Department of Veterans Affairs
Office of Inspector General
June 2017 Highlights

ADMINISTRATIVE INVESTIGATION

Misuse of Official Time and Failure to Properly Supervise, Oklahoma City VA Healthcare System

The Office of Inspector General's (OIG's) Administrative Investigations Division received an allegation that a former (since removed) Research Investigator (subject employee) at the Oklahoma City VA Healthcare System (HCS) did not show up for work at VA and was instead working at Johns Hopkins University (JHU) during his official VA duty hours. Further, the former (now retired) Associate Chief of Staff (ACOS) for Research allegedly improperly approved the subject employee's pay for the time he was absent from VA. OIG found that, between April 2014 and September 2016, the subject employee teleworked without authorization for 157 hours, collected dual compensation from VA and JHU for 1,374 hours, and misused his official time when he received VA pay for 441 hours while traveling and giving lectures during his VA duty hours that were not VA sponsored. OIG further found that the former ACOS failed in his supervisory responsibilities by being unaware of the subject employee's attendance, yet certifying the subject employee's subsidiary timecards as well as VA's electronic time and attendance system for hours he was not present at the facility and/or did not work. We referred the dual compensation matter to the Western District of Oklahoma United States Attorney's Office. They reviewed the evidence, declined to proceed with criminal charges, and advised OIG to proceed with the matter administratively. The subject employee's use of unauthorized telework, misuse of official time, dual compensation, and falsely claimed hours created a cost to VA of $102,542.
[Click here to access report.]

OIG REPORTS

Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3

In May 2015, Congresswoman Kathleen Rice and Congressman Mike Coffman requested the OIG review allegations that a supervisor at a VA facility in Bronx, NY, made unauthorized commitments by splitting prosthetic purchases in increments below $25,000 in fiscal years (FY) 2011 and 2012. Congresswoman Rice asked OIG to assess VA's claim that related procurement records were destroyed during Hurricane Sandy in October 2012. OIG did not substantiate that the Purchase Card Program Manager (PCPM) made unauthorized commitments by splitting prosthetic purchases but did determine that Network Contracting Office (NCO) 3 and the PCPM erroneously reported approximately $54.4 million of prosthetic purchases in Federal Procurement Data Systems (FPDS) during FY 2011 and 2012. This erroneous reporting included the alleged split purchases under review. The PCPM erroneously reported contract purchases because NCO 3 was not meeting a performance metric that measured acquisitions on contracts. This occurred because the NCO 3 Contract Manager did not provide oversight or ensure implementation of the required segregation of duties for FPDS reporting. The erroneous reporting of prosthetic purchases was eventually

removed from FPDS in 2013. We did identify 11 unauthorized commitments totaling approximately $457,000 for prosthetic purchases that exceeded the warrants of the purchasers. The facility was unable to provide documentation of compliance with VA policies showing that these payments had been made by purchase cardholders in accordance with their warrant authority. The unauthorized commitments must now be ratified. We did not substantiate VA's claim that procurement records for prosthetic purchases at NCO 3 were destroyed during Hurricane Sandy. All the prosthetic procurement files had been stored on the 14th floor of the medical center and were not in an area affected by the hurricane. [Click here to access report.]

Review of Veterans Health Administration Care and Privacy Standards for Women Veterans

OIG conducted a Congressionally-requested review to evaluate Veterans Health Administration (VHA) provisions of care for women veterans, both general and gender-specific, proficiencies of Designated Women's Health Providers (DWHP), and VHA facilities' compliance to privacy standards for women veterans. OIG found that 82.5 percent and 17.5 percent of gender-specific care visits for women veterans were performed at VA and non-VA facilities, respectively, during FY 2014. We identified that as of September 2, 2015, there were 2,294 DWHP representing the equivalent of 1,864.7 full-time employees (FTEs). We found that 39.8 percent of those FTEs practiced at a VA medical facility, while 60.2 percent practiced in a VA community based outpatient clinic (CBOC) setting. Among these DWHPs, 1,236 (53.9 percent) were shown to have women veteran populations of less than 10 percent of their total patient panel. We found that 547 of the 1,236 providers (44.3 percent) had documented proficiencies. OIG noted that VHA has identified those providers with a low percentage of women veterans, but we could not verify that the provided documentation satisfied the proficiency requirements for all of these providers. During FY 2014, we found that 20.4 percent of the 93 CBOCs evaluated did not meet specific VHA requirements for protecting the privacy of women veterans. OIG noted slight improvement in FY 2015; 14.3 percent of the 56 CBOCs evaluated did not meet the same VHA requirements for women veterans' privacy. [Click here to access report.]

Review of VHA's "Our Doctors" Website Accuracy

OIG conducted a review in response to a letter from 10 current or former members of Congress requesting investigation of inaccurate information that was posted on the VHA "Our Doctors" website. OIG's review found that VHA had not clearly defined the processes involved in uploads of information to the "Our Doctors" website, had not required adequate validation prior to posting information to the website, and had not defined a frequency of updates that would identify normal changes occurring in providers' credentials over time. In addition, processes did not allow for facility level corrections. The result was that some inaccurate information was posted on the "Our Doctors" website. When brought to their attention, VHA facilities reviewed the information and initiated corrective action plans. Although VHA has issued some clarification and a disclaimer, further definitions and clarification are needed. Oversight processes need to be implemented at facility, network, and national levels. OIG identified two system weaknesses and recommended that the Acting Under Secretary

for Health (AUSH) ensure that VHA develops and implements a policy defining the purpose, responsibilities, and requirements for ensuring current credentials information on the "Our Doctors" website and develops and implements an oversight process for accuracy of the information posted on the "Our Doctors" website.
[Click here to access report.]

