



Department of Veterans Affairs

Office of Inspector General

September 2015 Highlights

CONGRESSIONAL TESTIMONY

Deputy Inspector General Explains Steps Office of Inspector General Takes To Protect and Educate Whistleblowers to Senate Panel

Linda A. Halliday, Deputy Inspector General, testified before the Committee on Homeland Security and Governmental Affairs, United States Senate, at a hearing titled, "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers." Ms. Halliday discussed the fundamental importance of whistleblowers to the Office of Inspector General (OIG) mission and how the OIG works to protect and encourage Federal employees to come forward with allegations of waste, fraud, abuse, and mismanagement. She elaborated on the OIG's efforts to educate employees about whistleblower protections, to encourage employees to report suspected wrongdoing, and to protect the identities of those who do. Ms. Halliday also emphasized that while the OIG strongly encourages any employee with information of wrongdoing to report it to the OIG, it is imperative that employees ensure they are doing so in a manner that does not compromise sensitive veteran information. She was accompanied by Mr. Quentin G. Aucoin, Assistant Inspector General for Investigations.

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

ADMINISTRATIVE INVESTIGATION

OIG Finds Two Veterans Benefits Administration Senior Executive Service Members Misused Positions for Personal and Financial Gain, Veterans Benefits Administration Mismanaged Relocation Program

The Chairman and Ranking Member of the House Committee on Veterans' Affairs (HVAC) and the Chairman and Ranking Member of the Senate Committee on Veterans' Affairs requested the OIG investigate allegations concerning financial benefits and preference given at VA. An anonymous complainant alleged that Ms. Diana Rubens, Philadelphia VA Regional Office (VARO) Director, improperly received \$288,206.77 in relocation expenses for transferring from the Veterans Benefits Administration (VBA) Headquarters to her current position at the VARO and retained her high-level Senior Executive Service (SES) salary, despite the position being two levels lower on VA's SES pay scale. OIG was also asked to conduct a broader review of VA's Permanent Change of Station (PCS) Relocation program. Ms. Rubens was reassigned from her position as Deputy Under Secretary for Field Operations to the position of Director, Philadelphia VARO, effective June 1, 2014. VA paid \$274,019.12 related to Ms. Rubens' PCS move. Relocation expenses paid for Ms. Rubens' move were generally allowable under Federal and VA policy; however, the OIG identified issues with the timeliness of VA's approval of Ms. Rubens' participation in the Appraised Value Offer program, as well as a 17-day extension for temporary quarters subsistence expense allowance. In addition, Ms. Rubens was reimbursed \$76.50 for alcoholic beverages, which is prohibited, and \$47 for meal and tip expenses that were not supported by required receipts. More importantly, OIG concluded that Ms. Rubens inappropriately used her position of authority for personal and financial benefit when she

participated personally and substantially in creating the Philadelphia VARO Director vacancy and then volunteering for the vacancy.

During the course of the investigation, OIG identified a second instance of a senior executive's inappropriate use of her position. Ms. Kimberly Graves was reassigned from her position as the Director of VBA's Eastern Area Office to the position of Director, St. Paul VARO, effective October 19, 2014. VA paid \$129,467.56 related to Ms. Graves' PCS move. OIG concluded that Ms. Graves also inappropriately used her position of authority for personal and financial benefit when she participated personally and substantially in creating the St. Paul VARO Director vacancy and then volunteering for the vacancy. Both Ms. Rubens' and Ms. Graves' reassignments resulted in a significant decrease in job responsibilities, yet both retained their annual salaries—\$181,497 and \$173,949, respectively. Based on Federal regulations, OIG determined that VA could not reduce their annual salaries upon reassignment despite the decrease in the scope of their responsibilities. However, a senior executive's annual salary can be reduced if the individual receives a less than fully successful annual summary rating; fails to meet performance requirements for a critical element; or, as a disciplinary or adverse action resulting from conduct related activity. OIG also reviewed records related to 23 VBA reassignments of employees who were either promoted to SES positions or were moved to different SES positions in fiscal years (FY) 2013, 2014, and 2015. Twenty-one of the 23 reassignments included salary increases. OIG determined that VBA management used moves of senior executives as a method to justify annual salary increases and used VA's PCS program to pay moving expenses for these employees. From FY 2010 to 2013, U.S. Office of Personnel Management guidelines precluded all SES employees from receiving annual pay increases. In FY 2012, the VA Secretary determined no VBA executives would receive performance awards based on concerns over the backlog of veterans' disability claims.

OIG identified salary increases that did not consistently reflect changes in the positions' scope of responsibility and that when VBA filled vacant SES positions the selectees often received significant annual salary increases over what their predecessors were paid. For example, one VARO Director received a salary increase of \$30,417 or 22 percent more than his predecessor. Annual salary increases associated with these relocations totaled about \$321,000, and PCS relocation expenses paid were valued at about \$1.3 million. Additionally, VBA paid \$140,000 in unjustified relocation incentives. In total, VA spent just over \$1.8 million on the reassignments. OIG does not question the need to reassign some staff to manage a national network of VAROs; however, we concluded that VBA misused VA's PCS program for the benefit of its SES workforce. OIG made criminal referrals to the U.S. Attorney's Office, District of Columbia, regarding official actions orchestrated by Ms. Rubens and Ms. Graves. Formal decisions regarding prosecutorial merit are pending. OIG provided 12 recommendations to VA to increase oversight of the Department's PCS program and to determine appropriate administrative actions to take, if any, against senior VBA officials.

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

OIG REPORTS**OIG Substantiates Whistleblower's Claims of Extensive, Persistent Problems in Veterans Health Care Enrollment Records, Atlanta, Georgia**

At the request of the HVAC, OIG conducted a review of Veterans Health Administration's (VHA) Health Eligibility Center (HEC) to evaluate the merit of allegations of mismanagement pertaining to a backlog of pending health care applications, veterans who died while their applications were pending, purged or deleted veteran health records, and unprocessed applications. OIG substantiated the existence of about 867,000 pending records that had not reached a final determination as of September 30, 2015. OIG also substantiated that pending records included entries for over 307,000 individuals reported as deceased by the Social Security Administration (SSA). However, due to limitations in the HEC's Enrollment System (ES) data, OIG could not reliably determine how many pending records existed as a result of applications for health care. This occurred because the enrollment program did not effectively define, collect, and manage enrollment data. In addition, VHA lacked adequate procedures to identify date of death information and implement necessary updates to the individual's status. OIG also substantiated that employees incorrectly marked unprocessed applications as completed and possibly deleted 10,000 or more transactions from the HEC's Workload Reporting and Productivity (WRAP) tool over the past 5 years. WRAP was vulnerable because the HEC did not ensure that adequate business processes and security controls were in place, manage WRAP user permissions, and maintain audit trails to identify reviews and approvals of any deleted transactions.

