PODCAST TRANSCRIPT

SEPTEMBER 2018 HIGHLIGHTS

SEPTEMBER 2018

Mitzyn Pierce:

This is Mitzyn Pierce, a congressional relations specialist with the VA Office of Inspector General in Washington, DC. Here are the September highlights:

Dr. David Daigh, Assistant Inspector General for Healthcare Inspections, testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, on the OIG's prior oversight work concerning the sterile processing of reusable medical equipment by Veterans Health Administration facilities. High-quality sterile processing of reusable instruments and equipment is critical to patient safety, yet has traditionally been difficult for VA to consistently deliver. Dr. Daigh highlighted specific instances from recent OIG reports showing that improper sterile processing has resulted in canceled surgeries and delays in procedures, inefficiency due to repeat processing, and increased risk of patient harm. These reports include *Critical Deficiencies at the Washington, DC VA Medical Center; Healthcare Inspection – Delayed Access to Primary Care, Contaminated Reusable Medical Equipment, and Follow-Up of Registered Nurse Staffing Concerns, Southern Arizona VA Health Care System*, *Tucson, Arizona;* and various Comprehensive Healthcare Inspection Program or (CHIP) reviews.

In September, the OIG published 27 oversight reports covering a broad range of VA programs. In the report *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota,* the OIG examined the care of a patient who was admitted to the inpatient mental health unit and died from a self-inflicted gunshot wound less than 24 hours after discharge. Among other findings, the OIG determined the inpatient treatment team failed to collaborate with outpatient providers, facilitate outpatient medication management, and educate the patient about limiting firearms access. The Suicide Prevention Coordinator did not collaborate with the treatment team, determine the need for a patient record flag prior to discharge, or provide required training. Although the OIG did not determine that identified deficits caused the patient's suicide, it made seven recommendations related to improving care coordination, documentation, training, and administrative processes.

In response to two non-fatal opioid overdoses involving residents of a clinical rehabilitation and treatment program operated at a VA facility in New York, the OIG assessed concerns regarding illicit fentanyl use and urine drug screening practices at the facility. In the resulting report, *Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York,* the OIG made eight recommendations related to drug screening

guidelines, timely laboratory turnaround times and result notifications, and other concerns. This report will be the subject of a separate companion podcast in October 2018.

In another report, *Review of Accuracy of Reported Pending Disability Claims Backlog Statistics*, the OIG found that although the Veterans Benefits Administration (VBA) reported it had reduced its claims backlog by 88 percent (from a peak of 611,000 claims in March 2013), its reported backlog included only about 79 percent of all claims that were awaiting rating decisions for more than 125 days. The OIG found that what the backlog represented was not always clearly defined, possibly resulting in significant understating. More importantly, VBA's prioritization of its backlog resulted in delays in processing other claims, even if they were older and required rating decisions. The OIG recommended that VBA reconsider which claims are reported in the disability claims backlog and provide a clear definition. Also, the OIG recommended VBA implement a plan to provide consistent oversight and training of claims assistants.

Other OIG oversight reports published in September included *VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016*, *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, and *VA Policy for Administering Traumatic Brain Injury Examinations*.

Of the 27 reports, seven were CHIPs. These CHIP reviews include a focus on how leadership impacts the quality of care delivered in the inpatient and outpatient settings of the facilities. The seven facilities inspected were the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas; the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois; the Battle Creek, Michigan, VA Medical Center; the Gulf Coast Veterans Health Care System in Biloxi, Mississippi; the Northport, New York, VA Medical Center; the Oklahoma City, Oklahoma, VA Health Care System; and the Roseburg, Oregon, VA Health Care System. For these seven facilities, the OIG issued 47 recommendations for improvement.

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 slash O-I-G.