



# Department of Veterans Affairs

## Office of Inspector General

### June 2013 Highlights

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#### **CONGRESSIONAL TESTIMONY**

##### **Assistant Inspector General for Audits and Evaluations Tells Congress That VA Systems Remain at Risk Due to Weaknesses in Information Technology Security**

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on Office of Inspector General (OIG) reports related to the security of VA's information technology (IT) systems and Veterans' data. Ms. Halliday discussed IT security control weaknesses that OIG has reported on for over 10 years through the Audit of VA's Consolidated Financial Statements and in audits conducted under the *Federal Information Security Management Act*, as well as other audits and reviews recently conducted. VA's decentralized and complex system infrastructure poses significant challenges to implementing effective security measures. Until VA fully implements key elements of its information security program and addresses OIG's outstanding audit recommendations, VA's mission-critical systems and sensitive Veterans' data remain at increased and unnecessary risk of attack or compromise. Ms. Halliday was accompanied by Ms. Sondra McCauley, Deputy AIG for Audits and Evaluations, and Mr. Michael Bowman, Director, OIG's Information Technology and Security Audits Division. [\[Click here to access testimony.\]](#)

#### **ADMINISTRATIVE INVESTIGATION**

##### **Former VA Senior Human Resources Official and VA Contractor Misrepresented Veteran Hiring Results for 2012 VA Hiring Fair in Detroit, Michigan**

A former (retired) VA Senior Official and a VA contractor employee knowingly misrepresented the results of the June 2012 Detroit, MI, VA for Vets Veterans Hiring Fair. Further, the former VA Senior Official did not properly manage the VA workforce, frequently used obscene and demeaning language, engaged in verbally abusive behavior toward VA staff and VA contractor employees, and engaged in the appearance of a conflict of interest. In addition, a contractor received over \$500,000 for a data management system that was not designed to capture accurate data to support VA's needs. [\[Click here to access report.\]](#)

#### **OIG REPORTS**

##### **VA in Compliance with Several Key Climate Change Mandates, but More Needed To Curb Greenhouse Emissions**

In response to a February 25, 2013, request from the Congressional Bicameral Task Force on Climate Change, OIG assessed whether VA is doing all that it can to address this growing threat. OIG found VA partially complied with several key requirements but can do more to address climate change. VA has done considerable planning and met selected targets in the areas of energy management, water management, and green buildings sustainability. However, VA did not meet selected targets for reducing greenhouse gas emissions and fleet petroleum consumption. This was due to factors such as significant growth in VA programs, competing operational standards, and

regulatory requirements. Since 2008, VA has increased staffing by 21 percent and expanded its fleet by 39 percent to better serve Veteran needs, but this has posed a challenge to meeting certain targets. Generally, VA had the authority needed to reduce heat trapping pollution emissions and strengthen its resiliency to climate change effects. OIG recommended the Executive in Charge for the Office of Management (OM) and Chief Financial Officer coordinate with the Acting Assistant Secretary of the Office of Human Resources and Administration (HR&A) to implement existing telework expansion plans and encourage VA employees to use alternative forms of commuting for reducing greenhouse gas emissions. The Executive in Charge should also identify additional strategies for meeting requirements to reduce both greenhouse gas emissions and fleet petroleum consumption. The Executive in Charge concurred with OIG's findings and recommendations and provided technical revisions that were incorporated in OIG's report as appropriate. HR&A planned to work with OM to address the report findings and recommendations. [\[Click here to access report.\]](#)

### **VA Could Spend Up to \$17.5M for Excess Call Center Capacity and Duplicative Human Resource Services for Veteran Hiring Initiative**

OIG evaluated whether HR&A had adequate controls to ensure its Veteran Employment Services Office (VESO) acquisitions were appropriate and justified. OIG found that HR&A acquired excess services to support VESO operations when it expanded an interagency agreement (IA) with the Office of Personnel Management to provide two employment call centers operating 24 hours a day, 7 days a week. These call centers had call volumes so low during a 13-month period that each call center employee handled an average of 2.4 calls per day. Additionally, HR&A funded its IA to develop and maintain VESO's Veteran employment Web site, duplicating key components of existing HR&A and Veterans Benefits Administration (VBA) employment Web sites. VESO also awarded a \$4.4 million 1-year contract for human resources support services that duplicated its own internal capabilities and contracted for certain inherently Governmental functions. These acquisitions occurred because VESO did not conduct a thorough analysis to justify the need for the services. OIG estimated at least \$13.1 million will be spent through fiscal year 2015 on excess call center capacity unless corrective action is taken. These funds, and the estimated \$4.4 million, could be better used to provide employment services to Veterans with greater efficiency and accountability. OIG recommended HR&A improve its acquisition practices by assessing program needs against VA's existing capacities and capabilities and establishing program metrics. The Acting Assistant Secretary for HR&A concurred with OIG's findings and recommendations and provided an appropriate action plan.

