Department of Veterans Affairs
Office of Inspector General
September 2011 Highlights

OIG REPORTS

VHA Could Reduce Workers' Compensation Costs by $264 Million Over 5 Years

The Office of Inspector General (OIG) conducted an audit to determine whether Veterans Health Administration (VHA) has effectively managed Workers' Compensation Program (WCP) claims to reduce VA's overall WCP costs. VHA has nearly doubled its timeliness in initiating WCP claims since 2001. However, evidence was sometimes lacking and VHA had not consistently updated files or made job offers to employees who could work. Fraud detection was lacking due to competing priorities. OIG projected VHA could reduce costs by $264 million over 5 years. Additionally, converting claimants 65 years of age or older to more appropriate benefit programs could reduce VHA's costs about $463.9 million over 5 years but would require legislative action. OIG recommended the Under Secretary for Health provide adequate staff, clear oversight, standard guidance, and fraud detection procedures to improve WCP case management. OIG recommended the Assistant Secretary for Human Resources and Administration propose legislation to move retirement age individuals to appropriate retirement programs. [Click here to access report.]

Audit Leads to Quick Action to Correct Deficiencies in Verifying Personal Identity for Government ID Cards

An audit was conducted by OIG to assess whether VA's Enrollment Centers met Homeland Security Presidential Directive 12 and other Government-wide requirements when providing Personal Identity Verification (PIV) credentials. OIG found significant control lapses and missing procedures that compromised the integrity of the credentialing process. VA's PIV credentialing operation was never evaluated and certified to Government standards. VA may have issued thousands of PIV credentials without determining whether applicants are known or suspected terrorists; the authenticity of applicants' documents were not verified; some applicant background investigations were uninitiated or results were incomplete; and staff compromised system integrity by disregarding separation of duties. OIG recommended the Enrollment Centers stop issuing PIV credentials until control deficiencies in the credentialing process are addressed, and VA assesses and accredits the existing processes to meet Government-wide requirements. The Assistant Secretary for Operations, Security, and Preparedness concurred with OIG's findings and recommendations and took immediate actions to mitigate risk associated with the program. [Click here to access report.]

VBA Claims Brokering Process Not Effective at Improving Timeliness, Accuracy of Claims

OIG evaluated the effectiveness of Veterans Benefits Administration's (VBA) claims brokering. To help address VBA's major challenge of processing the increased number of Veterans' compensation benefit claims, VBA has increased claims brokering from Veterans Service Centers (VSCs) to resource centers or other VSCs to better align

workload with staffing resources. OIG found VBA can improve the effectiveness of claims brokering by ensuring area offices consider additional factors affecting timeliness and accuracy. For nearly 171,000 brokered claims completed during fiscal year (FY) 2009, OIG projected the average processing time of 201 days would have been 49 days less if VBA had avoided the claims processing delays identified in this report. Of nearly 117,000 claims VBA brokered for ratings, OIG projected area offices brokered about 54,000 (46.2 percent) to facilities with lower rating accuracy rates than original VSCs. In addition, staff at three of seven VA Regional Offices (VAROs) OIG visited brokered claims without area office approval. Increased effectiveness will reduce the risks of claims-processing inaccuracies. OIG recommended the VBA revise brokering policies and procedures to help improve claims-processing timeliness and accuracy, include brokered claims-processing timeliness and accuracy performance measurements in director performance plans, and evaluate VSC compliance with revised brokering policies and procedures. [Click here to access report.]

Chicago Medical Center Moves Homeless Female Veterans After OIG Reports Safety, Security, and Privacy Issues

OIG advised VHA of serious safety, security, and privacy issues affecting female Veterans in a homeless facility identified during ongoing audit work that required immediate management attention. The OIG site visit to the Jesse Brown VA Medical Center (VAMC), Chicago, IL, revealed that since 2002, the VAMC's Grant and Per Diem (GPD) program staff has placed 22 homeless female Veterans, some with a history of sexual trauma and domestic violence, in a male-only facility without adequately addressing the safety, security, and privacy needs of female Veterans, needlessly exposing homeless female Veterans to safety, security, and privacy risks. After OIG discussed this issue with senior VAMC officials, they arranged for the immediate move of the women to a non-VA funded facility that provided services to homeless females. OIG recommended the GPD staff better understand the contents and requirements of the grant proposals, review policies and procedures, and make program changes as needed. OIG also recommended an inventory of all active homeless grant programs, and remove females from male-only or other inappropriate facilities, then prevent future placement of female Veterans in these facilities. [Click here to access report.]

