Department of Veterans Affairs
Office of Inspector General
December 2011 Highlights

ADMINISTRATIVE INVESTIGATION

Manager Interfered With Hiring Process, Then Failed To Tell the Truth About It

An Office of Inspector General (OIG) administrative investigation found that an Office of Business Oversight (OBO) senior official, as part of a recruitment process, attempted to pressure a subordinate into making a false representation concerning an interview score and the proper standing of a preferred job applicant. The U.S. Department of Justice declined criminal prosecution in favor of available administrative remedies. In addition, another OBO senior official failed to properly discharge his duties and responsibilities as a supervisor when he, after receiving two separate complaints alleging serious misconduct, failed in both instances to investigate and take the appropriate corrective action. Furthermore, both OBO senior officials failed to testify freely and honestly in connection with the investigation. [Click here to access report.]

OIG REPORTS

Audit Finds Major Acquisition Reviews Performed Only on 32 Percent of VA Contracts, $2.9M Could Be Saved with Competition

This audit examined how well recent major acquisition process changes strengthened the quality of Veterans Health Administration's (VHA's) contracts. The changes were not effective because new Integrated Oversight Processes (IOP) were not followed consistently and VA and VHA acquisition management did not provide adequate guidance and oversight needed to implement these processes. While the quality of contracts improved when the IOP was used, VHA did not perform IOP reviews for an estimated 3,000 contracts, which were valued at $1.58 billion and awarded between June 2009 and May 2010. OIG also found that VHA needs management tools to effectively monitor contract workload and optimal staffing levels. Comparisons of Government cost estimates for noncompetitive contracts showed VA could have put about $2.9 million to better use through competitive procurements. Without these tools, VHA lacks the information needed to effectively manage its contracting activities. [Click here to access report.]

Failure to Disclose Relevant Selection Factors Shows Potential Bias in $133 Million IT Contract

OIG evaluated the Secure VA-Chief Information Security Officer Support Services acquisition process to determine whether the solicitation, proposal evaluation, and contract award processes were conducted in line with full and open competition requirements. OIG found the acquisition process demonstrated a potential bias by using knowledge of VA procedures and practices as a significant selection factor without clear disclosure of its relative importance when asking for bids. As such, the technical evaluation process favored awarding the contract to the incumbent, Booz-Allen Hamilton, the same contractor who provided VA's Information Assurance and Information Technology Security Services for the past 2 years. VA awarded the

contract for $133 million at a premium of 16 percent ($18 million) and 22 percent ($24 million) over the two other offerors. [Click here to access report.]

Emergency Calls to San Diego Call Center Not Properly Triaged, Staff Training and Better Management Oversight Needed

OIG conducted an inspection to determine the validity of multiple allegations regarding the management of emergency calls at the Primary Care Call Center (PCCC), VA San Diego Healthcare System (HCS), San Diego, CA. OIG substantiated the allegations that PCCC agents were not following established procedures for referring emergency calls for triage, PCCC agents were inexperienced and lacked appropriate training, and managers did not evaluate the root causes of identified ongoing problems. OIG concluded that the PCCC had serious problems that put patients at risk. OIG recommended that the System Director ensure that Managers monitor PCCC agents' compliance with procedures, and re-evaluate processes to ensure all emergency calls are routed appropriately; PCCC agents receive initial training on required competencies and that competencies are confirmed annually thereafter; and Root Cause Analyses in response to patient event reports are completed and appropriate action taken as needed. The Veterans Integrated Services Network (VISN) and System Directors concurred with OIG's findings and recommendations and provided acceptable action plans. [Click here to access report.]

Clearer Risk Warnings Needed for Chronic Kidney Patients Undergoing Procedures with Contrast Media

The OIG assessed the extent to which informed consent was documented for Veterans with chronic kidney disease who underwent procedures that involved intravascular injection of contrast media, and described efforts to minimize kidney injury. OIG identified 107 patients with pre-existing kidney impairment who underwent cardiac catheterizations or peripheral vascular procedures during April 1–July 30, 2010. These patients needed to be aware of their higher risk of kidney injury in order to give informed consent. OIG found that, although 101 patients (94 percent) signed informed consent documents, only 24 of informed consent documents (22 percent) included any information about the risk of kidney injury. Explicit reference to the increased risk of kidney injury associated with contrast media for patients with pre-existing kidney disease was present in only two informed consent documents. However, practitioners evidently were aware of the increased risk of kidney injury because they ordered interventions to mitigate kidney injury in 93 percent of these high-risk patients. OIG recommended that the Under Secretary for Health implement a plan to ensure that patients with chronic kidney disease who are undergoing procedures requiring contrast media be provided sufficient information to give informed consent. [Click here to access report.]

