PODCAST TRANSCRIPT
APRIL 2019 HIGHLIGHTS

Meredith Majerle:
This is Meredith Majerle, a Supervisory Management Analyst, with the VA Office of Inspector General in Kansas City, Missouri. Here are the April highlights.

Inspector General Michael Missal gave a presentation to more than 140 attendees at the New England Intergovernmental Audit Forum in Boston, Massachusetts, who had gathered to discuss effective leadership, change leadership, and practices in data-driven management. His conference presentation, “Leadership in a Changing Environment,” detailed the steps leaders and personnel in any organization can take to improve its work environment and create a culture that encourages positive change.

Inspector General Missal and Comptroller General of the United States Gene L. Dodaro, who also serves as the head of the Government Accountability Office (or GAO), met to discuss GAO’s 2019 High Risk List. The High-Risk List includes over 30 areas considered to be at high risk for waste, fraud, abuse, or mismanagement, or in need of transformation. The OIG and GAO have complementary oversight responsibilities regarding VA, which makes coordination of particular importance. Among the concerns they discussed was the addition of VA’s acquisition management to the High-Risk List.


The OIG’s Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testified before the U.S. House Committee on Veterans’ Affairs’s Subcommittee on Technology and Modernization. His testimony focused on the effectiveness of VA’s information security program, the progress made, and challenges VA continues to face in developing the systems needed to effectively carry out their mission:

“Our audits have shown that IT systems development and management at VA is a longstanding high-risk challenge. Despite some incremental advances, our reports indicate VA IT programs are still often susceptible to cost overruns, schedule slippages, and performance problems.”

The OIG’s Criminal Investigations division recently closed an investigation that resulted in the conviction and sentencing of a man for his scheme to defraud the VA of disability benefits. The man exaggerated his disability to receive the VA’s 100 percent disabled rating when in fact he was rated at 10 percent. As a result, he defrauded the VA of $1.3 million over approximately 36 years. He was sentenced to 12 months in prison and ordered to pay over $1.2 million in restitution to VA.
The OIG published two oversight reports in April. In the report *Quality and Coordination of a Patient’s Care at the VA Eastern Colorado Health Care System*, the OIG reviewed a complainant’s allegations and substantiated that the facility’s care providers, at the time of a patient’s most recent hospital admission, failed to complete thorough evaluations including reconciliation of medications. The OIG made eight recommendations related to medication reconciliation, provider education, infection source, care transitions, discharge planning, podiatry clinic scheduling, wound care clinic consults and practices, and resident supervision. In the second report, *Review of Delays in Clinical Consult Processing at VA Boston Healthcare System*, the OIG reviewed a complaint that staff inappropriately discontinued consults. The complaint was not substantiated and the OIG did not make further recommendations.

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