



Department of Veterans Affairs

Office of Inspector General

June 2015 Highlights

CONGRESSIONAL TESTIMONY

Office of Inspector General Testifies Conditions Persist That Put Beneficiaries and Their VA-Derived Estates at Unnecessary Risk

Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, concerning the Office of Inspector General's (OIG) work related to VA's Fiduciary Program. He told the Committee that despite major changes to structure, oversight and operation of the Fiduciary Program since OIG's 2010 audit, significant challenges remain. Mr. Abe discussed recent audit work in the Fiduciary Program including a report issued on June 1st, *Audit of the Fiduciary Program's Management of Field Examinations*, where OIG reported that the Veterans Benefits Administration (VBA) faces a large and growing backlog of field examinations, which are critical tools for VBA to assess the competency and welfare of these beneficiaries. His testimony also included past and recent investigations that have uncovered unscrupulous fiduciaries who have misappropriated from tens of thousands to millions of dollars from the accounts of unsuspecting VA beneficiaries under the supervision of the Fiduciary Program. This type of theft can only be stopped by aggressive and consistent oversight by the Fiduciary Program. Mr. Abe was accompanied by Mr. Quentin G. Aucoin, Assistant Inspector General for Investigations, and Mr. Tim Crowe, Director, Bay Pines Office of Audits and Evaluations.

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

OIG REPORTS

Tomah VA Staff Acted Appropriately for Patient Experiencing Acute Stroke at Rural Hospital Not Equipped To Treat Problem of This Magnitude

OIG conducted an inspection at the request of Senator Tammy Baldwin and Senator Ron Johnson to assess allegations of poor care and delayed care of a patient at the Tomah VA Medical Center (VAMC) Urgent Care Clinic (UCC) in Tomah, WI. OIG did not substantiate the general allegations of poor care and delayed care; that the patient waited 3 hours before being seen; that other patients arrived, were treated, and released before the case patient; that a physician was unaware of acute ischemic stroke symptoms and treatment; or, that the Tomah VAMC computerized tomography machine was broken. OIG substantiated the allegation that the physician did not affirmatively diagnose the first neurologic event the patient experienced as a transient ischemic attack or acute ischemic stroke; however, the physician properly considered broad diagnostic possibilities for the syncopal episode, which occurred while the patient was in the Tomah VAMC UCC waiting room awaiting a mental health (MH) evaluation. OIG did not substantiate that the physician failed to treat the patient's second neurologic event, an acute ischemic stroke, with sufficient urgency. OIG determined that transferring the patient to Gundersen Health System by ground ambulance was the appropriate action after a stroke was definitively diagnosed. OIG found that the Tomah

VAMC does not own or operate an air ambulance and that one was not available to transfer the patient. OIG concluded that, overall, the UCC staff acted appropriately in the face of a patient experiencing a sudden and unexpected acute ischemic stroke while waiting for a MH evaluation in a rural hospital that is not equipped to treat a health problem of this magnitude. OIG identified opportunities for improvement, none of which impacted this patient's care, and made three recommendations to the Interim Under Secretary for Health and six recommendations to the Tomah VAMC Director.

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

Atlanta VAMC Attempted To Provide Mental Health Treatment to Troubled Veteran, Review Confirms Health Information Disclosed

At the request of the Chairman and Ranking Member, Senate Committee on Veterans' Affairs, and the Chairman and Ranking Member, House Committee on Veterans' Affairs, OIG conducted a review of a patient's care at the Atlanta VAMC (facility), Decatur, GA, prior to the patient's death and evaluated an improper disclosure of protected health information outside VA. OIG determined that facility staff provided, or attempted to provide, appropriate MH treatment and psychosocial support services. Although the veteran verbalized suicidal ideation, she was reluctant to engage in psychotherapy. The veteran missed two MH appointments, but when contacted, exercised her right and declined further MH services. OIG identified appointment scheduling and follow-up deficiencies, a 23-day delay in placing a high-risk for suicide flag, and inconsistent compliance with some high-risk protocol requirements. However, OIG does not believe that these deficiencies had a direct impact on the outcome, as the veteran died more than 2 months after she was referred for placement on the high-risk protocol, more than a month after the missed MH appointments, and 1 week after a face-to-face contact with a clinician. OIG confirmed that information in the veteran's electronic health record (EHR) was improperly disclosed. The record was designated as "non-sensitive" at the time of the disclosure, and Veterans Health Administration (VHA) currently lacks the ability to audit access to non-sensitive records. OIG recommended that the Interim Under Secretary for Health evaluate options to identify individuals who access non-sensitive patient EHRs. OIG also recommended that the facility Director ensure that staff comply with guidelines for appointment scheduling, notification, and follow-up; make patient contacts in accordance with treatment plans; and adhere to suicide prevention program requirements. The Interim Under Secretary for Health, and the VISN and facility Directors, concurred with our recommendations and provided acceptable action plans. [\[Click here to access report.\]](#)

Allegation That Greater Los Angeles Health Care System Deleted Magnetic Resonance Imaging Exam Requests Unfounded But Delays May Have Put Some Veterans at Risk for Complications