In addition, the Office of Information and Technology (OIT) did not provide proper oversight for the development, security, and data backup retention for WRAP. OIT also did not collect and retain WRAP audit logs in accordance with VA policy. Finally, OIG substantiated that the HEC identified over 11,000 unprocessed health care applications and about 28,000 other transactions in January 2013. This backlog developed because the HEC did not adequately monitor and manage its workload and lacked controls to ensure entry of WRAP workload into ES. OIG provided recommendations to the Under Secretary for Health (USH) to address ES data integrity issues, enrollment program policy limitations, and the access and security of the WRAP tool. OIG also provided recommendations to the Assistant Secretary OIT to implement adequate security controls for the WRAP tool, and ensure the collection and retention of WRAP audit logs and system backups. OIG further recommended that the USH and Assistant Secretary OIT confer with the Office of Human Resources and the Office of General Counsel to fully evaluate the implications of the findings of the report, determine if administrative action should be taken against any VHA or OIT senior officials involved, and ensure that appropriate action is taken. The USH and Assistant Secretary OIT concurred with OIG findings and recommendations. [\[Click here to access report.\]](#)

Medical Officer, Nurse, Psychologist, Physician Assistant, and Physical Therapist Are VHA's Top Five Critical Need Occupations

OIG conducted its second of several determinations of VHA occupations with the largest staffing shortages, as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014. OIG interpreted “largest staffing shortage” to encompass broader deliberation than simply the number needed to replace or backfill vacant positions for an occupation and refer to occupations that met broader criteria as critical need occupations. OIG performed a rule-based analysis of VHA data to identify critical need occupations, analyzed data on gains and losses for these occupations, and assessed VHA’s progress with implementing staffing models. OIG determined that the top five critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, and Physical Therapist. The identification of these occupations remains unchanged from OIG’s initial determination reported in January 2015. OIG’s analysis of staffing gains and losses shows that for these critical need occupations, a significant percentage of total gains was offset by losses. OIG determined that the number of regrettable losses (that is, resignations and transfers to other government agencies) for many critical need occupations was high. This analysis likely does not capture the effect of the 2014 Veterans Access, Choice, and Accountability Act, as that law was implemented on August 7, 2014, and OIG’s analysis only includes data up until September 30, 2014. However, OIG’s analysis does provide an understanding of the historical pattern of staffing changes at VHA leading up to the enactment of that law. Further, OIG found that VHA’s staffing model is in development and consists of different models covering distinct areas of VHA staffing needs. VHA is working on extending the Specialty Productivity Access Report and Quadrant staffing tool to more occupations. OIG made two recommendations. [\[Click here to access report.\]](#)

Palo Alto, California, Health Care System Allowed Technology Firm’s Staff Access to VA Patient Information Without Required Background Investigations

In October 2014, the HVAC provided OIG a complainant’s allegation that the VA Palo Alto Health Care System (PAHCS) Chief of Informatics entered into an illegal agreement with Kyron, a health technology company, to allow data sharing of sensitive VA patient information. This allegation involved veterans’ personally identifiable information (PII), protected health information (PHI), and other sensitive information being vulnerable to increased risks of compromised confidentiality. Allegedly, sensitive VA patient information was transmitted outside of VA’s firewall. The complainant also alleged Kyron personnel received access to VA patient information through VA systems and networks without appropriate background investigations. OIG did not substantiate the allegations that the Chief of Informatics formed an illegal agreement with Kyron or that sensitive patient information was transmitted outside of VA’s firewall. However, OIG substantiated the allegation that Kyron personnel received access to VA patient information without appropriate background investigations. OIG determined the Chief of Informatics, who was also the local program manager for the pilot program, failed to ensure Kyron personnel met the appropriate background investigation requirements before granting access to VA patient information. The Chief of Informatics also failed to ensure Kyron personnel completed VA’s security and privacy awareness training. Further, the Information Security Officers (ISOs) failed to execute their required

responsibilities by not providing PAHCS management and staff guidance on information security matters. More specifically, the ISOs did not coordinate, advise, and participate in the development and maintenance of system security documentation and system risk analysis prior to Kyron placing its software on a VA server. As a result, Kyron did not have formal authorization to operate its software on a VA server. OIG concluded the lack of coordination between the Chief of Informatics and ISOs in executing the Kyron agreement potentially jeopardized the confidentiality of veteran's PII, PHI, and other sensitive information. The Chief of Informatics admitted to proceeding with the pilot before obtaining documented support from the local ISOs. After the OIG informed PAHCS officials of the initial results in November 2014, they discontinued Kyron's personnel access to VA de-identified patient information until Kyron's personnel received VA completed background investigations, appropriate security, and privacy training. [\[Click here to access report.\]](#)

Review of \$1.3 Billion System Reveals Inadequate Cost Control, Unplanned Requirements Changes, and Inefficient Contracting

In February 2013, OIG reported VA could not provide reasonable assurance the Veterans Benefits Management System (VBMS) would meet its goals of increasing claims processing accuracy to 98 percent and eliminating the disability claims backlog by 2015. OIG conducted this follow-up review to determine how effectively VA is managing cost, performance, and schedule of VBMS development to meet its claims processing accuracy and backlog elimination goals. VA remained partially effective in managing VBMS development to help meet claims processing accuracy and backlog elimination goals. However, since September 2009, total estimated VBMS costs increased significantly from about \$579.2 million to approximately \$1.3 billion in January 2015. The increases were due to inadequate cost control, unplanned changes in system and business requirements, and inefficient contracting practices. As a result, VA could not ensure an effective return on its investment and total actual VBMS system development costs remained unknown. Amid evolving requirements, VBMS did not fully provide the capability to process claims from initial application to benefits delivery. Users lacked training needed to leverage the enhanced functionality provided. System response-time issues resulted from rapid software enhancements while system disruptions were due to inadequate service continuity practices. Until these issues are addressed, VA will continue to lack assurance of meeting its claims processing accuracy and backlog elimination goals by the end of 2015. OIG recommended the Executive in Charge of Information and Technology, in conjunction with the Under Secretary for Benefits (USB), define and stabilize system and business requirements, address system performance problems, deploy required functionality to process claims end-to-end, and institute metrics needed to identify and ensure progress toward meeting stated goals. [\[Click here to access report.\]](#)

Audit Finds VA's Contracted Care Networks Lack Medical Providers in Geographic Locations Where Veterans Need Them

