CONGRESSIONAL TESTIMONY
Deputy Assistant Inspector General for Audits and Evaluations Testifies Before House Committee on Veterans’ Affairs on VA’s Longstanding Information Security Weaknesses
Sondra F. McCauley, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans’ Affairs, United States House of Representatives, on the security of VA’s information technology (IT) systems. Ms. McCauley discussed the results of the annual audit of VA’s consolidated financial statement that for the 15th year in a row found IT security was a material weakness. She did acknowledge some improvements in VA’s IT security management but noted that these improvements require time to be fully implemented and to show evidence of their effectiveness. Ms. McCauley was accompanied by Mr. Michael Bowman, Director, Information Technology and Security Audits Division. [Click here to access testimony.]

OIG REPORTS
Without Corrective Action Veterans Health Administration Could Inappropriately Award and Manage $795 Million in Support Service Contracts Over Next 5 Years
In fiscal year (FY) 2012, the Office of Management and Budget stated Government spending for support service functions quadrupled over the past decade. Previous Office of Inspector General (OIG) audits identified recurring systemic deficiencies in virtually all phases of the Veterans Health Administration’s (VHA) contracting processes. VHA’s support service contract costs increased 60 percent from approximately $503 million for about 5,100 contracts in FY 2012 to just over $805 million for about 4,700 support service contracts in FY 2013. OIG determined whether staff adequately developed, awarded, and monitored VHA support service contracts. OIG found VHA did not have effective internal controls or follow existing controls to ensure adequate development, award, monitoring, and documentation of support service contracts. Within OIG’s statistical sample of 95 support service contracts, OIG found 1 or more contract deficiencies in each. The contract deficiencies included insufficient documentation of key contract development and award decisions, assurance that paid invoice amounts were correct and funds were de-obligated following the contract completion, and a complete history of contract actions in VA’s mandatory Electronic Contract Management System. These deficiencies occurred because VHA management did not have an effective quality assurance program, Integrated Oversight Process reviews were not completed, and contracting officers did not delegate and meet with contracting officers’ representatives as required. If VHA does not take timely action to improve its support service contracting processes, OIG estimated it will inappropriately compete, award, and manage contract funds totaling $159 million annually or $795 million over the next 5 years through FY 2019. OIG recommended VHA improve their quality assurance and training programs, revise and complete Integrated Oversight Process reviews, objectively evaluate contracting officer’s performance, and ensure contracting officers’ representatives are delegated.
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and met with quarterly. The Under Secretary for Health (USH) concurred with OIG’s recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions. [Click here to access report.]

OIG Questions $5 Million in Public Affairs Outreach Contracts, Finds Inadequate Oversight and Lack of Performance Metrics

OIG evaluated the merits of Hotline complaints that VA’s Office of Public and Intergovernmental Affairs (OPIA) awarded an outreach contract to Woodpile Studios, Inc., alleging that it yielded no apparent increase in the use of VA health care, benefits, or services by veterans. Furthermore, the complaint alleged that OPIA then planned to solicit new outreach contracts without evaluating the effectiveness of the prior contract. OIG substantiated the allegations regarding OPIA mismanagement of its outreach contracts. OIG confirmed that in July 2010, OPIA awarded a contract to Woodpile Studios, Inc., to provide support for outreach campaigns at an initial cost of $5.2 million. However, OPIA could not demonstrate that contract activities resulted in increased awareness of and access to VA health care, benefits, and services for veterans. OIG also confirmed that OPIA solicited significant new outreach service contracts without evaluating the effectiveness of the previous contract. OPIA management stated that leadership turnover contributed to ineffective oversight of the outreach contract management and solicitations. Consequently, Woodpile contractors performed functions that were inherently Governmental. Questionable use of a labor-hour order instead of a performance-based contract contributed to invoices for activities that did not clearly link to accomplishment of VA outreach goals. By awarding new contracts without first evaluating the performance of the prior Woodpile contract, OPIA continued to expend funds on questionable outreach activities. OPIA also lacked performance metrics to fully assess improvements in access to VA benefits and services for veterans. OIG recommended that the Assistant Secretary for OPIA ensure effective oversight of outreach contract management and prevent contractors from performing inherently Governmental tasks. The Assistant Secretary should also implement metrics to ensure the outreach campaigns improve veteran awareness and access to VA services. The Acting Assistant Secretary for OPIA concurred with OIG’s report recommendations and summarized corrective actions for OIG consideration. OIG will monitor implementation of the corrective action plans. [Click here to access report.]