OIG conducted an inspection in response to congressional requests to assess the merit of allegations regarding the deletion of magnetic resonance imaging (MRI) exam requests (orders) and the destruction of medical files at the VA Greater Los Angeles Healthcare System (facility), Los Angeles, CA. OIG did not substantiate that MRI orders were deleted or mass purged or that records were destroyed. OIG found that orders cannot be deleted or destroyed from the computer system. Each order OIG reviewed

was canceled individually. OIG did not substantiate the allegation that patients suffered adverse or clinically significant consequences from canceled dated MRI orders in late 2008. OIG reviewed 1,474 MRI orders and found sufficient evidence to support that cancelations did not impact patient care outcomes. However, OIG identified quality of care concerns where a delay or inability to schedule MRIs placed patients at risk for more complicated and prolonged management. Incidentally, OIG identified 170 MRI studies ordered in 2008 that were still pending. OIG determined the facility had not consistently implemented its process to cancel orders older than 1 year. Additionally, radiology clerical staff did not consistently annotate accurate reasons for canceled orders and appointments. OIG also found that the facility should strengthen its view alert notification process to ensure ordering providers were notified of canceled orders. OIG recommended that the Facility Director ensure that the Radiology Department managers confirm that ordered exams are scheduled and completed within the VHA required timeframe, periodically review pending lists of MRI exams to ensure timely scheduling, and implement a consistent procedure for canceling MRI orders. OIG also recommended that responsible providers are notified of canceled MRI orders and that radiology clerical staff accurately annotate reasons for canceling MRI orders and appointments in the EHR. [\[Click here to access report.\]](#)

Improvements Needed in Patient Care, Dental and Neurosurgical Services, and Maternity Information at Muskogee, Oklahoma, VAMC

At the request of Senator James Inhofe, OIG conducted an evaluation of several allegations concerning quality of care and access to care at the Jack C. Montgomery VAMC, Muskogee, Oklahoma. OIG substantiated some of the allegations regarding quality of care. OIG substantiated a patient did not receive appropriate treatment for his back pain because of a delay in the diagnosis of a malignancy, which may have been the source of pain. OIG did not substantiate a failure to provide a patient operative care associated with bleeding gastrointestinal polyps, a failure in VA agreeing to pay for a patient's open heart surgery resulting in a delay, or a provider's failure to address leg swelling or a nose bleed affected the rupture of a patient's "brain aneurysm." OIG did not substantiate the VA advised a patient to wait until he tore the remaining two healthy discs in his back and then call 911 to make it a medical emergency. OIG did not substantiate a delay in scheduling a computed tomography scan and a colonoscopy. OIG substantiated the access to care allegations. OIG substantiated a patient experienced poor access to dental services and that the patient was not notified by mail of his scheduled appointment. OIG also substantiated that another patient experienced poor access to neurosurgical services. OIG conducted a broad review of the facility's Non-VA Care Coordination maternity care processes in response to allegations concerning delayed and denied consult requests. While OIG did not substantiate the allegations, OIG found that information pregnant patients receive in a facility document, as well as the non-VA maternity care providers' authorization document, are potentially ambiguous in wording when applied to select cases. In addition, OIG found concerns with Dental Services, parking access and safety, and provider documentation of telephone communications. OIG made eight recommendations.

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

OIG Recommends VA Consider Expanding Recovery Coordination Activities for Post-Traumatic Stress Disorder Patients in Des Moines, Iowa, VAMC Review

OIG conducted an inspection at the request of Senator Joni Ernst to review allegations regarding poor MH care resulting in a patient's death at the VA Central Iowa Health Care System (VACIHCS), Des Moines, IA. OIG did not substantiate the allegation that the patient had been denied long-term MH services at the time of a winter 2015 Emergency Department visit. OIG found no documentation that the patient had requested these services or that his clinical condition would have warranted admission at that time. OIG did not substantiate that the patient received poor quality of care through the Emergency Department but concluded that VACIHCS did not comply with VHA policy regarding case management services. OIG reviewed MH programs at VACIHCS from the perspective of how they interfaced to provide care for this patient. The facility appeared to be substantially in compliance with its policy regarding time frames for consult completion. The patient did not experience a delay in obtaining MH, as he had not requested these services in the 2 years prior to his winter 2015 Emergency Department visit. OIG determined that the patient was not contacted by the local recovery coordinator because his name did not appear on the list of seriously mentally ill patients; for purposes of recovery coordinator activities, seriously mentally ill patients are considered to be those patients with a diagnosis of schizophrenia, bipolar disorder, or psychoses. This patient had anxiety, depression, and post-traumatic stress disorder (PTSD) but had never been diagnosed with schizophrenia, bipolar disorder, or a psychoses that would have triggered contact from the local recovery coordinator. OIG made two recommendations. The Interim Under Secretary for Health and the Acting Veterans Integrated Service Network (VISN) and Acting Facility Directors concurred with the recommendations and provided an acceptable action plan.