Accuracy in Part-time Physicians' Time and Attendance Improves, but Better Controls Still Needed

OIG conducted a follow-up audit to assess the effectiveness of implementation actions from two prior OIG audits that identified weaknesses in VHA's management controls over part-time physicians' time and attendance. Implementation of prior recommendations has reduced the number of days part-time physicians might not be meeting their employment obligations. OIG noted a decrease in the percentage of days with no evidence of VA activity from 33 percent in 2003 to 11 percent in 2010. Also, only 3 percent of part-time physicians were not on duty as required—a drop from prior audits, which reported 11 and 8 percent, respectively. OIG found VHA abolished written physician service agreements and other controls were not implemented, such as monitoring the type of time logged, validating attendance according to current procedures, and timely and accurately recording actual hours. OIG recommended VHA

reinstitute written agreements for all part-time physicians, require management establish oversight on time and attendance, and clarify standard operating procedures for time and attendance monitors. VHA agreed with OIG's findings and recommendations. [Click here to access report.]

National Contract Oversight Processes Need Improvement at VA's National Acquisition Center

Systemic weaknesses in VA's procurement activities represent a major management challenge for VA. OIG focused on National Acquisition Center (NAC) operations, the largest combined contracting activity in VA. OIG found general contract development and award actions were in accordance with Federal and VA Acquisition Regulations. However, NAC management did not ensure staff fully utilized VA's mandatory Electronic Contract Management System (eCMS) to develop and award national contracts. Limited oversight and compliance monitoring of eCMS resulted in an impaired and diminished visibility of procurement actions, which in turn may have lead to significant delays in the contract awards and inadequate controls to ensure timeliness. VA agreed with OIG's findings and recommendations and plans to complete all corrective actions by September 30, 2012. [Click here to access report.]

OIG Makes Five Recommendations to Improve Infection Control Practices

OIG evaluated selected infection prevention (IP) practices in VHA facilities by determining whether facilities complied with required IP practices in patient care units, trained employees on the Occupational Safety and Health Administration Bloodborne Pathogens Rule, and performed N95 respirator fit testing. OIG conducted the review at 69 facilities during Combined Assessment Program (CAP) reviews performed from January 1, 2010, through March 31, 2011. VHA facilities recognized the importance of maintaining consistent IP practices to ensure Veterans' safety and reduce the incidence of health care-associated infections. OIG identified five areas where compliance with selected IP requirements needed to improve and recommended that corrective actions are initiated when hand hygiene performance falls below established thresholds, ultraviolet germicidal irradiation fixtures are turned on and functional, negative pressure is monitored and within acceptable levels in occupied airborne infection isolation rooms, employees with occupational exposure risk complete annual Occupational Safety and Health Administration Bloodborne Pathogens Rule training, and designated employees complete annual N95 respirator fit testing. [Click here to access report.]

OIG Identifies Three Areas in Need of Improvement in Management of Laboratory, Radiology, and Pathology Test Results

OIG evaluated the management of test results in VHA facilities by determining whether facilities complied with VHA policy and Joint Commission standards related to communicating critical clinical laboratory, radiology, and anatomic pathology test results; periodically monitored communication of critical test results to evaluate effectiveness; documented appropriate notification and follow-up actions in medical records when critical test results were generated; and notified patients of normal test results. OIG also followed up on a previous report published in 2002. This review was conducted at 25 facilities during CAP reviews performed from October 1, 2010, through

March 31, 2011. In response to OIG's 2002 report, VHA provided system-wide guidance for management of test results and made significant improvements related to diagnostic clinician communication and documentation of critical results. OIG identified three areas where compliance with VHA requirements needed improvement and recommended that facilities' written policies be comprehensive and define processes for monitoring the effectiveness of communicating critical results to practitioners and patients, that ordering practitioners notify patients of all critical results within the defined timeframes, and that practitioners notify patients of normal results and that managers monitor compliance. [Click here to access report.]

