Department of Veterans Affairs
Office of Inspector General
March 2012 Highlights

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General Tells Senate Panel Homeless Veteran Program Lacks Safety, Security, and Health Standards

Linda A. Halliday, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Committee on Veterans' Affairs, United States Senate, on the results of a recent Office of Inspector General (OIG) report, *Audit of the Veterans Health Administration's Homeless Providers Grant and Per Diem Program*. The report found a lack of program safety, security, privacy, and health and welfare standards; an incomplete grant application evaluation process; and an inconsistent monitoring program that impacted the program's effectiveness. Ms. Halliday was accompanied by Mr. Gary Abe, Director of OIG's Seattle, WA, Office of Audits and Evaluations. [Click here to access testimony.]

OIG REPORTS

VA Can Save Almost $11M with Better Controls Over Payments for Prosthetic Limbs

At the request of the House Veterans' Affairs Committee Chairman, OIG evaluated the management and acquisition practices the Veterans Health Administration (VHA) used to procure prosthetic limbs. In each of the last 5 years, VHA has served nearly 12,000 amputees. VA procures prosthetic limbs or fabricates them in prosthetic labs. OIG found overpayments for prosthetic limbs were a systemic issue in VA. Of the 3,900 payments examined by OIG, 915 (23 percent) included overpayments. These overpayments were valued at about $2.2 million for fiscal year 2010. VHA could continue to process improper payments over the next 4 years if it does not strengthen controls over payments. OIG estimated the value of these potential overpayments at $8.6 million. Finally, VHA management did not know the current capabilities of their labs. Overall, VHA needs to strengthen management and acquisition practices to procure and fabricate prosthetic limbs. The Under Secretary for Health concurred with our findings and recommendations. [Click here to access report.]

OIG Publishes First Ever Study of VA's Capacity to Care for Veterans with Traumatic Amputations

Also at the request of the Chairman of the House Committee on Veterans' Affairs, OIG conducted a review to evaluate VA's capacity to deliver prosthetic care. By analysis of integrated data from VA and the Department of Defense (DoD) for nearly 500,000 Veterans, OIG found Veterans with traumatic amputations are a complex population with a variety of medical conditions and are significant users of all VA health care services, not just prosthetic services. Furthermore, this is the first ever study to characterize the population of 1,288 Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) service members with major traumatic amputations. OIG found that OEF/OIF/OND Veterans generally were adapting to living with their amputations. However, Veterans with upper extremity amputations

consistently did not fare as well as those Veterans with lower extremity amputations in their psychosocial adaptation, activity limitation, and prosthetic satisfaction. OIG recommended that VHA consider: (1) the wide-ranging medical needs of traumatic amputees beyond the prosthetic and mental health (MH) concerns identified in this report; then adjust, if necessary, the provision and management of health care services accordingly; (2) evaluating the needs of Veterans with traumatic upper limb amputations to improve their satisfaction; and (3) Veterans' concerns with VA approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of Veterans with amputations. VHA concurred with our recommendations and provided acceptable action plans. [Click here to access report.]

Better Management of Prosthetics Inventories Could Save VA $35 Million and Avoid Disruptions to Patients

OIG conducted this audit to evaluate VA medical centers' (VAMC) prosthetic inventory management. OIG found VHA cannot accurately account for prosthetic inventories. VAMC inventories exceeded current needs for almost 47 percent of approximately 93,000 specific prosthetic items and inventories were too low for nearly 11 percent of the items. As a result, VAMCs spent about $35.5 million buying prosthetics in excess of current needs—increasing the risks of supply expiration. Inaccurate inventories disrupt patient care due to shortages and lead to losses associated with diversion. OIG recommended the Under Secretary for Health develop plans to implement an improved inventory system and develop a training-to-certification program for prosthetic inventory managers. The Under Secretary for Health concurred with our findings.
[Click here to access report.]

