

STATEMENT OF
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BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. Chairman and Members of the subcommittee, I am pleased to be here today to discuss the results of our Combined Assessment Program review of the Department of Veterans Affairs (VA) Richard L. Roudebush VA Medical Center (VAMC), Indianapolis, Indiana. I will also summarize our hotline and investigative activities throughout the State of Indiana.

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of my Office's effort to visit VA facilities on a cyclic basis, and to ensure that safe, high quality health care and benefits are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of my Office's auditors, investigators, and healthcare inspectors to provide collaborative assessments of VA field facilities. At VA health care facilities:

- Auditors' review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness Briefings to improve employee awareness of fraudulent activities that can occur in VA programs.
- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing safe, high quality health care, and improving access to care, with high patient satisfaction.

In addition to this typical CAP review coverage, Office of Inspector General (OIG) staff may examine issues or allegations that have been referred to the OIG by employees, patients, members of Congress, or others.

Our review at the Indianapolis Medical Center covered operations for Fiscal Years 1999 to 2000. In performing this review we inspected the structural and environmental conditions of the physical plant; interviewed medical center

managers, employees, and patients; and reviewed pertinent administrative, financial, and clinical records. The CAP team consisted of auditors, investigators, and healthcare inspectors who examined 22 health care activities and 20 separate administrative activities.

The team concluded that administrative and clinical activities were generally operating satisfactorily. The medical center had adopted innovative treatment programs that provided significant benefits for veterans' well being. For example:

- Staff fully implemented the primary care model supported by a Patient Response Center to manage patients' problems over the telephone, eliminating any unnecessary outpatient visits.
- Rehabilitation employees consistently evaluated their patients' progress using Functional Independence Measures which improved and personalized the treatment planning process, and reduced Rehabilitation Clinic waiting times for appointments from 21 to 14 days.
- Pathology and Laboratory Medicine Service had sound controls to ensure highly accurate tissue diagnoses, and rapid communication of critical laboratory values to treating physicians ensuring effective treatment for serious illnesses.
- Non-laboratory ancillary testing devices such as glucometers produced consistently accurate results attributable to the Ancillary Testing Coordinator's intensive surveillance and monitoring of their use by nursing personnel.

Although we concluded that clinical and administrative activities generally were operating satisfactorily, we made suggestions and recommendations in several areas that appeared vulnerable or were in need of improvement.

Our Roudebush VA Medical Center CAP report contains the details of our review and our conclusions, as well as 38 suggestions and 4 formal recommendations for improvement. The report also contains management's concurrence with our recommendations, including implementation plans that we believe are responsive and constructive. We recommended improvements in the following activities:

- Administrative controls over human subject research projects
- Surgical patient informed consents
- Controlled substances inspections
- Government purchase card program
- Administrative oversight and review
- Training and education
- Program development and Performance improvement
- Treatment environment, Infection control, and Safety
- Medical record documentation
- Timekeeping for part-time physicians

- Equipment and Medical supplies inventories
- Information technology security

During the CAP review, my staff received inquiries from 23 patients and employees at the Medical Center. Many of the individuals who we talked to had multiple concerns which we categorized into the following areas:

- patient safety or quality of care issues
- personnel and staffing-related issues
- administrative and resource mismanagement issues
- alleged fraud or other criminal activities
- miscellaneous issues

We followed-up on all of the allegations we received. In some cases, we referred the individuals to other appropriate offices such as the General Counsel or the Office of Resolution Management. In our opinion, there existed no particular pattern to these inquiries that would cause us to recommend any systemic remedial action to medical center management.

In addition, during the CAP visit my investigative staff conducted several 60-minute fraud awareness briefings. Approximately 163 Roudebush VA Medical Center employees attended these presentations. Each session provided discussions of how fraud occurs, criminal case examples, and information to assist employees in preventing and reporting fraud.

Our complete 54-page CAP report on the Richard L. Roudebush VA Medical Center can be found on our website at <http://www.va.gov/oig/53/reports/2001-2reports.htm>.

Hotline Activity

The OIG operates a hotline where veterans, employees, and members of the public can report crimes, fraud, waste, abuse, and mismanagement involving VA programs and operations by mail, e-mail, fax, or toll-free telephone number. Our annual contacts exceed 15,000 from which we open approximately 1,200 hotline cases for OIG or Departmental review of specific and serious allegations. Approximately one-third of the cases are substantiated. For the past 3 fiscal years, our Hotline has opened 15 cases involving VA facilities located within the State of Indiana. Summaries and pertinent excerpts of the cases have been provided to the committee. The cases included allegations involving quality of patient care, benefits fraud, mismanagement of resources, and employee misconduct. The allegations did not reveal any unusual trends or problems in Indiana VA facilities, and were representative of the types of allegations we receive nationwide.

Investigative Activity

We have conducted 26 criminal investigations in the State of Indiana during the last 2 years. The OIG Central Field Office conducts these investigations. The Special Agent in Charge of the office reports that he and his staff enjoy a good working relationship with VA officials in the state and issues or allegations of criminal conduct have been referred for investigation in a timely manner.

Eleven of our cases in Indiana are still under active investigation with several pending criminal prosecution. During the past year, the majority of our investigative work in Indiana has involved the Department's Compensation and Pension programs and several of these cases have been initiated based on referrals from VA officials working in the benefits delivery system. Our investigative work at the Richard L. Roudebush VA Medical Center includes instances of diversion of drugs from the VA facility. In each case, we received cooperation and assistance from VA management and we have worked closely with the VA Police at this facility to address matters of mutual concern.

Closing

Mr. Chairman, this completes my opening statement. I will be glad to answer any questions that you or Members of the Sub-Committee may have.