



# Department of Veterans Affairs

## Office of Inspector General

### July 2011 Highlights

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#### CONGRESSIONAL TESTIMONY

##### **Assistant Inspector General for Healthcare Inspections Testifies on VA Mental Health Care: Progress Made, But More Work Needs To Be Done**

John D. Daigh, Jr., M.D., Assistant Inspector General (AIG) for Healthcare Inspections, testified before the Committee on Veterans' Affairs, United States Senate, on VA mental health (MH) care. Dr. Daigh discussed the results of the Office of Inspector General's (OIG's) work in the area of MH, including reports on system-wide reviews and reports on the care provided to individual Veterans. Specifically, he focused on the importance of the coordination of care between primary care providers and MH care providers. He also discussed the recent follow-up review of VA's Mental Health Residential Rehabilitation Treatment Programs where OIG evaluated any improvements made or problems remaining since OIG's 2009 report. Dr. Daigh concluded that continued attention must be given to improving staffing and access to care; providing continuity during integral care transitions; coordinating care for individual Veterans with MH issues; and linking pain management, MH, and substance use programs. Dr. Daigh was accompanied by Michael Shepherd, M.D., Senior Physician, in OIG's Office of Healthcare Inspections. [\[Click here to access testimony.\]](#)

##### **Ineligible "Veteran-Owned" Firms Receive VA Contracts, AIG for Audits and Evaluations Tells House Panel**

Belinda J. Finn, AIG for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work related to VA's Veteran-Owned and Service-Disabled Veteran-Owned Small Business (VOSB and SDVOSB) programs. OIG's recent report, *Audit of the Veteran-Owned and Service-Disabled Veteran-Owned Small Business Programs*, found that 76 percent of the businesses OIG reviewed were ineligible for the program and/or the specific VOSB or SDVOSB contract award, potentially resulting in \$2.5 billion awarded to ineligible businesses over the next 5 years. Ms. Finn was accompanied by Mr. James J. O'Neill, AIG for Investigations, whose office's work recently resulted in the successful prosecution of the Chief Executive Officer of a business that had been awarded SDVOSB set-aside construction contracts for which the company was not eligible. [\[Click here to access testimony.\]](#)

#### OIG REPORTS

##### **VA at Risk of Awarding \$2.5 Billion to Ineligible Businesses over Next 5 Years**

OIG audited VA's Veteran-Owned Small Business and Service-Disabled Veteran-Owned Small Business programs to assess whether businesses met program and contract eligibility requirements and VA provided effective management oversight. OIG found that VA awards ineligible businesses at least 1,400 VOSB and SDVOSB contracts valued at \$500 million, annually. Moreover, VA will award \$2.5 billion to ineligible businesses over the next 5 years if it does not strengthen contracting officer oversight and business verification procedures. Seventy-six percent of the reviewed

businesses were ineligible to participate in the programs or to receive the contracts, which totaled \$46.5 million in awards, including \$26.7 million in *American Recovery and Reinvestment Act of 2009* contracts. VA's fiscal year (FY) 2010 socioeconomic goal accomplishment data may also be overstated by 3 to 17 percent due to awards made to ineligible businesses. OIG recommended VA implement comprehensive program controls to ensure awards are not made to ineligible businesses and improve adherence to Federal and VA regulations. The Under Secretary for Health, the Office of Small and Disadvantaged Business Utilization, and the Office of Acquisition, Logistics, and Construction agreed with OIG's findings. [\[Click here to access report.\]](#)

### **Recurring Contracting and Pricing Issues Persist in Health Care Resource Contracts**

In August 2006, the VA Secretary signed into policy VA Directive 1663, *Healthcare Resources Contracting – Buying, Title 38 U.S.C. § 8153*, under which VA may enter into non-competitive (sole-source) contracts with affiliated institutions for health care resources. VA Directive 1663 requires a pre-award review for health care resources procured on a sole-source basis that are valued at more than \$500,000. The report advised VA of OIG's collective findings in pre-award reviews since VA Directive 1663 became effective. OIG determined that the Veterans Health Administration (VHA) has not effectively implemented all the requirements set forth in VA Directive 1663 due to lack of resources, training, and enforcement, which resulted in recurring contracting and pricing issues with sole-source contracts with affiliated institutions. OIG's report also discusses findings regarding conflict of interest issues and recommends that VA seek personal services contracting authority. The Under Secretary for Health concurred with all OIG findings and recommendations. [\[Click here to access report.\]](#)