OIG assessed the adequacy of Patient-Centered Community Care (PC3) provider networks developed under VHA contracts valued at approximately \$9.4 billion. OIG found inadequate PC3 provider networks contributed significantly to VA medical

facilities' limited use of PC3. VHA spent \$3.8 million of its \$2.8 billion FY 2014 non-VA care (NVC) budget (0.14 percent) on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its NVC expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because PC3 networks lacked needed specialty care providers, returned authorizations had to be re-authorized through NVC and increased veterans' wait times for care, and NVC provided veterans more timely care than PC3. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3, the CBO lacked an effective implementation strategy for the roll-out of PC3, and neither VHA nor the PC3 contractors maintained adequate data to measure and monitor network adequacy. OIG recommended the USH strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex healthcare initiatives. [\[Click here to access report.\]](#)

VA May Have Overpaid \$3 Million Plus for Kentucky Land Purchase Then Misrepresented Information to Congress on Increase in Market Value, Louisville, Kentucky

OIG reviewed VA's appraisal process in support of land purchased in Louisville, KY. OIG determined VA's Office of Acquisition, Logistics, and Construction (OALC) conducted two appraisals of the property in December 2010 and in February 2012. The first appraisal valued the property at \$9,850,000. The second appraisal valued the property at \$12,905,000. However, OALC did not obtain a required review appraisal, conducted by an independent third party, necessary for determining the appropriateness of the two appraisals prior to purchasing the land for \$12,905,000. Instead, VA obtained the review appraisal at a cost of \$2,477 nearly two years after the property was purchased. Spending \$2,447 for the review appraisal was a waste of the taxpayers' money since the sale was complete and no further action could be taken based on the review appraisal. As a result, VA may have overpaid more than \$3 million for this property. Furthermore, OALC misrepresented information provided to the HVAC regarding the 31 percent increase in market value. OALC reported the analysis of highest and best use of the property was revised from residential to mixed-use development. This was contrary to OIG's findings, as both appraisals state that the highest and best use of the property would be for mixed-use development.

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

VA's Contracted Care Network Did Not Provide VA Clinical Documentation Timely, VA Made \$870K in Improper Payments

OIG estimates PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during our period of review from January 1, 2014, through September 30, 2014. OIG estimates that 48 percent of the clinical documentation was provided to VA late and 20 percent was incomplete. VHA made about \$870,400 of improper payments when payments should not have been made

prior to receiving complete clinical documentation. VHA did not apply contract penalties to Health Net Federal Services, LLC when it did not meet performance requirements related to the timely return of clinical documentation. VHA applied a penalty of only \$753. The maximum allowable penalty was \$15,909. If VA exercises the remaining 3 option years of the PC3 contract without adequately addressing the identified issues, VA could make about \$5.5 million in improper payments and missed assessed penalties. OIG also found that PC3 patients experienced delays in VHA referring and following up on their care with TriWest Healthcare Alliance Corporation (TriWest), as well as TriWest not timely notifying VHA of three malignancy diagnoses resulting from colonoscopies. These issues occurred because VHA relied on contractor-reported data, lacked an adequate program for monitoring contractor performance, and a process to verify whether the contractor meets contract performance standards. As a result, VHA lacked assurance that PC3 is providing patients adequate continuity of care. OIG recommended VHA implement a mechanism to verify PC3 contractors' performance without relying on contractors' self-reported data, VHA ensure PC3 contractors properly annotate and report critical findings in a timely manner, and that VHA imposes financial or other remedies when contractors fail to meet requirements. [\[Click here to access report.\]](#)

St. Louis, Missouri, Health Care System Mental Health Leadership Provided Insufficient Oversight for Consult Processing, Better Guidance Needed

OIG determined the merits of allegations received during May and June 2014. OIG substantiated the allegation that the St. Louis, MO, VA Health Care System (HCS) inappropriately changed the status of consults to "complete" prior to the provider actually completing the appointment with the patient. Starting in October 2013 and continuing through June 2014, an HCS employee inappropriately changed the status of 12 of 20 sampled consults (60 percent) to "Complete" before the provider completed the appointment. OIG found that St. Louis VA HCS Mental Health (MH) Clinic leadership did not provide sufficient oversight for processing consults and the St. Louis VA HCS did not have well-defined guidance to ensure staff took appropriate actions when processing consults. In addition, OIG substantiated the allegation that St. Louis VA HCS psychiatrists received performance pay based on productivity data. OIG reviewed the FY 2013 performance pay assessments completed by the Associate Chief of Staff for MH for eight full-time outpatient psychiatrists and found they each received an average of \$13,710 in total performance pay. Seven of the eight psychiatrists met or exceeded the productivity goal. As a result, each received an average of \$2,920 for meeting the productivity goal. OIG determined that the one psychiatrist who did not meet the productivity goal received no performance pay for productivity, but he did receive 80 percent of the performance pay—a total of \$11,896—because he met the other goals of his performance pay assessment. OIG recommended the Acting Director of the St. Louis VA HCS ensure staff receive appropriate training and guidance on consult management and perform a follow up analysis of completed consults to ensure they are not completed inappropriately. The Acting Director of the St. Louis VA HCS concurred with the OIG's report. The Acting Director's corrective actions were acceptable and OIG considers the recommendations closed. [\[Click here to access report.\]](#)

Review Does Not Substantiate Substandard Prostate Cancer Screening at VA Eastern Colorado HCS, Denver, Colorado

At the request of Congressman Mike Coffman, the OIG Office of Healthcare Inspections conducted an inspection to determine the quality of care provided to a patient who alleged that substandard prostate cancer screening delayed his diagnosis of prostate cancer at the VA Eastern Colorado HCS, Denver, CO. OIG did not substantiate that the patient received substandard prostate cancer screening. OIG found that guidelines for prostate cancer screening vary. During the time the patient was followed by VHA providers, prostate-specific antigen (PSA) testing without a digital (finger) rectal examination (DRE) for prostate cancer screening of an asymptomatic patient from 2010 to present was consistent with VHA guidance, U.S. Preventive Services Task Force, and 2013 American Urological Association guidelines, but differed from the 2009 American Urological Association Best Practice Statement. Test results in September 2011 showed that the patient had an elevated PSA level. A DRE performed in March 2012 revealed the patient had an enlarged prostate. Further testing later in March 2012 showed the PSA level was within normal range. The patient had a urology visit in April, a prostate biopsy in May, and a referral to radiation oncology in June 2012. The patient was reportedly cancer free at the time of this review. OIG made no recommendations.

