



Department of Veterans Affairs

Office of Inspector General

June 2010 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Testifies on VA's Implementation of OIG Recommendations

Deputy Inspector General Richard Griffin testified before the Committee on Veterans' Affairs, U.S. House of Representatives, on the Office of Inspector General's (OIG's) follow-up program and VA's implementation of OIG recommendations. Mr. Griffin discussed the follow-up process between OIG and VA and reported that while VA generally implements OIG recommendations in a timely manner (about 94 percent of recommendations are implemented within 1-year of issuance), there are still significant unrealized savings and program changes that could improve benefits and services to Veterans. He was accompanied by Richard Ehrlichman, Assistant Inspector General for Management and Administration. [\[Click here for Statement.\]](#)

OIG REPORTS

VA Could Save \$38.5 Million on Health Care Staffing Services with Better Contracting Practices

An audit of Veterans Integrated Service Network (VISN) procurements of Federal Supply Schedule (FSS) health care staffing services determined that contracting officers did not adequately review order prices and ensure compliance with Federal Acquisition Regulation ordering and competition requirements during the period of review. In addition, the Procurement and Logistics Office lacked an effective oversight process for health care staffing services procurements and had not worked effectively with the National Acquisition Center (NAC) to implement adequate FSS procurement policies, procedures, and training. OIG projected that medical facilities overpaid FSS vendors about \$5.8 million for labor and \$1.8 million for travel expenses. Consequently, the Veterans Health Administration (VHA) could reduce its FSS health care staffing services costs by about \$38.5 million over the next 5 years if it strengthened its price evaluation and ordering practices and met competition requirements. [\[Click here for Report.\]](#)

NAC Not Leveraging Volume Buying Power in Health Care Services Contracts

OIG conducted a series of pre- and post-award reviews of proposals and contracts awarded by VA's NAC for Professional and Allied Health Care Staffing Services under FSS Schedule 6211. The reviews found that the prices awarded at the contract level were not fair and reasonable and the methodologies used by VA contracting officers to determine fair and reasonable pricing were inadequate. OIG made several recommendations to the Deputy Assistant Secretary for Acquisition and Logistics to correct these issues. [\[Click here for report.\]](#)

Millions at Risk to Fraud in Non-VA Fee Care Program

OIG's review of fraud management for the Non-VA Fee Care Program found that although Federal law requires agencies to maintain controls that safeguard against

fraud, VHA has not established controls designed to prevent and detect fraud primarily because it had not identified fraud as a significant risk to the Fee Program. OIG estimates that the Fee Program could be paying between \$114 million and \$380 million annually for fraudulent claims. OIG recommended that the Under Secretary for Health establish a fraud management program with controls such as data analysis and high-risk payment reviews, system software edits, employee fraud training, and fraud awareness and reporting. [\[Click here for report.\]](#)

Prohibited Personnel Practices, Misuse of Position Substantiated in VHA HR Office

An administrative investigation substantiated that a VHA Director of Human Resources Development engaged in prohibited personnel practices when he twice gave preference in hiring to a friend. OIG also found that a Human Resources Specialist, as a conference planner, improperly accepted gifts from prohibited sources when she solicited and accepted hotel reward points and that she failed to testify honestly about receiving the points. The Human Resources Specialist further misused her official time, position, and VA-owned equipment to conduct personal business as well as business for her privately-owned company.

VA Care Not a Factor in Veteran's Suicide

A congressional request prompted OIG to evaluate the care of a Veteran who committed suicide 5 days after discharge from a VHA medical facility. The patient was hospitalized for treatment of depression and anxiety, but denied having any suicidal ideations. OIG found that the patient received appropriate care and that clinicians made reasonable decisions and acceptable discharge plans based on what they knew about the patient's home safety situation. At the time of discharge, the patient was competent to make decisions and did not voice suicidal ideations. The VISN and VA Medical Center (VAMC) Directors agreed with the findings and OIG made no recommendations. [\[Click here for report.\]](#)

Poor Coordination and Communication Results in Delays in Veterans' Care at Orlando VAMC

