

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Health Administration

*Review of  
Allegations at  
VA Medical Center  
Providence, Rhode Island*

December 17, 2012  
10-01937-63

## ACRONYMS AND ABBREVIATIONS

CFO	Chief Financial Officer
DEO	Designated Education Officer
FMS	Facilities Management Service
HR	Human Resources
HRM	Human Resources Management
OIG	Office of Inspector General
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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# Report Highlights: Review of Allegations at VA Medical Center Providence, Rhode Island

## Why We Did This Audit

The VA Office of Inspector General conducted this review in response to allegations received by our Hotline Division. The purpose of the review was to determine the validity of 11 allegations related primarily to financial and administrative matters at the VA Medical Center, Providence, RI.

## What We Found

We partially or fully substantiated 7 of the 11 allegations made by the complainant. We identified opportunities for management to improve oversight and strengthen controls over financial and administrative activities. Providence VA Medical Center officials did not always ensure applicable laws and policies were followed.

We identified potential monetary benefits totaling \$4,444 related to inappropriate uses of appropriated funds. Additionally, for two of the four allegations we did not substantiate, we identified issues requiring action. We recommended strengthening the oversight and compliance with policies and procedures.

## What We Recommended

We recommended the Veterans Integrated Service Network (VISN) 1 Director improve oversight and strengthen controls to ensure employees follow applicable laws and policies. We also recommended the Network Director ensures Providence VA Medical Center management requires the property owner of space leased by the

Providence VA Medical Center take action to alleviate the potential for future water damage and, if necessary, move employees in the work areas impacted to more suitable workspace.

## Agency Comments

The VISN 1 Director concurred with our findings and recommendations and provided an appropriate action plan. The planned actions are responsive and we will follow up on the implementation of corrective actions.

A handwritten signature in black ink that reads "Linda A. Halliday".

**LINDA A. HALLIDAY**  
Assistant Inspector General  
for Audits and Evaluations

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## INTRODUCTION

- Objective** The Office of Inspector General (OIG) conducted this review in response to allegations received by our Hotline Division related primarily to financial and administrative matters at the VA Medical Center (VAMC), Providence, RI. The purpose of the review was to determine the validity of allegations and recommend corrective actions if necessary.
- Complaint** In March 2010, OIG’s Hotline Division received 14 allegations from a complainant. We determined two of the allegations were not related directly to the Providence VAMC. One allegation was related to the Boston VAMC and the other was related to Veterans Integrated Service Network (VISN) 1. We determined 1 of the 12 allegations required immediate attention and corrective action in consideration that the financial risks associated with the allegation may be an indicator of a systemic problem VA-wide. The OIG reviewed this allegation and issued a separate report (*Veterans Health Administration Review of Retention Incentive Payments at VA Medical Center Providence, Rhode Island*, Report Number 10-0937-68, January 20, 2011), which addressed misuse of retention incentive payments. This report addresses the remaining 11 allegations.
- Facility Overview** Providence VAMC is part of VISN 1 and serves a veteran population of about 84,300 throughout Rhode Island and southern Massachusetts. The VAMC is a primary and secondary health care facility that provides a broad range of inpatient and outpatient health care services. Comprehensive health care is provided through primary and specialty care in the areas of medicine, surgery, and psychiatry. The VAMC has 73 acute care beds.
- VAMC Resources and Workload** In FY 2011, medical care expenditures totaled about \$225 million. FY 2011 staffing was 1,122 full-time employee equivalents. In FY 2011, the VAMC treated 33,083 patients and provided 20,558 inpatient days of care.

## RESULTS AND RECOMMENDATIONS

### Review of Allegations at VA Medical Center Providence, Rhode Island

We conducted a review to determine the validity of allegations received by our Hotline Division. The allegations related primarily to financial and administrative matters at the Providence VAMC. We partially or fully substantiated 7 of the 11 allegations.

#### ***Allegations 1 and 2***

**The VAMC Chief Financial Officer did not include all known unrecorded obligations on the FY 2009 year-end Annual Certification of Accounting Records for Prosthetics Service and Fee Care.**

We substantiated the complainant's allegations the Chief Financial Officer (CFO) was aware of unrecorded obligations in Prosthetics Service and non-VA-provided care<sup>1</sup> at the end of FY 2009 and failed to fund the obligations or show the known unrecorded obligations on the VAMC's Annual Certification of Accounting Records. The VAMC Director and CFO are required to submit the annual certification to the Veterans Health Administration's (VHA) Office of Finance after the close of each fiscal year.

In FY 2009, the Chief of Prosthetics Service requested additional funds totaling about \$13,000 from Fiscal Service to pay for supplies delivered near the end of the fiscal year. Prosthetics Service staff made this request because they did not have sufficient funds available in their fund control point. In response to Prosthetics Service's request, a Fiscal Service employee sent the Chief of Prosthetics Service an email stating there was no funding available and to consider their fund control point closed for FY 2009.