### **OIG Finds VHA Facility Capabilities Appropriate for Level of Surgical Care**

OIG conducted a retrospective review to characterize where seven complex and intermediate surgical procedures were performed at VHA facilities and at non-VHA facilities through fee basis arrangements prior to VHA's release of Directive 2010-018, *Facility Infrastructure Requirements To Perform Standard, Intermediate, or Complex Surgical Procedures*, on May 6, 2010. OIG found that VHA facilities had appropriate infrastructure to support surgeries performed. Although some surgeries were performed at VHA facilities with designations of lower complexity than required by the Directive, these surgeries were performed prior to the publication of the Directive, and OIG identified no adverse patient outcomes clearly attributable to facility infrastructure. OIG also found that VHA referred complex surgeries to non-VHA facilities with sufficient capabilities to support the surgeries performed. OIG made no recommendations. [\[Click here to access report.\]](#)

### **Lack of Management Controls Results in Loss of Veterans' Grant Records at Durham, North Carolina, VAMC**

At the request of Senator Richard Burr, OIG conducted an inspection of the Prosthetic and Sensory Aids Service (PSAS) at the Durham, NC, VAMC. Specifically, OIG reviewed the potential loss of Veterans' Home Improvement and Structural Alterations (HISA) grant records that contained Personally Identifiable Information (PII), which may

have caused undue delays in providing these critical modifications to Veteran's homes. OIG was unable to determine the exact number of HISA records missing but estimates that as many as 90 records are missing. OIG found numerous discrepancies in the oversight and administration of the HISA program, which contributed to the lack of management control over this program. The review found that facility managers did not place appropriate emphasis on protecting, investigating, and reporting lost or stolen files that contained PII. More than 3 weeks passed from the discovery of the lost records to notification of appropriate authorities. Since the discovery of the missing files, personnel and leadership changes in the prosthetics department have been addressed. [\[Click here to access report.\]](#)

### **OIG Substantiates Inadequate Management of Electronic Waiting Lists at Atlanta, Georgia, VAMC, Mental Health Clinics**

OIG conducted an evaluation regarding inadequate management of the electronic waiting list (EWL) for several MH clinics at the Atlanta, GA, VAMC. OIG substantiated that several MH clinics had significantly high numbers of patients on their EWLs over a period of months in FY 2010, and OIG substantiated that facility managers were aware of the EWLs but were slow in taking actions to address the condition. While the facility has since provided resources to eliminate the MH EWLs, ongoing actions are necessary to ensure the condition does not recur. OIG substantiated that FY 2010 funds were inappropriately used to pay a contractor's FY 2009 expenses and that there were delays in payments to the contractor. OIG recommended that the VAMC Director ensure ongoing actions are taken to minimize and/or alleviate MH EWLs and that responsible staff follow fiscal guidelines. The Acting VISN Director agreed with the findings and recommendations. [\[Click here to access report.\]](#)

### **OIG Finds Contractors Failed to Comply with VA Information Security Policies**

OIG substantiated allegations that a contractor did not comply with VA information security policies for accessing mission critical systems and networks. Specifically, contractor personnel improperly shared user accounts when accessing VA networks and systems; did not readily initiate actions to terminate accounts of separated employees; and did not obtain appropriate security clearances or complete security training for access to VA systems and networks. In addition, VA has not implemented oversight to ensure the contractor complies with VA information security policies and procedures, making sensitive data at risk of inappropriate disclosure or misuse. VA agreed with OIG's findings and recommendations. [\[Click here to access report.\]](#)