VA's Reporting on Improper Payments Not in Full Compliance with Improper Payments Elimination and Recovery Act

OIG conducted this review as required by the *Improper Payments Elimination and Recovery Act (IPERA).* OIG evaluated VA's accuracy, completeness of reporting, and performance in reducing and recapturing improper payments. OIG found VA did not fully comply with the IPERA requirements. VA reported improper payment rates greater than 10 percent for 3 VHA programs. OIG identified an additional fourth program also exceeded 10 percent. VHA's statistical sampling methodology did not achieve the required margin of error and the Veterans Benefits Administration (VBA) did not consult with a statistician, nor calculate margins of error. Further, OIG's calculated improper payment estimates did not match that reported in VA's Performance and Accountability Report for VBA's Compensation and Pension programs, likely due to the Pension program's significantly understated rate. In addition, VA's reduction targets for two programs were not met. OIG recommended VA take steps to ensure compliance with IPERA. OIG requested VA provide acceptable implementation plans within 30 days of this report to address the recommendations.
[Click here to access report.]

Homeless Veteran Program Lacks Safety, Security & Health Standards, Better Grant Evaluation Process & Oversight Needed
OIG conducted this audit to determine whether community agencies receiving funds from the Grant and Per Diem Program (GPDP) are providing services to homeless Veterans as agreed upon in their grant agreements or authorized changes of scope. OIG also examined whether program funding is effectively aligned with program priorities. OIG found the VHA GPDP provided services to homeless Veterans and had successfully assisted Veterans to live independently in safe and affordable permanent housing. However, an incomplete grant application evaluation process; a lack of program safety, security, privacy, and health and welfare standards; and an inconsistent monitoring program impacted the program's effectiveness. As a result, VHA did not ensure homeless Veterans consistently received the supportive services agreed to in approved grants. In addition, funding was not aligned effectively with program goals. OIG recommended strengthening the grant application and evaluation process by publishing policies and standards, updating the inspection checklists, and implementing procedures to ensure grant providers have the capability to deliver services. The Under Secretary for Health concurred with OIG's findings and recommendations and provided appropriate action plans. [Click here to access report.]

Network Offices Overseeing VA Medical Facilities Lack Adequate Financial Management, Fiscal Controls
OIG conducted this audit to determine if VHA's Veterans Integrated Service Network (VISN) office management controls and fiscal operations promoted the proper stewardship of VA funds. OIG found VHA lacked budgetary controls and reliable data to monitor VISN offices, evaluate performance relative to operational costs, and ensure the effective and efficient use of funds, leading to a 500 percent increase above the estimated $26.7 million at inception. VHA allowed VISN offices to operate independently, believing required fiscal controls were in place. However, growth in the offices' costs and increases in operational costs show VHA needs stronger VISN office fiscal controls. OIG recommended VHA implement a financial management system and fiscal controls. The Under Secretary for Health agreed with OIG's findings and recommendations and provided appropriate action plans. [Click here to access report.]

Unmonitored Staff Growth, Inadequate Performance Management Noted at Network Offices Overseeing VA Medical Facilities
OIG conducted this audit to determine if VHA's VISN office management controls and fiscal operations promoted the proper stewardship of VA funds and compliance with VA policies. OIG found VHA lacked the management controls needed to oversee and evaluate the effectiveness of VISN staff and organizational structures. The VISN offices' autonomy allowed for unchecked lapses in office growth, a weak performance management system, and a lack of complete fundamental staffing data used in decision-making. This resulted in unjustified organizational structures and staffing levels, ineffective oversight and stewardship of VA funds, and significant differences in management and operations between each of the VISN offices. OIG recommended VHA strengthen the VISN offices' system for performance management and implement controls over organizational structures and staffing. The Under Secretary for Health

agreed with the findings and recommendations and provided appropriate action plans. [Click here to access report.]

OIG Reviews Circumstances Surrounding Veteran's Self-Extubation and Subsequent Death at Edward Hines Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection at the Edward Hines Jr. VA Hospital, Hines, IL, at the request of the Chicago, IL, OIG Office of Criminal Investigations Division. The inspection did not substantiate that substandard quality of care contributed to the self-extubation and subsequent death of a Veteran, and found that facility staff (the intensive care managers, respiratory care services manager, risk managers, and performance improvement managers) had reviewed the incident and developed performance improvement procedures. The inspection also revealed that the Biomedical Engineering Department installed metal cages to prevent tampering, silencing, and disabling the telemetry alarms at the central nurses' station in the medical and surgical intensive care units. However, the design of the cages does not prevent disabling of the alarms. OIG recommended reporting the incident to the VA National Center for Patient Safety to decrease the potential for poor patient outcomes. The VISN and Facility Directors agreed with the findings and recommendations. [Click here to access report.]