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

### **Combined Assessment Program Summary Report Recommends Four Ways VA Can Improve Detection of Colon Cancer**

OIG completed an evaluation of colorectal cancer (CRC) screening and follow-up activities in Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to follow up on OIG's report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC

screening program. OIG evaluated CRC screening, follow-up diagnostic testing, and patient results notification at 53 facilities during Combined Assessment Program reviews performed from October 1, 2011, through September 30, 2012, and identified four areas that needed improvement. OIG recommended that clinicians:

(1) communicate positive CRC screening test, diagnostic test, and biopsy results to patients within 14 days and document notification in the electronic health record; (2) document follow-up plans or document that no follow-up is warranted within 14 days of positive CRC screening results; (3) discuss diagnostic testing options with patients and ensure desired testing is performed within 60 days of the positive CRC screening results; and (4) complete general or surgical evaluations within 30 days of positive CRC pathology. [\[Click here to access report.\]](#)

### **Poor Recordkeeping, Nurse Understaffing Noted at VA Long-Term Spinal Cord Injury Unit in Cleveland, Ohio**

OIG conducted an inspection to assess the merit of allegations regarding poor quality care and management on the long-term care (LTC) spinal cord injury (SCI) unit at the Louis Stokes VA Medical Center (VAMC) in Cleveland, OH. OIG did not substantiate allegations regarding infection control infractions. However, OIG found that staff nurses did not consistently document resident care and nurse managers had not taken effective actions in response to conduct, absences, and other issues. OIG also found understaffing on all shifts and that float staff pulled from other units during staffing shortages lacked the training and competencies to work with this complex and challenging patient population. OIG recommended that the VAMC Director ensure that: staffing levels on the LTC SCI unit are consistent with VHA requirements and the VAMC's SCI Master Nurse Staffing Plan, LTC SCI nursing staff consistently provide and document resident care, LTC SCI nurse managers take action to investigate and address conduct related issues, and float staff assigned to the LTC SCI unit have the training and competencies required for the unit. [\[Click here to access report.\]](#)

### **Inspection Results for Houston, Texas, VA Regional Office**

OIG evaluated the Houston, TX, VA Regional Office (VARO) to see how well it accomplishes its mission. OIG found VARO staff did not accurately process 37 (62 percent) of 60 disability claims OIG reviewed. OIG sampled claims for certain types of medical disabilities that OIG considered to be at higher risk of processing errors, so these results do not represent the overall accuracy of disability claims processing at this VARO. Specific to the claims OIG reviewed, 22 of 30 temporary 100 percent disability evaluations were inaccurate. Generally, these errors occurred because VARO management did not ensure staff took appropriate action to reduce benefits when required, and staff did not follow-up on requests for hearings where Veterans could present additional evidence to show that temporary 100 percent evaluations were still warranted. Also, staff misinterpreted VBA policy and inaccurately processed 15 of 30 traumatic brain injury (TBI) claims. Further, VARO managers did not ensure staff accurately completed Systematic Analyses of Operations (SAOs) or addressed Gulf War Veterans' entitlement to mental health (MH) treatment. VARO staff provided adequate outreach to homeless Veterans. OIG recommended the VARO Director implement a plan to ensure staff comply with VBA policy to reduce temporary

100 percent disability evaluations and follow up on hearing requests associated with proposed reductions in benefits. The Director should also ensure staff review the 689 temporary 100 percent disability evaluations remaining from OIG's inspection universe and take action to manage these evaluations appropriately. Further, the Director should implement a plan to ensure effective training and accurate second signature reviews of TBI injury claims. The Director should also provide refresher training and ensure the SAO checklist is amended to address all elements required by current VBA policy. The VARO Director concurred with OIG's recommendations. [\[Click here to access report.\]](#)

### **Inspection Results for Wilmington, Delaware, VARO**

OIG evaluated the Wilmington, DE, VARO to see how well it accomplishes its mission. OIG found VARO staff did not accurately process 17 (50 percent) of 34 disability claims OIG reviewed. OIG sampled claims for certain types of medical disabilities that OIG considered to be at higher risk of processing errors, so these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits. Specific to the claims OIG reviewed, 17 of 30 temporary 100 percent disability evaluations were inaccurate. Generally, these errors occurred because VARO staff did not input suspense diaries, take timely actions to schedule medical reexaminations, or reduce benefits as appropriate. All four TBI claims that VARO staff completed from April through June 2012 were correctly processed. Further, management ensured SAOs were complete and timely. However, staff did not always annotate Gulf War Veterans' entitlement to MH care on decision documents. Staff also did not provide adequate outreach to homeless Veterans in their area of jurisdiction. OIG recommended the VARO Director develop and implement a plan to ensure staff input suspense diaries, schedule medical reexaminations, and follow up to reduce benefits for temporary 100 percent disability evaluations when appropriate. The Director should also ensure staff review the temporary 100 percent disability evaluations to determine if reexaminations are required for those claims not reviewed as part of the OIG statistical sample. Management should also implement a plan to provide adequate outreach to homeless shelters and service providers. The VARO Director concurred with OIG's recommendations. [\[Click here to access report.\]](#)