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

Inadequate Care, Inappropriate Cancellation of Consults at Kansas City, Missouri, VA Medical Center

OIG conducted an inspection at the request of Representative Kevin Yoder in response to concerns about the extent to which a patient received timely and adequate care for post-traumatic stress disorder (PTSD) and other health care needs at the Kansas City VA Medical Center (VAMC), Kansas City, MO. OIG did not substantiate the allegation that the patient was told he would have to wait 30 days for inpatient treatment for PTSD. OIG found that the patient had multiple health issues and had been screened for admission to another program and assigned an admission date to the other program 35 days after being screened. However, the patient died a few days after acceptance into the program. OIG substantiated that aspects of the patient's care were inadequate. In particular, OIG found that some requests for outpatient consultations were inappropriately cancelled or discontinued, the patient's abnormal findings and/or care needs were not fully assessed, and appropriate consults were not made when the patient was treated in the Emergency Department. Whether addressing these issues previously would have resulted in a different outcome for the patient is unknown. However, addressing these issues now will help facilitate a more patient-centered environment, especially for those veterans with complex medical and MH issues. Incidental to the review, OIG noted that because the VAMC did not have a signed release of information, staffs were unable to discuss the patient's care with a family member. OIG made one recommendation to the Interim USH and three recommendations to the Facility Director. The Interim USH and the Veterans Integrated Service Network (VISN) and Facility Directors concurred with OIG findings and recommendations. [\[Click here to access report.\]](#)

Incorrect Wage Rates at Hudson Valley HCS Results in Nearly \$600K in Overpayments to 104 Employees in Calendar Year 2014, Montrose, New York

OIG evaluated the merits of an allegation that wage rates paid to Federal Wage Service (FWS) employees working at the Castle Point campus within the Hudson Valley Health Care System (HVHCS) were inappropriate. OIG substantiated the allegation that wage rates paid to FWS employees in the Engineering and Environmental Management Services at the Castle Point campus were incorrect. OIG found all 256 FWS employees in the Engineering and Environmental Management Services were assigned Montrose as their official duty station, regardless of whether they regularly performed their duties at Montrose or Castle Point. OIG determined that 104 of the 256 HVHCS FWS employees in the Engineering and Environmental Management Services performed their regular duties at the Castle Point campus during calendar year (CY) 2014. These 104 employees incorrectly received the higher Montrose wage rate instead of the correct wage rate for Castle Point. OIG found management officials in the Engineering and Environmental Management Services did not follow VA policy on determining employees' official duty stations. In addition, OIG found Human Resources oversight on ensuring the accuracy of official duty stations for employees was insufficient. OIG estimated HVHCS's use of inappropriate wage rates for the Castle Point FWS employees in the Engineering and Environmental Management Services resulted in overpayments of about \$592,550 in CY 2014. If HVHCS does not correct the official duty station for the 104 employees, this could result in additional overpayments of about \$3 million over the next 5 years. OIG recommended the Interim Director of VISN 3 ensure HVHCS management takes immediate steps to correct inappropriate wage rates paid to FWS employees and improve controls over the designation of official duty stations. OIG also recommended the Interim Director take steps to determine whether administrative actions are appropriate to hold HVHCS officials accountable.

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

Alleged Suicides and Inappropriate Changes to MH Treatment Program at Coatesville, Pennsylvania, VAMC

OIG conducted an inspection to assess the merit of allegations that two suicides may have occurred following the early termination of case management services, and two suicides may have occurred with the closure of a sub-acute psychiatric inpatient ward at the Coatesville VAMC in Coatesville, PA. OIG also assessed allegations that the VAMC did not follow VHA guidelines in closing or modifying other MH care programs. OIG did not substantiate that any patient suicides occurred due to early termination of case management or the closure of a sub-acute psychiatric inpatient ward. OIG found that the VAMC complied with VHA policy when it closed the beds on the ward. OIG did not substantiate that the changes were made without regard to patient safety. OIG did not substantiate that the consolidation of two Domiciliary Care for Homeless Veterans (DCHV) units violated VHA policy. OIG substantiated the allegation that admission criteria to the DCHV program were restrictive; however, the issue was identified during a VHA site visit and corrected. OIG substantiated that the VAMC's decision to close the Community Transition and Wellness Center violated VHA policy. OIG found that the VAMC did not transition the Community Transition and Wellness Center program to a Psychosocial Rehabilitation and Recovery Center as required by VHA policy. OIG

recommended that the Facility Director coordinate with VHA leadership regarding the establishment of a Psychosocial Rehabilitation and Recovery Center.

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

VA Contracted Care Network Referred Oncology Patients to Providers Who Did Not Meet Clinical Accreditation Standards, North Las Vegas, Nevada

OIG performed this review to determine the merits of allegations made to the OIG in November 2014. The complainant alleged that a VA Southern Nevada Healthcare System (VASNHS) employee limited the choice of providers for patients needing NVC for radiation oncology treatments and directed patients to one NVC provider because of a friendship with a physician associated with the provider's business. It was further alleged the VASNHS Chief of Staff directed staff not to refer patients to the NVC provider and the NVC provider had a previous contract that VA canceled due to poor performance. OIG did not substantiate the allegations. However, while reviewing these allegations OIG found TriWest, a Patient-Centered Community Care contractor, referred 15 of 58 oncology patients to network practices that did not meet clinical accreditation standards established under the terms of the Patient-Centered Community Care contract. OIG recommended the USH ensure that TriWest refers radiation oncology patients only to practices/facilities properly accredited under the terms of the contract, determine whether the Patient-Centered Community Care contract needs to be amended, and to ensure patients receive radiation oncology treatments that meet VHA's standards of care. [\[Click here to access report.\]](#)

OIG Finds Seattle, Washington, VARO Mismanaged Unprocessed Mail, Unnecessarily Proposed To Discontinue Unemployability Benefits

On March 6, 2015, OIG received allegations that Seattle, WA, VARO staffs were storing more than 1,000 pieces of unprocessed mail, primarily Employment Questionnaires, which were needed to continue individual unemployability (IU) benefits, for several months. The complainant alleged the mismanagement of Employment Questionnaires resulted in the transmission of hundreds of unnecessary notifications proposing to discontinue IU benefits. The complainant also alleged VARO management delayed taking any action to process the unprocessed mail. OIG substantiated VARO staff mismanaged unprocessed mail relating to IU benefits and unnecessarily proposed to discontinue IU benefits for 27 (20 percent) of the 132 employment questionnaires OIG reviewed. OIG did not substantiate the allegation that VARO management delayed taking corrective actions to address unprocessed mail—rather, the Director instructed staff to take immediate action to process the mail once he learned of the situation. Recommendations for improvement included convening administrative investigation boards to determine why VARO management was unaware that unprocessed mail had been stored within the Intake Processing Center (IPC) and why IPC staff did not seek assistance for processing employment questionnaires. OIG also recommended refresher training for staff with oversight and functional responsibility for mail processing. Further, OIG recommended that the USB ensure audit trails coexist with corrective action plans in all instances of mismanagement or data manipulation. VBA's Pacific District Director concurred in principle with OIG's first two recommendations but

proposed an alternative to administrative investigation boards. OIG will monitor planned actions and follow up on their implementation. [\[Click here to access report.\]](#)