Opioid Management Practice Concerns, John J. Pershing VA Medical Center, Poplar Bluff, Missouri

OIG conducted an inspection to evaluate allegations regarding opioid management practices at the John J. Pershing VA Medical Center (VAMC), Poplar Bluff, MO. The summarized allegations included the following:

(1) Long-term opioid therapy for pain was poorly managed for certain patients.
(2) Opioid prescriptions were written for patients without documentation of an opioid risk stratification tool, such as the opioid risk tool (ORT).
(3) Some providers did not consistently use urine drug screening (UDS), order confirmatory tests to evaluate for diversion, or further evaluate UDS results that were suggestive of urine tampering.
(4) Opioid pain care agreements, including signed informed consents, were not consistently completed prior to initiating long-term opioid therapy for pain.

OIG substantiated poor management of long-term opioid pain therapy for 10 patients. We found documentation for the condition requiring opioid therapy, but did not find risk evaluation when clinically significant changes to a patient's health status occurred. We also found that a provider lacked knowledge of safe and effective methods for tapering patients' opioids. In addition, OIG substantiated that opioid prescriptions were written for patients without documentation of an opioid risk stratification tool such as ORT. VHA's Opioid Safety Initiative provides guidelines to develop tools to identify high-risk patients. Using the ORT helps a provider risk stratify patients for initiating or continuing opioid therapy, and the ORT can help guide providers in determining the frequency of obtaining UDS for patients on long-term opioid therapy for pain. OIG substantiated that some providers did not consistently use UDS, order confirmatory tests to evaluate for diversion, or further evaluate UDS results that were suggestive of urine tampering for the patients reviewed. We substantiated that some patients did not have signed informed consents prior to initiating long-term opioid therapy for pain.
[Click here to access report.]

Review of Alleged Mismanagement of VA's Human Resources and Administration Contract Funds

In September 2015, OIG received an allegation that the Office of Human Resources and Administration's (OHRA's) VA Learning University (VALU) management authorized vendor payment for a dashboard tool (DT) before receiving the deliverable. In addition, the complainant alleged OHRA provided a competitive advantage to a vendor by helping the vendor develop a performance work statement for a future contract to maintain the DT. The DT is a web-based interface designed to organize and manage OHRA and VALU program data, such as performance metrics and training outcomes. We substantiated the allegation that VALU management authorized final payment in April 2015 for the DT that had not been delivered. OIG determined VALU did not accept

the DT because it did not have the capability to operate the tool. Authorizing final payment before delivery did not allow VA to determine whether the DT conformed to applicable contract quality requirements. The former Dean of VALU did not assign responsibility for identifying and procuring a hosting solution to any individual or office. Additionally, the former Dean did not take timely action to obtain roughly $3,200 in funding to purchase a hosting solution. As a result, OHRA was unable to use its estimated $3.7 million investment in the DT. As of March 2017, OHRA had not purchased a hosting solution on which to operate the DT, and it remained in the possession of the vendor. We did not substantiate the allegation that OHRA provided a competitive advantage to a vendor for a future contract to maintain the DT. We found OHRA officials drafted a performance work statement for a DT maintenance contract. An Office of Acquisition Operations Contracting Officer (CO) appropriately refused to approve the performance work statement as it was determined the contract was unnecessary because VALU officials could not demonstrate they were in possession of the DT. [Click here to access report.]

Review of Alleged Mismanagement of VA's Personal Identity Verification Processes

OIG conducted this review to determine the merits of allegations involving the mismanagement of the Personal Identity Verification (PIV) Program and related systems. In June 2015, OIG received a Hotline complaint alleging VA's Security and Investigations Center (SIC) was inappropriately permitting the issuance of PIV cards and VA network system access to individuals without completed background investigations or adjudicated fingerprints. SIC personnel process and adjudicate background investigations for all moderate and high-risk public trust and national security positions for Federal employees within VA. They also process all levels of investigation for contractors performing jobs and functions for VA. We did not find instances where VA's SIC was inappropriately authorizing the issuance of PIV cards and allowing VA network system access to individuals without a completed Special Agreement Check (SAC) and a scheduled background investigation as required by VA policy. We reviewed VA local policies and procedures as they related to PIV card authorizations. To evaluate business processes and compliance with VA policies, we selected 32 cases to sample from VA's Security Manager system of record. The 32 cases included 25 individuals chosen randomly, 6 personnel from SIC management, and 1 individual named in the complaint as having received a PIV card without meeting VA policy requirements. OIG observed SIC personnel accessing each of these cases in the system of record and reviewing the electronic records, SAC, background investigation dates, and any relevant comments associated with each case. OIG found each case reviewed met VA policy requirements for PIV card authorization. As a result, we concluded that SIC personnel appropriately authorized the issuance of PIV cards in accordance with VA policy. We did not substantiate the allegations of SIC's mismanagement of the PIV Program and related systems. Additionally, OIG did not find any instances of improper processing of selected cases. [Click here to access report.]

Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities
OIG's Hotline received an allegation in October 2014 that VA was paying full price for physician services to a non-VA care provider rather than paying lower contract rates, resulting in overpayments of provider claims for non-VA care. OIG substantiated the allegation that, contrary to Government regulations, VHA Florida claims processing centers did not reimburse a non-VA care provider based on the applicable Medicare rates, when appropriate. OIG determined that VHA payments exceeded Medicare rates in 52 of the 55 examples provided by the complainant, of which 44 (valued at $27,010) were related to specific physician administered drugs. The associated overpayments totaled $28,295. Based on these results, we expanded our review to all payments made by Florida VA facilities from October 1, 2012 through March 31, 2016 for these types of services. For this time period, our review of 73,124 payments to non-VA care providers for physician-administered drugs identified 26,178 overpayments (35.8 percent), totaling approximately $17.2 million, and ranging from $.01 to $47,943.40. Of this $17.2 million, VHA overpaid approximately $6.9 million (40.2 percent) to the provider identified in the allegation. These overpayments occurred because VHA did not use Medicare rates for physician administered drugs, as published by the Centers for Medicare & Medicaid Services. These funds could have been more effectively spent on veteran care. VHA stated that they would provide OIG with documentation to support completion of the action plans.
[Click here to access report.]

Review of Alleged Inappropriate Contract Actions Related to VA's Lease of a Digital Imaging Network-Picture Archival Communication System
In June 2015, OIG received an allegation regarding the procurement strategy used by VA under the Department of Defense (DoD) Digital Imaging Network-Picture Archival Communication (DIN-PACS) contract. The complainant alleged that VA did not perform a proper business case analysis of its procurement strategy of leasing versus purchasing DIN-PACS. The complainant further alleged technical evaluations were manipulated, excessive amounts of equipment were purchased, and an award was made at a cost 30 percent higher than recommended by the CO. OIG reviewed the Veterans Integrated Service Network (VISN) 1 DIN-PACS lease and found that VA did not adequately evaluate the advantages or disadvantages of leasing versus purchasing DIN-PACS. Furthermore, VA did not comply with the Federal Acquisition Regulation (FAR) and DoD contract, as required by the contract terms, to determine that prices were fair and reasonable once it elected to use the DoD contract to lease the DIN-PACS. This occurred because VA's CO misinterpreted an internal directive and did not fully comply with FAR Part 7.4, which requires a lease versus purchase analysis. The CO did not ensure the acquisition team fully complied with FAR to conduct this analysis even after receiving advice from VA's General Counsel. In addition, VA lacked documented evidence of a formal contract oversight review as required by VA's Integrated Oversight Process. As a result, the decision of VA's CO to lease DIN-PAC systems at an estimated value of $9 million could lead to the wasteful spending of taxpayer dollars. We did not substantiate that VA manipulated technical evaluations, purchased excessive amounts of equipment, or made an award 30 percent higher than

recommended. OIG considers their corrective action plans acceptable and will follow up on the implementation. [Click here to access report.]

Alleged Misdiagnosis and Delay in Treatment, Providence VAMC, Providence, Rhode Island

OIG conducted a health care inspection to evaluate allegations that a provider at the Providence, RI, VAMC misdiagnosed a patient's Achilles tendon rupture (ATR) in 2014, leading to a delay in treatment and further injury. OIG substantiated that, on two occasions, an emergency department (ED) provider did not respond to a patient's complaint that he may have an ATR and misdiagnosed him with a sprained ankle. We substantiated that the sprained ankle misdiagnosis caused a 16-day delay in treatment of the ATR. We could not substantiate that the misdiagnosis, delay in treatment for the ATR, and the treatment prescribed for a sprained ankle versus an ATR in the ED worsened the injury. However, a delay in ATR diagnosis or treatment may result in a worse outcome. Providers utilize a combination of ATR-specific clinical assessments and tests to diagnose and determine the extent of an ATR. However, because the ED provider did not document the proper assessments, which would have provided a clinical baseline of the ATR, we could not discern whether the injury became worse during the 16 days the patient was treated for a sprained ankle. In addition to the 16-day delay, we identified other timeframes when different treatments affecting optimal outcomes could have occurred. The initial assessment occurred 3 days after injury. The patient was given options for conservative or surgical treatments within 4 weeks of injury and pursued conservative treatment. The patient had complaints of persistent pain after 6 months of conservative treatment and subsequently decided to undergo Achilles tendon surgery. OIG could not determine the extent to which the 3-day delay in seeking treatment, the 16-day delay in diagnosis, and/or the 6-month delay by the patient's initial choice of non-operative treatment contributed to unfavorable healing. We found a peer review was done but documentation of the peer review process was incomplete. OIG identified that the Chief of Emergency Medicine did not follow up on the patient's complaint about his first ED visit. [Click here to access report.]

Sterile Compounding Environment and Practices, Overton Brooks VAMC, Shreveport, Louisiana

OIG inspected the Overton Brooks VAMC, Shreveport, LA, to determine whether deficient conditions in the compounding pharmacy placed patients at risk. OIG confirmed the facility did not comply with key elements of United States Pharmacopeia (USP) <797> (which outlines safe sterile compounding requirements and practices) as initially identified in October 2016 by the Louisiana Board of Pharmacy. The Board's findings included a lack of proper cleaning of the compounding rooms and incomplete air and surface testing and certification in compounding areas. During our site visit, OIG found continuing noncompliance with USP <797> requirements. Specifically, we found that:

(1) Cleaning logs from September 2016 through January 27, 2017, reflected 4 days with no evidence of appropriate cleaning and mopping of floors.
(2) Only 18 percent of applicable employees had all required training and competency documentation.

(3) Air and surface testing and certification had not been completed as required.