OIG Substantiates Poor Management of Patient Abuse Cases at the Charlie Norwood VAMC, Augusta, Georgia

OIG conducted an inspection to determine the validity of allegations that two patient abuse cases were not managed properly, and as a result, patients were placed at risk at the Charlie Norwood VAMC, Augusta, GA. OIG substantiated that some staff members and managers did not comply with policies for reporting patient abuse or evaluating victims and events, and that some managers did not take appropriate or timely administrative action. OIG found no evidence, however, that patients were actually harmed by these procedural breaches. OIG substantiated that a senior executive acted improperly in the administrative action involving substantiated patient abuse and that responsible managers did not report a nurse to the State Licensing Board (SLB) as required. Veterans Integrated Service Network (VISN) and Medical Center Directors concurred with OIG's recommendations and provided acceptable action plans. [Click here to access report.]

Allegation of Surgeon Privileging and Resident Supervision Issues Substantiated at the W.G. (Bill) Hefner VAMC, Salisbury, North Carolina

OIG conducted an inspection to determine the validity of allegations of surgeon privileging and resident supervision issues at the W. G. (Bill) Hefner VAMC in Salisbury, NC. OIG substantiated the allegation that some surgeons performed certain operative procedures without the appropriate corresponding privileges; however, OIG did not find evidence that poor surgical outcomes resulted. OIG substantiated the allegation that residents in Surgical Service were not supervised as required by VHA policy, and that there was no surgeon on site 2 days per week while residents were seeing patients in the clinic. OIG found that resident-authored progress notes were not consistently co-signed by a supervising surgeon in the timeframe verbalized as acceptable by clinical leadership. OIG also found that interval notes documenting patients' current condition and need for surgery were not consistently entered into the medical record by the attending surgeon. The VISN and VAMC Directors concurred with OIG's findings and recommendations and provided acceptable action plans. [Click here to access report.]

Allegations of Poor Quality of Care Substantiated at the VA Nebraska-Western Iowa HCS, Omaha, Nebraska and VA Central Iowa HCS, Des Moines, Iowa

OIG conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient at both the Omaha, NE and Des Moines, IA, HCSs. The complainant alleged that while at the Omaha HCS, a patient suffered a stroke that

was unnoticed by staff, did not receive assistance with activities of daily living (ADLs), did not receive rehabilitative therapy, did not receive a pulmonary treatment, did not receive pain medication timely, and had a delay in receiving medication by mail. The complainant also alleged that while at the Des Moines HCS, the patient did not receive assistance with his ADLs, speech therapy, and discharge planning. OIG substantiated that the patient did not receive one pulmonary treatment, medication by mail timely, and was not reassessed for pain medication effectiveness. OIG recommended the Omaha HCS Director ensure clinicians review the delay in medication by mail and ensure pain assessments and reassessments are done according to policy. [Click here to access report.]

Allegations of Poor Quality of Care Substantiated at the Corpus Christi Community Based Outpatient Clinic, Harlingen, Texas

OIG evaluated the validity of allegations regarding quality of care at the Corpus Christi Community Based Outpatient Clinic (CBOC) in Corpus Christi, TX. OIG substantiated the allegation that a CBOC primary care provider did not diagnose a patient's fractured ankle when the patient presented for evaluation. The facility had taken appropriate action prior to the review. OIG substantiated that a CBOC primary care provider prescribed antibiotics without first obtaining wound cultures. OIG identified two factors that affected this patient's care: failure to implement the facility's Skin Integrity Management Program Policy for managing the skin integrity of outpatients and fee-basis records not always being available in the medical record. The facility identified opportunities for improvement prior to OIG's review, which were found to be acceptable. OIG recommended that the VAMC Director ensure that the CBOC follow the Skin Integrity Management Program Policy. [Click here to access report.]