Review of a Covered Drug Manufacturer's Interim Agreement Under Letter Contract With VA's National Acquisition Center

OIG conducted a review of an Interim Agreement (IA) under a letter contract with the VA National Acquisition Center (NAC). Under Federal Acquisition Regulation (FAR) Section 16.603, a letter contract serves to provide more time for the negotiation and award of a formal contract and should be in place no longer than 180 days. The NAC has awarded IAs and letter contracts with pharmaceutical manufacturers for purposes of compliance with Section 603 of the Veterans Health Care Act of 1992, Public Law 102-585 (P.L.). The review determined that the IA had been in place nearly seven years and lacked a schedule for definitizing a formal contract, in violation of FAR requirements. The review also determined that Federal Ceiling Prices mandated by the P.L. cannot be calculated correctly under an IA. The NAC has awarded 165 IAs in the last 10 years, and 153 of them exceeded the prescribed timeframes for definitizing a formal contract. OALC concurred with OIG's findings and recommended corrective actions. [\[Click here to access report.\]](#)

Allegations Regarding Quality of Care and Professional Conduct Not Substantiated, Contractual Issues Substantiated at the VA North Texas HCS, Dallas, Texas, Provided by the University of Texas—Southwestern Medical Center

In response to anonymous allegations, OIG conducted a review of cardiothoracic (CT) surgery and perfusion services provided by the University of Texas Southwestern Medical Center (UTSW) at the VA North Texas Health Care System (VANTHS) in Dallas, TX. The allegations involved quality of care issues with regards to CT surgery, professional conduct of the CT surgeons, and contractual issues for CT surgery and perfusion services. The review was conducted by OIG's Office of Contract Review and Healthcare Inspections. OIG's review did not substantiate any of the allegations of poor quality of care or unprofessional conduct by the UTSW CT surgeons. However, OIG substantiated four issues with regards to UTSW contract for CT surgery and perfusion services. OIG found that VANTHS has not had a long-term contract with UTSW for CT surgery since September 2010 and there is no evidence that prices paid to UTSW for CT surgery and perfusion services have been determined to be fair and reasonable. Management has concurred with OIG's findings and recommendations. [\[Click here to access report.\]](#)

Healthcare Inspection Notes Deficiencies in Arterial Study Timeliness, Pain Assessments at Chicago, Illinois, VA Facility

OIG conducted an inspection to assess the merit of allegations made by a confidential complainant relating to quality of care concerns in a diagnostic evaluation at the Jesse Brown VAMC, Chicago, IL. OIG substantiated a delay in scheduling and completing the lower extremity arterial study. OIG could not substantiate the allegation that the patient's requirement for limb amputation would have been different had he received the vascular laboratory lower extremity arterial study sooner. Although not an allegation, OIG identified an additional quality of care issue with this patient's care. During three

providers' visits, the patient did not receive complete pain assessments. OIG recommended that the Facility Director: (1) evaluate the scheduling process for vascular consultations and diagnostic tests, and take action if factors potentially impacting quality of care are identified; (2) evaluate the practice of vascular laboratory technicians interpreting the urgency of providers' consult requests and whether providers are notified when consult requests are not scheduled within the providers' timeframe, and take action if needed; (3) ensure that managers develop a policy defining who is responsible for provider and patient notification of consults ordered through the Emergency Department or Urgent Care Clinic that are not completed timely according to VHA policy; (4) ensure that providers perform comprehensive pain assessments according to VHA policy, and monitor compliance; (5) ensure that managers conduct an internal evaluation of the case discussed in this report; and, (6) consult with Regional Counsel regarding possible institutional disclosure. [\[Click here to access report.\]](#)

Follow-Up Review Shows VISN and Facility Leadership Took Effective Corrective Actions To Reopen Intensive Care Unit in Fort Wayne, Indiana

OIG conducted an oversight review to follow up on recommendations OIG made in the published report, *Healthcare Inspections-Follow-Up Review of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana* (Report No. 13-00670-262, Issued on August 28, 2014). The purpose of the review was to evaluate the progress VA Northern Indiana Healthcare System's Fort Wayne campus (facility) had made in implementing the action plan outlined in response to the 2014 report. On October 22, 2014, the facility reopened the Intensive Care Unit (ICU). During OIG's onsite visit in April 2015, OIG found that the facility continued to support 16 medical beds with telemetry capability and 4 ICU beds. OIG determined that VISN 11 and facility leadership had completed actions to reopen the ICU and taken actions to actively recruit and hire staff to fill leadership and qualified clinical positions. OIG also determined that nursing leadership assessed the utilization of the nursing staff to systematically plan assignments. In summary, OIG found the VISN and facility leadership exercised oversight and implementation of corrective actions to resolve the conditions identified in the 2014 report. The facility is now admitting patients to the acute medical unit and the ICU. OIG made no further recommendations.

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

Results of Benefits Inspection of Lincoln, Nebraska, VARO

Overall, OIG benefits inspectors determined Lincoln VARO claims processing staff incorrectly processed 8 of the 66 disability claims (12 percent) selected for review. One of the claims processing errors resulted in improper benefits payments of \$12,650 to one veteran over a 1-year period. OIG benefits inspectors sample disability claims considered at increased risk of processing errors, so inspection results do not represent the accuracy of all disability claims processed at the Lincoln VARO. OIG staff found VARO staff incorrectly processed 7 of 30 claims related to temporary 100 percent disability evaluations but correctly processed all 30 of the traumatic brain injury (TBI) claims sampled. One of the sample cases relating to Special Monthly Compensation (SMC) and ancillary benefits was processed incorrectly. Lincoln VARO staff followed policy and accurately established claims in an electronic system of records using correct

dates of claims for the 30 claims sampled. Inspectors also determined VARO staff delayed processing actions for 7 of the 30 benefits reduction cases which resulted in approximately \$6,000 in improper benefit payments from August 2014 until March 2015. Generally, the errors OIG identified during the 2015 inspection related to prioritization of workload. But for the workload restrictions imposed by VBA's Central Office and the Central Area, the Lincoln VARO had the potential to be compliant in all areas OIG inspected. The Director of the Lincoln VARO concurred with all recommendations and the planned corrective actions are responsive. OIG has plans to follow up on corrective actions as required. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Fort Harrison, Montana, VARO