During late FY 2009, the VAMC authorized veterans to receive fee care at local community-based hospitals. The Chiefs of Fee Care and Patient Services submitted a written request to cover these unexpected FY 2009 expenses, which were estimated at \$275,000. The CFO recalled seeing the request; however, he did not provide funds to cover obligations because the request did not detail the exact amount needed.<sup>2</sup> Typically, VA relies upon an estimate of costs to establish an obligation to cover anticipated expenses. We were unable to determine why the CFO did not coordinate with the Chiefs of Fee Care and Patient Services to obtain the support needed to establish an appropriate obligation.

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<sup>1</sup> The purpose of non-VA-provided care is to assist veterans who cannot easily receive care at a VAMC. VA pays for medical care costs of eligible veterans who receive care from non-VA providers when VAMCs are unable to provide specific medical care. It is commonly referred to as fee care.

<sup>2</sup> The VAMC identified funds in FY 2010 and paid for the supplies and fee care expenses with FY 2009 appropriations.

The VAMC's FY 2009 certification statement stated that no known unrecorded obligations existed at the end of the accounting period. We recognize the unexpected prosthetics and fee care expenses occurred late in the fiscal year. However, these were known unrecorded obligations and should have been listed as exceptions on the VAMC's FY 2009 Annual Certification of Accounting Records.

**Recommendation** 1. We recommended the Veterans Integrated Service Network 1 Director establish controls to ensure the Providence VA Medical Center accurately certifies its Annual Certification of Accounting Records.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated the new facility Chief Financial Officer implemented controls to ensure compliance with requirements related to the Annual Certification of Accounting Records. We consider the actions acceptable, and we will monitor the Providence VA Medical Center's progress on implementing the controls. Appendix C provides the full text of the Network Director's comments.

**Allegation 3**

**VAMC officials entered into a prohibited contract for a Human Resource contract employee.**

We substantiated the complainant's allegation VAMC officials entered into a prohibited contract for a Human Resources (HR) contract employee.

In 2008, the Providence VAMC awarded a contract to a staffing service for an individual to provide HR services at the medical center. The contract was a sole-source award to the staffing service vendor for obtaining the services of a specific individual. The vendor's employee is a retired Providence VAMC HR employee. Two months before retiring—and before the contract was awarded to the staffing agency—the employee had submitted an offer in response to a VAMC contract solicitation. Contracting personnel determined her offer was ineligible because she was a VAMC employee when she submitted her bid. After her bid was determined ineligible—but while she was still an employee—the VAMC awarded a contract to the staffing service.

We concluded this is a personal services contract. A personal services contract creates a relationship between the Government and the contractor's personnel. The Government is normally required to obtain its employees by direct hire under competitive appointment or other procedures required by civil service laws. Obtaining personal services by contract, rather than by direct hire, circumvents those laws unless Congress has specifically authorized acquisition of the services by contract. We based our conclusions on factors such as some of the specific job requirements noted in the contract's statement of work.

The contract's statement of work listed 14 services to be performed by an individual possessing experience utilizing VA personnel systems and familiarity with VA regulations. These services were similar to work the retired employee performed as a VAMC HR specialist. The following are examples of the services required in the statement of work.

- Author and issue human resource bulletins on an "as-needed" basis.
- Review all requests for recruitment, retention, and relocation incentives, and requests for Above Minimum Entrance Rate hires for technical accuracy.
- Serve as the database administrator for the Healthcare Integrity and Protection Data Bank for the VAMC.

With regard to the contracting process, the requirements for the position were overly restrictive regarding the qualifications of the person needed to perform the work. These restrictive requirements limited competition and only one vendor responded to the solicitation. The original contract was for a base period of 2 months with two 1-year option periods. At the end of this period, the VAMC awarded a new contract to the same staffing service vendor, which used the same retired VA employee to provide the same services for an additional base year and a 1-year option period.

By September 2012, the vendor will have been under contract with VA for more than 4 years using the same retired employee. If VAMC management continues to need these services, it should recruit and hire staff by direct hire under competitive appointment or other appropriate civil service procedures.

This contract was awarded before VA established its Integrated Oversight Process (IOP) in June 2009. The IOP replaced the traditional technical and legal reviews of contracts required by VA Acquisition Regulation. Depending on the type and estimated value of a contract and what is being procured, the IOP requires a peer review or second-level supervisory review, a contract review team, or a contract review board to evaluate a contract. The IOP, if followed properly, strengthens controls to help prevent the award of prohibited contracts. Since the IOP is now in place, we are not making a recommendation to strengthen the related contract controls or oversight.



- Recommendation** 2. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director terminates this contract, and if the services are still needed, recruits and hires under appropriate civil service procedures.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated the contract was terminated effective September 30, 2012. The Providence VA Medical Center plans to temporarily appoint the former contract employee for up to 120 days so her functions can be effectively transferred to the Assistant Chief of Human Resources. We consider the planned actions acceptable, and we will follow up to ensure the temporary appointment does not exceed 120 days. Appendix C provides the full text of the Network Director's comments.

**Allegation 4**

**The VAMC Director had an inappropriate dental procedure.**

We did not substantiate the complainant's allegation that it was not appropriate for the VAMC Director to have a dental procedure performed in the medical center's Dental Service.

