VETERAN OVERSIGHT NOW PODCAST TRANSCRIPT

DR. JULIE KROVIAK, DAIG, DISCUSSES THE NEW VET CENTER INSPECTION PROGRAM

FEBRUARY 2022

Fred Baker:

Welcome back to another podcast episode of veteran oversight now. The official podcast of the VA Office of Inspector General. I'm your host Fred Baker.

Each month we'll bring you highlights of the VA OIG's recent oversight activities and interview key stakeholders in the office's critical work for veterans. Today we're excited to have Dr. Julie Kroviak, deputy assistant inspector general for healthcare inspections. Welcome Dr. Kroviak.

Dr. Julie Kroviak:

Thanks, Fred.

Fred Baker:

Dr. Kroviak, we're here today to talk about the recently implemented Vet Center Inspection Program. Before we get into that discussion. I'd really like the listeners to know a little bit more about who you are and what you do here at the VA OIG.

Dr. Julie Kroviak:

So, like you said I'm the deputy assistant inspector general, office of health care inspections. I get to supervise a wide variety of staff, the majority of whom have significant clinical training and experience serving veterans. I am the daughter of a veteran. I grew up in New England with an unexpected move into Alabama in the middle of my sophomore year of high school. That was for my dad's job, so you can imagine I still give him honest feedback about that move.

But currently I live in Northern Virginia. I've got a husband, who's also a physician, four really active kids, two really active dogs. And if I'm not working here, I'm keeping the kids and dogs out of trouble or reading. I love reading, always have book in my hands, and I can tell you there have been several instances where I've fallen down the stairs reading. These were witnessed events, so just shows you my passion for reading when I'm not at work.

Fred Baker:

Sure, any particular genre.

Dr. Julie Kroviak:

Oh, I love historical fiction. I really love historical fiction, but I'll read just about anything.

Fred Baker:

So, what was the last book you read.

Dr. Julie Kroviak:

So, I read a book called *Anxious People*, which is actually a comedy of sorts. It's— I don't remember the author. He's Swedish. It's actually very popular right now and that's more of a comic look at just putting a wide variety of people in a hostage situation, if you can believe. But it's very interesting.

Fred Baker:

Interesting. We'll have to check it out.

Fred Baker:

So, do me a favor and tell me a little bit about how you came to the VA OIG.

Dr. Julie Kroviak:

So, I started, I did my undergrad work here at Georgetown and I majored in Latin American literature, go figure. I'll end up going back to Alabama from medical school, and my first year as a medical student they throw you into the arena, to say, and they have you interview a patient. So, they sent us to an affiliate hospital. My assignment happened to be at the VA, and from the moment I walked in that hospital I didn't want to leave. I was just overwhelmed by this sense of humility among the veterans, the camaraderie and support they offered each other. This service first kind of attitude. I was hooked, and might my fate was truly sealed at that moment. I didn't know it yet. I'll come back to Georgetown for internal medicine residency, and I'll complete it here and I will jump right to the DC VA to start practicing primary care.

And 11 years I did that. Two different wars, and I love what I do now, but that was the most incredible professional experience I've ever had. Nothing can compete with taking care of thousands of veterans. I learned so much about medicine, more about life, and I am incredibly in debt to that population.

Fred Baker:

So, after you got to know the veteran community a little bit better. \Did you cut your father some slack?

Dr. Julie Kroviak:

No. No way.

Fred Baker:

So, the time period that you were doing that care is interesting because that's a very young demographic versus, you know, the Vietnam vet, World War II vet era demographic that we're all familiar with how. How did that change your perspective on veterans and health care?

Dr. Julie Kroviak:

Oh, I was a different doctor. So, I started in 2003. I was taking care of what you would consider that stereotypical Vietnam, Korea veteran and they had significant physical issues, as well as mental. But once the younger population started enrolling and engaging in care, overnight I almost felt like a pediatrician and the diseases, and the Management I was putting into play was focused so much more on the mental health.

