2011-02935-IQ-0115

Department of Veterans Affairs

Memorandum

Date: March 7, 2012

From: Assistant Inspector General for Investigations (51)

Subj: Administrative Investigation, Misuse of Time and Resources, VA Ambulatory Surgery Unit, United States Air Force Academy, Colorado Springs, Colorado (2011-02935-IQ-0115)

To: Director, VA Eastern Colorado Health Care System

1. VA Office of Inspector General Administrative Investigations Division investigated allegations that (b) (7)(C) (b) (7)(C) employed by Colorado Anesthesia Services (CAS), failed to report on 13 days that she was to work at VA and that (b) (7)(C) located at the U. S. Air Force Academy (USAFA), failed to disclose (b) (7)(C) s absences, (b) (7)(C) and (b) (7)(C) also allegedly solicited and accepted gratuities and (b) (7)(C) and Dr. Peter D'Ambrosia, USAFA Attending Physician, allegedly misused resources when he injected (b) (7)(C) who was not a veteran patient, with prescription medication while both were on duty. To assess these allegations, we interviewed (b) (7)(C) Dr. D'Ambrosia; (b) (7)(C) Dr. Thomas Whitehill, Chief of Surgical Services, VA Eastern Colorado Health Care System; and CAS employees. We also reviewed email, pay, and contract records, as well as Federal laws, regulations, and VA policy.

2. We concluded that (b) (7)(C) failed to report for duty and did not coordinate leave as required by VA's contract and that (b) (7)(C) did not establish and maintain proper time and attendance records for contractor services prior to certifying payment. We suggest that you ensure that (b) (7)(C) maintains appropriate time and attendance records to comply with the VA contract for anesthesia services. We also suggest that (b) (7)(C) receive refresher training on ethics regulations concerning gifts and gratuities from contractors. Further, we found that Dr. D'Ambrosia misused resources when he injected (b) (7)(C) with prescription medication during their VA tour of duty. We suggest that Dr. D'Ambrosia receive refresher training on his roles and responsibilities as a VA physician. We also found an ambiguity in the chains of command for VA, contractor, and USAFA employees, and although Dr. Whitehill created new organizational charts in an effort to address this issue, we found that there was still confusion at the facility. We suggest further distribution and explanation of reporting chains to medical professionals working at the facility. We are providing this memorandum to you for your information and official use and whatever action you deem appropriate. **No response is necessary.**

Misuse of Time and Attendance

3. Federal acquisition regulations state that Government contractors must conduct themselves with the highest degree of integrity and honesty. 48 CFR § 3.1002. Contract

records reflected that VA contracted with CAS for 40 hours of anesthesia coverage per week, on-call telephone coverage on weeknights, and overtime as needed at the USAFA. The contract required that the contractor be present at the medical treatment facility and be actually performing the required services for the period specified in the contract and that the contractor not invoice for any time that they were not physically present at the USAFA performing services. VA259-P00781, dated April 1, 2010. Contract records stated that the contract anesthesiologist must send an email to the COTR within 24 hours after performing overtime, stating the date and number of hours worked and that the information provided was true and accurate. In addition, the contract prohibited the contractor from invoicing any time that its employees were not physically present at the USAFA performing services. Id., at Section B.4, Subsection 1.2.3. The contract stated that services performed by the contractor must be performed in accordance with VA policies, procedures, and regulations of the medical staff by-laws of the VA facility. Section B.5, subsection 1c. Moreover, the contract stated that the anesthesiologist must be present at the Ambulatory Surgery Unit at USAFA; must be actually performing the required services for the period specified in the contract; and that CAS's monthly invoices would be reduced by a prorated amount for services billed but not performed. Id., at Section B.5, Subsection 12.