Pharmacy managers did not report the Louisiana Board of Pharmacy's findings to appropriate leaders or committees. Facility leaders learned of the Board's reports after OIG's unannounced site visit. In February 2017, Food and Drug Administration (FDA) investigators conducted an extensive review of the facility's compliance with FDA guidance on compounded sterile preparations (CSPs). Facility and VISN leaders implemented interim measures to ensure patient safety that included:

(1) Sending chemotherapy CSP orders to the Alexandria, LA, VAMC for compounding.
(2) Outsourcing routine compounding to a local pharmacy.
(3) Limiting CSP activities to immediate use.

Facility and VISN officials also implemented an action plan to correct the identified USP <797> deficiencies before re-opening the onsite pharmacy compounding areas. We reviewed the electronic health records (EHRs) of hospitalized patients who were administered CSP and diagnosed with selected types of infections subsequent to the CSP administration starting in FY 2016 through January 6, 2017. OIG did not identify any patients who developed infections after intravenous infusions or injections of compounded medications. [Click here to access report.]

Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VAMC, Detroit, Michigan

OIG conducted a health care inspection regarding alleged surgical service mismanagement and quality of care issues at the John D. Dingell VAMC, Detroit, MI. We substantiated that the Surgical Service ACOS had negative interactions with operating room (OR) staff; however, this did not result in adverse patient outcomes. We did not substantiate that the ACOS had unprofessional behavior unaddressed by leadership. OIG substantiated that the ACOS reduced general surgeons' access to surgical cases and OR time. The ACOS performed most of the general surgery cases; however, the Chief of Staff supported the ACOS' actions. OIG substantiated that the ACOS altered the daily surgical schedule over a 2-year timeframe (2013–2015) to accommodate his elective cases, which resulted in patient delays for previously scheduled cases and patient complaints. The facility developed a policy to minimize disruption in the surgical schedule; however, the new policy was not consistently followed. We substantiated that the ACOS did not adhere to VHA and facility policy regarding certain aspects of the supervision of surgical residents including correct documentation of the ACOS' presence during surgeries, communication of a designated back-up surgeon when absent from the OR, and ensuring completion of post-operative notes. OIG substantiated that the ACOS performed elective colonoscopy procedures in the OR. These procedures increased OR utilization time, but the practice did not violate VHA or facility policy. We did not substantiate that performing these procedures in the OR diluted morbidity and mortality data. We did not substantiate that the ACOS performed colonoscopy examinations without the appropriate equipment available or that the ACOS exercised poor clinical decision making that resulted in negative outcomes for many patients, including patient deaths. However, we reviewed 53 cases with quality of care concerns and found 3 instances where clinical judgement may have

affected patients' adverse outcomes. We also found that a requested autopsy was not done and facility staff did not fully comply with VHA peer review requirements. [Click here to access report.]

Inspection of the Veterans Administration Regional Office, Boise, Idaho
In October 2016, OIG evaluated the Veterans Administration Regional Office (VARO), Boise, Idaho, to determine how well Veterans Service Center (VSC) staff processed disability claims, how timely and accurately they processed proposed rating reductions, how accurately they entered claims-related information, and how well they responded to special controlled correspondence. Staff did not consistently process one of two types of disability claims. OIG reviewed 30 of 144 veterans' traumatic brain injury claims and found that Rating Veterans Service Representatives (RVSRs) accurately processed 29 of the claims. However, RVSRs did not always process entitlement to Special Monthly Compensation (SMC) and ancillary benefits consistent with Veterans Benefits Administration (VBA) policy. OIG reviewed all 13 veterans' SMC claims and found RVSRs incorrectly processed 8. This resulted in 84 improper monthly payments made to 3 veterans totaling approximately $24,300. Staff generally processed proposed rating reductions accurately. However, after reviewing 30 of 89 benefits reductions cases, OIG found that staff delayed or incorrectly processed 15 of the cases. Delays and processing inaccuracies resulted in roughly $11,300 in overpayments and an underpayment of approximately $320, representing 8 improper monthly payments from July to September 2016. Staff need to improve the accuracy of claims-related information input into the electronic systems at the time of claims establishment. We reviewed 30 of 156 newly established claims and found staff did not correctly input claim and claimant information into the electronic systems in 9 instances because of an ineffective review process and infrequent refresher training. Consequently, the potential existed for claims to be misrouted and processing to be delayed. Also, a claims assistant did not update the correct code in the electronic systems, resulting in a veteran's personally identifiable information (PII) being sent to a power of attorney who was not representing him. VARO staff processed special controlled correspondence timely but need to improve accuracy. OIG reviewed 30 of 115 special controlled correspondences and found that staff incorrectly processed 3 of these cases because of a lack of training and inadequate oversight. The errors affected data integrity, misrepresented workload performance, and provided inaccurate information. [Click here to access report.]

Alleged Urology Consult Scheduling Delays, Cincinnati VAMC, Cincinnati, Ohio
OIG conducted a health care inspection in response to a complainant's concerns regarding delays in the scheduling of urology outpatient consults at the Cincinnati, OH, VAMC. Specific allegations included the following:

(1) The Urology Section scheduler retired and was not replaced for 7 months.
(2) The new scheduler was floated from the Urology Section to work in other locations.
(3) The new scheduler was not fully trained for the position.

(4) As of July 10, 2015, about 160 veterans were still awaiting an initial appointment even though their providers had requested urology outpatient consult services as early as May 2015.

