



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT July 2021 Highlights

This is Adam Roy with the Department of Veterans Affairs, Office of Inspector General, and you're listening to highlights for July 2021. I'll share investigation updates and briefly summarize several published reports. But first, a quick summary of recent congressional testimony by Deputy Inspector General David Case and Deputy Assistant Inspector General for Audits and Evaluations Leigh Ann Searight.

David testified before [the Senate Veterans' Affairs Committee](#) and the [House Veterans' Affairs Subcommittee on Technology Modernization](#) on VA's progress at deploying the new electronic health record system. He focused on OIG's recent audits on unreliable cost estimates for various infrastructure upgrades as well as a healthcare inspection that reviewed the training given to VA staff at Mann-Grandstaff VA Medical Center in Spokane, Washington. David discussed the work that VA needs to do to be more transparent and accountable to Congress to comply with existing statutes. He answered questions regarding VA's need for a revised governance structure that actively involves Veterans Health Administration users, and he provided an update into the review of allegations that VA staff altered and withheld information from OIG staff.

Leigh Ann testified before the [House Veteran's Affairs Subcommittee on Oversight and Investigations](#). She discussed the status of recommendations from two OIG oversight reports of VA's police program that identified governance and information management systems challenges. The findings of the [December 2018](#) report have not been addressed, and VA still does not have adequate or coordinated governance over its police program. The [June 2020 report](#) concluded that VA did not have an effective strategy to update its police information system. The OIG made seven recommendations in its 2020 report, and VA has taken sufficient action to close two of the recommendations. Leigh Ann stated that an effective governance structure is critically important to the functioning of any program. Moreover, an effective police program governance is dependent on access to accurate and timely information to provide strategic direction, make informed decisions, and maintain accountability.

Now to investigation updates.

A former pharmacy technician at the East Orange VA Medical Center in New Jersey was indicted on charges of conspiracy to steal pre-retail medical products belonging to the United States, theft of government property, and theft of government medical products. An investigation by the VA OIG, the FBI, and VA Police Service resulted in charges alleging the defendant stole prescription HIV medication from the facility for several years. The loss to VA is approximately \$10 million.

A former VA Puget Sound Healthcare System pharmacist was sentenced in the Western District of Washington to one year of imprisonment (time served) and three years' supervised release. This investigation revealed that the defendant attempted to acquire an AR-15 rifle and threatened in text messages to kill two VA employees. The defendant was previously charged in the Superior Court of

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King County, Washington, with cyberstalking. The state charges were dismissed so that this matter could be pursued in federal court. This investigation, which was initiated based upon a hotline complaint, was conducted by the VA OIG and several other agencies.

A veteran was arrested after being charged in the Middle District of Florida with the interstate transmission of threats to kidnap or injure. An investigation by the VA OIG and the FBI resulted in charges alleging that between November 2020 and May 2021, the defendant sent over 100 text messages in which he threatened to use explosives to injure or kill various Bay Pines VA Healthcare System employees.

The owner of a former VA-appointed professional fiduciary was sentenced to 47 years' imprisonment and three years' supervised release and the owner's spouse was sentenced to 15 years' imprisonment and three years' supervised release after both previously pleaded guilty in connection with a fiduciary fraud scheme. Both defendants will be required to pay the entire amount of stolen funds as restitution to the victims. An investigation by the VA OIG and several other agencies revealed that from November 2006 to July 2017, the defendants engaged in a sophisticated financial scheme with two other individuals to defraud victims of their VA and Social Security Administration beneficiary funds. The defendants used funds that were unlawfully transferred from their clients' accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately \$3.3 million. Both defendants were sentenced in the District of New Mexico.