### **Beneficiary Travel at Increased Risk for Improper Payments at Cincinnati, OH, VAMC**

OIG reviewed the validity of allegations of mismanagement and fraud at the Cincinnati, OH, VA Medical Center (VAMC) Beneficiary Travel Office (BTO). The Beneficiary Travel program provides reimbursements to offset travel costs associated with obtaining VA health care services. OIG partially or fully validated four of nine allegations, and identified processing inconsistencies in the BTO. BTO staff approved some travel reimbursement claims for uncompleted medical appointments, and approved travel vouchers associated with patient-cancelled and no show appointments that staff

preprinted prior to the beneficiaries' appointments. OIG also identified one occurrence where a beneficiary was inappropriately approved travel reimbursement to the Cincinnati VAMC, and determined a former supervisor improperly authorized wheelchair van services under an expired contract. The Cincinnati VAMC Director concurred with all recommendations. [\[Click here to access report.\]](#)

### **OIG Substantiates Lapses in Execution of Suicide Safety Measures at West Palm Beach, Florida, VAMC**

OIG performed an inspection at the West Palm Beach, FL, VAMC to determine the validity of allegations regarding a high-risk patient attempting suicide in the emergency department and again on the MH unit. The complainant also expressed concerns about staff training; poor communication with the family; staff actions regarding an art therapy class; and the patient's transfer to a non-VA treatment center. OIG substantiated that due to lapses in carrying out suicide safety measures, the patient was able to attempt suicide twice while under the care of facility providers. While not part of the allegations, OIG found that the facility's internal reviews of the events did not fully adhere to the National Center for Patient Safety guidelines for completion of root cause analysis. Two of the complainant's allegations resulted in recommendations to the Veterans Integrated Service Network (VISN) and VAMC Directors. [\[Click here to access report.\]](#)

### **Allegations Regarding Hospice Care Substantiated at Baltimore, Maryland, VA Rehabilitation and Extended Care Center**

OIG conducted a review to determine the validity of two allegations regarding hospice care at the Baltimore VA Rehabilitation and Extended Care Center, which is part of the VA Maryland Health Care System (HCS). OIG substantiated that two patients did not have adequate pain management as defined by VHA policy and hospice industry standards. The review identified five factors that contributed to the pain management deficiencies: (1) facility staff did not develop individualized and comprehensive pain management care plans, (2) patient pain reassessments were not appropriately documented, (3) clinical staff did not have sufficient training on the principles of pain management for hospice patients, (4) hospice interdisciplinary teams were not effectively used, and (5) clinical pharmacists were not actively involved in the pain management process. OIG did not substantiate that the lack of "piped in" oxygen, suction, and air compromised hospice patient safety and comfort. OIG found that the facility provided appropriate oxygen, suction, and air. OIG made four recommendations to address the factors that contributed to the pain management deficiencies. Management agreed with the findings and recommendations. [\[Click here to access report.\]](#)

### **Hospice and Palliative Care Improvements Needed at Detroit, Michigan, VAMC**

OIG evaluated the validity of allegations that facility staff at the John D. Dingell VAMC in Detroit, MI, did not respect a patient's treatment decision, misrepresented the family's wishes, and treated the patient and family disrespectfully. OIG did not substantiate that the patient's attending physician misrepresented the family's wishes and was unprofessional. OIG substantiated: (1) staff did not provide comfort care to the patient prior to the patient's transfer from acute care to hospice care, (2) physicians delayed the

patient's transfer to the hospice unit, and (3) nursing staff did not show compassion to a dying patient and the patient's family. OIG recommended that the VAMC Director ensure that all clinical staff receives training in hospice and palliative care and that the VAMC follows hospice care guidelines to ensure all family members have adequate privacy for initial bereavement. The VISN and VAMC Directors concurred with our findings and recommendations and provided acceptable action plans. OIG will follow up until the planned actions are completed. [\[Click here to access report.\]](#)

### **Community Based Outpatient Clinics Reviews at Multiple VISNs**

OIG reviewed seven Community Based Outpatient Clinics (CBOCs) during the week of March 7, 2011. CBOCs were reviewed in VISN 1 at Springfield, MA; in VISN 6 at Morehead City and Raleigh, NC; in VISN 9 at Clarksville and Cookeville, TN; in VISN 16 at Wichita Falls, TX; and, in VISN 20 at Klamath Falls, OR. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, management of laboratory results, and CBOC contracts. OIG noted opportunities for improvement and made 16 recommendations to VISN and facility managers. [\[Click here to access report.\]](#)

