Department of Veterans Affairs
Office of Inspector General
February 2012 Highlights

CONGRESSIONAL TESTIMONY

Open Market Purchases at VA Not a New Issue, Deputy AIG for Audits and Evaluations Tells House Veterans' Affairs Committee

Linda A. Halliday, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the scope and methodology of the Office of Inspector General's (OIG's) ongoing reviews of the VA's administration of the Pharmaceutical Prime Vendor contract. She described OIG's past reporting on open market purchases over the last 12 years and OIG's concerns that the Government was not sufficiently aggregating its buying power to obtain fair and reasonable prices. She was accompanied by Mr. Michael Grivnovics, Director, Federal Supply Service Division, and Mark Myers, Director, Healthcare Resources Division, in OIG's Office of Contract Review.

Veteran-Owned Small Business Contracts Subject of House Committee on Oversight and Government Reform Hearing

Belinda J. Finn, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Subcommittee on Technology, Information Policy, Intergovernmental Relations, and Procurement Reform, Committee on Oversight and Government Reform, United States House of Representatives, on OIG's work related to VA's Veteran-Owned and Service-Disabled Veteran-Owned Small Business (VOSB and SDVOSB, respectively) programs. An OIG report, released in July 2011, found that 76 percent of the businesses OIG reviewed were ineligible for the program and/or the specific VOSB or SDVOSB contract award, potentially resulting in $2.5 billion awarded to ineligible businesses over the next 5 years. Ms. Finn was accompanied by Mr. James J. O'Neill, AIG for Investigations, whose office's work recently resulted in the successful prosecution of the Chief Executive Officer of a business that had been awarded SDVOSB set-aside construction contracts for which the company was not eligible.

ADMINISTRATIVE INVESTIGATIONS

VA Researchers in Waco, Texas, Worked for Texas A&M University on Government's Time, Drew Salaries from Both

An OIG administrative investigation found that a Senior Official at the Veterans Integrated Service Network (VISN) 17 Center of Excellence, Waco, TX, misused official time when she took and approved authorized absences for her subordinates to conduct non-VA grant work for a non-VA entity during their VA duty hours, receiving remuneration from the entity. The Senior Official also created the appearance of preferential treatment when she loaned $7,000 to a subordinate to cover monies not yet paid to the subordinate by the entity and engaged in a conflict of interest when she recommended approval for Joint Employment Agreements between VA and the entity. OIG further found that the Center of Excellence did not maintain time and attendance records that accurately reflected the time delegated to VA versus tasks associated with the entity during employee tours of duty to alleviate improper salary supplementation. [Click here to access report.]

Tampa Clinician Engaged in Conflict of Interest, Referred VA Radiology Patients to Private Business Associate

Another administrative investigation found that a medical center clinician at the James A. Haley Veterans' Hospital, Tampa, FL, engaged in a conflict of interest when the clinician referred VA patients to a VA fee-for-service provider, while the clinician also had a private working relationship with them as the owner of a private company. OIG also found that the clinician improperly accepted gifts from the provider, misused VA time and resources to conduct tasks for the private business during the VA workday, and improperly used VA time and resources to develop an application for personal gain. OIG further found that the clinician failed to follow VA policy when the clinician sent VA patient radiology and photograph images from a VA-assigned e-mail account to private e-mail accounts and accessed them on non-VA issued equipment. Finally, OIG found that the clinician also violated VA policy when the clinician asked other VA employees to log onto the VA network using the clinician's username and password to falsely reflect that the clinician was at a VA duty station when the clinician was not.
[Click here to access report.]

OIG REPORTS

VA Resolves Infection Control Issues at Dayton Dental Clinic, Ongoing Monitoring Processes Adopted To Ensure Patient Safety

A review was conducted by OIG to follow-up on the report, Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, OH (Report No. 10-03330-148, April 25, 2011). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented. In the past 18 months, facility managers have taken appropriate actions and the conditions identified in the 2011 OIG report were resolved. Monitoring processes are in place to ensure ongoing compliance with standards. OIG considers the recommendations closed. [Click here to access report.]