4. Contract records reflected that the COTR was required to establish and maintain a record-keeping system that recorded the services performed by anesthesiologists and that the records consist of time and attendance logs to ensure that required services were received. Further, any incidents of contractor non-compliance as evidenced by the monitoring procedure must be forwarded immediately to the Contracting Officer; documentation of services performed must be reviewed prior to certifying payment; and contract monitoring and record-keeping procedures must be sufficient to ensure proper payment and allow audit verification that services were provided. Id., at Section B.5, Subsection 25a and b.

5. (b) (7)(C) told us that she conducted a fact-finding inquiry based on allegations she received that were identical to those sent to OIG. The allegations included 11 dates between November 2010 and April 2011 that (b) (7)(C) was absent for the entire workday and 2 when she left 4 hours early. For the fact-finding, (b) (7)(C) reviewed physician notes, and based on her review she concluded that (b) (7)(C) was not present at the clinic for 10 of the 11 dates. To address the results of her inquiry, (b) (7)(C) met with (b) (7)(C) and (b) (7)(C) on April 27, 2011. (b) (7)(C) s Report of Contact reflected that (b) (7)(C) told (b) (7)(C) that she (b) (7)(C) was away from her duty station on the identified dates but that (b) (7)(C) authorized it. (b) (7)(C) said that she worked overtime and instead of charging VA for the overtime, she took off those days. The Report of Contract reflected that (b) (7)(C) told (b) (7)(C) that she never gave (b) (7)(C) permission to take time off in a paid or unpaid status and that she assumed that when (b) (7)(C) was not at her duty station, she coordinated her leave with (b) (7)(C) (b) (7)(C) told us that (b) (7)(C) told her when she would be out of the office; however, she said that if (b) (7)(C) thought that (b) (7)(C) could approve her leave, it would be a misunderstanding on the part of (b) (7)(C)

6. Email records reflected that following the April 27 meeting, a CAS employee told (b) (7)(C) that CAS would discount $15,628.80 from her April month-end payroll and remove 88 hours from the VA April 2011 invoice to account for the 13 days that (b) (7)(C) was not present or left early. CAS records reflected that for the April 2011 billing cycle, they subtracted $15,628.80 from (b) (7)(C) s pay and invoiced VA for the time that (b) (7)(C) worked minus 88 hours. (b) (7)(C) said in an email to a CAS employee, (b) (7)(C) Dr. Whitehill, and others that on 7 of the days that she was away from the facility, she was delivering paperwork and performing "other work related duties in Denver." (b) (7)(C) told us that she volunteered to perform these administrative tasks until a courier service was arranged, since she lived "pretty close" to the Denver VA Medical Center. (b) (7)(C) said that on 2 of the days she did not have clinical duties; on 2 other days she was present at the clinic; and on 1 day she was at the Denver VA Medical Center.

7. (b) (7)(C) told us that she did not report overtime she worked earlier in the week to compensate for the time that she was absent from the clinic or that she delivered documents to Denver. She said that she thought that was acceptable, since a September 7, 2010, email she received from (b) (7)(C) authorized her to leave at noon on a specific workday and stated that she had until the end of the billing cycle to make up the hours. However, (b) (7)(C) could not recall if she averaged the overtime on a weekly or a monthly basis, but she said that she "probably" averaged the hours per week, which would be "the easiest thing" for her. (b) (7)(C) could not provide us any timekeeping or other records reflecting any overtime worked, and she did not comply with our request for copies of her work calendar. (b) (7)(C) and a CAS employee all told us that CAS deducted $15,628.80 from the amount they invoiced VA, due to (b) (7)(C) s absences.

8. The Report of Contract reflected that (b) (7)(C) explained to (b) (7)(C) that the VA contract with CAS "clearly states the process for leave usage" to which (b) (7)(C) did not adhere, and that "overtime costs were written into the contract and VA was prepared to compensate as outlined in the contract." CAS invoice records reflected that (b) (7)(C) began submitting overtime in May 2011, the month following this meeting.