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

Review Finds Many Inappropriate Referral and Scheduling Practices at Togus, Maine, VAMC Mental Health Service

OIG conducted an inspection at the request of former Ranking Member of the House Committee on Veterans' Affairs, Michael Michaud, regarding allegations of mismanagement of MH consults and other access to care concerns at the VA Maine Healthcare System (facility). OIG substantiated allegations that staff were directed to discontinue using the consult package for MH services referrals in certain circumstances and language in the consult package directed providers not to request MH consults if the patient was not willing to be seen within 14 days. OIG also found that referral processes within the MH services made it difficult to track whether patients' requests for services were met. OIG did not substantiate the allegation that staff were directed to restrict who could submit MH consults. Although OIG did not substantiate the allegation that staff were directed to close consults before services were rendered, OIG found that this practice occurred. OIG did not substantiate the allegation that facility leadership directed staff to utilize workshops to meet VHA's benchmark for timely MH assessments and follow-up. OIG found that there were concerns about the clinical appropriateness of certain group workshops, patients' attendance in workshops did not "count" towards meeting VHA performance measures, and some of the MH Chief's correspondence with staff emphasized meeting performance measures. OIG did not

substantiate the allegation that, in order to meet VHA's benchmark for same day access, staff were directed to use drop-in clinics instead of scheduling appointments or that staff were directed to omit certain information from clinical notes to limit the number of veterans seeking MH services. OIG did not substantiate the allegation that licensed independent providers were directed to see patients for medication management. OIG substantiated the allegation that some of the alleged practices have persisted despite other reviews. OIG made eight recommendations. [\[Click here to access report.\]](#)

Physician Possessed Proper Credentials but Not Granted Privileges To Interpret Medical Studies at Columbia, South Carolina, VAMC

OIG conducted an inspection to assess the merit of allegations received from Senator Bernie Sanders, then-Chairman of the Senate Veterans' Affairs Committee, regarding provider credentialing and privileging concerns at the William Jennings Bryan Dorn VAMC (facility), Columbia, SC. OIG substantiated that a cardiologist was interpreting non-invasive vascular studies without being granted privileges to do so by the facility; however, the cardiologist had the required education and training and was subsequently granted the required privileges. OIG substantiated that the standards of the American College of Radiology and Intersocietal Accreditation Commission were not used for the interpretation and reporting of non-invasive vascular imaging studies. However, the VHA does not require adherence to these standards, and the facility was compliant with VA National Radiology Program Standard Operating Procedures. OIG did not substantiate that a community based outpatient clinic (CBOC) ultrasound technician did not have the required training and competencies to perform non-invasive vascular studies. OIG recommended that the Facility Director ensure that provider privileges reflect current practice. The VISN and Facility Directors concurred with our recommendation and provided an acceptable action plan. [\[Click here to access report.\]](#)

VA Facility Not in Compliance with VHA Outpatient Scheduling Guidelines

OIG conducted a review at the request of former Representative Jack Kingston to assess allegations regarding MH and treatment deficiencies at the Brunswick CBOC, Brunswick, Georgia. OIG substantiated that a patient was unable to contact or schedule an appointment with his psychiatrist over several weeks in late summer 2014 when the provider was on leave. It did not appear that the psychiatrist informed the My HealthVet coordinator or designated a surrogate to respond to secure messages in her absence. OIG found that the process of scheduling follow-up appointments did not comply with VHA outpatient scheduling guidelines. OIG did not substantiate that the patient did not have a treatment plan for his PTSD, although OIG did find long periods when the patient did not see his psychiatrist or social worker therapist. While OIG confirmed that the patient was not prescribed anti-anxiety medications by a VA provider for more than a year, OIG did not substantiate the CBOC providers withheld this medication as the complainant implied. OIG substantiated that the CBOC did not offer group therapy for patients with PTSD at the time of the complaint and OIG substantiated that the patient was not receiving or participating in psychotherapy at the time of the complaint. OIG made five recommendations. [\[Click here to access report.\]](#)

Audit of VA's Fiduciary Program Shows Growing Backlog of Field Exams To Assess Competency of Vulnerable Veterans

The Fiduciary Program was established to protect veterans and other beneficiaries who, due to injury, disease, or age, are unable to manage their VA benefits. Field examinations are a critical tool for VBA to assess the competency and welfare of these beneficiaries. OIG conducted this audit to assess whether the Fiduciary Program scheduled and completed field examinations within timeliness standards. OIG concluded VBA did not meet timeliness standards for about 45,500 (42 percent) of approximately 109,000 pending and completed field examinations during calendar year (CY) 2013. OIG followed-up by examining reported program performance for the first 9 months of CY 2014 and identified approximately 21,900 field examinations not completed and exceeding VBA timeliness standards, representing an approximately 15 percent increase. This occurred because Field Examiner staffing did not keep pace with the growth in the beneficiary population, and VBA did not staff the hubs (VA consolidated individual VARO fiduciary activities into six regional Fiduciary Hubs) according to their staffing plan. During CY 2013, the beneficiary population under the supervision of the Fiduciary Program grew 10 percent, while the number of Field Examiners assigned grew 2 percent. VBA's staffing plan set a target of 1 Field Examiner for every 325 beneficiaries. However, as of September 30, 2014, VBA employed 1 Field Examiner for every 386 beneficiaries supervised under the Fiduciary Program. Untimely field examinations placed about \$360.7 million in benefit payments and about \$487.6 million in estate values at increased risk. In addition, VBA did not schedule required field examinations for a projected 1,800 beneficiaries in CY 2013. Lapses in scheduling occurred because of inadequate management oversight. As a result, beneficiaries' well-being and approximately \$36.1 million in benefit payments were placed at increased risk. [\[Click here to access report.\]](#)

