Department of Veterans Affairs
Office of Inspector General
December 2012 Highlights

OIG REPORTS

Report on Military Sexual Trauma Describes VA Resources Available to Women Veterans, Recommends Review of Travel Policy

At the request of the Senate Veteran's Affairs Committee, the Office of Inspector General (OIG) reviewed mental health (MH) services provided to women with a history of military sexual trauma (MST) treated at Veterans Health Administration (VHA) residential and inpatient programs. OIG reviewed patient medical records, VHA policy and program self-assessments, and conducted onsite visits at eight programs. OIG found that patients often had more than one MH diagnosis and that 90 percent had received VHA MH care within 3 months of admission. The programs reviewed provided evidenced-based psychotherapy techniques, gender-specific care, and same gender therapists. Women were often admitted to programs outside their Veterans Integrated Service Network (VISN). Obtaining authorization for travel funding was frequently cited as a problem for patients and staff. OIG found that current VHA travel policy is not aligned with MST policy. OIG recommended that the Under Secretary for Health (USH) review existing VHA policy pertaining to authorization of travel for Veterans seeking MST-related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. [Click here to access report.]

VA Violated *Anti-Deficiency Act* by Combining Minor Construction Projects, Better Controls on Medical Center Funding Needed

At the request of the House Committee on Appropriations, and following irregularities identified at the Miami VA Healthcare System (HCS), OIG reviewed the VHA Minor Construction Program. VA medical facilities combined design and construction work for 7 of 30 minor construction projects into 3 projects exceeding the $10 million minor construction limit. VHA violated the *Anti-Deficiency Act* by combining five minor construction projects into two projects exceeding the $10 million threshold. OIG found VHA lacks assurance that construction projects are designed within their approved scopes, medical facility funding is used appropriately, and underperforming projects are identified in a timely manner. OIG recommended the USH publish Minor Construction policy and develop procedures to ensure projects are executed within their approved scopes. VHA should implement funding mechanisms, ensure program reviews are performed, and strengthen project tracking reports. The USH agreed with OIG's recommendations and provided an acceptable action plan.
[Click here to access report.]

VHA Needs To Improve Oversight and Controls over Finances and Administration at Providence, Rhode Island, Medical Center

The purpose of this review was to determine the validity of 11 allegations relating to financial and administrative matters at the Providence VA Medical Center (VAMC), Providence, RI. OIG partially or fully substantiated 7 of the 11 allegations made by the complainant. OIG identified opportunities for management to improve oversight and

strengthen controls over financial and administrative activities. Providence VAMC officials did not always ensure applicable laws and policies were followed. OIG also questioned costs totaling $4,444 related to misuse of appropriated funds. Additionally, for two of the four allegations OIG did not substantiate, OIG identified issues requiring action. OIG recommended strengthening the oversight and compliance with policies and procedures, as well as improving controls to ensure employees comply with applicable laws and policies. The VISN 1 Director concurred with OIG's findings and recommendations and provided an appropriate action plan. [Click here to access report.]

Deceptive Inventory Management Practices Noted at Castle Point, New York, Pharmacy

OIG's Office of Healthcare Inspections conducted a review to determine the validity of several allegations at the Castle Point Campus of the VA Hudson Valley HCS in Castle Point, NY. OIG did not substantiate that patients died in the chemotherapy clinic or during transfer to community hospitals; however, OIG found issues with chemotherapy treatment timeliness. OIG presented findings to the Director about deceptive pharmacy inventory management practices, which resulted in the appointment of an Administrative Investigation Board (AIB). OIG reviewed and concurred with the findings and recommendations of the AIB. OIG confirmed that supplies were moved to the basement to exclude them from the pharmacy inventory count but did not substantiate that they remained there and went unused. OIG determined that there were drug shortages caused by an inadequate inventory management system and national vendor back-orders. OIG did not substantiate allegations related to physician hiring, safety issues for pharmacy staff who worked alone, or a pharmacy manager's conduct. OIG recommended that the Director follow the AIB's recommendations and provide ethics training and a repercussion-free reporting system for pharmacy staff.
[Click here to access report.]

IG Recommends Improvements To Reduce Patient Falls at Canandaigua, New York, Community Living Center

OIG conducted a review to assess the merit of an allegation concerning an increased number of patient injuries due to "unnecessary roughness" by staff in the community living center (CLC) at the Canandaigua VAMC in Canandaigua, NY. OIG did not substantiate the allegation. However, OIG found that since October 2011, the CLC experienced an upward trend in patient falls with a spike in April and May 2012. Facility leaders were aware of the increase in patient falls and had taken steps to identify contributing factors and implement preventive strategies prior to OIG's review. OIG found that the facility's Falls Reduction Program could be strengthened and recommended that the facility Director implement procedures to ensure that CLC unit-level reviews of patient falls are patient-specific and address the specific circumstances surrounding the fall and that fall prevention interventions are documented in patient care plans. Management agreed with the findings and recommendations and provided an acceptable improvement plan. [Click here to access report.]

