



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT MARCH 2019 HIGHLIGHTS

Toni Woodard:

This is Toni Woodard, Hotline team director with the VA Office of Inspector General in Atlanta. Here are the March highlights.

Inspector General Michael Missal testified before the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. [His testimony](#) outlined how the OIG's [Strategic Plan](#) has guided its efforts to improve VA's many programs and operations. Inspector General Missal noted major challenges facing VA, including implementation of legislation to improve access to care and changes to VA benefit processes. Recent OIG reports were highlighted at the hearing that include recommendations for VA to take corrective action that will improve benefits, care, and services for eligible veterans, their families, and caregivers.

"In keeping with our Strategic Plan, OIG will focus not only on the oversight of programmatic areas, such as VA health care and benefits, but we also examine key factors that cut across VA administrations and program offices to drive success or perpetuate deficiencies. These include VA's stewardship of taxpayer dollars, leadership and governance structures and practices, and VA's capacity for careful planning and innovation." — Inspector General Michael Missal

Among the oversight publications released in March, the OIG distributed a [report](#) that assessed the VA's information security program in accordance with the Federal Information Security Modernization Act of 2014 (FISMA). VA continues to face significant challenges complying with those requirements, resulting in 28 OIG recommendations to improve VA's information security program.

Another report, the [Review of Hepatitis C Virus Care within the Veterans Health Administration](#), examined VA's use of direct-acting antivirals (or DAAs), which can cure chronic hepatitis C infection. The report was released the same week that VA [announced](#) "it is on track to eliminate the hepatitis C virus...in as few as two months, in all Veterans willing and able to be treated." VA received over \$3 billion for its patients to receive DAA treatment. The OIG's review determined that 85.5 percent of patients who were not provided DAA treatment during the review period had acceptable reasons documented in their electronic health record or reflected patients' preferences. Moreover, an estimated 99 percent of patients studied had follow-up testing to confirm the treatment had worked. Still, the OIG, made two recommendations to address the missing documentation in the remaining patient records and to ensure that every treatment has follow-up testing to determine its success going forward.

# VA Office of Inspector General

## PODCAST TRANSCRIPT

---

The OIG also issued an [Issue Statement](#) on Forever GI Bill housing payments, which examined VA's timeline of early implementation actions and the impediments to meeting the bill's mandates. The Issue Statement discloses information previously provided to members of Congress in response to 13 members' request, with some additional context.

OIG podcasts are produced by OIG staff. You will find two others posted in March on the media section of our website related to [hepatitis c](#) and the [falsification of blood pressure readings at two VA clinics](#). For more information on the congressional hearing and all OIG March publications—or to report fraud, waste, abuse, and possible criminal activity—visit the OIG website at [www.va.gov/oig](http://www.va.gov/oig).