Our review revealed that in February 2006 the VAMC Director had a tooth extracted by the VAMC's Dental Service staff. Local VAMC policy states that a VAMC employee suffering from a non-job-related illness or injury, which interferes with his or her ability to perform assigned duties, may seek first aid or emergency treatment at the medical center to relieve discomfort and enable the employee to remain at work.

The VAMC Director said he tried to get an appointment with his own dentist, but his dentist was not available to see him at that time. He further stated he was in pain, it was an emergent situation, and he could remain on the job by having the procedure performed at Dental Service. The former Chief of Dental Service, who performed the procedure, told us that there was no pressure put on him to perform the procedure. In fact, he stated it was his decision to remove the tooth. Progress notes support the Chief of Dental Service's testimony.

This was an emergency, and the VAMC Director followed local VAMC policy.

We made no recommendation on this allegation.

**Allegation 5**

**Fee Care obligated State Nursing Home funds at the direction of Fiscal Service without supporting documentation.**

We substantiated the complainant's allegation that Fee Care staff increased their obligation without supporting documentation. Further, it appears this change was made at the direction of Fiscal Service.

State Nursing Home funds are earmarked and can only be used for the State Nursing Home program. The complainant alleged that at the end of FY 2009, Fiscal Service staff directed the Fee Care office to obligate State Nursing Home program funds, valued at \$2,590, in order to reduce its year-end available balance to less than a dollar without documenting the obligation of purchases of services.

The Chief of Fee Care, who established the \$2,590 obligation, could not provide documentation to identify services the VAMC purchased with this year-end obligation. The Chief of Patient Services, who approved the obligation, also could not provide documentation to identify services the VAMC purchased. A report of estimated or changed obligations showed the purpose of obligating State Nursing Home program funds was to increase the obligation at the request of Fiscal Service. No goods or services were purchased—this was an obligation to reduce available program funds.

Title 31, United States Code, §1501, *Documentary Evidence Requirement for Government Obligations*, states an amount shall be recorded as an obligation of the United States Government only when supported by documentary evidence.

- Recommendation** 3. We recommended the Veterans Integrated Service Network 1 Director require the Providence VA Medical Center Director to implement controls ensuring all fund obligations are accompanied by supporting documentation to justify the obligation as required by law.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated controls have been implemented to require Providence VA Medical Center services to document appropriate analysis in support of fund requests. We consider the actions acceptable, and we will monitor the Providence VA Medical Center's progress on implementing the controls. Appendix C provides the full text of the Network Director's comments.

**Allegation 6**

**The VAMC had a personal services contract with a chaplain and later hired him as a Providence VAMC Chaplain ahead of qualified veterans.**

We did not substantiate the complainant's allegation the VAMC entered into a personal services contract with a chaplain in Chaplain Service and later hired the chaplain ahead of qualified veterans. While we did not determine the VAMC obtained the chaplain's services through a personal services contract, we identified issues with how the VAMC acquired the chaplain's services.

*Chaplain  
Services Not  
Obtained  
Competitively*

From FY 2003 to FY 2009, the VAMC procured the chaplain's services through a combination of purchase orders and a service contract. There was no evidence the VAMC purchased the services through full and open competition as required by statute or provided sole-source justifications as required by the Federal Acquisition Regulation.

*Attempts To  
Recruit a  
Chaplain*

The VA National Chaplain Center solicits applications for endorsed Chaplain positions within VA. When a VAMC is in need of a Chaplain, the VA National Chaplain Center provides a list of qualified candidates. In December 2003, Providence VAMC attempted to hire a full-time Protestant Chaplain. The chaplain, a non-veteran and of Protestant faith, was listed seventh of seven candidates on the Certificate of Eligibles provided by VA's National Chaplain Center, and two veterans were rated as the top two candidates. The VAMC did not attempt to hire the two veterans. Instead, the VAMC retained the chaplain's services under a purchase order rather than making a selection from Certificate of Eligibles.

In July 2008, the VAMC issued a vacancy announcement to recruit a Protestant Chaplain. The individual was listed number four on a list of eight candidates. Although two service-connected disabled veterans were rated ahead of the individual on the Certificate of Eligibles, one of the eligible veterans had taken another position and the other veteran was not a Protestant Chaplain. The third individual on the list was not a veteran. The VAMC selected the chaplain, and he became a VAMC employee in February 2009.

*Recommendation*

4. We recommended the Veterans Integrated Service Network 1 Director ensure service contracts are awarded based on adequate competition or, if competition is not feasible, are supported by limited or sole-source justifications as required by Federal Acquisition Regulation.

*Management  
Comments  
and OIG  
Response*

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director advised contracting functions are no longer under the supervision of Providence VA Medical Center leadership as they have been centralized to the Acquisition Resource Center. Further, he stated new procedures have been implemented to ensure compliance with Federal Acquisition Regulation. We are closing this recommendation based on the Network Director's response. Appendix C provides the full text of the Network Director's comments.

