CONGRESSIONAL TESTIMONY
Inspector General Testifies Before the House Veterans’ Affairs Subcommittee on Disability Assistance and Memorial Affairs
Mr. Michael J. Missal, Inspector General, testified before the Subcommittee on Disability Assistance and Memorial Affairs, House Veterans’ Affairs Committee, on September 27, 2016, on the results of the Office of Inspector General’s (OIG) Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans. Mr. Missal’s testimony pertained to necessary adjustments that the Veterans Benefits Administration (VBA) needs to make regarding compensation and pension benefits for veterans incarcerated in Federal, state, or local penal institutions as required by Federal law. OIG also reported that there was a lapse in the computer matching agreement between VA and the Bureau of Prisons for almost 7 years so no matching was occurring with regards to veterans in Federal penal institutions. The lack of a computer matching agreement and a lack of focus on these non-rating claims indicate weak financial stewardship. In total, OIG estimated that overpayments by VBA on these cases alone totaled approximately $307.9 million. Mr. Missal was accompanied by Mr. Nick Dahl, Director, OIG’s Audits and Evaluations Division in Bedford, Massachusetts. [Click here to access testimony.]

OIG REPORTS
Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System
At the request of several members of Congress, OIG evaluated the significant events that led to major delays in construction and to the increase in cost of the Denver Medical Center, Eastern Colorado Health Care System project (Denver project), to the current estimated cost of $1.675 billion. OIG conducted the review from July 2015 through May 2016. The concept for the Denver Medical Center Replacement project dates back to the late 1990s and was in response to the region’s growth in the veteran population and the need to replace an aging and inadequate facility built in 1951. The new facility will be larger than the current facility by approximately 600,000 square feet. The Denver project will provide additional functional capability, such as more examination, treatment, and dental procedure rooms, as well as 30 beds designated for Spinal Cord Injury patients (the existing hospital has none). The project took years to start due to decisions under five former VA Secretaries that resulted in extensive changes to the concept, scope, and design of the project from 2000 through 2009. Significant and unnecessary cost overruns and schedule slippages related to the construction of the Denver Medical Center were primarily the result of poor business decisions, inexperience with the type of contract used, and mismanagement by VA senior leaders. OIG’s review identified major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning and design, construction, acquisition, and change order issues. Congress appropriated $800 million between 2004 and 2012 for land acquisition, design, construction, and
consultant services. VA’s 2009 acquisition plan initially estimated construction would be finished in 2013. However, 2015 project estimates placed the final cost at approximately $1.675 billion, or more than twice VA’s fiscal year (FY) 2009 approved $800 million project budget. The project is estimated to be completed mid-to-late 2018, or almost 20 years after VA identified the need to replace its aging facility.

[Click here to access report.]

Audit of VBA’s Post-9/11 G.I. Bill Tuition and Fee Payments
OIG evaluated VBA’s oversight of Post 9/11 G.I. Bill tuition and fee payments to determine if payments were appropriate and accurate. Of the $5.2 billion in Post-9/11 G.I. Bill tuition and fee payments made for nearly 796,000 students during academic year 2013-2014 (August 1, 2013, to July 31, 2014), OIG reviewed more than $1.7 million in payments made to 50 statistically-selected schools for 225 students. OIG found VBA staff at the Regional Processing Offices (RPO) made 46 improper payments totaling just under $90,900. In addition, OIG identified 39 overpayments totaling just under $96,400 where the RPOs had not initiated recoupment actions. In total, 32 of the reviewed schools, including 19 for-profit schools, had improper payments and missed recoupments. Furthermore, 20 of the 32 identified schools lacked compliance surveys. Due to program design, VBA must make payments prospectively based on the enrollment information submitted by the schools. Many of these improper payments and missed recoupments occurred because School Certifying Officials’ (SCOs) submitted incorrect and/or incomplete information on students’ enrollment certifications. To help reduce improper payments and missed recoupments, VBA needs to:
(1) improve the SCOs’ awareness of program requirements related to the submission of accurate and complete enrollment certifications; (2) refine the school selection process and ensure the completion of required compliance surveys to improve the verification and monitoring of tuition and fee certifications; (3) develop adequate guidance regarding allowable book fees and repeated classes; and (4) verify and obtain supporting documentation for mitigating circumstances. From the more than $5.2 billion tuition and fee payments made for academic year 2013-2014, OIG projected that VBA made about $247.6 million in improper payments and more than $205.5 million in missed recoupments annually. As a result, VBA may have an estimated $2.3 billion in improper tuition and fee payments and missed recoupments ($1.2 billion in improper payments and $1 billion in missed recoupments) over the next 5 academic school years if it does not strengthen program controls. OIG recommended VBA improve school outreach to ensure accurate and complete certifications are submitted, develop risk profiles for schools to periodically review and verify their certifications, incorporate risk factors into the prioritization and completion of compliance surveys, revise the SCO Handbook, and ensure that mitigating circumstances are properly verified and supporting documentation is obtained. Furthermore, OIG recommended VBA strengthen policies and controls related to the discontinuance and recoupment of payments, repeated classes, and satisfactory academic progress and that it take action, where appropriate, to recover identified improper payments and initiate recoupments.

