**VA OIG Podcast Transcript 20171206-6**
OIG Highlights November 2017
November 2017

[Crystle Poge] Hi, I am Crystle Poge with the VA Office of Inspector General Information Release Office and here are November's highlights.

The OIG published its *Semiannual Report to Congress* (or SAR), that chronicles the office's oversight of the Department of Veterans' Affairs between April 1 and September 30, 2017. During that six-month period, OIG issued 194 reports and work products on VA programs and operations. Those products identified more than $9 billion in monetary impact, for a return on investment of $134 for every dollar expended on OIG oversight. The SAR is available on the OIG's website.

Inspector General Michael Missal testified before the Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. The hearing was on *VA Efforts to Prevent and Combat Opioid Overmedication*. Mr. Missal's remarks focused on VA's recent efforts in this area and the findings and recommendations from our recent report, *Healthcare Inspection—Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*.

[Inspector General Missal] "*…with increasing opioid overdose deaths, the emphasis has appropriately shifted to opioid dose reduction, increased assessments, and closer monitoring of patients on chronic opioid therapy…*"

[Crystle Poge] As part of the Veterans Day celebrations, Inspector General Missal attended the U.S. Senate's Veterans Appreciation Reception at the Russell Senate Office Building and then the National Veterans Day Ceremony at Arlington National Cemetery, where he was joined by OIG staff to honor our nation's men and women who have served.

The OIG published 13 oversight reports in November. Of note were the first in a series of revamped Comprehensive Healthcare Inspection Program Reviews (or CHIPS) that have been tailored to better convey

the state of particular systems or facilities. This month's CHIPS focused on the *VA Long Beach Healthcare System* and *the James J. Peters VA Medical Center, Bronx, New York.* The CHIP reviews replace the OIG's Combined Assessment Program (CAP) and Community Based Outpatient Clinic (CBOC) reviews. CHIP reviews provide a focused evaluation of the impact that VHA leadership has upon the quality of care delivered in the inpatient and outpatient settings of the facility. The review covers key clinical and administrative processes that are associated with promoting quality care.

In our audit, *Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System*, the OIG substantiated that staff improperly used unofficial wait lists for group therapies.

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