A veteran pleaded guilty in the Western District of North Carolina to theft of government funds. A VA OIG investigation revealed that the veteran fraudulently received compensation benefits for blindness. The veteran was rated as having "light perception only" and 5/200 vision for approximately 30 years upon his discharge from the Army. This investigation revealed that the defendant maintained a driver's license in multiple states while claiming blindness. During a 15-year period, the defendant and his wife purchased over 30 automobiles that he routinely drove, including on long-distance trips, to perform errands, and to VA medical appointments. The loss to VA is approximately \$978,000.

The son of a deceased VA beneficiary pleaded guilty in the District of New Jersey to theft of government funds. A VA OIG investigation revealed that from September 2006 until June 2018, the defendant repeatedly conducted withdrawals of VA survivors pension benefits from his deceased mother's bank account. The loss to VA is over \$200,000.

The VA OIG published 19 reports in July. Read the reports and their summaries online at www.va.gov/oig. I'll now highlight several reports.

The OIG audited VA's Electronic Health Record Modernization program to determine whether information technology infrastructure upgrade cost estimates met VA standards and Government Accountability Office guidance. The OIG also examined whether reports to Congress included all IT

infrastructure upgrade costs needed to support the program. The audit revealed weaknesses in how cost estimates were developed and reported. Specifically, the \$4.3 billion in infrastructure estimates reported to Congress were unreliable and lacked complete documentation. Also, VA did not report to Congress other critical program-related upgrade costs of about \$2.5 billion, thus significantly underreporting total costs. The OIG made six recommendations for improving the reliability and reporting of cost estimates, including ensuring all costs are disclosed in estimates provided to Congress as required.

Related to the new health record modernization system, the OIG conducted an inspection to assess training at the Mann-Grandstaff VA Medical Center in Spokane, Washington. Here, the OIG made 11 recommendations related to training content and delivery, evaluating contractor performance, evaluating training, reviewing the governance of the electronic health record modernization effort, tracking electronic health record patient complaints, and assessment of employee morale.

In another report, the OIG assessed whether VHA effectively monitored participants in the Contracted Residential Services program, which provides temporary housing and services to veterans experiencing homelessness. The audit team also examined how VHA administered program contracts to ensure veterans received needed services, contractors met the contract terms and conditions, and funds were used appropriately. The team found that medical facility staff did not consistently prepare case management documentation for veterans and monitor their progress in the program. Contracting officers also did not always properly delegate responsibilities to staff who functioned as contracting officer's representatives. Other issues identified included invoices that lacked required supporting documentation. Based on its review of a statistical sample of 14 contracts, the audit team estimated that 107 of 119 contracts had monitoring and administration deficiencies, and that VHA made about \$35.3 million in improper payments. The OIG made five recommendations for corrective action.

The OIG also conducted an inspection at the VA Salt Lake City Healthcare System in Utah to assess allegations of lack of care coordination, a delay in care, refusal to hire a pharmacist, relocation delays, and bussing patients to the facility for care. The OIG substantiated the nurse delayed care by not returning the patient's call or discussing the patient's request and being off medications with the covering provider. The facility conducted an internal review that was incomplete and included inaccurate information, and leaders were unable to determine if an institutional disclosure was warranted. The OIG substantiated the Orem, Utah community based outpatient clinic relocation was delayed; however, the facility implemented a contingency plan to address the delay. The OIG did not substantiate a lack of care coordination, that the chief of pharmacy refused to hire a pharmacist and it affected the patient's ability to obtain medication, and that patients were bussed to the main facility for care. The OIG made three recommendations.

Finally, the OIG published five Comprehensive Healthcare Inspection Program—or CHIP—reports in July, including reports on two Veterans Integrated Service Networks. One report focused on the COVID-19 pandemic readiness and response in Network 19, serving Colorado, Montana, Oklahoma,

Utah, and Wyoming. Another report evaluated leadership performance and oversight in Network 10, serving Ohio, Indiana, and Michigan. The three other CHIP reports were on the VA Portland Health Care System in Oregon, the VA Puget Sound Health Care System in Seattle, Washington, and the Boise VA Medical Center in Idaho.

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

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