



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT

JUNE 2018 HIGHLIGHTS

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Allyson Pokres:

This is Allyson Pokres, with the VA Office of Inspector General in Washington, D.C. Here are the June highlights.

Inspector General Michael Missal testified before the House Committee on Veterans' Affairs Subcommittee on Health for its hearing on *More Than Just Filling Vacancies: A Closer Look at VA Hiring Authorities, Recruiting and Retention*. The hearing examined Veterans Health Administration staffing shortages. It also focused on the impact of the provisions of the *VA Choice and Quality Employment Act of 2017*. Central to the discussion was the OIG's recent report *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*. Inspector General Missal's testimony highlighted the differences between this report and its four predecessors, noting that the most recent iteration of the report reveals the self-reported gaps in both clinical and nonclinical occupations for 140 VA medical centers.

"Medical center directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG's four previous VHA staffing reports. Our analysis showed that 138 of 140 facilities listed the medical officer occupational series as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities, 108 listed the nurse occupational series as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported." – Inspector General Michael Missal

In June the OIG published eight oversight reports including three Comprehensive Healthcare Inspection Program reviews (or CHIPS).

Another OIG June report, *FY 2017 Risk Assessment of VA's Charge Card Programs*, revealed a medium risk of illegal, improper, or erroneous purchases to VA's different charge card programs. The OIG's data mining of purchase card transactions identified potential misuse of those cards. The OIG's ongoing investigations, audits, and reviews will continue to monitor and identify any patterns of purchase card transactions that do not comply with the Federal Acquisition Regulations or VA policies and procedures.

Also, the OIG released CHIP reports on the Memphis VA Medical Center, the Phoenix VA Health Care System, and the VA Hudson Valley Health Care System in Montrose, New York. The CHIP reviews include a focus on how leadership impacts the quality of care delivered in the inpatient and outpatient

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settings of the facilities. For these three facilities, the OIG issued a total of 32 recommendations for improvement in the oversight reports. Additional CHIP reports and other OIG reports can be found on the website publications page.

For more information on these and other OIG activities, or to report waste, abuse, mismanagement, fraud, or other possible criminal activity, visit the OIG website at V-A dot G-O-V backslash O-I-G.