. The defendant attempted to obtain an upfront payment from VA of over $3 million and acquired approximately $7.4 million from state governments and private entities by making similar false representations.

In another pandemic-related investigation, a registered nurse at a VA medical center in Detroit was charged in the Eastern District of Michigan with theft of government property and theft or embezzlement related to a healthcare program. The VA OIG, Department of Health and Human Services OIG, and VA Police Service conducted an investigation that resulted in charges alleging that the defendant stole authentic COVID-19 vaccination record cards and the vaccine lot numbers necessary to

make the cards appear legitimate. It is alleged that the defendant then resold the cards for $150 to $200 each to individuals within the metro Detroit area.

A VA medical center employee in Biloxi pleaded guilty in the Southern District of Mississippi to theft of government property. An investigation by the VA OIG, FBI, and US Postal Inspection Service revealed that the defendant stole N95 masks, electronics, and medical devices from the facility. The defendant received approximately $73,000 after reselling the items at second-hand retailers.

A defendant was indicted in the Northern District of Texas for conspiracy to commit healthcare fraud. An investigation resulted in charges alleging that the defendant's role as a marketer was instrumental in a fraud scheme in which the Department of Defense's TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs, also called CHAMPVA, were billed approximately $4 million for unnecessary laboratory testing. Of this amount, approximately $655,000 was billed to CHAMPVA. This investigation was conducted by VA OIG; the Defense Criminal Investigative Service; the FBI; and the OIGs from the Department of Health and Human Services, the Department of Labor, and the Office of Personnel Management.

Now, I'll highlight several VA OIG reports published last month.

An administrative investigation focused on the circumstances of a veteran's death on the Edith Nourse Rogers Memorial Veterans Hospital campus in Bedford, Massachusetts. A veteran resided at an independent living facility operated by a private company in space leased through VA's enhanced-use lease program. A month after the veteran was reported missing, another resident found his body in an emergency exit stairwell down the hall from his room. The VA police department's failure to locate the veteran resulted in part because Veterans Health Administration policy requires extensive searches for missing patients but not for missing residents. The then police chief also improperly stopped routine patrols of the building in which the veteran was found, and inadequate oversight of the lease terms resulted in stairwells not being cleaned. Routine patrols or cleanings likely would have found the veteran earlier. VA concurred with the OIG's seven recommendations to improve policies and procedures.

In another report, the OIG determined that Blue Water Navy Outreach Requirements were met but claims processing and procedures could improve. Since 1991, Vietnam veterans in a defined area are presumed to have been exposed to harmful herbicides such as Agent Orange. The Blue Water Navy Vietnam Veterans Act of 2019 extended this presumption to veterans who served within 12 nautical miles of Vietnam. This OIG review examined whether Veterans Benefit Administration employees notified Navy veterans of their potential eligibility for medical benefits under the act and also whether the employees correctly determined claimants' eligibility for benefits and made accurate rating decisions on the veterans' claims. Although VBA met its outreach requirements and generally determined veterans' herbicide exposure correctly, VBA had not established procedures for resolving unlikely ship location search results used to help determine eligibility. In addition, approximately 46 percent of

VBA's rating decisions were inaccurate from April through June 2020, resulting in about $37.2 million in improper payments to veterans. The OIG made three recommendations for corrective action.

In fiscal year 2019, VA provided veterans with about $318 million in medically prescribed prosthetic and rehabilitative items such as artificial limbs, shoes, shoe inserts, and compression garments. A VA OIG report titled, *Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors,* explains how the OIG audited to determine whether the Veterans Health Administration's oversight ensured medical facilities paid reasonable prices when reimbursing vendors for these items. The OIG found that medical facilities sometimes reimbursed vendors at unreasonable rates because VHA's oversight of prosthetic spending was ineffective. Medical facilities spent about $10 million more than reasonable rates between October 2019 and March 2020. Furthermore, the OIG found that prosthetic spending data was unreliable—about 36,200 transactions in the national prosthetics patient database from October 2019 through March 2020 contained at least one inaccurate data element, including the price paid. The OIG made four recommendations, including monitoring spending to make sure medical facilities reimburse vendors at reasonable prices.

