



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT JULY 2019 HIGHLIGHTS

Jessica Rodriguez:

This is Jessica Rodriguez, a Supervisory Management Analyst with the VA Office of Inspector General in Atlanta, Georgia. Here are the July highlights.

Inspector General Michael Missal testified before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations at the hearing [*Learning From Whistleblowers At The Department Of Veterans Affairs*](#). His [*testimony*](#) focused on the OIG's interactions and communications with complainants, whistleblower protections, and engagement with other agencies such as VA's Office of Accountability and Whistleblower Protection and the U.S. Office of Special Counsel. Inspector General Missal acknowledged the important role whistleblowers and other complainants play in exposing potential fraud, waste, or abuse. He emphasized the OIG's commitment to protecting the identity of whistleblowers:

"The OIG values whistleblowers and the information they provide as we explore areas for potential oversight for VA. It is incumbent upon VA stakeholders to protect whistleblowers from retaliation and foster an environment where no one fears the consequences of reporting problems or ideas for potential improvement."— Inspector General Michael Missal

Inspector General Missal also provided the keynote address at the annual Hotline Worldwide Outreach Symposium hosted by the Department of Defense in recognition of National Whistleblower Day. A broad range of representatives from federal, state, and local agencies whose staff operate hotlines around the world attended. The Inspector General's remarks focused on lessons learned from the VA OIG's hotline work, future challenges, and promising practices for supporting hotline personnel and operations. The OIG's hotline receives more than 35,000 contacts a year and is often a whistleblower's first point of contact with the OIG.

There were 15 oversight reports published in July including three Comprehensive Healthcare Inspection Program reports for the [*Cheyenne VA Medical Center, in Wyoming*](#); the [*Amarillo VA Health Care System in Texas*](#); and the [*James H. Quillen VA Medical Center in Mountain Home, Tennessee*](#). For these three facilities the OIG made 41 recommendations for improvement.

In the report [*Management of Major Medical Leases Needs Improvement*](#), the OIG reviewed the development and acquisition of 24 major medical leases authorized under the Veterans Access, Choice, and Accountability Act of 2014 (or VACAA). The OIG found that VA major medical leases authorized by VACAA are on average approximately 22 months behind schedule and made eight recommendations to assist VA to achieve timelier and more cost-efficient acquisition of major medical leases.

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Another report, *Episodes of Non-Adherence to Privacy and Security Policies at the Tibor Rubin VA Medical Center in Long Beach, California*, reviewed noncompliance with Veterans Health Administration and VA policies on the privacy and security of patient information at the medical center. The OIG found possible breaches of patient personal health information resulting from the software interface between medical devices and electronic health records, and the use of unapproved communications. The OIG made six recommendations related to communication and education, disclosure of protected patient information, VHA policy review, and compliance with the use of logbooks.

A recent OIG criminal investigation resulted in a former VA fiduciary pleading guilty to misappropriating and embezzling funds he received as a fiduciary for incompetent and disabled veterans. The defendant misappropriated and embezzled at least \$39,500 from the veterans and beneficiaries in his charge. As a result, he faces a maximum statutory penalty of five years' imprisonment and a fine of \$250,000 and restitution. For more information, see the Department of Justice news release *Former U.S. Department Of Veteran Affairs Fiduciary Pleads Guilty To Embezzling From Disabled Veterans*.

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