9. (b) (7)(C) told us that she did not, as the contract required, establish and maintain a recordkeeping system for (b) (7)(C) s time and attendance which would allow her to review services performed prior to certifying payment. She said that since she was not physically located at the same facility, her current recordkeeping practices, which involved examining medical records, made it difficult to account for every day that (b) (7)(C) was to be present. She also said that had time and attendance logs existed, as (b) (7)(C) for the contract, she would be responsible for maintaining those logs.

Gratuities

10. The Standards of Ethical Conduct for Employees of the Executive Branch state an employee shall not solicit or accept any gift or other item of monetary value from any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency. 5 CFR § 2635.101(b)(4). The standards require employees to endeavor to avoid any actions creating the appearance that they are violating the law or

ethical standards. Whether particular circumstances create an appearance that the law or standards have been violated shall be determined from the perspective of a reasonable person with knowledge of the relevant facts. 5 CFR § 2635.101(b)(14).

11. (b) (7)(C) told us that in her inquiry she addressed the allegation that (b) (7)(C) gave gifts to (b) (7)(C) to include cosmetic products, a bicycle, and exercise equipment during her fact-finding. (b) (7)(C) and (b) (7)(C) both told us that (b) (7)(C) offered to lend (b) (7)(C) her bicycle when (b) (7)(C) began an exercise regimen. (b) (7)(C) told us that during her meeting with (b) (7)(C) she instructed (b) (7)(C) to immediately return the bicycle to (b) (7)(C), which (b) (7)(C) agreed to do. (b) (7)(C) told us that she had it for 3 to 4 months and that she returned it when (b) (7)(C) told (b) (7)(C) that she wanted the bicycle back. (b) (7)(C) told us that her returning the bicycle had "nothing to do" with believing the action was improper. (b) (7)(C) said she did not consider the bicycle a gift or an item of value, because she said that she planned to use it and give it back to (b) (7)(C). (b) (7)(C) told us that (b) (7)(C) also gave her two or three resistance bands, which according to (b) (7)(C)'s report had a relative value of $3.00 to $5.00. (b) (7)(C) and (b) (7)(C) told us that (b) (7)(C) gave (b) (7)(C) used bottles of a cosmetic product, which she valued at $40.00 to $50.00. (b) (7)(C) told us that during their meeting, (b) (7)(C) told (b) (7)(C) that she would dispose of the product. (b) (7)(C) and (b) (7)(C) told us that (b) (7)(C) returned the cosmetic product to (b) (7)(C), because (b) (7)(C) did not like the product.

12. Although training records reflected that (b) (7)(C) received healthcare ethics training in June 2010, she told us that she did not know, at the time, that Federal regulations prohibited a Federal employee from accepting gifts or things of monetary value from VA contractors.

Misuse of Resources

13. Federal regulations state an employee has a duty to protect and conserve Government property and shall not use such property, or allow its use, for other than authorized purposes. 5 CFR § 2635.704(a). They further state that an employee must use official time in an honest effort to perform official duties and that employees have an obligation to expend an honest effort and a reasonable proportion of his time in the performance of official duties. Id., at 2635.705(a).

14. (b) (7)(C)'s fact-finding did not address an allegation that (b) (7)(C) asked a VA physician, Dr. D'Ambrosia, to inject her with prescription medication. (b) (7)(C) told us that in the fall of 2010 and while on duty, she had a conversation with Dr. D'Ambrosia about pain that she felt in her knee and that during their conversation Dr. D'Ambrosia offered to inject steroids into (b) (7)(C)'s knee. She said that she did not know if Dr. D'Ambrosia brought the steroids from home or if he obtained them from VA inventory. Dr. D'Ambrosia told us that while he and (b) (7)(C) were on duty, he examined her knee and told her that she had "a very simple diagnosis" that "probably" needed a steroid injection. He said that at that time, he offered to get (b) (7)(C) an appointment with another doctor at the University of Colorado Hospital orthopedic clinic where he also worked. Dr. D'Ambrosia further said that (b) (7)(C) approached him shortly thereafter with the needed steroids and asked him to

inject them into her knee, which he said that he did. Dr. D'Ambrosia could not tell us if the steroids used for the injection were from VA inventory or not and that he did know where (b) (7)(C) got the medication.

