



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT AUGUST 2018 HIGHLIGHTS

AUGUST 2018

Dr. Melanie Krause:

This is Dr. Melanie Krause, the Assistant Inspector General for the Office of Management and Administration within the VA Office of Inspector General in Washington, DC. Here are the August highlights:

Inspector General Michael Missal released the OIG's new strategic plan for 2018 to 2022. The plan outlines the OIG's goals, objectives, strategies, and measures for achieving our mission of serving veterans and the public by conducting effective oversight of VA programs and operations.

Additionally, the plan refines the OIG's vision and values. If you missed it, Inspector General Missal discussed the plan on a previous OIG podcast, which is available on the VA OIG website.

The OIG's Office of Investigations concluded its work with the FBI and IRS's Criminal Investigation division on a joint case that resulted in the sentencing of a parking lot owner to 70 months in federal prison.

He was convicted for orchestrating a long-running bribery scheme in which he stole \$13 million that should have been paid to VA as part of a contract for operating parking facilities on the VA's Los Angeles medical campus.

Turning to this month's publications, Inspector General Missal and OIG senior staff briefed Senator Tammy Baldwin and her staff on the OIG's report on a *Review of Two Mental Health Patients Who Died by Suicide at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin*.

The OIG conducted a healthcare inspection to assess the care of a patient who committed suicide less than 48 hours after being discharged from the Madison facility. During the inspection the OIG learned of a second patient death by suicide that occurred 13 months prior to the first patient's death.

The inspection found multiple areas of concern regarding the quality of care received by both patients. The OIG made 11 recommendations for improvement to strengthen programs, processes, policies, and clinical staff training.

In the report, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, the OIG reviewed whether staff followed proper procedures for processing veterans' claims of PTSD related to sexual trauma experienced while serving in the military prior to denying those claims.

The OIG estimates, based on its sample, that Veterans Benefits Administration staff incorrectly processed about 1,300 of the 2,700 (more than half) of the military sexual trauma-related claims denied during the review period.

This may have resulted in the denial of benefits to veterans who could have been entitled to receive them. The OIG made six recommendations to the Under Secretary for Benefits including that staff review all of the approximately 5,500 such claims denied from October 2016 through September 2017.

The OIG also issued its audit report on the Veterans Health Administration's Program of Comprehensive Assistance for Family Caregivers to determine if services were effectively provided to qualified veterans and their caregivers.

The OIG found that veterans and their caregivers did not receive consistent access to the program.

Caregiver support coordinators also did not determine eligibility within the required 45 days for about 65 percent of the more than 1,800 veterans approved for the program during the audit period. Among other findings, VA staff did not correctly apply eligibility criteria when enrolling veterans. Ineligible veterans who were discharged from the program during the audit period had caregivers who received \$4.8 million in improper payments.

The OIG made six recommendations related to additional program oversight and measures to improve the accuracy of eligibility determinations.

In all, the OIG published 21 oversight reports in August, including an examination of such additional topic areas as Intraoperative Radiofrequency Ablation and other Surgical Service Concerns, Use of Otherwise Classified Codes for Prosthetic Limb Components, and the Misuse of Time and Resources.

Of the 21 reports, 11 were Comprehensive Healthcare Inspection Program reports (or CHIPS). These CHIP reviews include a focus on how leadership impacts the quality of care delivered in the inpatient and outpatient settings of the facilities.

The 11 facilities inspected were the Central Arkansas Veterans Healthcare System; the Bay Pines, Florida, VA Healthcare System; the Chillicothe VA Medical Center in Ohio; the Tomah VA Medical Center in Wisconsin; the Beckley VA Medical Center in West Virginia; the VA Ann Arbor Healthcare System; the Dayton, Ohio, VA Medical Center; the Erie VA Medical Center in Pennsylvania; the John J. Pershing VA Medical Center in Missouri; the Ralph H. Johnson VA Medical Center in South Carolina; and the VA St. Louis Health Care System.

For these 11 facilities, the OIG issued 54 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.