



Department of Veterans Affairs

Office of Inspector General

July 2015 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies on OIG's Interactions with Potential Whistleblowers and Hotline Complaint Process

Linda A. Halliday, Deputy Inspector General, testified before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, on "Whistleblower Claims at the U.S. Department of Veterans Affairs." She discussed how the Office of Inspector General (OIG) interacts with individuals who report allegations concerning VA programs and operations to the OIG Hotline. Ms. Halliday emphasized that these individuals are the lifeline of OIG organizations, and that the OIG is committed to protecting their identities, understanding their concerns, objectively seeking the truth, and ensuring VA pursues accountability and corrective action for wrongdoing. She reaffirmed the OIG's commitment to review and evaluate ways in which the OIG can enhance its interactions with individuals who report allegations, and she described recent initiatives to strengthen the OIG's internal whistleblower training and Whistleblower Protection Ombudsman programs. She was accompanied by Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections, and Ms. Maureen T. Regan, Counselor to the Inspector General.

[\[Click here to access testimony.\]](#)

OIG REPORTS

OIG Recommends Veterans Health Administration Review How It Compensates Non-VA Facilities for Lung Transplantation To Ensure Proper Reimbursement

OIG conducted an inspection at the request of Senator Charles E. Grassley and the VA Secretary to assess the merit of allegations that the Iowa City VA Health Care System (facility), Iowa City, IA, provided poor quality of care; failed to comply with the Veterans Access, Choice, and Accountability Act of 2014; and refused to pay for a patient's lung transplant outside of the VA. OIG did not substantiate the allegation that the patient received poor care during a summer 2014 admission to the facility, and while it could not be confirmed whether or not family members were told the patient had pneumonia, OIG determined that the patient and family members understood that the patient had received antibiotics for "an infection." In addition, OIG did not substantiate the allegation that the patient received inadequate treatment for her worsening respiratory condition between summer and fall of 2014. Rather, clinicians aggressively pursued testing during this time to determine whether the patient could receive a lung transplant. OIG did substantiate that while she was an inpatient in fall 2014, physicians did not properly address the patient's multiple episodes of oxygen desaturation and that the patient sustained an acute kidney injury. However, OIG did not conclude the kidney injury resulted from poor quality of care or that it disqualified her from receiving a lung transplant. Finally, OIG did not substantiate the allegation that the facility failed to appropriately address concerns regarding the patient's care when brought to the attention of the patient advocate and Chief of Staff; failed to comply with the Veterans Access, Choice, and Accountability Act; or refused to pay for a lung transplant at a

non-VA hospital. OIG made two recommendations. The Interim Under Secretary for Health (USH) and the Veterans Integrated Service Network (VISN) and Facility Directors provided an acceptable action plan. [[Click here to access report.](#)]

Most Allegations Refuted in OIG Review of the Jacksonville Outpatient Clinic, Jacksonville, Florida

OIG conducted an inspection in response to an anonymous complaint to Mike Coffman, Chairman of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives Committee on Veterans' Affairs, regarding multiple allegations about the staff and management of the Jacksonville Outpatient Clinic (OPC) in Jacksonville, FL. This review determined whether the allegations had merit. OIG substantiated that VA maintenance and engineering employees at the Lake City facility provide repair and installation services for VA equipment at the OPC, but this was reasonable. OIG substantiated that female veterans were not able to obtain mammography imaging services until June 2014, which was the planned opening date for the mammography suite. OIG also substantiated that the waiting area carpets were heavily stained. OIG did not substantiate allegations that veterans were turned away without being seen; 19 primary care providers treated only 145 veterans in a week; the specialty clinic manager did not enforce tours of duty or break times; complaints about managers bullying staff members were not addressed; Surgical Services staff did nothing while waiting for the operating room air system to be fixed; or that dietary staff saw only 20 veterans in a week and made an onsite community garden. Further, OIG did not substantiate allegations that non-VA mammography requests were denied; Wi-Fi access was not available; the clinic was dirty, and housekeeping staff were not trained; security staff did not follow up on an event; or the administrative area access was blocked, and staff members were advised to stay out of that area altogether. OIG made one recommendation. The VISN and Facility Directors concurred with the recommendation and provided an acceptable action plan. [[Click here to access report.](#)]

OIG Makes Ten Recommendations To Increase Effectiveness of VA Substance Abuse Inpatient Rehabilitation Programs

In the Joint Explanatory Statement to accompany the fiscal year 2015 omnibus appropriations bill, Congress requested OIG review the operations and effectiveness of VA substance abuse inpatient rehabilitation programs and report:

- (1) The current number of inpatient rehabilitation programs.
- (2) The annual number of veterans who participate and their average length of treatment.
- (3) The average length of time for VA treatment compared to non-VA residential treatment.
- (4) The rate of recidivism for both types of programs.
- (5) The process used to refer patients to VA treatment.
- (6) The degree of supervision of patients in VA programs and how often drug tests are performed.
- (7) How well mental health (MH) and substance abuse treatment are integrated for veterans with comorbidities.

OIG recommended Mental Health Services:

- (1) Liaison with internal and external entities regarding standardized data collection from screening processes to core outcome measures to improve program monitoring and by which MH Services can develop collaborative treatment initiatives.
- (2) Ensure system-wide use of the 596 stop code.
- (3) Review the consistency of current processes and provides specific guidance on reducing inflow of contraband into residential substance use treatment programs.
- (4) Consider requiring programs to document patients' physical status in addition to presence when completing physical bed checks.
- (5) Clarify the intent of the requirement for and use of closed circuit television with respect to residential substance use programs.
- (6) Review and evaluate whether reversal agents such as naloxone are readily available at each residential substance use treatment program.
- (7) Encourage more widespread incorporation of programming with a specialized focus on MH comorbidities.
- (8) Encourage discussion of addiction focused pharmacotherapy with residential substance use treatment program patients.
- (9) Ensure that active MH comorbidities are addressed in residential substance use rehabilitation treatment program interdisciplinary treatment plans.
- (10) Ensure documentation of post-discharge aftercare appointment arrangements for MH comorbidities. [[Click here to access report.](#)]