15. Although (b) (7)(C) did not address the issue of Dr. D'Ambrosia injecting steroids into (b) (7)(C) 's knee while both were on duty, Dr. Whitehill told us that he spoke to Dr. D'Ambrosia about the "difference between good samartitanism and appropriate clinical behavior" shortly after learning of the incident. However, Dr. D'Ambrosia told us that he and Dr. Whitehill never discussed the matter.

16. Dr. D'Ambrosia told us that he provided medical treatment to a certified registered nurse anesthetist who suffered a wrist injury after falling while on duty at the USAFA facility. He said that he told Dr. Whitehill of that incident for "clarification" on regulations regarding treating a patient on VA time. He said that Dr. Whitehill offered no other information other than "he understood and just left it at that." He also said that he "definitely followed regulations since" and provided two more recent examples of times that he did not provide medical attention to VA employees when asked to do so.

17. Records of (b) (7)(C) s fact-finding inquiry reflected that she took appropriate action to remove (b) (7)(C) as key personnel from the CAS contract. (b) (7)(C) told us that she would no longer provide regular anesthesia support to VA after September 8, 2011. Records also reflected that (b) (7)(C) instructed (b) (7)(C) to not "accept gifts from contract staff for any reason." (b) (7)(C) and Dr. Whitehill told us that they asked (b) (7)(C) to prepare and give a presentation on ethics for VA staff located at the USAFA facility. Dr. Whitehill told us that he attended and that the presentation was "good" and centered on conflicts of interest.

Reporting Chain Ambiguity

18. Dr. Whitehill told us that employees located at the USAFA facility asked him to create a new organizational chart to remove "ambiguity" in the reporting chain. He said that (b) (7)(C) "watch[ed] over a clinical operation" for which she did not have sufficient experience and that placing (b) (7)(C) in an administrative role over clinicians was "probably not the right thing to do." Dr. Whitehill said that there was another nurse manager, (b) (7)(C) creating "two pathways of information exchange. One was from the clinical side, by (b) (7)(C) . The other was from the administrative side by (b) (7)(C) Dr. Whitehill also said that Air Force personnel expressed concern to him, because he said that they "weren't quite sure who to talk to about different matters." Records reflected that Dr. Whitehill drafted a new organizational chart with only (b) (7)(C) placed in a supervisory role for the clinicians at the facility.

19. Dr. Whitehill told us that the chart was created and distributed about July 25, 2011; he met with employees; and employees at the facility should no longer be confused. However, Dr. D'Ambrosia told us that he believed that (b) (7)(C) was still in a supervisory role at the clinic. Further, records reflected that (b) (7)(C) was confused and misunderstood the

parameters of [redacted] authority, because she said that she believed that [redacted] had the authority to modify [redacted] schedule.

Conclusion

20. We concluded that [redacted] failed to report for duty and did not coordinate leave as required by VA's contract and that [redacted] did not establish and maintain proper time and attendance records for contractor services prior to certifying payment. We suggest that you ensure that [redacted] maintains appropriate time and attendance records to comply with VA's contract for anesthesia services. We also suggest that [redacted] receive refresher training on ethics regulations concerning gifts and gratuities from contractors. Further, we found that Dr. D'Ambrosia misused resources when he injected [redacted] with prescription medication during their VA tour of duty. We suggest that Dr. D'Ambrosia receive refresher training on his roles and responsibilities as a VA physician. We also found an ambiguity in the chains of command for VA, contractor, and USAFA employees, and although Dr. Whitehill created new organizational charts in an effort to address this issue, we found that there was still confusion at the facility. We suggest further distribution and explanation of reporting chains to medical professionals working at the facility.

21. We are providing this memorandum to you for your information and official use and whatever action you deem appropriate. It is subject to the provisions of the Privacy Act of 1974 (5 U.S.C. § 552a). If you have any questions, please contact [redacted]

[redacted]