



## Department of Veterans Affairs

### Office of Inspector General

October 19, 2015

On Thursday, October 22, 2015, the Council of the Inspectors General for Integrity and Efficiency (CIGIE) will recognize three VA Office of Inspector General (OIG) projects with Awards for Excellence at the 18<sup>th</sup> Annual Inspector General Community Awards Ceremony.

The VA OIG projects that will be recognized are:

- **[Award for Excellence in Investigations – James Haley Veterans Hospital Identity Fraud Investigation Team](#)** – This investigation was the combined efforts of Federal and state agencies to unravel a complex interrelated fraud scheme by VA medical center clerk and a hospital volunteer that compromised medical records containing veteran-patients' personal identifying information (PII) and sold the information for money and drugs knowing it would be used to file fraudulent tax returns. The [former VA clerk](#) worked in hospital admissions and targeted the patients, stealing their identities as they were admitted to the VA hospital in Tampa, Florida. A third defendant, a former employee of the company contracted by the same VA hospital to shred sensitive records, was convicted on charges of stealing and selling VA medical records that were intended to be destroyed. VA OIG Special Agents conducted joint investigations with the Internal Revenue Service Criminal Investigative Division into the misuse of stolen VA PII, resulting in nine additional arrests and convictions. As of October 14<sup>th</sup>, 12 defendants have been convicted and will serve a combined 97.5 years and 1 is awaiting sentencing. The Tampa Police Department, Florida Highway Patrol, Hillsborough County, Florida, Police Department, and the Department of Justice in Florida and Washington, DC, also worked on this case.
- **[Award for Excellence in Audit - VA National Call Center for Homeless Veterans Audit Team](#)** – This audit identified needed improvements in VA's National Call Center for Homeless Veterans to ensure homeless and at-risk veterans receive timely access to VA homelessness support services. The Call Center is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. We found that homeless and at-risk veterans who contacted the Call Center often experienced problems accessing a counselor, obtaining a referral, or receiving needed support services after they were referred to VA medical facilities.

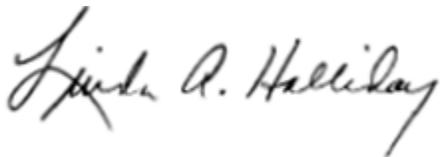
Of the estimated 79,500 homeless and at-risk veterans who contacted the Call Center, the VA OIG found that 21,000 had to leave voice mail messages because counselors were unavailable, and 13,000 of these calls were not

referred to VA medical facilities because they were inaudible or lacked contact information. The Call Center did not refer an additional 3,000 homeless and at-risk veterans who had provided all of the needed information for a referral. Further, the Call Center closed over 24,000 referrals even though VA medical facilities had not provided the referred homeless and at-risk veterans needed support services. In total, the audit identified 40,000 missed opportunities where the Call Center either did not refer a homeless or at-risk veteran to a VA medical facility or did not follow-up and ensure the VA medical facility provided the veteran needed homelessness support services after the referral.

This report has led to needed improvements in the operation of VA's National Call Center for Homeless Veterans and has highlighted program changes that will help ensure VA efficiently spends the \$1.4 billion in the VA FY 2016 budget request to assist homeless veterans and end veteran homelessness.

- [\*\*Award for Excellence in Multiple Disciplines – Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System Team\*\*](#) – This report was based on the work of staff from each OIG directorate who reviewed allegations related to patient deaths, wait times, and scheduling practicing irregularities at the Phoenix VA Health Care System in Phoenix, Arizona. This sensitive review was conducted under time constraints and under close watch by Congress, VA, and most importantly veterans. In the course of 5 months, the OIG staff published 2 reports that enabled VA to take action to schedule thousands of veterans for needed medical care and made a total of 28 recommendations that offered VA a road map for implementing changes to put veterans' needs first and help untangle the scheduling bureaucracy that impedes veterans' access to health care services.

These awards continue the VA OIG's distinguished record of recognition by our peers in the IG community and represent the VA OIG staff's continued efforts to make a difference in how VA delivers services to our Nation's veterans.

A handwritten signature in cursive script, reading "Linda A. Halliday". The signature is written in black ink and is positioned in the lower-left quadrant of the page.