OIG Finds Durham, North Carolina, VA Medical Center Failed To Take Promised Actions To Help Veterans With Home Improvement Grants

The OIG performed a follow-up review based on a complaint that recommendations from our previous report (Prosthetic and Sensory Aids Service Records Review, Report No. 11-01416-212, July 7, 2011) had not been fully implemented. The original report,

completed at the request of Senator Richard Burr, Ranking Member of the Senate Committee on Veterans' Affairs, made several recommendations to improve the management of the Prosthetics and Sensory Aids program. Due to additional allegations we conducted this second review. The facility response outlines significant steps to strengthen controls and oversight over the Prosthetic and Sensory Aids Service. [Click here to access report.]

Triage, Communication, and Referral Practices Between Emergency Department and Primary Care in Need of Improvement at Dallas VA Medical Center

OIG conducted an inspection to determine the validity of allegations concerning quality of care, safety, and management issues in the Emergency Department (ED) at the Dallas VA Medical Center (VAMC), Dallas, TX. OIG substantiated allegations of inadequate triage practices by registered nurses (RNs), poor communication, and inappropriate referrals of patients from the primary care clinics (PCCs) to the ED. OIG did not substantiate allegations of a delayed admission, poor surgery response to ED consultation requests, inadequate staffing, inappropriate scheduling of physicians, and excessive verbal and physical assaults on ED staff. Additionally, OIG identified improvement opportunities related to orthopedic consultations, the work environment, and the inter-facility transfer process. OIG recommended that the Facility Director ensure that (1) RN triage practices are consistently performed and that training is completed, (2) communication between the ED and PCCs is improved, (3) managers monitor orthopedic surgery response timeliness, (4) ED managers and staff undergo training to help promote a positive work environment, and (5) the current inter-facility process is assessed and that appropriate administrative support is provided for required paperwork. The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. [Click here to access report.]

OIG Substantiated Delay in Hyperthyroidism Diagnosis, But Patient Outcome Not Negatively Impacted at Tennessee Valley HCS

The OIG evaluated allegations of a delay in Graves' disease diagnosis and treatment at a community based outpatient clinic (CBOC) of the Tennessee Valley HCS (the System). OIG substantiated that there was about a 6-week delay in initiating the appropriate work-up of a patient's hyperthyroidism. However, this delay did not cause a delay in treatment that harmed the patient or negatively impacted his outcome. OIG also found that other System providers failed to notify the patient of both abnormal and normal test results in a timely manner. OIG recommended that the System Director require that providers ordering laboratory, radiographic, and other tests and studies inform patients of test results and arrange for appropriate follow-up according to policy. The VISN and System Directors agreed with our report. [Click here to access report.]

Pressure Ulcer and Privacy Incident Management Should Be Strengthened at Northport, New York VAMC

The OIG conducted a review to determine the validity of allegations that residents were malnourished and abused, staff supported residents' sexual activities in inappropriate ways, and that staff removed confidential employee information from the medical center. OIG did not substantiate the allegations of malnutrition, abuse, or that staff

supported resident's sexual activities in inappropriate ways. However, OIG did find the pressure ulcer rates at the facility were higher than benchmarks. OIG could not substantiate or refute the allegation that staff removed confidential employee information from the medical center, or the lack of Nurse Manager's action. However, OIG did find that medical center staff did not provide timely communication and follow-up for a breach of privacy related to resident identification bands. OIG recommended processes be strengthened to improve pressure ulcer management in the community living center units. OIG also recommended that privacy incidents be managed in accordance with VA policy related to timely follow-up and patient notification. The VISN 3 and Medical Center Directors agreed with our findings and recommendations. [Click here to access report.]