OIG substantiated that after the Urology Section scheduler retired, a new scheduler was not assigned to the Urology Section until 7 months later. However, other schedulers filled the gaps in coverage. While we substantiated the new Urology Section scheduler was required to work in other locations, we found the scheduler worked the majority of his/her time in the Urology Section. OIG did not substantiate the scheduler was not fully trained for his/her duties when assigned to the Urology Section. We substantiated as of July 6, 2015, that 166 Urology Section outpatient consults remained in pending or active status. However, while 85 (52 percent) were pending or active for more than 30 days, 81 (48 percent) of the consults were not over 30 days old. By August 31, 2015, the number was reduced to 11. To assess patient outcomes related to scheduling delays, OIG reviewed the EHR of 39 patients who had outpatient urology consults requested between January 1–August 31, 2015, that remained in a pending or active status for greater than 30 days and who had inpatient hospital stays before August 31, 2015. OIG did not find evidence that delays in outpatient urology consult appointment scheduling contributed to patients' hospital admissions within the timeframe of the review. We found from January 11 through May 23, 2016, the scheduling improvements noted in August 2015 were maintained, with no more than eight urology outpatient consults in a pending or active status. A review of outstanding consults in June 2016 confirmed that problems with delays in consult scheduling had not recurred.
[Click here to access report.]

Non-VA Colonoscopy Follow-Up Concerns, Southeast Louisiana Veterans HCS, New Orleans, Louisiana

OIG conducted an inspection to assess allegations regarding the management of follow-up care for patients who had colonoscopies from 2006 through 2012 via Non-VA Care Coordination (NVCC) at the Southeast Louisiana Veterans HCS, New Orleans, LA. Specific allegations were:

(1) System leadership failed to provide appropriate follow-up for roughly 16,000 to 18,000 patients who received colonoscopies through NVCC.
(2) System leadership failed to notify patients who had been potentially harmed.
(3) System clinicians did not timely receive and review the results of colonoscopies completed for seven patients through NVCC referrals.
(4) The System Director knew of the issue and did nothing.

At the time of our inspection, system managers had completed a review of the patients and taken action. We chose to examine the adequacy of the system's review. OIG could not substantiate system leaders failed to provide appropriate follow-up for patients as we determined system managers did not reliably identify all potentially affected patients. OIG identified patients who had developed colorectal cancer and were not on the system's list. We also found system leaders did not take appropriate steps to ensure the validity of case reviews of identified patients. OIG did not substantiate system managers failed to notify a patient who had suffered harm. We substantiated the system did not timely receive results for two of seven identified patients who underwent NVCC colonoscopy procedures but did not substantiate the System Director

knew of the issue and did nothing about it. While developing a more flexible clinical reminder for colorectal cancer screening, system leaders discovered delays in scheduling the procedure when recommended. The System Director became aware of this and initiated a protected quality review for patients. After OIG's review, the system generated a report reflecting evidence of their 2014 colonoscopy lookback and confirmed 12,964 patient colonoscopy reports were reviewed and clinical reminders were updated to reflect the appropriate return timeframe for procedures performed from September 1, 2005 to December 30, 2013. [Click here to access report.]

Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VAMC, Dublin, Georgia

OIG conducted this review in response to allegations that Dublin VAMC purchase cardholders split purchases and made duplicate payments to Ryland Contracting Inc. and Sterilizer Technical Specialists. OIG substantiated the allegation that VAMC Dublin cardholders in Engineering Service made unauthorized commitments by splitting purchases and exceeding micro purchase limits. Of 130 sampled purchases made from October 2012 through March 2015, 23 were split purchases that avoided the $3,000 limit for supplies and 14 were purchases that exceeded the $2,500 limit for services. This was not prevented because approving officials did not adequately monitor cardholders to ensure compliance with VA policy. As a result, of 5,100 purchase card transactions totaling roughly $7.1 million, we estimated approximately 100 transactions totaling about $240,000 (3.4 percent) were unauthorized commitments and improper payments. We did not substantiate the allegation that cardholders made duplicate payments to Ryland Contracting Inc. and Sterilizer Technical Specialists. However, OIG found cardholders inappropriately made 91 micro purchases for services received from these vendors without establishing contracts. This was not prevented because approving officials did not adequately review cardholder transactions to identify service purchases exceeding VHA's $5,000 threshold for establishing contracts during a FY. As a result, cardholders purchased and received services totaling approximately $218,000 that avoided federal competition requirements. [Click here to access report.]

Alleged Unreported Surgical Incidents and Deaths, VA Caribbean HCS, San Juan, Puerto Rico

OIG conducted a health care inspection in 2016 in response to complaints concerning the VA Caribbean HCS, San Juan, PR. An anonymous complainant alleged surgical incidents and deaths were unreported because of a conflict of interest between a quality management employee and a senior leader. During interviews, we did not find evidence of a conflict of interest. Therefore, OIG reviewed the validity of the allegation regarding the reporting of surgical incidents and deaths. OIG did not substantiate surgical incidents or deaths were unreported. We compared information regarding surgical deaths extracted from the corporate data warehouse with the facility morbidity and mortality committee minutes and found the data to be congruent with information in patients' EHR. OIG distributed a bilingual survey (English and Spanish) to 128 VA Caribbean HCS Quality Management, OR, and Post-Operative Care Unit staff as well as surgeons. OIG asked the following survey questions: (1) "Do you have any concerns about the reporting of incidents in surgery?" and (2) "Are incidents in surgery being

reported as required?" We had an 11 percent response rate to the survey, with no employees reporting concerns regarding incidents in surgery. Surgical service staff completed a Critical Incident Tracking Notification report when incidents occurred, including deaths in the OR, incorrect surgeries (wrong patient, wrong procedure, wrong side/site, wrong implant), retained surgical items, OR fires, and OR burns. This information was aggregated and included in the quarterly National Surgery Office report and reconciled with records from the National Patient Safety Office. OIG found the facility had an electronic system for reporting incidents. The facility Patient Safety Improvement Program described a "culture of safety," which includes identification and reporting of incidents, review of incidents to determine underlying causes, and implementation of changes to reduce the likelihood of recurrence.
[Click here to access report.]