Fred Baker:

And I think that kind of plays into the veterans or the vet center inspection program. But before we talk about that, I want to talk a little bit more about what the what the healthcare inspection program overall does. So, VHA is the largest integrated healthcare system in the US, and according to their own numbers, they serve 9,000,000 enrolled veterans each year. How daunting is the task of providing oversight to an organization of that size, and what are some of the challenges?

Dr. Julie Kroviak:

So, honestly, it's not daunting at all. It is the most worthy of worthy challenges. From my experience, from the staff that I supervise, their experience, and actually frontline delivery and care, there's nothing daunting about wanting to everyday improve the care those veterans are giving—are getting— and we have such incredible talent supporting that mission, that it's just not overwhelming. We can do it. We

can support them, and I love using that talent in creative and innovative ways to support improvements in the care. VHA provides. And I'm so invested in it from my previous experience in delivering care, but my teams might even beat me in that investment. So, every day, we are thinking of who we were on that front line and trying to make it easier for those people to deliver care and ultimately for the veteran to get the highest quality of care.

Fred Baker:

So, for the listener, introduce a couple of the, introduce the primary products that your office produces and just generally speaking, how you go about producing those products.

Dr. Julie Kroviak:

OK, so we are organized in teams to produce a wide variety of publications. So, we have the CHIPS, which are our comprehensive healthcare inspection programs. These teams go around and hit every facility approximately every three years, looking at very specific issues related to quality-of-care delivery and looking at leadership of facilities to see how they're working together to make sure veterans are getting what they need. We do that at the VISN level too. So, the regional architecture of these hospitals puts them under an umbrella of VISN. So, there's leaders at the vision, there's even clinical expertise at the VISN. So, we go talk to these regional leaders as well and report on those findings. Our old-fashioned hotlines—people, whether they're staff, veterans, caregivers, any stakeholder who might have an issue with what's going on with care or something at a facility, they'll call us. They'll put in a web-based complaint or concern. And our teams will go and inspect and find out what's going on.

We have mental health reviews, so I've got an army of expertise psychiatrists, psychologists, nurse practitioners, all who have delivered mental health care to veterans. They now work and look at issues related to care delivery for those really complex high-risk veterans. I've got a women's health review team, so women veterans. You know, we are thrilled to have opened that team about a year ago, and we're putting out some really exciting work looking at that provision of care for this population.

National reviews—we look at big topics across the department. You know, pain management, suicide, things that are clearly impacting care delivery, and we use big data to describe that story.

We're now venturing into the community care, so purchased care programs, trying to understand the quality and access issues that veterans are facing on that front.

And then internally we do a really cool product. It's a consult, so when our friends in audit or criminal investigations are looking at something that might have had clinical impact to veterans, they pull us along for the ride and we get to offer our expertise on that front as well.

Fred Baker:

So, it's certainly a broad array of products and oversight opportunities. So, for the purpose of this program, we're going to talk about the vet center inspection program. Tell us what the Vet Center is, how long they've been around, and describe their role compared to the role of some other VA facilities.

Dr. Julie Kroviak:

OK. So, these are some counseling centers that are out in the community. They are not within a facility. They are—they started in 1979, so if you can kind of go back in history to understand what was going on with veterans who had recently returned from combat. They were experiencing quite a bit of readjustment issues, and the level of mistrust with the VA and any, you know, traditional government entity was very low. But these people needed help, so RCS, which is readjustment counseling services, they're under—they're within VA. They opened up these centers staffed with therapists who could provide some level of support to these veterans through counseling, individual and group, and to help them on that front. But they advertise themselves as care without the hassle and also as being separate from VA. So, the medical, there were no records that were shared. There were actually no records at all initially. no medications were prescribed. It was just really trying to support these veterans as they struggled with what would come to be known as PTSD, and interestingly. RCS identifies PTSD even before the American Psychiatric Association does.