*Allegation 7*

**VAMC management falsified a 2009 report to VA Central Office involving its Annual Incentive Awards Ceremony and further made inappropriate purchases using appropriated funds.**

We did not substantiate the complainant's allegation Providence VAMC management falsified a report to VA Central Office that stated no more than 100 people attended its 2009 awards ceremony or that the VAMC did not

exceed the \$20 per person expenditure limitation. However, we did substantiate the VAMC made inappropriate purchases with appropriated funds.

*VAMC Annual  
Incentive  
Awards  
Ceremony*

VA's Annual Incentive Awards Ceremony reporting requirements state facilities must report to VA's Office of Financial Policy if more than 100 people have attended a facility's awards ceremony or the facility spent more than \$20 per person.

The complainant alleged that VAMC management falsified a 2009 report concerning the facility's 2009 incentive awards ceremony, which was held during the 2009 employee recognition summer picnic and holiday tea party. However, we found the VAMC's annual award ceremony did not take place during the facility's annual picnic or holiday tea party. Additionally, we found no evidence that more than 100 people attended the official awards ceremony, or the facility spent more than the \$20 per person expenditure limitation.

*Misuse of  
Appropriated  
Funds*

We found VAMC purchase cardholders made inappropriate purchases totaling \$4,444 with appropriated funds in FYs 2009 and 2010. In FY 2009, the VAMC used appropriated funds totaling \$1,666 to procure various items such as canopies, grills, propane, and ice for the annual summer picnic. In FY 2010, the VAMC used appropriated funds totaling \$2,778 to procure items for the summer picnic and purchase food for the holiday tea party. Senior policy officials in VA Central Office agreed these purchases were inappropriate as appropriated funds are to be used only for what the appropriation is intended.

*Recommendation*

5. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director establishes controls to ensure appropriated funds are used only for the intended purpose of the appropriation.

*Management  
Comments  
and OIG  
Response*

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated that Providence VA Medical Center Fiscal Service managers with responsibility for overseeing appropriation of funds received training on Appropriation Law. We will follow up to ensure the Providence VA Medical Center remains in compliance. Appendix C provides the full text of the Network Director's comments.

*Allegation 8*

**The medical center is not following VHA policy when it comes to managing disbursement agreements resulting in the mismanagement of resources.**

We partially substantiated the complainant's allegation that VAMC management is not following VHA policy regarding the roles and

responsibilities of the individuals overseeing disbursement agreements. However, we did not find this resulted in the mismanagement of resources.

A disbursement agreement is a payroll mechanism by which VA allows a disbursing agent<sup>3</sup> to administer either salary payments or fringe benefits for medical and dental residents assigned to a VA facility. Disbursement agreements cover residents training in VA locations whether inpatient or outpatient and provide a mechanism to achieve equity between resident salaries and benefits provided by the affiliated, sponsoring institutions and those provided by VA.

We found the VAMC's Fiscal Service staff was obtaining annual rate changes from the disbursing agent. However, this did not result in mismanagement of any funds. VHA Handbook 1400.05 states the VAMC's Designated Education Officer (DEO) has oversight responsibility for all health professionals training at the VAMC and is responsible for obtaining annual rate changes that are paid to the disbursing agent for resident's services. The DEO is also responsible for communicating these rate changes to the appropriate parties, including the VAMC's CFO and Chief of Human Resources Management (HRM), and securing approval of the rate changes from VHA's Office of Academic Affiliations.

- Recommendation** 6. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director requires the Designated Education Officer to obtain and oversee annual rate changes for disbursing agreements.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated the Providence VA Medical Center reassigned responsibility for obtaining annual rate changes to the Designated Education Officer and the Chief of Human Resources is also involved in overseeing annual rate changes. We consider the actions acceptable, and we will monitor the Providence VA Medical Center's progress on implementing the new process. Appendix C provides the full text of the Network Director's comments.

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<sup>3</sup> The disbursing agent is the entity that pays the residents' stipends and fringe benefits as an agent of VA then VA reimburses the disbursing agent for resident stipends and benefits under a disbursement agreement for educational activities performed by residents assigned to VA. Generally, the entity in whose affiliated programs are accredited and with whom VA must have an affiliation agreement to permit clinical training at VA and the disbursing agent are the same entity.

**Allegation 9**

**The Chief of Facilities Management Service was inappropriately granted authorized absence to attend court proceedings involving his former employer.**

We substantiated the complainant's allegation the Chief of Facilities Management Service (FMS) was inappropriately granted authorized absence to attend a court trial.

The Chief of FMS attended a trial at which he was a witness for a former coworker's lawsuit against their former employer, a local government. He was appropriately granted 8 hours of authorized absence in May 2007 to attend a court deposition. However, VAMC time and attendance records showed he was not charged leave for an additional 25 days during the period of June to August 2007 while he attended the trial. The Chief of FMS did not provide documentation showing 25 days of court leave was approved or any documentation of the actual time he served as a witness.

Title 5, United States Code, Part III, §6322, states an individual employed by the Government is entitled to leave to serve "as a witness on behalf of any party in connection with any judicial proceeding to which the United States, the District of Columbia, or a State or local government is a party."

