PODCAST TRANSCRIPT

JUNE 2019 HIGHLIGHTS

Quintin Durden:

This is Quintin Durden, a Management Analyst with the VA Office of Inspector General in Washington, D.C. Here are the June highlights.

Inspector General Michael Missal provided congressional testimony for two House subcommittees. The first was for a hearing on *Examining VA's Police Force* before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. His testimony focused on the four key areas of concern revealed in a prior OIG report, the *Inadequate Governance of the VA Police Program at Medical Facilities*. The four concerns centered on the OIG's findings regarding deficient tracking of police program operations and performance, lack of police staffing models and officer shortages, delays in inspections of police operations, and inadequate guidance on how VA police investigate alleged misconduct of facility leaders who manage the police program.

The second testimony was given before the House Committee on Oversight and Reform's Subcommittee on Government Operations on *Ensuring Quality Healthcare for Our Veterans*. Inspector General Missal's testimony highlighted the status of VA's implementation of OIG recommendations issued more than a year ago in its report on *Critical Deficiencies at the Washington DC VA Medical Center*, as well as OIG's follow-up activities. Although the statement recognized progress in such areas as incident reporting and reprocessing of surgical instruments, Inspector General Missal expressed concerns with several areas requiring continued improvement at the medical center—some of which are also being observed in other facilities across the nation such as staffing shortages.

An OIG criminal investigation resulted in an additional guilty plea from a veteran owner of a construction company who claimed to own and run a Service-Disabled Veteran-Owned Small Business, the kind of business that qualifies for certain set-aside government contracts. He pled guilty to making a false statement to a government agency about a $350 million award. A nonveteran owner of the same company pled guilty to conspiracy to commit wire fraud. The investigation revealed the veteran falsely claimed to control and operate the construction company when it was actually owned and operated by his nonveteran coconspirators. The nonveteran defendant submitted false invoices and other documentation. VA awarded $118 million in set-aside contracts to the company. When the company grew too large to compete for the small business contracts, the nonveteran used the veteran defendant's minority status to set up a second company, which was awarded an additional $11 million in set-aside contracts.

The OIG published 13 oversight reports in June including two Comprehensive Healthcare Inspection Program reports for the *Jesse Brown VA Medical Center* in Chicago, Illinois, and the *Edward Hines, Jr. VA Hospital* in Hines, Illinois. In the report *Exempt Veterans Charged VA Home Loan Funding Fees,* the OIG determined the Veterans Benefits Administration (or VBA) had inadequate controls to ensure disabled veterans who are exempt did not pay VA home loan guaranty funding fees. The OIG estimated

that VA charged nearly 73,000 exempt veterans about $286.4 million in funding fees between 2012 and 2017. The OIG recommended the Under Secretary for Benefits makes certain the Loan Guaranty Service identifies exempt veterans who were improperly charged funding fees and issues refunds and conducts ongoing periodic reviews.

Another report, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, examined clinical pharmacists who work in a mental health outpatient care setting. The OIG found that mental health clinical pharmacists did not adequately coordinate with licensed providers with prescribing authority, that inconsistent descriptions of pharmacists' duties existed among facilities, and facilities lacked a clear and standardized referral process. The OIG made nine recommendations to the Under Secretary for Health.

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