Diagnosis of Pulmonary Embolism Not Adequately Pursued at the Oklahoma City, Oklahoma, VAMC

OIG conducted a review to determine the validity of allegations of misdiagnosis by providers at the VAMC in Oklahoma City, OK. The complainant alleged that a patient was given a diagnosis of communicable pneumonia, placed in a room with four other patients in the facility's emergency room (ER), and then incorrectly given a diagnosis of lung cancer. When the patient left the facility and went to a community hospital, the patient was found to have acute pulmonary embolism. OIG did not substantiate that the patient was placed in a room with four other patients or that the patient was given a diagnosis of lung cancer. OIG found that providers did not adequately pursue a possible diagnosis of pulmonary embolism at initial presentation or upon admission to the facility. OIG recommended that the VAMC Director obtain a peer review assessment of the care provided to this patient during both presentations to the ER and subsequent admission. The VISN and VAMC Directors concurred with OIG's findings. OIG will follow up until the planned actions are completed. [Click here to access report.]

Allegations of Quality of Care Issues Not Substantiated at the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

OIG conducted an inspection to determine the validity of multiple allegations regarding the quality of care in the mental health (MH) and two medical specialty clinics at the

Captain James A. Lovell Federal Health Care Center, Chicago, IL. The complainant alleged that a patient did not have drug screens completed prior to being prescribed narcotics and that the patient's death was not properly reported and investigated. OIG substantiated the allegation that urine drug screens were not performed. OIG found that the case was properly reported and investigated; however, the peer reviewer of the case was not certified in pain management. OIG did not substantiate the other allegations related to MH providers issuing narcotics outside the narcotic agreement, the contract physician self-referring, the physician in a specialty clinic taking multiple weeks of annual leave, and that manager's were aware that multiple patients did not receive care during that time. OIG recommended that the Center Director ensure that patients with narcotic agreements are appropriately monitored for compliance with prescription medications and a physician certified in pain management review this case. [Click here to access report.]

OIG Finds Bedsores Not Caused by Neglect or Abuse at Fresno, California, VA Health Care System

OIG evaluated the validity of an allegation regarding patient neglect and abuse at the VA Central California Health Care System (HCS), Fresno, CA. The complainant alleged that a patient developed bedsores (pressure ulcers) due to neglect and abuse while an inpatient on the HCS's medical units and as a resident in the community living center. OIG did not substantiate the allegation. OIG found that the patient developed pressure ulcers while being treated by the HCS as well as subsequent pressure ulcers that developed when not an inpatient. OIG concluded that these were not the result of neglect or abuse but more likely the result of his debilitated catabolic state, and the insertion of a Foley catheter used in the treatment of life-threatening urosepsis. OIG determined that the patient was assessed for skin breakdown and pressure ulcer interventions were initiated by the system in a timely manner. OIG made no recommendations. [Click here to access report.]

Seven CBOCs Reviewed

OIG reviewed seven CBOCs during the week of June 20, 2011. CBOCs were reviewed in VISN 17 at San Antonio (North Central Federal Clinic), Uvalde, and Tyler, TX; and, in VISN 18 at Alamogordo and Artesia, NM, and Bellemont and Kingman, AZ. The parent facilities of these CBOCs are South Texas Veterans HCS, VA North Texas HCS, New Mexico VA HCS, and Northern Arizona VA HCS, respectively. 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: MH continuity of care, short-term fee basis care, women's health, credentialing and privileging, skills competency, environment and emergency management, Primary Care Management Module, and contracts. OIG noted opportunities for improvement and made a total of 45 recommendations to the VISN and facility managers. [Click here to access report.]

