



## HIGHLIGHTS July 2009

### **OIG REPORTS**

#### **OIG Kicks Off New Inspections of Community Based Outpatient Clinics**

The Office of Inspector General (OIG) began a new series of cyclical reports of Community Based Outpatient Clinics (CBOCs) detailing the CBOC inspection process, including site-specific information gathering and review, medical record reviews for compliance with performance measures, onsite inspections, and CBOC contract reviews. [\[Click for Report\]](#)

As the first report in the series, OIG reviewed six CBOCs within Veterans Integrated Service Network (VISN) 1 to assess whether they operate in a manner that provides Veterans with consistent, safe, high quality health care. OIG noted several opportunities for improvement and made recommendations to address all of these issues. [\[Click for report.\]](#)

#### **Comprehensive Review of Specialty Service Needed at Ft. Harrison, MT**

OIG reviewed actions taken by the Veteran Health Administration (VHA) to address allegations that a physician at the VA Montana Health Care System, in Ft. Harrison, MT, was providing substandard care and engaging in improper medical record documentation practices. OIG found that management officials were initially impeded in addressing these issues due to an insufficient Administrative Board of Investigation product. VHA management officials appropriately obtained external peer reviews of care provided by the subject physician and took necessary personnel actions. OIG recommended VHA perform a comprehensive review of care in the specialty referenced in this report and offer new examinations to Veterans treated by the subject physician. [\[Click for Report.\]](#)

#### **Additional Steps Needed to Screen, Monitor Patients in Residential Mental Health Care Facilities**

In accordance with Public Law 110-387, OIG reviewed all residential mental health care facilities, including domiciliaries, within VHA. This national review assessed the availability of facilities in each VISN, the supervision and support provided to patients, the ratio of staff to patients, the appropriateness of rules and procedures for the prescription and administration of medications to patients, and protocols for handling missed appointments. Among the findings were that less than half of sites visited had

appropriate policies for screening patients for admission; post-discharge monitoring was not evident in 29 percent of patient records; 11 percent of patients allowed to self-medicate narcotics received more than a 7-day supply of medications; and more than half of self-medicating patients had no documentation of an order for self-medication. OIG made recommendations in the five review areas to improve the care provided to Veterans in residential mental health care facilities. [\[Click for Report.\]](#)

### **Contracting Deficiencies Cited in Review of VA, University of Texas Southwest Agreement for Gulf War Research**

At the request of the former Secretary of Veterans Affairs, OIG reviewed a contract between VA and The University of Texas Southwestern Medical Center at Dallas (UTSWMC) to conduct Gulf War Illness research. The contract did not include a collaborative pilot study as directed by the Conference Report accompanying the appropriations bill for FY 2006 and did not protect the Government's interests. The review also found that UTSWMC defaulted when it unilaterally, and without notice, changed the informed consent form to prohibit VA access to certain data obtained by UTSWMC in conducting the research. UTSWMC refused to discontinue use of the revised form. OIG concluded that UTSWMC's continued refusal to comply with the terms and conditions set forth in the contract left VA no option but to terminate the contract for default. [\[Click for Report.\]](#)

### **Reducing Unnecessary Open Market Purchases Will Save \$41 Million**

OIG audited open market purchases made by VHA to determine if medical facilities purchased items on the open market when identical or like items were available for purchase through an existing Federal Supply Schedule (FSS) at a lower price. OIG determined that increased usage of the FSS as well as improved oversight would reduce unnecessary open market medical equipment and supply purchases. These changes will reduce VA's health care item costs by approximately \$8.2 million annually or \$41 million over 5 years. [\[Click for Report.\]](#)

### **Audit Shows Electronic Contract Management System Ineffective, Data Incomplete**

OIG audited the effectiveness of the Electronic Contract Management System (eCMS) to determine whether it improves the VA procurement process and provides effective procurement oversight. The audit revealed that VA is not using eCMS effectively and that procurement information in the system is incomplete. Incomplete information prohibits VA from benefitting from the full capabilities of the system and from generating reliable reports when making procurement management decisions. OIG determined that integrating eCMS with IFCAP (VA's Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System), or the Financial Management System would provide VA with improved acquisition efficiency, reporting, and control over spending. [\[Click for Report.\]](#)

### **OIG Reviews Vet Centers' Operational Procedures, Recommends Improvements**

OIG performed a review of VHA's Vet Centers to gather information about their operational procedures. OIG noted several opportunities to strengthen the Vet Centers'

effectiveness, oversight, and continuous improvement and made recommendations to address all of these issues. [\[Click for Report.\]](#)

