PODCAST TRANSCRIPT

SEPTEMBER 2019 HIGHLIGHTS

CHRISTOPHER HOFFMAN:

This is Christopher Hoffman, a Health Systems Specialist with the VA Office of Inspector General in Baltimore, Maryland. Here are the September highlights.

The OIG testified at two congressional hearings. Inspector General Michael Missal provided testimony before the House Committee on Veterans' Affairs on the critical impact that barriers to VA hiring can have on access to quality health care. His testimony focused on the challenges the OIG has identified in VA's efforts to recruit and retain a highly qualified workforce that supports and delivers health care to millions of veterans. Inspector General Missal highlighted the OIG's significant oversight efforts regarding these concerns, including recommendations for addressing occupation-specific staffing shortages, inconsistent leadership, the transparency and reliability of VA's data, and other major management issues.

> "*Although VHA has made some improvements it continues to face a number of challenges addressing its significant staffing needs. VA has experienced chronic healthcare professional shortages since at least 2015. The department must enhance its ability to maintain a robust work force in an increasingly competitive recruitment environment and with anticipated healthcare worker shortages in several practice areas*."

Assistant Inspector General for Audits and Evaluations Larry Reinkemeyer also testified before the House Veterans' Affairs Subcommittee on Technology Modernization at a hearing on the future of VA scheduling, including an examination of prior VA improvement initiatives. AIG Reinkemeyer's statement to the subcommittee focused on findings from the OIG report on VA's implementation of its scheduling software enhancement project. The OIG determined that the scheduling enhancement project management team did not effectively plan and oversee the project to ensure scheduling enhancements were adequately developed and met users' needs.

Among the OIG's criminal investigations work conducted this month, a former VA nurse was charged with one count of obtaining a controlled substance by misrepresentation, fraud, deception, and subterfuge, and one count of tampering with a consumer product. The former nurse used her position at a VA medical center to obtain doses of morphine that were to be given to the veterans under her care in a hospice unit. She mixed water with a portion of the liquid morphine doses, and then orally administered the diluted medication to patients. She then allegedly ingested a diluted amount of the remaining drug. She faces up to 11 years in prison for both charges and as much as $500,000 in fines.

The OIG published 26 oversight reports in September including five Comprehensive Healthcare Inspection Program reports for the *Tuscaloosa VA Medical Center in Alabama*, *North Florida/South Florida Veterans Health System in Gainesville*, *Hunter Holmes McGuire VA Medical Center in*

Virginia, *Sheridan VA Medical Center in Wyoming*, and the *Eastern Oklahoma VA Health Care System in Muskogee*.

The OIG published its sixth legislatively mandated report on VA medical center staffing shortages, based on medical center directors' survey responses. Of the 140 facilities surveyed, 96 percent identified at least one severe occupational staffing shortage. The most frequently cited shortages were for medical officers (particularly within psychiatry) and nurse occupations. The lack of qualified applicants and noncompetitive salaries were the most frequently noted reasons for the shortages.

In the report on *State Prescription Drug Monitoring Programs,* the OIG outlined the need for database queries that provide valuable information about controlled substances patients have received outside of VA and are critical to combatting veteran opioid abuse, overmedication, and deaths. The OIG estimated that clinicians did not annually check these databases for 73 percent of nearly 780,000 VA patients prescribed opioids in the 12-month period ending in March 2018. Not querying the databases put some veterans at greater risk of opioid abuse, adverse drug interactions, and drug diversion. The OIG made eight recommendations for improvement.

In another report, *Accuracy of Claims Decisions Involving Conditions of the Spine*, the OIG estimated the Veterans Benefits Administration incorrectly processed more than half of the 62,000 claims decided in the first six months of 2018, accounting for at least $5.9 million in over or underpayments. The OIG recommended updates to the disability rating process and better internal controls to help ensure the accuracy and consistency of claims decisions for spine conditions.

The remaining reports focused on such issues as sole-source service contracting, hospice and palliative care, construction project management at a VA medical center, inadequate beneficiary fiduciary field system controls, and failures in patient care.

OIG podcasts are produced by the OIG staff. You will find other OIG podcasts in the media section of our website. For more information on the congressional hearings and all September publications—or to report fraud, waste, abuse, or possible criminal activity—visit the OIG website at https://www.va.gov/oig/.