Department of Veterans Affairs
Office of Inspector General
January 2012 Highlights

OIG REPORTS

Veterans at Temple, TX, Not Receiving Timely Specialty Medical Care, Accuracy of VA Wait Times Data Questioned

The Office of Inspector General (OIG) conducted an inspection to determine the validity of allegations regarding patient care delays and reusable medical equipment (RME) concerns at the Olin E. Teague Veterans' Medical Center (VAMC) in Temple, TX. A complainant alleged that: (1) hundreds of scheduled gastroenterology (GI), mammogram, radiation oncology, and breast biopsy fee-basis consults dating back to 2009 place the health of patients at risk; (2) prolonged wait times for GI care lead to delays in diagnosis of colorectal and other cancers, and (3) RME issues have not been properly addressed, including unclean scopes that were almost used on patients, equipment failures, and use of new equipment without an approved standard operating procedure. OIG substantiated hundreds of fee-basis GI, mammogram, radiation oncology, and breast biopsy consults requiring action; however, OIG did not find evidence of patient harm due to delays in follow-up. OIG substantiated GI wait times in excess of Veterans Health Administration requirements following initial positive screenings. In addition, staff indicated that appointments were routinely made incorrectly by using the next available appointment date instead of the patient's desired date. OIG did not substantiate that RME issues have not been properly addressed. OIG made three recommendations. [Click here to access report.]

OIG Did Not Substantiate Quality of Care Issues at Edward Hines, Jr. , VA Hospital, Hines, Illinois

At the request of Congressman Peter Roskam's office, the OIG conducted an inspection and oversight review to determine the validity of allegations regarding the quality of care received by a patient at the Edward Hines, Jr., VA Hospital, Hines, IL. OIG did not substantiate the allegations that the patient did not receive help with his activities of daily living, or receive ordered rehabilitative treatments during his respite care admission. OIG substantiated that the patient was seen by two staff physicians and a resident physician during his 5-hour stay in the emergency department (ED), but did not substantiate that the physicians did not communicate or coordinate care for the patient. OIG substantiated the allegation that the patient did not receive rehabilitative treatments during his inpatient stay and while acutely ill; however, he did not meet the criteria for an intervention. OIG did not substantiate the allegations that he had a Foley catheter inserted, or that discharge instructions and medication reconciliation were not provided. OIG made no recommendations. [Click here to access report.]

Sacramento VA's Anesthesia Service Leadership, Staffing Found Lacking; Patient Privacy Breach Also Noted

OIG conducted an oversight inspection to review actions taken to address a complainant's allegations that an anesthesiologist provided inadequate care to two patients, leadership did not take effective actions to address Anesthesia Service

operational issues, and providers breached patient privacy policy at the Sacramento VAMC, Mather, CA. OIG did not substantiate the allegation that the subject anesthesiologist provided inadequate anesthesia care. OIG substantiated the allegations that VAMC leaders had not taken effective actions to resolve Anesthesia Service's operational issues and that VAMC providers' breached patient privacy and VA information security policies. OIG recommended that the VAMC Director (1) comply with the Anesthesia Service's leadership and staffing requirements as detailed in the Veterans Integrated Service Network (VISN) Team report; (2) implement processes to formally monitor patient outcomes in the operating room (OR) and promote a culture of patient safety in the OR, and address the concerns raised by the VISN team in its review of the Surgery and Anesthesia Services; and (3) consult with Regional Counsel to determine whether patient notification of a breach in privacy is required. Management agreed with the recommendations and provided acceptable action plans. [Click here to access report.]

OIG Did Not Substantiate Discharge, Travel, and Treatment Issues at Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri

OIG evaluated allegations of premature discharge, excessively long travel distance, and unsuccessful treatment in a patient with end-stage liver disease. These complaints related to two episodes of VA fee-based care at a St. Louis area private-sector hospital. OIG did not substantiate the complainant's allegation that "someone dropped the ball" in the care of this patient. The patient was referred by providers at the Harry S. Truman Memorial Veterans' Hospital to a qualified private-sector specialist for a transjugular intrahepatic portosystemic shunt procedure. The patient and his wife were aware of the rationale for the procedure, location of the private sector hospital, and the potential complications. The patient was discharged in stable condition, and the medical record reflects adequate communication between the various medical providers to ensure continuity of care. OIG made no recommendations. [Click here to access report.]