OIG Review Finds Quality and Coordination of Care Issues at Three VISN 11 Facilities Prior to Veteran’s Suicide

At the request of Congresswoman Jackie Walorski, OIG’s Office of Healthcare Inspections conducted an evaluation in response to allegations relating to access and quality issues at the Northern Indiana Health Care System (HCS), Fort Wayne, IN, affecting a patient who ultimately died by suicide after a self-inflicted gunshot wound. OIG determined that, although the outcome may have been the same for this patient, there were several missed opportunities where the patient’s care and the effectiveness of VA’s system processes could have been improved. Communication breakdowns and providers’ failures to review information available in the patient’s electronic health record (EHR) during care transitions compromised the patient’s mental health and primary care and diminished the benefits associated with the VA’s EHR system. The advantages of
comprehensive access to health records and exchange of health information, which are key features of the EHR system, were not consistently and effectively utilized. OIG found an absence of oversight in facilitating the continuum of this patient’s care. OIG found no indication that VA providers analyzed the patient’s multiple suicide risk factors. Further, although VHA has extensive policy specifications to help ensure a patient’s mental health course is comprehensively and continuously monitored, in the totality of this case, the policy was more abstract than applied. OIG made 14 recommendations. [Click here to access report.]

Review Finds Gaps in Patient Rounds and Documentation at Spinal Cord Unit, Hampton VA Medical Center, Hampton, Virginia
OIG conducted an inspection to assess the validity of allegations that improper nursing care resulted in a patient’s death at the Hampton VA Medical Center (VAMC), Hampton, VA. The complainant alleged that nursing staff did not conduct required rounds and failed to properly respond when staff received reports that the patient’s condition was deteriorating. The complainant also alleged that the patient’s health record was incomplete. OIG substantiated that the nursing staff did not perform patient rounds in accordance with VAMC policy, which requires a patient to be checked every 30 minutes. In addition, OIG found no documentation of actions taken when non-nursing staff notified Spinal Cord Injury staff of a change in the patient’s condition. OIG could not determine whether a failure to immediately assess the patient for possible problems led to this patient’s death. OIG recommended that the Hampton VAMC Director initiate a review to evaluate patient rounds and EHR documentation policies, train and educate appropriate staff to ensure consistent adherence to patient assessment and documentation procedures, and consult with Regional Counsel regarding institutional disclosure. [Click here to access report.]

OIG Recommends Strengthening Radiology Scheduling Processes at VA Loma Linda HCS, Loma Linda, California
OIG conducted a review to assess the merit of allegations concerning radiology scheduling and other administrative issues at the VA Loma Linda HCS. OIG substantiated that blind scheduling occurred; however, OIG found no evidence of treatment delays. OIG could not substantiate the allegation that patients did not consistently receive appointment reminder letters. OIG concluded that scheduling clerks needed to consistently document patients’ actions or dispositions in the Appointment Management and the Radiology Package programs. Program managers needed to monitor exam cancellations to ensure the appropriate reason is documented between these two programs. OIG substantiated that non-VA imaging exams were not uploaded into the EHRs for three subject patients. However, OIG concluded that uploading these images would not have influenced treatment courses for the patients because clinicians were aware of the exam results. OIG did not substantiate the allegation of staff mismanagement in the ultrasound walk-in clinic. OIG concluded that the number of staff on duty as well as the volume and complexity of ultrasound orders influenced the clinic’s early closure. OIG also did not substantiate that staff were not timely in notifying patients with Breast Imaging Reporting and Database System category zero results. OIG made five recommendations. [Click here to access report.]
Review Finds No Clinically Significant Delay in Gastroenterology Care at Durham VAMC, Durham, North Carolina

OIG conducted an inspection to determine whether a patient, who is now deceased, received appropriate and timely diagnostic testing for colorectal cancer (CRC) at the Durham VAMC in Durham, NC. OIG confirmed that almost 8 months elapsed between the patient’s initial gastrointestinal-related complaints in January 2011 until his colonoscopy in August. OIG did not find that this 8-month timeframe represented a clinically significant delay in care. The patient’s clinical presentation was unusual for a patient with CRC for both the early age of onset, as well as the short time period from initial symptoms to the discovery of advanced cancer. None of the providers were suspicious for CRC given the patient’s age at presentation and no known family history, and they reasonably considered inflammatory bowel disease as the more likely diagnosis. OIG could not say with certainty that the patient’s outcome would have been different had he received the diagnostic colonoscopy sooner. The colonoscopy and subsequent computerized tomography scan revealed the patient had a large mass and advanced CRC with metastasis to the liver. As CRC is typically a slow-growing cancer, the patient likely had advanced CRC at the time of his initial presentation with symptoms. OIG made no recommendations. [Click here to access report.]