OIG Substantiates Provider Workload and Staffing Negatively Impacted Access and Quality of Care at Wasilla, Alaska, CBOC

OIG conducted an inspection at the request of Senator Lisa Murkowski to assess the merit of allegations regarding (1) provider availability, workload, access, quality of care, and security at the Mat-Su VA Community Based Outpatient Clinic (CBOC), Wasilla, AK, and (2) scheduling practices at the Alaska VA Healthcare System, Anchorage, AK. OIG substantiated the allegation that provider workload and staffing negatively impacted access to care at the Mat-Su VA CBOC for the patients reviewed. OIG further substantiated that the Mat-Su VA CBOC lacked a permanent provider from May to October 2014. OIG substantiated that decreased and delayed access resulted in quality of care issues. Patient care was compromised by a lack of communication, care coordination, and follow-up, in addition to outright delays in the provision of care. OIG did not substantiate the allegation that since its opening, the Mat-Su VA CBOC has been plagued by security issues. OIG substantiated the allegation that the facility did not comply with Veterans Health Administration (VHA) scheduling directives in 2008. However, OIG did not find evidence of current scheduling irregularities. OIG substantiated the allegation that adequate urology services were not available to patients following the departure of the system's only urologist in 2008. In addition, OIG found organizational structure and processes lacking, particularly in areas under the domain of clinical leadership. Insufficient processes in peer review, provider evaluation, and committee activity and reporting, as well as issues of culture and employee morale, have the potential to compromise patient safety. OIG made nine recommendations.

The VISN and Facility Directors concurred with the recommendations and provided acceptable action plans. [[Click here to access report.](#)]

Incorrect Code Status on Patient's Wristband Led to Delay in Life Saving Intervention at VA Northern California HCS, Mather, California

At the request of Congressman Ami Bera, M.D., OIG conducted an evaluation to assess the circumstances of a patient's death and actions taken by staff subsequently at the VA Northern California Health Care System (HCS) (the facility), Mather, CA. OIG found that facility staff did not follow through on the patient's request upon admission to discuss advance directives. OIG found no evidence of advance care planning discussion during the patient's hospital stay. OIG substantiated that the patient's wristband had the incorrect code status of Do Not Resuscitate/Do Not Intubate printed on it and that staff did not verify the wristband code status during the patient's 9-day hospital stay. OIG found that the wristband had clinical warnings not pertinent to the patient's current condition. OIG also found that nurses were using a duplicate copy of the wristband as a "workaround" when administering medications. OIG substantiated that the incorrect code status on the patient's wristband led to a delay in life-saving intervention. OIG did not substantiate the allegations that medical-surgical unit staff were afraid to speak up because of the culture of bullying and retaliation on the unit. However, OIG concluded that an evaluation of the unit is warranted based on the unit's All Employee Survey scores related to supervisory behaviors. OIG also concluded that facility leaders need to implement a plan for proactive employee support in response to traumatic events. OIG did not substantiate the allegation that a physician berated staff participating in the code. The facility had already started to implement corrective actions to ensure that staff verify and document patients' code status. The facility performed an institutional disclosure of adverse events to the patient's family and conducted a comprehensive review of the care provided for this patient in accordance with VHA policy. OIG made five recommendations. [[Click here to access report.](#)]

OIG Review Finds Backlog of Undelivered Prosthetic Devices and Staffing Issues at Palo Alto, California, Health Care System Dental Service

OIG conducted an inspection in response to a request from Congresswoman Jackie Speier to evaluate the merit of allegations regarding Dental Service scheduling as well as administrative issues at the VA Palo Alto HCS, Palo Alto, CA. A complainant identified five patients with alleged scheduling issues. OIG substantiated that two of the five patients' appointments were canceled and rescheduled to later dates. OIG did not find evidence of long-term impacts on their clinical outcomes. OIG noted a 5-month delay in scheduling appointment dates for the two patients. OIG substantiated that the staffing ratio for dental assistants to dentists was slightly below VHA recommendations. OIG substantiated that dentists and residents assumed dental assistant duties after dental assistants ended their tours of duty, including the cleaning of instruments and disinfection of environmental surfaces. OIG was informed that in order to assist patients still being seen after dental assistants ended their tours of duty, all dentists and residents were given access to the Omnicells to obtain any necessary supplies. OIG substantiated that the dental clinic had a long backlog of undelivered prosthetic devices. The system instituted corrective actions, but due to incomplete documentation, OIG was

not able to fully assess progress in reducing “backlogs” of undelivered prostheses. OIG substantiated that Dental Service had broken and/or insufficient equipment. OIG determined that additional equipment and a radiograph software program have been purchased. OIG concluded that the Dental Service presented numerous concerns and challenges and that it would be beneficial for the VISN to review the Service after all corrective actions have been implemented. OIG made four recommendations.

[\[Click here to access report.\]](#)

Colorectal Cancer Screening Issues Unsubstantiated at Palo Alto, California, Health Care System

OIG’s Office of Healthcare Inspections conducted an inspection at the request of Congresswoman Jackie Speier in response to complaints about the colorectal cancer screening process and other administrative issues at the VA Palo Alto Health Care System (system), Palo Alto, CA. This inspection determined the merit of the allegations. The complainant alleged that the use of fecal immunochemical test (FIT) was substandard care for colorectal cancer screening, that the nearby community medical groups did not use it, and that FIT was a poor substitute for colonoscopy. OIG found the system implemented FIT for screening and that the use of FIT was consistent with current literature and VA and community recommendations. The complainant alleged that an erroneous letter implying that FIT and colonoscopy were equal tests was sent to patients with the purported author’s signature block but without the individual’s permission. OIG substantiated this allegation. Patients no longer receive this letter as of January 2014. The complainant alleged that the FIT machine sensitivity was low and can be manipulated. OIG did not substantiate this allegation, as the value was pre-set by the manufacturer. The complainant alleged that patients were not given a choice of FIT or colonoscopy for colorectal cancer screening. OIG did not substantiate this allegation, as primary care providers discussed the risks and benefits of both modalities with patients during clinic encounters before ordering tests. OIG recommended that the System Director implement procedures to prevent the unauthorized use of individuals’ signature blocks on form letters. [\[Click here to access report.\]](#)