VBA Needs More Proactive Measures to Prevent and Detect Fraud in New Process to Obtain Medical Evidence from Private Physicians

This audit was conducted by OIG to provide an early assessment of VA's internal controls over the use of disability benefits questionnaires (DBQ). OIG wanted to determine whether adequate front-end controls to identify and minimize risks were in place before benefit payments were initiated. VA implemented the new DBQ process to reduce the claims backlog by changing the way VA collects medical evidence to support claims. VA expects DBQs to replace the current need for Compensation and Pension medical exams by relying on information from Veterans and private physicians. OIG expects the volume of claims processed using DBQs to increase significantly. OIG's review found VA has a quality assurance review process, but it verifies only a limited number of DBQs and does so after claims are awarded. These quality assurance reviews do not provide reasonable assurance that fraud will be detected in the DBQ program as it accepts claims. The Under Secretary for Benefits and Under Secretary for Health generally concurred with the report recommendations. OIG will follow-up on the implementation of corrective actions. [Click here to access report.]

Treatment Delays, Understaffing Found at Buffalo, New York, VA Medical Center Emergency Department

The merit of allegations concerning quality of care and physician staffing were assessed in the Emergency Department (ED) of the VA Western New York Healthcare System (facility), Buffalo, NY. OIG substantiated the allegation that two patients did not receive adequate evaluation and management in the ED. The same physician evaluated both patients and both patients returned to the ED and required admission. OIG did not substantiate quality of care concerns for a third patient. Facility managers had identified quality of care concerns with this physician, yet they had not taken appropriate corrective actions in response to these concerns. OIG substantiated the allegation that the ED was understaffed and that physicians often worked excessive clinical hours. OIG also substantiated that the facility was on diversion overnight while two physicians were staffing the ED and inpatient beds were available. However, OIG did not identify any patients who were diverted to local hospitals. Four recommendations were made to improve quality of patient care and staffing in the ED, as well as to follow-up on quality of care concerns raised in specific cases. The VISN and Interim Facility Directors agreed with the findings and recommendations and provided acceptable action plans. [Click here to access report.]

Stronger Security Controls Needed to Check Unauthorized Access to VA Financial Dashboard Information

OIG evaluated the merits of allegations that VA did not use an appropriate contract vehicle to develop and implement the "Systems to Drive Performance" (STDP) dashboard, a system to track cost accounting data to facilitate senior leadership decision making. OIG did not substantiate the allegations regarding an inappropriate STDP contract vehicle, inadequate system testing, and system redundancy. However, OIG substantiated the allegation that VA did not adequately protect sensitive information from unauthorized access and disclosure. Specifically, OIG determined that more than 20 system users had inappropriate access to sensitive STDP information. VA's National Data Systems Group did not consistently approve requests for user access to STDP. Further, project managers did not report unauthorized access as a security event. STDP project managers were not fully aware of VA's security requirements for system development, nor had they formalized user account management procedures. Inadequate Information Security Officer oversight contributed to weaknesses in user account management and failure to report excessive user privileges as security violations. The Principal Deputy Assistant Secretary for Information and Technology and the Assistant Secretary for Management agreed with OIG's findings and recommendations. [Click here to access report.]

Kansas, Clinic Faulted for Mismanaging Patient's Care; Reporting of Death, Triage, Physician Supervision Also Criticized

An inspection was conducted by OIG to determine the validity of allegations regarding the quality of care at the Salina, KS, Community Based Outpatient Clinic (CBOC). OIG substantiated the allegation that the care of the patient was mismanaged. OIG was unable to determine and did not assert that a more prompt medical response would have resulted in preventing the patient's death. OIG found lack of proper, timely reporting of this death at multiple levels, but could not substantiate that there was an

institutional attempt by Salina CBOC or facility staff to "cover-up" the mismanagement of the patient's care; that the Root Cause Analysis (RCA) was perfunctory or lacking in sufficiently strong recommendations; and that facility management may have taken adverse action against the individual who reported the incident. OIG found inadequate triage practices, physician supervision, and physician availability on the day of the events in question; oversight reviews of all the relevant clinicians who were, or should have been, involved in the patient's care were not performed; and that adversarial staff relationships existed at the CBOC which may have impeded effective staff communication about the patient in this case. Additionally, OIG found that some issues identified during the RCA were not fully corrected. Six recommendations were made to improve operations. [Click here to access report.]

