This is Dana Agundez, with the VA Office of Inspector General in San Diego. Here are the July highlights.

Inspector General Michael Missal and Deputy Inspector General David Case attended the commemoration event marking the 40th Anniversary of the passage of the Inspector General Act of 1978. The program was hosted by the Council of the Inspectors General on Integrity and Efficiency (or CIGIE) at the U.S. Capitol Visitor Center. The daylong event reflected on the influence and accomplishments of the Inspector General community over the last four decades in preserving the integrity of and public faith in government, and reinforced the continuing importance of independent oversight.

Inspector General Missal also met this month with the Inspectors General from the United States Postal Service, Departments of Defense, Health and Human Services, Homeland Security, and Justice. They continued their discussions on the challenges that government agencies and the OIG community faces in developing responses to the nation’s opioid crisis. The group is working to better understand these challenges, current response efforts, and possible opportunities for future cooperative OIG work on opioid abuse matters.

In July the OIG published nine oversight reports, including two Comprehensive Healthcare Inspection Program reviews (or CHIPS).

In the oversight report Unwarranted Medical Reexaminations for Disability Benefits, the OIG reviewed whether Veterans Benefits Administration (or VBA) employees required disabled veterans to submit to unwarranted medical reexaminations. The VBA may request reexaminations for veterans if there is a need to verify the continued existence or the current severity of a disability. Examinations are an important tool to ensure taxpayer dollars are used only as required to address veterans’ needs—which in some cases can improve over time—but unwarranted reexaminations cause an undue hardship for veterans and waste money. The OIG found that from March through August 2017, VBA spent $10.1 million on unwarranted reexaminations. That means that VBA would waste an estimated additional $100.6 million over the next five years unless it ensures that VBA employees only request reexaminations when necessary. The OIG made four recommendations, including establishing internal controls to ensure that each reexamination is necessary.
In another oversight report, the OIG reviewed circumstances surrounding a patient’s death from a heroin overdose in the report *Patient Overdose Death in the Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility*. The inspection determined that the program lacked protocols, processes, and policies for initiating medication-assisted therapy, for tracking patients’ no-shows for the substance abuse day program, and for updating urine drug test procedures. OIG staff also found deficiencies in the Cardiopulmonary Resuscitation committee’s review of code delays. The OIG made three recommendations related to medication-assisted therapy initiation, the no-show policies, and staff training on no-show procedures.

The CHIP reports released this month focused on the San Diego Healthcare System and Palo Alto Health Care System. 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 two facilities, the OIG issued 13 recommendations for improvement.

The OIG’s Criminal Investigations Division concluded a joint investigation with the Office of Personnel Management’s Office of Inspector General. That investigation resulted in the conviction of a VA field examiner for wire fraud, mail fraud, financial conflict of interest, theft of public money, and making false statements. The field examiner schemed to defraud a disabled and incompetent veteran of over $680,000.

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.