Better Management Oversight of Vocational Rehab Program Needed To Help Veterans Successfully Operate Own Businesses

OIG evaluated the effectiveness of the Veterans Benefits Administration's (VBA) Vocational Rehabilitation and Employment (VR&E) program's self-employment services. OIG found VBA needs to strengthen management of these services to ensure its area offices effectively plan and provide the self-employment services needed for Veterans to successfully operate their own businesses. VR&E misidentified Veterans participating in self-employment services and did not record all program expenses. Insufficient oversight of data resulted in inadequate resources to accomplish program goals. Program staff was unaware of the correct criteria for rehabilitating Veterans. VBA guidance was not clear when providing services to Veterans with established businesses or when approving plan expenses. OIG recommended improving management and oversight for self-employment services by establishing procedures to ensure approvals for these services are appropriate, data collection on program operations is accurate, performance measures are implemented, and staff training is conducted.

[Click here to access report.]

VHA Can Improve Specialty Care Services with Staffing Methodology that Implements Productivity Standards

OIG assessed whether VHA has an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services. Audits and inspections continue to identify the need for VHA to improve their staffing methodology by implementing productivity standards. Public law mandates VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. OIG found VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. The USH agreed with OIG's finding and recommendations.

[Click here to access report.]

QUI TAM AND CIVIL FRAUD

Amgen Inc. Enters into $762 Million Settlement for Promoting Drugs for Uses Not Approved by FDA

A multi-agency investigation resulted in a global settlement to settle civil and criminal allegations that Amgen Inc. illegally introduced into interstate commerce a misbranded drug. The investigation revealed that Amgen promoted Aranesp and two other drugs it manufactured for "off-label" uses and doses that were not approved by the Food and Drug Administration (FDA) and were not properly reimbursable by Federal insurance programs. Also, the corporation offered illegal kickbacks in an effort to influence health care providers to select its products regardless of whether they were reimbursable by Federal health care programs or were medically necessary. The corporation also engaged in false price reporting practices involving several of its drugs. The corporation

agreed to pay $612 million to the Federal government and the states to settle civil allegations and a $136 million criminal fine and a $14 million criminal forfeiture to settle the criminal charge. VA will receive $4,765,847 of the civil settlement.

Pfizer Agrees to $55 Million Settlement For Off-Label Marketing of Protonix
The Department of Justice announced that Pfizer Inc. has agreed to pay $55 million to resolve allegations that Wyeth LLC, which was acquired by Pfizer in 2009, illegally introduced into interstate commerce the misbranded drug Protonix between February 2000 and June 2001. A VA OIG, FDA Office of Criminal Investigations, Health and Human Services OIG, and Federal Bureau of Investigation (FBI) investigation revealed that Wyeth manufactured and promoted Protonix, a proton pump inhibitor (PPI), that was used by physicians to treat various forms of gastro-esophageal reflux disease (GERD). Wyeth sought and obtained approval from the FDA to promote Protonix for short-term treatment of erosive esophagitis, a condition associated with GERD that can only be diagnosed with an invasive endoscopy. However, the Government alleged that the company promoted Protonix for all forms of GERD. The company also promoted Protonix as the "best PPI for nighttime heartburn," even though there was never any clinical evidence to support this misleading claim. Finally, the Government alleged that Wyeth used continuing medical education programs to promote Protonix for unapproved uses.

CRIMINAL INVESTIGATIONS

Fiduciary's Legal Assistant Sentenced for Theft from Veterans
The legal assistant of an attorney, who was also his wife, was sentenced to 46 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $2,352,107 to VA and $282,112 to the Internal Revenue Service. An OIG investigation revealed that the defendant and her husband, who served as a court-appointed guardian and Federal fiduciary for 54 Veterans, conspired to steal from the Veterans' bank accounts and failed to report the income on their Federal tax returns. The attorney is awaiting sentencing.

