



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT DECEMBER 2018 HIGHLIGHTS

DECEMBER 2018

Nancy Barsamian:

This is Nancy Barsamian, a health systems specialist with the VA Office of Inspector General in Bedford, Massachusetts. Here are the December highlights:

VA Inspector General Michael Missal joined DOJ Inspector General Michael Horowitz (Chair of the Council of the Inspectors General on Integrity and Efficiency) to meet with former President Jimmy Carter at his Presidential Library and Museum in Atlanta. The meeting was one of the 40th Anniversary events commemorating passage of the *Inspector General Act*. Inspectors General Missal and Horowitz presented President Carter with a signed picture of all current Inspectors General in appreciation for President Carter's signing of the Act.

The OIG's Assistant Inspector General for the Office of Healthcare Inspections Dr. David Daigh received the 2018 Presidential Rank Award of Distinguished Executive. The award is one of the most prestigious honors conferred to the career Senior Executive Service (or SES) by the President of the United States. Only one percent of the career SES may receive this rank. Dr. Daigh is a board-certified neurologist, certified public accountant, engineer, and retired Army Colonel. He has published more than 1,600 healthcare OIG oversight reports, testified at over a dozen congressional hearings, and conducted hundreds of briefings on how to improve healthcare services to veterans in such areas as crisis call responses, traumatic brain injury, military sexual trauma, and pain management. The OIG is proud and honored to have Dr. Daigh leading its efforts to improve care for the millions of veterans receiving VA health services.

The OIG published 20 oversight reports in December including 15 Comprehensive Healthcare Inspection Program (or CHIP) reviews. For the 15 facilities that received a CHIP review, the OIG issued a total of 81 recommendations for improvement.

Among the other releases, the OIG issued a report of *VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students*. The OIG estimated that 86 percent of State Approving Agencies did not adequately oversee the education and training programs to make certain only eligible programs participated. Lack of programs' documentation for continuing their eligibility to receive Post-9/11 GI Bill funds and unsupported marketing claims gave the Veterans Benefits Administration and taxpayers little assurance that VA funds—more than an estimated \$580 million annually—were being properly used for quality instruction for veterans and their dependents. The OIG made six recommendations to strengthen program compliance.

# VA Office of Inspector General

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The OIG also published the report *Inadequate Governance of the VA Police Program at Medical Facilities* that audited the VA security and law enforcement program. The OIG found that VA did not have adequate and coordinated governance over its police program to ensure effective management and oversight for its approximately 4,000 police officers serving 139 medical facilities. The problems stemmed from confusion about police program roles and authority as well as the lack of a coordinated or centralized governance structure. The OIG made five recommendations to improve the staffing and management of VA's police program.

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