



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT AUGUST 2021 HIGHLIGHTS

Welcome back to another podcast episode by the Veterans Affairs, Office of the Inspector General. This is Adam Roy, and I'll be sharing recently published oversight work and investigative updates for the month of August 2021. As we approach the end of the Federal government fiscal year, the VA OIG has been busy. In August alone, we published 24 reports on a wide variety of VA programs and services impacting our veterans. I'll highlight several of these reports shortly. I encourage those interested in learning more about the work we do here at the VA OIG to visit our website—www.va.gov/oig. There you will find all published reports, previously published monthly highlights, and up-to-date data on the results of our audits, evaluations, and healthcare inspections.

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Now let's talk investigations. We start with a New Jersey man who pleaded guilty to stealing HIV medication. The defendant conspired with a former pharmacy technician at the East Orange VA Medical Center to steal and sell \$8.2 million of medication.

Over in Ohio, a veteran pleaded guilty to influencing, impeding, or retaliating against a federal employee by threatening a family member. The VA OIG found the defendant sent a threatening text message to his VA social worker after he was discharged from a housing program due to misconduct. The defendant threatened to kill the social worker's family members because he blamed the social worker for his removal from the program.

Elsewhere, in a case of stolen valor, a veteran was sentenced in the Southern District of Florida to six months' imprisonment, three years' supervised release with nine months' home confinement, and ordered to pay restitution of approximately \$318,000. The VA OIG investigation revealed that the defendant lied about his military service history, to include lying about receiving a Combat Infantryman Badge earned during a deployment to Panama. By lying, it enabled the defendant to receive VA compensation benefits and healthcare benefits.

An ex-daughter-in-law of a deceased VA beneficiary was sentenced in the District of Arizona to five years' supervised probation and ordered to pay approximately \$232,000 for unlawfully using compensation benefits intended for the deceased VA beneficiary from August 2003 until September 2019.

A former pharmacy technician at the Kerrville VA Medical Center in Texas and two accomplices were indicted on numerous charges in connection with a drug diversion and distribution scheme. The

technician allegedly stole in excess of 40 packages containing controlled substances intended for veterans from the mail, then sold the narcotics to his co-conspirators for further distribution.

In New York, a veteran was arrested for making threats to various VA call center employees, including threatening to blow up the VA Medical Center in Buffalo, New York.

And a Florida veteran was indicted on theft of government funds and making false statements. Allegedly, he lied about his physical disabilities and made up combat stories that he told to VA in order to obtain a 100 percent VA disability rating.

And finally, two individuals were indicted on charges of kidnapping and extortion. It's alleged they kidnapped an elderly female with dementia from a parking lot at the West Los Angeles VA Medical Center and then withdrew about \$17,000 from her checking account without her consent. Within hours of beginning its investigation, the FBI located the victim's phone at a nearby hotel and rescued the victim.

Let's switch over to reports. In August, the OIG published its annual risk assessment of VA's charge card program. We evaluated the three types of charge cards—purchase, travel, and fleet for transactions during fiscal year 2020. So, what did we find? Well, we determined that the purchase card program remains at medium risk of illegal, improper, or erroneous purchases, which is similar to findings in fiscal year 2019 and 2018. However, data analytics identified potential misuse of purchase cards, and OIG investigations and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation, or FAR, and VA policies and procedures. Both travel and fleet card programs remain at low risk primarily because they had no year-end spending surges, but also because they accounted for just 1.4 percent and 0.3 percent, respectively, of VA's fiscal year 2020 spending.

In another report titled, *Ineffective Governance of Prescription Drug Return Program Creates Risk of Diversion and Limits Value to VA*, the OIG audited VHA to determine if it was effectively overseeing the drug return program to maximize benefits to taxpayers and ensure drugs waiting to be returned are not diverted or otherwise abused. VHA pharmacies can return prescription drugs that become damaged or expire before use through a reverse distributor for credit or destruction. The OIG found medical facility pharmacy chiefs did not effectively implement the program and did not follow requirements in VA's contract with the reverse distributor, Pharma Logistics. This increased the risk of drug diversion and ultimately put about \$18.1 million at risk. The OIG found pharmacy chiefs did not fully understand the program's requirements and responsible officials within VHA did not effectively oversee the contract, govern the program, or communicate requirements to medical facilities. The OIG made eight recommendations that included ensuring medical facilities are properly securing and accounting for drugs set aside for return. Related to this report topic, we also published a management advisory memo, titled, *Medical Facilities Forfeited Drug Return Credits through Inadequate Monitoring of Vendor Invoices*. While auditing the VHA prescription drug return program, we found VHA is at increased risk

for not receiving all drug return credits. VA ended its contract with national drug return vendor Pharma Logistics in October 2020 but will continue to receive final invoices through at least April 2022. VHA lost at least an estimated \$2.1 million worth of drug return credits because pharmacy chiefs did not always monitor preliminary invoices, reconcile job settlement statements to identify outstanding credits, and request extensions to allow additional time for credit processing. The OIG will continue its oversight work on prescription drug returns within VHA and plans to issue a full report with specific recommendations.

The OIG also published a report on VHA's staffing models. Congressional members requested we look at the progress VHA was making in developing a comprehensive staffing model. The report identified that VA and VHA define staffing models differently, as the associated program office directors reported inconsistent staffing model roles and responsibilities. Limited staffing resources were reported as a barrier to the development, validation, and implementation of staffing models. The OIG made three recommendations to the VHA under secretary for health: One to coordinate with VA to review roles, responsibilities, and number of staff required to develop, validate, and implement VHA staffing models; Two to evaluate status, and provide a timeline for development, validation, and implementation of staffing models; and Three to evaluate status, and provide a timeline for implementation of requirements related to HR Smart, the VA's human capital system of record for positions.