Benefits Inspection Division Visits Regional Offices in Fargo, North Dakota; White River Junction, Vermont; and Providence, Rhode Island

OIG evaluated how well the Fargo, ND, VA Regional Office (VARO) accomplishes its mission. OIG found the Fargo VARO staff followed the Veterans Benefits Administration's (VBA) policy for completing Systematic Analyses of Operations (SAOs) and correcting errors identified through the Systematic Technical Accuracy Review program. VARO performance was generally effective in processing traumatic brain injury (TBI) and herbicide exposure-related disability claims and handling mail. 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 or establish controls for future medical reexaminations. VARO staff did not correctly process 26 (39 percent) of the 67 disability claims sampled as part of the inspection. These results do not represent the overall accuracy of disability claims processing at this VARO. VARO management did not ensure staff accurately addressed Gulf War Veterans' entitlement to mental health (MH) treatment. Processing of competency determinations was not fully effective, resulting in unnecessary delays in final decisions and improper benefits payments. A lack of management controls over

receipt, development, and completion of homeless Veterans' claims resulted in processing delays. Finally, the VARO did not require the Homeless Veterans Outreach Coordinator to perform duties related to homeless Veterans outreach. [Click here to access report.]

In another review, OIG evaluated how well the White River Junction, VT, VARO accomplishes its mission. The staff accurately processed TBI claims. They timely processed homeless Veterans' claims and effectively provided outreach efforts to homeless shelters and service providers. Inaccuracies in temporary 100 percent disability evaluations resulted from not scheduling medical reexaminations. Inaccuracies in processing herbicide exposure claims occurred when staff did not obtain medical examination reports sufficient for evaluating related disabilities. Overall, the VARO did not correctly process 37 percent of disability claims reviewed. [Click here to access report.]

Lastly, OIG evaluated how well the Providence, RI, VARO accomplishes its mission. OIG found the Providence, RI, VARO staff provided adequate outreach to homeless shelters and service providers. VARO performance was generally effective in processing herbicide exposure-related and homeless Veterans' claims and in correcting errors identified by VBA's internal review program. 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. Also, VARO staff used inadequate exam reports to process TBI claims. They also did not correctly process 25 (37 percent) of the 68 disability claims sampled during the inspection. VARO management did not ensure staff timely completed SAOs, properly processed mail, or accurately addressed Gulf War Veterans' entitlement to MH treatment. Further, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions. [Click here to access report.]

Inspection Results for VA Clinics in Colorado and Nebraska

The OIG reviewed four Community Based Outpatient Clinics (CBOCs) during the weeks of October 17 and October 31, 2011. CBOCs were reviewed in VISN 19 at Montrose, CO, and in VISN 23 at Bellevue, Lincoln, and Norfolk, NE. 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: short-term fee basis care, women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, and environment and emergency management. OIG noted opportunities for improvement and made a total of 11 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS

Veteran Sentenced for Assault of Spokane, Washington, VAMC Nurses

A Veteran was sentenced to 40 months' incarceration, 36 months' supervised release, and ordered to pay restitution of $300,411 to VA for reimbursement of Office of

Workers' Compensation Program and other related costs. An OIG investigation revealed that the defendant physically assaulted two Spokane, WA, VAMC nurses during a visit to the ED. The assault resulted in serious bodily injury to both nurses.

Veteran Pleads Guilty to Assault of White River Junction, Vermont, VAMC Employee

A Veteran pled guilty to assault of a Federal employee with a dangerous weapon. An OIG and VA Police Service investigation revealed that while in the emergency room of the White River Junction, VT, VAMC, the defendant locked the door, then took a scalpel from a hospital cart and gained control of a nurse by holding the scalpel to her throat. VA Police officers were able to subdue the defendant and the nurse sustained no injuries.

Veteran Arrested for Making Threats to Phoenix, Arizona, VA Call Center

A Veteran was arrested for making terroristic threats to a call agent at the VA National Call Center, Phoenix, AZ. An OIG and local police investigation revealed that the defendant informed the call agent that he was going to go to the Atlanta, GA, VARO and shoot the first 3,000 people he saw if he did not receive a permanent rating decision within 5 business days. A search of the defendant revealed a fully loaded 10mm handgun concealed in a shoulder holster with an additional magazine of bullets in his front pocket.

Columbia, SC, VAMC Nurse's Aide Pleads Guilty to Simple Assault

A Columbia, SC, VAMC nurse's aide pled guilty to simple assault following his indictment and arrest for fondling the genitals of an amputee patient. The victim was a resident in the VAMC's nursing home. As a condition of his plea, the defendant was barred from seeking future VA employment. The defendant initially gave a sworn statement denying the charges. Following an OIG polygraph exam, the defendant confessed to assaulting the patient.

Former VA Employee Arrested for Stalking Ex-Coworker

A former VA employee was arrested for violating a protective order and stalking. The defendant was charged in Federal court with sending communications to a current VA employee at work and was charged in State court with stalking the male employee outside of VA facilities. An OIG, VA Police Service, and local sheriff's investigation revealed that the defendant, who worked for VA in 2006, had never met the VA employee and stated, that God had told her that the VA employee had to be with her.