Veterans Health Administration Consolidated Mail Outpatient Pharmacies Mail Medications to Nearly One in Five Deceased Patients After Date of Death

OIG conducted an inspection to review allegations regarding the quality and coordination of care of a patient at the Kansas City VAMC, Kansas City, MO, and the Kirksville VA Clinic, a Harry S. Truman Memorial Veterans' Hospital, Columbia, MO, clinic. OIG substantiated that the patient experienced multiple hip dislocations after replacement surgery. The recurrent hip dislocations resolved after revision surgery. OIG did not substantiate that the Kansas City VAMC delayed payment for ambulance transportation. OIG substantiated that the patient's evaluation for potential aortic aneurysm repair was delayed, but did not substantiate that the aortic aneurysm probably resulted in his death or that VA providers inappropriately postponed surgical repair. OIG substantiated that the patient did not receive appropriate evaluation for recurrent falls and weakness; additionally, his primary care provider did not follow usual practice in prescribing medications associated with increased fall risk. OIG could not substantiate that the patient was involved in a motor vehicle accident at the VA. OIG found reports of a fall but no reports of a motor vehicle accident for the specified date. OIG substantiated that prescriptions were mailed to the patient after his death. OIG reviewed pharmacy data files to determine whether medications were being dispensed after patients' deaths across VHA. OIG found that 17.2 percent of patients, or

29,173 patients, who died between July 1, 2013, to June 30, 2014, were dispensed at least one prescription after death on the average of 33 days after death; 96 percent of the dispensed medications were for non-controlled substances. OIG could not substantiate the allegation that the patient was denied care three times at the Kirksville CBOC. OIG made five recommendations. The Interim Under Secretary for Health, VISN and Facility Directors concurred with our recommendations and provided acceptable action plans. [\[Click here to access report.\]](#)

\$43.1 Million in VHA Funds Went Unmanaged for 3 Years While Parked at the U.S. Government Printing Office

OIG received a Hotline allegation that VA had “parked” approximately \$43 million in annual appropriations at the U.S. Government Printing Office (GPO) and that the funds remained unexpended with little activity since the transfer of funds in 2011. “Parking” refers to the transfer of funds to a revolving fund through an intra-agency agreement in an attempt to keep the funds available for new work after the period of availability for the funds expires. OIG initiated this review to determine if VA officials appropriately managed these funds. OIG substantiated that VA parked \$43 million dollars at GPO for an excessively long period. VA had no contract or agreement with GPO on the specific need for these funds. OIG found that approximately \$35.2 million of approximately \$43.1 million remained unused at GPO as of July 2014 in a deposit account for enrollment communications. OIG identified approximately \$5.6 million had been paid to the VA Supply Fund as service fees, despite there being no services rendered. In addition, VA only expended approximately \$2.3 million over the 34-month period from October 2011 through July 2014, which was not used consistently with the intended need. OIG determined VHA Chief Business Office (CBO) officials, in conjunction with VA Supply Fund officials, accepted almost \$43.1 million of fiscal year (FY) 2011 funds from within VHA without a bona fide need. CBO transferred approximately \$43.1 million in FY 2011 appropriations to the Supply Fund to print and distribute tailored handbooks, but the funds were deposited in an unrelated account designated for enrollment communications at GPO. As such, CBO officials were able to use the funds in the GPO account at their discretion with no designated purpose. Supply Fund management acknowledged that they should not have accepted the funds without a bona fide need or charged fees on funds transferred through these accounts. OIG found that Supply Fund staff did not provide adequate fiscal oversight of the transferred funds. Supply Fund staff did not regularly review open obligations as required by VA policy or reconcile VA’s financial accounting records with source documents related to the transferred funds. Thus, this funding went essentially unmanaged for 3 FYs. Then, in April 2014, Supply Fund management inappropriately changed the funds’ obligation end dates without ensuring that the obligations were still valid. Further, OIG found a lack of transparency in VA’s financial accounting records with respect to the change of obligation end dates. OIG concluded a breakdown of VA fiscal controls and a lack of oversight led to the parking of funds for an excessively long period and the failure to detect and properly use and manage these funds. VA financial and Supply Fund policies contain provisions on the management, use, and oversight of appropriated funds. However, the policies were not followed and there was a lack of supervisory review to ensure the policies were implemented properly. OIG recommended VA consult with its Office of General

Counsel to remedy the inappropriate expenditure of approximately \$2.3 million of expired funds, take action to deobligate any outstanding balances as deemed appropriate, and evaluate the need for Supply Fund to refund the service fees valued at \$5.6 million. OIG also recommended VA implement corrective actions to ensure fiscal controls are enforced to avoid future misuse of appropriated funds. OIG recommended VA review fiscal controls in the Financial Management System to ensure data integrity and an audit trail that reflects the occurrence and source of any accounting record changes. Finally, OIG recommended VA confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any, against management for directing the misuse of approximately \$43.1 million of FY 2011 appropriated funds. The Principal Executive Director for the Office of Acquisition, Logistics, and Construction agreed with our findings and recommendations and provided plans to implement acceptable corrective actions. The Deputy Assistant Secretary for Finance also concurred and will put processes in place to track the history of new obligations. The Deputy Under Secretary for Health for Operations and Management concurred and will confer with the Office of General Counsel to determine the appropriate administrative action to take. [\[Click here to access report.\]](#)

