

VA OIG Podcast Transcript 20180531-16

OIG Highlights May 2018

May 2018

[Octavia Robotham] This is Octavia Robotham, with the VA Office of Inspector General in Washington, D.C. Here are the May highlights.

The OIG published its *Semiannual Report to Congress* (or SAR), chronicling the office's oversight of the Department of Veterans Affairs between October 1, 2017 and March 31, 2018. During this six-month period, OIG issued 155 reports and work products on VA programs and operations. Those products identified more than \$1.6 billion in monetary impact, for a return on investment of \$25 for every dollar expended on OIG oversight. The SAR is available on the OIG's website.

Inspector General Michael Missal testified before the House Committee on Veterans' Affairs at the hearing *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure*. Inspector General Missal's remarks highlighted the deficiencies the OIG team identified during its review of the Washington DC VAMC. The review highlighted the breakdown of supply chain and inventory systems that made it difficult to get medical supplies to patient care areas when needed. It also highlighted long-standing deficiencies in sterile processing, backlog of prosthetic requests, staffing shortages, inefficient leadership at multiple levels, and a culture of complacency at the hospital that allowed problems to persist. The report is also available on the VA OIG website. Additionally, Inspector General Missal addressed several questions from committee members on the role of regional VA offices in overseeing troubled medical facilities.

Inspector General Missal attended the 2018 Council of the Inspectors General on Integrity and Efficiency conference on leveraging diverse talents in a changing federal environment. The annual conference provides the Inspectors General the opportunity to gather as an oversight community to discuss multiagency concerns. The OIG is seeking a diverse and committed workforce, so please check out our LinkedIn page if you want to explore career opportunities.

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Also in May the OIG published 10 oversight reports including four Comprehensive Healthcare Inspection Program or (CHIP) reviews.

Of note, the OIG's audit on *VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017* (or IPERA) reviewed whether VA complied with the requirements of the Act for fiscal year 2017. The OIG found that the VA met four of six IPERA requirements and did not fully comply with two requirements for that time period. The OIG recommended the Veterans Health Administration and the Veterans Benefits Administration develop a timeline to take corrective action and implement steps to reduce improper payments for its applicable programs and activities.

Also, the OIG conducted Comprehensive Healthcare Inspection Program reviews (or CHIPS) at the VA Sierra Nevada Health Care System in Reno, Nevada; VA Puget Sound Health Care System in Seattle; Cincinnati VA Medical Center; and the William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina. 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 four facilities, the OIG issued a total of 28 recommendations for improvement.

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.