We also published two reports on military sexual trauma. In the first, titled, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, the OIG made six recommendations intended to help VBA fix claims processing deficiencies and better process claims in the future. This report examined whether VBA effectively implemented recommendations from a related August 2018 report; concluding they had not. In the second report, the OIG surveyed and interviewed military sexual trauma coordinators and points of contact within the Veterans Integrated Service Network. We also reviewed the culture of safety for patients requesting military sexual trauma-related care. Based on the analysis of survey results and interview information, the OIG found that insufficient protected administrative time, role demands, insufficient support staff, and inadequate funding and outreach materials challenged the coordinators' ability to fulfill their responsibilities. Check out the podcast page on our website for the companion podcast on this report, which features an interview with the OIG report team.

Multiple healthcare inspections were published this month. The OIG reported on deficiencies in coordination of care for patients with treatment-resistant depression at the VA San Diego Healthcare System. Specifically, we evaluated allegations related to patients receiving ketamine for treatment-resistant depression in the community after authorizations for the care lapsed in September 2019. The OIG made two recommendations to the under secretary for health related to community care providers' review of VA's protocol for ordering ketamine and ketamine research. Four recommendations were also made to the facility director related to community care processes for coordination of non-VA care and ensuring coordinated transitions for patients returning to care at the facility.

In another inspection, the OIG assessed allegations that staff at the Fayetteville VA Medical Center in North Carolina failed to coordinate appropriate care for a patient seeking community living center placement and respite care, and did not provide medications for the patient while at a community assisted living center. The OIG did not substantiate that the facility failed to coordinate placement or provide medications for the patient while at the community assisted living center. However, the facility failed to coordinate respite services due to an improper determination of the patient's eligibility. In addition, the OIG found that the psychiatrist used the involuntary commitment process in a manner inconsistent with the state's parameters and failed to adequately assess the patient's decision-making capacity and determine whether the patient had a healthcare agent. Providers also missed opportunities to coordinate the patient's specialty care needs. The OIG made seven recommendations.

The OIG also inspected the COVID-19 screening and treatment of a patient with serious mental illness who died at the Michael E. DeBakey VA Medical Center in Houston, Texas. We found that facility staff did not complete the patient's COVID-19 temperature screening and failed to medically manage the symptomatic patient. The patient disappeared, was found non-responsive off-site four days later, taken to the facility, and died the following day. Mental health staff failed to address surrogacy documentation discrepancies and educate the family on COVID-19 screening and the visitor policy. Facility staff did not comply with the missing patient policy, report an adverse event, or ensure a timely review of the patient's care. Facility leaders did not timely or accurately disclose to the patient's family the medical mismanagement that led to the patient's adverse clinical outcome. Ultimately, the OIG made nine recommendations related to COVID-19 screening, visitor policy, mental health care coordination, surrogacy, missing and at-risk patients, adverse events, issue briefs, root cause analyses, and institutional disclosures.

We also completed two healthcare inspections at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina. One inspection reviewed allegations referred by Chairman Mark Takano, House Committee on Veterans' Affairs, regarding the mental health care provided to a patient who died by suicide. The OIG found that facility staff did not adequately evaluate the patient when reviewing high-risk status and did not assign a mental health treatment coordinator prior to discharge. Facility staff did not complete required outreach to the patient, comply with VHA suicide risk assessment procedures, or notify facility leaders of the patient's death by suicide. In the other inspection, the OIG evaluated concerns related to staff's management of a patient's reported act of intimate partner violence and related assistance program implementation at the facility. The OIG found that despite reports of intimate partner violence, inpatient and outpatient staff did not consult with the assistance program point of contact, and inpatient staff did not ensure the spouse felt safe with the patient returning home upon discharge. The inpatient psychiatry resident did not timely complete a progress note addendum and facility staff failed to consider consultation with the Office of Chief Counsel. Also, the facility director did not ensure development of an assistance program protocol, facility staff and leaders did not

accurately identify the assigned program coordinator as a resource, and VHA guidance about intimate partner violence training responsibilities was unclear.

A financial inspection team assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Miami VA Healthcare System in Florida. This review focused on four areas: (1) use of the Medical/Surgical Prime Vendor-Next Generation program, a collection of contracts that streamlines purchasing for certain medical supplies; (2) use of purchase cards, such as requirements for documenting transactions; (3) the number of administrative staff compared to similar facilities and the accurate recording of labor costs; and (4) efficiency in pharmacy operations, such as inventory management and the healthcare system's efforts to reduce costs. The OIG made 12 recommendations.

And finally, a snapshot of recent work by the Comprehensive Healthcare Inspection Program. CHIP reports help ensure veterans receive high-quality and timely services. Inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. Currently, areas of focus for CHIP inspection teams include reviewing the following:

- (1) Leadership and organizational risks
- (2) Quality, safety, and value
- (3) Credentialing and privileging
- (4) Environment of care
- (5) Medication management
- (6) Mental health care
- (7) Geriatric care
- (8) Women's health
- (9) High-risk processes

In August, we published nine CHIP reports covering VA health care systems and medical centers in Aurora and Grand Junction, Colorado; Fort Harrison, Montana; Sheridan, Wyoming; Spokane, Washington; Roseburg, Oregon; and Salt Lake City, Utah. We also published CHIP reports for VISN 20, the northwest health network in Vancouver, Washington, and a focused evaluation of VHA facilities' quality, safety, and value programs for fiscal year 2020. Find summaries of all VA OIG reports online at our website. Thank you for listening to the monthly highlights for August 2021.

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