PODCAST TRANSCRIPT

RECENT PROGRESS AND THE ROAD AHEAD

JANUARY 14, 2020

Fred Baker:

This is Fred Baker, Communications Director for the VA Office of Inspector General in Washington, DC. Joining me today is Inspector General Michael Missal to discuss the OIG's recent accomplishments and goals for 2020.

Many of the OIG's successes are chronicled in the 82nd *Semiannual Report to Congress* that was released before the 2019 holidays. It covers the OIG's oversight of VA from April 1 to September 30, 2019, and provides a useful snapshot of the OIG's activities during these six months.

Mr. Missal, what story does the semiannual report tell about the OIG's recent oversight activities?

IG Michael Missal:

The SAR highlights the productivity of our office in the second half of FY 2019, as well as the great impact we had on veterans and their families. The report highlights that the OIG issued 161 reports and other publications on VA programs and operations over the six-month reporting period. Those investigations, inspections, audits, reviews, evaluations, and other work identified more than $1.8 billion in monetary impact, resulting in a return on investment of $24 for every dollar expended on OIG oversight. The OIG made 661 recommendations to improve the operations of VA. A listing of all report recommendations is provided in a user-friendly dashboard on the VA OIG website.

As for our law enforcement activities, OIG actions led to 131 arrests for a wide variety of crimes such as fraud, bribery, embezzlement, identity theft, and drug diversion. The work of the OIG also resulted in 914 administrative sanctions and corrective actions in that same six-month period.

Fred Baker:

You mentioned the breadth of oversight activities the OIG is involved in. How do you focus your work to have the greatest impact?

IG Michael Missal:

Our mission is to provide effective oversight of VA's programs and operations. To achieve that mission, we try to focus our work on the most impactful projects, including those matters involving actual or potential harm to veterans, and system and program breakdowns that delay or deny veterans' access to the benefits, services, and the health care they deserve. Some of our more significant work during the past six months included a report on the improper denial or rejection of non-VA emergency care claims

for an estimated 17,000 veterans; the indictment of a former VA pathologist for involuntary manslaughter and other charges related to his work at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas; a report that revealed VA inappropriately charged about 72,900 veterans approximately $286.4 million in home loan funding fees from which they were exempt; and a report on the suicide of a patient in a locked mental health unit at the West Palm Beach, Florida, VA Medical Center. Although some of these appear to focus on a specific individual or incident, the issues and related recommendations are often applicable to changes needed to VA systems and practices across the nation.

To make our work as meaningful as possible, we attempt to identify the root causes of any problems identified. This provides VA with a road map for meaningful and sustained change. For example, the OIG's sixth report on staffing deficiencies within VA medical facilities that we issued during this time frame revealed that some gaps in clinical and nonclinical positions persist. This was due, in part, to the lack of a comprehensive staffing model for all key positions that would facilitate meaningful hiring, retention, recruitment, and resource allocation decision-making.

In addition, while most VA staff strive to provide the best possible services and benefits to veterans, unfortunately, there are some who do not. Our work seeks to identify those VA staff who have not acted appropriately, sometimes resulting in harm to veterans. In many cases, the harm would have been avoided or mitigated by either earlier reporting when wrongdoing was suspected, or more careful supervision by VA.

Fred Baker:

As we start a new year, what are some of your priorities for the months ahead?

IG Michael Missal:

The OIG's mission of effective oversight is all the more critical in the year ahead when VA will be executing its largest budget in history and implementing initiatives of massive scope, such as the development of an integrated electronic health records system. That program alone is projected to cost over $10 billion and take 10 years to fully implement. We will continue to execute our strategic plan that focuses on five core goals: (1) improving the quality, management, efficiency and delivery of health care in VA facilities and the community; (2) ensuring veterans and their families receive accurate benefits in a timely manner; (3) promoting the sound stewardship of taxpayer funds and helping to reduce the risk of fraud, waste, and abuse; (4) assessing the effectiveness of leadership and governance; and (5) analyzing the quality of VA's infrastructure systems, including information technology, data security, and financial management that support VA's operations.

We are committed to working with VA leaders and personnel at every level to help VA provide the best possible service to veterans, their families, and caregivers, while ensuring taxpayers' money is spent appropriately. I am grateful to have a dedicated staff guided by our core principles of independence,

transparency, objectivity, and fairness. We look forward to continuing our work with VA, Congress, veterans service organizations, and others affected by VA's actions as we address the enormous challenges facing the Department.

Fred Baker:

Inspector General Missal, thank you for your time today.

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