[Click here to access report.]
Review of VBA’s Special Monthly Compensation Housebound Benefits
OIG reviewed whether the VBA properly granted entitlement to all statutory housebound special monthly compensation (SMC) benefits for living veterans with a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent. This review focused on whether VBA failed to pay or delayed paying any of these benefits. OIG also assessed the accuracy of SMC evaluations for veterans receiving compensation at the housebound rate, including statutory housebound, and housebound in fact, as well as SMC that had been incorrectly coded as housebound benefits. OIG conducted its review from March 2015 through February 2016. The first review objective focused on a population of about 186,000 living veterans’ cases nationwide that at some point were entitled to statutory housebound SMC benefits based on a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent as of March 10, 2015. To address the second objective, OIG reviewed a population of about 98,400 veterans’ cases nationwide receiving compensation at the housebound rate for any reason as of March 10, 2015. OIG conducted onsite interviews with VBA management and staff at eight VA regional offices (VARO) from September through November 2015. OIG reviewed a statistically selected random sample of 250 cases with eligibility to statutory housebound benefits, based on veterans having a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent as of March 10, 2015. OIG also reviewed a stratified random sample of 247 cases of veterans receiving compensation at the housebound rate and grouped according to their combined evaluation. OIG identified errors in 45 of 250 cases (18 percent) in which veterans were entitled to statutory housebound benefits based on having a single disability rated as 100 percent disabling and one or more disabilities independently rated at 60 percent or more. Errors included failure to grant housebound benefits, failure to pay housebound benefits that had been granted, and prematurely reducing housebound benefits. OIG also found errors in 127 of 247 cases (51 percent) in which veterans were being paid compensation at the housebound rate. In 10 additional cases, OIG could not determine whether housebound in fact benefits were accurate because VBA’s eligibility criteria were unclear. OIG identified different error rates within each group of the stratified sample. As a result, OIG estimated an overall error rate of 10 percent for veterans being paid compensation at the housebound rate, and a 27 percent error rate for veterans with combined evaluations that were 90 percent or less. Generally, the inaccuracies OIG identified involved housebound benefits for unemployable veterans, entry of SMC codes into the electronic system, and housebound benefits on an in fact basis. Veterans entitled to statutory housebound benefits did not consistently receive correct benefits decisions. OIG estimated errors in 33,400 of 186,000 cases. OIG estimated that these errors resulted in veterans being underpaid $110.1 million through February 2015, and receiving recurring underpayments of $1.8 million per month as of March 2015. In addition, OIG estimated that VBA staff delayed paying veterans $54.3 million. Errors for veterans receiving compensation at the housebound rate also resulted in incorrect benefits decisions. OIG estimated errors in 2,600 of 9,800 cases for which veterans’ combined evaluations were 90 percent or less. OIG estimated that these errors resulted in veterans being overpaid $44.3 million through February 2015, with ongoing overpayments of $1.1 million per month as of March 2015. The Principal
Deputy Under Secretary for Benefits concurred with OIG recommendations and stated that VBA will conduct an annual review of SMC housebound benefits with the initial review in October 2016, and then each October thereafter. [Click here to access report.]

**Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VARO**

In October 2015, OIG received a request from U.S. Senators Richard Blumenthal and Tammy Baldwin to review an incident concerning the improper dissemination of veterans’ personally identifiable information (PII) by a Wisconsin Department of Veterans Affairs (WDVA) employee to an unauthorized recipient over VA’s email server. OIG substantiated the allegation that on April 1, 2015, a WDVA employee improperly disseminated over VA’s email server a monthly claims report. The report contained updates of Wisconsin veterans’ disability claims to unaccredited County and Tribal Veterans Service Organization employees not authorized to handle sensitive information, as well as to a Wisconsin veteran. The Milwaukee VARO sharing of claims information with WDVA was consistent with Federal policy. This incident occurred because VA did not have adequate processes and information security controls in place to safeguard against unauthorized disclosure of PII. VA’s Office of Information and Technology did not adequately configure VA’s information security filtering software to block the dissemination of unencrypted sensitive data before releasing information to WDVA. In addition, the VARO did not have a formal agreement with WDVA for sharing PII. VA put Wisconsin veterans’ PII at unnecessary risk of interception and misuse. Further, VA’s 2015 Federal Information Security Modernization Act audit reported security deficiencies similar in type to those identified in this report as material weaknesses over the last few years. OIG recommended the Assistant Secretary for Information and Technology improve VA’s email security filtering software controls, establish formal agreements with third-party organizations, evaluate whether permanent encryption controls are needed for non-VA employees with VA accounts, and conduct reviews of processes and controls at VAROs collaborating with third party organizations to ensure security of sensitive veterans’ information. The Assistant Secretary for Information and Technology nonconcurred with OIG’s recommendations and stated that VA’s position was unchanged since its response in February 2016 to the Senate Committee on Homeland Security and Governmental Affairs. The Assistant Secretary noted that all policies, procedures, and required training were already in place. However, OIG continues to maintain its position that VA did not have adequate processes and information security controls in place to safeguard against unauthorized disclosure of PII. [Click here to access report.]

**Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona**

At the request of Senator Jeff Flake, OIG determined the merit of allegations regarding a delay in treating a patient diagnosed with lung cancer at the Phoenix VA Health Care System (HCS), Phoenix, AZ. OIG substantiated a delay between the diagnosis of the lung cancer and treatment. OIG could not determine whether this delay impacted the final outcome. OIG substantiated a delay in identification of symptoms of cancer...
metastasis; however, OIG did not substantiate a delay in treatment once the brain metastasis was discovered. OIG identified lack of patient education and primary care provider involvement in the coordination of subsequent cancer-related specialty appointments as factors contributing to delays in care. OIG did not substantiate the allegation that following his craniotomy there was a failure to communicate the patient’s status to the patient and family. The patient and his family received accurate information regarding his status and the plan to transition the patient to a non-VA nursing home and place him in hospice. OIG did not substantiate a failure to adequately manage the patient’s pain. Pain management monitoring, decisions, and education were documented in the electronic health record (EHR). OIG identified several additional issues during our review. The patient’s risk for depression was not fully assessed following the new diagnosis of lung cancer. Although the EHR contained evidence that system providers were aware of results of non-VA testing, non-VA medical records were not consistently available in the EHR. Service agreements were not active for the oncology and neurology services. Consults placed during the course of the patient’s treatment were designated with routine urgency even though the clinical expectation and actual need was for a more urgent response.

[Click here to access report.]

Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington

OIG conducted an inspection at the request of Senator Patty Murray at the Mann-Grandstaff VA Medical Center (VAMC), Spokane, WA, in response to allegations of failures in Emergency Department (ED) care, mental health (MH) services, and suicide prevention training. OIG did not substantiate a failure to actively recruit and retain qualified ED providers. OIG did not substantiate that the VAMC’s change from an ED to an Urgent Care Clinic (UCC) with a reduction in operating hours resulted in a deficiency in care. OIG determined that the VAMC was thoughtful in planning an approach to align the delivery of care with resources thereby reducing the potential for adverse events after the loss of ED providers. VAMC leaders took steps to inform the public before changing to a UCC and tracked after-hour attempts to access care once the change occurred. OIG did not substantiate that quality of care issues contributed to the death by suicide of a patient. OIG determined that from the time of his initial contact until his last contact with the VAMC’s MH staff, the patient was assessed by an interdisciplinary team for risk of suicide and determined to be not at risk for self-harm. OIG substantiated that VAMC leaders failed to comply with Veterans Health Administration (VHA) requirements for suicide prevention training. OIG found that not all health care providers who required training had completed the Suicide Risk Assessment for Clinicians course within the required first 90 days of hire and the VAMC lacked a process to assign and track the required training that has since been resolved. Only three staff were delinquent in completion of the training as of May 17, 2016. At the time of publication, OIG closed the recommendation that the Interim VAMC Director strengthen processes to ensure suicide prevention training is completed per VHA requirements and monitor compliance. [Click here to access report.]
Summarization of Select Aspects of the VA Pacific Islands HCS, Honolulu, Hawaii
OIG conducted a review of the VA Pacific Islands Health Care System (VAPIHCS), Honolulu, HI, to collect and summarize supplementary data in support of an August 2015 Combined Assessment Program (CAP) review and to respond to Senator Mazie K. Hirono’s concerns about access to care, travel benefits, cultural diversity, homeless services, and MH care. OIG reviewed VHA’s 6-point plan to address capacity and access to care within VAPIHCS primary care clinics. OIG found VAPIHCS has similar administrative and clinician availability issues found across the VA system for non-VA care compounded by a shortage of providers, the complexity of island logistics, and the diversity of the population served. VAPIHCS Beneficiary Travel Program’s expenditures are substantial due to providing care for patients across multiple islands. VAPIHCS acknowledged a delay in processing travel benefits claims, but expected to resolve the backlog by January 2016. As of August 2016, all but 21 of the unprocessed claims were resolved. OIG found that while there may be occasions when a provider’s management of a situation could potentially lack cultural sensitivity and competence, interviewees did not report this was a wide-spread problem. OIG also found VAPIHCS offers a comprehensive array of services for homeless veterans, a variety of general and specialty MH services, and has improved staffing in the Suicide Prevention Program. In February 2014, VAPIHCS had one of the highest wait lists VA-wide for patients wanting primary care appointments. VAPIHCS implemented a 6-point plan to increase primary care panel sizes, extend clinic hours, increase primary care staffing at the community based outpatient clinics (CBOC), contact and schedule appointments for wait-listed veterans, and educate veterans on the importance of keeping appointments or calling to cancel. OIG found VAPIHCS had substantially improved access to care for new patients awaiting primary care appointments. [Click here to access report.]

Review of VA’s Award of the Patient-Centered Community Care Contracts
OIG reviewed VA Patient-Centered Community Care (PC3) contracts to determine whether they were adequately developed and awarded. In September 2013, VA awarded the PC3 contracts to provide veterans with a comprehensive, nationwide network of high quality, specialty health care services. The contracts were awarded for an estimated $9.4 billion, with a potential cost to VA of $27 billion. OIG found significant weaknesses in the planning, evaluation, and award of the PC3 contracts. The PC3 contracts were not developed or awarded in accordance with acquisition regulations and VA policy intended to ensure services acquired are based on need and at fair and reasonable prices. The contracting officials solicited proposals from vendors without clearly articulating VA’s requirements. Thus, the vendors bidding on the solicitation did not have sufficient information on the type of specialty health care services they would need to provide, where to provide them, and the frequency. Therefore, VA increased the risk of not achieving the objectives of PC3 by inadequately identifying its health care service requirements. OIG found that documentation supporting vital contract award decisions was either not in VA’s Electronic Contract Management System or incomplete. Of the documents available, OIG noted that the awarded costs were actually negotiated at a higher rate than originally proposed by one of the vendors. The evidence for these decisions was not documented in the price negotiation memo. Accountability for ensuring the effective award of these contracts was not vested with a
senior executive at VA. Although the contracting officer had the authority to execute these contracts, the level of oversight for this degree of contract risk did not provide reasonable assurance that VA’s interests were adequately protected. OIG recommended the Principal Executive Director for Acquisition, Logistics, and Construction improve oversight and accountability, and ensure sufficient planning on all high-dollar value and complex acquisitions. An acceptable corrective action plan was provided and OIG will follow up on its implementation. [Click here to access report.]