In a similar review, OIG reviewed six CBOCs during the week of April 11, 2011. CBOCs were reviewed in VISN 16 at Branson, MO and Harrison, AR; Conroe and Lufkin, TX; and Hammond and Houma, LA. The review covered the following focused topic areas: MH continuity of care, short-term fee basis, women's health, credentialing and privileging, skills competency, environment and emergency management, Primary Care Management Module, and contracts. OIG noted opportunities for improvement and made 24 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

Lastly, OIG reviewed eight CBOCs during the week of May 16, 2011. CBOCs were reviewed in VISN 4 at Bradford (McKean County) and Franklin (Venango County), PA; and Camp Hill and Pottsville/Frackville, PA; and, in VISN 23 at Mission, SD and Newcastle, WY; and Hibbing and Rochester, MN. The review covered the same focused topic areas in the VISN 16 review referenced above. OIG noted opportunities for improvement and made 57 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

### **OIG Reviews VA Regional Offices in Huntington, West Virginia, and New York, New York**

The Benefits Inspection Division conducted an onsite inspection of the Huntington, WV, VA Regional Office (VARO) to review disability compensation claims processing and Veterans Service Center operations. OIG found that management ensured staff followed the Veterans Benefits Administration's (VBA's) policy for establishing dates of claim, processing incoming mail, and completing Systematic Analyses of Operations (SAOs). The average time to complete claims was 146 days, 29 days better than the national target of 175 days. The VARO was generally effective in processing post-

traumatic stress disorder (PTSD) claims, handling mail, and correcting errors identified through the Systematic Technical Accuracy Reviews (STAR). However, management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury claims, and herbicide exposure-related claims. Overall, the staff did not accurately process 36 (38 percent) of the 95 disability claims reviewed. The recent implementation of the Quality Review and Training Team is a step toward addressing these deficiencies. Although they were not timely in recording Notices of Disagreement (NODs) for appealed claims, it was better than the national average regarding appeals processing timeliness. Further, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions and improper benefits payments. OIG recommended management monitor the effectiveness of its quality review process and provide refresher training on traumatic brain injury and herbicide exposure-related claims processing. VARO management also needs to ensure accurate processing of final competency determinations. The VARO Director concurred with our recommendations. [\[Click here to access report.\]](#)

In a similar review of the New York, NY, VARO, OIG found the VARO staff correctly established dates of claim in the electronic record. VARO performance was generally effective in processing herbicide exposure-related claims and correcting errors identified by VBA's STAR program staff. However, the VARO lacked effective controls and accuracy in processing some disability claims. Some of the identified inaccuracies resulted when staff did not schedule future medical reexaminations as required, as well as from staff using insufficient medical examinations to make final disability determinations. Overall, VARO staff did not accurately process 30 (31 percent) of the 98 disability claims OIG reviewed. The VARO instituted a new practice to improve claims processing accuracy to support rating decisions. OIG noted the reallocation of staff to a high priority national project resulted in untimely final competency determinations. OIG recommended VARO management strengthen controls over processing NODs, completing SAOs, handling mail, and completing final competency determinations timely. The VARO Director concurred with our recommendations. [\[Click here to access report.\]](#)

## **CRIMINAL INVESTIGATIONS**

### **Company and Four Defendants Indicted for SDVOSB Fraud**

A company and four defendants were indicted for conspiracy to defraud the Government, major program fraud, wire fraud, money laundering, and false statements. Subsequently, the four defendants were arrested and eight search and seizure warrants were executed. A joint VA OIG, Small Business Administration OIG, General Services Administration OIG, and Defense Criminal Investigative Service (DCIS) investigation determined that the SDVOSB acted as a pass-through company for a larger company and that the owner of the SDVOSB was not a service-disabled Veteran. Based on information provided by OIG, VA's Suspension and Debarment Committee suspended the company and the four defendants from doing business with the Federal Government.