OIG Confirms Second Instance of Data Manipulation by a Houston, Texas, VA Regional Office Employee

On December 13, 2014, OIG received an allegation from VBA senior leadership in VA Central Office that a Houston VA Regional Office (VARO) employee inappropriately removed veteran benefit claims controls from their electronic record. VBA uses electronic system controls to identify types of claims, and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. Similarly, OIG received, and confirmed, an allegation of data manipulation at the Houston VARO several months earlier by another employee. However, the periods of each employee's alleged data manipulations did not overlap. OIG substantiated the most recent allegation that the employee inappropriately cancelled and cleared controls in the electronic record used to track and identify benefits claims without taking proper actions to complete the claims. VBA's internal review team determined the employee incorrectly cancelled and cleared system controls in 81 (89 percent) of 91 claims pending in FY 2013. The VBA team's review was limited to FY 2013, as a specific inventory goal was in place that year, and as the employee's number of cases cancelled in FY 2014 was determined to be significantly lower. OIG sampled 32 of the 81 (40 percent) cases and determined the internal review team accurately identified cases that were not completed properly. The employee conceded the actions were inappropriate and stated the actions were the result of attempts to improve the appearance of the pending claim inventory for the employee's team. Furthermore, the employee stated he had no knowledge of any other employees manipulating data. These inappropriate actions misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may never have received decisions on their claims if the VARO's internal review team had not discovered the improper actions by the employee. However, as VBA completed over 1.1 million claims in FY 2013, and the

Houston VARO completed over 38,200 in FY 2013, the 81 cases determined to be incorrectly cancelled and cleared by the employee does not materially impair VBA's data integrity associated with its reported pending workload of claims nationwide. Therefore, OIG recommended the Houston VARO Director take immediate action to correct, as appropriate, all actions the employee took to cancel and clear controls so that veterans claims are accurate moving forward. OIG also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee. Finally, OIG recommended the Director submit the remaining and previously unavailable claims the employee cancelled in FY 2013 to OIG for our review. [\[Click here to access report.\]](#)

Review Finds Excessive Waste When Pharmacy Staff Prepares Compounded Sterile Products at San Antonio, Texas, VA Facility

OIG conducted an inspection to assess the merit of allegations made by a complainant regarding the intravenous compounded sterile product (CSP) medication error rate, improper aseptic technique while mixing CSPs, and excessive CSP wastage at the South Texas Veterans Health Care System (system), San Antonio, TX. A CSP is a pharmaceutical preparation that has been made or modified using manufacturer labeled instructions in a controlled sterile environment. OIG did not substantiate the allegation that the system's pharmacy compounding error rate was high. OIG also did not substantiate that pharmacy personnel did not observe aseptic technique while compounding sterile products. However, OIG did substantiate excessive waste of CSPs. Because the stability of most compounded sterile products increases with refrigerated storage, OIG recommended that the System Director ensure that processes be developed to improve storage conditions of CSPs on patient units in an effort to reduce unnecessary waste. [\[Click here to access report.\]](#)

Unclear Eligibility Requirements Has Resulted in Inequitable Access to VHA's Homeless Providers Grant and Per Diem Program

OIG conducted this audit to determine if VHA's Grant and Per Diem (GPD) program case management oversight ensures services to eligible veterans are provided in accordance with grant agreements. OIG found VHA's oversight of homeless providers' case management helped to ensure services were provided in accordance with grant agreements for those veterans in the program. However, eligibility requirements need to be clarified so all homeless veterans have equal access to case management services. OIG found 15 of 130 VA medical facilities (12 percent) within 6 different VISNs required veterans to be eligible for VA health care to participate in the GPD program. GPD policy only requires an individual to have served in the active military, naval, or air service, and been discharged or released under conditions other than dishonorable. The VHA Handbook and US Code provide minimum active duty requirements to be eligible for VA health care benefits. VHA has been silent on addressing this additional eligibility requirement in its current policy. VHA has not aggressively pursued an Office of General Counsel formal opinion and confusion at all program levels regarding eligibility requirements has resulted in inequitable access to case management services. In addition, OIG observed medication security issues at 5 of 22 providers (23 percent) OIG visited within 5 of the 6 medical facilities in our

sample. This occurred because VHA and program providers did not ensure controls were sufficient to properly secure medications. As a result, veterans' health and rehabilitation are potentially at risk. [\[Click here to access report.\]](#)

Staff Purchased Excess Medical Supplies and Did Not Identify Inventory Discrepancies at the East Orange, New Jersey, VAMC