### **North Florida/South Georgia Veterans Health System Corrects Pulmonary Staffing**

OIG performed a healthcare inspection at the North Florida/South Georgia Veterans Health System in Gainesville, FL, to determine the validity of allegations regarding quality of care issues and the adequacy of pulmonary services. OIG substantiated the allegation that one pulmonology fellow was previously responsible for covering inpatient consultations and the medical intensive care unit (MICU); however, prior to the inspection, there was a realignment of duties that resulted in increased pulmonary coverage. OIG also substantiated that one fellow managed critically ill patients in the MICU while also covering Shands Hospital at the University of Florida, but the medical center had back-up assistance and there was no evidence that this negatively impacted patient care. Lastly, OIG substantiated that fee basis requests for various treatments for lung cancer had declined, but that this decline was the result of improved processes and did not result in treatment delays as alleged. [\[Click for Report.\]](#)

### **Allegations of Denial of Care at VA Central Iowa Health Care System Unfounded**

OIG conducted an inspection in response to allegations that three Veterans were denied access to care after 4:30 p.m. at the VA Central Iowa Health Care System's Knoxville Division, Knoxville, IA. OIG did not substantiate this allegation, but found that a number of employees did not fully understand the new procedures implemented when the hours of operation changed to Monday through Friday, 7:00 a.m. to 4:30 p.m. OIG recommended that management develop a policy to define how to handle emergencies occurring on VA grounds. Additionally, OIG recommended the facility provide employees and Veterans with the necessary information and guidance on changes to facility hours and procedures. [\[Click for Report.\]](#)

### **Allegations Against Tomah, WI, VA Medical Center Not Validated**

OIG conducted an inspection in response to allegations that a registered nurse at the Tomah VA Medical Center (VAMC) in Tomah, WI, provided inappropriate care during an incident involving a terminally ill patient in the Community Living Center. OIG did not substantiate that an intentional unsafe act occurred or that the patient died as a result of the incident; however, managers failed to follow VHA and medical center policy related to allegations of patient abuse. OIG recommended that managers ensure staff immediately report suspected incidents of patient abuse and that further actions are taken in accordance with VHA and medical center policy. [\[Click for Report.\]](#)

## **CRIMINAL INVESTIGATIONS**

### **Defendants Sentenced for Theft of VA Pharmaceuticals**

Two defendants were sentenced to 6 months' incarceration, 36 months' probation, 500 hours' community service, and ordered to pay \$670,000 in restitution. The defendants previously pled guilty to the unauthorized sale, purchase, and trade of pharmaceuticals belonging to a public health care entity. A third defendant, a former VA pharmacist, was previously sentenced to 18 months' incarceration, 36 months' probation, 300 hours' community service, and ordered to pay \$670,000 in restitution after pleading guilty to

conspiracy to steal from a health care benefit program. To date, VA has received \$161,000 in restitution from the three defendants. An OIG investigation revealed that for over 3 years the defendants were involved in a scheme to steal and sell stolen VA pharmaceuticals. The former VA pharmacist stole approximately \$850,000 worth of non-controlled pharmaceuticals from the Hines, IL, VAMC and then used a small portion of the stolen drugs to stock his personally-owned pharmacy, while selling the remaining drugs to the second defendant who owned a pharmaceutical distributorship. The final defendant was a pharmacy technician who handled the day-to-day operations of the distributorship and assisted with the sale of the stolen pharmaceuticals. The former VA pharmacist's license was placed on probation for 2 years, and he was also fined \$7,000 by his state licensing agency. Licensing action is also pending against the other defendants.

### **Veterans and Associates Sentenced for Drug Distribution in Richmond and Hampton, VA**

Two Veterans and two associates were sentenced on charges relating to distributing VA-prescribed Oxycontin, Oxycodone, Percocet, and Xanax. One Veteran was sentenced to 40 years' incarceration, with 37 years suspended, and ordered to complete a drug treatment program. A second Veteran was sentenced to 10 years' incarceration, with 9 years suspended, and 1 year of home confinement after pleading guilty to distribution of morphine. An associate of the Veterans was sentenced to 10 years' incarceration, all suspended, and ordered to complete a drug diversion detention program and drug treatment program. Another associate of the Veterans was sentenced to 45 years' incarceration, all suspended, and ordered to complete a drug diversion detention program and drug treatment program. An OIG and State Police Task Force investigation revealed that many Veterans in the Richmond and Hampton, VA, areas were selling their VA-prescribed narcotics to various associates who then distributed the narcotics throughout the community.