So, bottom line, they were always meant to be separate. They were meant to give care to veterans who had issues related to their combat experience.

Fred Baker:

So, if you could just explain a little bit more about that separation. You know, we have health care records sharing now. What does that look like between the vet centers and in VA?

Dr. Julie Kroviak:

Yeah, so it's really important to remember these are not clinical settings. There's…care is provided in terms of counseling, but diagnoses are not made, certainly medications are not prescribed. And while VA has a current medical record, even before we talk about the Cerner record, RCS used to keep paper, the vet centers used to keep paper records and then around 2003 they adopt a medical record electronic that is completely separate does not interface at all, by design, by intention, with VA medical record.

And that probably wouldn't have been an issue per se if the focus didn't necessarily change to targeting high-risk veterans, really the issue of reducing risk for suicide.

And, so, as those risks became more on the forefront and more a target of VA clinical staff, it did create or does create some issues in that coordination or lack of coordination and separation of these two entities for some veterans.

Fred Baker:

OK, so before we go into that, who is eligible for care at these vet centers.

Dr. Julie Kroviak:

So, you combat veterans for sure, which is what initially prompted their design, but now the eligibility has expanded: reservists,

Family members now can actually, of combat and reservists, can actually get services provided as well related to, you know, family counseling, marriage counseling, things like that.

Fred Baker:

So, it sounds like initially these vet centers we're just, we're more places that vets could go and just talk, right? Talk about their problems and receive some type of counseling.

Dr. Julie Kroviak:

Yeah, and that's an incredible service they were providing. And I'm not trying to downgrade it at all because otherwise there would have been nothing that these veterans—who didn't even have a diagnosis yet, if you can imagine how crippling and isolating that could be—could go talk to peers. Could be in groups of people with similar experiences. And that actually was incredible groundwork for future treatment and evidence-based therapies for posttraumatic stress.

Fred Baker:

So, when you talk about the kind of the transition toward the higher risk of veterans and the coordination of care is that why we decided to start inspecting these programs.

Dr. Julie Kroviak:

There are many reasons we should be at war in the right place inspecting these. But you are absolutely right. We've recognized through our vast array of mental health products, including hotlines, that many veterans were using resources at the vet center. But as we started to think about really being part of that suicide risk reduction, we felt it was incredibly reasonable to start inspecting these centers and

understanding how, if that care coordination needed to happen, was it happening? Was it timely and did everybody know how to do it who was working at the centers. So many things we needed to understand to make sure that that partnership was actually working and, like I said, it gets tricky because these are meant to be separate. But as we are getting aggressive with suicide risk reduction, the department is, too. So, they did start implementing policies that required certain aspects of coordination and higher-level clinical care integration for veterans deemed high risk for suicide.

Fred Baker:

As you mentioned earlier, you already do a comprehensive health care inspection. How did those differ from these vet center inspections and are there any similarities?

Dr. Julie Kroviak:

There are incredible similarities in that we are very fortunate to have a groundwork to understand how to do reviews in general. But remember these are not clinical centers, so we can't, you know, evaluate them in the same way. So, we have the tools to know how to do the reviews, but we really had to target the issues or the programs and services that are provided that are very different than the medical centers.

Fred Baker:

So, what does that inspection process look like? Do they go to the center? Are they using a template style of inspection format? What are they doing when they're inspecting?

Dr. Julie Kroviak:

So sadly, as you know, many of our programs have faced obstacles. This, we debuted this program during the pandemic. So initially these were all virtual reviews, meaning leadership interviews occurred over video format, and our environment of care was really limited and using, you know, on site cameras and kind of having staff walk us through it in a virtual setting. But two weeks ago, we went back on the road. So, we are now physically inspecting these and conducting our interviews and data reviews on site.

Fred Baker:

And how many of the vet center programs are there or vet centers are there.