OIG evaluated the merits of allegations that Logistics Service at the East Orange VAMC purchased excess medical supplies resulting in mismanagement of Government resources and that a Logistics Service employee was misusing official time by leaving early every Friday. OIG substantiated the allegation that Medical Supply Distribution Section (MSDS) staff at the East Orange VAMC purchased medical supplies that were beyond normal stock levels. VHA policy defines a normal stock level as the maximum amount of an item that should be maintained in stock. During an inspection of primary storage areas at the medical center, OIG identified about 2,900 excess medical supply items valued at approximately \$48,100. OIG reviewed inventory reports to determine whether additional excess medical supplies existed. However, OIG determined that the inventory reports were inaccurate, and as a result, OIG could not determine the extent of excess medical supplies at the East Orange VAMC. These inventory issues occurred because Logistics Service and MSDS management did not effectively monitor the staffs' management of the facility's medical supply inventories. Additionally, when they did identify inventory discrepancies, logistics staff did not determine why discrepancies were occurring. Without such action, East Orange VAMC cannot implement corrective actions to account for its physical inventories or increase the accuracy of the information in their inventory system. OIG did not substantiate the time and attendance allegation. OIG recommended the Interim Director of VISN 3 ensure the VA New Jersey Health Care System take steps to improve medical supply inventory controls to minimize purchases of excess medical supplies. [\[Click here to access report.\]](#)

OIG Recommends VA Define Specific Criteria for Solo Physicians' Professional Practice Evaluations in VHA Facilities

OIG conducted a review to assess whether VHA facilities with a solo physician in four selected specialties (gastroenterology, pathology, nuclear medicine, and radiation oncology) used specialty-specific information for professional practice evaluation and had a physician with comparable privileges generate and/or review the professional practice information. Eighteen facilities validated that they had a solo physician in 1 or more of the 4 specialties during FY 2014 for a total of 21 physicians. This review covered all affected facilities. OIG found good compliance with facilities completing general Focused and Ongoing Professional Practice Evaluation forms. However, each facility is able to select the criteria or monitors they use for professional practice evaluations, and a majority of the information was generic. OIG made two recommendations. [\[Click here to access report.\]](#)

OIG Finds Reprocessing Equipment Is Properly Maintained at Huntington, West Virginia, VAMC

OIG conducted an inspection in response to complaints concerning responsibility for, and proper maintenance of, the MEDIVATORS Advantage Plus Endoscope

Reprocessing System[®] at the Huntington VAMC (facility), Huntington, WV. OIG did not substantiate the allegation that staff responsible for cleaning gastrointestinal endoscopes failed to perform required maintenance on reprocessing equipment by not replacing filters. OIG did not find documentation to support that the reprocessing equipment became clogged and potentially created a patient safety risk. OIG did not substantiate the allegation that replacing filters on the reprocessing equipment is the responsibility of Sterile Processing Service staff rather than Biomedical Engineering staff. Facility policy states that reprocessing equipment filters will be changed by Biomedical Engineering staff. OIG made no recommendations. The VISN and Facility Directors concurred with our findings. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In June 2015, OIG published four 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 nine activities: (1) Quality Management, (2) Medication Management, (3) Coordination of Care, (4) MRI Safety, (5) Acute Ischemic Stroke Care, (6) MH Residential Rehabilitation Treatment Program, (7) Emergency Airway Management, (8) Environment of Care, and (9) Surgical Complexity. OIG also published two CAP summary reports evaluating Community Living Centers and medication oversight and education.

[VA Sierra Nevada Health Care System, Reno, Nevada](#)

[VA Boston Healthcare System, Boston, Massachusetts](#)

[Phoenix VA Health Care System, Phoenix, Arizona](#)

[North Florida/South Georgia Veterans Health System, Gainesville, Florida](#)

[CAP Summary - Evaluation of Selected Requirements in Veterans Health](#)

[Administration Community Living Centers](#)

[CAP Summary - Evaluation of Medication Oversight and Education in Veterans Health](#)

[Administration Facilities](#)

Community Based Outpatient Clinic Reviews

In June 2015, OIG published six 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 four operational activities: (1) Environment of Care, (2) Alcohol Use Disorder, (3) Human Immunodeficiency Virus (HIV) Screening, and (4) Outpatient Documentation. OIG also published a CBOC summary report evaluating medication oversight and education.

[VA Sierra Nevada Health Care System, Reno, Nevada](#)

[VA Palo Alto Health Care System, Palo Alto, California](#)

[Phoenix VA Health Care System, Phoenix, Arizona](#)

[William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina](#)

[Chillicothe VA Medical Center, Chillicothe, Ohio](#)

[North Florida/South Georgia Veterans Health System, Gainesville, Florida](#)

[CBOC Summary – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics](#)

CRIMINAL INVESTIGATIONS

Three Subjects Arrested for Service-Disabled Veteran-Owned Small Business Fraud

Three subjects were indicted and arrested for major fraud against the Government and wire fraud. A VA OIG and Small Business Administration (SBA) OIG investigation revealed that the defendants used a “pass-through” scheme to create a Service-Disabled Veteran-Owned Small Business (SDVOSB) in order to qualify for and obtain VA SDVOSB set-aside construction contracts at the San Juan, PR, VAMC. The defendants created the fraud scheme by using a service-disabled sibling, who was a full-time U.S. Postal Service (USPS) employee, with no construction experience or equipment to establish a construction business. The defendants created the SDVOSB after learning that construction contracts would only be awarded to SDVOSBs as a result of a Government stimulus package supporting SDVOSBs. The VA contracts included American Recovery and Reinvestment Act (ARRA) funds and were worth approximately \$8.4 million.