Alleged Inappropriate Opioid Prescribing Practices, Rutherford County CBOC, Rutherfordton, North Carolina
OIG conducted an inspection in response to complaints about inappropriate opioid prescribing practices at the Rutherford County CBOC, Rutherfordton, NC, associated with the Asheville VAMC, Asheville, NC. OIG did not substantiate that CBOC primary care physicians were being forced to write prescriptions for opioids. However, during OIG’s review, we noted the clinical and administrative environment in which CBOC providers prescribed opioids and managed the pain-related needs of their patients and found several processes that negatively impacted the delivery of quality patient care. OIG recommended that the Facility Director ensure that: (1) primary care physicians are able to assess, treat, monitor, and reassess patients on chronic opioid therapy within the appropriate timeframe; (2) the Veterans’ Integrated Pain Management Clinic meets non-opioid pain management needs of patients as evidenced by timely consultation completions; (3) clinical and administrative demands of chronic opioid therapy care are considered when determining appropriateness of primary care physician staffing and that staffing plans are in place for planned and unplanned provider vacancies and absences; (4) benzodiazepine appropriateness evaluations are completed as required for chronic opioid therapy patients with post-traumatic stress disorder (PTSD); (5) primary care and MH providers communicate and coordinate care for PTSD patients receiving both opioids and benzodiazepines; and (6) regular communication occurs between facility leadership and CBOC leadership to support consistent high quality care. [Click here to access report.]

Review of VA’s Alleged Improper Termination of the e-Learning Task Order
In March 2015, U.S. Senator Mark Warner requested that OIG evaluate an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated. OIG did not substantiate that VA’s decision to terminate the e-learning task order was improper, as the Federal Acquisition Regulation provides broad latitude for termination for convenience of the Government. In February 2014, VA awarded the e-learning task order for approximately $2.8 million. In September 2014, Office of Logistics and Supply Chain Management (OLSCM) officials determined the development of the e-learning training was not meeting its needs because the curriculum included courses not needed and did not include sufficient content. OLSCM officials decided to use existing VA online training. In February 2015, the task order was terminated for the convenience of the Government after paying the contractor approximately $1.9 million, which included settlement fees of approximately $56,000. According to the contracting officer’s representative, the $1.9 million was spent on various deliverables, including project management, quality assurance, curriculum,
implementation and evaluation plans, a curriculum design document, a prototype, weekly progress reports, and eight courses in various stages of completion. The termination occurred because of the lack of coordination between Veterans Affairs Acquisition Academy (VAAA) and OLSCM to identify Office of Acquisition and Logistics’ e-learning training needs and the best method to deliver that instruction. VAAA’s personnel developed the e-learning requirement without coordinating the development with OLSCM. If the planning of the task order had been properly coordinated between VAAA and OLSCM, it might not have resulted in the termination of the task order and the payment of approximately $1.9 million for supply management courseware that was not completed. OIG recommended the Deputy Assistant Secretary for Acquisition and Logistics implement a mechanism to ensure proper coordination between VAAA and OLSCM when developing logistics training. The Principal Executive Director provided evidence of the agreement made to ensure proper coordination when developing logistics training. OIG considers the recommendation closed.

[Click here to access report.]

Review of Alleged Waste of Funds at VHA's Madison VAMC, Madison, Wisconsin

OIG received an allegation regarding the potential waste of funds at the Madison VAMC, located in Madison, WI. The complainant alleged that the VAMC had purchased a laser lead extractor in 2012 for about $1 million and never used it. The complainant also alleged that the VAMC spent approximately $125,000 on a robot to distribute supplies that could not operate autonomously within the hospital and installed a patient lift for about $2,500, despite staff stating that they did not need it and would not use it. OIG substantiated the allegation that the Cardiology department did not use the laser lead extractor. OIG found that the VAMC did not purchase but leased this device at a cost of about $100,000. Even though the laser lead extractor had been on hand for nearly two and a half years, the Cardiology department was unable to use it because of operating room space utilization and staffing issues. Instead, the Cardiology department sent veterans to non-VA facilities to have the procedures performed. OIG determined that VAMC officials involved in the decision to lease the device did not ensure the lease of the laser lead extractor was the most cost-effective approach for extracting pacemaker and defibrillator leads. OIG found that the VAMC purchased two robots for nearly $313,000. OIG substantiated the allegation that the VAMC could not use the robots effectively because, when planning the acquisition, the logistics department did not consider whether the robots could operate effectively within the facility. As a result, the two robots have not been used in about 2 years. OIG concluded that the VAMC could have better used the roughly $410,000 it spent to lease the laser lead extractor and purchase the robots. OIG did not substantiate the allegation regarding the patient lift. The VAMC installed the lift in response to an encounter with a double amputee bariatric patient and Safe Patient Handling Program guidance. OIG found that the lift provides a benefit to employees and ensures the safety of patients when they need to be moved. OIG recommended the Veterans Integrated Service Network (VISN) 12 Acting Director ensure Madison VAMC management complies with VAMC policy requiring sufficient justification supporting equipment acquisition requests. OIG also recommended the VISN 12 Acting Director conduct an analysis to ensure VISN facilities are effectively utilizing any laser lead
extractors. The VISN 12 Acting Director provided plans for corrective action. OIG will monitor planned actions and follow up on their implementation.
[Click here to access report.]