**Pharmaceutical Company Agrees to Pay \$34.3 Million for Off-Label Marketing**

A pharmaceutical company entered into a settlement agreement with the Government after an OIG, Federal Bureau of Investigation, and Food and Drug Administration investigation determined that the company promoted an antiepileptic drug to physicians for several off-label indications, which included treatment for migraines, pain, anxiety, and bipolar disorder. As a result of this agreement, the company pled guilty to a misdemeanor count of misbranding under the *Federal Food, Drug, and Cosmetic Act*. This pharmaceutical company agreed to pay over \$25.7 million to settle civil liabilities associated with the investigation. VA's portion of the civil settlement is approximately \$669,000. The company also agreed to pay a criminal fine of \$7.55 million and an asset forfeiture of \$1.078 million.

**Fiduciary's Assistant Pleads Guilty to Bank Fraud**

An administrative assistant working for a VA appointed fiduciary pled guilty to bank fraud. An OIG investigation revealed that the defendant forged the fiduciary's signature on more than 325 checks from several VA beneficiary accounts. The checks were made payable to the defendant and were deposited into the defendant's personal bank account. In furtherance of the scheme, the defendant transferred funds from one Veteran's account to another to conceal the thefts. The loss to VA is \$626,107.

**Veteran Indicted for Attempted Sexual Assault of Phoenix, Arizona, VAMC Employee**

A Veteran was arrested and subsequently indicted after attempting to sexually assault a Phoenix, AZ, VAMC employee. An OIG investigation was initiated after VA Police responded to a call regarding a Veteran assaulting a VA social worker in her office at the VAMC. The defendant is in custody pending a mental competency evaluation.

**Veteran Indicted for Assaulting White River Junction, Vermont, VAMC Nurse**

A Veteran was indicted for assaulting a VA nurse at the White River Junction, VT, VAMC. OIG previously arrested the Veteran based on a criminal complaint related to this incident. An OIG and VA Police investigation revealed that, while in the emergency room, the defendant locked the door, took a scalpel from a hospital cart and physically gained control of the nurse by holding the scalpel to her throat. VA police officers were able to subdue the Veteran, and the nurse sustained no injuries.

**Veteran Sentenced for Assaulting Two Spokane, Washington, VAMC Nurses**

A Veteran was sentenced to 40 months' incarceration and 3 years' supervised release after being found guilty at trial of assaulting a Federal employee. The Veteran seriously injured two VA nurses during a visit to the Spokane, WA, VAMC emergency department.

**Veteran Sentenced for Threats to Seattle, Washington, VAMC Employee**

A Veteran was sentenced to 99 days' incarceration and 3 years' supervised release after pleading guilty to threatening to murder a VA employee. An OIG and VA Police investigation determined that the Veteran made a telephonic threat to a VA employee in the patient advocate's office at the Seattle, WA, VAMC.

**Veteran Indicted for Making Threats to the Director of the White River Junction, Vermont, VAMC**

A Veteran, who is also a former VA employee, was indicted for transmitting an interstate e-mail communication that threatened to injure the director of the White River Junction, VT, VAMC. An OIG and VA Police investigation disclosed that the Veteran, whose employment was terminated in 2008, submitted numerous harassing e-mails to VAMC personnel, including one that caused a 6-hour facility shutdown in anticipation of his arrival.

**Veteran Sentenced for “Stolen Valor” Fraud**

A Veteran was sentenced to 6 months' incarceration, 36 months' supervised release, and ordered to pay restitution of \$143,606 after pleading guilty to theft of Government property and making a false statement. An OIG investigation revealed that the defendant submitted fraudulent military discharge documents to the Bay Pines, FL, VAMC that resulted in the defendant receiving VA health care benefits he was not entitled to receive.