OIG Reviews Allegations Regarding Minneapolis, Minnesota, Outpatient Dental Clinic

OIG conducted an inspection to determine the validity of allegations regarding a failure to obtain informed consent, communicate the plan of care to family and non-VA nursing home (NH) staff, and provide appropriate care after a dental procedure at the Minneapolis, MN, VA Health Care System outpatient dental clinic. OIG did not substantiate that the provider failed to obtain informed consent prior to extracting multiple teeth. The provider determined that the patient had decision-making capacity and was able to participate in the informed consent process on the day of the oral surgery procedure. OIG substantiated that family and NH staff were not aware of the planned extractions. Prior to OIG's arrival, the facility had taken steps to improve the content and flow of information between NHs and facility clinics. The facility subsequently established plans for additional improvement. OIG did not substantiate that VA failed to provide appropriate post-extraction care. OIG made no recommendations. [Click here to access report.]

Quality of Care Allegations Against Northport, New York, VAMC ED Not Substantiated

OIG performed an inspection to determine the validity of allegations regarding quality of care in the ED at the Northport, NY, VAMC. Specifically, a complainant alleged that: (1) a Northport VAMC ED physician failed to diagnose an acute myocardial infarction; and (2) a Northport VAMC ED physician behaved unprofessionally. OIG did not substantiate the allegation that a VAMC ED physician failed to diagnose an acute myocardial infarction. While the patient in question was ultimately shown to have had an acute myocardial infarction, OIG found that the physician in question initiated an appropriate evaluation for a patient presenting to an ED with atypical chest pain. The physician obtained a targeted history and physical examination, an electrocardiogram,

and appropriate blood tests. However, the patient refused to remain in observation and left against medical advice, cutting short his evaluation. OIG did not substantiate the allegation that the ED physician behaved unprofessionally. OIG did not find evidence that the physician yelled at another patient as alleged, nor did we find evidence of any other unprofessional behavior by the physician. OIG made no recommendations. [Click here to access report.]

Use of Restraints at Salem, Virginia, VAMC, Found To Be Appropriate
OIG's Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the use of restraints at the Salem, VA, VAMC. A complainant alleged that a nurse made comments that provoked a patient into striking two staff members, which resulted in the patient being kept in restraints as punishment for more than 24 hours. The complainant also alleged that facility leadership did not respond to past reported allegations of other patient mistreatment. OIG did not substantiate the allegations. OIG found no evidence that a nurse provoked the patient to act out, or that the patient was kept in restraints as a form of punishment. The initiation and continued use of restraints was appropriate and adequately documented to ensure the patient and staff members' safety. We found that facility leaders investigated the patient's mistreatment allegations and determined that no further action was required. OIG identified an opportunity to improve the observation and 15-minute check sheets used for patients in restraints. OIG discussed this with facility leaders while onsite. Therefore, we made no recommendations. [Click here to access report.]

Benefits Inspection Division Visits Honolulu, Hawaii, and Manila, Philippines
OIG's Benefits Inspection Division conducted a review to determine how well the Honolulu, HI, VA Regional Office (VARO) accomplishes its mission. OIG found the Honolulu VARO faced a number of management challenges contributing to a range of issues in Veteran Service Center operations. Challenges included training for inexperienced supervisors, incorporating oversight in the Workload Management Plan, and improving communication with staff. The VARO staff accurately processed traumatic brain injury (TBI) claims and, in general, accurately processed herbicide exposure-related claims and corrected errors identified by VBA's Systematic Technical Accuracy Review (STAR) program. However, they lacked accuracy in processing temporary 100 percent disability evaluations, mostly when staff did not schedule required medical reexaminations. VARO staff did not accurately process 29 (47 percent) of 62 disability claims we sampled as part of our inspection. These results do not represent the accuracy of overall disability claims processing at this VARO. VARO management needed to provide more oversight to ensure completion of Systematic Analyses of Operations (SAOs) and that staff properly processed mail. Oversight of homeless Veterans' claims processing and homeless shelters outreach programs were also ineffective. The VARO Director concurred with our findings and the planned actions are responsive.
[Click here to access report.]

