



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT OCTOBER 2018 HIGHLIGHTS

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Cynthia Watson:

This is Cynthia Watson, a Senior Program Analyst with the VA Office of Inspector General's Hotline division in Washington, DC. Here are the October highlights:

The VA OIG's oversight work was recognized by the Inspector General community with four awards for excellence, including the prestigious Gaston L. Gianni, Jr. Better Government Award. On October 17, Inspector General Michael Missal and representatives from the selected teams accepted these awards on behalf of the VA OIG at the annual ceremony of the Council of the Inspectors General on Integrity and Efficiency.

The OIG published five oversight reports in October. In the report on the *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide at the Minneapolis VA Health Care System*, the OIG team assessed allegations concerning the Sterile Processing Services (or SPS). The team substantiated several complaints including that SPS equipment was tampered with, sterile sets were missing instruments, surgical procedures were delayed because sterile instruments were unavailable, and that SPS experienced staffing shortages. The Interim Veterans Integrated Service Network and Facility Directors concurred with the OIG's 12 recommendations.

We also released a report about VA's mismanagement of the *Emergency Cache Program*. That program is responsible for stockpiling a standard supply of drugs and medical supplies at 141 VA medical facilities around the country for use in an emergency. The OIG found some caches had expired, or had missing or excess drugs that undercut mission-readiness. The OIG made seven recommendations for corrective action.

Three Comprehensive Healthcare Inspection Program reports (or CHIPS) were also released for the Charles George VA Medical Center in Asheville, North Carolina; the VA Boston Healthcare System; and the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. For these three facilities, the OIG issued 24 recommendations for improvement.

The OIG's Office of Investigations concluded its work in a joint investigation with the FBI regarding a \$2 million scheme to defraud the VA of education benefits. A former VA official pleaded guilty to his role in demanding and receiving bribes from three for-profit schools in exchange for enrolling disabled veterans in those schools and facilitating VA's payments. This was the fourth individual to plead guilty as part of this investigation.

For more information on these reports, or to report wrongdoing, visit the OIG website at www.va.gov/oig.