Benefits Inspection Division Visits Regional Offices in Montgomery, Alabama; St. Petersburg, Florida; and Pittsburgh, Pennsylvania

This inspection was conducted to evaluate how well the Montgomery, AL, VA Regional Office (VARO) accomplishes their mission. OIG found the Montgomery VARO staff timely processed homeless Veterans' claims and provided adequate outreach to homeless shelters and service providers. In general, the VARO accurately processed herbicide exposure-related claims, corrected errors identified by Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review (STAR) program, and completed all elements of Systematic Analysis of Operations (SAO) timely. However, the VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations occurred when staff did not schedule required medical reexaminations. Inaccuracies related to traumatic brain injury (TBI) claims resulted from staff using insufficient medical examinations to make final disability determinations. Overall, VARO staff did not accurately process 24 (29 percent) of 83 disability claims sampled as part of OIG's inspection. These results do not represent the overall accuracy of disability claims processing at this VARO. The VARO staff did not properly process mail or accurately address Gulf War Veterans' entitlement to mental health treatment. Further, delays in making final competency determinations occurred when staff did not prioritize these decisions as required. The VARO Director concurred with OIG's findings and recommendations and the planned actions were responsive. [Click here to access report.]

In another review, OIG evaluated how well the St. Petersburg, FL, VARO accomplishes its mission. OIG found the St. Petersburg VARO staff timely processed homeless Veterans' claims, provided adequate outreach to homeless shelters and service providers, and followed VBA's policy for correcting errors identified by STAR program staff. VARO performance was generally effective in processing herbicide exposure-related claims. However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule medical reexaminations. In addition, VARO staff used insufficient medical examination reports to process TBI claims. VARO staff did not correctly process 42 (47 percent) of the 90 disability claims sampled during OIG's inspection. These results do not represent the overall accuracy of disability claims processing at this VARO. VARO management did not ensure staff completed SAOs, properly processed mail, or accurately addressed Gulf War Veterans'

entitlement to mental health treatment. Further, processing of competency determinations was not effective, resulting in unnecessary delays in making final decisions and improper benefits payments. OIG recommended the VARO Director develop and implement a plan to monitor the effectiveness of training and ensure staff follow current VBA policy. The VARO Director concurred with OIG's recommendations. [Click here to access report.]

Lastly, OIG evaluated how well the Pittsburgh, PA, VARO accomplishes its mission. OIG found the Pittsburgh VARO staff corrected errors identified by the VBA's STAR program. VARO performance was generally effective in processing herbicide exposure-related claims. However, it lacked accuracy in processing some disability claims. VARO staff did not accurately process 36 (41 percent) of 88 disability claims sampled as part of OIG's inspection. These results do not represent the overall accuracy of disability claims processing at this VARO. Also, VARO management did not always provide oversight to ensure staff addressed all elements of SAOs, considered Gulf War Veterans' entitlement to mental health treatment, and provided outreach to homeless shelters and service providers. Oversight and policy guidance needed for proper mail-handling were lacking as well. Finally, delays in making final competency determinations occurred when staff did not prioritize these decisions. The VARO Director concurred with OIG's findings and recommendations.
[Click here to access report.]

Inspection Results for VA Clinics in New York
Four CBOCs were reviewed by OIG during the week of October 3, 2011. CBOCs were reviewed in VISN 2 at Catskill, Clifton Park, Glens Falls, and Schenectady, NY. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: management of diabetes mellitus-lower limb peripheral vascular disease, short-term fee basis care, women's health, credentialing and privileging, environment and emergency management, heart failure follow-up, and CBOC contracts. OIG noted opportunities for improvement and made a total of four recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Construction Company Owner, Son-In-Law Indicted for Fraud Involving Nearly $11Million in Contracts Intended for Veteran-Owned Businesses
The owner of a New Mexico construction company and his son-in-law were indicted for conspiracy, major fraud, and false statements. An OIG investigation determined that the owner of the company paid his step-brother approximately $50,000 to use his service-disabled Veteran status in order to qualify and obtain $10.9 million in VA SDVOSB contracts. The owner's step-brother previously pled guilty to a criminal information charging him with conspiracy, major fraud, and wire fraud.

Contractors Plead Guilty to Defrauding VA in Home Renovation Scheme
A former residential sales manager for a loan servicing company and a former contractor pled guilty to wire fraud. The loan servicing company managed foreclosed properties under a VA contract and hired construction companies to complete

necessary repairs. The properties were then re-sold and the company was reimbursed for repair expenses by VA. The defendants, who are brothers, engaged in fraud by having the sales manager steer repair contracts to a company affiliated with the contractor in exchange for $14,000 in cash payments. The investigation resulted in the discovery of a separate scheme involving another residential sales manager with the same loan servicing company and two additional contractors who were indicted for conspiring to commit bribery and wire fraud. The contractors paid the sales manager as much as $147,258 to steer repair work on VA-owned houses to companies affiliated with the contractors. The sales manager recruited other loan servicing company employees into the scheme and paid them on behalf of himself and the other conspirators. One of these other sales managers previously pled guilty to wire fraud for his role in the conspiracy.