OIG Review Identifies Need for Improved Triage, Telephone Appointment Scheduling at Casa Grande, Arizona, CBOC

OIG conducted an inspection in response to allegations received by Congresswoman Ann Kirkpatrick’s office concerning quality of care issues at the CBOC, Casa Grande, AZ. The CBOC is part of the Southern Arizona Health Care System, Tucson, AZ. OIG did not substantiate that 28 of 38 staff had resigned or transferred. OIG could not substantiate that a patient was placed “on hold” and was never able to reach a scheduler. OIG found that the call response time and call abandonment rate did not meet VHA goals. OIG could not substantiate that a patient suffered a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment. OIG did not substantiate the allegation that the patient was told she would have to wait 6 weeks for a post-hospitalization appointment in 2012. However, there were delays in assessment of the patient’s condition prior to two community hospital admissions and a delay in follow-up for the patient after one of the hospitalizations. OIG did not substantiate that a patient committed suicide because he was denied a mental health appointment. The

patient had a scheduled appointment with a Tucson mental health provider prior to his death. According to his electronic health record (EHR), the patient canceled the appointment. OIG did not substantiate that patients were being “double booked” for appointments for the same provider or that a scheduler is “overriding the schedule” and overbooking evaluation appointments. OIG recommended that the Health Care System Director ensure that same day access appointments and post hospitalization follow-up appointments at the CBOC are triaged appropriately and timely and that processes are strengthened to improve telephone appointment scheduling practices. The Acting VISN Director and System Director concurred with the findings and recommendations and provided acceptable improvement plans. [[Click here to access report.](#)]

OIG Review Finds Improved Communication Needed with Families and Caregivers at VA Black Hills Health Care System, Fort Meade, South Dakota

OIG conducted a review in response to allegations received by former Senator Tim Johnson concerning communication with family and the quality of care for a patient at VA Black Hills Health Care System (system), Fort Meade, SD. The complainant alleged that a patient was inappropriately discharged from the system in fall 2013. Additionally, in spring 2014, after the patient was recovering from surgery, system staff failed to contact the patient’s wife when he was transferred from the system’s emergency department (ED) to a non-VA community hospital, the non-VA community hospital found an abscess under a drain tube, and system staff failed to take the patient’s complaints of a smell from the drain tube seriously. OIG found that system staff documented appropriate family notification when the patient was transferred from the system’s Community Living Center to the ED. However, OIG did not find documentation that the patient’s family was notified as required when he was subsequently transferred from the ED to a non-VA community hospital. While OIG substantiated that the patient was discharged from the system and readmitted to a community hospital with multiple medical problems the following day in fall 2013, OIG did not find that the patient’s discharge from the system was inappropriate. OIG did not substantiate quality of care concerns related to the presence of an abscess and the failure of system staff to take patient complaints of a smell from the drain tube seriously in spring 2013. OIG made one recommendation. The VISN and Facility Directors concurred with the recommendation and provided an acceptable action plan. [[Click here to access report.](#)]

Pervasive Dissatisfaction Found with Patient-Centered Community Care Contracts, Vendors Returned 41 Percent of Authorizations for Patient Care to VA

OIG examined VHA’s use of Patient-Centered Community Care (PC3) contracted care to determine if it was causing patient care delays. OIG found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities OIG reviewed to stop using the PC3 program as intended. OIG projected PC3 contractors returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling. PC3 contractors scheduled appointments without discussing the tentative appointment with the veteran, which VHA refers to as blind scheduling. OIG determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and

PC3 contractors schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. This was the second of a series of reports addressing PC3 service delivery issues. OIG is conducting additional reviews to evaluate the adequacy of the PC3 contract, provider networks, and the completeness of the medical documentation for PC3 payments. OIG will report these results separately. OIG recommended the Interim USH ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements. [[Click here to access report.](#)]

OIG, VHA Disagree on Finding of Improper Sole-Source Contracts To Fund Educational Costs

OIG conducted a review of contracts awarded sole-source to affiliated Schools of Medicine (SOM) for education costs pursuant to VHA Handbook 1400.10. The review determined that the contracts do not meet the requirements of the Federal Acquisition Regulation and that the authority cited by VHA Handbook 1400.10, 38 U.S.C. § 8153, does not authorize the funding of physician resident training costs of VA's affiliated SOMs. The review also concluded that the provisions in VA Handbook 1400.10 were inconsistent with the provisions in VA Handbook 1400.05, which establishes policy for payment relating to resident training programs that are authorized under 38 U.S.C. Section 7604(c). VHA, based on advice from the Office of General Counsel, did not concur with the findings. [[Click here to access report.](#)]

Improvements Needed in Monitoring Patients During Transportation and in Handoff Communication at West Palm Beach, Florida, VA Medical Center

OIG conducted an inspection in response to allegations about the lack of timeliness of care and management action at the West Palm Beach VA Medical Center (VAMC), West Palm Beach, FL. OIG substantiated the allegation that the patient was not on the schedule for an interventional radiology (IR) procedure; however, the patient was brought to the IR area for insertion of a peripherally inserted central catheter line (a non-IR procedure). OIG substantiated that the patient was transported from the ED to the IR area without being appropriately monitored and was not placed on a monitor immediately on arrival to the IR area. In addition, OIG found that required communication between nursing staff in the ED and the IR nurse did not take place prior to the patient being transported from the ED to the IR area. OIG also found that the facility policy for handoff communication does not describe how handoff communication is to be documented. OIG did not substantiate that cardiopulmonary resuscitation (CPR) was not begun promptly when a "code" was called. A review of the patient's EHR found that when the patient was recognized to be in distress, resuscitation efforts took place quickly. OIG did not substantiate the allegation that management was notified of CPR timeliness concerns but failed to take proper action. OIG recommended that the Facility Director ensure that unstable patients be appropriately monitored during transport from one location to another. OIG also recommended that the Facility Director ensure that ED and IR nursing staff receive education in handoff communication

requirements and that the facility policy for handoff communications be reviewed for inclusion of documentation of handoff communication. The VISN and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans. [[Click here to access report.](#)]