### **Veteran Sentenced for Theft of Health Care Benefits**

A Veteran was sentenced to 84 months' incarceration and ordered to pay \$90,567 in restitution after pleading guilty to fraud, identity theft, and drug diversion. A joint OIG, Drug Enforcement Agency, Defense Criminal Investigative Service, and local police investigation revealed that the defendant used various alias names and social security numbers in order to fraudulently receive approximately \$50,000 in TRICARE benefits and approximately \$33,000 in VA medical benefits. The defendant also attempted to apply for VA compensation benefits and submitted numerous false documents claiming she had been honorably discharged as a U.S. Army officer after serving in the Middle East during Operation Enduring Freedom. The investigation further determined that the defendant was not eligible for VA or Department of Defense benefits because she was discharged from the Army for not meeting military standards after serving only 37 days. Additionally, the investigation revealed that the defendant was employed as a pharmacist at a national pharmacy chain for 2 years without a pharmacy degree or license.

### **Widow Pleads Guilty to Theft of VA Benefits**

The widow of a Veteran pled guilty to theft of Government funds after an OIG investigation disclosed that she fraudulently received VA Dependency and Indemnity Compensation (DIC) benefits. The defendant remarried more than 14 years ago and falsely certified to VA that she was unmarried in order to continue to receive VA DIC benefits. The loss to VA is \$151,796.

### **Veteran Indicted for Making False Statements to VA**

A Veteran was indicted for false statements and false declarations before a court. An OIG and Federal Bureau of Investigation (FBI) investigation determined that the defendant submitted a fraudulent disability compensation claim to VA for medical conditions caused by Agent Orange exposure during his military service in Vietnam. The defendant also made a similar claim to a U.S. Magistrate Judge during an initial appearance for unrelated Federal charges. The investigation determined that the defendant was never in Vietnam during his military service and was never exposed to Agent Orange.

### **Attorney Sentenced for Bribery of West Haven, CT, VAMC Employee**

An attorney was sentenced to 2 years' incarceration and 2 years' probation after having previously pled guilty to bribery and tax fraud charges. A joint OIG, FBI, Internal Revenue Service, General Services Administration OIG, and VA Police investigation determined that the defendant bribed a former West Haven, CT, VAMC employee to obtain contracts for work at the medical center. The former VA employee previously pled guilty to bribery charges and is awaiting sentencing.

### **Former Big Spring, TX, Pharmacy Technician Sentenced for Drug Theft**

A former Big Spring, TX, VAMC pharmacy technician was sentenced to 12 months' incarceration and 1 year of probation after pleading guilty to obtaining a controlled substance by fraud. An OIG and VA Police investigation revealed that the defendant accessed pharmacy profiles of unsuspecting Veterans and then created electronic prescriptions for controlled substances using the Veterans' names. More than 2,800 units of Hydrocodone and 450 units of Alprazolam were dispensed and mailed to the defendant's residence.

### **Former Nashville, TN, Nurse Sentenced for Drug Theft**

A former Nashville, TN, VAMC nurse was sentenced to 24 months' incarceration after pleading guilty to obtaining a controlled substance by fraud and theft. An OIG investigation revealed that the defendant stole hydrocodone from patients to support her ex-husband's drug addiction.

### **Former Martinsburg, WV, Nursing Assistant Pleads Guilty to Theft**

A former Martinsburg, WV, VAMC nursing assistant pled guilty to the unauthorized use of an access device. An OIG and VA Police investigation revealed that the defendant used debit cards belonging to two patients to fraudulently obtain money, goods, and services totaling approximately \$56,000.

**Gainesville, Florida, VAMC Cashier Charged with Theft**

A criminal information was filed against a Gainesville, FL, VAMC agent cashier charging her with theft of Government funds. An OIG investigation determined that during a 2-month period, the employee embezzled approximately \$12,000 by submitting fraudulent patient travel vouchers.

**Memphis, TN, Researcher Pleads Guilty to Child Pornography Charges**

A researcher working at the Memphis, TN, VAMC as a research specialist under a VA grant program pled guilty to a criminal information charging him with the receipt, possession, and transmission of child pornography. An OIG, Immigration and Customs Enforcement, FBI, and VA Police investigation determined that the defendant accessed and used VA computer systems to obtain and transmit child pornography.

**Houston VARO Employee Arrested for Making Terrorist Threats**

A Houston VARO employee was arrested by local law enforcement officers with the assistance of OIG on a warrant from another state for making terrorist threats.

**Veteran Arrested for Probation Violation**

A Veteran was arrested by a U.S. Marshals Fugitive Apprehension Strike Team with the assistance of OIG for a probation violation stemming from an aggravated assault charge in which the Veteran assaulted a VA Police Officer.

*(original signed by:)*

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