Benefits Inspection Division Reviews VAROs in Seattle, Washington, and Hartford, Connecticut

OIG evaluated how well the Seattle, WA, VARO accomplishes its mission. VARO staff were generally effective in processing post traumatic stress disorder (PTSD) and herbicide-related claims, correcting errors identified by the VBA's Systematic Technical Accuracy Review (STAR) program, and Systematic Analyses of Operations (SAOs) were timely and complete. However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted from human error in not scheduling required future medical reexaminations. Inadequate training resulted in errors in processing traumatic brain injury (TBI) claims. Overall, staff did not accurately process 34 (28 percent) of the 120 disability claims reviewed. VARO management did not have mechanisms in place for Veterans Service Center (VSC) staff to accurately establish dates of claim or timely process Notices of Disagreement (NOD) for appealed claims within the VBA's 7-day standard. Management directives lacked procedures for ensuring proper mail handling. OIG recommended the VARO Director implement a plan to assess the effectiveness and adequacy of Rating Veterans Service Representative training on processing TBI claims. Stronger controls are needed over establishing dates of claim, processing NODs, and handling claims-related mail. Additionally, staff need training on how to use the Control of Veterans Records System to manage mail. [Click here to access report.]

OIG evaluated the Hartford, CT, VARO. OIG found the Hartford VARO staff properly established dates of claim in the electronic record and corrected errors identified by the VBA's STAR program staff. VARO performance was generally effective in processing claims related to herbicide exposure and PTSD, and handling claims-related mail. However, the VARO lacked effective controls and accuracy processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule medical reexaminations. Errors in processing TBI related claims occurred because staff used insufficient medical examinations and incorrectly evaluated the severity of disabilities. Overall, VARO staff did not accurately process 28 (28 percent) of the 100 disability claims we reviewed. OIG recommended VARO management provide additional training to improve the accuracy of evaluating residuals of TBI. Management needs to strengthen controls over processing NODs, improve oversight of SAOs, and amend the VARO workload management plan to ensure timely completion of competency determinations. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Home Health Care Company Agrees To Pay Government $150 Million to Settle Fraud Complaint

A home health care services company was charged in a criminal complaint with conspiracy to commit health care fraud and entered into a deferred prosecution agreement. Accordingly, the company has agreed to pay a criminal penalty of $20 million and to pay approximately $130 million in civil settlements, including the settlement of Federal *False Claims Act* violations. VA was awarded approximately $5.2 million as part of the civil settlement. Additionally, one of the company's former homecare nurses was sentenced to 3 years' probation, with the first 6 months to be

restricted to home confinement, after pleading guilty to health care fraud by admitting to billing for homecare services that were not provided.

Former Long Beach, California, VAMC Nurse Arrested on Identity Theft Charges
A former Long Beach, CA, VAMC nurse was arrested after an OIG and local police investigation revealed that she stole the personal identifying information of 45 patients and used it to commit identity theft by making purchases using their identities.

Defendant Pleads Guilty to Identity Theft
A non-Veteran pled guilty to wire fraud, false statements, health care fraud, and theft after an OIG and Defense Criminal Investigative Service investigation revealed that he fraudulently obtained and used the DD-214 of a retired military Veteran to obtain VA medical services, as well as Tricare benefits for his spouse. The defendant also obtained VA and Department of Defense identification cards and diverted the Veteran's VA compensation and Army retirement pay to his own bank account. The defendant filed numerous fraudulent documents with VA in an attempt to obtain additional compensation, education, and vocational rehabilitation benefits. The overall loss to the Government was approximately $33,000.

Veteran Pleads Guilty to Theft of Government Funds
A Veteran pled guilty to theft of Government funds after an OIG and Social Security Administration (SSA) investigation revealed that he fraudulently received VA individual unemployability benefits and SSA disability benefits. The defendant concealed earned income from both VA and SSA. The loss to VA is $72,921 and the loss to SSA is $28,765.

Former Cleveland, Ohio, VARO Employee Sentenced for Theft of Government Funds
A former Cleveland, OH, VARO employee was sentenced to 5 years' probation and ordered to pay $11,259 in restitution to VA after pleading guilty to theft of Government funds. An OIG investigation revealed that while employed by VA the defendant diverted retroactive payments intended for Veterans by changing the direct deposit information to her own account. After the retroactive payments were deposited into her account, she changed the deposit information back to the Veterans' bank accounts.

