

## VA OIG Podcast Transcript 20180201-9

OIG Highlights January 2018

January 2018

[LaTasha Smith] This is LaTasha Smith, a management and program analyst, with the VA Office of Inspector General in Atlanta. Here are January's highlights.

Inspector General Missal participated in a roundtable discussion convened by the House Committee on Veterans' Affairs' Subcommittee on Health. The roundtable focused on VA's efforts to address deficiencies identified by the General Accountability Office (or GAO) that led to VA being put on the High-Risk List. GAO's High-Risk List is updated about every two years. It calls attention to the agency program areas and processes that are at most risk of fraud, waste, abuse, and mismanagement. The roundtable discussions examined what reforms are needed to remove VA from the list.

The *VA Fraud Waste and Abuse Advisory Committee* invited Inspector General Missal to attend their January meeting. He provided an overview about the OIG's work; findings from some of our recent work, including the Choice program; and answered questions from the group.

The OIG hosted representatives of eight veterans service organizations in a meeting with the Inspector General and OIG senior staff. The meeting continued the OIG's dialogue with leaders from organizations serving veterans and their families. Attendees shared their concerns and their ideas for issue areas that the OIG could consider for oversight in order to improve VA programs and operations.

The OIG's Atlanta office hosted the Inspector General for a two-day site visit where he held a town hall, presented awards, and met individually with staff. He also joined a team from the Denver Benefits Inspection Division on their site visit to the Atlanta VA Regional Office as a part of the ongoing *National Review of Denied PTSD Claims Due To Military Sexual Trauma*. At the regional office, Inspector General Missal met with the director, interviewed managers, and observed staff involved in disability compensation claims processing.

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The VA OIG published sixteen oversight reports in January, including Comprehensive Healthcare Inspection Program Reviews (or CHIPS) conducted at the *New Mexico VA Health Care System in Albuquerque, South Texas Veterans Healthcare System in San Antonio, Minneapolis VA Health Care System, VA Southern Oregon Rehabilitation Center and Clinics, Grand Junction Veterans Health Care System in Colorado, and the Huntington VA Medical Center in West Virginia*. The CHIP reviews include a focus on how leadership impacts the quality of care delivered in the inpatient and outpatient settings of the facilities. For these six facilities, OIG issued a total of 65 recommendations for improvement.

Other reports looked at important issues such as how VA manages disruptive behavior in facilities, medical center network security, women's health care issues, management of medical support assistant workforces, and improper relocation allowances and locality pay.

For more information on these and other OIG activities, or to report waste, abuse, mismanagement, fraud, or other possible criminal activity, visit the OIG website at V-A dot G-O-V backslash O-I-G.