Providence VAMC policy authorizes court leave as an authorized absence without charge to leave or loss of pay for jury duty or to appear as a witness in a nonofficial capacity on behalf of a State or local government. The policy requires individuals to submit evidence of actual time served as a witness or juror. Local policy further states that for excused absence of more than a day, there must be written justification submitted through the Chief of HRM and forwarded to the VAMC Director for final approval.

The Chief of FMS acknowledged he had taken time off to attend the trial during 2007 and was paid during his absence. He recalled that when the trial began, the Chief of HRM told him that VA policy allowed time to participate as a witness in a judicial proceeding that involved a Federal, State, or municipal government. The Chief of HRM told us he did not recall speaking with the Chief of FMS about this subject.

The Chief of FMS stated he discussed court leave with the Associate Director who authorized the absence. The Associate Director told us he was aware the Chief of FMS attended a trial but was not aware the Chief of FMS was not charged any leave for this time. Although the Associate Director believes he told the Chief of FMS he could attend the trial, the Associate Director did not recall receiving a written request.

**Recommendations** 7. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director charges the Chief of

Facilities Management Service 25 days of annual leave because his absence was not supported by an approved written justification.

8. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director institutes a control that ensures at the point timecards are certified appropriate documentation in support of approved excused absences is in place.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed in principle with our finding and provided a responsive action plan to address our recommendation. The Network Director advised the Chief of Facilities Management will be charged 21 days of annual leave and stated that all personnel performing timekeeper functions have received training. Further, the payroll department will conduct semiannual timekeeper audits to ensure compliance with timekeeper functions including ensuring documentation is in place to support excused absences. We consider the planned actions acceptable, and we will monitor the Providence VA Medical Center's progress on implementing the planned actions. Appendix C provides the full text of the Network Director's comments.

**Allegation 10**

**The VAMC did not enforce a contractual clause with a property owner after Government property was damaged and employees were exposed to environmental hazards.**

We did not substantiate the allegation; however, further action is required to improve work conditions for medical center employees located in an off-campus building leased by the medical center.

In November 2009, three Fiscal Service employees who worked in space leased by the Providence VAMC reported to Employee Health. They believed they became ill because of the leaking walls and ceiling in their office. A nurse practitioner from Employee Health stated the symptoms may have been due to environmental conditions at their office. Their immediate supervisor completed an Incident Report describing the incident and the corrective action to be taken.

The report stated water leakage had been occurring for over a year and VAMC management and the property owner were aware of the leaking ceilings and mold. The property owner attempted various repairs, such as replacing damaged ceiling panels, removing damaged insulation, and waterproofing the outside of the building. The supervisor noted the area continued to leak during periods of rain and had a strong noticeable odor, which affected the health of employees assigned to the office. The supervisor also noted the VAMC was "in the process of relocating employees to an unaffected area pending resolution."

The lease agreement states the property owner is responsible for maintaining the building, building systems, and all equipment, and fixtures, and keeping them in good repair and condition. Although the property owner made some repairs, Fiscal Service employees stated the walls and ceilings continue to leak during heavy rains. In addition, the employees stated they had not been relocated to a new workspace. The medical facility's Supervisor of Environmental Safety/Health reported he conducted a full air quality assessment and determined the air quality was at an acceptable level. His initial assessment also concluded water would continue to come in through the walls and ceilings when heavy rain occurred.

While we did not determine what actions are required to stop future water leaks and damage, VAMC management should take further action to improve the safety of its employees' work environment. VAMC management should require the property owner to make the necessary repairs to alleviate the water leakage. If the problem is not resolved, VAMC management should consider moving employees in the affected areas to more suitable workspace.

- Recommendation** 9. We recommended the Veterans Integrated Service Network 1 Director ensure the Providence VA Medical Center Director requires the property owner to make necessary repairs to alleviate future water leaks and damage, and if not repaired, moves employees in the affected areas to a more suitable workspace.

**Management  
Comments  
and OIG  
Response**

The Veterans Integrated Service Network 1 Director agreed with our finding. The Network Director stated the landlord has taken appropriate measures to provide permanent fixes and there have been no work disruptions during the past year. We are closing this recommendation based on the Network Director's response. Appendix C provides the full text of the Network Director's comments.

**Allegation 11**

**A former employee was paid 32 hours of annual leave without providing documentation to support his claim.**

We did not substantiate the allegation that a former VAMC employee was paid 32 hours of annual leave without furnishing the necessary documentation to support his claim.

VA and the former employee reached a settlement agreement. In the settlement agreement, the former employee gave up rights to further claims and the VA agreed to restore the former employee 32 hours of annual leave and pay \$750 in attorney fees. The Merit Systems Protection Board accepted the agreement.

We made no recommendation on this allegation.



**Review  
Conclusion**

We partially or fully substantiated 7 of the 11 allegations made by the complainant. We identified opportunities for management to improve oversight and strengthen controls over financial and administrative activities. Providence VA Medical Center management did not always ensure applicable laws and policies were followed. We identified potential monetary benefits totaling \$4,444 related to inappropriate uses of appropriated funds. Additionally, for two of the four allegations we did not substantiate, we identified issues requiring action and made recommendations to take corrective action.