Four Subjects Arrested for Fraud Against the Government

Four subjects were indicted and arrested for major fraud against the Government, wire fraud, tampering with a witness, and other charges. A multi-agency investigation revealed that the defendants were owners of and/or officers in multiple companies, all classified and operated as small businesses. At one time, all of the companies operated under the SBA 8(a) program or the VA SDVOSB program. The investigation further revealed that from February 2003 to October 2014 the defendants conspired with each other and other persons to defraud the United States and its agencies of over \$140 million in contract payments from 8(a) and SDVOSB contracts by fraudulently claiming that the companies were owned by disadvantaged persons and a service-disabled veteran. The VA portion of the contracts included ARRA funds and were worth approximately \$7.9 million.

West Palm Beach, Florida, VAMC Employee Sentenced for “Kickbacks”

A West Palm Beach, FL, VAMC employee, who was the chief of prosthetics, was sentenced to 9 months’ incarceration, 6 months’ home confinement, 1 year supervised release, and a \$15,000 fine. An OIG investigation revealed that the defendant solicited and accepted over \$71,000 in kickbacks from a durable medical equipment (DME) vendor to create fraudulent orders, which were never provided to veterans. For over 4 years, the defendant used his position at VA to steer over \$2.2 million in DME orders to the vendor. Additionally, the defendant conspired with the vendor to create an orthotic shoe fitting business in which they agreed to split the profits. The loss to VA is approximately \$143,019 for the fraudulent DME orders and \$671,730 in overcharges.

West Roxbury, Massachusetts, VAMC Employee and Contractor Charged with Wire Fraud

A West Roxbury, MA, VAMC employee and a VA contractor were charged with wire fraud. An OIG investigation revealed that from October 2012 to October 2014 the employee and contractor conspired to order goods and services that were not needed and were never provided to VA. The VA employee, who was responsible for the maintenance and information technology support of medical equipment, created the false purchase orders and paid the contractor using his VA-issued credit card. The investigation determined that on 82 occasions VA paid the contractor and his company a total of \$222,242. The employee and contractor then divided the proceeds.

Contract Employee Sentenced for Identity Theft

A former employee of a company contracted by the Tampa, FL, VAMC to shred sensitive documents was sentenced to 81 months' incarceration and ordered to pay the Internal Revenue Service (IRS) \$1.16 million in restitution and VA \$1,981 in restitution after pleading guilty to access device fraud and aggravated identity theft. An OIG, IRS Criminal Investigation Division, Florida Department of Law Enforcement, Florida Highway Patrol, and local police investigation revealed that the defendant stole medical records containing veterans' personally identifiable information (PII) that were supposed to be destroyed. The defendant then sold the records to multiple defendants who subsequently used the PII to file \$1.4 million in fraudulent tax returns.

Long Beach, California, VAMC Pharmacy Technician Indicted for Tampering with Consumer Products and Possession of Controlled Substances by Deception

A Long Beach, CA, VAMC pharmacy technician was indicted for tampering with consumer products and possession of controlled substances by deception. An OIG investigation revealed the employee diverted Vicodin, Soma, and morphine. The employee also admitted to diverting a large quantity of fentanyl while compounding intravenous (IV) medications or by withdrawing 10–12 percent of the fluid from fentanyl IV bags. The reduced quantity of fluid in the tainted IV bags was later administered to patients. Additionally, the employee admitted to using diverted narcotics while on duty.

Northport, New York, VAMC Pharmacist Arrested for Theft of Government Property

A Northport, NY, VAMC pharmacist was arrested for theft of Government property. An OIG and VA Police Service investigation revealed that the defendant diverted a variety of non-controlled substances, to include blood pressure medication, cholesterol medication, and anti-nausea medication from the VAMC. The defendant admitted to the theft of pharmaceuticals from VA for many years, and a subsequent search of his residence resulted in the recovery of more than 30 stock bottles of medicines intended for VA patients.

Veteran Sentenced for Drug Distribution

A veteran was sentenced to 18 months' incarceration after pleading guilty to possession with intent to distribute a Class A and Class B substance (heroin and amphetamine). An OIG, Drug Enforcement Administration, and VA Police Service investigation

revealed that the defendant, while residing at the Bedford, MA, VAMC, sold prescription and illicit drugs to veterans who were receiving treatment for substance abuse. During the time the defendant was selling drugs at the VAMC, he was on pretrial release after being charged with armed bank robbery. The investigation was initiated based on a history of illicit drugs being used at the VAMC, recent drug overdoses, and the concerns of medical staff that the sale and use of drugs was interfering with substance abuse treatment.

Hot Springs, South Dakota, VAMC Employee Indicted for Assault of a Federal Employee

A Hot Springs, SD, VAMC food service worker was indicted for assault of a Federal employee. The defendant made multiple threats to VA staff, threatened to kill a VA Police officer, and threatened to blow up bridges and kill civilians. While at the medical center, the defendant grabbed a female nurse and forced her hands on his genitals. The defendant later exposed himself to the same nurse and stated he would “kill girls that won’t go out with me.”

Veteran Sentenced for Threats to VA

A veteran was sentenced to 3 years’ supervised probation and ordered to attend counseling for MH, substance abuse, and anger management after pleading guilty to assault on Government officials. The defendant was incarcerated for several months prior to his sentencing due to the severity of the threat. An OIG, VA Police Service, Federal Bureau of Investigation, and local law enforcement investigation revealed that the defendant threatened to shoot and kill doctors and nurses at the Fayetteville, NC, VAMC and staff at Fort Bragg, NC.