Former Fiduciary Sentenced for Misappropriation
A former VA fiduciary was sentenced to 24 months' incarceration and ordered to pay $121,424 in restitution after pleading guilty to misappropriation by a fiduciary. An OIG investigation determined that the defendant began embezzling VA funds from a Veteran within a few months of becoming a fiduciary, during a time when the Veteran was undergoing dialysis treatments. The defendant failed to pay or provide for the Veteran's living expenses in a timely manner and used the funds for his own personal use. Unfortunately the Veteran died during the course of the investigation.

Fiduciary Indicted for Theft
A VA-appointed fiduciary was indicted for theft of public funds. An OIG investigation revealed that the defendant misappropriated funds from various Veterans' accounts by withholding their funds from deposit or writing checks to himself. An OIG forensic audit documented a theft of $236,204 in VA funds.

Fiduciary Arrested for Embezzlement
The former estate manager of a non-profit corporation, who was also a VA fiduciary, pled guilty to theft of Government property. A VA OIG, Social Security Administration (SSA) OIG, and local law enforcement investigation revealed that the defendant embezzled approximately $52,000 from disabled Veterans and Social Security beneficiaries. The defendant embezzled funds from 23 victims, including 3 disabled Veterans, by creating a payee code that issued checks to the defendant and by purchasing gift cards at retail stores. After discovering discrepancies, the non-profit corporation took prompt action to terminate the employee, notify authorities, and refund the victims' accounts.

Veteran Sentenced for Arson at the Jesse Brown VAMC, Chicago, Illinois
A Veteran was sentenced to 6 years' incarceration after pleading guilty to aggravated arson. An OIG, VA Police Service, and local fire department investigation determined that the defendant set fire to his room at the Jesse Brown VAMC in Chicago, IL. The fire caused damage to the room and extensive smoke and water damage throughout the ward. Two VA police officers also suffered minor smoke inhalation while evacuating the ward. The investigation further revealed that the defendant tampered with the ceiling-mounted fire suppression sprinkler heads, causing them to malfunction during the fire.

Northport, New York, VAMC Employee Found Guilty of Assaulting Co-Worker
A Northport, NY, VAMC employee was found guilty at trial of assaulting a co-worker. An OIG and VA Police Service investigation revealed that the defendant assaulted the co-worker in a private office at the VAMC. The victim was subsequently diagnosed with hand and wrist injuries.

Former Manchester, New Hampshire, VAMC Employee Arrested for Disorderly Conduct
A former Manchester, NH, VAMC employee was arrested for disorderly conduct. An OIG and VA Police Service investigation revealed that the defendant grabbed a VA police officer and shoved him several times before being restrained. The investigation also disclosed that the defendant made threatening comments to a VA physician prior to the altercation with the officer. The defendant was terminated from VA employment.

Former New Mexico Clinic Contract Employee Pleads Guilty to Possession of Child Pornography
A former VA contract employee pled guilty to possession of child pornography. An OIG investigation determined that the defendant accessed internet websites containing images of child pornography and then saved the images to his VA-issued computers while working at two VA clinics in New Mexico. The defendant remains in custody pending sentencing.

Former Health Care Worker Indicted for Diverting Drugs
A former health care worker, who provided contract services to VA in 2008, was indicted for possession of a controlled substance by fraud and tampering with consumer

products with reckless disregard. A multi-agency investigation revealed that the defendant stole syringes filled with the narcotic painkiller fentanyl, which were prepared and intended for patients scheduled to undergo medical procedures, and replaced them with syringes he had previously stolen and filled with saline. The defendant, who was infected with Hepatitis C, used the stolen syringes to inject himself, causing them to become tainted. As a result, over 30 patients became infected with Hepatitis C, including three Veterans. Two of the Veterans were exposed to the defendant during procedures at a private hospital and one during a procedure at a VAMC.

Veteran Sentenced for Drug Distribution at a Phoenix, Arizona, VA Clinic
A Veteran was sentenced to 10 years' incarceration after pleading guilty to possession of crystal methamphetamine with intent to sell. An OIG and local law enforcement investigation determined that the defendant sold crystal methamphetamine in the parking lot of a Phoenix, AZ, VA clinic. A subsequent search of the defendant's vehicle resulted in the seizure of crystal methamphetamine, a digital gram scale, and a drug ledger.

USPS Employee Pleads Guilty to Theft of VA Drugs
A U.S. Postal Service (USPS) employee pled guilty to theft of Government mail by an employee. An OIG and USPS OIG investigation revealed that between June 2011 and April 2012 the defendant stole approximately 18 VA shipments of controlled narcotics.

Son of Deceased Beneficiary Sentenced for Theft of VA Benefits
The son of a deceased beneficiary pled guilty to theft of Government funds. An OIG and FBI investigation revealed that the defendant stole VA benefits that were direct deposited to a joint bank account after his father's death in March 2006. The defendant used the stolen funds for personal use. The loss to VA is $202,662.