Review Finds No Delays in Treatment for Patients with Legionnaire's Disease at Pittsburgh, Pennsylvania, VA Healthcare System

OIG conducted an inspection in response to complaints about delayed reporting of positive Legionella test results in 2012, potentially delaying treatment and causing death for patients at the VA Pittsburgh Healthcare System, Pittsburgh, PA. The complainant also alleged that water samples for Legionella monitoring were collected improperly by excessively flushing the water line prior to collection in order to obtain false negative results. OIG substantiated that reporting of positive Legionella test results was occasionally delayed but found no evidence of delays in treatment for patients with Legionnaires' disease, either for those who died or for those who survived. OIG did not substantiate that water samples collected for environmental cultures of Legionella were collected improperly. OIG made no recommendations. [[Click here to access report.](#)]

Better Communication with Community Providers Needed at Veterans Health Care System of the Ozarks

OIG assessed the merit of allegations regarding the quality of care provided to a patient at the Gene Taylor CBOC, Mount Vernon, MO. OIG substantiated that CBOC staff did not appropriately evaluate the patient's gastroesophageal reflux disease symptoms but concluded that it is unlikely that this influenced his outcome. A non-VA specialist diagnosed the patient with esophageal cancer within 3 months of his first complaints of increased heartburn. VHA policy requires VA providers to manage conditions for which they prescribe medications, even if the patient is also seeing a non-VA provider for that condition (dual care). The patient's EHR did not list which medical records the VA provider had available when increasing the patient's medication. OIG cannot determine whether the CBOC provider's summarized notes accurately reflected the patient's non-VA care or whether the CBOC provider needed to take additional action. OIG did not substantiate that CBOC providers inappropriately denied a request for Nexium. VHA's drug formulary lists preferred medications based on competitive pricing, safety, and efficacy. VHA requires facilities to have a process for reviewing non-formulary medication requests which may be approved if certain criteria are satisfied. In this case, the CBOC provider offered to prescribe Nexium if the patient tried other medications first, as required under VHA policy. The patient was in the process of trying other medications when he was diagnosed with cancer; he then requested that further medication management be done by his non-VA physicians. OIG made one recommendation to the Interim USH and one recommendation to the Veterans Health Care System of the Ozarks Director. The Interim USH and VISN and Facility Directors agreed with the findings and recommendations and provided acceptable improvement plans. [[Click here to access report.](#)]

OIG Review Finds Delayed Surgery, Opportunities for Improvement in Coordination of Non-VA Care at Eastern Colorado HCS, Denver, Colorado

OIG assessed the merit of an allegation made by a complainant that a consult delay may have resulted in a patient's death at the VA Eastern Colorado Health Care System (facility), Denver, CO. OIG substantiated that there was a delay in surgery; however, OIG could not substantiate that it contributed to the patient's death. According to the patient's death certificate, the patient died of natural causes, specifically, hypertension and cardiovascular disease. Without an autopsy, OIG cannot determine that the patient died of a ruptured aortic abdominal or common iliac artery aneurysm. The patient's surgery was delayed due to the unavailability of the facility's endovascular surgeon and the subsequent referral for non-VA medical care. Prior to a site visit, Non-VA Care Coordination (NVCC) managers had identified the possible delay in processing the patient's NVCC consult and instituted corrective actions. However, OIG found that there was still confusion between the requesting provider and the NVCC staff in the interpretation of the "urgency" field in the consult request and what it meant to "process" the consult. OIG made one recommendation. [[Click here to access report.](#)]

OIG Recommends Changes to Admission Process for Short-Stay Rehabilitation Unit at Tuscaloosa VAMC, Tuscaloosa, Alabama

OIG conducted an inspection in response to an anonymous complaint concerning the Short-Stay Rehabilitation Unit (Valor Center) at the Tuscaloosa VAMC, Tuscaloosa, AL. OIG did not substantiate that the facility did not have a screening process for prospective Valor Center patients or that patients were inappropriately admitted to the Valor Center. However, OIG determined that the Valor Center prospective patient screening practices at the time of the site review were not in compliance with the facility's Community Living Center and the Valor Center admission policies. Also, while not an allegation, OIG determined that pre-admission consults with the facility psychiatrist were not documented in patients' EHR. OIG did not substantiate that staff who point out potential wrongdoing were intimidated, transferred, harassed, or terminated. OIG substantiated that the Associate Chief of Staff for Geriatrics and Extended Care Services was the decision maker for admissions to the Valor Center and that performance-based pay was connected to the Valor Center's average daily bed census. However, OIG determined that neither was against VHA policy, and the performance pay incentive did not influence the Associate Chief of Staff's Valor Center admission decisions. OIG substantiated poor hand-off communication for newly admitted patients. OIG made three recommendations. The VISN and Facility Directors concurred with the recommendations and provided an acceptable action plan. [[Click here to access report.](#)]

Review Finds Surgical Resident Progress Notes Not Cosigned Timely at the Omaha, Nebraska, Health Care System

OIG assessed the merit of allegations regarding lack of supervision for vascular surgery residents resulting in poor patient care at the VA Nebraska-Western Iowa Health Care System, Omaha, NE. OIG did not substantiate the allegation that vascular residents were not supervised by attending surgeons. OIG found that vascular resident supervision documentation met VHA requirements and the Accreditation Council for

Graduate Medical Education (accrediting body for resident supervision programs) guidelines. The six cases identified by the complainant did not demonstrate adverse events or near misses attributable to a lack of resident supervision. During the review, OIG found that attending surgeons did not cosign vascular surgical resident notes timely. VHA policy requires that facilities define and document the timeframe for cosigning resident notes. While local policy defines a 7-day timeframe for attending surgeons' co-signature of outpatient resident progress notes, OIG did not find a documented timeframe requirement for co-signature of inpatient resident progress notes. OIG did not find that delays in attending surgeons' co-signatures on resident notes resulted in poor patient care. OIG made two recommendations. The VISN and System Directors concurred with the findings and recommendations and provided acceptable action plans. [[Click here to access report.](#)]