Review of Alleged Contractor Information Security Violations in the Alaska VA HCS, Anchorage, Alaska

In December 2014, OIG’s Hotline received an allegation that ProCare Home Medical, Inc., (ProCare) was improperly storing and sharing VA sensitive data on contractor personal devices in violation of Federal information security standards. More specifically, the complainant alleged that ProCare was allowing its employees to use personal computers and phones to access the company computer system and download VA sensitive data, including veterans’ personal health information. OIG substantiated the allegation that ProCare employees, according to its staff, accessed electronic sensitive veteran data with their personal computers from home through an unauthorized cloud-based system without encryption controls. OIG also noted that ProCare employees or malicious users could potentially use personal devices on an unauthorized wireless network to access sensitive veteran information. In addition, OIG determined that ProCare was storing sensitive hard copy and electronic veteran information in an unsecured manner at their facility. OIG further noted that ProCare could not provide evidence that applicable ProCare personnel had completed VA required security awareness training or signed the Contractor Rules of Behavior prior to receiving access to VA sensitive data. These security deficiencies occurred because VA did not provide effective oversight of ProCare personnel to ensure the appropriate protection of veteran information at the contractor facility. As a result, veteran sensitive information was vulnerable to loss, theft, and misuse, including identity theft or fraud. OIG found no evidence that veteran sensitive information was compromised. OIG recommended the VA Northwest Health Network management assign a local Contracting Officer’s Representative and Information Security Officer to provide oversight of Alaska VA HCS contractors. OIG also recommended the VA Northwest Health Network management, in conjunction with the Assistant Secretary for Information and Technology, conduct a site assessment of ProCare information security controls to ensure compliance with VA information security requirements. The Assistant Secretary for Information and Technology and the VA Northwest Health Network Acting Director provided an appropriate corrective action plan. OIG will follow up on the implementation of the corrective actions. [Click here to access report.]

OIG Determination of VHA Occupational Staffing Shortages

OIG conducted its third determination of VHA occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014. OIG analyzed VHA facility rankings of critical occupations, to interpret “largest staffing shortages.” This is a broader deliberation than simply the number needed to replace or backfill vacant positions. OIG performed a rules-based analysis on VHA data to identify these occupations, analyzed data on gains and losses for occupations with the largest staffing shortages, and assessed VHA’s progress with implementing staffing models. OIG determined that the largest critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, Physical
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Therapist, and Medical Technologist. Because of a tie for 5th place, OIG identified six occupations in our determination. OIG’s analysis of the staffing gains and losses for the first full year after implementation of the Veterans Access, Choice, and Accountability Act of 2014 shows that for critical need occupations, a significant percentage of the total gains continues to be offset by staff losses. OIG also determined that the percentage of regrettable losses to total onboard staff in many critical need occupations was high relative to net increases in onboard staff. While VHA has made progress in developing and implementing staffing models, OIG did not identify a plan that included a set of milestones and timelines for further staffing model development to achieve full implementation. VHA has a draft report on staffing models which is pending presentation to senior leadership. OIG made four recommendations, two of which are repeat recommendations. [Click here to access report.]

Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor HCS, New York, New York

OIG conducted an inspection in response to complaints about operating room (OR) reusable medical equipment (RME) and Sterile Processing Service (SPS) at the Manhattan Campus of the VA New York Harbor HCS, New York, NY. Following OIG’s first site visit, VHA completed external reviews of select components of the OR/SPS program. The HCS made some progress in addressing the recommendations. On a second visit in October 2015, OIG found continued unresolved concerns in aspects of the program. OIG substantiated that some OR RME trays were missing instruments and/or were not properly processed with filters or indicators. OIG found that SPS medical support technicians failed to place external tags on rigid containers or use standardized methods on count sheets. OIG determined there was no significant harm to 14 patients who had SPS-related cancellations or delays of surgeries or other SPS-related concerns during a 5-month period. OIG substantiated that some OR RME containers and packages were heavy and stored above head level, which placed nurses at risk for injury. OIG did not find documentation of training for proper handling of sterile packages for OR staff or a formal process in place to track and trend issues with packages. OIG confirmed that SPS staff were not consistently available in the SPS-OR sterile storage rooms. OIG did not substantiate that OR nurses had to leave patients to get supplies and instruments, creating a dangerous patient care situation. OIG found that SPS staffing levels appeared inadequate and may not support newly expanded hours. OIG found the HCS did not have an effective SPS quality control program and that OR and SPS staff members did not collaborate or communicate well, which created a contentious culture and interfered with resolving problems. [Click here to access report.]