OIG conducted an inspection in response to allegations of inadequate coordination of care with Fee Basis Service (FB), Interfacility Consults (IFC), and Project Health Effectiveness through Resource Optimization (HERO) at the Orlando, FL, VAMC. OIG confirmed that Veterans experienced delay of medical care due to poor coordination and communication in the care management system; however, no patients were harmed because of these delays. OIG confirmed that the FB authorization letter and communication between FB staff and Veterans needed improvement, and that the VAMC had not established a formalized system to ensure timeliness of care for Veterans requiring IFCs. The inspection found that Project HERO was not meeting its contractual performance benchmarks of 100 percent compliance for timely referrals and communication with FB providers. HERO's current performance benchmarks regarding access to care and return of medical records average 90 percent. The VISN and VAMC Directors concurred with the findings and recommendations. [\[Click here for report.\]](#)

OIG Evaluates VHA's Quality Management Programs at 44 Facilities

An evaluation was conducted by OIG to determine whether VHA facilities had comprehensive, effective quality management (QM) programs designed to monitor patient care activities and coordinate improvement efforts. Furthermore, the evaluation reviewed whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. Although all 44 facilities reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses. Senior managers at all facilities reported that they support their QM programs and actively participate. The Under Secretary for Health concurred with OIG's five recommendations to improve operations. [\[Click here for report.\]](#)

Community Based Outpatient Clinic Reviews Performed Throughout VISN 9

OIG performed reviews of six Community Based Outpatient Clinics (CBOCs) within VISN 9 to assess if they provide Veterans with consistent, safe, high quality health care. The reviews covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, suicide safety plans, and CBOC contracts. Reviews included facilities in Smithville, MS; Chattanooga, Knoxville, Memphis (Memphis-South) and Nashville (Vine Hill), TN; and Norton, VA. OIG noted several opportunities for improvement and made 21 recommendations. [\[Click here for report.\]](#)

Respiratory Care, Nurse Staffing Issues Unfounded at Memphis VAMC

Two anonymous complaints regarding respiratory therapy (RT) and nurse staffing issues at the Memphis, TN, VAMC prompted a review by OIG. OIG confirmed that two RTs and a surgery resident were unable to intubate a patient; however, OIG did not substantiate that this contributed to the patient's death. Medical record documentation clearly reflects that the patient was ventilated between intubation attempts and RT competency files reflected appropriate certification and competence in airway management. OIG did not substantiate the other allegations and noted that actions were being taken to enhance RT and nurse staffing in both areas. OIG made no recommendations. [\[Click here for report.\]](#)

CRIMINAL INVESTIGATIONS**Fiduciary and Wife Indicted for Misappropriation**

An attorney and his wife, who worked with him at his law office, were indicted for misappropriation by a fiduciary, conspiracy, false statements, and tax fraud. A joint investigation conducted by VA OIG, Social Security Administration (SSA) OIG, and Internal Revenue Service Criminal Investigations Division revealed that while the attorney was serving as both a court-appointed guardian and fiduciary, he and his wife stole approximately \$2.3 million from the bank accounts of 54 Veterans. Additionally, they failed to report the misappropriated funds as income on their tax returns. The attorney also served as a representative payee for 14 of those Veterans' Social Security benefits.

Former Phoenix, Arizona, VAMC Employee Sentenced for Theft

A former Phoenix, AZ, VAMC mailroom employee was sentenced to 60 days' deferred incarceration, 18 months' probation, and ordered to pay restitution of \$2,786 after pleading guilty to theft. An OIG and VA Police investigation determined that the defendant stole two VA desktop computers, a Government-issued credit card, and mail from the VA mailroom. No VA personally identifiable information (PII) was stored on the stolen computers.

Veteran Pleads Guilty to Making Threats Against Jackson, Mississippi, VARO Employees

A Veteran pled guilty to making threats against VA employees. An OIG investigation revealed that the defendant contacted his Disabled American Veterans representative at the Jackson, MS, VA Regional Office (VARO), after nine of his VA claims were denied and stated that he was going to kill one VA employee for each claim that the VARO had denied him. The defendant is also facing additional State charges for threats made to employees of a cellular phone company.

Son of VA Beneficiary Indicted for Misappropriation of Benefits

The son of a VA beneficiary was indicted for making false statements. An OIG investigation revealed that from 2003 to 2006, while serving as his father's fiduciary, the defendant misappropriated \$157,517 of his father's funds for his personal use and falsified annual accounting reports to the VARO.