Sheridan, Wyoming HCS Lacked Process To Identify Patient's Aspiration Risk, Respiratory Distress Not Adequately Addressed

OIG reviewed quality of care allegations at the Sheridan VA HCS, Sheridan, WY. OIG could not substantiate the allegation that the facility did not adhere to clinical care recommendations previously identified by the facility for the management of a patient's dysphagia (difficulty swallowing). Documentation indicated staff knowledge of the patient's risk for aspiration; however, EHR's do not provide conclusive evidence of steps taken to manage the patient's dysphagia. OIG found that the facility lacked a mechanism that would assist staff in quickly detecting previously identified dysphagia and aspiration risk. OIG found that the patient's respiratory distress was not adequately addressed after admission in the hours immediately prior to the patient's death. OIG did not substantiate that the patient received a suprapubic catheter to ease the patient's care for previous caregivers, that the facility failed to adequately address the patient's care needs as an outpatient causing him to become more acutely ill before being admitted, or that the facility refused to provide physical therapy for the patient. OIG was also unable to substantiate that the facility refused to receive the patient via ambulance on multiple occasions. OIG found opportunities to align actual practice in the area of provider privileging with local facility and VHA policy. OIG recommended that the Facility Director: (1) ensure that staff comply with VHA and facility policies and practices related to the management of dysphagia, including assessment, and documentation of the patient's response to the provided care recommendations and aspiration risk precautions; (2) implement applicable recommendations from previous event-related reviews, if any; and, (3) review local credentialing and privileging processes to ensure compliance with VHA Handbook 1100.19. The VISN and Facility Directors concurred with the findings and recommendations.

[[Click here to access report.](#)]

OIG Finds Inadequate Psychiatrist Staffing, Improper Scheduling at Central Alabama VA HCS, Montgomery, Alabama

OIG conducted a review at the Central Alabama VA HCS (CAVHCS), Montgomery, AL. In relation to one or more of the CBOCs, OIG substantiated: inadequate psychiatrist staffing; waiting lists to see providers; improper scheduling of patients on the Recall

Reminder list; excessive wait times for ambulance transport for MH patients requiring non-emergent hospitalization; inadequate primary care (PC)-MH integration; and non-compliance with MH staffing and medication trial requirements. OIG confirmed some PC providers could not enter a MH consult but found this to be an acceptable practice. OIG did not substantiate that: multiple MH patients committed suicide due to care delays; leaders refused to provide inpatient detoxification (detox) services; patients did not receive medical treatment for substance use disorders (SUD) and were discharged from the ED with only anti-anxiety medication; patients had to pay for private-sector detox; 24-hour ED observation for detox was insufficient; or the substance abuse treatment program had an inefficient admission process. OIG did not substantiate that the Disturbed Behavior Committee refused to issue a behavioral patient record flag but it did take an excessive amount of time to do so. OIG did not substantiate that providers routinely prescribed benzodiazepines to high-risk patients, but sometimes they did not document their rationales. Some medication combinations could have placed patients at risk. OIG found that MH treatment coordinators were not assigned consistently. OIG could not substantiate that CBOC providers could not be reached after hours, that MH peer reviews, were not conducted, or that there were not “enough” acute MH beds. CAVHCS leaders were aware of many issues but often did not implement timely corrective actions. OIG made 17 recommendations to improve operations. [[Click here to access report.](#)]

Inspection Substantiates Delays and Lack of Follow-Up in Non-VA Care Program at Montgomery, Alabama, VA Facility

OIG reviewed allegations of deficient consult management, contractor, and administrative practices at the CAVHCS, Montgomery, AL. OIG substantiated delays securing NVCC services, lack of follow-up, delays in getting NVCC care authorized, staff not verifying eligibility for NVCC care, some NVCC consults being cancelled, and some CBOC nurses scheduling patients directly with community providers. OIG also substantiated insufficient NVCC staffing and repeated leadership changes. OIG could not substantiate that 8,000 consults were reassigned to NVCC, that intra-facility consults went unanswered for months, that patients were not notified when appointments were scheduled, that there were delays in oncology care, or that a patient’s colorectal cancer metastasized due to delays in oncology care. OIG did not substantiate that the Dothan CBOC primary care contractor improperly billed for physician-led primary care appointments or that contract providers did not notify patients of critical fecal occult blood test results. OIG substantiated that a contracted private medical group (PMG) completed inadequate initial history and physical exams, that those reports were not always available in the patients’ VA medical records, and some patients with care needs identified by PMG were at risk due to poor or non-existent documentation. OIG substantiated that CAVHCS had multiple vacancies in important clinical areas; that the Podiatry Service did not follow appointment scheduling guidelines; and that Administrative Boards of Investigation were not consistently chartered, completed, or followed through in response to serious events. OIG substantiated that CAVHCS leaders were aware of many of the issues identified in the report and determined that a fractured organizational culture contributed to the development and perpetuation of these issues. OIG was unable to fully evaluate eight

additional allegations due to insufficient information and/or details. OIG made seven recommendations. [[Click here to access report.](#)]

Allegations of Chronic Cleanliness Issues at the Hunter Holmes McGuire VAMC, Richmond, Virginia, Not Substantiated

OIG conducted an inspection in response to complaints about the environment of care and the possible presence of mold in the Spinal Cord Injury and Disorders (SCI/D) units at the Hunter Holmes McGuire VAMC, Richmond, VA. The complainant alleged that chronic cleanliness issues were associated with patient reports of chronic respiratory problems and lost time from work for SCI/D staff; facility managers did not act to rule out the presence of black mold; and, indoor air potentially contained high levels of mold in the SCI/D units, and senior leadership concealed this information. OIG did not substantiate the allegations. OIG found that the facility monitored cleanliness and cleaning processes and did not identify chronic cleanliness issues in the SCI/D units. OIG did not confirm effects on respiratory conditions of SCI/D patients or lost time for staff related to cleanliness issues in the environment of care. The facility sampled indoor air quality in March 2014 and acted on the mold level from one sample although no limits or standards for mold levels were established. The facility communicated air sampling results and actions taken to VISN leaders and external partners. OIG made no recommendations. [[Click here to access report.](#)]