Contract Employee Sentenced for Theft of Firearm at San Joaquin Valley National Cemetery, Santa Nella, California
An employee, working for a VA contractor at the San Joaquin Valley National Cemetery in Santa Nella, CA, was sentenced to 180 days' incarceration and 36 months' probation after pleading guilty to theft of a firearm. An OIG and local sheriff's office investigation revealed that the defendant stole an M-14 rifle that had been left at the cemetery by a California National Guard soldier after a burial service. The weapon was recovered.

Former U.S. Postal Service Supervisor and Employee Plead Guilty to Theft of $2.8 Million in U.S. Treasury Checks from Atlanta Mail Facility
A former USPS supervisor and employee pled guilty to theft of Government money and possession of stolen U.S. Treasury checks. A joint VA OIG, U.S. Secret Service, SSA OIG, USPS OIG, USPS Inspection Service, and Georgia Department of Revenue investigation revealed that the defendants stole 1,300 U.S. Treasury checks worth $2.8 million while employed at an Atlanta mail distribution facility. The defendants subsequently provided them to a network of brokers and check cashers (other co-defendants) who negotiated the checks and split the proceeds with the defendants. A search of one defendant's residence resulted in the recovery of 661 recently stolen U.S.

Treasury checks, which included 9 VA benefit checks, totaling over $590,000. The two defendants are believed to be the source of all the stolen checks, which has led to the subsequent arrest of 11 additional defendants.

Veteran Pleads Guilty to Theft of Government Funds
A Veteran pled guilty to theft of Government funds after receiving more than $12,000 in VA health care benefits that he was not entitled to receive. An OIG investigation revealed that the defendant provided VA with a fraudulent DD-214 falsely listed him as the recipient of a Purple Heart and other related decorations. Additionally, the defendant made claims in various Veteran circles about being identified in a book documenting combat experiences in Vietnam and went as far as claiming to be the main figure in a combat pictorial. In actuality, the defendant's true DD-214 revealed that he did not serve in combat and that he was discharged under Other Than Honorable conditions.

Cousin of Disabled Veteran Arrested for Theft
The cousin of a disabled Veteran was arrested for elder abuse, grand theft, forgery, and burglary. An OIG investigation revealed that the defendant stole his cousin's checkbook from his room at the Livermore VAMC CLC in Livermore, CA, and then forged and negotiated several checks. The loss to the Veteran is over $20,000.

Veteran Sentenced to Incarceration for Travel Benefit Fraud Against Seattle, Washington, VAMC
A Veteran, who defrauded VA of approximately $23,000 in travel benefits, was sentenced to 1 year of incarceration. The defendant submitted false travel vouchers claiming that he traveled 498 miles round-trip to attend medical appointments, when in actuality he resided 3 miles from the VAMC. The defendant was one of eight Veterans and two VA travel clerks charged in a conspiracy and bribery scheme at the Seattle, WA, VAMC to submit inflated and fictitious travel benefit vouchers.

Veteran Sentenced for Travel Benefit Fraud Against Ann Arbor, Michigan, VAMC
A Veteran, who previously pled guilty to theft of public money, was sentenced to 6 months' incarceration, 2 years' probation and ordered to pay $15,857 in restitution to the Ann Arbor, MI, VAMC. The jail sentence was suspended as long as the defendant maintains certain educational requirements. An OIG investigation revealed that the defendant submitted false claims in order to obtain travel reimbursement benefits that she was not entitled to receive.

Veteran Sentenced to Probation for Travel Benefit Fraud Against Albuquerque, New Mexico, VAMC
A Veteran was sentenced to 3 years' probation and ordered to pay VA $19,136 in restitution after pleading guilty to fraud. An OIG investigation determined that the defendant claimed that he was traveling 450 miles roundtrip to the Albuquerque, NM, VAMC, when in fact he did not possess a driver's license and was living within walking distance of the facility.

Former Birmingham, Alabama, VAMC Employee Sentenced for Purchase Card Fraud

A former Birmingham, AL, VAMC employee was sentenced to 1 month of incarceration, 4 months' home detention, 48 months' supervised release, and ordered to pay $6,215 in restitution. An OIG investigation revealed that for over 3 months the defendant misused Government purchase cards, accruing approximately $6,000 in charges for personal expenses, to include vacation and utility bills. The defendant falsely reported that the purchase cards were stolen and fraudulently used and as a result was reissued additional purchase cards.

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