Results for Benefits Inspection Review of Buffalo, New York, VA Regional Office

OIG evaluated the Buffalo VA Regional Office (VARO) to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 17 of 89 disability claims (19 percent) reviewed. OIG sampled claims considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Eight of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, generally because the VARO did not prioritize the processing of these cases to reduce benefits. This error rate has improved significantly in comparison with errors found in 17 of 30 claims reviewed in 2011. These errors resulted from staff not establishing suspense diaries in the electronic record for future VA medical reexaminations. VARO staff incorrectly processed 3 of 30 traumatic brain injury (TBI) claims because of a lack of training on Veterans Benefits Administration (VBA) rating policies. This is a significant improvement since our 2011 review where OIG found 8 of 11 TBI claims had processing errors. Staff also incorrectly processed 6 of 29 claims related to Special Monthly Compensation (SMC) and ancillary benefits, generally due to a lack of training. VARO managers still did not comply with VBA policy for completing Systematic Analyses of Operations (SAOs). In 2014, OIG determined 6 of the 11 mandatory SAOs lacked thorough analyses or were not completed at all. Staff also delayed completing 12 of 30 rating reduction claims OIG reviewed because VARO management did not prioritize this work. OIG recommended the Buffalo VARO Director implement plans to ensure staff prioritize benefits reductions cases and take appropriate action on the 206 temporary 100 percent disability evaluations remaining from our inspection universe. The Director should also implement plans to monitor the effectiveness of staff training and second-signature reviews of SMC cases, as well as ensure complete SAOs. The VARO Director concurred with all recommendations. [Click here to access report.]
Results for Benefits Inspection Review of Providence, Rhode Island, VARO
OIG evaluated the Providence VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 17 (31 percent) of 55 disability claims reviewed. OIG sampled claims considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 8 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate, primarily because management did not prioritize processing of claims requiring medical reexaminations. VARO staff processed 4 of 15 TBI claims incorrectly, generally by over evaluating TBI-residual disabilities. VARO staff also incorrectly processed 5 of 10 SMC and ancillary benefits claims due to a lack of recent training. Management did not timely submit or complete 3 of 11 SAOs due to inadequate oversight. VARO staff also did not correctly process 7 of 20 benefits reduction cases due to other higher workload priorities. OIG recommended the Providence VARO Director review the 70 temporary 100 percent disability evaluations remaining from OIG’s inspection universe and take appropriate action, as well as provide oversight to ensure staff follow VBA guidance on processing reminder notifications for medical reexaminations. The Director should ensure staff receive refresher training on proper processing of TBI and SMC and ancillary benefits claims, and implement plans to ensure effectiveness of that training. In addition, action is needed to develop and implement a plan to ensure timely completion of SAOs and amend, implement, and monitor the Workload Management Plan to ensure benefits reduction actions are processed timely. The VARO Director concurred with all recommendations.

Results for Benefits Inspection Review of Huntington, West Virginia, VARO
OIG evaluated the Huntington VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 27 (40 percent) of 68 disability claims OIG reviewed. OIG sampled claims considered at increased risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 16 of 30 temporary 100 percent disability evaluations were inaccurate, primarily because staff delayed reducing benefits after receiving medical evidence that veterans' disabilities had improved, or delayed scheduling required reexaminations after receiving reminder notifications. In contrast, 22 of the 30 cases reviewed during our 2011 inspection contained errors, generally because VARO staff did not enter suspense diaries in the electronic record. Staff incorrectly processed 6 of 26 TBI claims, primarily because they misinterpreted VBA policy for rating a TBI with a coexisting mental condition. By comparison, in 2011, 3 of 5 cases reviewed during an inspection contained errors due to staff misinterpreting TBI policy and inadequate quality assurance. VARO staff also incorrectly processed 5 of 12 claims related to SMC and ancillary benefits. Generally, SMC errors occurred because staff did not follow local second-signature policy. For two consecutive benefit inspections, VARO managers ensured SAOs were complete and timely. However, staff delayed completing 8 of 28 benefits reduction cases because VARO management considered other work to be a higher priority. OIG recommended the VARO Director develop and implement a plan to ensure staff review and take appropriate action on the 138 temporary 100 percent disability evaluations remaining from OIG’s inspection.
universe. The Director needs to ensure staff return insufficient medical examination reports, provide refresher training on processing TBI claims, and monitor training effectiveness. Further, the Director should provide training and ensure effective second-signature reviews of SMC claims, as well as develop a plan to prioritize actions on benefits reduction cases. The VARO Director concurred with all recommendations. [Click here to access report.]