Dr. Julie Kroviak:

There are 300 currently vet centers and they're organized into zones and districts. So, we statistically sample where we're going to go, who were going to talk to get a comprehensive sampling to understand operations.

Fred Baker:

And are they on a cycle similar to a CHIP.

Dr. Julie Kroviak:

Yep. Yeah, we actually we were hoping to even tighten up that schedule, but we need to hit all 300 of these and we have a team that is very motivated to do that.

Fred Baker:

That's quite a task. Are there specific areas that they're looking at?

Dr. Julie Kroviak:

Yep, so leadership will be a story that we tell in every single report we write from now on, so this is included. We're looking at leadership in local and regional levels for each vet center that we visit. Importantly, we're looking for their internal quality reviews. You know care is being provided, and we need to know that there is appropriate oversight and intervention and when issues are found that plans are in place to remediate. We did add a topic this year, for good reason just the COVID-19 response; so how did the facility or how did these centers transition to provide safe care, continuous care and just in line with keeping staff and clients safe?

Environment of care—you know that's just what are these centers looking like? Are they clean? Are they safe? Are information protected when anybody accesses them. But most importantly, we're looking at those suicide prevention activities that I described earlier and making sure that staff is trained and supervised in providing those types of activities.

Fred Baker:

So how many have you done to date and what are you finding? Are there any trends?

Dr. Julie Kroviak:

Yeah, so we've published five to date, and there are a few in the pipeline now that should be out in the next couple months. But we are certainly finding issues specifically related to those suicide prevention

requirements, that engagement with the clinicals-VHA when patients are screened to be at risk for suicide, as well as supervision and training. We found we had quite a few findings and recommendations based on shortcomings and those requirements. The good news is this is a smaller network as opposed to VHA clinical, so we are really hopeful that with the first five publications that this information is being shared broadly across the vet centers, which there's, you know, 300. But it's much smaller staff and we're hoping that, even though we haven't hit that one vet center, that leader's reading one of the five reports, if not all of them, and understanding where our findings were, and they're actually fixing them so that when we go there, we'll, you know, be able to give the A plus grade and then start thinking about things that we can review the next time, just to keep them pushing forward in quality and taking care of their clients, but in particular those high-risk veterans.

Fred Baker:

So, can you articulate clearly—because a lot of it does sound clinical when you talk about what you're looking at—can you articulate clearly how these inspections translate to a better care for the veteran?

Dr. Julie Kroviak:

Yeah, so let's say a veteran who is high risk who's not engaged in any type of medical care. So, he's that stereotypical veteran who doesn't want to get help Maybe a family member has pushed them to go or friend pushes them to go to the vet center, and they engage in some counseling with what is a licensed social worker. So, they're talking about their experiences, and they're talking about potentially suicidal thoughts or issues with substance abuse, things that when that counselors listening to them, they're really afraid that this veteran is at risk for suicide.

There are, once that provider has reached that concern, like "Whoa, I'm really concerned about this veteran," all these things should be coming into play that make sure the local VHA clinical facility is aware of who this veteran is, what their current needs are, and can reach out to engage them. It's lifesaving, however you look at it—and it is happening right now—and I'm confident our recommendations that we've already published will be read across the vet center network by leaders that we haven't inspected, and they will be immediately paying more attention to that type of veteran I'm describing?

Fred Baker:

Dr. Julie Kroviak, deputy assistant inspector general for healthcare inspections, here at the VA Office of Inspector General. Thank you, Dr. Kroviak, for joining us.

Dr. Julie Kroviak:

Thanks, Fred.

Fred Baker:

We appreciate everything you and your organization does to improve the quality of veteran health care. Have a great day.

OK, now I'll turn it over to Adam Roy for this month highlights. Take it, Adam.

Adam Roy:

Thanks Fred.

The VA OIG started off 2022 with several investigations moving forward in January.

Let's take a look at a couple bribery schemes.