Surgical Service Concerns, Fayetteville VAMC, Fayetteville, North Carolina

OIG conducted an inspection to assess the merit of allegations from an anonymous complainant regarding the Surgical Service at the Fayetteville VAMC, Fayetteville, NC. OIG substantiated that some patients were not properly evaluated prior to surgery; however, OIG could not substantiate that inadequate preoperative evaluations caused an increase in surgical complications. OIG substantiated that patient deaths that occurred within 30 days of surgery were not reviewed as required, and that peer
reviews were not conducted as required. OIG substantiated that a gynecological procedure was stopped after surgery had begun because of a lack of instruments, and there were ongoing problems with obtaining and maintaining surgical supplies and instruments. OIG substantiated that a surgical technician was placed in charge of the surgery schedule; however, this action was appropriate. OIG did not substantiate that staff were bypassed in the scheduling process or that surgeons had to perform cases without adequate assistance. OIG substantiated that surgical technician positions that were not being actively recruited and that having different service alignments for the surgical technician positions led to confusion. OIG did not substantiate that complication rates of surgical residents exceeded 30 percent. OIG did not substantiate that the Chief of Surgery awarded a contract or that the contract was not offered to other bidders. OIG found that the VAMC’s surgical post-operative clinic did not have the same nurse staffing pattern as other outpatient clinics. OIG recommended that recommendations from previous reviews, if any, be implemented; that preoperative patients are adequately evaluated; that peer reviews are completed in accordance with VHA policy; that necessary surgical supplies, equipment, and instruments are available; that the organizational structure for surgical technicians be evaluated; and that the surgical outpatient clinic have the same nurse staffing as other outpatient clinics. [Click here to access report.]

Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA HCS, Albuquerque, New Mexico
OIG conducted an inspection in response to allegations concerning the lack of follow-up care for patients with positive colorectal cancer (CRC) screening at the New Mexico VA HCS, Albuquerque, NM. OIG did not substantiate that laboratory staff had a list of 300 patients who had tested positive for fecal occult blood, but no follow-up had been done. OIG determined that laboratory personnel do not keep lists of patients with positive fecal occult results. However, OIG found that laboratory staff flagged positive results in patients’ EHR which generated a “view alert” to providers and that providers did not consistently notify patients of positive fecal immunochemical tests (used to determine presence of occult blood) in FYs 2013 and 2014. As a result, some patients did not receive timely follow-up care. OIG identified nine patients diagnosed with colorectal cancer who experienced delays and, in some instances, significant delays that may have affected the patients’ clinical outcomes. Such delays placed patients at unnecessary risk for adverse outcomes. OIG determined that during FYs 2013 and 2014, the HCS did not have a process in place to monitor provider compliance with CRC screening. In 2012, HCS leaders assigned a registered nurse to follow up on positive fecal immunochemical tests and report to the Chief of Staff monthly. However, the employee transferred from the HCS, and the position had been vacant for over 2 years. OIG found that HCS leaders did not institute processes for monitoring provider compliance with CRC screening and reporting to ensure that patients received timely notification of results and appropriate follow-up care. [Click here to access report.]

CRC Screening Practices, Charlie Norwood VAMC, Augusta, Georgia
OIG conducted a review to assess the merit of allegations involving CRC screening practices at the Charlie Norwood VAMC in Augusta, GA. OIG substantiated that
patients over the age of 50 were only being scheduled for preventative [screening] colonoscopies if blood was detected in their stools; however, OIG did not substantiate the implied inappropriateness of this process for patients with average risk for developing CRC. VHA and the Centers for Disease Control and Prevention (CDC) have identified several effective CRC screening methods, including a fecal occult blood test, for patients at average risk. However, OIG found that facility staff did not fully comply with VHA guidelines on shared decision-making for patients who preferred screening colonoscopies rather than fecal occult blood tests. VAMC managers have since revised the screening colonoscopy consult process. However, VAMC providers did not have a common understanding about the current local process for requesting screening colonoscopies for average risk patients. OIG did not substantiate the allegation that patients have been diagnosed with CRC because they did not receive appropriate preventative [screening] colonoscopies. OIG found that, in general, the patients included in the sample received fecal occult blood tests in accordance with VHA and VISN 7 guidance and CDC guidelines. [Click here to access report.]

Alleged Manipulation of Outpatient Appointments, Central Alabama VA HCS, Montgomery, Alabama
OIG reviewed an allegation that clinics cancelled appointments 30 minutes prior to the appointments, indicating manipulation of performance measures at Central Alabama VA Health Care System (CAVHCS), Montgomery, AL. OIG did not substantiate the allegation that clinics cancelled appointments 30 minutes prior to the appointments in an attempt to manipulate performance measures. OIG randomly selected and reviewed 276 EHRs for patients with appointments cancelled by selected clinics prior to appointment times during the 1st and 2nd quarters of FY 2015. OIG found that two appointments were cancelled within 30 minutes of the scheduled appointment times; both patients had subsequent visits within 14 days of the appointment dates. OIG found that of 42 same-day clinic cancellations, 39 (93 percent) appointments were rescheduled; however, 26 (67 percent) appointments were not rescheduled within 14 days of the original appointment date. Although some appointments were not rescheduled “timely," OIG found that 267 (97 percent) appointments were rescheduled and that 253 (95 percent) rescheduled appointments resulted in completed visits. OIG did not find indications in the EHRs reviewed that the cancellations were suspicious. OIG did not identify suspicious patterns or trends in CAVHCS-wide data that could indicate non-compliance with VHA scheduling guidelines. Further, as CAVHCS has consistently performed in the bottom 20 percent of all VHA facilities in access to care measures, it appears less plausible that staff participated in large-scale, coordinated efforts to manipulate appointment times. [Click here to access report.]

