PODCAST TRANSCRIPT

JANUARY 2019 HIGHLIGHTS

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Host Lance Vanderhoof:

This is Lance Vanderhoof, a project manager with the VA Office of Inspector General in Salt Lake City, Utah. Here are the January highlights:

Inspector General Michael Missal appeared as a guest on two news shows: *Government Matters* and *Federal Drive*.

On *Government Matters,* which is a DC affiliate program for ABC that covers the federal government, the IG and host Francis Rose discussed some of VA's Major Management Challenges and how the OIG identifies these challenges and tracks trends. They also talked about VA's track record for implementing OIG recommendations and the difficulties faced by leaders trying to effect change while in acting instead of permanent positions.

Tom Temin, host of the series *Federal Drive* on the *Federal News Network*, interviewed Inspector General Missal about the findings in OIG's two recent reports *Inadequate Governance of the VA Police Program at Medical Facilities* and *Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments*.

The OIG published six oversight reports in January including one Comprehensive Healthcare Inspection Program (or CHIP) report. In addition to looking at how leadership and other key factors affect the care delivered in the inpatient and outpatient settings at the DC VA Medical Center, this report also includes an appendix with spot-checks conducted on the hospital's progress in implementing several OIG recommendations from the report on *Critical Deficiencies at the Washington DC VA Medical Center*. The OIG's unannounced comprehensive inspection report included 18 recommendations to improve administration and clinical care at the facility. As to the spot-checking conducted, the OIG Rapid Response Team found the facility was taking steps in the right direction in improving supply availability, addressing the backlog of prosthetic consults, and several other areas. Frequent changes in key leadership positions, however, was continuing to impede the facility's progress on a number of improvement initiatives. Additional time and oversight is needed to evaluate whether the facility's fully implemented action plans will be effective in addressing and remediating the identified deficient conditions.

Among the other releases, the OIG issued a report of *Mismanagement of the VA Executive Protection Division.* It details allegations of mismanagement and misuse of the VA Executive Protection Division by former VA Secretary David Shulkin. The OIG found that there were no published operational

policies or procedures on critical executive protection functions and a lack of adequate threat assessments. The OIG also identified several potential security vulnerabilities. Regarding Secretary Shulkin's use of the Protection Division, the OIG found that the former Secretary violated ethical regulations in allowing government resources and time to be spent transporting his spouse on several occasions. The OIG made 12 recommendations to strengthen the Protection Division's administrative and security operations.

The OIG also published the report *Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic in Salem, Virginia,* that confirmed a former VA contract doctor appears to have falsely documented patients' blood pressure readings. The OIG determined the doctor repeatedly falsified blood pressure retest readings (recording results that were just below the level at which he would have been required to conduct additional follow-up work), and failed to provide proper treatment to patients with hypertension—increasing their risk for stroke, heart attacks, and other adverse outcomes. The OIG made five recommendations related to patient care follow-up, data integrity, policy and procedure development, leadership responsiveness, and contract-related training. This was the second recent OIG report on falsified blood pressure reporting in a VA healthcare setting. The prior report on a Lexington, Kentucky, community-based outpatient clinic found that in 99.5 percent of more than 1,000 encounters, the primary care provider documented repeat blood pressure readings below the threshold for follow-up testing and treatment. High-risk patients were put at unnecessary risk of harm and several patients had adverse health events and poor treatment, including an acute cardiac event.

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