Defendants Indicted for Identity, Bank, and Wire Fraud

Both a home health care worker, provided by a VA contractor, and her cousin were indicted for conspiracy, identity fraud, bank fraud, and wire fraud for stealing the identity of a Veteran and then using that information to steal approximately \$36,000 from his bank account. An OIG and local police investigation revealed that the Veteran's PII was stolen while the home health care worker was providing nursing services in the Veteran's home. The health care worker then provided the PII and financial information to her cousin, who resided in another state. The defendants then accessed the Veteran's account electronically to steal the funds.

Shipping Supervisor Arrested for Drug Theft from Oklahoma City VAMC

A United Parcel Service (UPS) supervisor was arrested for larceny of a controlled dangerous substance. An OIG, VA Police, and UPS investigation revealed that the defendant was stealing prescription morphine and oxycodone shipped from the Oklahoma City, OK, VAMC. The defendant confessed to stealing the drugs to support a drug habit. During the investigation, three other UPS employees were interviewed and subsequently resigned.

Veterans Arrested for Drug Distribution at Philadelphia VAMC

Four Veterans were arrested for distribution of class II and class III narcotics, to include Percocet, Xanax, and Suboxone pills. An OIG, VA Police, and local police investigation at the Philadelphia, PA, VAMC revealed that the defendants sold various drugs during an undercover operation to a confidential informant and an undercover police officer

over a period of several months. A fifth Veteran who was charged remains a fugitive, and a sixth Veteran expired prior to being arrested.

Former Bedford, Massachusetts, VAMC Employees Sentenced for Fraud

Two former Bedford, MA, VAMC employees were sentenced after being convicted of conspiracy, identity fraud, and access device fraud. The first defendant was sentenced to 366 days' incarceration and 2 years' supervised release. The second defendant was sentenced to 6 months' home confinement and 2 years' probation. Both defendants were ordered to pay joint restitution of \$3,365. An OIG, VA Police, and U.S. Secret Service investigation revealed that the defendants stole checks, credit card numbers, and bank account numbers from several disabled Veterans who lived at the VAMC's long-term care facility. The defendants shared the information with a third co-conspirator who was previously sentenced after pleading guilty. The three defendants used the Veterans' accounts and identities to purchase goods and services over the telephone and internet.

Former Providence, Rhode Island, Employee Pleads Guilty to Theft of VA Computers

A former VA Compensated Work Therapy program employee pled guilty to conspiracy and theft of Government property after an OIG and VA Police investigation revealed that the defendant stole two computers from the Providence, RI, VAMC. Neither computer contained PII. The defendant admitted to stealing the computers and selling them to buy cocaine.

Daughter of Deceased Beneficiary Agrees to Pay Restitution

The daughter of a deceased VA beneficiary was found responsible for the theft of VA funds after a civil suit was filed by the United States Attorney's Office. An OIG investigation disclosed the daughter stole VA benefits issued after her mother's death in July 2005. The daughter entered into a Consent Judgment and agreed to pay VA \$151,000, plus interest, and \$350 in court costs.

Veteran and Wife Plead Guilty to Theft Involving Unemployment Benefits

A Veteran and his wife pled guilty to theft of Government funds after an OIG and SSA OIG investigation revealed that the Veteran fraudulently received VA and SSA benefits after claiming that he was unemployable due to his disabilities. The investigation determined that the Veteran was employed as a long haul truck driver and allowed his employer to knowingly pay him using his wife's social security number in order to continue to receive fraudulent unemployability compensation benefits. The employer was also charged in this investigation with making false statements; plea negotiations are continuing. The loss to VA is \$71,816, and the loss to SSA is \$48,174.

Son of Deceased Beneficiary Pleads Guilty to Theft

The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to inform VA of his father's death in March 2004 and subsequently stole VA benefits that were deposited to his father's account. The loss to VA is approximately \$94,000.

Former Mail Carrier Sentenced for Theft

A former U.S. Postal Service (USPS) rural carrier was sentenced to 24 months' probation and a \$1,000 fine after having previously pled guilty to obstruction of U.S. mail and drug possession. An OIG and USPS OIG investigation revealed that the defendant stole VA prescription medication parcels, gift cards, and other valuables from the mail. In at least one instance, the defendant intercepted a Veteran's pain medication and replaced it with acetaminophen.

*(original signed by Richard J. Griffin,
Deputy Inspector General for:)*

GEORGE J. OPFER
Inspector General