### **Inspection Results for Clinics in Multiple Health Care Systems**

OIG reviewed the Central Texas Veterans Health Care System's (HCS's) five Community Based Outpatient Clinics (CBOCs) during the week of March 4, 2013, and the VA Texas Valley Coastal Bend HCS's four CBOCs during the week of April 1, 2013. The purpose of the review was to assess whether the CBOCs provide Veterans with consistent and safe high-quality health care. The review covered the clinical care components of women's health cervical cancer screening and tetanus and pneumococcal vaccinations. OIG also randomly selected the following CBOCs for site visits and evaluated credentialing and privileging, environment of care, and emergency management processes: Cedar Park CBOC, Cedar Park, TX; Corpus Christi Satellite Clinic, Corpus Christi, TX; Harlingen Outpatient Clinic, Harlingen, TX; Laredo CBOC, Laredo, TX; and McAllen Satellite Clinic, McAllen, TX. OIG noted opportunities for

improvement and made a total of 12 recommendations to the Veterans Integrated Service Network (VISN) and facility managers. [\[Click here to access report.\]](#)

OIG also conducted a review covering the same health care topics at the VA Pacific Islands HCS's six CBOCs during the week of March 18, 2013. OIG noted opportunities for improvement and made a total of four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

## **CRIMINAL INVESTIGATIONS**

### **Construction Company Owner Pleads Guilty to Obstructing a Federal Grand Jury Investigation**

The owner of a large construction company pled guilty to obstructing a Federal grand jury investigation by altering and deleting documents from his computer. A multi-agency investigation revealed that the defendant, a former minority owner of two Service-Disabled Veteran-Owned Small Businesses (SDVOSB), received a grand jury subpoena for records relating to his business dealings with another company and claims that this other company was an SDVOSB. The defendant subsequently deleted documents on his computer that were relevant to the pending investigation.

### **Former Philadelphia, Pennsylvania, VAMC Nursing Assistant and Accomplice Plead Guilty to Theft by Deception**

A former Philadelphia, PA, VAMC nursing assistant and an accomplice pled guilty to theft by deception. An OIG investigation revealed that the defendant stole the credit card number of a Veteran who resided at the medical center nursing home and, with the assistance of the co-defendant, used or attempted to use the number to obtain merchandise from various vendors. When interviewed, the former employee admitted that in addition to stealing the Veteran's credit card number, she also stole cash from various Veterans residing in the nursing home. The defendants were responsible for approximately \$17,000 in actual or attempted losses.

### **Former Pittsburgh, Pennsylvania, VAMC Program Support Clerk Charged with Theft of Government Funds and False Statements**

A former Pittsburgh, PA, VAMC program support clerk was charged in a criminal information with theft of Government funds and false statements. An OIG and VA Police Service investigation revealed that the defendant submitted to VA a fraudulent Special Order document from the PA Air National Guard. The Special Order stated that the defendant was being deployed for active duty, and as a result, VA placed the defendant into a military leave and pay status entitling the defendant to special leave and pay benefits. The investigation determined that the defendant accepted employment with a local township government and never reported for active duty. The defendant received \$14,164 in special leave and pay benefits, which included health care benefits.

### **Waco, Texas, VAMC Police Service Employee Arrested for Theft**

A Waco, TX, VAMC Police Service employee was arrested and indicted for theft of Government property and access device fraud. A VA OIG and General Services

Administration (GSA) OIG investigation revealed that the defendant fraudulently used the GSA fleet vehicle credit card to purchase gas and services for others in exchange for cash.

### **San Francisco, California, Social Worker Resigns After Drug Theft**

A former San Francisco, CA, social worker resigned her position after an OIG investigation determined that she entered a Veteran's room and stole his prescription morphine.

### **Veteran Arrested for Making Threats to Detroit, Michigan, VARO**

A Veteran was arrested for making terroristic threats by telephone. An OIG and local sheriff's investigation was initiated after the Veteran called the VA Crisis Hotline and said he had 4 pounds of C-4 and ball bearings and that he was going to the Detroit, MI, VARO for payback after being denied benefits. Arrest and search warrants were subsequently obtained for the Veteran and his residence. The MI State Police Special Weapons and Tactics team executed the entry and took the Veteran, who resisted and attempted to flee, into custody. Two shotguns and a 30-06 scoped rifle were recovered from the Veteran's home.

