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OIG Highlights February 2018
February 2018

[Ashley Shingler] This is Ashley Shingler, an investigative analyst, with the VA Office of Inspector General in Washington, D.C. Here are February's highlights.

Inspector General Michael Missal and senior staff participated in several meetings on Capitol Hill to brief members and staff on recently published OIG reports and ongoing initiatives. These meetings provided valuable opportunities to discuss the OIG's work, demonstrate our commitment to transparency, and better understand the concerns of lawmakers and their constituents.

Inspector General Missal also met with other Inspectors General from the Department of Justice, U.S. Postal Service, Department of Homeland Security, and Department of Health & Human Services regarding the federal government's response to the nation's opioid crisis. The IG's shared information pertaining to their opioid oversight work and explored potential opportunities for conducting joint initiatives.

The VA OIG published 17 oversight reports in February. The Administrative Investigation – *VA Secretary and Delegation Travel to Europe* received significant media, Hill, and public attention. In this report, the OIG investigated an anonymous allegation through its Hotline that Secretary of Veterans Affairs David Shulkin and other senior leaders misused VA funds in connection with travel to Copenhagen and London.

Other OIG oversight reports reviewed important issues to include allegations of abuse of veterans in medical foster homes, a review of traumatic brain injury benefit examinations, as well as excessive lease costs and handicap accessibility issues at a VA clinic.

Also, the OIG conducted Comprehensive Healthcare Inspection Program Reviews (or CHIPS) at the *Jonathan M. Wainwright Memorial VA Medical Center, Hampton VA Medical Center*, *Robert J. Dole VA Medical Center, and Wilkes-Barre VA Medical Center. Reviews were*

also conducted for the Health Care Systems of Northern California, Miami, Black Hills South Dakota, New York Harbor, Central Alabama, West Texas, and Alexandria Louisiana. The CHIP reviews include a focus on how leadership impacts the quality of care delivered in the inpatient and outpatient settings of the facilities. For these 11 facilities, the OIG issued a total of 109 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 backslash O-I-G.