Combined Assessment Program Reviews
In September 2016, OIG published one CAP Summary review containing OIG findings at 48 medical facilities during CAP reviews performed across the country from April 1, 2015, through March 31, 2016. OIG generated an individual CAP report for each facility. For this report, OIG summarized the data collected from the individual facility CAP reviews.
CAP Summary-Evaluation of Advance Directives in VHA Facilities

CRIMINAL INVESTIGATIONS

Non-Veteran Business Owner Sentenced for Service-Disabled Veteran-Owned Small Business Fraud

The non-veteran owner of a Service-Disabled Veteran-Owned Small Business (SDVOSB) was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million fine after previously being found guilty at trial of conspiracy to defraud the United States and wire fraud. Criminal asset forfeiture proceedings are still pending. A VA OIG, Small Business Administration OIG, General Services Administration OIG, Army Criminal Investigation Division, and Navy Criminal Investigative Service investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service-disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts. The case involved over 200 VA construction contracts that occurred in at least 7 states.

Non-Veterans Sentenced for Conspiracy to Commit Mail and Wire Fraud

Two non-veterans were sentenced after pleading guilty to conspiracy to commit mail and wire fraud. The first defendant was sentenced to 30 months' incarceration, 2 years' supervised release, and was ordered to participate in a mandatory drug treatment program and to forfeit $1,108,735. The second defendant was sentenced to 12 months' home detention, 2 years' supervised release, and was ordered to forfeit $130,173. A multi-agency investigation resulted in the discovery of an extensive Surety Bond fraud scheme involving multiple Federal agencies and over $935 million in Government construction contracts. The defendants, along with other co-conspirators, used Government-owned lands or fraudulent trusts as assets to back Bid, Payment, and Performance bonding while accepting over $10 million in bonding fees. The affected VA contracts totaled more than $97 million, including some American Reinvestment and Recovery funds.

Contractor Enters into Agreement with the Government

A VA contractor entered into a Criminal Enforcement Agreement (CEA) with the Government to resolve criminal liability for its employee(s) criminal conduct. Per the CEA, the contractor accepted legal responsibility for the criminal conduct and agreed to pay a $12,000,000 penalty. Attached to the CEA are a Criminal Information, signed Waiver of Indictment, and Statement of Facts that will be filed in U.S. District Court if the contractor fails to comply with the terms of the CEA. During an OIG and Federal Bureau of Investigation investigation, it was discovered that the VA contractor paid bribes to the former director (previously convicted) of the Cleveland and Dayton VAMCs in exchange for confidential VA contract information.
Former Department of Labor Claims Supervisor Sentenced for Bribery
A former Department of Labor (DOL) claims supervisor was sentenced to 51 months’ incarceration, 3 years’ supervised release, and was ordered to pay approximately $2 million in restitution to DOL after pleading guilty to bribery of a public official. A second defendant was sentenced to 36 months’ probation and was ordered to pay approximately $299,000 in restitution ($7,192 to VA), after pleading guilty to Conspiracy to Commit Health Care Fraud. In total, 28 defendants, comprised of Office of Workers’ Compensation Program (OWCP) claimants (former Postal Service and VA employees), doctors and medical provider employees, a DOL claims examiner, and a claims representative were charged with various crimes related to their roles in this health care fraud scheme. A multi-agency investigation revealed that the defendants’ actions caused more than $9.5 million to be fraudulently billed to DOL OWCP.

Defendant Sentenced for Mail Fraud
A defendant was sentenced to 53 months’ incarceration (to run concurrently with additional state imposed sentences) and to pay restitution of $2,043,702 after pleading guilty to mail fraud. A VA OIG and U.S. Postal Inspection Service investigation revealed that the defendant utilized the mail to defraud veterans through the use of fraudulent businesses that were incorporated by the defendant to ostensibly assist veterans in applying for VA benefits. The defendant falsely represented that she was investing the veterans’ VA funds in annuities. In addition to veterans, the defendant also defrauded other non-veteran senior citizens. The loss to veterans was $394,000.

Former Hampton, Virginia, VAMC Nurse Sentenced for Aggravated Sexual Abuse and False Statements
A former Hampton, VA, VAMC registered nurse was sentenced to 17 years’ incarceration, 20 years’ probation, was ordered to pay the victim $122,211 in restitution, and to register as a sex offender after being found guilty at trial of aggravated sexual abuse and false statements. An OIG investigation resulted in the defendant being charged with administering morphine to a patient against her wishes and then sexually assaulting her multiple times.

