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OIG Highlights March 2018
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[Rich Roa] This is Rich Roa, a congressional relations specialist with the VA Office of Inspector General in Washington, D.C. Here are the March highlights.

Inspector General Michael Missal and senior staff briefed lawmakers and their staff on the findings of the OIG final report on *Critical Deficiencies at the Washington DC VA Medical Center.* The report details how leaders at the medical center and in VA regional and national oversight positions had repeatedly been made aware of—and failed to remediate—long-standing problems with core hospital services that affect the delivery of patient care. These ranged from problems with getting supplies to patient care areas when needed to issues with having sterile instruments ready for use in time for scheduled procedures. That there were no adverse outcomes for patients found was due in large part to the efforts of dedicated front-line healthcare providers. The VA has reported some progress and provided action plans for implementing the 40 OIG recommendations made in this report.

Among his meetings with other agencies, Inspector General Missal attended the annual coordination meeting between the Council of the Inspectors General on Integrity and Efficiency and the U.S. Government Accountability Office (or GAO). The meeting was a valuable opportunity for Inspectors General and GAO executives to discuss major initiatives, emerging issues, and efforts to avoid duplicative work.

The OIG published 30 oversight reports in March on a range of significant subjects. Topics included quality of care concerns at medical centers, drug control policy, contract mismanagement, concerns regarding patient resuscitation procedures, wait times, Choice access, vocation rehabilitation payments, and consult management in Veterans Integrated Service Network 15.

Of note, the OIG's *Audit of the Personnel Suitability Program* evaluated controls over the adjudication of background investigations

at VA medical facilities for the five-year period ending September 30, 2016. The report found that VA did not provide effective governance of the program that was needed to ensure that background investigation requirements were met at VA medical facilities nationwide.

Also, the OIG conducted Comprehensive Healthcare Inspection Program reviews (or CHIPS) at the *Martinsburg VA Medical Center in Martinsburg, West Virginia*; the *Samuel S. Stratton VA Medical Center in Albany, New York*; the *VA North Texas Health Care System in Dallas, Texas*; the *Fayetteville VA Medical Center in North Carolina;* the *Illiana Health Care System in Danville*, Illinois*;* the *Tennessee Valley Healthcare System in Nashville, Tennessee;* the *Nebraska-Western Iowa Healthcare Center in Omaha, Nebraska;* the *Providence VA Medical Center in Rhode Island;* the *J. Zablocki VA Medical Center in Milwaukee, Wisconsin;* and the *Jonathan M. Wainwright VA Medical Center in Walla Walla, Washington*. 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 ten facilities, the OIG issued a total of 92 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.