Results of Benefits Inspection at Louisville, Kentucky, VA Regional Office

Overall, OIG benefits inspectors determined Louisville VA Regional Office (VARO) claims processing staff incorrectly processed 11 of the 85 disability claims (13 percent) selected for review. The claims processing errors resulted in over \$151,000 in improper benefits payments to eight veterans from February 2006 to November 2014. The OIG benefits Inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Louisville VARO. The OIG report indicated VARO staff incorrectly processed 7 of 30 claims related to temporary 100 percent disability evaluations but accurately processed all 30 disability claims related to traumatic brain injuries. Results in these two areas showed significant improvement since the VARO was last inspected in 2011. However, OIG reported 4 of the 25 sample cases relating to Special Monthly Compensation and ancillary benefits contained errors. Louisville VARO staff followed policy and accurately established claims in an electronic system of records using correct dates of claims for the 30 claims sampled. OIG inspectors also determined VARO staff delayed processing actions in 11 of the 30 benefits reduction cases sampled that resulted in over \$93,000 in improper benefit payments from January 2013 until December 2014. The improper payments resulted from delays in taking actions to reduce the benefits because VARO management considered other work to be a higher priority. The Director of the Louisville VARO concurred with all recommendations and OIG plans to follow up in the future to ensure the planned corrective actions were implemented. [[Click here to access report.](#)]

Results of Benefits Inspection at Cleveland, Ohio, VARO

OIG evaluated VARO Cleveland, OH, to see how well it accomplishes the mission of processing disability claims and providing services to veterans. OIG Benefits Inspectors conducted this work in December 2014. OIG found that VARO Cleveland did not consistently process the three types of disability claims reviewed. Overall, staff did not accurately process 30 of 90 disability claims (33 percent) reviewed. As a result, 404 improper monthly payments were made to 18 veterans totaling approximately \$737,231. OIG sampled claims considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO. In a 2012 inspection report of this VARO, the most frequent errors associated with temporary 100 percent disability evaluations occurred because staff did not establish suspense diaries. During this 2014 inspection, OIG did not identify similar errors. However, in September 2012, the VARO management was provided with a list of 712 temporary 100 percent disability evaluations to process. As of December 2014, staff had not taken action on seven of those claims. Therefore, OIG finds the actions taken by VARO staff, as it relates to the Veterans Benefits Administration's (VBA) national review plan, ineffective. OIG also reported in 2012 that Traumatic Brain Injury (TBI) claims processing errors resulted from staff misinterpreting VBA policy. During this inspection OIG found similar issues and determined the VARO management's actions in response to the previous recommendation were not effective. VARO staff also established incorrect dates of claim in VBA's electronic systems of record for 3 of 30 claims OIG reviewed. Staff also did not timely or accurately complete 24 of 30 proposed benefits reduction cases due to other higher workload priorities. OIG recommended the Director review the 880 temporary 100 percent disability evaluations pending as of October 8, 2014; certify action has been accomplished on the 7 cases from the 2012 inspection; and provide training on temporary 100 percent disability evaluations, Special Monthly Compensation, and dates of claim. Further, OIG recommended the Director ensure staff follow VBA's second signature requirements for TBI claims, monitor the effectiveness of TBI training, and prioritize benefits reduction cases. The VARO Director concurred with the recommendations. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In July 2015, OIG published six Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following eleven activities:

- (1) Quality Management
- (2) Medication Management
- (3) Coordination of Care
- (4) Emergency Airway Management
- (5) Advance Directives

- (6) Computed Tomography Radiation Monitoring
- (7) Suicide Prevention Program
- (8) Environment of Care
- (9) MH Residential Rehabilitation Treatment Program
- (10) Surgical Complexi
- (11) Medication Management – Controlled Substances Inspection Program

[Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois](#)

[Chillicothe VA Medical Center, Chillicothe, Ohio](#)

[Iowa City VA Health Care System, Iowa City, Iowa](#)

[Central Texas Veterans Health Care System, Temple, Texas](#)

[Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts](#)

[Mann-Grandstaff VA Medical Center, Spokane, Washington](#)

Community Based Outpatient Clinic Reviews

In July 2015, OIG published four CBOC reviews containing OIG’s findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The CBOC reviews evaluated five operational activities:

- (1) Environment of Care
- (2) Alcohol Use Disorder
- (3) Outpatient Lab Results Management
- (4) Human Immunodeficiency Virus Screening
- (5) Outpatient Documentation

[Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts](#)

[Iowa City VA Health Care System, Iowa City, Iowa](#)

[Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois](#)

[Central Texas Veterans Health Care System, Temple, Texas](#)

CRIMINAL INVESTIGATIONS

Grand Jury Returns 50-Count Indictment Against Former Augusta, Georgia, VAMC Chief of Fee Basis Who Falsified Medical Consults

The former Augusta, GA, VAMC chief of fee basis was indicted on 50 counts and subsequently arrested for false statements related to health care matters. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 non-VA care coordination consults at the medical center. Specifically, the defendant directed his subordinates to falsely document, “Services provided or patient refused services,” in the patients’ VA EHR even though employees had not reviewed the records or contacted the patients. OIG’s Office of Healthcare Inspections conducted a review of the approximately 2,700 patient records and determined that 500 patients never received care and/or refused services.