Overall, OIG benefits inspectors determined Fort Harrison VARO claims processing staff incorrectly processed 2 of the 66 disability claims (3 percent) selected for review. One of the claims processing errors resulted in approximately \$2,410 in improper benefits payments over a period of 7 months. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Fort Harrison VARO. The OIG report indicated VARO staff incorrectly processed 2 of 30 claims related to temporary 100 percent disability evaluations but accurately processed all 30 disability claims related to TBIs—a significant improvement from the 2011 benefits inspection. During the 2011 review, 10 of the 30 temporary 100 disability evaluations and 3 of the 23 TBI cases OIG sampled contained processing errors. OIG's report also indicated that VARO staff accurately processed all six SMC and ancillary benefits claims received during calendar year 2014. Additionally, VARO staff followed policy and accurately established claims in an electronic system of records using correct dates of claims for the 30 claims sampled. However, delayed processing actions in 3 of the 30 benefits reduction cases resulted in approximately \$4,991 in improper benefit payments. The improper payments resulted from delays in taking actions to reduce the benefits because VARO management considered other work to be a higher priority. The Director of the Fort Harrison VARO concurred with all recommendations and OIG plans to follow up to ensure the planned corrective actions were implemented. [\[Click here to access report.\]](#)

Results of Benefits Inspection of San Diego, California, VARO

Overall, OIG benefits inspectors determined San Diego VARO claims processing staff incorrectly processed 23 of the 90 (26 percent) disability claims selected for review. The claims processing errors resulted in over \$111,000 in improper benefits payments from April 2012, until October 2014. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the San Diego VARO. OIG staff found VARO staff incorrectly processed 10 of 30 claims related to temporary 100 percent disability evaluations but processed 28 of the 30 TBI claims correctly. Results in these two areas showed significant improvement since the VARO was last inspected in 2012. However, OIG reported 11 of the 30 sample cases relating to SMC and ancillary benefits contained errors. San Diego VARO staff followed policy and accurately established claims in an electronic system of records using correct dates of claims for

the 30 claims sampled. Inspectors also determined VARO staff delayed or incorrectly processed 7 of the 30 benefits reduction cases which resulted in approximately \$7,900 in improper benefit payments from November 2013 until October 2014. The improper payments resulted from delays in taking actions to reduce the benefits because VARO management considered other work to be a higher priority. The Director of the San Diego VARO concurred with all recommendations; however, OIG indicated the Director's planned corrective actions were inadequate because they did not adequately address the recommendations. OIG has plans to follow up with the VARO to determine if the effectiveness of the corrective actions. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Sioux Falls, South Dakota, VARO

Overall, OIG benefits inspectors determined Sioux Falls VARO claims processing staff incorrectly processed 3 of the 62 (5 percent) disability claims selected for review. The claims processing errors resulted in approximately \$3,600 in improper benefits payments at the time of OIG's inspection in June 2015. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Sioux Falls VARO. OIG staff found VARO staff correctly processed 29 of 30 claims related to temporary 100 percent disability evaluations, and processed all 30 TBI claims correctly. Results in the temporary 100 percent evaluations suggests improvement since the VARO was last inspected in 2012. However, OIG reported the two cases reviewed relating to SMC and ancillary benefits contained errors. Sioux Falls VARO staff accurately established the correct date of claim in an electronic system of records for all 30 claims sampled. OIG inspectors also determined VARO staff delayed taking action in processing 7 of the 30 benefits reduction cases because VARO management did not prioritize this workload. The Director of the Sioux Falls VARO concurred with OIG's recommendations for improvement. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Honolulu, Hawaii, VARO

Overall, OIG benefits inspectors determined Honolulu VARO claims processing staff incorrectly processed 20 of the 69 (29 percent) disability claims selected for review. The claims processing errors resulted in approximately \$135,085 in improper benefits payments at the time of OIG's inspection in April 2015. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Honolulu VARO. OIG staff found VARO staff incorrectly processed 5 of 30 claims related to temporary 100 percent disability evaluations, and processed 8 of 30 TBI claims incorrectly. Results in the temporary 100 percent disability evaluations suggest improvement since the VARO was last inspected in 2012. However, OIG reported 7 of 9 cases relating to SMC and ancillary benefits contained errors. Honolulu VARO staff accurately established the correct date of claim in an electronic system of records for all 30 claims sampled. OIG inspectors also determined VARO staff delayed taking action in processing 14 of the 30 benefits reduction cases because VARO management did not prioritize this workload. The Director of the Honolulu VARO concurred with OIG's recommendations for improvement. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Phoenix, Arizona, VARO

Overall, OIG benefits inspectors determined Phoenix VARO claims processing staff incorrectly processed 10 of the 90 (11 percent) disability claims selected for review. The claims processing errors resulted in approximately \$35,500 in improper benefits payments at the time of OIG's inspection in March 2015. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Phoenix VARO. OIG staff found VARO staff correctly processed 28 of 30 claims related to temporary 100 percent disability evaluations, and correctly processed 28 of the 30 TBI claims. Results in these two areas suggest improvement since the VARO was last inspected in 2012. However, OIG reported 6 of the 30 sample cases relating to SMC and ancillary benefits contained errors. Phoenix VARO staff accurately established the correct date of claim in an electronic system of records for all 30 claims sampled. OIG inspectors determined VARO staff delayed or incorrectly processed 9 of the 30 benefits reduction cases because VARO management did not prioritize this workload. The Director of the Phoenix VARO concurred with OIG's recommendations for improvement. [\[Click here to access report.\]](#)

Results of Benefits Inspection of Los Angeles, California, VARO

Overall, OIG benefits inspectors determined Los Angeles VARO claims processing staff incorrectly processed 24 of the 90 (27 percent) disability claims selected for review. The claims processing errors resulted in approximately \$499,976 in improper benefits payments at the time of OIG's inspection in February 2015. The OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Los Angeles VARO. OIG staff found VARO staff incorrectly processed 13 of 30 claims related to temporary 100 percent disability evaluations, and processed 7 of 30 TBI claims incorrectly. Results in these two areas do not suggest improvement since the VARO was last inspected in 2012. OIG reported 4 of 30 cases relating to SMC and ancillary benefits contained errors. Los Angeles VARO staff did not accurately establish the correct date of claim in an electronic system of records for 2 of 30 claims sampled. OIG inspectors also determined VARO staff delayed taking action in processing 3 of the 30 benefits reduction cases because VARO management did not prioritize this workload. The Director of the Los Angeles VARO concurred with OIG's recommendations for improvement. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In September 2015, 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 nine activities:

- (1) Quality Management
- (2) Advance Directives

- (3) Emergency Airway Management
- (4) Environment of Care
- (5) Medication Management
- (6) Coordination of Care
- (7) Surgical Complexity
- (8) MH Residential Rehabilitation Treatment Program
- (9) Suicide Prevention Program

[Durham VAMC, Durham, North Carolina](#)

[Robley Rex VAMC, Louisville, Kentucky](#)

[VA Maine HCS, Augusta, Maine](#)

[VA New Jersey HCS, East Orange, New Jersey](#)

[William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin](#)

[Manchester VAMC, Manchester, New Hampshire](#)

Community Based Outpatient Clinic Reviews

In September 2015, OIG published nine 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 four operational activities:

- (1) Alcohol Use Disorder Care
- (2) Human Immunodeficiency Virus Screening
- (3) Outpatient Lab Results
- (4) Environment of Care

[VA Maine HCS, Augusta, Maine](#)

[Durham VAMC, Durham, North Carolina](#)

[Robley Rex VAMC, Louisville, Kentucky](#)

[VA Pittsburgh HCS, Pittsburgh, Pennsylvania](#)

[Alaska VA HCS, Anchorage, Alaska](#)

[William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin](#)

[Manchester VAMC, Manchester, New Hampshire](#)

[VA Pacific Islands HCS, Honolulu, Hawaii](#)

[Arkansas Veterans HCS, Little Rock, Arkansas](#)

CRIMINAL INVESTIGATIONS

VA Fiduciary Arrested for Criminal Mistreatment and Theft

A VA fiduciary assigned to over 80 veterans was indicted and arrested for criminal mistreatment and theft. A VA OIG, SSA OIG, and Oregon Department of Justice's Medicaid Fraud Control Unit investigation revealed that the defendant overcharged her clients, deposited checks intended for veteran clients into personal and business accounts, and failed to provide final estates to surviving heirs of deceased clients. The total loss to the beneficiaries is approximately \$211,000.

VA Fiduciary Sentenced for Misappropriation by a Fiduciary

A VA fiduciary was sentenced to 366 days' incarceration, 3 years' supervised release, and was ordered to pay restitution of \$159,961 after pleading guilty to misappropriation by a fiduciary. An OIG investigation revealed that the defendant stole funds and personal property from his VA and non-Federal clients for whom he served as a state-appointed conservator.

VA Fiduciary Pleads Guilty to Misappropriation by a Fiduciary

A VA fiduciary pled guilty to misappropriation by a fiduciary. An OIG investigation revealed that for over 5 years the defendant embezzled \$141,734 from 22 veterans by setting up a sham health care company and opening a bank account in its name in order to receive funds from veterans, taking excessive cash withdrawals on veterans' accounts, transferring VA funds from one veteran's account to other veterans' accounts in a Ponzi-style scheme, and taking excessive fiduciary fees from veterans.

VA Fiduciary Sentenced for Theft

A VA court-appointed fiduciary was sentenced to 15 months' incarceration, 12 months' supervised release, and was ordered to pay restitution of \$321,512 after pleading guilty to theft of Government property, Social Security representative fraud, and criminal forfeiture related to allegations of theft. A \$320,000 Forfeiture Money Judgment was also issued, and an order of Disbarment was filed. A VA OIG and SSA OIG investigation revealed that the defendant failed to provide fiduciary accountings to VA and misused over \$89,636 in VA funds issued to an incompetent veteran.

VA Beneficiary's Granddaughter Sentenced for the Financial Exploitation of a Vulnerable Adult

A VA beneficiary's granddaughter was sentenced to 1 to 2 years' incarceration (suspended), 2 years' probation, 40 hours' community service, and ordered to pay restitution of \$41,567 after pleading guilty to the financial exploitation of a vulnerable adult. An OIG and state Attorney General's Office investigation revealed that the defendant stole over \$40,000 of her grandmother's funds, to include \$23,830 of VA benefits. The victim, who received VA widow's benefits, suffered from dementia and resided in a nursing home. The victim died during the investigation.

Former VA Fiduciary Sentenced for Theft by Conversion

A former VA fiduciary was sentenced to 10 years' probation and ordered to pay VA restitution of \$15,747 after pleading guilty to theft by conversion. An OIG investigation revealed that the defendant, appointed as a VA fiduciary to manage a veteran's financial affairs, diverted VA funds for his own use.

Former Madison, Wisconsin, VAMC Employee Sentenced for Identity Theft

A former Madison, WI, VAMC employee was sentenced to 18 months' incarceration (stayed) and 5 years' probation after pleading guilty to misappropriating an identity to obtain money and theft. An OIG and local police investigation revealed that the defendant stole the PII of deceased veterans while employed at the medical center and used the information to open credit card accounts.

Veteran Indicted for VA Compensation Fraud

A veteran was indicted for false statements and theft of Government funds. An OIG investigation revealed that in 1998 the defendant provided a medical exam from a non-VA ophthalmologist that stated his visual acuity was "hand motion" only, his vision would not get better, and could not be corrected by surgery. VA awarded the defendant a 100 percent disability rating in 1998 for blindness. The investigation further revealed that the defendant had a valid driver's license, rode a motorcycle, and worked for 6 years (2006-2012) as a mail clerk at a private business. A VA ophthalmologist examined the defendant and determined he is not and could never have been blind. The loss to VA is approximately \$468,000.

Veteran Pleads Guilty to Theft of VA Compensation Benefits

A veteran pled guilty to theft of Government funds after an OIG investigation revealed that he claimed false stressors in order to fraudulently collect VA compensation benefits for 13 years. The defendant claimed that he participated in a "dead body detail" during Operation Desert Storm; that he was involved in an incident where a fellow soldier's Humvee was fired upon causing the vehicle to lose control and crash, killing the soldier; and that he was involved in firefights with Iraqi combatants. The defendant was able to successfully obtain multiple diagnoses of PTSD dating back to the 1990's by referencing these false stressors and requesting a Central Office review with emphasis on entitlement for PTSD. The investigation revealed that from July 1991 to January 1992 the defendant served as a U.S. Army administrative clerk in Saudi Arabia and Kuwait and did not serve in a combat role or engage in combat during his tour of duty overseas. The defendant was never issued a weapon overseas. Additionally, the defendant was not involved in any Humvee accident or "dead body detail." The loss to VA is \$150,164. The defendant was previously convicted in 1996 as the result of an OIG investigation involving the VA Home Loan Program.