## Appendix A Scope and Methodology

This report focuses on 11 allegations related to financial and administrative matters at Providence VAMC. We reviewed applicable laws, policies, and procedures that applied to each of the allegations. In addition, the following describes the scope of our review and methodology used to address each specific allegation.

### **Allegations 1 and 2**

To review these allegations, we: interviewed Prosthetics Service, Fee Care, and Fiscal Service staff to obtain an understanding of the FY 2009 year-end activity related to the funding of obligations; interviewed VA Central Office Financial Management and Accounting staff to obtain an understanding of the requirements of the Annual Certification of Accounting Records; and, obtained copies of the VAMC's FY 2009 annual certification to determine whether exceptions were reported and to identify the VAMC officials who signed the certifications.

### **Allegation 3**

To review this allegation, we: interviewed HRM staff to determine the former employee's responsibilities as a contractor within the HR office, obtained the former employee's personnel records to determine her retirement date; reviewed and analyzed the original contract; and, interviewed VISN contracting staff to obtain information on the solicitation process.

### **Allegation 4**

To review this allegation, we: interviewed Patient Services and Dental Service staff to determine the events leading up to the Director's dental procedure; discussed the procedure with the former Chief of Dental Service, who performed the procedure; and, reviewed relevant dental records.

### **Allegation 5**

To review this allegation, we: interviewed Fee Care, Fiscal Service, and Patient Services staff to discuss the local process for obligating funds and to obtain details on the increase of FY 2009 year-end obligations; obtained a copy of the *Estimated Miscellaneous Obligation or Change in Obligation* report that showed the obligation activity and the justification for the year-end increase; and, obtained the FY 2009 *Financial Management System Status of Allowance* report to determine the effect the increase had on the year-end obligation.

### **Allegation 6**

To review this allegation, we: interviewed the Chief of HRM and a contract specialist to determine the local process for obtaining a chaplain; reviewed Federal Acquisition Regulation criteria related to Simplified Acquisition Requirements; reviewed the contract and purchase orders for FYs 2006–2008 to determine the rate and terms of payments to the chaplain; and obtained the 2003 and 2008 Certificates of Eligibles to determine where the chaplain's name appeared on the list.

### **Allegation 7**

To review this allegation, we: interviewed personnel in VA Central Office Accounting Policy Service to obtain information on spending appropriated

funds and reporting requirements related to annual incentive award ceremonies; obtained information from a VA Office of General Counsel attorney on the propriety of using appropriated funds to purchase food; reviewed Government Accountability Office reports and VA policy addressing the use of appropriated funds to purchase food for Government employees; and, obtained copies of purchase orders and specific vendor payment history documenting use of appropriated funds to purchase and rent items related to the annual employee recognition picnic and holiday tea party.

**Allegation 8** To review this allegation, we: reviewed VHA Handbook 1400.05 to determine the responsibilities of individuals involved with oversight and administration of VA's disbursement agreements; and, reviewed two prior internal VA reports on reviews conducted at Providence VAMC addressing issues related to disbursement agreements.

**Allegation 9** To review this allegation, we: interviewed VAMC officials and staff to determine who authorized the paid administrative absence of a service chief; reviewed leave records for this individual to determine whether annual or administrative leave was taken during the period in question; and, reviewed time and leave records from the VA Personnel and Accounting Integrated Data System covering the period from April 29 through September 1, 2007.

**Allegation 10** To review this allegation, we: interviewed VAMC personnel to discuss their recollection of storm damage that affected Government property and potentially resulted in employee health issues; reviewed the Incident Report and Air Quality Report related to the water damage; reviewed Providence VAMC policy and VA Directives related to occupational safety and health; and, reviewed the lease agreement to determine the property owner's responsibilities.

**Allegation 11** To review this allegation, we: reviewed copies of legal documents submitted to the Merit Systems Protection Board; and, reviewed copies of the signed settlement agreement between VA and the petitioner.

**Reliability of Data** To address our review objectives, we obtained a computer-generated payroll data report from the OIG Data Analysis Section for one individual for 2007. We also requested payroll printouts from the Providence VAMC payroll department for the same individual for April through August 2007. We compared the electronic data from the OIG Data Analysis Section with the payroll printouts and concluded that the data were sufficiently reliable for the purpose of our review.

**Government Standards** We conducted our review in accordance with *Quality Standards for Inspections* published by the Council of Inspectors General on Integrity and Efficiency. We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objective. We believe the evidence

obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

**Appendix B Potential Monetary Benefits in Accordance With  
Inspector General Act Amendments**

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
5	The medical center made inappropriate purchases with appropriated funds in FYs 2009 and 2010.	\$4,444	\$0
<b>Total</b>		<b>\$4,444</b>	<b>\$0</b>

## Appendix C Veterans Integrated Service Network Director Comments



**VA** Defining  
**HEALTH** **EXCELLENCE**  
**CARE** in the 21st Century

**VA NEW ENGLAND HEALTHCARE SYSTEM**  
NETWORK OFFICE, BUILDING 61  
200 SPRINGS ROAD  
BEDFORD, MA 01730

**Date:** December 4, 2012

**To:** Assistant Inspector General for Audits and Evaluations (52)

**From:** Network Director (10N1)

**Subj:** OIG Review of Allegations re Financial and Admin Matters VAMC Providence

I have reviewed and concur with the action plans included in the attached memorandum regarding the Review of Allegations at VA Medical Center Providence, Rhode Island.