Review of Alleged Mismanagement of VHA's Patient Transportation Service Contract for the Jesse Brown VAMC, Chicago, Illinois
In March 2015, OIG received an allegation of mismanagement of the patient transportation service contract for the Jesse Brown VAMC, Chicago, IL, which resulted in a waste of funds. We substantiated the allegation of contract mismanagement. Specifically, the Great Lakes Acquisition Center (GLAC) CO did not adequately validate performance requirements to determine the required quantity of transportation trips. The CO did not adequately determine price reasonableness or fully fund the contract prior to obligating the government. Finally, the CO did not document required contract information in VA's Electronic Contract Management System. This occurred because the GLAC CO did not ensure required reviews were performed for the awarded contract and for four modifications that either funded or extended the contract, increasing its value from roughly $885,000 to more than $6 million. Also, VA did not solicit competition to ensure fair and reasonable pricing. As a result, VA lacks assurance that the amount paid was the best value to the government. In addition, VA potentially violated the *Antideficiency Act* if funds were not available at the time VA incurred obligations for the services performed. The AUSH provided a plan for corrective action. We considered the plan acceptable and will follow up on its implementation.
[Click here to access report.]

Review of Alleged Misuse of Resources by VHA's Strategic Investment Management, Business Architecture Division
OIG received an anonymous Hotline complaint in February 2015 stating that the VHA Strategic Investment Management, Business Architecture Division misused Government funds when it purchased Troux Technologies' Architect software. The complainant also stated that VA already had project management and architecture tools available; therefore, the purchase of this software was a duplication of existing software functionality. OIG conducted this review to determine the merits of the allegations. We did not substantiate the allegation that VHA acquired Troux Technologies' Architect software. However, VHA procured other Troux Enterprise Portfolio Management (EPM) tools, including Troux Navigate for a report-creation capability and Troux Insight as a business analysis engine. OIG did not substantiate the allegation that the purchase of other Troux services was a duplication of existing VA project management and

architecture software functionality. At the time of the allegation, VHA was developing EPM capabilities through a contract with Troux Technologies, Inc. Prior to awarding the contract to Troux Technologies, Inc., VHA conducted a review of business activities and identified functionality gaps for portfolio management. VHA's "Alternatives Analysis Review" provided several possible vendor solutions to address the gaps, one of which was Troux EPM software. The analysis identified weaknesses within VA existing systems inventory and noted that the current toolset could not provide portfolio management functionality without extensive modification. OIG conducted a review of VA's systems inventory and found no EPM capability that met VHA's requirements. We did not substantiate the allegations. [Click here to access report.]

Dermatology Clinic Staffing and Other Concerns at the Dayton VAMC

OIG conducted a Combined Assessment Program review at the Dayton VAMC, Dayton, OH. Prior to the site visit, OIG administered a survey regarding patient safety and quality of care known as the Employee Assessment Review (EAR). An EAR respondent reported in the 3rd and 4th quarters of FY 2012 and during FYs 2013–2014 that:

(1) Patient Business Service (PBS) schedulers assigned on a temporary basis to cover the Dermatology Clinic were not adequately trained in its specific scheduling practices; therefore, appointments were not consistently scheduled in accordance with preferred dates.
(2) PBS schedulers did not return calls to patients in a timely manner.
(3) Dermatology appointments were not scheduled timely.
(4) One of 20 patients with scheduling delays had a clinically significant adverse outcome as a result.

In this case, deficient conditions dated back several years and had since been corrected by facility managers. Therefore, OIG summarized the allegations, described the conditions that existed at the time of the allegations, and outlined the sequence of events in FYs 2012–2014 while focusing on facility corrective actions. OIG also performed a look-back of patients diagnosed with new melanomas or other skin cancers from FY 2013 through 3rd quarter FY 2016 and provided a status of Dermatology Clinic-related operations as of 4th quarter FY 2016. In 2012, the Dermatology Clinic lost its permanently assigned PBS scheduler. PBS schedulers had to cover the Dermatology Clinic and other specialty care clinics during FYs 2012–2014 (and in the 1st and 2nd quarters of FY 2015). The Chief of Dermatology Service regularly reported the staffing challenges to leadership. Documentation showed clinical and administrative managers attempted to work together to improve clinic access and timeliness. While we substantiated specific instances of inadequate scheduling practices, poor follow-up to patient telephone calls, and delayed appointments during the time PBS schedulers covered the Dermatology Clinic, we did not substantiate systemic deficiencies in those areas. While we substantiated scheduling delays, OIG did not substantiate patients experienced clinically significant adverse outcomes in the cases provided by the survey respondent or in our look-back of patients diagnosed with new melanomas or other skin cancers. [Click here to access report.]

Clinical Assessment Program Reviews
In June 2017, OIG published three Clinical 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 ten activities:

(1) Quality, Safety, and Value;
(2) Environment of Care;
(3) Medication Management;
(4) Coordination of Care;
(5) Moderate Sedation;
(6) Community Nursing Home Oversight;
(7) Management of Disruptive/Violent Behavior;
(8) Mental Health Residential Rehabilitation Treatment Program;
(9) Post-Traumatic Stress Disorder Care; and
(10) Diagnostic Care.