In one, a former Miami, Florida VA Medical Center employee was arrested for her role in a bribery and kickback scheme involving multiple vendors and VA employees. While employed by the VA, she was responsible for supervising the ordering of goods and services. According to the investigation, she and other VA employees placed orders in exchange for cash bribes and kickbacks from corrupt vendors. Often, these supplies were grossly inflated, and some orders were only partially fulfilled or not fulfilled at all. After leaving VA, she immediately began working for one of the vendors and allegedly continued to pay kickbacks and bribes to VA employees. The vendors charged in this case were responsible for over $37.6 million in purchase card orders and contracts. We will continue to update you as this case goes forward.

In another one, two individuals were sentenced for their roles in a bribery scheme involving a former VA contracting officer's representative at the Anchorage VA Medical Center in Alaska. The VA employee gave preferential treatment to two service-disabled veteran-owned small businesses in return for nearly $30,000 in bribery payments. These two companies obtained more than $5 million in snow removal and housekeeping contracts as a result. One of the individuals, a former bookkeeper, was sentenced to 36 months' probation and ordered to pay restitution of more than $52,000. The other individual, who owned one of the companies, was sentenced to a year in jail and will pay nearly $350,000 in restitution. Nice work VA OIG investigators on this one!

In another case, a defendant was sentenced in connection with a compounding pharmacy scheme. Compounding pharmacies are similar to regular pharmacies in that they both prepare medications prescribed for a patient by a doctor. However, compounding pharmacies often customize medication based on a patient's specific needs. In this case, the VA OIG, Defense Criminal Investigative Service, US Postal Inspection Service, and Homeland Security Investigations investigated a Louisiana-based compounding pharmacy office manager who knowingly submitted payment requests for compounded

medications for which there was no medical necessity. The defendant was sentenced to three years' probation and will pay restitution of $180,000. TRICARE and CHAMPVA were billed over $15 million as a result of this scheme with the loss to VA approximately $600,000.

Over the past couple years, this pandemic has proven the importance of personal protective equipment, like N95 masks. While so many continue to work tirelessly to ensure health workers have them, that more are being ordered regularly, and that these masks are being distributed to the places where they are most needed most, there will always be those who try and take advantage of a situation, like this former VA employee who oversaw supply chain management for the Gulf Coast Veterans Healthcare System. The defendant stole N95 masks from the Biloxi VA Medical Center in Mississippi, and then sold them at secondhand retailers. The defendant, who made more than $73,000 doing this, sold the 3M N95 masks for an average of $18 per mask. That's 35 times their procured value of about $0.50 cents per mask. This defendant will be going to jail for 12 months and will pay over $60,000 in restitution and fines.

Wrapping up our investigative updates, a diving school owner was sentenced in connection with an education benefits fraud scheme. A multiagency investigation by the VA OIG, Department of Education OIG, and the FBI revealed that the diving school owner fraudulently obtained reaccreditation by submitting false and misleading information. By obtaining reaccreditation, the school maintained eligibility for federal education benefits from VA and the Department of Education. The defendant was sentenced in the District of New Jersey to 27 months' imprisonment, three years' supervised release, restitution of $1.1 million, and a fine of $50,000.

In January, the VA OIG published several reports. I'm going to highlight a few now.

Our audit team published another report related to VA's use of the of the Defense Logistics Agency's Electronic Catalog for Medical Items. A little background here…In 2019, VA decided to use the Defense Logistics Agency's system, planning to spend $2.2 billion deploying it across the Veterans Health Administration over the next 15 years. The system is already 20 years old, and as VA OIG's Deputy Assistant Inspector General for Audits and Evaluations Leigh Ann Searight stated in her November 2021 testimony to the subcommittees of the House Committee on Veterans Affairs, the system failed to meet 44 percent of the staff's requirements at the first hospital where it was deployed—the joint VA-Department of Defense health care center near Chicago. A report, covering operational gaps with the system, was published in November 2021 as well. This month's report was the result of a VA OIG review that determined whether electronic catalog procurements complied with regulations, policies, and the agreement's terms. The OIG found that the electronic catalog ordering guide does not require VA officials to consider Federal Supply Schedule contracts before ordering. The guide incorrectly describes how to apply the Rule of Two, which requires contracting officers to award contracts to veteran-owned small businesses if they reasonably expect that at least two such businesses will submit offers and that the awards can be made at fair and reasonable prices that offer the best value

