PODCAST TRANSCRIPT

NOVEMBER 2019 HIGHLIGHTS

TANYA OBERLE:

This is Tanya Oberle, a health systems specialist with the VA Office of Inspector General in Seattle, Washington. Here are the November highlights.

Inspector General Michael Missal testified at a hearing before the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies regarding the, "Office of Accountability and Whistleblower Protection's Failures at VA." Inspector General Missal's statement to the subcommittee focused on major findings from the recent OIG report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, that found VA failed to properly implement several key provisions of the act, as well as other authorities. The OIG made 22 recommendations to strengthen the Office of Accountability and Whistleblower Protection and increase employee accountability.

Additionally, Inspector General Missal was a guest on the news show *Government Matters* where he and host Francis Rose discussed the OIG's findings in the report.

The OIG published its *Semiannual Report to Congress,* covering the reporting period for April through September 2019. During this time, the OIG issued 161 publications on VA programs and operations, made 661 recommendations, and conducted investigations that led to 131 arrests. The OIG audits, investigations, inspections, evaluations, and other reviews identified more than $1.8 billion in monetary benefits, for a return of $24 for every dollar invested in OIG oversight.

A recent OIG criminal investigation resulted in a former VA employee, his daughter, and ex-wife being indicted for their part in a scheme to defraud the VA of healthcare benefits. The indictment alleges that the daughter and ex-wife managed two transportation companies and the former VA employee received kickbacks for awarding these companies healthcare contracts to transport veterans needing medical treatment. As a result, the defendants were charged with conspiracy to commit healthcare fraud and wire fraud. For more information, see the Department of Justice news release *Former VA Employee And Two Family Members Indicted With Defrauding Veterans Healthcare In The Villages*.

The OIG published 15 oversight reports in November including eight Comprehensive Healthcare Inspection Program reports. In the report *VHA Did Not Effectively Manage Appeals of Non-VA Care Claims*, the OIG found significant deficiencies with Office of Community Care's Payment Operations and Management (POM) directorate's administration of appeals for non-VA care claims decisions. The OIG concluded that VHA and the POM directorate failed to effectively oversee appeals management and processing before and after implementation of the new law. Additionally, the report noted VHA did not effectively prepare for the new appeals process and faces significant challenges in identifying and processing appeals.

In another report*, Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System*, the OIG reviewed allegations of deficiencies in quality of care and administrative processes that contributed to two patient deaths by suicide and one patient's self-harm behavior at the Alaska VA Healthcare System's outpatient Social and Behavioral Health Services. The OIG substantiated several concerns including that facility staff failed to follow Veterans Health Administration and facility missing-patient policies; patients did not have follow-up appointments scheduled as indicated in the providers' order; and providers were sometimes double-booked while providing same-day access coverage. The OIG made 11 recommendations related to Behavioral Health Service's policies and procedures, Same Day Access Clinic coverage, scheduling processes, implementation of the Behavioral Health Interdisciplinary Program and concerns with the Mental Health Treatment Coordinator, behavioral health emergency plans, and the culture of the facility.

Other reports reviewed Do Not Attempt Resuscitation orders, surgical and sterile processing services, possible disclosure of third-party information when responding to Privacy Act requests, VA's compliance with the Digital Accountability and Transparency Act of 2014, and allegations involving ophthalmology equipment-related maintenance. Additionally, the eight Comprehensive Healthcare Inspection Program reviews published in November resulted in 101 recommendations for improvement.

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