PODCAST TRANSCRIPT
OCTOBER 2019 HIGHLIGHTS

Lindsay Gold:

This is Lindsay Gold, a health system specialist with the VA Office of Inspector General in San Diego, California. Here are the October highlights.

Inspector General Michael Missal testified before the House Veterans' Affairs Subcommittee on Oversight and Investigations on "*Protecting Whistleblowers and Promoting Accountability: Is VA Doing Its Job?"* Inspector General Missal's statement to the subcommittee focused on the major findings from the OIG report titled *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017.* The OIG team identified a number of failings in the report, including the missteps of prior leaders of the Office of Accountability and Whistleblower Protection (or OAWP) that resulted in mistrust of the office by some VA employees and whistleblowers, the impact of which is still being felt today. His statement included this:

> "*As detailed in our report we identified significant deficiencies in the operations of the OAWP. We made six overall findings. First, that the OAWP misinterpreted its statutory mandate resulting in failures to act within its investigative authority. Second, that the OAWP did not consistently conduct procedurally sound, accurate, thorough, and unbiased investigations and related activities. Third, they struggled with implementing the Act's enhanced authority to hold executives covered by the Act accountable. Fourth, the OAWP failed to fully protect whistleblowers from retaliation. Fifth, VA failed to implement various requirements under the Act including revising supervisors' performance plans and developing supervisors training regarding whistleblowers rights. And sixth, the OAWP lacked transparency in its information management practices*."

The report, which was also released in October, identified troubling activities within each area of inquiry and made 22 recommendations to strengthen the office's operations and compliance with the Act.

Assistant Inspector General for the Office of Healthcare Inspections Dr. David Daigh also testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations for its hearing on "*Broken Promises: Assessing VA's Systems for Protecting Veterans from Clinical Harm.*" He described findings of OIG reports that identified shortcomings related to VA's credentialing and privileging processes. His testimony highlighted barriers and challenges to VHA's efforts to implement programs that ensure licensed independent healthcare practitioners have the appropriate qualifications to provide services within the scope of their license. He emphasized the need for VHA to properly manage and oversee these programs because they are key to ensuring veterans receive health care from highly qualified providers.

The OIG and Department of Justice jointly announced the establishment of their VA Health Care Fraud Task Force. The task force initially will focus on investigating and prosecuting healthcare fraud in VA's growing Community Care program. The task force is working with US Attorney's Offices nationwide.

The OIG published six oversight reports in October including one Comprehensive Healthcare Inspection Program report for the *Valley Coastal Bend Health Care System in Texas.* Also released was an overview of all Comprehensive Healthcare Inspection Program reports during FY 2018.

In another report, *Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives*, the OIG reviewed an allegation that the Milwaukee, Wisconsin, VA regional office stored veterans' sensitive personal information on network drives likely accessible to unauthorized users. The OIG team substantiated that veterans' sensitive personal information was unprotected on two shared drives, putting those affected at risk of fraud or identity theft. The OIG made three recommendations regarding training, technical controls, and oversight procedures to secure protected health information and personally identifiable information.

Other reports looked at VA's use of temporary price reductions on federal supply schedule pharmaceutical contracts and how VA manages the use of more than 50,000 mobile devices that store and transmit protected information.

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