

VA OIG Podcast Transcript 20171231-7

OIG Highlights December 2017

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[Quintin Durden] This is Quintin Durden with the VA Office of Inspector General. I am a the Deputy Director for the HR and Operations Division within the Office of Management and Administration. Here are December's highlights.

The OIG launched its new page on the social media site LinkedIn, which is the best known professional networking site with more than 400 million users worldwide. The LinkedIn page will help raise awareness of the OIG's work so that veterans, stakeholders, and potential job applicants can learn more about what we do. You can find the VA OIG on LinkedIn by searching for Department of Veterans Affairs, Office of Inspector General and follow us to receive periodic updates about job postings, various directorate activities, employee testimonials, and OIG in the news. The LinkedIn page will complement such other social media offerings as the OIG's new podcasts and Twitter, which you can connect to on our website.

Inspector General Michael Missal participated in a number of stakeholder and field events, including presenting at the Veterans Health Administration National Leadership Council meeting. IG Missal spoke to VA's health care leaders about recent OIG accomplishments, such as the launch of a newly designed series of Comprehensive Health Inspection Program (or CHIP) reports and our work being done on national reviews of critical issues.

The OIG's Bay Pines, Florida, office hosted the Inspector General where he met with staff, received project updates, and participated in the unannounced inspection of the Bay Pines VA Health Care System as part of a scheduled CHIP review. He spoke with patients, facility leaders, and observed how OIG teams conduct inspections in the field.

The OIG published eight oversight reports in December that addressed a wide range of important issues from leadership in particular medical facilities, to manipulation of benefit appeal data, and allegations related to a patient's death. As one example, the *Review of Alleged Mismanagement of the Real Time Location System Project* report

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examined the VA's efforts to implement tools to automate and improve how medical items can be tracked and monitored within health care settings. The OIG found that managers failed to comply with VA policy and guidance during implementation and when it deployed assets for the system without appropriate project oversight or meeting VA information security requirements.

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.