Birmingham VAMC, Birmingham, Alabama
Atlanta VA Medical Center, Decatur, Georgia
White River Junction VAMC, White River Junction, Vermont

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Former VA Vendor Indicted for Conspiracy to Steal Government Funds
A former VA vendor was indicted for conspiracy to steal Government funds. A VA OIG and Federal Deposit Insurance Corporation OIG investigation revealed that from February 2014 to April 2015 a former St. Louis, MO, VAMC supervisor issued purchase card payments totaling $451,853 to this defendant and two other vendors for unnecessary maintenance work at the medical center. During this time, the vendors kicked back approximately $136,500 in cash payments to the former supervisor. This defendant received approximately $181,673 in payments and kicked back approximately $56,250. This investigation is ongoing and there is an anticipated loss of $532,876.

Former Martinsburg, West Virginia, Chief of Staff Arrested for Drug Diversion
The former Martinsburg, WV, Chief of Staff was arrested after being indicted for acquiring fentanyl by misrepresentation, fraud, deception, and subterfuge. The indictment, which was the result of an OIG and VA Police Service investigation, alleged that the defendant acquired fentanyl by fraudulently entering patient information into the facility's Omnicell medication dispensers.

Former Alexandria, Louisiana, VAMC Nurse Arrested for Drug Diversion
A former Alexandria, LA, VAMC licensed practical nurse, who was assigned to the Community Living Center, was arrested for theft of Schedule II narcotics. An OIG investigation resulted in charges alleging that the defendant stole narcotic medications, specifically oxycodone and hydrocodone, by obtaining the medications and then failing to dispense them to patients.

Veteran Charged with Travel Benefit Fraud
A veteran was charged with theft of Government funds and false statements. An OIG and VA Police Service investigation resulted in the defendant being indicted for allegedly submitting fraudulent travel vouchers to the Martinsburg, WV, VAMC. For nearly five years, the defendant is alleged to have claimed an address 123 miles from the medical center when in reality he resided in Department of Housing and Urban Development (HUD)-VA Supportive Housing that was located 5 miles from the facility. The loss to VA is approximately $30,000.

Veterans Benefits Administration Investigations

Veteran and Wife Indicted for Conspiracy and Theft of Government Funds
A veteran and his wife were indicted for conspiracy and theft of Government funds. A VA OIG and Social Security Administration (SSA) OIG investigation resulted in charges that the two defendants filed fraudulent claims alleging that the veteran was unable to care for himself as a result of injuries received during combat operations in Iraq. The veteran claimed the loss of use of both feet from a spinal cord injury he sustained as a result of an improvised explosive device. The total fraud loss is approximately $900,000, to include a loss to VA of approximately $600,000.

Veteran Sentenced for Wire Fraud
A veteran was sentenced to 3 years' incarceration and was ordered to pay restitution of $646,000 after pleading guilty to wire fraud. A multi-agency investigation revealed that the veteran and his sister provided false medical documentation to VA, SSA, and other agencies in order to fraudulently obtain caregiver support, VA compensation, and other benefits. The investigation determined that the veteran also submitted fraudulent documents to the Army in order to obtain a Purple Heart and Combat Infantry Badge, which he then used as a basis for his benefits. The Army subsequently stripped the veteran of the awards. The loss to VA is $343,000.

Veteran Found Guilty of VA Compensation Fraud
A veteran was found guilty at trial of health care fraud and false statements relating to a health care matter. An OIG investigation revealed that the defendant, who was rated 100 percent disabled and received special monthly compensation for loss of use of both feet, was able to mow his lawn and walk up and down his driveway without any assistance. Additionally, the defendant received adaptive housing and various prosthetics devices to assist with his alleged disability. The loss to VA is approximately $300,000.

Veteran Arrested for VA Compensation Fraud
A veteran was arrested for theft of Government funds. An OIG investigation resulted in the defendant being charged with fraudulently claiming a neurological disorder that allegedly led to the partial paralysis of her legs and left arm. The defendant claimed she could not walk for long distances, drive a vehicle, or provide basic care for herself. The investigation revealed that the defendant maintained a very physically active lifestyle, to include running several miles a day, participating in daily vigorous exercise classes at her gym, and mowing her yard. The loss to VA is approximately $190,000.

Veteran Sentenced for VA Pension Fraud
A veteran was sentenced to 9 months' incarceration and was ordered to pay VA restitution of $205,534 after pleading guilty to theft of Government funds and Social Security fraud. A VA OIG and SSA OIG investigation revealed that the defendant was issued a Social Security Number (SSN) in 1969, which he used to enlist in the military, and then in 1984 the defendant obtained a second SSN. In 2005 the defendant used his first SSN to apply for VA pension benefits claiming he was disabled and that he did not have any sources of income. However, from 2005 to 2012, the defendant worked under his second SSN and in October 2012 began receiving Social Security Disability benefits. The defendant failed to report any of his employment income to VA.

Veteran and Wife Plead Guilty to VA Pension Fraud
A veteran pled guilty to conspiracy to defraud the United States, and his wife pled guilty to misprision of a felony. An OIG investigation revealed that from June 2009 to January 2017, the veteran collected $65,509 in VA special monthly pension benefits by falsely claiming that he was blind. The investigation revealed that the veteran had a valid driver's license, drove a vehicle, and performed other normal daily activities without assistance. The veteran's wife assisted the veteran in appearing to be blind by guiding him throughout his VA appointments.