Combined Assessment Program Reviews
In November 2014, 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 12 activities: (1) Quality Management, (2) Environment of Care, (3) Acute Ischemic Stroke Care, (4) Community Living Center Resident Independence and Dignity, (5) Magnetic Resonance Imaging Safety, (6) Medication Management, (7) Continuity of Care, (8) Management of Test Results, (9) Management of Workplace Violence, (10) Mental Health Residential Rehabilitation Treatment Program, (11) Suicide Prevention Program, and (12) Coordination of Care.

Central Alabama Veterans HCS, Montgomery, Alabama
Miami HCS, Miami, Florida
Robert J. Dole VAMC, Wichita, Kansas
Minneapolis VA HCS, Minneapolis, Minnesota
West Texas VA HCS, Big Springs, Texas
Jonathan M. Wainwright Memorial VAMC, Walla Walla, Washington

Community Based Outpatient Clinic Reviews
In November 2014, OIG published two Community Based Outpatient Clinic (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 purpose of the CBOC reviews was to evaluate three operational activities: (1) Environment of Care, (2) Alcohol Use Disorder, and (3) Medication Management.

Northern California HCS, Mather, California
Miami HCS, Miami, Florida

CRIMINAL INVESTIGATIONS
Former Director of the North Charleston, South Carolina, VA Consolidated Mail Outpatient Pharmacy Charged with Theft of Government Property
The former director of the North Charleston, SC, VA Consolidated Mail Outpatient Pharmacy was charged by the U.S. Attorney for the District of South Carolina with stealing prescription medications from VA.
Contractor Sentenced for Service-Disabled Veteran-Owned Small Business Fraud
The president and owner of a company providing office supplies and furniture to VA was sentenced to 8 months’ home confinement, 2 years’ supervised release, and ordered to pay VA restitution of $100,000 after pleading guilty to making false claims. An OIG investigation revealed that for a number of years the defendant represented to VA that her company was a Service-Disabled Veteran-Owned Small Business by claiming her father-in-law was the service-disabled owner and operator of the business. In fact, her father-in-law was not service-disabled and never owned or operated the business.

VA Contractor Sentenced for Wire Fraud
A VA contractor was sentenced to 20 years’ incarceration and 3 years’ supervised release after pleading guilty to wire fraud. An OIG investigation revealed that the defendant, who had a contract to supply latex gloves to VA, accepted more than $150 million from investors who believed they were financing his VA contracts. In reality, sales to VA were only about $25,000 per year. The defendant admitted to operating a large-scale Ponzi scheme, falsifying VA documents, and instructing his employees to impersonate VA officials. The loss to investors is $109 million. The defendant is expected to forfeit his interest in 10 properties and pay restitution of at least $50 million.

Veterans Sentenced for Assault of VA Police Officers in Waco, Texas, and Bath, New York VAMCs
A veteran was sentenced to 24 months’ incarceration, 3 years’ supervised release, and ordered to pay a $1,000 fine after pleading guilty to assault. An OIG investigation revealed that the defendant struck and injured a Waco, TX, VAMC police officer. In another case, a second veteran was sentenced to 3 years’ probation and 100 hours’ community service after pleading guilty to assaulting two VA police officers at the Bath, NY, VAMC.

Veteran Pleads Guilty to Assault on a Federal Officer at Wilmington, Delaware, VAMC
A veteran pled guilty to assault on a Federal officer. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant made an emergency phone call warning of a man with a gun at the Wilmington, DE, VAMC. When VA police officers responded, this same veteran pointed what appeared to be a handgun (later identified as a BB gun) at the officers. After failing to respond to repeated commands to drop his weapon, an officer fired two shots at the veteran with one shot grazing the veteran’s hand. During a subsequent interview, the defendant admitted that he was depressed, wanted to end his life, and was attempting to commit suicide by having a police officer shoot him. Subsequently, the veteran was committed to a psychiatric facility and later transferred to a Federal detention center.

North Little Rock, Arkansas, VAMC Employees Prosecuted for Threats to Federal Officials
A North Little Rock, AR, VAMC employee, who is also a veteran, was arrested for threats against a Federal official. An OIG investigation disclosed that the defendant
threatened to torture/kill his supervisor and also referenced going on a mass shooting spree at the VAMC. The defendant is currently being held without bond. A second North Little Rock, AR, VAMC employee, who is also a veteran, was convicted at trial of making threats against a Federal official and threats by interstate communications. An OIG investigation disclosed that the defendant contacted the VAMC and threatened to kill his supervisor. The defendant initially stated that he had a gun and that he had waited for his supervisor to come outside the VAMC. The defendant left and then made the threat to return and kill his supervisor. The defendant is currently being held pending a sentencing hearing.