**Veteran Sentenced for Theft of VA Benefits**

A Veteran was sentenced to 2 years' incarceration and ordered to pay \$70,749 in restitution after being found guilty at trial of unlawful possession of an altered discharge certificate, false representation of earning military decorations, false statements, and mail fraud. An OIG and DCIS investigation revealed that the defendant, a former elected county official, claimed to be a recipient of Vietnam Campaign and Service Medals while running for re-election in 2007. During the investigation into false representations of earning military decorations, the Veteran resigned his position as County Commissioner of Revenue. The investigation also determined that the defendant made false statements to VA related to an October 1973 murder at Fort Bragg while applying for VA benefits for his PTSD claim.

**Roseburg, Oregon, VAMC Pharmacy Technician Arrested for Theft**

A Roseburg, OR, VAMC pharmacy technician was arrested for theft of Government property after an OIG and Drug Enforcement Administration investigation revealed that the technician diverted more than 6,000 tablets of Oxycotin, oxycodone, Vicodin, and clonazepam from the pharmacy. For at least 18 months, the defendant created and posted false drug orders in the VistA database claiming that the narcotics were being dispensed from the VA pharmacy inventory as “refills” to the Accudose machines located throughout the facility. The loss to VA is approximately \$26,000.

**Former Salem, Virginia, VAMC Nurse Pleads Guilty to Obtaining Drugs by Fraud**

A former Salem, VA, VAMC registered nurse pled guilty to obtaining drugs by fraud. An OIG investigation revealed that the nurse engaged in a variety of schemes to divert over 7,000 micrograms of fentanyl from OmniCell machines. The defendant admitted to using the stolen narcotics while working at the VAMC.

**Former Dallas, Texas, VAMC Employee Sentenced for Child Pornography**

A former Dallas, TX, VAMC employee was sentenced to 5 years' deferred adjudication in addition to being ordered to register as a sex offender for possession of child pornography. An OIG investigation revealed that while working at the VAMC, the defendant used his VA computer to access and view child pornography.

**Deceased Beneficiary's Daughter Indicted for Theft of VA Funds**

The daughter of a deceased beneficiary was indicted for theft of Government funds after an OIG investigation determined that she stole VA benefits that were direct deposited to a joint account after her mother's death in August 2005. The loss to VA is \$78,038.

**Navy Deserter Sentenced for Identity Theft**

An active duty U.S. Navy sailor was sentenced to 21 months' incarceration, 3 years' supervised probation, and ordered to pay \$64,986 in restitution to VA. An OIG investigation revealed that the defendant deserted the U.S. Navy in 1985 after the theft of over \$8,000 in Navy funds and then assumed his brother's identity to avoid arrest. The defendant subsequently received VA pension benefits using his brother's identity. The defendant is also scheduled for a military court-martial on desertion and theft charges.

**Non-Veteran Indicted for Fraud and Identity Theft**

A non-Veteran was indicted on charges of wire fraud, false statements, health care fraud, theft, and aggravated identity theft. An OIG and DCIS investigation was initiated after a referral from a VARO that noticed numerous discrepancies in the defendant's claim forms. The defendant fraudulently obtained and submitted the DD-214 of a retired military Veteran to obtain VA medical services, as well as Tricare benefits for his spouse. The defendant also obtained VA and Department of Defense identification cards and diverted the Veteran's VA compensation and Army retirement pay to his own bank account. The defendant filed numerous documents with VA in an attempt to obtain additional compensation, education, and vocational rehabilitation benefits.

**Former VA Police Service Officer Sentenced for False Statements**

A former VA Police Service officer was sentenced to 14 months' incarceration after being convicted of false statements. An OIG investigation revealed that the former officer made numerous false statements on various VA applications for employment, as well as his Office of Personnel Management Questionnaire for Public Trust Positions. The investigation also revealed that the former officer served 32 months in a military prison related to charges of false statements that he made while in the U.S. Army. Additional weapon possession charges are pending.

**Fugitive Felons Arrested With OIG Assistance**

A Veteran was arrested by local officers with the assistance of OIG. The fugitive was wanted on felony warrants for aggravated battery with a deadly weapon, assault with a deadly weapon, violation of probation, and other charges. A second Veteran was arrested at the Houston, TX, VAMC with the assistance of OIG on a felony warrant for

failing to register as a sex offender. The fugitive was previously convicted of aggravated sexual assault on a child.



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