OIG conducted a similar review of the Manila, PI, VARO. The Manila VARO administers benefits to Veterans and their survivors residing in the Philippines and is the

only office located in a foreign country. OIG found the Manila VARO staff accurately processed TBI and Filipino Veterans Equity Compensation claims and provided adequate homeless outreach. VARO performance was generally effective in processing herbicide exposure-related claims and in following VBA policy for correcting errors identified by STAR program staff. However, the VARO lacked effective controls and accuracy in processing some disability claims. Overall, VARO staff did not correctly process 10 (38 percent) of the 26 disability claims we sampled during our inspection. These results do not represent the accuracy of overall disability claims processing at this VARO. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule or establish controls for medical reexaminations. Finally, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions and improper benefits payments. OIG recommended the VARO Director develop and implement a plan to ensure oversight and control of search mail, as well as completion of SAOs. Further, VARO management needs to implement controls to ensure staff properly process competency determinations. The VARO Director concurred with OIG's recommendations. [Click here to access report.]

Inspection Results for VA Clinics in Multiple VISNs

OIG reviewed four CBOCs during the week of October 17, 2011. CBOCs were reviewed in VISN 1 at Framingham, New Bedford, and Springfield, MA, and in VISN 2 at Elmira 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 16 recommendations to the VISN and facility managers. [Click here to access report.]

OIG reviewed four CBOCs during the week of October 31, 2011, in VISN 18 at Durango, CO; Raton and Silver City, NM; and Odessa, TX. OIG noted opportunities for improvement and made 24 recommendations to VISN and facility managers. [Click here to access report.]

OIG reviewed four CBOCs during the week of November 14, 2011, in VISN 16 at Pensacola (Joint Ambulatory Care Center), FL, and in VISN 17 at New Braunfels, San Antonio (North Central Federal Clinic), and Victoria, TX. OIG noted opportunities for improvement and made 14 recommendations to the VISN and facility managers. [Click here to access report.]

During the same week, OIG conducted a similar review at three CBOCs in VISN 7 at Florence, Rock Hill, and Sumter (Sumter County), SC. OIG noted opportunities for improvement and made six recommendations to the VISN and facility managers. [Click here to access report.]

OIG reviewed three VISN 21 CBOCs during the week of December 5, 2011, including those located in Chico, McClellan, and Oakland, CA. OIG noted opportunities for improvement and made 11 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Former St. Louis, Missouri, VAMC Employee Pleads Guilty to Bribery and Service-Disabled Veteran-Owned Small Business Fraud

A former VA employee pled guilty to a criminal information charging him with accepting illegal gratuities from Government contractors while he was employed at the St. Louis, MO, VAMC. The defendant admitted to accepting approximately $20,000 in cash, luxury baseball tickets, meals, and entertainment at a local club from two Government contractors while he was steering $3.4 million in Service-Disabled Veteran-Owned Small Business set-aside contracts to their companies. Both contractors previously pled guilty to a criminal information charging them with conspiracy related to paying improper bribes and gratuities to a Federal official, mail fraud, wire fraud, and making false statements. The contractors established a front company, purportedly owned and operated by a service-disabled Veteran, when in actuality, it was controlled and managed by the contractors.

Veteran Sentenced for Fraudulently Selling Certificates Bearing Forged U.S. Department or Agency Seals

A Veteran pled guilty to fraudulently selling certificates bearing forged U.S. department or agency seals and impersonating an officer or employee. Pursuant to the plea agreement, the defendant agreed to serve 36 months' incarceration, pay court ordered restitution to the victims, and abandon the property seized by OIG during the execution of a search warrant at his business. A multi-agency investigation, led by OIG, revealed that the defendant was operating an Internet printing business that sold counterfeit military awards and training certificates from all branches of the military, as well as law enforcement awards and training certificates. The fraud associated with this investigation is over $260,000.

Veteran Pleads Guilty to Assaulting VA Police Officer at Seattle, Washington, VAMC

A Veteran pled guilty to assaulting a VA police officer at the Seattle, WA, VAMC. An OIG and VA Police Service investigation revealed that the Veteran checked into the emergency room (ER) and informed an ER nurse that he was having suicidal thoughts to include "suicide by cop." When a VA police officer attempted to conduct a security screening, the defendant failed to comply with the officer's instructions and assaulted the officer. During the struggle, the defendant was able to obtain the officer's baton and attempted to take the officer's weapon until subdued by the officer and other responders. The assault resulted in injuries to the officer.