Veteran Arrested for Making Threats to Reno, Nevada, VAMC Employees
A veteran was arrested for threatening several Reno, NV, VAMC employees. An OIG and VA Police Service investigation revealed that the defendant, while receiving care at the VAMC, threatened to shoot three VA staffers with an M-16 rifle if he did not receive proper medical care. The defendant was criminally charged based on the severity of the threats and his prior criminal history.

Veteran Pleads Guilty to Theft and Identity Fraud
A veteran pled guilty to theft of Government funds and aggravated identity fraud after obtaining fraudulent benefits from VA and the Social Security Administration (SSA). A VA OIG and SSA OIG investigation revealed that the defendant had been collecting Individual Unemployment benefits since 1997 because of his fraudulent reporting of severe disabilities to VA and SSA. During this time, the defendant was working as a golf professional, pastor, and car salesman in multiple states. The aggravated identity charge was a result of the defendant working and purchasing vehicles using other individuals’ personal information in an attempt to hide his employment history from VA. The loss to VA is approximately $365,000, and the loss to SSA is approximately $407,000.

Non-Veteran Indicted for Identity Theft
A non-veteran was indicted for theft of identity, theft of services over $10,000, and theft by deception over $500. An OIG and local police investigation revealed that the defendant stole his brother’s identity and defrauded VA by obtaining controlled substances, health care, and beneficiary travel payments from the Louisville, KY, VAMC. The loss to VA is $20,567.

Defendant Arrested for Identity Theft
A defendant, who stole the identity of a veteran, was arrested for use of unauthorized access devices and aggravated identity theft. An OIG, Internal Revenue Service Task Force, and FBI investigation revealed that the defendant used a veteran’s identity that she obtained from a Kaplan University employee who oversaw VA education benefits.

Non-Veteran Arrested for Forgery and Identity Theft
A non-veteran was arrested for forgery and identity theft. An OIG and local police investigation revealed that the defendant provided false local court documents to VA
that named the defendant as a court-appointed guardian for a veteran. The documents included false court orders, as well as forged medical reports from doctors.

**Veteran Charged with Theft of VA Benefits**
A veteran was charged with theft of public money. An OIG investigation revealed that the defendant submitted an altered DD-214 to VA, fraudulently reporting that he received multiple combat awards including two Purple Hearts and a Silver Star. Based on the fraudulent DD-214, the defendant was awarded compensation for post-traumatic stress disorder and shell fragment wounds. When interviewed, the defendant admitted to not receiving any combat awards and to not suffering any combat injuries while in Vietnam. Based on the investigation, VA terminated the award. The loss to VA is $174,656.

**Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds**
The daughter of a deceased VA beneficiary was indicted and arrested for theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother’s death in December 2008. The loss to VA is $84,029.

**Veteran’s Daughter and Her Boyfriend Sentenced for Theft**
The daughter of a veteran was sentenced to 9 months’ incarceration, and her boyfriend was sentenced to 20 days’ incarceration after pleading guilty to theft. The defendants were also ordered to pay VA $25,423 in restitution. An OIG investigation revealed that the defendants contacted a VA Call Center and posed as the veteran in order to change the mailing address of the veteran’s VA benefits checks. The defendants then received, forged, and deposited the checks into a bank account they had opened in the veteran’s name.

**Defendant Arrested for Possession with Intent to Distribute a Controlled Substance at the Bronx, NY, VAMC**
A defendant was arrested for possession with intent to distribute a controlled substance for engaging in a conspiracy to distribute more than 5 kilograms of cocaine at the Bronx, NY, VAMC. An OIG, U.S. Postal Inspection Service, and Drug Enforcement Administration’s New York Organized Crime Drug Enforcement Strike Force investigation revealed that six U.S. Postal Service (USPS) Priority Mail parcels containing 1 to 2 kilograms of cocaine each were mailed from Puerto Rico to the medical center warehouse. The defendant would take possession of these packages from a VA employee and subsequently drive off station. Previously, two VAMC employees were arrested for their participation in this conspiracy. The defendant was arrested at his residence, and a search of the defendant’s vehicle revealed several hidden compartments utilized to transport contraband.
USPS Manager Arrested for Theft of Mail
A senior level USPS Service manager was indicted and arrested for theft of mail. A VA OIG, Postal Inspection Service, and Postal OIG investigation revealed that the defendant stole a large number of controlled VA pharmaceuticals shipped to veterans in Kentucky and Indiana. A search warrant was executed during the investigation, which resulted in the recovery of approximately 2,000 pills and numerous VA pills bottles. The loss to VA is $2,000.

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