Delayed Lung Cancer Diagnosis Allegations Not Substantiated at Southern Arizona HCS Clinic

At the request of Senator Jon Kyl, the OIG conducted an inspection to determine the validity of allegations concerning delay in cancer diagnosis and treatment at a Southern Arizona VA HCS CBOC. OIG did not substantiate the allegation that a CBOC provider failed to address the patient's complaints of fatigue and shortness of breath. OIG substantiated the allegation that the patient did not receive a chest x-ray for a period between 2007 through his final CBOC visit in February 2011. OIG could not substantiate the allegation of delayed diagnosis of lung cancer. OIG determined that the provider did not fully evaluate the cause of the patient's shortness of breath once cardiac causes had been ruled out and did not directly address the patient's gradual weight loss. The Southern Arizona VA HCS had already implemented quality assurance measures to address the issues raised in our review. We made no recommendations. [Click here to access report.]

Poor Coordination of Care and Resource Allocation Not Substantiated for VISN 20 and Southern Oregon Rehabilitation Center and Clinics, White City, Oregon

OIG evaluated the validity of allegations regarding poor coordination and resource allocation within VISN 20 and at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. OIG did not substantiate allegations regarding poor coordination of care and resource allocation in regard to SORCC. While patients do encounter delays in gaining access to specialty services in non-emergent situations, we found that SORCC, in conjunction with VISN 20, is actively engaged in a process to improve timeliness of surgical and imaging services for its beneficiaries. OIG did not substantiate that care reviewed in orthopedic surgery, neurologic surgery, and imaging services was below VA standards. OIG found that the completion of consults and the delivery of recommended treatments at SORCC occurred in compliance with prioritization as outlined in VA's Federal Benefits for Veterans, Dependents, and Survivors. While timeliness of surgical specialty referral appointments and care is not always optimal, this does not equate to a breach in VA standards. OIG made no recommendations. [Click here to access report.]

Inspection Results for VA Clinics in Florida, West Virginia, Ohio, Guam, and Hawaii

OIG reviewed eight CBOCs during the week of September 26, 2011. CBOCs were reviewed in VISN 8 at Ft. Pierce and Okeechobee, FL; in VISN 9 at Charleston and Williamson, WV; in VISN 10 at Mansfield and New Philadelphia, OH; and in VISN 21 at Agana Heights, GU, and Hilo, HI. The parent facilities of these CBOCs are West Palm Beach VAMC, Huntington VAMC, Louis Stokes VAMC, and VA Pacific Islands 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: mental health 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 41 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Former New York, New York, VAMC Union President Arrested for Theft of $112,500 in Union Funds

A former New York, NY, VAMC employee and union president of an American Federation of Government Employee's local was arrested for theft of union funds while on U.S. Government property. An OIG and Department of Labor, Office of Labor Management Standards, investigation revealed that the defendant embezzled approximately $112,500 by writing 187 checks to himself from the union's checking account.

Synthes Executive Sentenced for Medical Device Fraud

A fourth former Synthes Inc. executive was sentenced to 8 months' incarceration, 4 months' supervised release, and ordered to pay a $100,000 fine pursuant to a plea agreement charging him with violation of the "responsible corporate officer" doctrine with the strict liability offense of introducing into interstate commerce medical devices that were adulterated. A multi-agency investigation determined that this defendant and three others were involved in the unapproved trial of a bone-cement drug in which three patients died.

Company Owner Sentenced for Racketeering, Antitrust, and Weapons Violations

The owner of a drywall installation company was sentenced to 5 years' probation and the company was permanently dissolved by order of the court after the defendant pled guilty to racketeering, antitrust, and weapons violations. An OIG, Oregon Department of Justice, and Immigration and Customs Enforcement investigation revealed that the defendant, a subcontractor to a Service-Disabled Veteran-Owned Small Business contractor, falsely certified payroll records for employees working on non-Governmental and Government contracts, to include VA *American Recovery and Reinvestment Act of 2009* contracts at the Portland, OR, VAMC. The defendant falsely reported that he was paying the prevailing wage to employees working on these contracts.

Sister-in-Law Indicted for Misappropriating $190,000 from Incompetent Veteran
A VA fiduciary was indicted for misappropriation by a fiduciary after an OIG investigation determined that she diverted approximately $190,000 of her incompetent brother-in-law's VA funds for her personal use. The investigation determined that the defendant used the misappropriated funds to purchase a BMW and to make unauthorized investments. Although the VA field examiner reported that the Veteran was well cared for and living in excellent conditions, the investigation determined that the Veteran was being housed in a shed on the fiduciary's property. The investigation continues into the submission of the inaccurate field examiner reports.