Former Tucson, Arizona, Consolidated Mail Outpatient Pharmacy Technician Indicted for Drug Diversion
A former Tucson, AZ, Consolidated Mail Outpatient Pharmacy technician was indicted on drug charges. An OIG investigation revealed that the defendant stole 534 Soma tablets, a muscle relaxant, for personal use. The defendant resigned from VA as a result of this investigation.

Former Augusta, Georgia, VAMC Nurse Who Diverted Drugs Enters into Pretrial Diversion Agreement
A former Augusta, GA, VAMC registered nurse entered into a 12-month agreement for pretrial diversion for obtaining controlled substances by deception. An OIG and VA

Police investigation revealed that, from August 2009 to June 2010, the defendant stole VA narcotics from a medical center Pyxsis machine. The defendant admitted to diverting approximately 2-3 hydrocodone and/or oxycodone pills per shift for personal use.

Veteran's Daughter Indicted for Misappropriation by a Fiduciary
A VA fiduciary was arrested after being indicted for misappropriation by a fiduciary. An OIG investigation revealed that, while serving as her father's fiduciary, the defendant misused $27,024 in VA benefits.

Veteran Sentenced for Theft of VA Pension Benefits
A Veteran was sentenced to 3 years' incarceration and ordered to pay $32,466 in restitution after pleading guilty to theft of VA pension benefits. An OIG investigation revealed that the defendant, who is not married, falsified multiple VA documents claiming he was married and supporting six children.

Veteran Pleads Guilty to Travel Claims Fraud
A Veteran pled guilty to theft of Government funds after an OIG and VA Police investigation revealed that from January 2008 to September 2010 he filed 215 false travel vouchers. The defendant claimed that he was traveling 484 roundtrip miles between Idabel, OK, and the Oklahoma City, OK, VAMC; he actually resided in the Oklahoma City area. The loss to VA is approximately $35,700.

Veteran Sentenced for VA Compensation Fraud
A Veteran was sentenced to 5 years' probation and ordered to pay $110,238 in restitution after pleading guilty to making false statements. An OIG investigation revealed that since 2003 the defendant, who was collecting VA compensation due to unemployability, was employed full-time with a Government contractor and submitted false documentation to VA claiming he was unemployed.

Veteran's Son Sentenced for Theft of VA Funds
The son of a deceased Veteran was sentenced to 10 years' probation and ordered to pay $47,409 in restitution to VA and the U.S. Office of Personnel Management (OPM) after pleading guilty to misapplication of fiduciary property and theft. An OIG and OPM OIG investigation revealed that for 4 years the son routinely moved the Veteran from one nursing home to another, relocating the Veteran when the nursing home demanded payment. During this time period, approximately $20,000 in VA benefits and $36,000 in OPM benefits were stolen by the defendant from his father's bank account. The Veteran died shortly after being moved to his final nursing home.

Daughter-in-Law of Deceased VA Beneficiary Sentenced for Theft of VA Funds
The daughter-in-law of a deceased VA beneficiary was sentenced to 10 months' electronically monitored home confinement, 5 years' probation, and ordered to pay $114,683 in restitution after pleading guilty to the theft of Government property. An OIG investigation determined that the defendant withdrew funds from her deceased mother-in-law's bank account after her death in September 2002 and subsequently

redirected the monthly VA benefit checks to three separate addresses in order to continue to defraud VA. The defendant admitted to receiving, forging, and negotiating the benefit checks through multiple bank accounts and converting the funds to her own use.

Veteran Pleads Guilty to Firearms Possession
A Veteran pled guilty to a felony charge of possession of firearms in a Federal facility after an OIG, VA Police, and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation revealed that he brought a duffel bag into the Cleveland, OH, VAMC containing three loaded handguns, a fully loaded automatic assault rifle, and two hunting knives.

Fugitive Arrested with Assistance of OIG
The U.S. Marshals Service, with the assistance of OIG, arrested a Veteran as he was being released from the Phoenix, AZ, VAMC. The Veteran was a known member of a white supremacist group and was wanted on a probation violation stemming from a Federal weapons conviction.

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

GEORGE J. OPFER
Inspector General