Former East Orange, New Jersey, VAMC Supervisor and Contractors Sentenced for Fraud and Bribery

A former East Orange, NJ, VAMC supervisory engineer was sentenced to 46 months' incarceration and 1 year of probation after pleading guilty to honest services wire fraud, wire fraud, and engaging in a monetary transaction in criminally derived property. Between 2007 and 2012, the VA supervisor accepted more than \$1.2 million in kickback payments. In addition, a former East Orange, NJ, VA construction contractor was sentenced to 37 months' incarceration and 12 months' probation after pleading guilty to bribery and conspiracy to defraud the United States. Restitution and forfeitures are to be imposed at a later date for both defendants. An OIG, Federal Bureau of Investigations (FBI), and Internal Revenue Service (IRS) Criminal Investigations Division (CID) investigation revealed that the contractor paid \$671,000 in bribes to the VA supervisor in order to fraudulently obtain \$6 million in VA construction contracts, to include Service-Disabled Veteran-Owned Small Business (SDVOSB) contracts, and for failing to pay \$250,374 in Federal income taxes. The contractor and VA supervisor conspired to set up three companies that were used to obtain VA contracts, one of which was a fraudulently claimed SDVOSB company. As part of the same investigation, the owner of another company was previously sentenced to 2 years' probation, 6 months' home confinement, and ordered to pay a \$2,000 fine after pleading guilty to bribing the same VA supervisor. The company's owner wanted favorable treatment on VA contracts and made a payment of \$1,000 towards an agreed upon \$5,000 bribe. The owner and his company were later debarred from doing business with the Government.

West Roxbury, Massachusetts, Campus Contractor Pleads Guilty to Wire Fraud

A VA contractor pled guilty to wire fraud after an OIG investigation revealed that from October 2012 to October 2014 the contractor and a VA employee conspired to order goods and services that were not needed and were never provided to the Boston HCS – West Roxbury, MA, campus. The VA employee, who was responsible for the maintenance and information technology support of medical equipment, created the false purchase orders and paid the contractor using his VA-issued credit card. The investigation determined that for at least 82 purchases, the VA paid the contractor and his company a total of \$222,242. The employee and contractor then divided the proceeds.

Husband and Wife Convicted of Embezzling VA Education and Charitable Funds

A husband and wife were convicted at trial of embezzling VA education and charitable funds that were intended to provide job training, benefits, and equipment for injured Marines returning from Iraq and Afghanistan. An OIG and IRS CID investigation revealed that from 2007 to 2009 the defendants were directors of a tax-exempt foundation that trained injured veterans for careers in the film industry. The defendants conspired to defraud VA by submitting false claims in order to receive funds for training and equipment that were never provided. Also, although the defendants claimed to have donated over \$200,000 to start the foundation, they took over \$400,000 from the foundation's accounts. The defendants routinely commingled the finances of the foundation with their personal finances, thereby obstructing the ability of the IRS to

monitor the foundation's tax-exempt status and to determine the defendants' personal income tax liability. The loss to VA is \$213,176.

Former Ann Arbor, Michigan, VA Canteen Chief Arrested for Theft of Government Funds

A former Ann Arbor, MI, VA canteen chief was arrested for theft of Government funds. An OIG investigation revealed that the defendant embezzled more than \$150,000 in cash from the canteen. The total loss to VA in this case is approximately \$478,000.

Former District Manager of Pharmaceutical Company Pleads Guilty to Conspiracy to Commit Health Care Fraud

The former district manager of a pharmaceutical company pled guilty to conspiracy to commit health care fraud. This plea was the result of a larger multi-agency investigation into allegations of kickbacks, off-label marketing, and the submission of false claims in the form of prior authorizations.

VA Contractor Arrested for Providing Gratuity to VA Contracting Officer

A VA contractor was arrested after being indicted for providing a gratuity to a VA contracting officer. The contractor had moved to the Philippines and was arrested after returning to the U.S. An OIG and FBI investigation revealed that after receiving VA contracts the defendant paid for birthday trips to Las Vegas for the contracting officer's birthdays in 2008, 2009, and 2010. The gratuities included payment of airline tickets and hotel accommodations for the VA employee and her friends.

University Official Sentenced for Possession of Unauthorized Access Devices and Aggravated Identity Theft

A university official was sentenced to 34 months' incarceration and 1 year of supervised release after pleading guilty to possession of unauthorized access devices and aggravated identity theft. An OIG, FBI, and IRS Task Force investigation revealed that the defendant stole veterans' and military service members' identities that he obtained while overseeing VA education benefits at Kaplan University. During the investigation, law enforcement purchased or seized approximately 378 identities of veterans that either attended or applied to Kaplan University.

Former Rhode Island State Cemetery Employee Charged with Theft of Government Property

A former Rhode Island State cemetery employee was charged with theft of Government property. An OIG and Rhode Island State Police investigation revealed that for several years the defendant removed worn or broken grave markers from the cemetery and brought them to his residence. A search of the defendant's property revealed that approximately 150 VA-provided grave markers were being used as flooring for a shed and two make-shift garages. Additional grave markers and a box of American flags, allegedly stolen from the State veterans' cemetery, were also discovered on the defendant's property.

Husband and Wife Sentenced for Fraud and Identity Theft

A husband and wife were sentenced to 324 months' and 138 months' incarceration, respectively and were ordered to jointly pay \$1,820,759 in restitution. The husband pled guilty to conspiracy to commit mail and wire fraud, wire fraud, aggravated identity theft, and felon in possession of firearms and ammunition. The wife pled guilty to wire fraud and aggravated identity theft. An OIG, IRS CID, and local police investigation revealed that the defendants used veterans' personal identifying information from stolen Tampa, FL, VAMC medical records and private hospital records to file approximately \$5 million in fraudulent tax returns. Additionally, the husband, a previously convicted felon, was found in possession of multiple firearms during the execution of a search warrant at his residence.

Veteran Indicted for Threatening To Kill a VA Nurse at Palo Alto, California, VAMC

A veteran was indicted for transmitting a threat in interstate commerce and making threats to a Federal official. An OIG and VA Police Service investigation revealed that the defendant threatened to kill a VA nurse who he believed interfered with his "life/medical situation." The defendant used the My HealthVet website to transmit the threats, which included a statement about using his .357 firearm to blow the nurse's brains out. On the same day that the threat was transmitted to the nurse, the local police went to the veteran's home, seized a .22 caliber Hi-Point semiautomatic pistol, and transported him to a local hospital for psychological evaluation. The next day, the defendant threatened to strike the nurse in the head with an aluminum baseball bat if the nurse "crosses the line and affects his lifestyle."