to the government. An incorrect application of the rule could potentially exclude veteran-owned businesses from contracting opportunities. VA OIG found that officials did not follow documentation requirements, and that VHA's Procurement and Logistics Office did not annually review the electronic catalog agreement, as required. We made several recommendations. Visit our website for a full summary of this report.

Now, during COVID-19, VHA's Office of Community Care took steps to ensure veterans continued to have expanded access to health care in the community, as required by the VA MISSION Act of 2018. Policies were issued to VA facilities to postpone nonurgent appointments and offer alternatives to in-person care, such as telehealth. We conducted an audit to determine whether VHA effectively managed community care consults for routine appointments during the pandemic. But as the report outlines, the VA OIG found that routine community care consults were unscheduled for an average of 42 days, not meeting VHA's goal of 30 days. Because of the pandemic, community care staff faced significant challenges beyond their control that contributed to these scheduling delays, such as the lack of availability of appointments. We also found that some patients were hesitant to schedule appointments during the pandemic. Others failed to return phone calls or declined care once it was offered. Now, while these challenges prevented the OIG from evaluating whether timeliness could be improved, they do underscore the need to strengthen VHA's governance over community care. Report recommendations include that the under secretary for health develop guidelines requiring supervisors to monitor documentation of communication between staff and patients, establish a tool to monitor whether community care staff both document the suitability of alternatives to face-to-face care and offer them to eligible patients, and reassess the frequency and approach to its training for scheduling community care consults. The report, titled *Audit of Community Care Consults during COVID-19*, was published on January 19 and is available on our website.

Also, in January, the VA OIG published three Comprehensive Healthcare Inspection Program reports. Our teams go out and inspect a facility every three years, evaluating specific focus areas like mental health; quality, safety, and value; and suicide prevention. Then they publish a CHIP report summarizing the results. This month, we published reports on the Charles George VA Medical Center in Asheville, North Carolina; the VISN 8 Sunshine Healthcare Network, which includes facilities in Florida, Puerto Rico and the US Virgin Islands; and the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

The VA OIG also reviews broader issue areas across multiple VHA medical facilities. In the January report *Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020*, the VA OIG evaluated VHA's compliance with medication management requirements and processes related to long-term opioid use for pain. This report describes findings from healthcare inspections initiated at 36 VHA medical facilities from November 2019 through September 2020. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. The VA OIG found general compliance with many of the selected requirements; however, the

OIG identified several weaknesses related to behavior risk assessments, urine drug testing, informed consent, just to name a few.

That's it for January's reports. If you want our report summaries delivered right to your inbox, visit our website—www.va.gov/oig and sign up on our home page for email alerts. Thank you for tuning in.

This has been an official podcast of the VA Office of Inspector General. Veteran Oversight Now is produced by the Office of Communications and Public Affairs and is available at va.gov/oig. Tune in monthly to hear how the VA OIG serves veterans, their families, and caregivers, through meaningful independent oversight. Check out the website for more on the VA OIG oversight mission, read current reports, and keep up to date on the latest criminal investigations. Report potential crimes related to VA; waste or mismanagement; potential violations of laws, rules, or regulations; or risks to patients, employees, or property to the OIG online or call the hotline at 1-800- 488-8244. If you are a veteran in crisis or concerned about one, call the Veterans Crisis Line at 1-800- 273-8255, press 1, and speak with a qualified responder now.