Sincerely,

A handwritten signature in black ink that reads "Michael Mayo-Smith".

Michael Mayo-Smith, MD, MPH  
Network Director

## OIG Review of Allegations regarding Financial and Administrative Matters at VAMC Providence

**Recommendation 1:** OIG recommends the VISN 1 Director establish controls to ensure the Providence VAMC accurately certifies its Annual Certification of Accounting Records. (*Allegations 1 and 2*)

***Concur:*** The Veterans Health Administration (VHA) Office of the Chief Financial Officer (CFO) manages the Annual Certification of Accounting Records. Explicit directions/updates and important information to follow in performance of due diligence is posted on the VHA CFO Financial Oversight Share point web site. It is the responsibility of the Station CFO, Assistant CFO, Accounting Supervisor, and all Accountants to follow these directions to present to the Facility Director at the time when certifying this document. The expectation is that all responses are appropriate and that the certification is accurately represented by following the instructions provided, which will ensure ongoing compliance. Additional to this there are Department of Veterans Affairs (VA) required Internal/External controls that have been fully implemented by the new facility CFO. The Veterans Integrated Service Network (VISN) will follow up within 6 months to ensure the process remains in compliance.

The following describes the new Internal/External controls:

“Annual Certification of Accounting Records” process to ensure compliance, as follows:

**INTERNAL CONTROLS:** The Providence VAMC has a formal process in place for all services to review obligations and report any deficiencies to Budget as soon as a requirement for additional funds is anticipated. The process requires the service to complete a “needs and excess” analysis with their estimate of costs to establish an obligation to cover anticipated expenses. The request requires a formal submission to the Executive Management Resource Committee (ERMC) by email to:

- 1) Document the request and,
- 2) Establish the requirement for follow up.

By submitting the formal request, budget then needs to:

- o Adjust funding to cover the request
- o If no resources are available on station, then a request to VISN Budget is made to assist in covering the obligation
- o If no funding is available internally, or at the VISN, to then report the unrecorded obligation in the Annual Certification letter

Budget has a process with all services and specifically with Prosthetics to cover emergency orders at end of year. The process again covers the above three funding steps, and if not covered internally will be reported as unrecorded in the Annual Certification.

**EXTERNAL CONTROLS:** Previously, the Certification only required the Director and CFO signature after reviewing the requirement for the certification. The process now requires a comprehensive review of each requirement with a positive “YES” or negative “NO” with an explanation or backup for each of the responses. This process put more emphasis on the response and certification process.

**Recommendation 2:** OIG recommends the VISN 1 Director ensures the Providence VAMC Director terminates this contract, and if the services are still needed, recruits and hires under appropriate civil service procedures. (*Allegation 3*)

***Concur:*** The contract for this employee was terminated effective September 30, 2012. Because this employee has held a critical role in quality review of all recruitment and placement actions for more than 30 years, the difficulties that the organization has had in finding a suitable replacement, and the significant need to transition these functions effectively to the Assistant Chief of Human Resources (HR) at the facility, a temporary appointment not to exceed 120 days is being processed to effect a smooth transition.

The VISN will follow up within 3 months to ensure that this temporary appointment does not exceed the 120 day time frame as indicated.

**Recommendation 3:** OIG recommends the VISN 1 Director require the Providence VAMC Director to implement controls ensuring all fund obligations are accompanied by supporting documentation to justify the obligation as required by law. (*Allegation 5*)

***Concur:*** Controls have been implemented to ensure compliance. Attached is the Facility Executive Resource Management Committee (ERMC) Policy Memorandum which is the formal process to be followed on Station which provides the mechanisms to ensure ongoing compliance. The VISN will follow up within 6 months to ensure the process remains in compliance.

The following summarizes controls to ensure compliance for supporting documentation to justify obligations:

**INTERNAL CONTROLS:** The Providence VAMC has a formal process in place for all services to review obligations and report any deficiencies to Budget as soon as a requirement for additional funds is anticipated. The process requires the service to complete a “needs and excess” analysis with their estimate of costs to establish an obligation to cover anticipated expenses. The request requires a formal submission to the Executive Management Resource Committee (ERMC) by email to:

- 1) Document the request
- 2) Establish the requirement for follow up. The request that is submitted to the ERMC must be supportable and provide adequate documentation to identify the services to be purchased.

**EXTERNAL CONTROLS:** In Fiscal Year (FY) 2011 and 2012, the Department of Veterans Affairs established new controls over miscellaneous 1358 obligations. The new controls not only covered changes in software, but also enforced segregation of duties in the 1358 process over Requesting/ Approving and Certifying Officials. By implementing the new controls this has strengthened the 1358 process, and makes it incumbent to follow the documentation process in establishing proper obligations.