Veteran Sentenced for Making Threats to VA

A veteran was sentenced to 274 days’ incarceration, 5 years’ probation, and \$600 in fines and restitution after pleading guilty to criminal threats, resisting an executive officer, and MH firearms prohibition. An OIG and VA Police Service investigation revealed that the defendant arrived at the Long Beach, CA, VAMC and threatened to kill himself, his girlfriend, and three Long Beach, CA, VA police officers. The defendant also assaulted two of the officers while attempting to leave the medical center. During the investigation, a handgun and two rifles were recovered. The defendant was not legally permitted to possess these weapons.

Veteran Indicted for Child Pornography

A veteran was indicted on multiple charges of illegal use of a minor in nudity-oriented material or performance. An OIG investigation revealed that the defendant, while a resident at the Cleveland, OH, VAMC domiciliary, used a computer located in the domiciliary computer lab to view child pornography. A search warrant executed on the defendant’s personal computer tablet showed the defendant also used that device to view child pornography.

Veteran and Wife Indicted for VA Pension Fraud

A veteran and his wife were indicted for conspiracy to commit theft of Government funds and theft of Government funds. An OIG investigation revealed that for 8 years the defendants submitted numerous false VA Pension Eligibility Verification reports that concealed the earned income of his wife. This income would have disqualified the veteran from receiving pension benefits. The loss to VA is \$197,784.

Veteran Sentenced for Making False Statements

A veteran was sentenced to 10 months' incarceration and 3 years' probation after pleading guilty to making false statements. An OIG investigation revealed that the defendant submitted more than 90 fraudulent forms for 21 different veterans without their consent and then planned to keep for himself any benefits issued by VA. The defendant forged each veteran's signature and falsely stated that each veteran suffered from various medical conditions.

Veteran Sentenced for VA Education Fraud

A veteran was sentenced to 366 days' incarceration, 3 years' supervised release, ordered to pay VA restitution of \$75,955, and a forfeiture of \$70,000. An OIG investigation revealed that the defendant falsely claimed to be attending school at a community college. The defendant made these fraudulent claims in order to obtain Post-9/11 GI Bill benefits and carried out his scheme by falsely claiming to VA that the certifications were prepared and submitted by the school, when in fact they were sent by the defendant.

Son of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds

The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA Dependency and Indemnity Compensation benefits that were direct deposited after his mother's death in September 2005. The defendant admitted to using the funds for personal expenses. The loss to VA is \$147,723.

Niece of Deceased VA Beneficiary Indicted for Theft of Government Funds

The niece of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after her aunt's death in July 2007. The loss to VA is \$107,452.

Daughter of Deceased VA Beneficiary Arrested for Theft

The daughter of a deceased VA beneficiary was indicted and arrested for theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after her mother's death in January 2009. The loss to VA is \$87,016.

Non-Veteran Pleads Guilty to Health Care Fraud

A non-veteran pled guilty to health care fraud. An OIG investigation revealed that the defendant falsely claimed to have served from 1996 to 2010 in the Army National Guard, to have suffered from PTSD, and to have served in combat during two tours in Afghanistan. In actuality, the defendant never served in the military and was

incarcerated during the time period that she claimed to have been in the military. For over 2 years, the defendant received over \$20,000 in VA health care benefits in addition to non-VA care paid by VA. The defendant also fraudulently received more than 10,000 milligrams of oxycodone from VA. Soon after the defendant admitted to the fraudulent activity, she fled to New Mexico where she was apprehended by the U.S. Marshals Service and extradited to New Hampshire. The defendant is being held pending further judicial action.

Former White River Junction, Vermont, VAMC Canteen Chief Charged with False Pretenses and Embezzlement

A former White River Junction, VT, VAMC canteen chief was charged with false pretenses and embezzlement. An OIG investigation revealed that from June 2013 to August 2013 the defendant stole approximately \$1,200 from the facility's various funds and canteen safe. The defendant resigned from her position while under investigation.

Four Subjects Arrested for Theft of U.S. Treasury Checks

Four subjects, including two USPS mail sorters, were arrested for conspiracy, theft of mail, theft of Government funds, forgery, bank fraud, and aggravated identity theft for their roles in a conspiracy to steal U.S. Treasury checks from the mail and then to either sell the checks or deposit them in fraudulently opened bank accounts. A VA OIG, USPS OIG, U.S. Treasury OIG, and local police investigation resulted in the seizure of approximately 960 Treasury checks, to include some VA benefit checks, valued at \$1.6 million and the seizure of more than \$165,000 in proceeds gained as a result of the sale of the stolen checks. The investigation is ongoing as other suspects have been identified.

Veterans Arrested for Theft of VA Property

Two former veteran inpatients at the Coatesville, PA, VAMC were charged with theft by unlawful taking or disposition, receiving stolen property, and criminal conspiracy. An OIG, VA Police Service, and local law enforcement investigation determined that from April 2012 to February 2013 the defendants stole approximately 890 pounds of various metallic plumbing supplies from the medical center and sold them to scrap yards in two different cities. The loss to VA is approximately \$34,000.



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