In Fayetteville, Arkansas, the VA OIG conducted an inspection to evaluate progress at the Veterans Health Care System of the Ozarks in response to pathology reading errors identified during a follow-up review of cases interpreted by a former facility pathologist. The OIG found facility processes for disclosures of pathological errors and electronic health record amendment met VHA requirements. However, opportunities for improved tracking of clinical disclosure completion existed, and the facility lacked a process for clinical providers to communicate subsequent health changes to the clinical review team for reconsideration of institutional disclosure needs. Although amended reports were completed for patients identified with level 3 diagnostic errors, fewer than 5 percent of the amended reports were entered into electronic health records of patients identified with level 2 diagnostic errors at the time of the OIG site visit. The OIG made three recommendations.

The OIG reviews proposals submitted to VA for Federal Supply Schedule pharmaceutical contracts valued annually at $5 million or greater. These reviews help VA contract specialists negotiate fair and reasonable prices for the government and taxpayers. Individual reviews are not published because they contain sensitive commercial information. To promote transparency, the OIG issued a report summarizing the reviews of pharmaceutical contract proposals conducted in FY 2020. The 15 proposals had a cumulative 10-year estimated contract value of approximately $10 billion and included 515 offered drug items. This OIG report detailed how many proposals were accurate, complete, and current, and summarized pricing and prior recommendations for those that were not. The report did not include additional recommendations for VA response. Contract specialists have completed negotiations on the proposals, and the OIG's recommendations collectively resulted in approximately $42 million in savings for VA.

In a national healthcare review, the OIG identified clinical and non-clinical occupations experiencing staffing shortages within VHA. In this eighth staffing report, the OIG evaluated severe occupational staffing shortages and compared this information to the previous three years. The OIG found that 98 percent of facilities identified one or more severe occupational staffing shortages. Every year since 2014, medical officer and nurse occupations were identified as severe shortages. Within the medical officer occupational series, psychiatry was the most frequently identified clinical severe staffing shortage. Medical support assistance was the most frequently identified non-clinical severe staffing shortage. Since fiscal year 2018, the overall number of severe occupational staffing shortages decreased from 3,068 to 2,152. Similarly, the number of occupations reported by at least 20 percent of facilities decreased from 30 to 19. The OIG made no recommendations.

Two reports published in September concerned COVID-19. One addressed the Fayetteville VA Coastal Health Care System in North Carolina. The OIG assessed concerns about the care provided at this facility and the impact of COVID-19 on a patient with unintentional weight loss. The patient was later diagnosed with oral cancer and died at another VA medical center. The OIG substantiated that a primary care provider and dietitians did not provide quality care. The OIG also substantiated that the patient's nurse and dietitians did not coordinate care with the patient's primary care provider. The OIG made six recommendations.

In the second COVID-19-related report, the OIG conducted an inspection to assess allegations that community living center staff and leaders at the Illiana VA Medical Center in Danville, Illinois, failed to mitigate risk of and manage a COVID-19 outbreak. The OIG substantiated that the facility failed to observe general infection control practices and minimize the risk of exposure to COVID-19. The OIG did not substantiate a failure to notify residents, families, and staff of COVID-19 test results, but did substantiate a lack of a post-baseline testing plan and a failure to test all staff after potential exposure. The OIG found that actions taken by leaders following the community living center outbreak lacked input from frontline staff to identify corrective actions and opportunities for improvement. The OIG made 14 recommendations.

Last month, the VA OIG published reports for the first time under its new Vet Center Inspection Program. These three reports provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of social and psychological services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. The OIG's current inspection areas of focus for vet centers are leadership and organizational risks; quality reviews; COVID-19 response; suicide prevention; consultation, supervision, and training; and environment of care. We published three Vet Center Inspection Program reports in September.

And finally, we published 16 Comprehensive Healthcare Inspection Program or CHIP reports. The reports covered VA medical centers in West Palm Beach, Florida; Providence, Rhode Island;

Manchester, New Hampshire; Cheyenne, Wyoming; and White River Junction, Vermont. We also published reports for VA healthcare systems in West Haven, Connecticut; Miami, Florida; Oklahoma City, Oklahoma; Boston, Massachusetts; Augusta. Maine; Leeds, Massachusetts; and Muskogee, Oklahoma.

If you would like to learn more about recently published OIG reports, I encourage you to visit our website, www.va.gov/oig. There you will find summaries of all reports along with other information about the VA OIG. Thank you for listening.

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