**Recommendation 4:** OIG recommends the VISN 1 Director ensure service contracts are awarded based on adequate competition or, if competition is not feasible, are supported by limited or sole-source justifications as required by Federal Acquisition Regulation. (*Allegation 6*)

***Concur:*** The contracting functions have been centralized to the Acquisition Resource Center (ARC) and are no longer supervised by Providence VA Medical Center (VAMC) leadership. New procedures and monitors have been implemented to ensure all contracts are processed and awarded in accordance with the Federal Acquisition Regulations (FAR). Contracts are awarded based on adequate competition or if competition is not feasible, awards must be supported by limited or sole-source justifications as required by FAR.



**Recommendation 5:** OIG recommends the VISN 1 Director ensure the Providence VAMC Director establishes controls to ensure appropriated funds are used only for the intended purpose of the appropriation. (Allegation 7)

**Concur:** *In fiscal years (FY) 2010 and 2011 the VA Office of Management mandated training for all accountants through a series of Financial Management Training Conferences. The instruction mandated that all accountants attend at least one of the conferences. One of the courses offered covered Appropriation Law and guidelines. The Facility CFO (4/2010), ACFO (12/2010) and Accounting Supervisor (8/2010) attended the training as indicated. They hold responsibility for overseeing correct appropriation of funds. The VISN will follow up within 6 months to ensure the process remains in compliance.*

**Recommendation 6:** OIG recommends the VISN 1 Director ensure the Providence VAMC Director requires the Designated Education Officer to obtain and oversee annual rate changes for disbursing agreements. (Allegation 8)

**Concur:** *In accordance with Federal regulation, Providence VAMC has initiated a change of responsibility. At the time of the investigation the CFO had the responsibility for obtaining the annual rate changes and communicating them to the Chief of HR and the Designated Education Officer (DEO). Since then, the DEO has assumed the responsibility of obtaining annual rate changes and communicating them to the CFO, and Chief of HR and also oversees annual rate changes for disbursement for residents and fellow trainees at the Providence VAMC. The VISN will follow up within 6 months to ensure the process remains in compliance.*

**Recommendation 7:** OIG recommends the VISN 1 Director ensure the Providence VAMC Director charges the Chief of Facilities Management Service 25 days of annual leave because his absence was not supported by an approved written justification. (Allegation 9)

**Concur in principle:** *After an exhaustive review of this complex occurrence and in consultation with HRA and after receiving guidance from the Office of Personnel Management (OPM), the employee will be required to pay back 21 days as per payroll/HR processes. The guidance received from OPM states that "an employee is entitled to be paid time off without charge to leave for service as a juror or witness". This was the factor that determined a pay back of 21 days was appropriate.*

*According to the employee, a verbal request for Authorized Absence (AA) for court proceedings was initiated to the Chief of Human Resources and Associate Director of Operations. Subsequently, the Associate Director of Operations signed and approved timecards during this time period. There were no written requests initiated. The employee was a witness for 4 days and plaintiff for 14 days. The Director will charge the Chief of Facilities Management Service 21 days of annual leave.*

**Recommendation 8:** OIG recommends the VISN 1 Director ensure the Providence VAMC Director institutes a control that ensures at the point timecards are certified appropriate documentation in support of approved excused absences is in place. (Allegation 9)

**Concur:** *Personnel who perform timekeeper functions receive initial education and annual competency assessments. Providence VAMC currently has 75 timekeepers. Prior to performing timekeeper duties, an individual must certify to Information Resources Management that they have received training from the Fiscal Payroll Department. This training includes instructions about how to properly record court/jury leave. The Fiscal Payroll Department annually will update the training materials for any new information and appropriate inform timekeepers. Timekeepers must self certify that they have reviewed the new training material by email to the Payroll Department. Additionally the Payroll Department will semiannually perform Timekeeper audits to ensure that:*

- 1) *Each payroll technician is responsible for auditing their own time & leave units.*
- 2) *The audit is done during week 2 of the pay period.*
- 3) *The following items are reviewed: timecards are posted daily, leave posted correctly, and Overtime/ Compensatory Time posted correctly.*
- 4) *Premium pay remark codes are correctly posted.*
- 5) *Military orders, jury duty summons, etc. are provided if such leave is posted to timecard.*

*The current Providence VAMC compliance with the education requirement is 100%. The VISN will follow up within 6 months to ensure the process remains in compliance.*

**Recommendation 9:** *OIG recommends the VISN 1 Director ensure the Providence VAMC Director requires the property owner to make necessary repairs to alleviate future water leaks and damage, and if not repaired, moves employees in the affected areas to a more suitable workspace. (Allegation 10)*

**Concur:** *Water leaks in this building have occurred in the past due to wind-driven rain. The VISN 1 Director has reviewed these instances and found that in every instance they were addressed immediately by the landlord. In addition, the landlord has taken appropriate measures to provide permanent fixes and there have been no disruptions to work for the past year.*

## **Appendix D Office of Inspector General Contact and Staff Acknowledgments**

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Nick Dahl, Director John Cintolo James McCarthy
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