Former West Los Angeles, California, VAMC Payroll Technician Indicted for Wire Fraud and Theft of Government Funds
A former West Los Angeles, CA, VAMC payroll technician was indicted for wire fraud and theft of Government funds. An OIG investigation revealed that the former employee diverted 136 payroll allotments, totaling $4,689, from the pay of other employees to his own bank account. During the investigation, the employee confessed to the misappropriation and resigned. Subsequent investigative efforts revealed that the defendant allegedly engaged in another embezzlement scheme involving VA’s Financial Service Center (FSC). The former employee generated fraudulent vendor forms and sent them to the FSC in order to redirect VA suspense payments to bank accounts under his control. The loss associated with this second scheme is $110,424.
Former VA Fiduciary Pleads Guilty to Theft of Public Money
A former VA fiduciary pled guilty to theft of public money. The defendant, an attorney at the time, was appointed as a guardian for a 64-year-old veteran. An OIG investigation resulted in the defendant being charged with stealing approximately $36,000 in VA benefits from the veteran’s bank account between October 2009 and March 2011. The defendant used the embezzled funds for personal expenses.

Veteran's Niece Arrested for Criminal Mistreatment
A veteran’s niece was indicted and subsequently arrested for criminal mistreatment and other charges. An OIG and local sheriff’s investigation resulted in an allegation that the defendant removed the veteran’s VA-assigned fiduciary from a joint account and then took control of the veteran’s finances. The defendant then used the embezzled funds to make unauthorized purchases of a home and recreational vehicles. A financial analysis identified $124,174 in potential theft to include $15,500 in VA funds.

Defendant Sentenced for Identity Theft
A defendant was sentenced to 51 months’ incarceration, 36 months’ supervised release, and was ordered to pay $234,461 in restitution and to forfeit $20,252 after pleading guilty to False Claims Act and student loan fraud. An OIG and U.S. Department of Education investigation revealed that the defendant, a non-veteran, fraudulently received VA benefits by using the stolen identity of a veteran. The defendant obtained a VA Identification Card and VA health care benefits at the Kansas City, MO, VAMC using the identity of a veteran who has been incarcerated in Florida for the past 10 years. The defendant also obtained Veterans Retraining Assistance Program education benefits and Federal Student Aid at a local college using the veteran’s identity. In addition, the defendant admitted to stealing other veterans’ identities to receive VA medical care in Delaware, Florida, Georgia, Maryland, and Pennsylvania. The loss to VA is $214,710.

Veteran's Former Wife Indicted for Theft of Government Funds
The former wife of a deceased VA pension beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with allegedly stealing her former husband’s VA benefits after his death in August 2009. The defendant is also alleged to have divorced the veteran in July 1982 in order to ensure that her husband’s VA pension benefits continued. The defendant’s employment income would have made the veteran ineligible for pension benefits if the couple had not divorced. The veteran and the defendant lived together as husband and wife following the divorce. The loss to VA is approximately $290,000.

Veteran Sentenced for Theft of Government Funds
A veteran was sentenced to 5 months’ incarceration, 5 months’ home confinement, and 2 years’ probation after pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged after it was discovered that he worked numerous construction and home remodeling jobs for three different companies from 2006 to 2014 while in receipt of VA pension benefits. The defendant claimed on
his VA application that he was unable to work due to a degenerative back disease and reported no net worth or monthly income. The loss to VA is $121,156.

**Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds**
After pleading guilty to theft of Government funds, the son of a deceased VA beneficiary was sentenced to 12 months’ incarceration, 36 months’ supervised release, and was ordered to pay VA restitution of $178,789. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into a joint account after his mother’s death in November 2003.

**Son of Deceased VA Beneficiary Indicted for Theft of Government Funds**
The son of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were issued after his mother’s death in February 2009. During the investigation, the defendant initially claimed that his mother was alive. The indictment also included a forfeiture allegation listing a monetary judgement of $106,583 (VA loss) and a boat, which the defendant purchased with proceeds from the theft.

**Subject Pleads Guilty to Health Care Fraud**
An OIG and VA Police Service investigation resulted in a defendant being charged with, and subsequently pleading guilty to, fraudulently receiving $63,000 in VA services to include medical care, housing benefits, compensated work therapy pay, and beneficiary travel pay. The defendant was ineligible for these benefits as he failed to complete boot camp in the National Guard. The defendant’s false statements to the White River Junction, VT, VAMC, included claims that his DD-214 was destroyed in the St. Louis fire and that he was shot twice as a door gunner while rescuing Prisoners of War in Vietnam. The investigation further disclosed that during the time period the defendant claimed to be in Vietnam, he spent a portion of that time incarcerated in New Hampshire.

**Little Rock, Arkansas, Pharmacy Employee Indicted for Diversion of a Controlled Substance**
A VA pharmacy employee was indicted for diversion of a controlled substance. An OIG and Drug Enforcement Administration investigation revealed that three Little Rock, AR, VAMC pharmacy employees allegedly conspired to divert approximately 4,000 dosages of oxycodone, 1,500 dosages of hydrocodone, 13,200 dosages of Viagra, 1,320 dosages of Cialis, and 308 ounces of promethazine with codeine. All three employees have been removed from their pharmacy positions. Additional charges are pending in this investigation.

**Former West Haven, Connecticut, VAMC Employee Arrested for Sale of a Hallucinogenic/Narcotic**
A former West Haven, CT, VAMC employee was arrested for sale of a hallucinogenic/narcotic. An OIG, VA Police Service, and local police investigation resulted in the defendant being charged after he sold crack cocaine and prescription narcotics to an informant. After his arrest, a search warrant was executed at the
defendant’s residence where drug paraphernalia was discovered. Two other criminal complaints have been filed against individuals who supplied the defendant with the illicit drugs.

MICHAEL J. MISSAL
Inspector General