Veteran's Daughter Pleads Guilty to Misappropriating Over $200,000
The daughter of a Veteran, who was also his fiduciary, pled guilty to misappropriation by a fiduciary and conversion of Social Security benefits. An OIG investigation disclosed that the defendant became the Veteran's fiduciary in 2005 and subsequently embezzled over $200,000 in VA compensation benefits and over $20,000 in Social Security benefits. After initially claiming that a VA field examiner told her that she could spend the funds, the defendant admitted to OIG agents that she fraudulently spent the money intended for her father.

Veteran Sentenced for Making Threats to VA Fiduciary and Regional Office
A Veteran was sentenced to 10 days' incarceration and 1 year of probation after pleading guilty to threatening and intimidation. An OIG and local law enforcement investigation revealed that the defendant threatened his VA fiduciary and also threatened to go to the Phoenix, AZ, VA Regional Office and "Shoot everyone if the VA doesn't give me my money."

Veteran Arrested for Making Threats to the Asheville, North Carolina, VAMC
A Veteran was arrested after threatening to come back "shooting" at the Asheville, NC, VAMC after being denied beneficiary travel pay. An OIG investigation determined that approximately 2 hours after making his threat the defendant purchased an M-4 assault rifle and had the rifle in his home, along with several other firearms, when interviewed by OIG agents and local police. The defendant was released pending further judicial action and is under the supervision of the probation department.

Veteran Indicted for VA Home Loan Guaranty Program Fraud
A Veteran was indicted for a felony charge of securing the execution of a document by deception. An OIG investigation revealed that the Veteran fraudulently obtained a $232,000 residential loan through the VA Home Loan Guaranty Program by presenting falsified tax documents that misrepresented his annual income. The defendant subsequently defaulted on the loan, resulting in a loss to the Government of $58,147.

Miami, Florida, VAMC Employee Indicted for Identity Fraud
A Miami, FL, VAMC employee was indicted for aggravated identity fraud and access device fraud. An OIG, U.S. Secret Service, and U.S. Postal Inspection Service investigation revealed that the defendant sold personally identifiable

information of 22 Veterans to an undercover law enforcement agent on two separate occasions.

Veteran Sentenced for Theft of Government Funds
A Veteran was sentenced to 366 days' incarceration and ordered to pay $101,686 in restitution after pleading guilty to theft of Government funds and concealment of a material fact affecting Social Security disability payments. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant fraudulently received VA individual unemployability and SSA benefits by failing to report employment income. The loss to VA is $72,921.

Fayetteville, North Carolina, VAMC Compensated Work Therapy Employee Arrested for Theft
A compensated work therapy employee, with an extensive criminal history, was arrested for theft after an OIG, VA Police, and local police investigation revealed that he stole new, unused laptop computers from the Fayetteville, NC, VAMC. At least six computers were pawned in the local area, and three of those have been recovered. Nine stolen computers remain missing.

Veteran Pleads Guilty to Theft of VA Travel Benefits
A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that he used an address where he was not residing in order to inflate the mileage reimbursement paid by VA for his travel to and from medical appointments at the Montrose, NY, VAMC. The loss to VA is $65,343.

Former Reno, Nevada Canteen Manager Indicted for Theft of Government Property
A former Reno, NV, VAMC canteen manager was indicted for theft of Government property. An OIG investigation revealed that during an 18-month period the defendant stole $42,111 from 13 medical center vending machines by under-reporting the vending machine sales in order to conceal the thefts. The defendant admitted to using the stolen money to fund his gambling addiction.

Former Postal Employee Sentenced for Drug Theft
A former Postal employee was sentenced to 3 months' home confinement, 2 years' probation, and 150 hours' community service. A VA OIG and U.S. Postal Service OIG investigation determined that, between July 2009 and April 2011, the defendant diverted approximately 17 shipments of VA prescribed narcotics that were mailed to Veterans residing in the eastern Washington State area.

Daughter of Deceased Veteran Sentenced for Theft of VA Funds
The daughter of a deceased Veteran was sentenced to 2 years' probation and ordered to pay $69,368 in restitution after being found guilty at trial of larceny for stealing VA

compensation benefits. An OIG investigation revealed that the defendant stole VA benefit payments that were direct-deposited into a joint account after her father's death in November 2002.

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

GEORGE J. OPFER
Inspector General