Veteran Indicted for "Stolen Valor" Fraud

A Veteran was indicted for fraudulent use of a military discharge certificate, false writing, false claims about receipt of military medals, mail fraud, and theft of Government funds. An OIG and Defense Criminal Investigative Service investigation revealed that the defendant submitted an additional DD-214 to VA and the Department of Defense (DoD) that was fraudulently produced. The document falsely reflected that the defendant had been awarded a Purple Heart and a Combat Infantry Badge and that he had served

6 years in the U.S. Army. This additional DD-214 allowed the defendant to qualify for VA compensation benefits for post-traumatic stress disorder and military retirement. The loss to VA is approximately $38,000, and the DOD retirement overpayment is approximately $90,000.

Three Jackson, Mississippi, VAMC Employees Sentenced for Theft of VA Property
Three Jackson, MS, VAMC facility maintenance workers were sentenced after pleading guilty to embezzlement. The first defendant was sentenced to 5 years' probation and ordered to pay $608 in restitution; the second defendant was sentenced to 5 years' probation and ordered to pay $2,294 in restitution; and the third defendant was sentenced to 6 months' incarceration, 6 months' probation, and ordered to pay a $500 fine. An OIG and local police investigation determined that for over 18 months the defendants stole VA property, including flat panel televisions, commercial cleaning supplies, commercial cleaning equipment, computer equipment, and other miscellaneous property from the VAMC. Judicial action against a fourth employee is pending.

Veteran Sentenced for VA Pension Fraud
A Veteran, who is also a leader in a white supremacist organization, was sentenced to 6 months' home confinement, 2 years' supervised probation, and ordered to pay restitution of $192,837 after pleading guilty to false statements. The defendant was also given credit for time served towards 6 months' incarceration. A joint investigation between the OIG and the Federal Bureau of Investigation revealed that the defendant fraudulently received VA pension benefits by failing to report other income to VA.

Former U.S. Postal Service Employee Sentenced for Stealing VA Narcotics
A former U.S. Postal Service (USPS) employee was sentenced to 30 days' incarceration for stealing VA narcotics. Additional drug charges were deferred prosecution for 1 year. A VA OIG, USPS OIG, and local police investigation used real time and videotaped surveillance, in addition to the defendant's own statements, to determine that he stole Vicodin shipped from a VA Consolidated Mail Outpatient Pharmacy (CMOP).

United Parcel Service Employee Indicted for Theft of VA Narcotics
A United Parcel Service employee was indicted for attempted possession with intent to distribute a controlled substance. An OIG and Drug Enforcement Administration investigation determined that for over 8 months the defendant stole Schedule II and III narcotics shipped from the Jackson, MS, VAMC and the Murfreesboro, TN, CMOP.

Former Salisbury, North Carolina, VAMC Pharmacist Sentenced for Drug Diversion
A former Salisbury, NC, VAMC pharmacist was sentenced to 4 years' probation and a $2,500 fine after pleading guilty to acquisition or obtaining possession of a controlled substance by misrepresentation and false statements. An OIG investigation determined that the defendant stole medication relinquished to the pharmacy by patients checking into the VAMC for in-patient stays.

Long Beach, California, VAMC Pharmacy Technician Charged with Drug Violations Over 15-Year Period
A Long Beach, CA, VAMC pharmacy technician was charged with possession of a controlled substance and obtaining controlled substances through fraud. An OIG investigation revealed that for approximately 15 years the defendant used fraudulent prescriptions to obtain more than 44,000 tablets of a controlled substance.

Son of Deceased Beneficiary Sentenced for Theft of VA Funds
The son of a deceased beneficiary was sentenced to 13 months' incarceration, 3 years' probation, and ordered to pay restitution of $67,505 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds from a joint account after his mother's death in March 2006.

Wife of Deceased Veteran Arrested for Theft of VA Benefits
The wife of a deceased Veteran was arrested for theft in the first degree. An OIG investigation revealed that the defendant failed to notify VA of her husband's death and subsequently stole VA benefits that were issued after his death in July 2007. The loss to VA is $206,284.

Son of Deceased VA Beneficiary Charged with Theft of VA Benefits
The son of a widow beneficiary was charged with theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were issued after his mother's death in May 2005. The loss to VA is $74,093.

Veteran Sentenced for Travel Benefit Fraud
A Veteran was sentenced to 10 years' hard labor (suspended) and 5 years' supervised probation after pleading guilty to felony theft. An OIG and VA Police Service investigation determined that the defendant obtained a driver's license and identification card containing false addresses, and from 2009 until 2011 used the false identifications to submit 223 fraudulent beneficiary travel vouchers to the Alexandria, LA, VAMC. The loss to VA is $14,775.

(original signed by Richard J. Griffin,
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