### **Veteran Arrested for Making Threats to VA and Congressional Staff**

A Veteran, upset with his VA medical care, was arrested for making threats. An OIG and Federal Bureau of Investigation investigation revealed that the defendant called a U.S. Congressman's office and threatened to physically assault a congressional staff member and a West Palm Beach, FL, VAMC patient advocate.

### **Veteran Arrested for Wire Fraud**

A Veteran was arrested for wire fraud after a multi-agency investigation revealed that from 2007 to 2013 he created a series of fraudulent charter schools in order to receive approximately \$25,000,000 in surplus Government computer equipment under a GSA Computers for Learning program. The defendant subsequently obtained computers from VA facilities located in various states. Also, the defendant stole the identity of a former VA employee and listed the employee as a director of one of the schools. The loss to VA is approximately \$1,932,070.

### **Veteran Sentenced for Theft of VA Benefits**

A Veteran was sentenced to 36 months' incarceration, 36 months' supervised release, and ordered to pay \$142,668 in restitution after pleading guilty to theft of Government property. An OIG investigation disclosed that the defendant made false statements in order to fraudulently obtain VA disability benefits. From 2000 to 2012, the defendant received VA compensation payments for panic disorder with agoraphobia, a back injury, and aid and attendance. The defendant admitted that he exaggerated his disabilities and lied about his ability to work. Because the Veteran violated his probation on an unrelated case by committing this fraud, he was sentenced to an additional 8 months' incarceration to be served consecutive to the sentence imposed in this OIG case. The loss to VA is approximately \$329,000.

**Veteran Indicted for VA Home Loan Guaranty Fraud**

A Veteran was indicted for fraudulently obtaining a \$58,000 VA Home Loan Guaranty. An OIG investigation determined that the defendant falsely certified to VA that he would occupy the home as his primary residence. The defendant provided a fraudulent lease agreement to VA and the lender regarding his primary residence in order to qualify for the home loan. In 2011, the defendant refinanced the home and again falsely certified that he had previously occupied the home as his primary residence. The defendant subsequently admitted that he never intended to occupy the home as his primary residence, and in fact, purchased the home for his son.

**Veteran Indicted for Theft of Government Funds and Health Care Benefits Fraud**

A Veteran was indicted for theft of Government funds and health care benefits fraud. The defendant falsely claimed compensation for disabilities to include pain in his back, ankle and shoulder pain that prevented him from lifting his child, pain that required him to walk with a cane, and depression so severe that he was unemployable and socially isolated. An OIG investigation revealed that the defendant frequented bars in the area, attended college, and played recreational men's softball at an extremely high athletic level. The loss to VA is \$119,490.

**Veteran Arrested for Theft of Government Funds and False Statements**

A Veteran was arrested for theft of Government funds and false statements. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant was awarded individual unemployability and Social Security Disability Insurance based on a false claim that he was unable to work due to service-related injuries. The defendant, a full-time treasurer of a Fire Department since 2007, had his salary paid to his wife in order to hide his income from VA and SSA. The loss to VA is \$60,837, and the loss to SSA is \$141,181.

**Granddaughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds**

The granddaughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA benefits from her grandmother's bank account after her grandmother's death in April 2009. The defendant admitted to using the VA funds for her own expenses. The loss to VA is \$51,227.

**Veteran Arrested at VA Facility for Drug Trafficking**

A Veteran was arrested at the Charlotte, NC, CBOC for drug trafficking and maintaining a dwelling in furtherance of narcotics trafficking. An OIG and local law enforcement investigation revealed that the defendant sold his VA-provided Oxycodone to other people, to include an undercover officer. The Veteran was held on a \$100,000 secured bond.

**Veteran Sentenced for Drug Trafficking**

A Veteran was sentenced to 87 to 117 months' incarceration and ordered to pay a \$50,000 fine and \$2,254 in court costs after being convicted of trafficking in opium or

heroin. An OIG and local drug task force investigation revealed that the defendant sold his VA-provided hydrocodone to other people, to include an undercover officer.

**VA Pension Beneficiary Sentenced for Theft of Benefits**

A VA pension beneficiary was sentenced to 21 months' home confinement with electronic monitoring, 5 years' probation, and ordered to pay \$351,000 in restitution to VA and New York City after pleading guilty to mail fraud and theft of Government funds. An OIG and local police investigation revealed that the defendant fraudulently received her deceased husband's teacher's pension, which she failed to report to VA, causing VA to pay her approximately \$132,000 in VA pension benefits she was not entitled to receive.

**U.S. Postal Service Manager Pleads Guilty to Mail Theft**

A U.S. Postal Service (USPS) maintenance manager pled guilty to mail theft. A VA OIG and USPS OIG investigation revealed that from April to September 2012 the defendant stole approximately 17 VA parcels of controlled narcotics intended for disabled Veterans.



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