Five Veterans Arrested for Selling Heroin and Other Drugs at Bedford, Massachusetts, VAMC

Five Veterans were arrested for distributing and conspiracy to distribute controlled substances as the result of an OIG, Drug Enforcement Administration (DEA), and VA Police Service investigation. The defendants were charged with dealing drugs including heroin, oxycodone, Suboxone, and clonazepam at the Bedford, MA, VA Medical Center (VAMC). In some of the cases, the defendants were selling drugs that had been provided to them by the medical center. During the course of the investigation, an undercover OIG agent made several controlled buys of drugs from the defendants.

Former Bedford, Massachusetts, VAMC Employee Sentenced for Selling Cocaine to Veterans in Treatment Program

A former Bedford, MA, VAMC employee, who supervised Veterans undergoing substance abuse treatment at the medical center, was sentenced to 3 months' confinement in a halfway house and 3 months' home confinement after having previously pled guilty to distribution of controlled substances. During an OIG, VA Police Service, and DEA investigation the employee sold cocaine to a cooperating witness on three separate occasions while on VA property.

Former Hines, Illinois, Consolidated Mail Outpatient Pharmacy Employee Sentenced for Drug Theft

A former contract employee at the Hines, IL, Consolidated Mail Outpatient Pharmacy (CMOP) was sentenced to 15 months' incarceration, 36 months' supervised release, and ordered to pay $52,972 in restitution to VA. An OIG investigation revealed that the defendant stole numerous vials of Viagra from the CMOP to sell for personal gain.

Former Tucson, Arizona, CMOP Employee Sentenced for Drug Theft

A former Tucson, AZ, VA CMOP employee was sentenced to 18 months' incarceration (suspended) and 18 months' probation. An OIG investigation determined that the defendant stole over 500 Soma tablets for personal use while working as a pharmacy technician.

Veteran Pleads Guilty to Theft of $900,000 in Benefits Over 15 Years

A Veteran pled guilty to theft of Government funds after an OIG investigation

determined that he fraudulently received approximately $900,000 in VA compensation benefits for approximately 15 years. The defendant, who was treated by VA for numerous ailments, claimed to be wheelchair bound and required the need of an aide. The defendant gave various fabricated accounts to neighbors, the media, and VA staff on how his injury occurred, including being a U.S. Navy SEAL wounded during Operation Desert Storm, being injured during hand-to-hand combat training, falling down steps, and being shot by friendly fire while at Ft. Bragg. The investigation also revealed that while the defendant reported to VA that he was not ambulatory, he completed the North Carolina Basic Law Enforcement Training Program and later held jobs as a police officer and a child protective services officer.

AmeriCorps Member Pleads Guilty to Burglary and Sexual Offense at Perry Point, Maryland, VAMC

An AmeriCorps member, formally residing in leased housing at the Perry Point, MD, VAMC, pled guilty to burglary and a sex offense. An OIG and Maryland State Police investigation revealed that the defendant sexually assaulted a female AmeriCorps member at her residence, located on the grounds of the medical center. The defendant remains in custody pending sentencing.

Veteran Arrested for Sexual Abuse of Rochester, New York, VA Outpatient Clinic Nurse

A Veteran was arrested for sexual abuse in the first degree after an OIG, VA Police Service, and local police investigation revealed that he sexually assaulted a VA registered nurse during an appointment at the Rochester, NY, VA outpatient clinic. When interviewed, the defendant admitted to placing the nurse's hand on his genitals while the nurse was performing a blood draw at the phlebotomy clinic.

Veteran Convicted of Threatening Memphis, Tennessee, VA Employees

A Veteran was found guilty at trial of threatening VA employees. An OIG investigation revealed that the defendant made a series of threatening phone calls to two Memphis, TN, VA vocational rehabilitation employees at their residences. Due to the violent nature of the offense, the judge remanded the defendant into custody until his sentencing.

Veteran Sentenced for Threatening the Director of the White River Junction, Vermont, VAMC

A Veteran was sentenced to 2 years' probation after pleading guilty to disturbing the peace by electronic communication on Federal property. An OIG and VA Police Service investigation revealed that the defendant sent an e-mail, which threatened physical harm, to the director of the White River Junction, VT, VAMC. The defendant, a former medical center employee, previously submitted numerous harassing e-mails to VA personnel, including one that caused a 6-hour facility shutdown in anticipation of his arrival.