Daughter of Deceased VA Beneficiary Indicted for Theft of VA Funds

The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in December 2009. The defendant voluntarily surrendered an automated teller machine card in her deceased mother's name, which she admitted using to access the account. The defendant resigned from the Columbus Police Department during the investigation. The loss to VA is \$89,646.

Former Spouse of a Veteran Sentenced for Theft of Government Funds and False Statements

The former spouse of a veteran was sentenced to 3 years' probation and ordered to pay VA \$55,894 in restitution after pleading guilty to theft of Government funds and false statements. An OIG investigation revealed that the defendant, who was receiving VA widow's pension benefits, failed to report her remarriage and provided false statements in an effort to continue to fraudulently receive the benefits.

Veteran Sentenced for VA Compensation Theft

A veteran was sentenced to 2 years' probation, an \$8,000 fine, and was ordered to pay VA restitution of \$53,852 after pleading guilty to theft of public money. An OIG investigation revealed that the defendant, who was declared unemployable by VA as of September 2011, was employed prior to that timeframe and continued to work into 2015 for various employers, earning substantial income despite claiming to VA on three occasions that he was not employed. The defendant admitted to providing VA with false and incomplete information regarding his employment so he could receive the additional IU benefits.

Non-Veteran Arrested for Theft of Health Care Benefits

A non-veteran was arrested for theft in connection with health care, theft of Government property, fraudulent demand against the United States, and fraudulently holding oneself out to be a recipient of military decorations or medals. An OIG investigation revealed that the defendant falsely represented himself as both a United States Marine Corps and California Army National Guard veteran in order to obtain VA health care benefits. The loss to VA is \$13,623.

Former Rhode Island State Cemetery Employee Pleads Guilty to Theft of Government Property

A former Rhode Island State cemetery employee pled guilty to theft of Government property. An OIG and Rhode Island State Police investigation revealed that for several years the defendant removed worn or broken grave markers from the cemetery and brought them to his residence. A search of the defendant's property revealed that approximately 150 VA-provided grave markers were being used as flooring for a shed and two make-shift garages. Additional grave markers and a box of American flags, allegedly stolen from the State veterans' cemetery, were also discovered on the defendant's property.

Veteran Pleads Guilty to Assaulting East Orange, New Jersey, VAMC Employee

A veteran pled guilty to assaulting an East Orange, NJ, VAMC employee. An OIG investigation revealed that the defendant attacked a social worker by striking her with a cane and fracturing her elbow. The defendant was ordered by the court to be held pending sentencing.

Long Beach, California, VAMC Employee Arrested for Criminal Threats

A Long Beach, CA, VAMC employee was arrested for criminal threats. An OIG and VA Police Service investigation revealed that the defendant made threats against a VA employee who had accused him of sexual harassment/battery and also made threats against a witness. The defendant resigned in lieu of termination.

University of California, Los Angeles, Anesthesiologist Sentenced for Drug Diversion

A University of California, Los Angeles, anesthesiologist was sentenced to 2 years' probation, a \$10,000 fine, and ordered to undergo drug testing after pleading guilty to theft of Government property and possession of a controlled substance. In addition, the

California Medical Board adopted a stipulated civil settlement and disciplinary order between the anesthesiologist and the California Attorney General's Office involving gross negligence, incompetence, use of dangerous drugs, and unprofessional conduct. The civil agreement required the anesthesiologist to be placed on probation for 5 years, which included random drug testing, ethics training, psychiatric evaluation, psychotherapy, professional monitoring, and other requirements. An OIG investigation revealed that during a rotation at the West Los Angeles, CA, VAMC, and while providing anesthesia care to a veteran in surgery, the anesthesiologist collapsed in the operating room due to ingestion of three tablets of clonazepam and self-injection of ketamine, midazolam, and fentanyl. The defendant was found on the floor with a tourniquet around his wrist and empty vials of the controlled substances near him. The investigation determined that the defendant diverted the drugs from the VAMC. During sentencing, the anesthesiologist admitted placing the patient's life in danger.

Veterans and Other Subjects Arrested for Drug Distribution at the Philadelphia, Pennsylvania, VAMC

As part of "Operation Sentinel," 10 veterans were arrested for the distribution of heroin, oxycodone, Percocet, and methadone at the Philadelphia, PA, VAMC. Also, two additional subjects are being sought on outstanding arrest warrants; four other subjects will be issued U.S. District Court Violation Notices. A VA OIG, PA State Police, and VA Police Service investigation determined that the defendants were selling heroin and their VA-prescription medication to other veterans receiving treatment at the medical center. The investigation was initiated after a veteran seeking to overcome his drug addiction was pressured by the defendants to purchase narcotics at the VAMC and to sell them his VA prescription medication.

Lyons, New Jersey, VAMC Drug Distribution Investigations Result in Multiple Convictions

A 2-year VA OIG, FBI, and VA Police Service investigation, named *Operation Red, White, and Blue Magic* (OP RWB), was concluded this month. OP RWB resulted in seven defendants with extensive criminal histories being prosecuted on Federal drug distribution charges. The investigation was initiated following the death of a veteran at the Lyons, NJ, VAMC from a drug overdose. Five out of the seven defendants were VA employees and all seven subjects pled guilty. Along with receiving probation and monetary penalties, six of the seven defendants were sentenced to incarceration. Due to the success of OP RWB, *Operation Jersey Vice* (OP JV) was initiated. This investigation continued the pursuit of individuals selling illegal drugs on VA property. The case resulted in the successful prosecution of four defendants. OP RWB and OP JV led to four additional independent and successful investigations, including illegal drug activity and loan sharking.

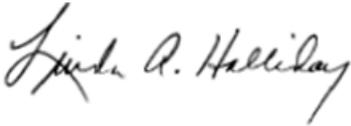
Two VA Employees and Others Arrested for Drug Distribution at the Long Beach, California, VAMC

Operation Diverted Dreams, which is a multi-agency drug investigation, has resulted in the arrest of 24 defendants, including two VA employees, who were charged with selling heroin, methamphetamine, marijuana, crack cocaine, oxycodone, Percocet, fentanyl,

and tramadol at the Long Beach, CA, VAMC. A handgun and a fully automatic SKS rifle were also sold to undercover officers during the investigation.

Two West Haven, Connecticut, VAMC Employees Arrested for Selling Narcotics and Endangering the Welfare of a Child

Two West Haven, CT, VAMC Food and Nutrition Service employees were arrested for selling narcotics and endangering the welfare of a child. An OIG and Statewide narcotics task force investigation determined that the defendants sold heroin during an undercover operation at the medical center. One of the employees had her 3-year-old child with her when she delivered the heroin to the other employee to sell.



Linda A. Halliday
Deputy Inspector General