Veteran Pleads Guilty in Attempt to Intimidate Nashville, Tennessee, VARO Employees
A Veteran initially charged with extortion pled guilty to an amended charge of disorderly conduct and was sentenced to 30 days' incarceration (suspended), 30 days' probation, and ordered to stay away from VA facilities unless on official business. An OIG investigation revealed that the defendant sent a series of threatening correspondence to the Nashville, TN, VARO in an attempt to intimidate and coerce VA employees into processing his claim. The defendant's criminal history included numerous weapon violations.

Veteran Sentenced for Drug Distribution
A Veteran was sentenced to 4 months' incarceration and 56 months' probation following a change of plea from not guilty to no contest. During a VA OIG, FBI, and local police investigation, the defendant sold controlled pharmaceuticals to an undercover OIG agent on three separate occasions.

Former Erie, Pennsylvania, VAMC Nurse Placed in Pretrial Diversion Program Following Indictment for Drug Possession
A former Erie, PA, VAMC registered nurse was placed into the pretrial diversion program for 12 months after being indicted for possession of a controlled substance by misrepresentation or deception. Prior to the indictment, the employee was terminated from employment at the VAMC. An OIG and VA Police Service investigation revealed that the defendant obtained controlled narcotics from a Pyxis narcotics dispensing unit for personal use. The defendant subsequently made entries in the Bar Code Medication Administration program indicating that she gave the medication to patients.

Veteran Indicted for "Stolen Valor" Fraud
A Veteran was indicted for falsely claiming to have been awarded military medals and then using those medals to support his VA claim for compensation. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant submitted a fraudulent DD-214 that reflected the defendant was a Navy SEAL and had been awarded a Purple Heart, Combat Action Ribbon, Joint Service Achievement Medal, and the Navy and Marine Corps Achievement Medal. As a result of this investigation, VA re-evaluated the Veteran's PTSD claim and his service-connection compensation was reduced from $1,478 to $580 per month. The loss to VA is $24,804.

Veteran Sentenced for Credit Card Fraud
A Veteran, who was the leader of a conspiracy to commit access device fraud and aggravated identity theft, was sentenced to 48 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $7,210. An OIG and VA Police Service investigation revealed that the defendant and two accomplices were responsible for the thefts of numerous Palo Alto, CA, VAMC employees' wallets. The investigation also revealed that the Veteran and his accomplices used credit cards from those stolen wallets to purchase thousands of dollars in gift cards, merchandise, and gas at local retail stores, with the gift cards being re-sold in an illegal gift card scheme. The two accomplices previously pled guilty to similar charges.

Veteran Sentenced for VA Compensation Fraud
A Veteran was sentenced to 5 months' incarceration, 5 months' home confinement, 3 years' supervised probation, and ordered to pay restitution of $92,399 to VA. An OIG investigation revealed that the defendant submitted several false statements to VA claiming that he was unable to work, resulting in the receipt of VA individual unemployability benefits. The investigation further determined that the Veteran was gainfully employed since 2003.

Veteran Sentenced for VA Pension Fraud
A Veteran was sentenced to 2 years' probation, fined $500, and ordered to pay $6,969 in restitution after pleading guilty to a criminal information that charged him with theft of Government property. An OIG investigation revealed that the Veteran made a material false statement when he informed VA that he had no income, despite earning significant income in the scrap metal business. The Veteran admitted to OIG agents that he was not entitled to the pension benefits and that he knowingly submitted the false statement about his income to avoid detection by VA. The loss to VA is over $100,000.

Eleven Veterans Indicted for Travel Benefit Fraud Against Columbia, South Carolina, VAMC
Eleven Veterans were indicted for false, fictitious, or fraudulent claims and fraudulent acceptance of payment after submitting numerous fraudulent travel vouchers for reimbursement. An OIG investigation determined that all of the defendants claimed to reside in areas that were a greater distance from the Columbia, SC, VAMC than they actually resided. The aggregate loss to VA is approximately $80,000.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to a joint account subsequent to the beneficiary's death in August 2005. The loss to VA is $79,192.

(for:)
GEORGE J. OPFER
Inspector General