Daughter-in-Law of Deceased Veteran Arrested for Larceny
The daughter-in-law of a deceased veteran was arrested for larceny by conversion. An OIG investigation resulted in the defendant being charged with allegedly stealing VA benefits that were direct deposited after the veteran's death. The loss to VA is $191,119.

Son of Deceased Beneficiary Pleads Guilty to Theft of Government Funds
The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole approximately $182,700 in VA benefits that were direct deposited after his mother's death. The defendant stole the funds by writing checks made payable to himself and forging his deceased mother's signature.

Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The son of a deceased VA beneficiary was sentenced to 24 months' probation and was ordered to pay VA restitution of $87,445 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in October 2008.

Other Investigations

Former Insys Therapeutics Manager Pleads Guilty to Conspiracy to Commit Wire Fraud

A former Insys Therapeutics, Inc. manager pled guilty to conspiracy to commit wire fraud. A multi-agency investigation determined that Insys created a reimbursement center for the purpose of obtaining prior authorizations for Subsys, their fentanyl-based pain medication. The reimbursement center then used a variety of fraudulent reimbursement schemes to obtain payment authorization from insurers and Pharmacy Benefit Managers (PBM). These schemes were used to defraud insurers and PBMs who were reluctant to approve payment for Subsys when it was prescribed off-label. The defendant was the manager for Insys' reimbursement services and directly supervised reimbursement center employees. The Civilian Health and Medical Program of VA paid Insys approximately $3.31 million for Subsys.

Defendants Sentenced in Construction Bond Scheme

A defendant was sentenced to 10 years' incarceration and was ordered to pay restitution of $3.98 million. Another defendant was sentenced to 4 years' incarceration and was ordered to pay restitution of $3.98 million. Both defendants were found guilty at trial of major fraud against the United States. A VA OIG, HUD OIG, United States Postal Inspection Service, and North Carolina Department of Insurance investigation revealed that the defendants participated in a fraudulent interstate construction bond scheme involving multiple federal agencies that had been occurring for several years. The total dollar amount of the bonds written during the fraudulent scheme was calculated at $113 million. Seven defendants either pled guilty or were found guilty at trial as a result of this investigation.

Computer School Owner Pleads Guilty to Theft of Government Funds

The owner and operator of a computer school pled guilty to theft of Government funds. As part of the plea agreement, the defendant agreed to pay $2.83 million in criminal restitution, including $1.27 million in forfeiture. A VA OIG and Department of Labor (DOL) OIG investigation revealed that between April 2013 and June 2014, the defendant logged onto the VA/DOL portal and enrolled approximately 182 veterans to attend her school using VRAP (Veterans Retraining Assistance Program) educational benefits. The vast majority of these veterans were either not eligible for VRAP and/or were not actually attending the classes. Additionally, the defendant certified the veterans for up to 12 months for a class that was only approved for 14 weeks. The defendant also charged the veterans $750 per month to allow them to continue to collect monthly benefits.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 66 months' incarceration and was ordered to pay $85,000 in restitution after previously being convicted at trial of aggravated identity theft, access device fraud, conspiracy to commit identity theft, and conspiracy to commit access device fraud. A VA OIG and Federal Housing Finance Authority OIG investigation revealed that the defendant obtained the PII of dozens of VA employees

from a former VA employee. The defendant then used the PII of the VA employees and of Freddie Mac pension plan participants to run credit reports, to open credit accounts, to make fraudulent purchases at high-end retailers, and to pay for plastic surgery in Miami, FL.

Veteran Arrested for Possession of Child Pornography
A veteran residing at the Big Springs, TX, VAMC was arrested for possession of child pornography. An OIG investigation resulted in charges that allege that the defendant utilized medical center internet protocol addresses to download at least four child pornographic images. Additional federal charges are pending based on the final number of images identified as a result of this investigation.

Assaults and Threats Made Against VA Employees

Veteran Sentenced After Making Threats to Long Beach, California, VAMC Staff
A veteran was sentenced to 460 days' incarceration and 3 years' probation after pleading guilty to obtaining an assault rifle as a prohibited person. An OIG investigation revealed that the defendant threatened to kill his VA physician, the physician's family, and three VA Police Service officers at the Long Beach, CA, VAMC. The defendant made the threats because he wanted specific medications.

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG's vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.

https://www.va.gov/oig/publications/administrative-investigation-advisories.asp

Administrative Investigation Advisories (June 2017)	
Advisory Number	**Title**
17-00126-268	Administrative Investigation - Alleged Misuse of Travel and Conference Funds, Veterans Health Administration, Office of Strategic Integration, Washington, DC
17-01079-274	Administrative Investigation - Alleged Misuse of Government-Owned Vehicle, Office of Acquisition, Logistics, and Construction, Washington, DC

ADMINISTRATIVE SUMMARIES OF INVESTIGATION

OIG conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through FY 2015, OIG received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

At this time, OIG has completed more than 100 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. As other administrative summaries of investigation are completed, OIG intends to post them to our website so that veterans and Congress have a complete picture of the work conducted in their state.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at **www.va.gov/oig/publications/administrative-summaries-of-investigation.asp** and selecting the appropriate state.

Administrative Summaries of Investigation (June 2017)	
Summary Number	**Location**
15-00986-130	Montgomery, Alabama, VAMC
14-02890-99	Phoenix, Arizona, VAMC

MICHAEL J. MISSAL
Inspector General