Veteran Arrested for Assaulting Reno, Nevada, VAMC Chief of Police

A Veteran was arrested by OIG agents for assaulting the Reno, NV, VAMC Chief of Police. The defendant, while intoxicated, became disruptive in the medical center

waiting area, made threats toward his primary care physician, and intimidated staff and patients. The chief arrived on the scene, identified himself to the defendant and attempted to calm the situation. The defendant subsequently punched the chief in the face, causing injuries.

Foreign National Arrested for Identity Theft
A Cuban national was arrested at the Phoenix, AZ, VAMC after being indicted for aggravated identity theft, false representation of a Social Security number, theft of Government property, and wire fraud. An OIG investigation revealed that the defendant used the identity of a Veteran from Puerto Rico to obtain VA compensation and medical care. The loss to VA is $414,745—$251,321 in VBA benefits and $163,424 in medical benefits.

Veteran Pleads Guilty to Making Threats and Travel Benefits Fraud
A Veteran pled guilty to making threats against a Federal government official and making false statements. An OIG investigation determined that from 2008 to 2011, the defendant provided a false address for his travel benefit claims to the Hampton, VA, VAMC. The defendant reported that he traveled from North Carolina, when in actuality he was travelling from Norfolk, VA. Following an interview of the subject and termination of excess travel reimbursement, the defendant threatened to assault the case agent. The loss to VA is approximately $8,000.

Naval Officer Indicted for VA Home Loan Guaranty Fraud
An active duty naval officer was indicted for wire fraud after an OIG and Naval Criminal Investigative Service (NCIS) investigation revealed that she applied for and received a VA Home Loan Guaranty based on fraudulent income and asset documents that she provided to a bank to secure a home mortgage. The defendant is currently serving 30 months' incarceration in a Navy brig after being found guilty of making misrepresentations concerning her education at the time of her enlistment.

Veteran's Daughter Pleads Guilty to Falsifying Business Records and Identity Theft
The daughter of a Veteran pled guilty to falsifying business records and identity theft after an OIG investigation revealed that she submitted fraudulent employment records in order to secure a VA home loan in her father's name. The loan was subsequently approved based on the false records and the home is now in foreclosure.

Veteran's Girlfriend Pleads Guilty to Defrauding VA
The girlfriend of a Veteran pled guilty to misprision of a felony for her part in structuring a business in her name in order to hide the Veteran's income from VA. An OIG and local police investigation revealed that the defendant and the Veteran operated a business for over 8 years while the Veteran received monthly VA pension benefits and co-pay exempt VA health care. In addition, the Veteran was previously charged with illegal distribution of his VA prescribed narcotics. The loss to VA is $220,072—$127,888 in pension overpayments and $92,184 in disallowed medical benefits. Criminal charges are pending against the Veteran.

Veteran and Wife Indicted for Theft of Government Funds
A Veteran and his wife were indicted for theft of Government funds and for acting as principals in the commission of an offense against the Government. An OIG investigation revealed that the Veteran, who was receiving individual unemployability benefits, owned and operated two separate automobile related-businesses, while reporting to VA that he was unemployed and unable to work due to his disability. The Veteran's wife, who was also his VA fiduciary, provided documentation furthering his scheme of convincing VA that he was unable to obtain or maintain substantial, gainful employment. The loss to VA is approximately $107,000.

Wife of Deceased U.S. Navy Service Member Sentenced for VA Compensation Fraud
The wife of a deceased U.S. Navy service member was sentenced to 6 months' incarceration, 6 months' home confinement, 3 years' supervised release, and ordered to pay $115,759 in restitution after pleading guilty to theft of Government funds. An NCIS investigation, supported by OIG, resulted in a previous guilty plea by the defendant in 2008 to involuntary manslaughter related to her husband's 1993 death. The defendant was not entitled to VA benefits because she was held responsible for her husband's death.

Son of Deceased Beneficiary Pleads Guilty to Theft of VA Funds
The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG investigation determined the defendant stole VA funds from a joint bank account after his mother's death in September 2005. The defendant admitted to using the VA benefits for personal expenses. The loss to VA is $87,894.

Fugitive Employed by Atlanta, Georgia, VAMC Arrested with Assistance of OIG
A VA employee, who was also a fugitive, was arrested at the Atlanta, GA, VAMC by local law enforcement officers with the assistance of OIG and VA Police Service. The fugitive was wanted on an outstanding felony warrant for a probation violation related to a previous conviction for armed robbery.

(original signed by Richard J. Griffin,
Deputy Inspector General for:)
GEORGE J. OPFER
Inspector General