Veteran's Wife Sentenced for Attempted Murder

A veteran's wife was sentenced to 15 years' incarceration for attempted murder. An OIG, VA Police Service, and local law enforcement investigation revealed that the veteran had been treated numerous times at the Mountain Home, TN, VAMC for unexplained life threatening illnesses, with indications of elevated levels of barium carbonate (used in rat poison). During the initial investigation into the possible poisoning, the defendant lured her husband behind their home, shot him in the back, and left him for dead. The victim survived and a subsequent search of the defendant's residence resulted in the discovery of evidence that indicated that the defendant had in fact been poisoning her husband.

Husband of Portland, Oregon, VAMC Employee Pleads Guilty to Assault

The husband of a Portland, OR, VAMC employee pled guilty to assault. An OIG and VA Police Service investigation revealed that the defendant hit and strangled his wife in the medical center parking lot.

Non-Veteran Arrested for Making Threats to New York, New York, VAMC Employee

A non-veteran was arrested for aggravated harassment by communicating a threat to VA staff. An OIG, VA Police Service, and local police investigation revealed that the defendant made telephonic threats to a New York, NY, VAMC employee. The defendant was angry with the medical center for not providing him health care. The

defendant stated “he would come to the medical center and do harm like a past incident that happened in Texas where a VA doctor was shot.”

Veteran Convicted of Stalking and Harassing Bronx, New York, VAMC Employee

A veteran was convicted at trial of stalking and harassment. In addition, the judge enacted a temporary order of protection until sentencing. An OIG, VA Police Service, and local district attorney’s investigation revealed that the defendant consistently sent letters and left telephone messages for a Bronx, NY, VAMC social worker who was formerly assigned to the defendant. The defendant had previously been warned several times by both VA Police and OIG agents not to have any contact with the victim.

Former Philadelphia, Pennsylvania, Nursing Assistant Sentenced for Billing Fraud

A former certified nursing assistant at the Philadelphia, PA, VAMC was sentenced to 6 months’ home confinement with electronic monitoring, 5 years’ supervised release, and ordered to pay VA \$45,063 in restitution. An OIG and VA Police Service investigation revealed that from May 2012 to September 2013 the defendant attempted to receive over \$125,000 by double billing the medical center for his services.

Four Subjects Charged with Fraud Relating to Workers’ Compensation Program

Four subjects were charged with health care fraud, conspiracy, and money laundering relating to their ownership and operation of multiple workers’ compensation clinics. A VA OIG, U.S. Postal Service (USPS) OIG, Department of Labor OIG, Department of Homeland Security OIG, and IRS CID investigation revealed that since January 2011 the defendants conspired to unlawfully bill multiple Federal agencies for false and fraudulent claims and for services not rendered. The investigation also revealed that in July 2013, shortly after executing a Federal search warrant on the subject business, two of the defendants laundered \$700,000 in order to conceal the money’s location from law enforcement. The overall loss to the Government is approximately \$5.6 million.

Ohio Home Health Care Employees Indicted for Health Care Fraud

Five employees of a northeast Ohio home health care provider, including the owners, were indicted for their roles in a health care fraud conspiracy. A Northern Ohio Health Care Fraud Task Force revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information on annual provider agreements submitted to the Cleveland, OH, VAMC. Asset forfeiture action is pending against property owned by the defendants. The overall loss to the Government is approximately \$7 million. Of this amount, the loss to VA is over \$300,000.

Veteran Sentenced for VA Compensation Fraud

A veteran was sentenced to 12 months’ home confinement, 36 months’ probation (to run concurrently with the home confinement), and ordered to pay restitution of \$456,649 after being convicted at trial of wire fraud and theft of Government funds. An OIG investigation revealed that the defendant was awarded a 100 percent VA disability with an individual unemployability enhancement after falsely claiming that his diabetes

was caused by his exposure to Agent Orange while serving in Vietnam. The investigation determined that the defendant was never in Vietnam.

Son-in-Law of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The son-in-law of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the beneficiary's death in September 2006. The loss to VA is \$114,000.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds

The daughter of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to her mother's account after her mother's death in April 2007. The loss to VA is \$103,191.

Daughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the daughter stole \$90,006 in VA benefits that were direct deposited after her mother's death in February 2008. The defendant admitted to not notifying VA of her mother's death in order to continue to fraudulently receive the VA funds.

Wife of Deceased Veteran Pleads Guilty to Theft of Government Funds

The wife of a deceased veteran pled guilty to theft of Government funds. A VA OIG, USPS, and Social Security Administration (SSA) OIG investigation revealed that the defendant remarried twice after the veteran's death, but provided documents to the Government indicating that she never remarried. The investigation also revealed that the two subsequent marriages were to two service members, in two different states, at the same time. The loss to VA is \$83,848, and the loss to SSA is \$48,260.

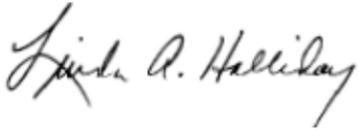
Non-Veteran Sentenced for Health Care Fraud

A non-veteran was sentenced to 3 years' probation and ordered to pay \$48,169 in restitution after pleading guilty to making a false claim for benefits. An OIG and Defense Criminal Investigative Service investigation revealed that the defendant fraudulently received \$48,169 in medical care from the Miami, FL, VAMC that he was not entitled to receive. The defendant also fraudulently applied for VA disability and compensation benefits numerous times, although no benefits were actually paid.

Two Former Muskogee, Oklahoma, VAMC Employees and Two Other Subjects Indicted for Drug Conspiracy

Two former Muskogee, OK, VAMC employees and two other subjects were indicted for drug conspiracy. An OIG and Drug Enforcement Administration investigation revealed that a former VAMC employee stole VA prescription pads from the medical center and used those pads to fraudulently obtain prescription narcotics. The former employee

organized a loose affiliation of associates to obtain and distribute these narcotics throughout southeast Oklahoma.

A handwritten signature in black ink that reads "Linda A. Halliday". The signature is written in a cursive style with a large, stylized initial 'L'.

Linda A. Halliday
Deputy Inspector General